Trauma and Gender in Natural Disaster and Conflict Contexts: A Comparative Study of Aceh, Indonesia and the Deep South of Thailand

Thesis submitted by
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Content Note

Before reading this thesis, readers should read the warning statement below.

Research reported in this thesis involved collecting the stories of people who have experienced natural disasters and violent conflict in order to promote the values of peace and development. Some of the material in this thesis may have an adverse effect on readers.

The thesis contains explicit reference to experiences of violence and psychological trauma which may be potentially triggering and unsuitable for:

- people who have experienced conflict
- people who have experienced natural disasters
- people who have experienced other social problems, such as sexual abuse or domestic violence

Some readers may be affected by the narratives contained in this thesis despite the writer's efforts to avoid gratuitous reference to violence and trauma in the content. In the event reading evokes an emotional experience of traumatic events, suggestions are to:

- stop reading
- take time off and return later
- skip reading the section in question

Any reader who has experienced traumatic events or PTSD should consider not reading this thesis.

The benefit of this thesis is that it identifies sources of psychological trauma after examining descriptions of their experiences by people who have experienced particular natural disasters and conflict, along with other social problems. This is sociologically important in order to better understand at a macro level how trauma is experienced in general, by humans in natural disaster or conflict situations or similar.

Abstract

This thesis investigates connections between psychological trauma, disaster and social relationships in the context of two sites with recent experience of natural disasters and violent conflict: first, Aceh, Indonesia, which was heavily impacted by the 2004 Indian Ocean tsunami and experienced almost thirty years of secessionist conflict between 1976 and 2006; and second, the Deep South of Thailand, which was impacted by storm surge on 11 November 2010 and which has experienced ongoing separatist insurgency since 2004. The broad aim of this study was to sociologically examine how people experienced and responded to the emotional and mental health impacts of natural disasters on top of violent conflict, including the ways in which these experiences and responses were shaped by a variety of social relations including gender, ethnicity, family and institutional arrangements for healthcare. Additionally, this research aims to find out more about how psychological trauma has been influenced by other social problems. These aims contribute both to sociological understanding of disasters and conflict and to the ways in which governments and aid organizations respond to interacting sources of psychological trauma.

Psychological trauma is deeply experienced through the bodies and affective practices of human action and yet simultaneously conceived and introduced through the professional discourses of medical-psychological sciences and relief agencies in Aceh and the Deep South of Thailand. In this manner, the thesis treats psychological trauma as both a personal and a collective, a material and a symbolic, phenomenon.

Descriptive research methods – including semi-structured interviews and observation – were used to investigate and describe the experiences of people exposed to natural disasters while living in a conflict situation. More than 300 participants were interviewed from the two research sites. Visual sociology was also used as a means to explore the experience of psychological trauma, to involve participants who found it difficult to explain their experiences, and to connect across languages.

The results show how the effects of violent conflict and other existing social problems (such as social inequality), along with cultural and religious beliefs, are embedded within the psychological trauma associated with natural disasters. The traumatic impacts of disasters, in other words, cannot be dissociated from those who experience violent conflict or social inequality. Across both sites, people reported common symptoms of psychological trauma – guilt, grief, nightmares, sadness, anger, insomnia, social withdrawal, forgetfulness, body freezing, shock, panic attacks, anxiety, feelings of helplessness, hopelessness, emptiness, loss and avoidance. While participants could describe how symptoms such as these changed over time it was clear that the relationships between sources and symptoms were varied and complex.

The impact of traumatic events was mediated by social institutions and processes in a number of important ways. Grief, for example, associated with the loss of spouses, children and parents were compounded by changes in family and parenting roles forced upon survivors. Many respondents were poorly prepared to assume caring responsibilities and struggled with cultural and gender role expectations as well as with low levels of institutional and extended family support. Injury and disablement introduced additional stresses to families as respondents struggled with stigma (and associated feelings of shame and weakness), dysfunctional sexual relationships, family conflict and violence and disruption to livelihoods. For young people, anxiety and mental health symptoms associated with exposure to traumatic events were compounded by adults' emotional reactions – the grief of parents amplifying fears over security and safety. Sexual abuse, forced recruitment as child soldiers, and other forms of exploitation added layers of complexity to the psychological trauma experienced by young people.

The experience was also mediated by interaction with psychological trauma with healthcare actors, include modern healthcare, local healthcare and family healthcare toward people who have mental illness. Patients were stigmatized by their illness in different social contexts. Male patients were stigmatized as lazy, unemployed, drug addicted, aggressive and poorly educated. Female patients were stigmatized as divorced and associated with rape and domestic violence. Lock-up with *Pasung* and other forms of abuse and neglect intensified the psychological trauma experienced by patients, as did the restriction of medical resources – medical staff, budgets, supplies and equipment. Psychological trauma symptoms are hard to identify due to stigmatization, social discrimination, stereotyping, local cultural beliefs, and violent conflict history.

While psychological trauma is often treated as the domain of psychology or health, it is simultaneously a sociological phenomenon and needs to be understood within the context of social relationships and networks. The outcomes of this research make a significant contribution to sociological understanding of how people experience and respond to emotional and mental health impacts of interacting sources of psychological trauma including natural disasters and violent conflict. Moreover, it is socially significant in terms of identifying the social factors that cause or amplify symptoms of mental illness following traumatic events.

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Chapter 1

Introduction

When I describe my research project, I ask members of the audience to: 'imagine yourself as a nine-year-old child who witnesses losing their father as a result of violent conflict. Then, the following day you lose your mother, sister, brother, friends, and members of their community in a natural disaster. Furthermore, your life before these disasters strike was extremely poor and blighted by domestic violence'. Then, I ask: 'How can you rebuild your life after a series of catastrophic events?' There is usually no answer from audiences when I ask them to express their feelings. It seems that everyone is rendered speechless. I tell the audience that these people's experiences are the starting point for my research. This research set out to explore, from a sociological perspective, how people experience and respond to the emotional and mental health impacts of natural disasters and violent conflict.

What is a disaster? Gill (2007, P.616) argues that, from a sociological perspective:

> what makes an event a disaster is not just physical destruction of a built environment or damage to a natural environment. Disasters are defined by people's experiences with and reaction to an event. That is, disasters are socially defined and their physical effects cannot be understood apart from their social context.

In this research, therefore, disasters have been conceptualized in relation to people's experiences and the ways in which people have responded to disaster events in their social context.

How is this research different from other research into trauma associated with natural disasters? Specifically, the research examines the impact of both natural disasters and violent conflict. In 2004, a tsunami and earthquake affected 14 countries in the Indian Ocean. At least two of these countries, Indonesia (Aceh region) and Sri Lanka, had experienced violent conflict for a period before they were struck by this natural disaster. Experience demonstrates that we are ill-prepared to cope with multiple kinds of disasters impacting in the same place and at the same time (Billon and Waizenegger, 2007). In addition, many people living in areas at greater risk of conflict, such as in Indonesia's Aceh Province, are afflicted with poverty (Rice, Graff and Lewis, 2006), social inequality (McCarthy, 2007), gender violence (Blackburn, 1999), and other social problems (Liss, 2007), all of which are implicated in the experience of psychological trauma. Yet aid organizations have been accused of ignoring many in Aceh who were victims of both violent conflict and natural disasters (Zeccola, 2011). Limited understanding, it seems, of the complexity of these interrelated sources of

trauma can result in reduced action to assist those affected most by the compounding impacts of natural disasters, violent conflict and other social problems.

This thesis is thus focused on the emotional and mental health impacts experienced by persons living in Aceh, Indonesia who were impacted by both a major tsunami on 26 December 2004 (that resulted in approximately 100,000 deaths) and by almost thirty years of conflict (also leading to an estimated 100,000 deaths). The other study site is the Deep South of Thailand, which was impacted by storm surge and other types of natural disaster which left an unknown number of dead, as well as experiencing almost ten years of violent conflict from 4 January 2004 with the resulting total number of dead at more than 6,000 (Chongsuvivatwong, Boegli and Hasuwannakit, 2014).

Background to the Research

The scientific method is predicated on the idea that researchers should position themselves as neutral observers. Yet since at least the late 19th Century questions have been asked about the truly 'neutral' state of social science research, especially the relationship between the researcher and social world through the process of data collection to data analysis (Giddens, 1993; Smith, 1983). As researchers interact with the field, their informants, the literature, personal interests and experiences, along with characteristics such as gender, race, class and ethnicity, all potentially influence the questions researchers ask and the ways in which they interpret data (Denzin and Lincoln, 1994). The experience of research itself can be intensely personal and emotionally challenging. Understanding something of the background of the researcher can be important, consequently, in examining potential biases and encouraging an open and reflexive attitude toward the data.

Thus, I would like to present some of my own story as it relates to natural disasters and violent conflict. This will help not only to answer the question about how my experiences have shaped this research but also to examine my motives and biases, and to acknowledge my limitations. Hence, I present my background in two parts: my personal experience, and my work experience.

My Personal Experience

I grew up in Bangkok, as a child born from a cross-cultural marriage. My mother is Thai-Buddhist and my father is Melayu-Muslim from Rueso, Narathiwat province in the Deep South of Thailand. My mother converted to Islam after her marriage to my father. My earliest memories are of growing up in Bangkok with my family from my mother's side. But almost every summer, I spent time with my family from my father's side, learning what to 'do and don't do', moving from Thai

culture to Melayu culture, from Buddhism to Islam, as I was living among people of a completely different culture. I am a Muslim. I was taught, without any explanation, that if someone practices a Buddhist ritual I was not allowed to participate – only to watch. Obviously, I do not expect myself to completely understand everything that I observed during fieldwork. My memories of living in the Deep South of Thailand are of a happy life filled with love, fun, peace and beauty before the violent conflict erupted on January 4, 2004. I learned about the conflict from television. The conflict in the Deep South of Thailand became headline news in every Thai newspaper for many years to come. At that time, I was 28 years old and working in Bangkok.

The public perception of the conflict of 4 January 2004 centred on weapons being stolen from the Rajanagarind (Pileng) Army Camp in Narathiwat's Sukirin district, the Deep South of Thailand, leaving four military personnel dead.

The following day, the Thai government declared martial law in four southern provinces – Pattani, Yala, Narathiwat, and four Amphoe within Songkhla. The four Amphoe of Songkhla are Chana, Na Thawi, Thepha, and Saba Yoi. In 2013, Amphoe Sadao was added. The civil conflict continues to this day and more than six thousand people have been killed. There are many causes of discontent in this part of Thailand, including separatist aspirations, injustice, unequal development, history, ethnic discrimination, Thai centralization and environmental destruction.

Personal Experiences of Natural Disaster

I have experienced natural disasters in both Indonesia and the Deep South of Thailand.

On May 27, 2006, I was conducting research in Yogyakarta, Indonesia, when an earthquake erupted. The earthquake's epicentre was in the Indian Ocean, about 37 kilometres to the south.

On that day, more than 5,000 people were killed and more than 30,000 injured. Nearly 600,000 houses were destroyed or damaged. Approximately 1,200,000 people were left homeless. After the earthquake, I saw a huge crowd running away and preparing for evacuation because they though a tsunami might follow the earthquake as had happened in Aceh. Although their fear was unfounded, their actions affected me, namely, screaming and panicking – images of the tsunami appeared in front of me immediately. My housemate and my neighbours shouted, 'run to the top of the apartment!', while they were escaping by motorcycle and car. I hoped I might not get wiped away by the giant wave if it really was coming. A few days before the earthquake, near my accommodation, Merapi Mountain began erupting. So, over the period of one day I had experienced elements of three kinds of natural disaster – earthquake, volcanic eruption and feared tsunami.

In the Deep South of Thailand, I lived through another natural disaster on November 1, 2010. On this day, the storm surge flooded many coastal areas. Pattani Bay, near where I was living, was severely damaged. More than three hundred houses were destroyed or damaged by the surge. The number of deaths was never revealed. But many people lost family members or witnessed family members affected by the storm surge and are still traumatized.

Later on, I became involved in a group of environmental NGOs which had strong connections with local people, especially in the flooded areas. I began by collecting data on victims and distributing aid, but then I established Pattani Bay Watch, an informal disaster preparedness network group. My aim was to gather the villagers, scholars from Prince of Songkhla University (PSU), and local government officers, and work out ways to prepare for the next disaster. To organize the Pattani Bay Watch network group, I drew on my experience working with medical doctors and staff from the epidemiology, medical faculty and nursing faculty, PSU, Hat Yai campus, Thailand since 2005.

My Experience of Violent Conflict

Dealing with my own psychological trauma was another challenge when conducting research in conflict zones, especially when listening to stories similar to my own experiences. As a direct consequence, I reflected on the most traumatic violent conflict experience told to me, and the stories that inspired me to conduct this research.

Experience of Traumatic Violent Conflict

On September 1, 2005, four of my students were riding motorcycles on the main road from Pattani to Yala when one of them was fatally shot. The local news online report attributed the death to rebels who were inciting violent conflict. However, there was another side of the story that was never shared with the public, a side that left me shocked, stunned and confused.

For many months following the shooting, almost all students and lecturers believed my student was killed because he was participating in one of my research studies. During the funeral, one of the survivors told me the group had gone to Yala by themselves, and the shooting was not related to me. He said that he had heard his friends speculate that I was the cause of the attack. ‘It is not true,’ he said. Two weeks after the funeral, another student who also survived the shooting called me, asking my forgiveness. This student told me that they were lying to their parents because they wanted to ride motorcycles with friends for a trip, and their journey was not related to my class. Nonetheless, being considered the cause of a person’s death affected me deeply. Five years after the incident, I was unable to share this story with anyone even though, as a lecturer working within the conflict zones

since 2005, I had been exposed to many outbreaks and outcomes of violence including the sounds of bombing, shooting, crime scenes, visiting victims, going to funerals, and many more. None of this prepared me for the death of my student who was fatally shot on the road.

Inspiring Situations

I was inspired by another experience. I was looking after two of my female students – one Muslim and one Buddhist – who were traumatized by their experience of violent conflict. As a lecturer who taught students under conditions of violent conflict, I liked to make friends and enquired about their condition. Once I had gained their confidence, I discovered both wanted to commit suicide. Convincing these students to meet a psychiatrist and psychologist and undergo treatment was not easy. One told me she had previously been used as a case study without permission, even though the presentation did not mention her name, and the other told me she was afraid her condition would become widely known. I established trust with the students after considerable discussion and I drove them only once to visit the psychiatrist. However, the students were prescribed medication that made them both sleepy, so the visits were stopped. However, despite my efforts to persuade the students to receive the assistance of a psychologist, the students rejected my appeals, stating 'You (researcher) have no psychological expertise. You should not deal with anyone who has psychological trauma'. I really felt the sting of their retort – and the limitations of my knowledge. At that time, I felt the gap and the limitations of my psychological knowledge, with the consequence that I could not engage fully in my situation.

The sensitivity of traumatized persons to being treated by non-professionals was confirmed later in my discussions with NGO workers who had themselves tried to counsel victims of violent conflict. They complained that some professional psychologists and scholars had rejected their action of counselling because they were not professional psychologists.

So, in short, having grown up in a multicultural family, and having lived through natural disasters and violent conflict, I am interested to conduct research into the sociological aspects of people traumatised by both violent conflict and natural disasters, especially those who have not only experienced both violent conflict and natural disasters, but who were confronted with ethical and cultural challenges when trying to seek and receive help.

Work Experience

I gained considerable experience talking to members of various ethnic communities whilst conducting my research in the Deep South of Thailand, and in Aceh, Indonesia.

In 1998, I began a Masters research project entitled 'The Consciousness of Ethnic Identity of the Thai Muslims in Rueso Community'. This research studied how the Thai Muslims in Rueso Community, Narathiwat Province, Thailand perceived their ethnic identity. After I graduated, I continued my research in ethnic identity in the Deep South of Thailand. In 2005, I became a lecturer at Prince of Songkla University (PSU), Pattani campus and then later, in 2005, I was awarded a scholarship from Asian Public Intellectual (API) to conduct research in Indonesia.

When I was working as a lecturer at PSU, I was part of Thailand's National Reconciliation Commission research team (National Reconciliation Commission, 2006). My research was focused on how the imposition of Thai national identity impacted the way ethnic Muslims of the Deep South of Thailand viewed themselves. During the period of Martial Law, declared after the eruption of civil unrest, Thai government officials used dogs to search suspect rebels' houses. My research examined how such actions undertaken by Thai government officers affected the way in which members of the Muslim community viewed themselves.

I spent six months in Indonesia conducting research entitled: 'Regionalism and Interethnic Relationship: A Case study Aceh, Indonesia' which was funded by Asian Public Intellectual (API) (Hasamoh, 2008). When I returned to Thailand from Indonesia, I maintained my previous networks and expanded them through my contacts with medical staff specialising in epidemiology, the medical faculty, nursing lecturers, and graduated volunteer students from PSU, Hat Yai campus and, additionally, lecturers and graduated students from the nursing faculty at Syiah Kuala University (SKU), Aceh province in a post-disaster recovery health project. After 2005, I started exchanging experience and knowledge of the emotional and mental health impacts of natural disasters and conflict, including through exchanges between Acehnese and Thai communities. Moreover, I worked with many organizations and institutions, including NGOs and local governments, during this period and to the present day.

Ongoing violent conflict and an unclear situation in the Deep South, Thailand has become an interesting research focus, attracting researchers from inside and outside Thailand. Hence, when I had a chance to be a research assistant and interpreter, I did not hesitate to accept because I expected to learn. However, some of the researchers became upset when key informants did not attend focus group interviews or other meetings. They blamed me, alleging I was not managing the project or developing good relationships with key informants. I tried to explain that key informants were afraid of the ongoing violent conflict and the danger of travel. Some researchers recorded conversations and interviews using a small pocket voice recorder without asking first for permission. I felt deeply uncomfortable – my discomfort only growing when I was subsequently exposed through PhD study to ethics protocols and codes of conduct for research.

I was motivated through my experiences to contribute to the discipline of sociology by undertaking a comparative study of areas characterised: first, by exposure to natural disasters following years of violent conflict; and second, by Muslim majorities who have different ethnicities within their region but who are in some ways considered 'minorities' by their respective national government administrations. More broadly, I hoped to promote better understanding of difficulties experienced by vulnerable people living in post-disaster areas; in particular those difficulties associated with emotions and mental health. Through this, I hoped to broaden the perspective of decision-making regarding public disaster responses, as well as to inform the activities of national institutions and many more organizations that deal with people living with psychological trauma from natural disasters and violent conflicts

Knowledge Gaps

The focus of this research is psychological trauma experienced simultaneously through both natural disasters and violent conflict. The research explores, further, how gender, ethnicity, religion, age and social circumstances (including other social problems such as domestic violence and sexual abuse) impact the experience of psychological trauma, and it compares such experiences across the two study sites.

Sociologists and other social scientists have long been interested in psychological trauma (various definitions of which are detailed in Chapter 2). Indeed, through concepts such as *mental alienation* (Durkheim, 1952) and *cultural trauma* (Alexander et al., 2004), classical and contemporary social theorists alike have grappled with how best to develop a socially embedded understanding of psychological harm. They have shown that social relationships implicated in the experience of psychological trauma extend beyond the immediacy of relations with family, neighbours and colleagues to include relationships that, through institutions, technological networks and epistemic communities, stretch across time and space. An important example of the latter is the medicalization of psychological trauma through its definition by the medical and psychological professions as a disorder characterized by specific, clinically diagnosable, symptoms; that is, as Post-Traumatic Stress Disorder (PTSD). Sociological perspectives do not question the experience of PTSD symptoms but stress the social causes of those symptoms and the consequences of PTSD diagnoses and treatment.

Sociological perspectives show that the psychological trauma experienced by people following disasters varies according to a range of social differences including history, ethnicity, religious beliefs and political contexts (Bolin and Bolton, 1986; Gaillard, 2010; Gill and Picou, 1991;

Wenger et al., 1986; Barter 2011). In a conflict situation, people develop psychological trauma from unpredictable sources and have a high chance of experiencing negative social impacts (Betancourt et al., 2010; Newman and Blackburn, 2002; Waizenegger and Hyndman, 2010; Wall, 2008). Natural disasters may create more psychological traumas among vulnerable people including women, children, economically or politically marginalized people, the elderly, the disabled or those with chronic disease (Gill, 2007; Billon and Waizenegger, 2007; Brown and Mikkelsen, 1997; Catani et al., 2008; Erikson, 1976). In the event of natural disasters and violent conflicts, moreover, not everyone is able to access aid or recovery programs (Gill, 2007; Zeccola, 2011). Much of the literature shows that psychological trauma can result from ineffective aid that ignores specific groups of people during natural disasters and violent conflict (Falk, 2003; Grant, 2015; Waizenegger, 2007; Waizenegger and Hyndman, 2010; Zeccola, 2011; Ziabari, 2011). For example, people who are involved with political issues, such as ex-combatants, have psychological trauma after the disaster but may be bypassed by aid workers.

Studies of natural disasters have generally focused on how these effect human behavior, aiming both to understand how people react to danger, deprivation and loss and to enable some kind of control over communities affected by disaster (Quarantelli and Dynes, 1977). Disaster sociologists have developed some knowledge of how natural disaster impacts on mental health (Fritz, 1996; Quarantelli, 1987; Perry and Quarantelli, 2005). Psychologists have similarly contributed to the study of psychological trauma in disaster contexts while the effects of armed conflict have often been studied by political scientists (Binder et al., 2007; Fassin and Rechtman, 2009; Richards, 1998). Within Thailand, studies of disaster have predominantly been carried out by politicians, lawyers, scientists and engineers (Department of Disaster Prevention and Mitigation, Ministry of Interior, Thailand, 2018; McCargo, 2009; Srisompob and Panyasak, 2006). Most of this research has focused on the scale of natural disasters and their associated economic costs, along with the number of people killed, injured or rendered homeless (Alcantara-Ayala, 2002; Barton, 2005; Bertazzi, 1998; Fritz, 1996).

This focus on the scale of disaster events leads some events to receive considerably more political, popular and scholarly attention than others. For example, more than 60,900 articles on the Indian ocean tsunami of 2004 can be found in Google Scholar (as of 30 May 2018) while there have been limited academic journal publications on people affected by the 2010 storm surge, flooding and landslides in the Deep South of Thailand.

As Chapter 2 will show, few studies have addressed the interactive effects of disaster events of different sizes and type, and fewer still have addressed the interactive effects of natural disasters

and violent conflict, including those effects that impact people's mental health. Qualitative studies which emphasize disaster and conflict victims' own accounts of trauma are similarly limited.

Research Question

How do age and the social constructs of gender, family, ethnicity, religion and institutions influence the compounding effects of psychological trauma caused by sustained conflict and natural disaster events in Aceh, Indonesia and the Deep South of Thailand?

Research Aims

This research aimed to investigate, from a sociological perspective, how psychological trauma is experienced by people exposed to both natural disasters and violent conflict. In addition, it aimed to explore how gender, ethnicity, religion, age and social circumstances (including other social problems) impact the experience of psychological trauma, and to compare experiences across two sites.

This comparative dimension is important for at least two reasons, the first being that the type and scale of disaster events might influence direct experience of those events as well as the responses of governments, non-government organizations, surrounding communities etc. This is just as true of conflict situations. The second reason to include a comparative dimension is that similar things can be said about people affected by disasters and conflicts; that is, that they live in difference sociocultural contexts and with different social problems.

The first research site was Aceh, Indonesia which was impacted by the 2004 Indian Ocean tsunami and which experienced almost thirty years of violent conflict between 4 December 1976 and 15 August 2005. The second research site was the Deep South of Thailand (Pattani, Yala, and Naratiwat in southern Thailand) which was impacted by storm surge (and other types of natural disaster) and which experienced more than ten years of violent conflict from 4 January 2004. Additionally, by studying the people of Aceh ten years after the tsunami and the people of the Deep South of Thailand in the context of ongoing violent conflict, the study aimed to explore how people responded and experienced mental health and emotional impacts of natural disaster and violent conflict, linking with factors such as gender, ethnicity, age and institutional responses, which all play

a role in the construction of psychological trauma. By studying the people of Aceh ten years after the tsunami, the aim was to investigate how psychological trauma had been managed and the extent to which it had been resolved.

Outline of the Thesis

The aims above are addressed in the chapters which follow.

Chapter 2, Theoretical Framework, provides a conceptual framework for analyzing the relationship between psychological trauma, natural disaster and conflict from a sociological perspective. I discuss how social science knowledge and its medicalization of psychological trauma has been known. I also explore how society views psychological trauma in different types of disasters differently. Broadly speaking, vulnerable groups of people appeared to have more psychological trauma than any other group found in sociological research on disaster. I draw on Gill's secondary trauma to conceptualize human bodies' experiences of social responses and relief efforts. I also investigate how society responds to those with psychological trauma as a consequence of natural disaster events and conflict along with other social problems and social institutions such as family. At the same time, gender, age and social contexts of people who experienced disasters were included in analysis. I treat psychological trauma as material and symbolic. Theoretical frameworks used in this study include traumatization, secondary trauma and cultural trauma.

Chapter 3, Methodology, is the discussion about sociological methodologies which are suitable for studying people's experiences of psychological trauma in the natural disaster and conflict contexts. I start the chapter by exploring different ways to conduct research on this sensitive topic that includes vulnerable people under unpredictable situations – natural disasters and conflicts. I discuss my choices of research methodology, comparative methodology and methods (semi-structured interviewed, participant observation and visual methodology). I also discuss my research ethics, risk management, informed consent, personal safety management, data security and operationalizing the methodology and languages used in the field. Apart from this, I explain the experience of data collection – the comfort zone for interviewing, traveling to interviews as well as my gender role in the interview. Self-reflexivity and how it shapes the data analysis are discussed. Lastly, I describe my research and how I interviewed more than 300 key informants in two research sites within a year.

Chapter 4, Background of the Study Sites, explores the diversity of the two research areas – Aceh of Indonesia and the Deep South of Thailand. This research is a comparative cross-nation study.

I start the chapter by exploring the population growth rates that may be affected by the natural disaster and conflict. I explore a variety of ethnic groups who live in the two research sites. I describe a minority within a minority ethnic group who live in the disaster-affected areas. I investigate a variety of religions, languages, economic situations, occupations, cultural differences. All of these can be used for describing common and/or different psychological trauma symptoms that people with mental illness have, and how they experience psychological trauma. I also describe the historical natural disaster experiences and a brief history of the violent conflict. I argue how multifactorial sources of psychological trauma from the first traumatic event influences psychological trauma of the second disaster event.

Chapter 5, Families, Disasters and Conflicts, is the first chapter for the findings gained from the data analysis. I show that psychological trauma is the product of the relationship between families, disasters and conflict. How other social problems generate complex psychological trauma is also presented. Psychological trauma in this study is seen as a combination of two elements: separation and a change of the relationship of surviving family members after the disaster event. I also discuss the roles and responsibilities of surviving family members when their family structure has changed. This chapter uncovers many sources of psychological trauma in the family. I found that the surviving family members face post-disaster problems and unhealthy relationship. These elements add another layer of complexity of the family's psychological trauma.

Chapter 6, Disaster, Conflict and Young People, discusses how the relationship between young people, natural disaster and conflict generate psychological trauma. I analyze young peoples' actual experiences of psychological trauma by interviewing and storytelling using visual sociology to tell their traumatic experience story. I identify relationships between the armed conflict actors and natural disaster along with other social problems associated with psychological trauma in young people. I discuss how young adults respond to traumatic events relating to their behaviors and explanations, and how these people should not be expected to have the same psychological trauma symptoms as adult even when they go through the same traumatic events. I discuss how psychological trauma in young people is complex when their experiences are embedded with other social problems like sexual abuse and being recruited as child soldier.

Chapter 7, Gender, Stigmatization and the Construction of Mental Health, discusses the effects of the disaster in relation to gender, stigmatization and the construction of mental health. I start the chapter by exploring how psychological trauma relates to gender, natural disaster, conflict and health. I describe gendered experiences of psychological trauma in response to the natural disaster and conflict, and I investigate how the early warning signs of psychological trauma may be unnoticeable. I describe the stigma and the feeling of shame, and I describe how psychological trauma and gender

stigma operates in a society. I describe the gendered roles of caring for the mentally ill. Effects of the disaster relating to sexual relationships, family violence and livelihoods are also discussed. Lastly, I present how the death of a partner is strongly associated with mental illness symptoms.

Chapter 8, Disasters, Conflict and Healthcare Institutions, discusses the relationships between disasters, conflict and healthcare institutions. I argue that psychological trauma is a product of the relationship between human experiences of natural disaster, violent conflict and other social life products – family, community organizations, economy and culture as well as the complexity of the healthcare system including modern, traditional and family healthcare. I describe how the relationship between family healthcare, local healthcare and modern healthcare in natural disaster and violent conflict contexts generate psychological trauma. I investigate the dynamic of psychological trauma caused by the natural disaster and violent conflict which is associated with the complexity of the medical knowledge. I also explore how family members practically care for people who appear to have psychological trauma before they experience a natural disaster, and how they view people with mental illness. Moreover, I explore the relationship between mental healthcare and social stigma, and describe how social stigma in psychological trauma has been constructed from inaccessibility to any types of healthcare along with unsuccessful medical treatments of mental illness. The contexts of violent conflict and natural disaster are another layers of complexity in medical service for mental health patients.

Chapter 9 is the Conclusion. I review my main empirical findings and discuss how my results answer the research questions and aims. I discuss how my conceptual framework is useful for analyzing psychological trauma caused by natural disasters and conflicts. I also discuss how sociological examinations of people who experienced the emotional and mental illness caused by natural disasters and conflict reveal that this trauma is framed by a variety of social interactions including gender, ethnicity, family and healthcare institutions. Moreover, I identify the sources of psychological trauma and describe how other social problems such as domestic violence, sexual abuse and exposure to complex psychological trauma development relate to the psychological trauma. In an attempt to meet the promise of understanding psychological trauma in a sociological phenomenon, I conclude that psychological trauma needs to be analyzed within the context of social relationship and networks. It is also important to understand the interactions between the sources of psychological trauma.

Chapter 2

Theoretical Framework

The word 'trauma' is commonly used in reference to injuries or wounds, to the experience of emotionally unsettling events and to ongoing psychological conditions – all of which are relevant to both conflict and disaster situations (Das, 2010; Norris et al., (2006); Pikoulis et al., 2004; Soutis, 2006). The purpose of this chapter is to explore how sociologists, more specifically, have conceptualized the relationships between disaster, conflict and psychological trauma and to outline the conceptual approach that will be taken through the rest of the thesis. Broadly, sociological research on disaster has demonstrated that some groups of people are more vulnerable than others as a consequence of their exposure to other social problems and are hence more likely to experience psychological trauma than others (Brown and Mikkelsen, 1997; Das, 2010; Perry and Quarantelli, 2005; Zeccola, 2011). Further, different types of disaster (in particular, technological and natural disasters) seem to have different impacts, in part because people view them differently and thus respond in different ways (Das, 2010; Gill, 2007; Perry and Quarantelli, 2005). Noting that the effects of disasters extend beyond the initial event, sociologists such as Gill (2007) argue the importance of exploring secondary trauma – psychological trauma associated with social responses to disaster victims, including relief efforts. Sociologists, consequently, treat disasters as both symbolic and material constructs – as events that are as much about how people understand and respond to events as they are about earthquakes, floodwaters and explosions.

There is comparatively little sociological research on the impacts of exposure to armed conflict. Mainly, sociologists have considered armed conflict from the perspective of external factors – political movements, international relations, economic change and arms trade. – that have negative consequences for human groups (Gilbert, 1998). That said, during and immediately following WWII a number of studies were undertaken in the US to understand how people respond to danger, loss and deprivation and how their responses can best be managed in emergency situations (Quarantelli, 1987).

However, sociologists have shown considerable interest in emotion and mental health, situating these in the relationships between individuals and communities, disasters and societal responses (Perry and Quarantelli, 2005). Lack of social support and unhealthy social interaction before, during and after disasters are sources of psychological trauma (Quarantelli and Dynes, 1977; Bolin and Bolton, 1986). The medicalization of psychological trauma also plays a key role in the definition and experience of mental health along with other social institutions and relationships such

as those based on gender, age and family (Das, 2010; Perry and Quarantelli, 2005; Cooper, 2013; Crossley, 1998).

This chapter will articulate a theoretical framework for examining psychological trauma from a sociological perspective. This chapter has three main parts. First, there will be a focus on psychological trauma and sociology. This section will explore the development of psychological trauma knowledge, including its medicalization, from a sociological perspective. Second, this chapter will explore relationships between psychological trauma, conflict and natural disasters. Third, the chapter will explore relationships between psychological trauma and social institutions including gender, age and family.

Psychological Trauma and Sociology

Sociologists have developed numerous concepts to explore the ways in which apparently individual psychological phenomena such as memory are sociologically embedded. Emile Durkheim, for example, studied and analysed suicide rates – explaining these subsequently with the concept of *mental alienation* (Durkheim, 1952). Durkheim argued that even the most personal of acts (suicide) was social. Through a comparative international study, he provided evidence of suicide rates that were remarkably stable in particular places over time. The pattern evident at the level of society thus needed explanation, which led Durkheim to alienation, the idea that individuals take their own lives because they are no longer integrated into society. This he then related to other social dynamics.

Consistent with his maxim that social facts must always be explained with other social facts, Durkheim demonstrated statistical relationships between suicide and gender, religion, race and economic change or instability. He claimed a link between human emotion and adjustment to changes in the city. However, Durkheim was more interested in how social stability and control were maintained than he was in the social dynamics and construction of emotional states. Subsequent scholars have argued that the language used by Durkheim (i.e. terms such as *mental alienation* and *insane*) may contribute to the stigmatization and social exclusion with which he explained suicide (Horton, 1964). Further, Durkheim's statistical methods and treatment of gender in terms of biological or sex role provide limited insight into the construction of masculinities and femininities and how these impact exclusion (Connell and Connell, 2005; Schippers, 2007).

Pioneering sociological researchers proposed a number of concepts and terms with which to explore painful memories and other things now commonly referred to as psychological trauma. For

example, Cannon wrote on the idea of traumatic shock and Durkheim on tension (Meštrović, 1985). Anthony Giddens (1999, 2006) focussed on risk arising from the application of science and technology and Robert K. Merton on anomie related to social change (Sztompka, 2000)

Others discuss civilizational incompetence (Sztompka, 1993); social friction (Etzioni, 1993); distrust syndrome (Sztompka, 1999); collective guilt; collective shame; crisis of identity; legitimation crisis (Habermas, 1975); and cultural lag (Ogburn, 1957). Additionally, the term stressful life event was presented by Meštrović (1985). Trauma is widely used in sociology to refer to painful memories, emotional pain, painful feelings, emotional stress and social suffering following an emotional shock (Allen, 2008; Cuny, 1983; Das, 2010; Kirmayer, 1996; Kleinman, Das and Lock, 1997). All these words show that sociologists have tried to understand the different ways we cope with psychological trauma arising from changes in or the breakdown of social relationships. Importantly, however, these concepts identify the sources of emotional stress but do not unpack the nature of psychological trauma itself.

Other sociologists, by contrast, with interests in emotional illness have borrowed terminology for integration into their own discipline. *Cultural trauma* has been proposed, for example, as a way to extend medical and psychiatric models of trauma to destructive effects on the body social – effects that create cultural disorientation and which challenge collective norms and institutions along with conflicting ways of life (Alexander et al., 2004). As Sztompka (2000) notes, however, cultural dislocation and disorientation is not necessarily traumatic. In fact, dislocation may stimulate political mobilisation and cultural innovation. Alexander (2002), for example, shows how cultural disorientation can be both traumatic and creative through his investigation of how the Holocaust turned into the dominant symbolic representation of evil in the late 20th century and led, subsequently, to the development of a supra-national moral universalism that has helped to proscribe genocidal acts since then. The importance of cultural trauma to this thesis will be discussed in more detail below.

Psychological Trauma and Social Relationships

As noted above, psychological traumatization is related to social processes and relationships. It can be caused by lack of social support and be a product of isolation experienced before, during and/or after a disaster event. Psychological trauma can also be related to how humans experience and remember their life stories in the context of disaster events. In addition, psychological trauma can be related to social context and so psychological trauma experiences can differ across societies and cultures.

Psychological Trauma and Stress

From a psychological perspective, psychological trauma is caused by stress (Resick, 2001). From a sociological perspective, according to Meštrović and Glassner (1983), stress refers to a person's condition where they lack social support, particularly when faced with object loss which has resulted from the changing of social relationships, such as with divorce, imprisonment, marital separation, death of a spouse, and people who move to live in a different culture or who move frequently within their own country. Meštrović (1985) pointed out that this condition has correlated with some health problems such as mental illness. He also proposed the model of *stressful life event* referring to those conditions. Thus stress is either any force or pressure causing injury and a lack of social support, more specifically, such as may occur when there is loss of, or separation from, a family member or friend in a disaster or conflict situation.

Psychological perspectives on trauma also emphasise the potential consequences of indirect exposure to stressful events through various kinds of social interaction. Concepts such as vicarious trauma, secondary victimization, contact victimization, compassion fatigue and secondary traumatic stress refer to harmful changes in people's view themselves, others, and the world, as a result of exposure in some way to the traumatic experiences of others (Baird and Kracen, 2006; Lerias and Byrne, 2003; Sabin-Farrell and Turpin, 2003). Mental health therapists, for example, have been identified as at risk of secondary traumatic stress both through exposure to the trauma narratives of those they treat and through the integration of these narratives with their own experiences (Baird and Kracen, 2006; Becker and Dochhorn, 2014; Canfield, 2005; Farrell and Turpin, 2003 and Lerias and Byrne, 2003).

The key point here is that trauma is not a fixed condition that emerges in relation to single stimuli. While specific stressors may be identified as a source of trauma, in many cases the experience of psychological harm is likely to arise from the interaction of multiple stresses and interactions over time. *Traumatization* is consequently one of three core concepts that will be used throughout this thesis to explore the relationships between disasters, conflict and trauma in a sociological manner. Traumatization is a process through which stressors, mediating factors and societal reactions interact to produce a range of trauma symptoms over time. The role that wider societal responses play in ongoing processes of traumatization following exposure to disasters and conflict will be discussed in more detail below.

Psychological Trauma and Social Interaction

Sociologists believe that psychological trauma results from a combination of horrible events and social interaction. The effect of such shared experiences among members in the society has been called *collective trauma* (Alexander et al., 2004). They believe that even though some people may not have been directly impacted by a disaster, they can feel traumatised by the situation nonetheless following, for example, interaction with another person or persons who have had disaster experience.

Halbwachs and Coser (1992) point out that psychological trauma can be associated with a change of environment or *space* and a group of people. They state that psychological trauma happens when people become disconnected with the environment around them, including when they cannot find the reference points that they are familiar with. In the Halbwachs and Coser definition, *space* includes the physical objects such as homes and a city, economic and religious practice. However, due to each society and each individual having its own space, everyone who has psychological trauma is different because psychological trauma was constructed from different social and cultural factors. In the era of globalization, studies of psychological trauma become more complex due to our forms of communication through technology such as television and the internet – changing the contemporary experience of space. Modern communication can rapidly and with intensity shape and reshape the images of events received through space and time.

Sztompka (2000) argues that traumatising events – those side-effects of major social change that induce cultural dislocation and disorientation – are both material and subjective. Disruption of peoples' routines, livelihoods and relationships that are highly traumatising in one context may not be traumatising in another. The cultural framing of disruptive events is, therefore, critical to whether they are experienced as sources of traumatization. As noted above, psychological trauma can contribute to the development of collective identity and mobilization of social movements as easily, in principle, as it can contribute to fear and delegitimation of the political order.

The concept of *cultural trauma* thus addresses the negative, adverse and dysfunctional effects of social change on human emotions (Sztompka, 2004; Alexander, 2004). As Sztompka (2000) explains, while the concept is borrowed from medicine and psychiatry, it differs in defining trauma as a culturally defined and interpreted shock to the cultural tissue of a society. Six stages are identified by Sztompka (2000) as typical in the emergence and evolution of cultural trauma. These include:

1. A structural and cultural background environment which is conductive to the emergence of trauma; followed by,
2. Exposure to a traumatizing situation or sequence of events; which are,

3. Framed through specific ways of defining, interpreting or narrating the traumatizing events that draw from the pool of inherited cultural resources; leading to the emergence of,
4. Traumatic symptoms, such as specific behavioral or belief patterns (shared ways of conduct or typical, widespread opinions; collective moods); thence,
5. Post-traumatic adaptions; and potentially,
6. Overcoming trauma – that is, the closing phase of the sequence, or the beginning of the new cycle of the traumatic sequence, when the alleviated trauma provides structural and cultural conduciveness for another kind of trauma to appear.

A number of sources of cultural trauma relevant to this thesis are readily identifiable in the literature including economic crisis (Rice et al., 2006), war (UNICEF, 1996), ethnic cleansing (Alexander, 2002) and revealing the truth about the past (Sztompka, 2000). However, it is important these are not treated in isolation. Thus, in applying the concept of cultural trauma throughout the thesis it is important to consider: first, the interaction between multiple sources of change; second, the manner in which traumatic reactions to change can themselves become sources of (secondary) traumatization; and third, the status of 'natural' events as social change agents.

Halbwachs (1992) proposed that the study of psychological trauma must consider memory's social frames, which include class, family, religion and nation – thus identifying memory as a social phenomenon and an object of social inquiry. Similarly, Meštrović (1985) states that psychological trauma is not just an event, but it is linked with *'the ideas of arrangements and de-arrangement of collective representations in the context of society conceived of as a cybernetic system'*. In his research, he defined social support as an event and the fact which both the fact and event are not different. Psychological trauma is consequently a product of social networks – including the representations of past and future events constructed by those networks – as much as it is a product of damaging events themselves.

The Medicalization of Psychological Trauma

The English word 'trauma' is derived from the Greek word which means physical wound (Pikoulis et al., 2004; Soutis, 2006). Prior to the late 19th century, there was limited recognition that trauma could be emotional and nor was trauma recognized as a psychological illness (Das, 2010). Trauma was acknowledged with official recognition in the 1980s of Post-Traumatic Stress Disorder (PTSD) and awareness has been developed from studies of PTSD since the 1990s. In medical science, psychological trauma is explained by linking with the body especially the response in the

hypothalamus-pituitary-adrenal (HPA) part of the brain. It is widely accepted that the results of psychological trauma not only appear in the form of disturbed sleep, insomnia and nightmares but also relate to some disease such as hypertension, heart disease and diabetes, depression, and anxiety (Wall, 2008). Similarly, Steiner (1948) states that the anatomy of psychological trauma is connected to the soul's life along with the four major organs of the body, namely heart, lung, kidney and body liver (Rentea, 2009).

The idea of trauma as a psychological condition useful for explaining forgetfulness, anxiety and shock to the cultural tissue of a social change has also entered the domain of social sciences and the humanities (Caruth, 1995; Maruyama, 1996; Neal, 1998). It has been widely used since to refer to emotional shock and a stressful life event (Allen, 2008; Das, 2010; Meštrović and Glassner, 1983). Nowadays, psychological trauma is also situated in many disciplines such as medicine, nursing, sociology and anthropology. It is interesting to note that psychological trauma definitions share some common elements in explanation which are related to three things; human body, emotion, and environmental change.

The Institutionalization of Psychological Trauma

In 1808, a German physician, Johann-Christian Reil, invented the word *psychiaterie* to describe new medical methods for the treatment for mental illness (Binder, Schaller and Clusmann, 2007; Richards, 1998)). The study of emotion was developed and became more specialized and included the emergence of medical technology such as drugs, electricity (for electro-shock therapy) and mental health hospitals. Psychotechnologies became a part of mental illness treatment. For example, a psychiatrist may recommend electroconvulsive treatment (electro-shock) or drugs for mental illness patients (Hull, 2008). Later on, the technology of medicine became a business, which makes profit for modern healthcare network actors (Goddard, 1973; Yoon, Choi and Park, 2007). However, medical treatment for mental health patients has been seen as a part of social control that includes medicalizing deviant behavior for anyone who is classified as different from social norms, such as slaves, black people, drug users, alcoholics, illegal drug users, people who have different sexuality and gender identities (Aubert and Messinger, 1958; Conrad, 1979; Meyer, 1995; Orcutt, 1976; Phillips, 1964 and Stoll, 1968). In the meantime, medical diagnosis, advice, and treatment dominates over the patient's body.

In 1967, the anti-psychiatry movement emerged (Cooper, 1972; Van Praag, 1978). This movement was critical of psychiatric training in teaching hospitals and psychiatric hospitals, including a suggestion that psychiatric treatment may harm patients rather than assist them to get better (Crossley, 1998; Foucault, 1988; Laing, 1990; Laing and Esterson, 2016; Van Praag, 1978). For

example, this movement was critical of theory and approaches such as the biomedical model, with significant comment around the labeling theory, deviant behavior, abnormal behavior and therapeutic facilities and equipment (Double, 2002; Szasz, 1960; Van Praag, 1978). The movement had a great influence in many countries around the world, such as in the USA and the UK.

The development and institutionalization of psychological trauma knowledge and mental health treatment has invoked debate over whether human behavior is based on natural biological characteristics or on social processes. Modern Western medicine has been known to focus on the biomedical model. One of five assumptions of this model is that the mind and the body can be treated separately, which is referred to as medicine's *mind/body dualism* (Nettleton, 2006). According to this assumption, the disease has been seen as an objective, which leads to considering psychological trauma to be a type of deviance that is able to be controlled by interventions such as using medicine (Cockerham, 2014; Freidson, 1962).

As noted above, this thesis treats psychological trauma as both material and constructed, or, as both biological and social. It is important to also note, therefore, that knowledge of mental health and treatment of mental illness developed alongside urban development and industrialization (Dubos, 1969; Trowell, 1981). Understanding and treatment of mental illness arguably thus reflects the circumstances of life in urban industrialized societies (Carrera-Bastos, O'Keefe, Cordain and Lindeberg, 2011; Cordain et al., 2002; Foucault, 1988; Rosen, 1959), raising questions about their relevance to rural people in general and to developing and non-Western societies more specifically (Huntington, 1971; Jacobs, 1971; So, 1990).

Mental Illness and Social Relationships

The sociological arguments referred to above, concerning connections between psychological trauma and social relationships, are supported by a number of psychological studies. In the mid-1970s, the concept of social support emerged in the mental health field and studies of the effect of stressful life events on human emotion (Cobb, 1976; Cohen and Wills, 1985; House, Landis and Umberson, 1988). Lack of social support, or social isolation, was found to affect mental and physical health resulting in increased risk of death (House et al., 1988; Ryff and Singer, 2001; Umberson and Karas Montez, 2010; Vogt, Mullooly, Ernst, Pope and Hollis, 1992). Human well-being, health maintenance, and disease treatment have a strong link with social interaction among humans (Cohen, 2004). Some research found that people who are more socially connected live longer and are healthier than people who are low in social interaction (Kawachi and Berkman, 2001; Umberson and Karas Montez, 2010). However, close social relationships are not always positive. Disagreement, lack of

privacy, envy, and embarrassment can be the cause of mental illness despite frequent interaction with friends and neighbours (Rook, 1984).

The effects of lack of social interaction are not only found in the city. Social isolation can be found where a person has experienced situations of natural disaster, war, violent conflict and other social problems as well (Kaniasty and Norris, 1993; Weick, 1993). Hence, it is interesting to investigate further whether people who have experience of disaster also have associated mental illness, along with other social problem issues.

Relationships Between Psychological Trauma, Conflict and Natural Disasters

In the mid-1940s, natural disaster was not a significant research topic. American sociologists were paying attention to and studying war-related matters by receiving funding support from the USA military (Quarantelli, 1987). Only when the war ended did they shift their interest to the study of peace-time disasters. The types of disaster were generally classified into two main groups, natural disasters and human-caused disasters including industrial or technological disasters. Natural disasters, human-caused disasters and conflict were thence studied separately.

Psychological Trauma and Conflict

During the Great War (1914–1918), psychological trauma was usually considered a non-existent disease. Soldiers exhibiting symptoms of what would today be called PTSD were suspected of concussions (‘shell shock’) or of cowardice and received limited therapy from the medical services (Fassin and Rechtman, 2009). Many faced punishment, including imprisonment and sometimes death. More recently, debate has surrounded the mysterious symptoms reported by veterans of the 1991 war in Iraq and subsequently referred to as Gulf War Syndrome – symptoms that do not always align with those attributed to PTSD and which, consequently, can make it difficult for veterans to access mental health assistance.

Fassin and Rechtman (2009) note that these conditions can appear even when wars are over, referring to a famous condition called ‘post-Vietnam syndrome’. Indirect experiences can also trigger psychological trauma – experiences such as witnessing people being murdered, seeing dead bodies or seeing people being tortured, beaten, or hurt (UNICEF, 1996). Moreover, psychological trauma can have a delayed appearance, sometimes well after a conflict situation.

Shuval (1957) studied people tortured by Nazis during the Second World War. Many survivors still had psychological trauma because they remembered the extremely difficult life,

including crowding and lack of privacy inside the camp. Moreover, she found that some survivors felt guilty when their families and friends were killed while they escaped. Another example of such psychological trauma was identified from refugee stories of Vietnamese from Hanoi, Vietnam, who were located in Boston, Massachusetts. Wall (2008) claims that the Vietnamese had war-related psychological trauma conditions in the form of depression, nightmares, inability to work gainfully, and panic anxiety.

Psychological Trauma and Natural Disasters

Sociological interest in natural disasters emerged around 1965-1975. Quarantelli (1978) states that in that decade most sociologists' interest was in the characteristics of different natural disaster agents such hurricanes and earthquakes and the ways in which these characteristics influenced societal responses. Thus, Lindell and Prater (2003) argue that while the basic elements of natural disasters appear in different forms and shapes it is the speed on onset, availability of perceptual clues before the event, intensity and duration of impact that most influence emergency response actions and resulting damage to people and infrastructure. Boin (2005) argues that war has similar crisis characteristics. Nonetheless, what distinguishes disasters from other natural and technological events is the scale of social disruption (Boin, 2005: 155; Quarantelli, 2005) and the way in which this disruption is understood (Alexander, 2005). It is in this sense that disasters and their impacts, including emotional and psychological impacts, were conceived as social constructs.

A new approach to psychological trauma and studies of disaster emerged from the mid-1970s which asserted that natural disasters have different impacts on each group defined by their cultural, social, economic and political environment (Gaillard, 2010; Mitchell, 1989; Mitchell, Devine and Jagger, 1989; Wenger, Dynes and Quarantelli, 1986). In one interesting research study Bolin and Bolton (1986) studied four communities in the US that were affected by different kinds of natural disasters. This research focused on families, gender and ethnic groups, and understood psychological trauma from natural disaster through the material change from the disaster effect including residential areas damage. The research found that natural disasters destroyed people's properties in four communities and that people had been forced by disaster situations to move to temporary housing in other areas. Moreover, they pointed out that natural disaster created a disaster syndrome, because people who were dislocated had high rates of a lack of social support from their kin and family. They also found that each ethnic group, race and religion had different ways to cope with the natural disaster, with some ethnic groups not liking any help from outsiders except from their own people and their own kin. Even though the researchers focused on social behaviour rather than disaster syndrome, they found the syndrome to be different in each particular group. Their research showed that

responses/impacts varied according to: 1) damage to residential areas; 2) residential dislocation; 3) temporary housing; 4) after-shock; 5) disaster agents; 6) insurance; and 7) kin support. It is interesting to note that three additional factors were found to be related to disaster syndrome. Those three factors were ethnicity, race and religion. They found that natural disaster created disaster syndrome which was different in each ethnic group, race and religion.

Similarly, Smith (2012) when she did research in Aceh, described psychological trauma from the tsunami of December 2004. Acehnese houses and rice fields were badly damaged and many people experienced the death of family members and friends. Tsunami waves also destroyed military camps and drowned between 100 and 700 GAM prisoners (Waizenegger, 2007). These data are close to information from multiple people interviewed for this thesis. The experience of seeing widespread material destruction was enough to create psychological trauma. Bolin and Bolton (1986) suggested having different and sensitive ways of recovery for people who had been impacted from natural disaster, rather than merely addressing material re-building. Many natural disaster recovery cases in Aceh, focus on rebuilding material things but rebuilding lives is also important (Kenny, Clarke, Fanany and Kingsbury, 2010; Steinberg and Smidt, 2010).

Another example of natural disaster induced psychological trauma is the Thailand tsunami case. Thai people have been confronted with natural disaster many times, mostly causing flooding which affected property and human life (Haraguchi and Lall, 2015; Lang, 2002). However, on December 2004, they were impacted by a tsunami on a much larger scale causing a lot of deaths and injuries in areas such as Koh Lanta, Koh Phi Phi, at Krabi province, Thailand (Rigg, Grundy-Warr, Law and Tan-Mullins, 2008). Moniruzzaman (2010) stated that the most major affected areas were Khao Lak and Thi Muang. He points out that two years after that tsunami many survivors are still suffering and have psychological trauma. He described that there were huge waves, water engulfed houses, whole neighbourhoods severely damaged, and dead bodies of friends found. Human reactions of intense fright and fear were witnessed, houses were destroyed, family members died and others were injured badly. Psychological trauma had become a part of the lives of surviving victims.

Moniruzzaman (2010) and Rittichainuwat (2011) detail a range of psychological trauma symptoms evident among tsunami survivors: hallucinations/seeing spirits, inability to speak a human language, inability to respond to questions, loss of memory and alcohol addiction (Rittichainuwat, 2011). Moreover, many doctors found that psychological trauma was promoted by post-tsunami wound infections. Many survivors exhibited ‘post-traumatic wound infection’ because the patients not only had a ‘standard’ wound caused directly during the tsunami event, but some infected wounds were also associated with a kind of unexplained disease linked to the tsunami and difficult to cure (Andresen et al., 2005; Blanc et al., 2008; Garzoni et al., 2005; Hiransuthikul, Tantisiriwat,

Lertutsahakul, Vibhagool and Boonma, 2005). Some who had many types of injuries from the tsunami can be described as having multitrauma (Johnson and Travis, 2006).

In summary, different types of disaster can have different impacts on mental health, as can the cultural, social economic and political environments in which these disasters occur. Lack of cultural sensitivity or understanding of local family, gender and ethnic norms, insensitivity to the impacts of previous sources of psychological trauma including armed conflict and domestic violence can consequently magnify the experience of trauma.

Psychological Trauma, Natural Disasters and Conflict

This research aims to find out more about how psychological trauma has been influenced by other social problems. Nonetheless, every kind of disaster is intersected by psychological trauma. Therefore, psychological trauma in this research is also a product of previous social violence and conflict: a product of things such as social inequality, poverty, domestic violence, sexual abuse, ethnic conflict and war. Norris et al. (2002) found that between the years 1981-2001 almost 60,000 people who were impacted by disasters experienced specific psychological problems such as anxiety and depression and most notably PTSD from different kinds of disaster. They also found that the problems were more severe among youth rather than adults, were more evident in developed countries than in developing countries, and impacted from mass conflict including terrorism more than from natural disasters. Likewise, different social background makes for different ways of understanding psychological trauma. Das (2010), however, proposes that people who are confronted with all kinds of disaster, such as genocide, earthquakes and industrial accidents, are faced with the same suffering called victimhood, even though each kind of disaster has a different effect on humans who are from different class, religion, family, ethnicity, nationality or other social background.

Gill (2007), in a review of disaster studies, shows both that some comparison of findings between different kinds of disaster is possible and that differences in the apparent impacts of natural and human-caused disasters have a sociological basis in the responses of communities to events and victims. He demonstrates that while technological disasters often precipitate a breakdown in social relations (that is, with the emergence of ‘toxic communities’), natural disasters are more often associated with the emergence of a ‘therapeutic’ or ‘altruistic’ community (Brown and Mikkelsen, 1997; Gill and Picou, 1991; Picou, Marshall and Gill, 2004). He points out that in natural disaster situations people come to support each other during the crisis while technological disaster survivors are often neglected as the impacts of contamination. It is reasonable to expect differences to be evident in relation to the trauma associated with armed conflict given the differential responses people

experience depending on whether they exhibit physical or psychological wounds (Alexander, 2002; Alexander et al., 2004; Amaratunga et al., 2009; Betancourt et al., 2010; Catani et al., 2008).

The concept of *secondary trauma* is used by Gill (2007) to explore these particular processes of traumatization. Gill (2007) argues that what makes an event a disaster is defined by people's experience and reaction to that event together with a variety of social issues which also influence experiences of that event such as ethnic conflict and poverty. Different types of disaster and different community characteristics, moreover, produce different kinds of reaction among those impacted directly by disaster events and, importantly, by surrounding communities. For the purposes of this thesis, the key insight here is the role that wider societal responses to disaster play in ongoing processes of traumatization following exposure to disasters and conflict. Secondary trauma is used throughout the thesis to explore how government agencies, aid organizations and others perceived and responded to people affected by natural disasters and violent conflict in the study sites. As Gill points out, even post-disaster people continue to suffer due to previously existing social problems such as racism, poverty and social inequality. At the same time, disaster has a power of change, only one possibility of which is secondary trauma (Erikson, 1976). As events (see Fritz 1961/1996), any disaster playing out in different 'space and time' may generate a different set of outcomes in disaster affected areas.

Psychological Trauma and Social Institutions – Gender, Age, Family

Family

The family is recognized in the social sciences as both a foundational and a highly variable institution across cultures (Malinowski, 1930). Discussion of the family often makes reference to three main elements – size and membership, the role of the family in society, and the effects of the social environment.

Family and Mental Health

Family relationships are associated with mental health. The benefit of a positive relationship among family members is that fewer symptoms of psychological trauma might appear (Cohen and Hoberman, 1983; Dressler, 1985). Mainly, the sharing of resources and emotional support among family members creates a positive mental health atmosphere. (Broadhead et al., 1983; Seeman, 1996). Hence, people who have been affected by disaster or conflict may get better by receiving emotional support from their family members (Dalgard and Tambs, 1995; Kaniasty and Norris, 1993; King,

King, Fairbank, Keane and Adams, 1998). However, not everyone gets a health benefit outcome from their family network. Disaster experiences can strain relationships in the family. The loss of a family member in the disaster events can lead to other social problems. Domestic violence can affect mental health as well (Coker, Smith, et al., 2002; Walen and Lachman, 2000; Wickrama and Kaspar, 2007).

The symptoms of psychological trauma are observed in conditions such as stress, depression and anxiety associated with family problems – conflict and violence (Cheers et al., 2006) – and social factors – social exclusion and social capital (Hunter, 2000). Family behavioural responses have appeared in the form of alcohol problems and smoking (Conigrave and Lee, 2012). Physical and psychological abuses in the family have been found. The traumatised members of a family may behave in ways that generate secondary/cyclical trauma for other family members, including children, through abusive behaviours such as humiliation, violence, threats of violence and sexual abuse (Coker, Davis, et al., 2002; Rorty, Yager and Rossotto, 1994; Shepard and Campbell, 1992). Many research studies show that exposure to traumatic events can be related to the development of drug addiction and children's poor academic performance, HIV-risk behaviour and serious mental disorders in family members (Bensley, Spieker, Van Eenwyk and Schoder, 1999; Dube et al., 2003; Goodman and Fallot, 1998). Serious illness and disability of family members can be related to family psychological trauma and family dysfunction between partners and parents. The functioning of the whole family membership can be affected (Banks, 2003; Clarke and McKay, 2008; Peterson, 1979; Rolland, 1993; Singleton, 2012; Sun and Li, 2009; Taanila, Kokkonen and Järvelin, 1996). Moreover, family problems along with other social problems have been found to be causes of suicide and other psychological trauma symptoms (Bandelow et al., 2004; Brent and Mann, 2005; Janik and Kravitz, 1994). Most of the caregivers who look after people with mental illness, chronic diseases and disability are other family members but social scientists have limited knowledge of the role of caregivers in the family (Talley and Crews, 2007).

Psychological Trauma, Family and Violent Conflict

Armed conflict is known to be associated with psychological trauma for family members such as infants, young adults, parents and partners (Burgess, 1942; Feldman and Vengrober, 2011). Catani et al. (2009), for example, detail a number of direct and indirect impacts arising from a quarter of a century of conflict in Afghanistan. They point out that many Afghans have died, been displaced, lack the necessities such as food and shelter and have in general been impoverished. Malnutrition, ill health and lack of education are widespread. In addition, family members such as children and partners in military families experience particularly high rates of psychological trauma (Allwood, Bell-Dolan and Husain, 2002; Nash and Litz, 2013).

Direct and indirect war experiences have a significant effect on relationships within the family. Separation from immediate family members and from relatives during war has also been associated with psychological trauma (Boulding, 1950; Macksoud and Aber, 1996; Medway, Davis, Cafferty, Chappell and O'Hearn, 1995). Some of the symptoms of psychological trauma in family members who experience separation are anxiety, depression, fear for other family members' safety, nightmares, flashbacks, intrusive thoughts and loneliness.

Galovski and Lyons (2004) reviewed literature on the impact of PTSD on veterans' families and possible interventions. Veterans themselves experienced numbing and avoidance and were responsible for high rates of domestic violence, with negative impacts on spouses' mental health and the cognitive and emotional development of children. As far back as 1942, Burgess (1942) reported that behaviours such as gambling, prostitution, drinking and illicit sexual behaviour are found more among men in the military than in civilian life. In sum, it is clear that direct experience of armed conflict is not the only source of psychological trauma for those impacted by conflict. Separation from family members during war, or secondary traumatization through exposure to the negative impacts of conflict on other family members' mental health, is common (Canfield, 2005; Dirkzwager, Bramsen, Adèr and van der Ploeg, 2005; Solomon et al., 1992; Van Ijzendoorn, Bakermans-Kranenburg and Sagi-Schwartz, 2003).

Family and Natural Disasters

Many researchers have found that exposure to natural disasters has short-term and long-term impacts on the family (Briere and Elliott, 2000; Ingram, Franco, Rumbaitis-del Rio and Khazai, 2006; Steinglass and Gerrity, 1990). The family can develop psychological trauma through grief over the loss of family members, separation from family members, fear of losing family members and property loss or damage in natural disasters (Kristensen, Weisæth, Hussain and Heir, 2015; Solomon, Bravo, Rubio-Stipec and Canino, 1993).

Different types of disaster such as tsunami, flooding and earthquake may lead to development of psychological trauma symptoms such as insomnia, dizziness, headache, palpitation, chest tightness, tremor, nervousness, lack of confidence, feeling of hopeless, depression, anxiety, anger, sleep disorder, somatic complaints, substance abuse, fear of death, fear of property loss, dissociation, aggression, antisocial behaviour and relationship problems with the family members (Briere and Elliott, 2000; Chen et al., 2007; Wickrama and Wickrama, 2008). Gender, age, ethnicity, neighborhood characteristics and family structure differences in family support have a significant effect in mental illness (Cohen and Wills, 1985; Dalgard and Tambs, 1995; Kawachi and Berkman, 2001; Zimet, Dahlem, Zimet and Farley, 1988).

Lindgaard, Iglebaek and Jensen (2009) found that family functioning in the natural disasters can be categorised into two types – functional and dysfunctional. They state that in the functional family, family members have been described as demonstrating the ability to express thoughts and feelings, tolerance for differences in opinion and aggressive emotion, ability to solve conflicts, ability to disclose feeling honestly, and generally mutually supportive behaviour. They also point out that dysfunctional families have been described as demonstrating poor social adjustment, a high rate of conflict between the members, and low levels of cohesion and expressiveness. Family members who experience natural disasters show a strong pattern of increase in psychological trauma symptoms which affect almost every individual in the family (Bokszczanin, 2008; Mendenhall and Berge, 2010; Titchener and Kapp, 1976).

People caring for other family members with a disability caused by disaster can suffer from physical and psychological illness. However, there are limited studies on how post-disaster care for family members with severe mental illness caused by disaster can affect the entire family (Person and Fuller, 2007). There has been limited study of how the actions of family members who provide care for other family member(s) with a disability can affect the entire family – parents, siblings, and extended family members – following disaster.

Children and Young Adults

The age of being considered a child or an adult differs across societies, situations, disciplines and can also depend on the young person's relationship with any connected adult. Based on international standards, on 20 November 1989, UNICEF defined a child as anyone below the age of 18 years old (UNICEF, 1989). Australia's *National Statement on Ethnical Conduct in Human Research* (National Health and Medical Research Council, Australian Research Council and Australian Vice -Chancellors' Committee, 2007) does not state clearly any threshold age between 'child' and 'young adult'. However, in this research, 'young adults' were defined as anyone 15 to 19 years old, which followed a suggestion from the Human Research Ethics Committee at the Australian National University. The committee was concerned about the emotional impact on children that could be triggered by research questions, especially as the researcher did not have professional training in psychology. The term 'young people' is also used through this thesis to signify those who, while children during the tsunami or storm surge events, were in the 15 to 19 year age range at the time they were interviewed.

Symptoms of psychological trauma in young people such as depression and anxiety have been found to be common across many disaster situations (Holt, Buckley and Whelan, 2008; Hughes, 2004; Jeney-Gammon, Daugherty, Finch Jr, Belter and Foster, 1993; Meltzer, Gatward, Goodman and

Ford, 2000; Pfefferbaum et al., 2013; Smith, Perrin, Yule and Rabe-Hesketh, 2001; Strauss, Last, Hersen and Kazdin, 1988; Thabet and Vostanis, 1999). Loss and separation from other family members appears to be particularly important in triggering symptoms of trauma (Goldstein, Wampler and Wise, 1997; Jensen and Shaw, 1993; Landis, 1960; Peek, 2008) while family context (Kiser and Black, 2005) and social background (Rabalais, Ruggiero and Scotti, 2002) play key mediating roles. Importantly, not all young people who have experienced traumatic events suffer from obvious psychological trauma and some appear to return to their own way of life soon after those events (Betancourt, Agnew-Blais, Gilman, Williams and Ellis, 2010; Newman and Blackburn, 2002).

The American Psychological Association (2008) states that knowledge about psychological trauma in young adults is underdeveloped. Likewise, this organization points out that most of the applied theory regarding psychological trauma and young adults (and/or children) is based on studies of adults (American Psychological Association, 2008). Besides, the psychological trauma effect, normally, has been raised with the role of family caregivers such as mother (Enarson, 1998; MacDonald, 2005; World Health Organization, 2006). Young adults have been seen as the most vulnerable group in the disaster event. Children who have experienced disaster and violent conflict also have more future life-years to develop chronic diseases activated by prior exposure (Cutter, 1995; Delica, 1998; Duraiappah, 1998; Myers, 1994; Pronczuk-Garbino, 2007). Moreover, children and young adults may demonstrate psychological trauma symptoms in very different ways to adults (Kenardy, Le Brocque, March and De Young, 2010). Previous research on children and psychological trauma has provided limited knowledge of how different types of violence exposure have affected children. They have been affected in various ways, especially children who live in dangerous environments (Garbarino, Dubrow, Kostelny and Pardo, 1992; Kupersmidt, Shahinfar and Voegler-Lee, 2002).

Children and Natural Disasters

On December 26, 2004, UNICEF (2004) reported on a study of 607,508 children aged under 18 years in tsunami-affected countries including Bangladesh, India, Indonesia, Maldives, Myanmar, Somalia, Sri Lanka, and Thailand (UNICEF, 2004). Fourteen to 39 percent of children in Sri Lanka were found to symptoms of PTSD (Neuner, Schauer, Catani, Ruf and Elbert, 2006). In Thailand's six south-western provinces almost 20,000 children (age 7 to 14 years) were directly affected by the tsunami (Thienkrua et al., 2006). The same study found that between two and nine months after the tsunami, 13 percent of 167 is displaced and living in camps children in the study who were displaced and living in camps, were experiencing PTSD, compared to 11 percent among the 99 children studied who were not displaced from villages affected by the tsunami, and 6 percent among the 105 not

displaced from unaffected villages. This study showed psychological trauma in young adults was associated with natural disaster experiences that included seeing the tsunami waves, seeing someone injured or dead, hearing the sound of screaming, delaying evacuation, feeling that some family member was in danger, feeling unable to escape, feeling fear or extreme panic, losing a close family member or friend, knowing a close family member or friend was injured, losing important belongings or their home and having sustained an injury.

Natural disasters have long-term emotional effects on children (Agustini, Asniar and Matsuo, 2011; Piyasil et al., 2007). For example, in 2005, six months after Hurricane Katrina that affected New Orleans, Louisiana, USA, 56 percent of children aged 7 to 12 years old who participated in a trauma study were found to have moderate to severe levels of psychological trauma (Salloum and Overstreet, 2008). Another study found that one year after the tsunami in Phang Nga, Thailand, 142 students or 10.4 percent of students in the study were found to have symptoms of PTSD such as sadness, depression, worries, panic attacks, problems adapting to new living arrangements and physical complications (Piyasil et al., 2008). Moreover, these children had limited access to mental health services. Consequences of the failure to treat children for emotional illness, include that they are likely to maintain and develop psychological trauma which might not surface until they enter adult life.

Children and Violent Conflict

UNICEF (1996) found that in Sarajevo, almost a million children suffered psychological trauma from the conflict. From their research, involving 1,505 children in 1993, UNICEF has pointed out that 55 percent surveyed had been shot at by snipers, and 66 percent had thought they would die in a particular situation. Moreover, in 1995, another survey found that in the same country, 91 percent of children had seen dead bodies, 67 percent had seen people being tortured, and 66 percent of children had seen people being murdered (UNICEF, 1996). More than two-thirds of children had lived through a situation where they defied death. UNICEF also found that these children have the potential to have psychological trauma which manifests in nightmares, difficulty in concentrating, depression, hopelessness and bad memories.

Cambodian children who experienced war from 1975 to 1979 were found to exhibit massive psychological trauma. Sixty five percent of young adults reported headaches while 50 percent reported recurring dreams, 55 percent nightmares, 50 percent being easily startled, 70 percent feeling ashamed of being alive, 58 percent avoiding memories, 43 percent completely avoiding discussion of traumatic events, 43 percent weight changes, 53 percent loss of energy, 48 percent loss of interest, 48 percent a sense of feeling guilty, 43 percent a pessimistic outlook, 43 percent brooding, 53 percent

feeling inadequate, 55 percent resentful, 60 percent expressed self-pity, 20 percent panic attacks, and 18 percent general anxiety (Kinzie, Sack, Angell, Manson and Rath, 1986). Moreover, this research also found suicidal thoughts reported by 15 percent of young adults.

Multiple Sources of Psychological Trauma for Children and Young Adults

The earliest psychological trauma studies found that psychological trauma among children and young adults associated with major disaster events were concurrently associated with other social problems such as sexual violence, family violence and poverty (Betancourt and Khan, 2008; Lawrence et al., 2015; Machel, Salgado, Klot, Sowa and UNICEF, 2001; Pfefferbaum et al., 2013; Saylor, 1993; Turner, Finkelhor and Ormrod, 2006). Mental illness among children and young adults is complex when many of them may be experiencing four or more different kinds of violence such as war or ethnic conflict, sexual abuse by peer, witness to murder, robbery, and others social issues within a year (Catani, Jacob, Schauer, Kohila and Neuner, 2008; Finkelhor, Ormrod and Turner, 2007; Singer, Anglin, yu Song and Lunghofer, 1995).

Psychological trauma may be severe but the source might not always be identified (Pynoos, Steinberg and Piacentini, 1999). However, in time of danger (and other social problems), many research studies have found the relationship of traumatic event and children's physiological responses such as heart rate increasing, which may associated with cardiovascular disease in late life (Luecken, Rodriguez and Appelhans, 2005; Pynoos et al., 1999).

Recent studies have found that children and young adults who have experienced traumatic events (either directly or indirectly) were at high risk of involvement in risky behaviours such as aggression, suicide, alcohol or drug addiction, depression, child soldier and crime (Betancourt et al., 2010; Derluyn, Broekaert, Schuyten and De Temmerman, 2004; Dube et al., 2003; Finkelhor, 2009; Margolin and Gordis, 2004; Morgan, Scourfield, Williams, Jasper and Lewis, 2003; Osofsky, 1995; Pfefferbaum et al., 2013; Pynoos and Nader, 1990; Simoni, Sehgal and Walters, 2004; Summerfield, 2000; Wessells, 2006).

Young Adults, Psychological Trauma and Social Interaction

A young adult with depressed parents may develop emotional illness (Billings and Moos, 1983; Downey and Coyne, 1990; Weissman et al., 1987). Parents play the major role in setting the family emotional atmosphere. A young adult's reaction to disasters and to other social problems is affiliated with the parents' emotion in relation to the disaster (Green et al., 1991; Jacobson, Fasman and DiMascio, 1975).

In summary, many children experienced traumatic events and, although there are only limited studies, they show multiple sources of disaster associated with young adults' psychological trauma. Moreover, young adults' experiences of depression and anxiety have been found to sometimes be a result of traumatic events such as natural disaster or war, along with other social problems. Short-term and long-term effects of psychological trauma in young adults may appear. In addition, a young adult is vulnerable to psychological trauma due to their limited coping mechanisms, as well as their limited access to mental health services. There is also a risk that risky behaviour might emerge later in their life.

Gender and Non-Western Societies in South-East Asia

The gender situation in Southeast Asia has been overviewed by Rosaldo (1974), who stated that women in Southeast Asia can be powerful, important and influential relative to men of similar social status and age. She pointed out that the extra-domestic or public roles for women and the domestic orientation of women are not totally separate, which is different from traditional roles in Western society (Rosaldo, 1974). Most of the early research on women in Southeast Asia had a great influence from Western knowledge, for example, women were perceived to have been dominated by men. Rosaldo (1974) stated that the dominant male can be found in the knowledge of Western societies especially through the feminist literature and scholarship of the 1970s and evolutionary theory assumptions (Steedly, 1999). However, women in Southeast Asia also have power in economic and political life through the responsibilities for house (land) and child care. Rosaldo (1980) pointed out that women can speak out in public, express the needs of infant children, and accept physically demanding tasks as well as tasks in politics, travel, labor, trade and love. For example, the Minangkabau ethnic group in West Sumatra, Indonesia has a matrilineal culture (Blackwood, 2000). Similarly, senior women in Southeast Asia have authority above men, especially over some male family members in her kin group. For example, women are the owner of the land, earn income, and also are able to make decisions (Atkinson, 1990; Blackwood, 2000). Kinship is another source of her power where with the support of other women she is sometimes able to exercise control above the dominant male (Dube, 1997). Later, women who have less power or marginal women have been addressed due to not every women having the same privileged social status (Andaya, 2007). Moreover, for analyzing gender in Southeast Asia (non-western context), it is interesting to understand more how disaster events can shape gender cultures.

Gender and Disaster

Sociological researches on the relationships between disasters and gender have focused largely on the contribution of gender to vulnerability. The proposition that women are more vulnerable is supported by death rates which are higher for women following natural disasters than they are for men (Pittaway, Bartolomei and Rees, 2007; Yumarni and Amaratunga, 2015). Differences in physical strength offer an obvious explanation for women's comparative vulnerability but research findings point towards a range of other contributing factors including: (1) unequal access to resources; (2) the gendered division of labor, with women having major responsibility for care of children, the elderly and the disabled; (3) exposure to domestic and/or sexual violence; and (4) other sources of trauma or hardship for those women who have become heads of households (Amaratunga, Haigh, Ginige, Amaratunga and Haigh, 2009; Felten-Biermann, 2006). The World Health Organization (2002) points out that perceptions of risk, access to relief services, social and economic, domestic and sexual violence, psychological, planning and delivery of relief services are all relevant to the outcomes of disaster events. Such findings have led to an increasing emphasis in disaster relief on empowering women (Amaratunga et al., 2009).

A strictly demographic approach to disaster vulnerability (one focused on who appears most likely to suffer negative outcomes on the basis of gender, age or income) is not sufficient to understand how constructions of gender and other dimensions of social difference influence women's experiences of disaster. Similarly, a strictly demographic approach provides limited insight into how constructions of gender influence men's experiences of disaster. Exploring how gender roles (or how femininities and masculinities) influence the experience of disaster is needed to understand how vulnerability is produced. As Connell (Connell, 1998; Connell and Connell, 2005) argues, femininities and masculinities are multiple, complex and even contradictory. In addition, women are also participants in the creation of men and boys when they interact. Hence, the construction of gender differences through power relations should be addressed in this research.

Conclusion

This chapter has explored psychological trauma in sociological theory, hence, psychological trauma has been treated as material and symbolic. Psychological trauma as experienced either individually collectively reflects objective events, the ways in which these are understood, and other major changes in society. Psychological trauma as a symbolic production of society is experienced through the bodies and mind of people who experience multiple social changes – conflict, disaster situation and other social problems.

Traumatization, secondary trauma and cultural trauma will be the core concepts for analyzing psychological trauma in this thesis. Traumatization refers to the processes through which psychological harm is experienced and, in many cases, amplified. The concept of traumatization will be used in this thesis to explore how harm emerges through exposure to disasters and conflict and through changes in the ways people view themselves, others and the world, as a result of these exposures and through their interactions with other people and institutions (Becker and Dochhorn, 2014). The concept of secondary trauma extends this through its particular emphasis on the harm that arises as a consequence of other people's and institution's responses to disasters and conflict (Gill, 2007). It is used throughout this thesis to explore how aid and other responses to disaster interact in their own ways with social problems such as poverty and ethnic conflict to produce psychological harm. Cultural trauma, meanwhile, refers to the adverse and dysfunctional effects of social change on human emotions (Alexander, 2004). The concept of cultural trauma is deployed through the thesis to explore reciprocal relationships between psychological harm and changes in the ways people live, organize and interact with each other.

Natural disasters are clearly associated with human emotions and a diversity of broader societal responses (Erikson, 1976; Fritz, 1996; Norris et al., 1990; Mitchell, et al., 1989). As Alexander (2004) argues, the psychological trauma that follows disaster events is mediated by a number of social and cultural factors, suggesting that trauma is as much a function of social and cultural crises as it is of geological and atmospheric events. Institutional and governance failures, economic collapse, stressed health and education systems, social conflict and alienation, and so on, interact with and intensify disaster events, particularly for those who are in some way more vulnerable. Avoiding or limiting cultural trauma, it follows, calls for recognition of social pain and for actors to develop a collective sense of who they are, where they come from and where they want to go (Alexander, 2004).

Chapter 3

Methodology

In this chapter, I endeavour to answer the question of what sociological methodologies are suitable for studying the lived experience of trauma in natural disaster and conflict contexts. In one sense, the technical aspects of disaster research are no different from any other sociological research. However, disaster contexts embody complex and distressing events which, in turn, raise unique methodological challenges. Disaster researchers hence argue that disaster research methodologies do indeed differ from conventional sociological research methodologies (Norris et al., 2006; Stallings, 2003). The research reported in this thesis explores a number of sensitive issues including conflict, disaster, gender, ethnicity, marginalisation and emotion. Each of these issues affects the ways people remember and the ways they tell their stories. Research methods must be sensitive to the issues themselves and the way they interact.

Sociologists are routinely trained in a variety of research methods suitable to both qualitative and quantitative methodologies including grounded theory and survey research. All of these methods are potentially relevant to disasters. However, the unpredictability, dynamism, sensitivity and social disruption characteristic of disasters require sociologists to situate their knowledge of general sociological research methods within an advanced understanding of theory pertaining to human behaviour in those disaster situations (Killian, 1956; Stallings, 2003). Hence, the effect of disaster on research methodology sets this field apart from research methods in general.

This chapter presents how I decided what research methodology to use in the field. It begins with a more detailed exploration of the challenge of disaster research in order to contextualize choice of research methodology which follows. The chapter goes on to describe how I used comparative methodology more specifically, after which it details the methods used to operationalize this methodology – semi-structured interviews, participant observation and visual methods. These were chosen because of their relevance to understanding psychological trauma in local context, studying and observing sensitive stories, and managing the potential to impose my own assumptions on the data. Research ethics and risk management were taken into account together with managing psychological risk, informed consent managing personal safety such as self-management, interview practices and data security. The chapter then discusses how I established rapport in Aceh and the Deep South of Thailand from before I went to collect information as a PhD student. Language used in

the field is important and this section explains the significance of language in research sites. At the end of this chapter, I discuss my own limitations and bias in order to practice self-reflexivity and consider how this might have affected the data analysis section.

The Challenge of Disaster Research

Since at least the 1940s, sociologists have recognised that disasters present special challenges for research (Drabek and Stephenson, 1971; Fritz and Williams, 1957). Lewis Killian argued in 1956 that disaster research is characterised by a number of limitations including the time available to develop theories and hypotheses, time to develop research instruments, time to decide which events are worthy of study (Stallings, 2003). Norris (2006) similarly argues that there are two challenges in disaster research methods, namely time and duration of the disaster event, and defining the affected population. He claims that the time and duration of the disaster effect is most challenging for disaster researchers because disasters are unpredictable situations and it is generally not easy for researchers to access the impact area quickly. Additionally, a disaster situation has special characteristics and sociologists never know where or when the next disaster will occur in doing research (Drabek, 1970). Moreover, Norris (2006) argues that the population of interest is also difficult to define. According to the varieties and diversities of human society, there are many relevant factors including location (developing countries or developed countries), gender, religion, ethnicity and age.

Doing research in developing countries raises additional challenges for disaster researchers. Khondker (2002) said that the difficulty of disaster method development, especially in developing countries, is that there are many layers of complexity, such as in terms of poverty and weak institutions. The latter affects not only the ability of countries to respond to disasters but the availability of data for researchers. Countries characterised by political conflict add another layer of complexity. For example, one characteristic of demographic population in the Deep South of Thailand is that there is a migrating labour force with people looking to work in Malaysia almost every monsoon season, despite the existing conflict conditions and many complex factors. Consequently, sociology does not have enough knowledge to deal with the group of people who are affected by the disasters and living in already complex conditions. For example, there are a number of natural disasters in conflict areas such as the tsunami affecting Acehnese in Indonesia in 2004 and residents in the Deep South of Thailand. However, many aid organizations have struggled to isolate people who have been affected by tsunami from conflict and other social issues.

Lack of data such as statistics or history documents affect people and service institutions. It is hard to plan and deliver services when the disaster victims need aid. For example, in the Deep South

of Thailand many historical archives have become restricted documents since the violent situation began in 2004. Moreover, the statistical data in some developing countries is not sensitive enough for understanding the diversities of the society, including ethnicity and gender which are a part of the important information for analysing mental health problems after the natural disaster occurred. In addition, in some situations many official records have been destroyed by both natural disasters and by the higher authorities. A lot of historical documents in Aceh were destroyed by the tsunami in 2004 and many local history documents in the Deep South of Thailand have been destroyed or prohibited by the Thai government for more than a decade. Hence, in relation to finding suitable research methods in the developing country context on top of the crisis situations, good fieldwork is the most important factor for gaining more knowledge.

The Choice of Research Methodology

Interview-based and ethnographic research methods have long been preferred by many disaster sociologists – beginning with Henry Samuel Price in 1920 and his study of the Halifax explosion (Quarantelli and Dynes, 1977). A broadly qualitative approach was taken, similar, to this thesis, involving a variety of specific methods including semi-structured interviews, participant observation and visual methods.

Studying human lives and their experiences by observing people in their own private territory, connecting with them by using their own language and interpreting the meaning in their own understanding is at the heart of qualitative research (Denzin, 1994). Qualitative methods offer tools to provide deep contextual explanations of the situations in which humans find themselves including, in this case, disaster events (Phillips, 2003). Qualitative research the context of people's lives, the practices and relationships in which they are embedded and the meaning of these practices and relationships for participants (Stallings, 2003). It may also explore, importantly, the emotional or affective dimension of practices and relationships (Norris et al., 2006).

The exploratory and descriptive nature of qualitative research has stimulated ongoing debate over the validity of observations and conclusions (Boudon, 2002; Kirk and Miller, 1986; Maxwell, 1992). That debate is not reprised here. However, there a number of challenges relevant to this thesis and its goal of informing better responses to disaster and conflict that are worth mentioning.

First, only a small number of key informants can be interviewed by disaster sociologists, and a small number of samples cannot represent every disaster situation. However, research results may be represented as 'lessons learned' – as opposed to universal generalizations – and used to encourage

reflection and questioning of previous beliefs and practices – including beliefs and practices relevant to disasters, conflict and mental health support.

Second, qualitative research is time-consuming for both researchers and participants with interviews typically taking at least one to two hours, perhaps with follow-up correspondence or discussion. However, the deep information and the details of their life experiences potentially allows for more knowledge to be gained about the human experiences in disasters.

Third, time spent formally interviewing key informants may be dwarfed by time spent less formally building trust or 'rapport' between interviewers and interviewees. The purpose of building trust is to observe non-verbal behaviour which can confirm the statements of key informants or lead to new questions. In addition, observing non-verbal behaviour provides insight into phenomena that are hard to describe verbally and/or to translate between languages.

Fourth, almost every researcher has their own social position and biases, including those based on class, gender and ethnicity. The social status of researchers might impact on the way people behave or answer questions. Informants may tell the stories they think the researchers want to hear or they may be embarrassed to discuss particular matters with outsiders or with members of the opposite sex. In this situation, the sociologist needs to build rapport (that is, a meaningful relationship) with the participants in order to begin understanding why they want to tell particular stories to the researchers.

Fifth, qualitative researchers must organize and analyze the largely unstructured data they collect. Systematic coding of these data is to more deeply understand social relationships in the key informants' world. The coding process is also the product of the relationship between the researcher and the respondent (McCracken, 1988).

Managing these challenges requires qualitative researchers to adopt a reflexive, or self-critical, attitude to their research and to invest significant time in developing rapport with their informants. During the analysis of data, for example, I explored my own ethnocentrism and how it might impact how I present the life stories of others, following Campbell and LeVine (1961). Through the process of categorizing the data, I attempted to ensure that every story of marginalized people or groups was reflected in the narrative and conclusions of this thesis. At the heart of creating categories is the gaining of more knowledge of social relationships and of the life-world of participants. Hence, similar stories have appeared in the form of major themes while unique life stories have been described in this thesis as well. Nonetheless, I admit that a lot of information could not be included in this thesis. This does not imply that those life experiences are less important than those that do appear. At the end, the outcome of this research is the product of communication between researcher, methodology and theoretical framework building (Ely, 1991). When I had to

make judgments about what information is best to use to fill knowledge gaps I attempted to ensure no one is behind (Stuart et al., 2016).

Ethical considerations are also very important for qualitative researchers to constantly assess. Every participant had to consent by filling in the ethics form or by making an oral statement. Ensuring that all participants, regardless of whether they appeared distressed, were provided with referral details for specialist assistance. The information sheet included full contact details for a range of services including psychologists and psychology hospitals, a psychology hotline, psychiatrists, and general medical care. Particular care was taken to ensure that any participants who did appear to be affected by research questions were referred to a psychologist or psychiatrist.

Comparative Methodology

There are many levels at which it is possible to do comparative research ranging from the macro-level to intra-national comparisons (Peacock, 1997). The macro-level involves comparing societies, nations, world regions and the world system. Intra-national comparisons focus on regions or communities, examining diversity among groups including those based on cultural, racial or ethnic groups, class and gender. Øyen (2004) raises many interesting questions about doing comparative study between countries, one of which is how do we know that one variable in one country carries the same cultural understanding in another country and therefore can be compared directly? Comparative cross-national research raises additional challenges for disaster sociologists. Researchers need to deal with many factors from the logistics of conducting fieldwork, the set of questions to interview, analysing and interpreting data and translating languages. Not only are two countries different from each other at both macro- and micro-levels, but also there are differences in the types of natural disaster.

The purpose of doing comparative study between Aceh, Indonesia and the Deep South of Thailand is for understanding the effect of natural disaster on top of conflict in a developing context. Even though they have different social contexts, these two countries are bound together through a joint history of trade relationships stretching as far back as 1450 (Bradley, 2015a; Reid, 1993) and of colonisation. Moreover, Aceh and the Deep South have shared religious beliefs with a Muslim ‘minority’ in both sites. Additionally, diversity among groups in both areas makes it difficult to recognize the Chinese and the Javanese and many more minority ethnic groups in Aceh, while the Sakai and the Chinese and many more ethnic groups are located in the Deep South. Not only is knowledge about trauma limited in the developing countries context, so too is understanding of the relationships between disaster, conflict and mental health in sociology more generally. Hence,

comparative study of two areas in different countries might help to explore more fully the socio-cultural context for psychological trauma.

Methods

Semi-structured Interviews

Semi-structured interviewing is a qualitative research tool used for collecting data. Harrell and Bradley (2009) stated that when conducting a semi-structured interview, the researcher has a set of questions and topics as a guideline to ask the participant. This is to ensure the researcher covers all information she/he needs to know. Harrell and Bradley further explain that collecting data in the form of conversation is part of the semi-structured interview. This method is used when the researcher wants to gain in-depth information of the topic and to thoroughly understand the phenomenon. When discussing sensitive research topics, semi-structured interview is also useful (Michalos, 2014).

In this research, over 300 key informants were interviewed over the course of a year. One simple way to recruit new key informants was building trust between the researcher and existing key informants. When a researcher gains sufficient trust, informants feel safe to speak out and there can be emotional connection with the researcher. Moreover, having a comfortable and secure place to interview is another key success factor in recruiting people. I chose to ask research questions wherever informants were comfortable and felt safe enough for sharing their traumatic stories. In Aceh, Indonesia, I interviewed 158 key informants: 91 female, 67 male. This included 13 young adults: 7 female and 6 male. While the Deep South of Thailand, I interviewed 155 key informants: 80 female and 75 male. This number included 14 young adults: ten female and four male (see Table 1). Moreover, my research collected information from 11 group interviews and seminars in Aceh and three group interviews and one seminar in the Deep South of Thailand.

Table 1: Key informant information from Aceh, Indonesia and the Deep South of Thailand

Research sites	**Adults**		**Young people**		**Total**
	Female	**Male**	**Female**	**Male**	
Aceh	91	67	7	6	158*
The Deep South of Thailand	80	75	10	4	155**
Total					**313**

*145 Acehnese (most Islamic), 5 Chinese (Buddhist), 3 Bataknese (Christian), 4 Javanese (Islam) and 1 India (Hindu).
**83 Melayu (most Islamic), 50 Thai (Buddhist), 5 Chinese (Buddhist), 3 Mon (ancestor spirit and Buddhist).
Note: mixed-marriage (ethnicity and religion) also existed. The key informants could have chosen to answer specific to one ethnic group or religion.

All questions in the interviews reflected the research aims. I began by asking a set of main questions before I moved on to a set of follow-up questions that explored the topic in detail. The use of follow-up questions helped to confirm or otherwise that the interviewee has understood the researcher's main questions and the researcher has understood the interviewee's answers. This makes the conversation develop between the interviewer and the interviewee (Michalos, 2014). The key questions were varied but formulated according to research aims and objectives. One difference between the follow-up questions asked of adults and young adults/children was in questions relating to God. This was because many more adults than children described their traumatic experiences in relation to 'acts of God', and often with apparent certainty.

A set of main research questions were, for example, 'Could you please tell me what happened on that day?', 'How has the natural disaster and/or conflict affected you and/or community and/or organization?', 'Could you please tell me how women/men (father, mother, husband, wife, son, daughter) are affected by the natural disaster and conflict?'. It was important to ask key informants to describe their experience in detail before I moved on to a set of follow-up questions. The follow-up questions included 'What is the meaning of natural disaster from your point of view?', 'Could you please describe more about what you saw on that day such as people's reactions – screaming, running?', 'When did you see their behaviour? What did you think, what did you do and how did you feel?', 'What does trauma mean?', 'What does crazy mean?', 'What kind of behaviour is considered as crazy?', 'What are people and/or community's reactions?', 'What does the conflict mean to you?', 'Could you please describe more?', 'Has anyone you know been affected and/or involved in the

situation?', 'Are you, your family members, relatives, friends, and organizations involved in the natural disaster and/or conflict?', 'Does anyone have injuries, disabilities, mental health issues, mood or sleep problems, and/or eating problems?', 'Did anyone help you when you experienced tsunami and/or storm and/or conflict surge such as family members (father, mother, daughter, son), people in the community and organizations?' 'If you did not receive any help, where were they when you faced the traumatic events such as staying in jail, being under arrest or escaping away from the conflict or working overseas?', 'Were you be able to access to any kind of aid?'.

Learning what types of questions should be asked during the interviews was challenging. This is because my research topic relates to psychologically traumatic experiences. Aceh was the first research site. My Acehnese friend and mentor recommended me to ask questions relating to tsunami prior to conflict questions due to the fact that experience of conflict was considered a more sensitive issue. I did this for a while, then I decided to let the key informants choose the topic they wanted to talk about themselves. Surprisingly, the key informants' responses varied. Many of them did not feel hesitant to share their conflict experience before the experience of natural disaster. On top of that, a lot of them asked me in return what type of information they needed to cover. Hence, I selected the key questions that needed to be answered. I applied this technique in the second research site. I found that there was no major difference of the informants' responses from the previous fieldwork.

I was able to gain invaluable experience of designing follow-up questions before I became a PhD student, and already had experience interviewing people who were affected by the violent conflict in the Deep South of Thailand. At that time, when the key informants displayed severe symptoms of psychological trauma such as crying, I felt sympathy for them, and sometimes even forgot questions that should be asked. I was struggling to continue the conversation until the end of the process. Later, I saw the value of having follow-up questions. This technique helped me get through the impact of emotional trauma on me.

In this research, some questions were created from my own experience of natural disaster and conflict. I was aware that my experience might dominate the respondents' answers. Therefore, I told them earlier that I also experienced the similar traumatic events, and that I wanted to find out more how our traumatic experiences shared some similarities and how they appeared different. Hence, I asked the key informants these questions: 'Do natural disaster and conflict create the same and/or different fear?', 'Which type of disaster – natural disaster and/or conflict has severely affected you? How and why?', 'Why do some have trauma while others don't?', 'How did both disasters affect your life?'.

Surprisingly, in most cases, participants were not shy to express their different perspectives. At some point, the interview process ended up by sharing traumatic experience between the interviewer and the interviewee. Our conversation was smoother and livelier. I was able to create follow-up questions through the conversation. In this way, this research gained deeper knowledge.

Being an outsider brings potential to misinterpret and misunderstand peoples' life experience. To avoid this, I was trying to summarise the conversation nearly every time at the end of the interview. This was to ensure that the answer was accurate and I did not select the answer that reflected my own experience only. I acknowledge that different answers from my experience have to be analysed and shared in this thesis as well.

The semi-structured interview was also used with young people, but with somewhat different questions to those asked of those who were adults at the time of disaster. Punch (2002) states that research with children is potentially different from research with adults mainly because of adult perceptions of children and children's marginalised position in adult society but least often because children are inherently different. When conducting research with young people, then, I made a decision to create a set of simple research questions that were not too complicated to be understood by young adults. Additionally, I used a visual sociology research method together with asking a set of research question, in order to gain more understanding of their experiences and point of view. For example, 'What do you think happened?', 'Could you please tell me what had happened on that day?', 'How has this affected your family and community?', 'What do you think about what is happening now?', 'What do you think about the response to the disaster?', 'What makes you most upset or worry about?', 'How do you know the situation called tsunami, earthquake and conflict?', 'You were only four years old on that day. How did you know the big waves in front of you were called tsunami?', 'How did you know that the earth that is shaking is called earthquake?', 'Did you think that the tsunami happened because of God?', 'Did you know what God is when you were young?', 'What did you see on that day?', 'How did you know it is a dangerous situation?', 'Who was with you on that day?', 'What happened with you physically?', 'Did you know what fear is and how it happened?'. Inevitably, all these questions were not used as they could make participants feel tired to answer to many questions. A long interview process might not work for everyone. For young people, a visual sociology research method (described in more detail below) was used together with the semi-structured interview. At the end of the interview process, I let them tell me any other stories and asked me any questions, for example, 'Was there anything else that you would like to tell me or that you want to know more about?'. Participants then revealed other traumatic experiences such as sexual abuse and recruitment as a child solider.

Interviewing minority ethnic groups in each site revealed different challenges. For example, Chinese in Indonesia were living with fear because they experienced mass massacre during anti-communist period between 1965 to 1966 (Cribb, 1990) while Thai-Buddhists are a minority ethnic group living in a Melayu-Muslim community (Internal Displacement Monitoring Centre, 2011). I asked questions that were specific for ethnic minority groups. My questions focused on their ethnic identity in relation to the disaster events. For example, 'How do you define yourselves in your society?', 'How do you live in this society among the majority ethnic group?', 'What does the natural disaster and conflict mean from your point of view?', 'How were you affected by the natural disaster and conflict event?', 'Who helped you after the disaster occurred?', 'How did/didn't you receive aid?', 'As you have different ethnicity, how does the traumatic event affect you/your family/community?'.

Regarding the interview of the Chinese ethnic group in Aceh, my Acehnese friend and mentor recommended I claim Chinese heritage as part of my own ethnic identity. It is true this is part of my family ancestry, evident enough in my physical appearance to confirm I am a Chinese descendant. In Thailand, when interviewing members of the Thai-Buddhist minority ethnic group, I interviewed the participants by myself as I have a strong Thai-central accent and share part of their ethnic identity.

Questions related to God

Interviewing Muslims in both research sites was another challenge because many Muslim participants expected me to know everything related to our shared religious beliefs. When I asked them how their experiences of disaster were associated with religious culture they seemed upset by my question. Many asked me why I did not know a simple religious teaching. They expected a Muslim should know the answer themselves. For example, some of my research questions were 'How did you know that the tsunami occurs by God?', 'What is the meaning of *Qayamat* (end of the world in Islamic culture)?' Many Muslims in Aceh doubted my Muslim identity even though I was wearing hijab, long shirt and long pants while talking to them. Then, I had to clarify that the readers of this research are non-Muslims. Hence, it would be good if the key informants answered in detail, so their life-experiences would not be based on my own interpretation. Together with the help of my Acehnese friends who were my interpreters, they confirmed my Muslim identity with the Muslim interviewees. As a Muslim sociologist, I found interviewing people who share the same religious identity extremely challenging.

I was aware of the gender sensitivity in the interviews (Byrd and Robinson, 1995; Fontana and Frey, 1994; Herod, 1993; Pini, 2005) but I found no obvious gender barriers when interviewing informants who had a different gender identity from mine. I created my research technique when their

partner was not located in the same interviewing space. I told them before I asked tough interview questions. How to answer them was their will. The sensitive questions such as a sexual relationship between the wife and husband, for example, 'How do partners' disabilities affect the sexual relationship?', 'Do you still have a psychological trauma?' For a partner with disabilities, the samples of research questions were: 'Are you capable to have sexual activities with your partners since you became a disabled person?' Moreover, I created a set of questions for single-parent families, specifically asking single-parent families who lost their partners because of the natural disaster and/or conflict, for example, 'As a single parent, how did you find raising your children alone?', 'Isn't it difficult for being a single father and/or single mother?' and 'Could you please describe more which part was hard for you?'

Participant Observation

Participant observation is used to collect data in naturalistic settings by ethnographers who observe and/or take part in the common and uncommon activities of the people being studied (DeWalt and DeWalt, 2011). Becker and Geer (1957) point out that interviewing develops the accuracy of information from the perspective of the participant observer. They mentioned three concerning problems of participant observation: to understand what the interviewee really wants to tell by learning the native language; to gain sensitive stories that interviewees are unwilling or unable to talk about; and to get information of the matter that people see through distorting lenses. In this research, participant observation was used together with the semi-structured interviews. My aim in using participant observation was to understand psychological trauma in a local context which observe sensitive stories that the key informants found difficulties to express, avoiding being trapped by distortion, and being aware of what the interviewer and interviewee may feel during the interview. Different types of research recording were used such as voice recorder, camera, video recorder, iPad and mobile phone. I used pocket notebooks where I wrote about key informants storytelling and keeping an ethnographic record. I ensured that all of this was retained to be used for the investigation.

Understanding Psychological Trauma in Local context

Spradley (2016) states that the central aim of ethnography is to understand another way of life from the 'native' point of view by learning from people who have learned to see, hear, act and think in ways that are different. To understand human being by learning and using local language, spending time with the people in the fieldwork, having an appropriate behaviour is the main part of ethnography research (Nunan, 1992; Polkinghorne, 2005; Tedlock, 1991). Conducting research in the Deep South of Thailand, I am a member of the Thai society in both areas: Bangkok and the Deep

South of Thailand. I share cultural and language knowledge with key informants when expressing their ideas in regard to their culture. When interviewing Aceh people, I learned their culture by understanding through my work experience.

In the beginning of my field work, Aceh was the first research site and during the interview process, I worked with local interpreters. The word 'trauma' in English was used when I asked the questions. However, the local interpreters also used the word, *takut* '(psychological) trauma' in the local language in the research questions. Surprisingly, nearly all informants responded by using the word 'trauma' in English. I assumed they might know this from the international aid workers who came to Aceh post-tsunami. However, I was sceptical that I might misunderstand the cultural perspective. I found some key informants were crying while they shared their life experience of the natural disaster and conflict. However, they still insisted that it did not relate to 'trauma' or even answered, 'I did not have trauma.'

When I analysed my field notes and all of my research questions, I was enlightened when some of them said that they did not want to be judged as a 'crazy person'. I found that in Acehnese culture, 'trauma' has the same definition as 'crazy' or '*orang gila*' in Indonesian language (and Malay language in the Deep South of Thailand). My suspicions were confirmed when I asked them direct questions in the interview, for example, 'Does the word 'trauma' have the same meaning with 'crazy'?' Many of them replied, 'Yes, it has the same meaning.' I found out later that my interpreter sometimes replaced the word 'trauma' with 'fear' or '*takut*' in Indonesia language (and Malay language in the Deep South of Thailand) because she was afraid that the key informants might not want to share their experiences of tragedy.

This type of situation is similar to the case of the Deep South of Thailand. However, many different factors were found in the second research site. For example, I found it difficult to translate the word 'psychological trauma' from English to Thai because Thai language has no words for 'psychological trauma' even though in the medical discipline of the Thai society, the words 'trauma' and/or 'PTSD' are used. It most cases, trauma was interpreted to refer physical wounds, scars or injuries, while understanding of 'psychological trauma' was limited. I had to find words that have similar meanings to continue the conversation together with the use of participant observation in the field.

I asked participants to describe their experience and I listened carefully to what they described in the local language. I began to understand how the word 'trauma' was used in a local context, but I still did not understand how psychological trauma was shaped in each culture. At this point, I started to add other follow-up questions to encourage participants to describe their feelings

and elaborate their physical sickness along with the meaning of the word '(psychological) trauma' from their understanding. I also used participant observation techniques, observing peoples' reactions in naturalistic conditions such as the family. I discovered that participants with symptoms of psychological trauma chose to keep silent when they interacted with other people in the community and/or family members. For example, some key informants did not respond to friends and family members when they were told to get over painful emotions because the tsunami was the will of God. I also found that psychological trauma caused by conflicts was more acceptable to talk about because the source of emotional damage has been interpreted as human action (in Aceh). Observing people in a public space, I found that participants' answers were shaped by the way they interacted with other people in the society. Traumascapes is a concept for explaining the relationship between psychological trauma, tragedy landscape, lived experiences of place, the researcher as a person and the researcher's findings (Calgaro, 2015; Tumarkin, 2004). This new term was theorized by Tumarkin (2004). I also observed other physical materials such as tsunami museums, war monuments, mental health hospitals, disaster-affected areas and others. Here, I discovered how psychological trauma has been constructed through material objects. The information gained from the face-to-face interview and observation together helped me to better answer my research questions.

Studying and Observing Sensitive Stories

Becker and Geer (1957) state that people do not always tell an interviewer everything of relevance. They point out that this may be because people do not want to speak about an issue or feeling, or because they think that to speak of a particular subject would be impolitic, impolite, or insensitive, because they do not think to, or because the interviewer does not inquire into the matter. Additionally, some sensitive topics might be difficult to describe in a word or sentence. The key informants may feel embarrassed to reveal their true emotions to others.

In the fieldwork, I stayed with a few host families and spent time visiting key informants' villages in different locations. At this point, I discovered that living conditions of the informants were different from the families who hosted me in terms of social backgrounds such as economic status, income and culture (See

Figure 1). I also had a chance to visit the victims of natural disasters and armed-conflicts who resettled in a new place or moved to another area. For example, key informants with low incomes and living in unhealthy conditions (armed conflict zone) were unlikely to talk about their poverty and conflict experiences. During the semi-structured interviews, I still did not completely understand how poverty, natural disasters and conflict were related to each other.

Figure 1: House of one key informant in Aceh, Indonesia

In Aceh, the key informants said that the armed-conflict was still considered a sensitive issue. I later discovered that neighbouring houses were used by separatist members, military forces and spies. In addition, in the key informants' village, I found houses of torture. In fact, many participants are still living in natural disaster-affected areas. Hence, even though the war has ended (in Aceh) or natural disaster has passed, these conditions still affect the key informants' psychological trauma and wellbeing. Similar conditions were found in the Deep South of Thailand where many military checkpoints are located in the middle of roads, especially the routes between remote areas and the city (See Figure 2).

Figure 2: Military checkpoints, the Deep South of Thailand

From this, I gained more understanding of how people perceive everyday fear. In addition to the impacts of poor living conditions such as poverty, on-going natural disaster and armed-conflict, I found it is important to observe physical conditions to understand the cause of these differences. Limitations to access mental health care services also create the experience of psychological trauma. Even though I used to live in the armed conflict area and experienced the natural disaster in the Deep South of Thailand, I discovered that other people's experience of natural disasters and conflicts are different.

The Distorting Lenses

It was particularly important to understand how interviewees from different social backgrounds answered questions. Answers may be influenced by the research process, especially when dealing with vulnerable people such as ethnic minorities, children, women and others. The interviewees' responses to sensitive questions along with power relations between the interviewer and interviewee are included in the list of concerns. Observing people under naturalistic conditions, the

researcher may receive different information from that which is told in more formal interviews. Use of file notes can, therefore, be an effective tool for documenting key informants' storytelling and describing social conditions. Additional note taking when collecting information, taking photos, using tape and video records was helpful when the researcher wanted to minimize the risk of missing some specific details such as house condition and specific environment surrounding the disaster area.

Regarding the number of deaths, for example, in research sites such as Pidië Regency, Aceh, Indonesia, key informants' stated beliefs seemed to relate to their experience and social position. Before I went to Pidië Regency as a PhD student I had already visited this area. I knew that this location could be relevant to my research because people had been affected by both violent conflict and natural disaster. To investigate effects of natural disaster and violent conflict, I was searching for basic information from many people. Nearly everyone I interviewed outside Pidië Regency told me that this area was an uninteresting research site in which only a small number were killed by the tsunami and earthquake compared with other areas such as Aceh city (approximately 100,000 people). I found later 'a small number' to be more than 500 people who had been killed by the tsunami. To understand how people were affected by the conflict and natural disaster I went to observe the actual site, which overlapped with areas most severely affected by armed the conflict and other social problems. When I arrived at the tsunami museum in Pidië, I found more than 100 names of victims displayed on the wall (See Figure 3). When I interviewed the local authority, I was told the total number of dead was more than 500 people but, again, the local authorities who worked for Pidië regency and even many the residents told me to focus more on Aceh city. *'Only 500 people died here. Nothing interesting'*, said many key informants. This can be explained in at least three ways. First, people compared deaths in Pidië regency with Aceh city (Banda Aceh) and felt sympathy for people in Aceh city and other areas (areas with approximately 3,000 to 30,000 deaths). Second, Pidië regency was most severely affected by violent conflict with nearly 100,000 deaths due to almost 30 years of the violent conflict. People compared the number of deaths in the tsunami with those due to the violent conflict situation. Third, war stopped after the tsunami struck this area. Many key informants found benefit of having the tsunami and afterwards the opportunity to move on in their life.

Due to a long history of armed conflict, after the tsunami, many problems were exposed. I also discovered that the famous torture house (located in Pidië) or *Rumoh Geudong* was burned down after the tsunami because some groups of people wanted to wipe out a crime scene. Hence, it was not so surprising that a large number of mental health patients came from this area. Although many things have been rebuilt, there were limited emergency response plans. I hardly saw tsunami evacuation signs. There were only unclear emergency evacuation routes, one abandoned evacuation building and structures. Many facilities that were built after the tsunami were in a bad condition (See Figure 4).

Participant observation helped me to look beyond what people initially told me, because distortions were hard to discover solely through interviews. The information gained from the interview may be used as a source but the researcher has to enter the field to describe the situation as it is in order to fully understand it.

Figure 3: Names of tsunami victims at the tsunami museum in Pidië, Aceh, Indonesia

Figure 4: Inside one evacuation building in bad condition, Aceh, Indonesia

Visual Methodology

Visual research methods may be particularly helpful for research participants who find it difficult to verbalise their experience due to its emotional or affective intensity (Jacobs, 2008; Peek and Stough, 2010; Sayre, 2006). Visual research techniques are designed to document truth from the participant's perspective (Luttrell and Chalfen, 2010). They reduce the authority of the researcher to some degree and raise the voices of research participants (Clark, 1999; Liebenberg, 2009). Drawing pictures, taking photos or shooting video can help participants who lack the confidence or social capital needed to communicate their knowledge or who are uneasy about having to talk about and/or explain their experiences.

In this research, such graphics were used for analysing the underlying meaning of the pictures through discussion with participants. I graduated from a school of art with a Bachelor's degree and have experience both in the use of digital and video cameras and have trained local people in the use of cameras for research.

I planned to use visual research technologies such as digital cameras, video recording and drawing of pictures in cases when informants appeared to be having difficulties giving their interview through verbal language. However, I found that the adult key participants from Aceh, Indonesia, and the Deep South, Thailand were able to communicate with verbal language, though the visual research technique was used with some young adult key informants.

When I had started planning to do research in Aceh, Indonesia, I had thought about my nursing friends' networks from the Syiah Kuala University at Aceh city. Many of them had been trained to use visual research techniques from Thai trainers through many workshops. However, during my research; they were not available to be my research assistants for a wide range of reasons. When I interviewed young people, I spent the first fifteen minutes to almost one hour establishing rapport before I asked them to draw pictures. The resulting data was in two categories of pictures - trauma experienced by natural disaster and trauma from violent conflict.

Equipment for drawing pictures included a range of drawing tools such as watercolour, pastel, pencil, crayon, and others. I found that all young people preferred to use the wooden coloured pencils rather than the other kinds of drawing equipment (See Figure 5).

Many of them did not feel confident at first when I asked them to draw the pictures. Some of them told me that the pictures might not be beautiful enough. For the less confident ones, I asked them to try it and not worry about how the pictures turned out. Interestingly, when they had starting drawing, through the particular shaping of the picture I was able to understand more about their

trauma experience. Hence, I was able to subsequently ask more probing questions and gain more meaningful insights.

Figure 5: Equipment for drawing pictures with young adults, the Deep South of Thailand

While interviewing young people, the ethics code of conduct (see below) was adhered to. I was assisted by the psychologist and when I was not sure about research questions that might evoke a young adult's trauma. I sought guidance from the psychologist. The psychologist also assisted me by helping me in the use of language that enables young people to better understand the research questions.

Research Ethics and Risk Management

Obviously, my research involved humans, and an especially vulnerable population. Conducting research about vulnerable populations requires many ethical considerations, especially in

relation to children and young people, people who have mental health problems, people who depend on medical care, people with unequal relationships such as women, elderly or ethnic minority groups, people living in other countries or people emigrating to other countries because of persecution and/or other repercussion experiences due to the conflict situation. Comprehensive ethical guidelines can be found in the National Health and Medical Research Council (2007) documents and at their website. Even though conducting research with vulnerable people is extremely sensitive the aim of doing research is to reduce the vulnerability and protect research participants. Hence, it is a duty for every researcher to apply ethical considerations to their research. The emphasis is on ensuring researchers do not mislead, mistreat or take advantage of others in their research studies.

As half of my research was conducted in Thailand, 'Ethical Considerations for Research in Cross-Cultural Setting' Curran (2006) was also a guideline for my fieldwork, especially in ethical dilemmas such as how to deal with conflicts of interest and justice concerns. During her research, Curran found there were misconceptions among some Thai villagers, including a view that she was working for her research assistant who had been working for a local NGOs that had a relationship with the villagers that was not entirely positive. Therefore, Curran found she had to reshape and clarify her relationship with the villagers, her research assistant, and the local NGOs.

I started my PhD at the Australian National University (ANU) before I moved to study at James Cook University (JCU). All research plans were approved by the ANU Human Research Ethics Committee. Following the completion of fieldwork, I informed both ANU and JCU ethics committees that everything went according to the plan. Since I did not propose to collect more data in the field, a resubmission for ethical approval at JCU was not required. Consideration of ethical issues specific to this research highlighted the important of managing the risk of adverse psychological reactions along with other threats to participant safety, ensuring participants were able to provide genuinely informed consent, managing personal safety, and data security.

Managing Psychological Risk

It was almost impossible for people participating in this study not to recall painful memories. Nonetheless, the likelihood of participation triggering an adverse psychological reaction among the majority of participants was considered to be low. Many of the participants in this research were community leaders of various kinds who were experienced in disaster recovery and used to dealing with a range of daily reminders of disaster and conflict events. When seeking referrals and approaching potential participants, the purpose and focus of the study were always made clear and people were warned that they may find some questions upsetting. This approach was consistent with

the findings of Newman and Kaloupek (2009) review of ethical issues associated with participation in traumatic stress studies. Newman and Kaloupek found that:

1. Participation in research tends not to elicit painful memories in the same way as everyday exposure to the context of trauma (e.g. from media reports).
2. Many research participants who report feeling distressed during interviews do not feel upset at the interview's completion. They enter into the research with the expectation of feeling emotional responses and, for the most part, are able to manage these.
3. Many participants in trauma studies report benefitting from their participation. This appears to be linked to participants' beliefs in the value and benefits of research.
4. Autonomy and respect for participants are consequently foundational in reducing risk. A key step in according participants autonomy and respect is to ensure free and informed consent. Even severely traumatized individuals are capable of determining whether it is in their best interests to participate but care must be taken to ensure potential participants do not in any way feel coerced.

Noting the principle 'that minimal risk is defined as the probability and magnitude of harm or discomfort anticipated in the research are not greater in and of themselves than those ordinarily encountered in daily life', Newman and Kaloupek conclude that extraordinary precautions are not warranted for trauma-related studies in general. However, this does not preclude the need for careful attention to ethical issues in research planning and execution.

It is important, therefore, to acknowledge that the possibility of triggering an adverse reaction did exist and, were this to happen, the consequences for the participant in question could be significant. I am not a trained psychologist and therefore did not intend to counsel participants. Noting the research by Newman and Kaloupek, and taking advice from staff at the ANU Counselling Service, I undertook to manage risks to participants by:

1. Ensuring that all participants were informed in advance of the purpose and focus of the interviews and ensuring that all participants, regardless of whether they appeared distressed, were provided with referral details for specialist assistance. The information sheet included full contact details for a range of services including psychologists and psychology hospitals, a psychology hotline, psychiatrists, and general medical care. Particular care was taken to ensure that any participants who did appear to be affected by research questions were referred to a psychologist or psychiatrist.
2. The diversity of the key informants is also important. If the key informant is a young adult, for that young adult there should be consent from their parents and assist by

psychiatrist or psychologist to be interviewed by the researcher. Moreover, I provided contact number of psychiatrists and/or psychologist, especially when conducting research with people who had mental health problems.

Informed Consent

It was important to tell all participants about the purpose of my research and the type of questions I intended asking. In addition, participants were informed they could withdraw from the study at any time and they could stop answering my questions at any time. Furthermore, I worked closely with the medical and nursing team in both countries. Consequently, participants were informed they could access mental treatment whenever they felt that they needed it.

All key informants were also informed before interviews started that the interview would be recorded (either audio or video) and their photograph taken. Only one woman asked me to delete her picture later because she still suffered such deep trauma from the violent conflict. In the Deep South, Thailand, I adopted a different practice due to the ongoing conflict situation. I selected only a few participants for taking a photo. As an extra precaution the documents and photos were stored separately from my accommodation because it is not safe to keep them at my accommodation despite being located inside a University campus.

The use of video and audio recordings was not intended for other purposes including commercial purposes. All recordings were kept confidential and their use explained more in the information sheet. Participants were informed that in the event recording excerpts are selected for reproduction in the thesis or elsewhere, they would be allowed to view and approve the edited version before it is published. All participants were asked to acknowledge their understanding of this through the consent process.

I conducted the research in Aceh under conditions that differed from those in Thailand, especially in regard to the many documents that I had to present to interviewees before starting. Documents for conducting research were divided into three groups:

1. Ethics documents: participant information sheet, semi-structured questions, video consent form, tape recorder consent form, letter from my supervisor asking permission to interview and observe.
2. Thailand and Aceh cooperation document: letter of recommendation from the head of post-disaster recovery on health project, Memorandum of Understanding between PSU and SKU, PSU and the Government of Aceh, Indonesia.

3. Permission letter from Aceh government: permission letter from Aceh immigration, permission letter from Aceh police department, permission letter from SKU Rector.

I was asked for a letter of permission to conduct the research by both government officers in Aceh, as well as by key informants such as village leaders, before an interview could commence.

In some contexts, the researchers should pay money to interviewees equally, according to participants' standards. However, in some social and cultural contexts, giving money to interviewees can be interpreted as contemptuous behaviour. Hence, the role of the researchers should include a basic investigation of the culture before committing to give something to the participants. Normally, taking account of local customs, small gifts such as key ring, payment for a communal meal or payment to a local family to provide food could be options and these were adopted in this research study.

Managing Personal Safety

Before I began the fieldwork, I submitted all detailed risk assessment and management plans to the University. Department of Foreign Affairs and Trade (DFAT) considered Yala, Pattani, Narathiwat and Songkla in the Deep South of Thailand as a 'do not travel area', a Level 4 Advisory, due to the threat of terrorist attack, in addition to risks common to developing countries including health (disease), personal safety (misadventure) and civil disorder. Management strategies for most of these risks are self-evident. I had an evacuation plan and regularly scheduled communication with my supervisor.

Nonetheless, during the course of my fieldwork, my Acehnese research assistant was afflicted with dengue fever, I was involved (but not injured) in a car accident and terrorist bombing and shooting incidents occurred multiple times in both study sites. These experiences, and exposure to the stories of research participants, contributed to the risk of vicarious psychological trauma – a risk I thought justified by the potential benefits from the research results.

Before commencing fieldwork, I consulted a psychologist over how I should deal with the personal risks of this research. Strategies focussed on self-management and on interview practices.

Self-Management

To ensure I could maintain work on this project it was important to maintain peak health, appropriate diet, fitness, and have regular time-off. Some of these strategies were implemented even before I entered the field. I felt it important to improve my strength and fitness in anticipation of the

unpredictable conditions under which I was conducting research under and recalling my previous disaster experiences. I had witnessed in many others injuries caused by the natural disaster in Yogyakarta and the heavy labour involved in delivery of goods such as water and rice for natural disaster victims in the Deep South of Thailand. At first, I planned to learn martial arts and self-defence before I began fieldwork but time limited me to only routine exercises for strength and fitness. Fortunately, nothing untoward happened during the interviewing and I had no need to defend myself.

When I went to do research in Aceh, even though I have a strong connection from working with the people there for almost ten years, I was regularly monitored by my close friends in Aceh. But I certainly felt more disconnected with the social safety network than I did in Thailand. Often, I had to interview new key informants by using snowball research techniques that drew me further from my established social network, and further into remote areas of the highest violent conflict. As a woman researcher traveling alone to unfamiliar areas and meeting with new people, it is normal to feel a little insecure. To build up my confidence and strengthen my sense of security, I undertook regular physical exercise to maintain a high level of personal fitness.

Conducting research in my home country was less stressful than working in Aceh. Not only do I have an extensive family network and many more friends in Thailand. I have knowledge about Thai legal systems and culture. I know from where or from whom I should seek help if I experience trouble. I feel ‘in control’ in The Deep South of Thailand, even though this area is considered a ‘do not visit area’ by the Australian Government. Nevertheless, I received monthly telephone calls from Australian Embassy staff to update me about the terrorist situation, especially the kidnapping of foreigners. Nevertheless, I started to learn self-defence such as Muay Thai, CrossFit and gun defence after I came back from the fieldwork. I also had some confidence that if I had to face a violent situation or confront people armed with a gun, I still had a chance to live due to my safety plan and preparedness.

From my previous experience, a two-hour interview is emotionally draining as well as physically exhausting. Even though, I was well prepared before I began my research it was still difficult to know how many people I could interview within a day, and how many hours per person I should allow. In fact I had more people willing to be interviewed than I could manage. Many of my interviewees were old friends who opened up to me and we spent a lot of valuable time together.

During and following fieldwork I followed the recommendations of mental health professionals responsible for supporting students at ANU and JCU. I implemented a range of self-care and self-prevention strategies to reduce the risk to myself of vicarious trauma. This included taking

regular breaks and doing exercise. However, despite the precautions, the research did impact negatively on my mental health. I took advice to build my self-awareness. I continue to take appropriate steps to manage my mental health even though these have meant extending the time it has taken to write this thesis.

Interview Practices

The basic recommendation by my psychologist was to focus on the research questions. In addition, I should not let trauma stories shared by participants become my own stories. Sharing some difficult trauma stories with trusted friends, or debriefing, is necessary in some cases. To strengthen my mental health, I took a regular break every third day, for one or two days. Once in every month or two, I went outside the site for a week, in order to relax and reduce emotional stress that came from the interviews. Nonetheless, I was mentally affected by the key participants' trauma stories. Sometimes I felt sick, dizzy and tired. When I faced these conditions, I allowed myself to take a break until I had a better feeling. In some situations, despite getting the trust from the people, I declined being exposed to stress. One time I was given permission to interview a group of women who were raped during the conflict, but I refused the chance because I felt their story would be extremely sad and possibly too stressful for me to handle emotionally.

For asking the sensitive questions of the key participants, a basic suggestion from the psychologist was that I use my own instinct to evaluate the key participants' emotions. In this research, I never forced anyone to be interviewed when I found them having difficulty dealing with their own trauma. Before I started asking the research questions I informed every key participant about the research procedure. They could stop the interview at any time when they felt stress. I found that some participants began crying when they felt strongly affected by some event, natural disasters or violent conflict. When they started crying, I stopped the conversation, asking them whether they could continue or move on to another question or stop the interview. Almost every key participant wanted to continue their story even though they were crying during their answers to my questions. From the two research sites, I found only one person in Aceh who had a deep trauma caused by violent conflict and perhaps could not continue her story in relation to that question. I evaluated this from the way that she kept repeating the same sentence. After I changed the question, she was smiling and told me her experiences smoothly. After I finished their interview, many told me that they were willing to share their story because they believed that my research outcome will contribute the future disaster preparedness plan, reducing the number of deaths and decreasing human suffering. These sentences all encouraged my endeavour to make this research a success and to have the best outcome.

Data Security

I am aware that my research is on a very sensitive topic and that the research result is a highly confidential record. As I was working with universities in both areas and I was living inside the universities, my research data was kept inside the university. Some confidential information such as mental health records was to be used only for my research purposes. The mental health records were be consented to by the participant through their own psychiatrists.

This study undertook research on a sensitive topic. All key informants' names were kept in a manner that maintained confidentiality, even though many key participants were willing to allow their real name to be used in this thesis. Care was taken to consider the safety of all participants, which might later be impacted by this research.

To prevent data from being stolen, multiple security measures were taken including controlling access to rooms and the building where data computer or media were kept. All data was isolated and protected from internal and external threats. The computer was not, for example, connected to the internet in order to prevent hacker or virus attack that corrupted the data. Hardcopy media and material was stored in locked rooms. Only the researcher had authorization to access the security areas. Key-code or door-lock was changed regularly.

Personal information such as names and addresses was removed from data files and stored separately. Information such as personal details that allowed research participants to be identified were not be used in these publications.

Additional ethical measures were taken for young adult participants:

(a) Minors in the Deep South, Thailand and Aceh, Indonesia were taken to include young people aged 15-19 years old. Interviews had only be undertaken with parental or guardian consent.

(b) Children younger than 15 years old were not included in this research.

(c) Parents or guardians of young people were involved in the consent process. Further, I asked for their suggestions about young people's circumstances and attitudes toward the research. Parents or guardians were only, however, be involved in the interview itself with the consent of the young person.

(d) Young adults had been discretely asked to send a non-verbal signal – such as grabbing a ball – to the researcher in the event they did not feel confident to speak out front of their parent or guardian. The relevant question(s) may be asked later, or skipped, depending on the willingness of young adult.

Operationalizing the methodology

Establishing Rapport

Rapport in traditional ethnography needs time for building the relationship for the interview (DiCicco-Bloom and Crabtree, 2006; Fontana and Frey, 1994). It is necessary to understand key participants from their point of view. The building of trust and honesty in the relationship was key in conducting this research project. It helped me gain access to participants and to secure interviews. The key informants felt comfortable to open up about highly distressing topics. Many shared previously secret stories with me and helped me connect with new people, telling their friends and family members that I was a trustworthy. At the same time, it was important not to restrict analysis to those stories recounted by respondents but to consider also facial expressions, gestures and residences. For example, I found that the key informants may have said that they did not have trauma. However, the teardrop on their face during the interview signified humiliating or painful experiences.

In order to get answers from participants, building the relationship between interviewer and interviewee is the key part of qualitative research (Goudy and Potter, 1975). In other words, building trust creates a friendly environment for the key participants. After they feel comfortable enough they will give information close to the reality, especially on sensitive topics such as trauma by natural disasters and violent conflict. In order to meet this stage, I endeavoured to develop positive relationships, at each site in different ways. I also acknowledged that for each person there are differences in culture, social status, gender, age, and ethnicity.

Before this Ph.D. research, I had been working as an interpreter and research assistant. I found that many interviewees' answers to the research questions varied slightly depending on factors such as the social status of the questioner, location, time, objective, and benefit of interest. In this study, I am aware of my own position which involves several social statuses, with both overlap and inconsistency, and the possibility of the perception of status impacting on the interview. However, I was clearly identified as a Ph.D. student while the other statuses were, hopefully, supporting factors in gaining more trust from interviewees.

Aceh: The Beginning of Rapport

I first traveled to Aceh, Indonesia, just a few months after the tsunami of Boxing Day, 2004. I had planned to study the experiences of Acehnese who had lived in the middle of the conflict between the Indonesian government and the Free Aceh Movement. The purpose was to help me understand the impact of violent conflict which had erupted in 2004 on residents of the Deep South of Thailand. The

research in Aceh was funded by a grant from by Asian Public Intellectuals (API). Arriving, in post-Tsunami Aceh, I was confronted, however, by a community in ruins – roads, houses and government buildings all laid to waste.

I immediately felt empathy for the Acehnese people, who had not only endured violent conflict but were also the victims of a devastating tsunami. An opportunity was presented to me – to study people who had lived through both a natural disaster and a violent conflict. Initially, I could not change my research topic but, whilst conducting my fieldwork, I became close to a group of Syiah Kuala University (SKU) Acehnese students, with whom I shared stories of my life as a Thai national. One of these students, who had been my interpreter, invited me to stay at her place that was conveniently located in Aceh city inside the university near the library. She lived at the room rental house. It was four meters wide, with no fan and a small window.

Aceh is a tropical coastal city. Hence, the weather is hot and humid, especially at night. Malaria is endemic and I remember being plagued by seemingly thousands of mosquitoes during the first night. The windows were inadequately screened against insects. Luckily, I did not contract malaria. In Aceh, people do not open their windows at night because of the belief that the hot wind can cause a sickness called '*masuk angin*' – *masuk* means 'in', and *angin* means 'wind'. Later, I bought a fan, fixed the insect screens and bought a mosquito net. Now I was ready to begin my research.

My Acehnese friend excelled in her kindness to me. Not only did she give me a bed, but also breakfast, tea, and donuts, which she served me every morning during my one and a half month stay. Moreover, she volunteered to be my research assistant, introducing me to many key members of the community, taking me to important places, such as her family's hometown in Sigli, which I found later was one of the key conflict areas, as well as one severely affected by the natural disaster. I returned her hospitality and friendship by organizing for her to undertake a nursing master's degree at my Thai university with financial assistance from the Aceh Government, together with some of my personal financial support.

During two years of her study in Thailand, we became as close as loving sisters and I took care of her during her pregnancy that began in her second year of study. In her village, she would have been expected to stay at home until delivery, nor leave the house on her own. My friend returned to her village for the birth, then, after three months, returned to Thailand to complete her studies.

These were difficult and challenging days for both of us, yet, today, this Acehnese friend is my closest friend. When I went back ten years later to conduct research for my Ph.D., her family took me in as a family member, providing accommodation, food, and safety, although my friend had

moved with her husband to live in another province. While I was with her family, her younger sister showed me a fan and rice cooker I had bought for her sister ten years ago. I was stunned. It is hard to describe my feeling of surprise.

During that time, I also stayed at the home of another Acehnese friend from Sigli. Before bed each night, we shared stories of our lives. I learned that she came from the most violent conflict area in Aceh, and indirectly experienced the tsunami. She did not tell me that she was deeply traumatized by violent conflict and tsunami, but almost every time she told me her story, she ended in tears.

She was first exposed to violence when she was 16 years old. Unknown persons were shooting at her house. Her mother had to press her head down on the ground and they both lay on the floor until it finished. This was the first time she felt the fear and terror of violent conflict. Moreover, her anxiety was increased after she heard stories of other people's recollections of violent conflict. Despite wishing to move, the family did not have the financial resources to live in another province. Her father's salary of AUD$150 per month, as a janitor at the elementary school, half of his salary sent to her for the tuition fee and living allowance. It was not enough for living cost and education materials. As a consequence, she had to work as a mathematics teacher to boost her income.

Nursing was not her subject of choice, instead she dreamt of being an engineer, but her mother disagreed. Apparently, being an engineer is a man's career. Eventually, she gained entrance to the Nursing Department in Aceh city and supported herself. Her home village became very poor after the violent conflict experienced there. Tragically, poverty and trauma were dual legacies of the violent conflict in Aceh.

When the tsunami struck, she was a second-year university student, and although wanting to return home she volunteered after listening to a radio broadcast asking for people with medical knowledge to help. The only drugs they had available were Paracetamol and vitamin C but there were long lines of people waiting for her help. She, along with all the people she was helping, struggled with unsafe drinking water, destroyed hospital and roads, destroyed communication systems. The sense of being cut off was complete: no one could get in to help and no one could get out seeking it. The situation was even worse when it was later revealed that almost 75 percent of nurses and doctors had passed away in the tsunami. The remaining 25 percent were deeply traumatized because they had lost their family members.

Later when I went to conduct my fieldwork in Aceh, I was invited to give a lecture at the nursing faculty. One student asked me how she should deal with the condition that both of her family members and patients faced with the tsunami situation at the same time. I told her I cannot answer this question.

Importantly, I was not the only person from my university building relationships in Aceh. On 21 December 2006, a Memoranda of Understanding (MoU) was signed between Prince of Songkla University (PSU), Thailand, and SKU followed, on 9 June 2010, with another MoU between PSU and the Government of Aceh, Indonesia. This MoU was focused on the academic exchange in the post-tsunami recovery period. The MoUs established a pathway to conduct research in Aceh which reduced the complicated bureaucratic system and enabled me to conduct research under post-conflict conditions, especially in remote areas where most of the conflict zones were located. When I went to interview the key informants in a village I then had to seek permission from the head of the village and hand all the documents to the head of the village and the key informants.

Aceh: Ongoing Rapport

After I finished my initial research in Aceh, Indonesia, I realized that if I wanted to continue to study Aceh society in the near future, I must maintain the relationships I had already established. Not only did I need to maintain a personal connection, I needed to establish and maintain an organizational structure to build a strong social network. The latter is essential as I cannot work successfully alone. Subsequently, I linked up with the Nursing Faculty and Epidemiology unit, Medical Faculty, PSU Hat Yai and then I discovered that these two faculties had planned to work with natural disaster victims in Aceh, Indonesia through the post-disaster recovery health project, a project funded by the Rockefeller Foundation and Johnson and Johnson. I did not hesitate to contact them immediately.

I met the project's head, who was both the founder and lecturer at Epidemiology, at Faculty of Medicine, PSU Hat Yai, Thailand. I volunteered to work with them to increase my expertise. In addition, we had the same goal; that is, learning from the people of Aceh who had experience of violent conflict and natural disasters. During this period, violent conflict erupted in the Deep South of Thailand, including in many parts of the upper south of Thailand that were affected by the tsunami at the same time as in Aceh.

I also found that nursing lecturers at PSU, Hat Yai had had a good relationship with nursing students in Aceh before the project started. Previously, in Aceh, there was no Master's degree in nursing. Hence, the first generation of nursing lecturers graduated from the international nursing program at PSU, Hat Yai campus. The tuition fees for the nursing degree at PSU, Hat Yai campus were less than at many universities in Jakarta, Indonesia, and more closely located to the students' homes. In addition, the University's ranking for its nursing faculty, PSU, Hat Yai is in second place in Southeast Asia, after Japan. Another additional advantage for the students is the taste of Thai food and traveling to study in Thailand. These are usually just dreams for many Acehnese students.

The upshot of this was that I not only extended my network in the Deep South, Thailand, but also extended my network in Aceh with SKU's students, government officers, and the local people who joined this project. Many of them had experienced natural disasters. Through this exchange process, a lot of local community members, hospitals, and public health centres in the southern part of Thailand have become an example of 'best practice' for studying sustainable development and post-disaster preparedness. My role at that time was acting as an interpreter, writing reports on lessons learned, and giving suggestions about Aceh culture for Thai staff.

A post-disaster recovery project on health also provided scholarships for lecturers and students from SKU to continue their education, offering Master and Doctoral degrees at PSU, Hat Yai. A few years later, other students from the other faculties such as the medical students from Aceh came to Thailand to continue their education. As the result, not only did I establish an intimate relationship with some Aceh people, but also with many community members and medical staff in the Deep South, Thailand. Hence, when I was conducting my PhD research, many of them helped me connect with key informants. These relationships are on-going. Indeed, many became key informants.

For example, an Acehnese friend who heads the Nursing Department both helped me to contact other key participants and guided me through the complicated bureaucratic system. As a lecturer within the nursing department, specializing in community nursing, he introduced me to many local as well as important visiting people and invited me to lecture at the university, where I discovered more people who had experience that related to my research topic. Due to his position, I also met with government officers and politicians from the most conflict-prone parts of Aceh province. My friend was also an important participant in his own right. After the tsunami struck Aceh, he opened his home as a shelter and as a centre point for international aid agencies. To this day, he opens his clinic at home to treat patients cheaply and sometimes for free. His reputation for kindness is widely known and he is affectionately called a bearded father (*Pak janggut*) because of his appearance.

In the first two months in Aceh during fieldwork for this thesis, I stayed with one psychologist who had been working with victims of both the tsunami and civil conflict. I met this psychologist through my old Aceh network of friends. I discovered that many tsunami victims knew of this psychologist, and they opened up to me during the interview when they learned I was a guest of this psychologist. The key participants know I am a sociologist. I never met anyone misunderstanding my role.

Later I stayed at the International University guesthouse provided by SKU, as a result of MoU collaboration between PSU and SKU. Then, on and off, I lived with my Acehnese friend in Sigli,

located amidst the conflict areas and also affected by the tsunami. Although I received free accommodation whilst researching in Aceh, I never forgot to give the gifts and small amounts of money for the families that provided me with food and accommodation. In the first two months, monthly, I went to Penang for renewing my visa and took a short break from the fieldwork. Occasionally, some of my relative's friends invited me to stay with them but I preferred live with my host family. I politely declined their invitations.

Whilst I was conducting my Ph.D. research in Aceh, I coordinated a new project for the Epidemiology unit, PSU, Hat Yai, with representatives of the provincial governor, at the time of both the most violent conflict in Aceh province and of the tsunami. The new project aimed to improve computer capacity to store various databases. Helping to organize this project helped me to get to know many important key informants who were the leaders of the regional government and the members of *Free Aceh Movement*. This project also helped reduce the complexity of documents I had to navigate when I started my interviews.

Rapport in the Deep South of Thailand

It was a different experience building rapport in the Deep South of Thailand because my relationship with that area, as outlined in Chapter 1, already existed. Although I was born and raised in Bangkok, my father came from Rueso district in the Deep South of Thailand and I regularly visited members of my father's family since I was an infant. Hence, I shared and learned the sociocultural patterns of the Melayu ethnic group even though my formal knowledge of other ethnic groups in Thailand, learned in school in Bangkok, was limited. Many village people recognize me as a part of a local family. They have introduced me to their friends and others family members as I have sought key participants for my research. Thus I had no difficulties finding people willing to be interviewed and to share information that they may otherwise have withheld from a stranger.

Since November 2005, I have been a lecturer at Prince of Songkla University (PSU), Pattani campus, Thailand. Consequently, I had many past and present students willing to help me connect with key participants for my Ph.D. research. At the same time, I worked as a volunteer with local NGOs in the Deep South of Thailand – mostly writing project proposals and reports – through whom I learned that there were no clearly identified individuals or organizations responsible for people impacted by violent conflict.

The violence that occurred in the Deep South of Thailand from 2004 was actually a war experience, even though the situation was not acknowledged as such by the Thai government. I began my research by applying the experience I had gained from being a research assistant at the Center for

Social Development, Political Science Faculty, Chulalongkorn University in Bangkok after I graduated with a Masters degree. This involved deepening my relationships with local NGOs in the Deep South of Thailand, with environmentalists, and the other civil society activists, especially women and youth, all of whom had experienced the violent conflict and a natural disaster event.

In 2006, after a few years of violent conflict in the Deep South, Thailand, I was one of the research team members for the National Reconciliation Commission, Thailand. My research focused on the impact of martial law on persons with Muslim identity (National Reconciliation Commission, 2006). During the conflict, I interviewed people from many human rights organizations and international NGOs who were interested in building peaceful relationships as well as in monitoring the situation. In addition, I was a president of many conferences and academic seminars. For example, I was the president of the fourth national sociology conference, entitled '*Same Land but Live like Different World: Sociology Imagination for the Future'*, during 22-23 September 2010 which enabled me to engage with many scholars and to extend my existing network. The downside of this close relationship that I faced when I had to interview the key informants in the Deep South, Thailand was that many of them did not know what story should be told because they thought I knew almost everything already. For example, I volunteered myself to work with some women's empowerment groups who were affected by conflict and I was the founder of the disaster preparedness network. My solution was to inform them that this time I was a Ph.D. student and I wanted to listen to their personal story from their particular point of view. However, I was also aware of my bias. Hence, I was always trying to get to know more people outside my circle. Because of the excellent reputation of my work and the organizations with which I had worked I was able to interview the key informants with minimal introduction. As a result, I was able to interview key informants who came from a variety of ethnic groups, religions, genders, and ages.

I had followed one disaster preparedness group who had experienced working in the Deep South, Thailand. The head of this group had started establishing the community group network in the Deep South, Thailand after many parts of Thailand had been affected by the tsunami in 2004. However, due to the violent conflict in the Deep South and some conflict among the members, he decided not to continue the project, moving to work with the people who had experienced the natural disaster in the upper south of Thailand which was funded by a health organization in Thailand. When I went to observe this activity I also met the key informants who came from the Deep South. I was surprised to learn that although the health organization had more than 4,000 scholars, no one wanted to work on disaster preparedness in the South (Upper and Deep) because the area was experiencing violent conflict and natural disaster.

To sum up, my previous work experience and the networks that I had established furnished me with an extensive network of people I could interview. In fact, I had more than 300 interviewees from Aceh, Indonesia and the Deep South, Thailand. Mostly, the time spent at each interview was no more than two hours. At some academic seminars in Aceh, Indonesia, the organizers invited me to share my knowledge and experience. Similarly, in the Deep South, Thailand, a workshop organizer invited me to be a moderator. This opened opportunities for me, listening to people discussing their experiences and answering my questions.

Languages Used in the Field

To conduct interviews, I used at least six languages – notably, Thai, Thai southern dialect, Melayu, Indonesian, Jam, and English. In the Deep South of Thailand, I needed at least three languages – Thai central dialect, Thai southern dialect, and Melayu while in Aceh, Indonesia, I used three languages – Indonesia, Jam, and English. Interpreters were hired as necessary.

Thai central dialect is my mother tongue. I can understand Thai southern dialect but struggle to speak it. Melayu language is another in which I have limited capacity. In 2005, I learned the Indonesian language at Gajamada University, Yogyakarta when I went to do research in Indonesia. My listening is better than my speaking. It is sufficient though to understand what my participants were saying and what was missing from my interpreters' interpretations. For Jam, I can only count the numbers, say greetings, and sing a song – enough to help establish friendship and elicit smiles from people in Aceh with whom I was interacting.

Indonesian is an official language in Indonesia, I know some basic Indonesian language, having studied Indonesia language at the Gajamada University and practised my speaking with my friends. This was enough for me to understand participants' responses during the interviews, but not for asking the questions. Interpreters were used. I found that understanding the speaking was very useful because I could check and sometimes correct research questions that were asked by my interpreters during the interviews. In addition, it saved time by avoiding the need to translate again from Indonesia language into the English language.

Jam language has been used by local people in Aceh. My first plan was to find interpreters as research assistants from among the nursing faculty at Syiah Kuala University, partly because nurses had been disciplined through their training to acknowledge the importance of maintaining the confidentiality of patient information. I also planned to reinforce ethical issues with my interpreters

before I interviewed the participants. However, I found later that hiring university interpreters would be very expensive and would exceed my maximum budget.

At the first date that I arrived in Banda Aceh, my Acehnese friend who was a lecturer at the nursing department offered her sister to be my research assistant. She has a high profile, was newly graduated from Sydney University and was fluent in three languages – Indonesian, Jam, and English. The ethical protocol was repeated to her again in relation to how to maintain patient information confidentiality.

During six months of my research, more than six interpreters had to substitute for the main interpreter, due to her sickness with Malaria fever, her mother's sickness, and her stress from transcribing the tape recording of interviews. Hence, I had to recruit more interpreters from her network, but in each case I ensured emphasis on the confidentiality of participants' information.

The benefit of a new interpreter was that some of them were local people who came from the conflict areas. Hence, the new interpreter could help me find more participants who had experienced the tsunami. However, not every interpreter could speak English very well, especially those in Aceh, Indonesia. Some of those interviewed preferred to have their friend as the interpreter, and I did not deny such requests.

However, at the last month, Aceh province had started to have new elections, at both local and national levels. The situation was tense and turned into conflict, and violence. Before the election date had started, the three local parties in Aceh had started attacking and killing each other by bombing, and shooting, especially in the remote areas where I planned to interview more participants.

During the period when I had been conducting my research, I always reported my situation to my supervisor, asked for a second opinion, and informed of violent conflict. I gave the detail that I was staying with my family friend who would offer protection from the violent conflict situation. In addition, I always ensured that I would receive the information and warning messages from my Acehnese friends to prepare myself, for example, in case the main governing party lost the election.

Later, when the violent conflict situation was increasing, I could not find any interpreters to assist me in the zones of most conflict. For my safety, I decided to terminate my research in Aceh, having already spent six months there.

The Experience of Data Collection

Flexibility and sensitivity were required to deal with the challenges of disaster research outlined earlier in this chapter, along with cultural and other differences among participants. Aftershocks, ongoing natural disasters, post-violence conflict and ongoing violent conflict were all considerations in the day-to-day planning of fieldwork. Aceh, Indonesia is considered as part of a 'ring of fire'. Until now, Aceh has to face monthly earthquakes, sometimes many times in a month. Even though, Aceh had a peace agreement with the national government, post-violence conflict, especially during the election period had existed. In the Deep South, Thailand, there has been ongoing violent conflict and yearly natural disasters have been happening. Due to unpredictable situations like the natural disaster and violent conflict, I found a number of people who migrated to another area such as living in another village or in other countries. I was trying to follow these people, but it is an option which depends on many factors such as budget, the consent of the key informant to give their interview, and researcher ability.

As a Ph.D. student who had experienced the violent conflict situations and natural disasters, under the fieldwork condition I have been learning to be prepared for every unpredictable situation. In addition, I felt responsible for the key informants who gave the research information. Many of them told me that they had never before talked to anyone about their trauma experience, but for research benefit and to better the lives of future generations, they felt a desire to share their story. Hence, my anxiety when conducting this research was that I had to ensure I survived and shared their stories with the public, in an academic space.

One of my safety plans when conducting the research was preparation to interview some participants more than once, in case the violent situations or the natural disaster happened during the appointment. I had been prepared to postpone the appointment with the interviewee if a disaster happening might affect to key informants' emotion. As the researcher I was attentive to signs of fear and of feeling uncomfortable about giving their interview. My role as a researcher was to not force them for only the researcher's benefit. In this research, I had to interview some of the key informants more than once, due to the violent situation happened during the appointment. Nevertheless, I was also conscious that in order to keep myself from deep depression I had to ensure that I had enough energy to focus on the research and avoided unnecessarily visiting the incident areas or the victims who had been affected by a violent situation.

Further, I needed to balance flexibility with organization. According to Acehnese culture, I could not conduct an interview until I had made an appointment for a face-to-face meeting, an appointment that was reconfirmed by text or telephone calls. Contacting my interviewees by email

was not a feasible option due to poor internet coverage and daily afternoon power outages. In addition, I needed time to send and process the official documents and to monitor and follow up interviewees almost every three days.

Comfort Zone for Interviewing

In the beginning, I was concerned about what would be a comfortable place in which to interview the key informants. For example, under a conflict situation, I assumed that interviewing the key informants at their own house or village in front of their relatives and families may create an uncomfortable feeling or even fear during the interviews. I recognized that the comfort zone of each key informant would depend on their culture, including ethnicity and religion. In addition, each person might need a comfort zone in a different area. In Aceh, Indonesia, I planned to mainly use Syiah Kuala University (SKU) which is situated at Aceh city because SKU is located in the city, affected in only a minor way by the violent conflict, but affected by natural disasters. Prince of Songkla University, Pattani, Thailand is acknowledged as a neutral zone and it close to the most affected natural disaster area, however, I found many interviewees felt relaxed and comfortable about being interviewed at home (in a living room), or in an office, a tea and coffee shop or a and friend's house. Before arranging the interview, I asked key informants about where a comfortable place for them was.

During the fieldwork, I found many key informants felt comfortable to be interviewed together with some trusted other such as friend(s), wife, husband, and other family member. I planned to conduct the face-to-face interview in a closed area because my research questions had high potential to evoke person's trauma. However, in some situations, participants felt comfortable to give their interview together with the one that they trusted. In addition, in the remote areas far away from the university it was hard to realistically invite the participants to an interview in the place that I had already prepared, due to the limitation of time and budget. Hence, the comfortable place for them to be interviewed had, in many cases, been chosen by the participants.

As a researcher, I tried to inform key informants about face-to-face interview research method. Mostly, I got cooperation from them but not every time. Even though I had already prepared the closed space for the interview, there were a number of key informants who preferred to be interviewed at their own house in the guest room, or at a friend's house, the meeting point, restaurant, coffee shop, workplace and public pavilion in the village, or other place. Some key informants were very busy with their work and social activities and I had to make another appointment date and time for when they were available.

Using snowball research methodology, I had a chance to follow up with some of the participants who had been affected by both natural disaster and violent conflict in the disaster areas. Not only had people travelled and migrated because of social factors such as education, job occupation, and poverty, but also under violent conflict and natural disaster situations people had often been forced to migrate.

Comfort Zone in Aceh, Indonesia

In Aceh, all important places such as government offices and the airport are situated in Aceh city, which brings many participants to travel to this area. Some key informants had been studying at the Syiah Kuala University and been affected by the tsunami when they were students. During the fieldwork, among natural disaster student victims who had been studying at that time, some of them had experienced the violent conflict, with many of them originally from the most violent conflict areas. In Aceh I also found that some key informants had moved back to their hometown to escape the violent conflict but had later been affected by natural disasters.

It was envisaged that most interviewing would take place under private conditions, such as in closed rooms or living rooms in the participants' houses. Yet young people in Aceh said that they felt more comfortable and relaxed giving the interview at school. Some of them were assisted by their own teachers. For young people in the Deep South of Thailand, by contrast, many felt safe to be interviewed in the village.

Due to the natural disaster in Aceh, Indonesia, almost every night, it was hard to get a deep sleep because I had to be careful of the earthquakes which happened monthly. In addition, almost night after night I felt small shakes whilst sleeping on the bed. Sometimes, I was called to run out of the house while taking a bath, because an earthquake was happening. Moreover, when I visited the disaster areas, I had to be aware of all kinds of the disaster which might be happening at any time. Sometimes my appointment had to be cancelled because a big earthquake had occurred, on one occasion with more than 300 houses damaged. Everyone who I planned to interview was busy with providing refuge and aid. I had to change my plans. Even though it was ten years since their experience of the tsunami, and essentially a post-conflict period, the interview was like the trigger that refreshed each key informant's memory. They were able to recollect and describe their trauma in considerable detail.

This research had been conducted after Aceh, Indonesia had a peace agreement. The post-conflict violence happened during local and national elections, which affected my data collection process. I had received a phone call and a face-to-face warning to increase caution for my own safety

by stocking food and water, in case the violent conflict occurred immediately after the election. Luckily, until the end of the research period in Aceh, Indonesia, nothing in my immediate proximity happened. However, a week before the election date, I went to the area of greatest conflict, a tsunami affected area, and there the local news reported about the attacking of local parties and consequent deaths and injuries. I had to be alert to almost monthly earthquakes which had been happening since the tsunami hit Aceh on 26 December 2004 as well as occasional outbursts of 'post-conflict' violence.

Despite snowball research methodology that I used for conducting the research, I did not have a network for interviewing the military who worked during the natural disaster and violent conflict. In addition, the latter were high-risk interview subjects and I felt insecure if I had to start interviewing the military outside my previously well-known network. Even though Aceh has a peace agreement, even now, the violent conflict remains a sensitive topic to discuss with anyone. I found that some key informants were deeply traumatized when starting to share their experience of violent conflict but easily shared their experience of the natural disaster. I observed the deeply traumatized participants repeating the same sentence many times, and appeared 'stuck' and unable to move to the other topic, crying and looking on the floor with blank eyes.

Comfort zone in the Deep South of Thailand

In the Deep South of Thailand, violent conflict has been occurring many times. I had to cancel one interview appointment due to the violent conflict happening at the front of a key informant's village. When some key informants chose to give their interview in a public space, they preferred to invite the other villagers who passed by, but this prevented or impeded the giving of their interview. As a result, occasionally, a face-to-face interview had become a group interview. However, I acknowledge that during the group interview someone might dominate the conversation above the other with less power to express their opinion. In my case, during the group interview, one fisherman changed his answer almost immediately from 'fear' to 'not afraid' when his friends were laughing at him when I asked how much fear he had experienced during the storm surge. His answer had changed when his friends told him that 'being a man he should not feel afraid of only a sound of thunder'. However, I found some benefit in accidentally conducting the group interview. It was the key informants helping each other provide information from their perspective, lively conversation, and fruitful information. Many of them were not hesitating to add more information, correcting each other's data during our conversation. Some of them told me that they do not want to give wrong information for me. Not only do I have a role of Ph.D. researcher, but also as a role of a lecturer with status who should not be given invalid data. Hence, interviewing many people should give me benefit in the research. Some said that this was their main reason for giving information. In addition, some

key informants quickly nominated which one was the rich key informant suitable for answering the particular research question. Sometimes another appointment was made with a key informant after finishing the group interview. I chose not to cancel the interview when it became a group interview because I felt it was not polite to cancel and some of the potential informants had been waiting for more than an hour just for the interview.

Even though the violent conflict had been happening near the key informants' village, many informants said that they feel safer and more secure among their own friends in a familiar environment, like home. Almost every time when I had been traveling to interview the key informants, I encountered evidence of incidents along the main roads such as cars with bullet holes and other crime scenes. I had been living in the Deep South, Thailand teaching at the local university, and had a family network in the zone of conflict. Nevertheless, for travel during data collection, it was almost impossible to avoid the violent conflict areas. For example, only three days after I had arrived at Pattani, the Deep South, more than 36 bombs exploded across many areas, the nearest incident happening at the ATM near my accommodation. As a Ph.D. researcher I was tense but always aware that the main lens must be the safety of key informants, my research assistants, and not just myself.

Travelling to Interviews

Walking, riding motorcycle and bicycle, driving a car, taking a local taxi were all the different traveling methods that I had used in Aceh, Indonesia. Different modes of transportation gave me different perspectives about people in Aceh. Before I went to interview informants or join a social activity, I informed my host family and asked their permission. In addition, I had friends and local interpreters who accompanied me while I was conducting the research in the field. When I had to interview the key informants in the areas of most conflict and the area's most prone to natural disaster, I made an appointment and informed my close friends before I arrived at the appointed place, in case an unpredictable situation happened.

In the most conflicted areas in Aceh, I usually woke up at 5:00 am to pray. After that, I went to walk and run from my host family's house to the beach. On the way, I imagined how people escaped from the tsunami. While I was walking, with every footstep, I was able to estimate the length of the distance between the seashore and the safe area. In the village and city complex that had been built by many aid organizations, I spent time walking, taking the pictures, talking with the people, and observing the houses. In some areas, I saw angry faces. Sometimes, I was yelled at by people who were sitting on public chairs. But I did not understand why? Later on, my Acehnese friend who walking with me told me that they were angry because many people had come and taken a lot of

pictures, promised to give many things such as a better house and money, but until now, these people had not returned and the tsunami victims' conditions had not changed.

Traveling in the Deep South, Thailand I used my own vehicle. Under violent conflict, the situation was tense and risky. From my experience, during the first few years of violent conflict every now and then, especially on a Friday, there was no public transportation because the drivers were threatened. Hence, when I was conducting Ph.D. research, mainly I used my own vehicle that was familiar to local people and safe enough for avoiding the BRN attack. One time, I was offered the loan of a police car when my car had accident but I declined it because most of the government officer's car license plates have been recorded by a group of BRN and now listed to be the main targets of violent conflict.

I travelled with my father and some of my local students. Many times, I travelled with the local NGOs who work closely with many communities in the Deep South, Thailand. However, one time there was a car accident after I had finished the interview, at dusk in the most violent conflict area. Within a few minutes of the accident, not only the police and the car insurance guarantor had arrived but also many soldiers together with Harvey tanks.

As I was about to begin the fieldwork, both in Aceh and Thailand, violent conflict flared again. There was shooting in the Deep South, Thailand, and bombing while in Aceh, Indonesia, especially during the election period, when the local parties had attacked each other. There also were monthly earthquakes in Aceh. Hence, the security plan had to be made before I commenced the fieldwork.

Gender and the Interview

As a woman researcher, I see through a gendered lens. Here, I am aware of my own limitations. Hence, in this research, I chose to interview male key participants as well as females and share their story in this research report. The surviving wives, husbands, family members and friends told their stories such as of a husband or wife who passed away by disaster.

Asking sensitive questions based on the gender approach, like 'As a man, do you still have trauma?' was challenging. Many men preferred not to show their weakness in front of their wife and family members. However, I found that some of them were not afraid to show their psychological trauma during the interview, even when among family members or friends. One participant even said that 'Even though I am a man, no one will understand my feeling of loss when I thought I might lose my wife and children. I was crying because I was very deeply sad.'

Limitation of female researcher

Due to cultural norms, I was careful interviewing married men. Face-to-face interviews were inappropriate for some cases. I interviewed males who were husbands who had a wife accompanying them. Wives liked to treat the researcher as a guest by bringing tea or snacks during the interview. Men appeared to prefer to be accompanied by wives when I asked the questions. My solution was trying to ask the husbands or wives politely for the interviewing to be conducted under the condition of privacy. I told them this was one of my research methods. Almost every time I got cooperation from them. However, on some occasions, it was difficult to ask them to leave because I as a female was interviewing male participants. My gender role was affecting perceptions and so I sometimes opened by being polite and not asking a wife to leave the interviewing area. For male participants who were accompanied by a wife, I tried to ask the sensitive questions at opportune times, such as when the wife went to the kitchen to prepare food. As a result, I found that many male participants immediately told me something like 'Yes! I still have trauma, but please do not tell my wife.'

When interviewing single fathers, I found that they sometimes appeared to feel ashamed and reluctant to speak out about psychological trauma, especially, about the difficult life in having to raise the children after their wife passed away as a result of the tsunami. Many asked me not to share their trauma story with their children or share the story with other people, 'Please do not tell anyone, my story might differ from the others' was a sentence repeated many times.

As a female researcher, I did not find any major problem with interviewing men or religious leaders in Aceh, Indonesia and the Deep South, Thailand. I was confident and I assumed that I had a good connection after having worked post-disaster on health and development projects with them for almost ten years. Many participants knew me before I had started conducting the research. Only one participant from the Deep South, Thailand clearly displayed discomfort to the point of not granting me an interview. He said that this was because I was studying in Australia and that this country is like the USA which he considered to be a country against Islam.

One limitation of this research was the omission of lesbian, gay, bisexual, and transgender (LGBT) lived experience. I did not purposely neglect to study this group. However, obstacles included: first, LGBT people in Aceh, Indonesia and the Deep South of Thailand are thought to be an extreme minority. Second, I did not have a network through which to contact them. Third, the LGBT community in Aceh has been vulnerable to arrest by the religious police (Sharia police) when they are exposed due to the illegality of same-sex couples living together. Many in the LGBT community have mental illness because of discrimination. For these reasons and time limitations, their story does not appear in this research.

Self-Reflexivity and Data Analysis

Researchers are not only to report the other voice, but also to acknowledge the relationship of their voice, including telling why and how they claim to know what they know (Tracy, 2010). In my own research the key element of my data analysis is to strive for objectivity, being careful to avoid possible bias or priority to people who have shared similar characteristics with me, as a person who has experienced natural disasters and violent conflict, as a woman and as one of an ethnic minority - Melayu, a Thai citizen, a mixed-marriage child, a sociologist, lecturer, and academic activist.

I have developed my expertise for researching the impact of natural disasters and violent conflict on people and for examining the resultant psychological trauma, through my ten-year association with many groups of people in Aceh, Indonesia, and the Deep South of Thailand. I had had extensive research and working experiences in both countries before I started my Ph.D. As a result, this expertise distinguished me from other researchers who have only spent a short period, usually less than one year, conducting their fieldwork. In summary, my research should be authoritative because of my language skills, awareness, and my practice of exercising cultural sensitivity, and also because of my utilisation of extensive close networks.

Nevertheless, I am fully aware of limitations of my connections. Firstly, not all NGOs will have a good relationship with the villagers and the local governments. Similarly, many local government agencies and local villagers have a limited understanding of NGOs. Moreover, when actually inside communities, amongst the villagers, I discovered the complexities of relationships and power structures such as the rivalry between formal and informal leaders, religious leaders, the member of villages, as well as gender issues.

In my role of Ph.D. student which was quite different from my previous role, I interviewed people who had various beliefs and ideas not encountered in my earlier networks. As a result, I was able to establish strong networks and continually extend existing relationships by using snowball sampling research methods that I had developed through my previous networks. Within a year, I was able to interview more than three hundred participants from both areas studied.

The driving force for my research has obviously come from my previous experiences of having been affected by natural disasters and violent conflict. I had my own descriptions of trauma by natural disasters and violent conflicts. However, in the role of sociologist, I cannot assume people's experiences, especially because we are coming from different social backgrounds.

As a woman, I was socialized by social norms to acknowledge that I am physically weaker than men. However, my social status as an older sister who has a younger brother and many cousins,

male and female, I was taught to be a leader, including being a role model for the other members for my family, relatives, and community members. The expectation of people surrounding me is that it becomes my responsibility for their safety. Third possibly influences my concern for women, children, and men who might have low social status.

On the point of my being a child of a mixed-marriage, I recognize the relevance of dominant and subordinate culture, including the gap of knowledge between two ethnic groups. Unintentional ignorance of the majority about people who are different by ethnicity and/or culture makes me have empathy for people who have less power and are often voiceless. I overcome my own experience by understanding the range of networks of relationships, including minorities among the minority. This is how it is for Thai-Buddhist, Thai-Christian, Sakai, and Chinese-Buddhist in the Deep South of Thailand and for Chinese-Buddhist, Batak-Christian, and Javanese in Aceh, Indonesia and for other people who have less power and no voice. All should have space in my data analysis.

I am also an academic activist. I have had years of experience in research experiences and development projects in both sites used for this research. Due to long-term relationships, I might see some things that may be useful for my data analysis. On the other hand, I acknowledge that my background might make me overlook some experiences that could otherwise be valuable from the sociological point of view.

Conclusion

In choosing research methodology appropriate to disaster and conflict contexts this thesis preferred qualitative research in order to gain deeper knowledge and understand the complex interactions between disasters, conflict, social responses and trauma. As noted in the Introduction, the unpredictability, dynamism, sensitivity and social disruption characteristic of disasters require sociologists to situate their knowledge of general sociological research methods within an advanced understanding of theory pertaining to human behaviour in those disaster situations (Killian, 1956; Stallings, 2003).

More specifically, in order to understand traumatization as a process I used a variety of data collection methods including semi-structured interviews and visual methodology. As traumatization is connected both to key informants' experiences and to the responses of others, methods were needed that are sensitive to the ways in which people adapt their behaviours, emotions and social performances in ways deemed acceptable by their society. I needed to explore both verbal and non-verbal communication – the ways in which people narrated their traumatic experiences through storytelling and words and the things they communicated through facial expressions, gestures, body

movements, tears and laughter during the course of interviews. Six languages were used to conduct interviews along with understanding of comfort zone and gender differences between researcher and interviewees. Visual methodology, used with young people, helped me to explore what participants struggled to vocalize – the small details and hidden meanings in their pictures. Additionally, I reflected on how my own social position might influence the ways in which interviewees from different social backgrounds answered questions.

To investigate secondary trauma, I built on interview and visual methods with observation of physical materials and people's daily activities. The experience of human tragedy can be seen in places, monuments, properties and construction sites. The experience of tragedy can equally be seen in absences – in unfinished houses, abandoned evacuation sites, and the materials and structures removed following traumatic events.

To explore cultural trauma, I used participant observation and rapport-building in the research sites to examine experiences of trauma in local contexts, studying and observing sensitive stories within long relationships in both research areas. Trust building was particularly important in this respect. Key informants needed to know they could trust the researcher and that their information will not be turned against them after sharing their stories. At this point, psychological trauma needed to be understood at the cultural level with sensitivity to peoples' religious beliefs, the ways in which institutions such as the family worked in each research site, and changing gender relations.

Chapter 4

Background of Study Sites

This chapter presents comparable information from the two research sites – Aceh, Indonesia and the Deep South of Thailand, including both general information on the sites, the natural disasters they have experienced and their histories of violent conflict. This summary of background information is intended to support the development of psychological trauma knowledge through the research.

People in these areas differ in a number of respects including history, culture, ethnicity, the root causes of violent conflict and types of natural disaster. At the same time, both research sites are within ASEAN countries and cross-cultural sharing across with the region is a part of their identity. Understanding both the commonalities and uniqueness of the sites is important in order to avoid ethnocentrism and over-generalization (Campbell and LeVine, 1961). Jobson and O'kearney (2008) argue that cultural differences can be related to traumatic experiences; that is, that the ways people process traumatic life events are related to their cultural experiences. They point out that cultural factors such as traumatic history, demographics, participant characteristics, and social roles of trauma survivors should all be considered as potential vulnerabilities. Cross-national comparison is thus used in this thesis to help unpack the relationships between culture and trauma (Peacock, 1997). The researcher's (my) background knowledge of the study sites and their cultures was an advantage when considering the impact of culture.

The southern part of Thailand and Aceh are geographically close. Hence, not only was the relationship between the universities from both countries close, but many Acehnese people had previously travelled to the southern part of Thailand. Many religious leaders had graduated from an Islamic traditional school in Pattani. Some of them could speak Thai because they had spent many years studying the Islamic religion in southern Thailand. Some Acehnese people acted as interpreters for Thai fishermen who were arrested for illegally fishing in Indonesian waters. Many diverse activities, such as shopping, vacationing at Phuket and other places in the southern provinces of Thailand, receiving medical treatment from the clinic at Hat Yai, Songkla, Thailand, admiring Thai actors, watching Thai horror movies, and having family members who live in the southern part of Thailand helped create a network between the southern Thailand people and Aceh people. I benefitted

from this close and friendly association between people of the regions. When I introduced myself as a Thai citizen, a lecturer at PSU, Pattani, and a Muslim in Thailand, almost every Aceh person expressed the view that they had something in common with me and welcomed me as a friend. The imprint of disaster damage could be found as the historical material context including the damage of the houses, the pictures of the deaths that exhibit in the museums, inside mosques and the tsunami graveyards.

General Information

Aceh

Aceh is a province of Indonesia situated on the island of Sumatra. The capital city is '*Banda Aceh*' (*Banda* means city). Aceh has an area of approximately 58,375.83 km2, with a population of approximately 4,494,410 in year 2010 (Badan Pusat Statistik, 2012) (See Table 2).

Table 2: Aceh Population by Province 1971, 1980, 1990, 1995, 2000 and 2010

Province	Population					
	1971	1980	1990	1995	2000	2010
Aceh	2 008 595	2 611 271	3 416 156	3 847 583	3 930 905	4 494 410
Indonesia	119 208 229	147 490 298	179 378 946	194 754 808	206 264 595	237 641 326

Including Non-Permanent Residents (Homeless, Seafarers, Boat Houses, and Dwellers / Lodgers)
Source: Population Census 1971, 1980, 1990, 2000 and Intercensal Population Survey (SUPAS) 1995

Population grew in Aceh between 1971 to 1995 from 2,008,595 to 3,847,583. By 2000, this had slowly increased to 3,930,905. Overall population growth has fallen to less than 1 percent since Aceh has conflict between 1976 to 2005. However, after Aceh experience by tsunami, in 2010, Aceh's population rate had increase to 4,494,410.

Aceh is home to a variety of ethnic groups. In 2014, these were re-classified into 12 categories for statistical purposes (Ananta, Arifin, Hasbullah, Handayani and Pramono, 2014). The categories included Aceh/Achin/Akhir/Asji/A-Tse/Ureueng Aceh combined with Lambai/Lamri, separated from the Alas, Aneuk Jamee, Singkil, Tamiang, Gayo, Simeulue and Kluet. Gayo can be broken down further into Gayo, Gayo Lut, Gayo Luwes and Gayo Serbe Jadi, while Sigulai is part of Simeulue. The Acehnese are the biggest ethnic group. However, there are many more minority ethnic

groups including Chinese, Arab, India, Bataknese, Sudanese, Turkish, Javanese and Peranakan Chinese living in Aceh province. These new ethnic categories still have some limitations, especially to understand mixed-marriage people who live in Aceh society.

The local ethnic groups that live in Aceh have different histories. For example, some Javanese are military officers who were working in Aceh area. Indian and Chinese ethnic groups have a long history with Aceh through trade (Brewster, 2011; Reid, 1980; Willmott, 2009). For the Indian ethnic group that has lived in Aceh city for more than three generations, the population declined from 300 to 100 because of the giant waves (Interview with the leader of Indian ethnic community). Besides a trade history, in 1965 – 1966, the Chinese in Indonesia experienced massacre (Cribb, 2001; Cribb and Coppel, 2009; Willmott, 2009). At the present time, many new generations of ethnic minorities consider themselves as Acehnese (Interviews of Chinese, India and Bataknese ethnic group). They described that they were born in and grew up in Aceh, hence, they consider Aceh province their home.

Many religions in Aceh can be found; namely, Islam, Protestantism, Catholicism, Hinduisum, Buddhism, Kong Hu Chu and others (SeeTable 3). Islam is the majority religion, followed by Protestant Christians, Roman Catholics, Buddhist and Hindu.

Table 3: Number of people adhering to various religions in Aceh

Religion/Gender	Female	Male	Total
Islam	1,972,541	1,946,363	3,918,904
Protestantism	19,825	19,524	39,349
Catholicism	2,331	2,327	4,658
Hinduisum	181	130	311
Buddhism	3,276	3,407	6,683
Kong Hu Chu	35	16	51
Others	434	463	897
Total	1,998,623	1,972,230	**3,970,853**

Source: Adapted from *Badan Pusat Statistik* (BPS), Population of Nanggroe Aceh Darussalam, *Post Earthquake and Tsunami*. Jakarta: 2005: 97-99.

The official language is Indonesian. The local language is Acehnese-Chamic (from Vietnam and Cambodia). Many Acehnese can speak Malay and Arabic. Another two common languages are Langkat and Asahan, mostly spoken in North Sumatra as local languages and in Kedah in Malaysia.

Economy in Aceh

Major contributors to the gross regional domestic product of Aceh are agriculture, mining and quarrying, oil and gas industries, non-oil and gas industries, electricity and water supply, building and construction, trade, hotel and restaurants, transportation and communication, banking and other financial intermediaries and services (Chatani, 2010). In 2007, exports included mineral fuels, mineral oil, fertilizers, cocoa and cocoa preparations, inorganic chemicals, animal or vegetable fats and oils, organic chemicals, fish, crustacean, wood, lumber, cork, printed book, plastic, apparels, live trees and other plants. Reflecting the employment profile of Aceh, training needs have been assessed as mostly vocational including retail shops and services (computer operator, photo copy and baby sister) 27 percent, followed by mechanic (motor bike and car repairing) 20.5 percent, sewing and embroidery 8.6 percent, repair (mobile phone) 10.5 percent, carpentry (furniture, wood design and building), food production and food processing (cake, bread, tempeh chip making, production edible mushroom and seeding) 8.1 percent, handicraft (merchandises, handicraft, bamboo work) 4.6 percent and others (brick production, duck feather) 0.8 percent respectively.

The Deep South of Thailand

The Deep South of Thailand is located in the southern part of the Kingdom of Thailand or Siam. In 2015, the total population from the registration record by sex and area, whole kingdom is 65,729,098.

The southern provinces of Thailand are commonly divided into two parts, fourteen provinces; the Upper South and the Deep South. They have a combined area of 70,715.2 km^2. The Upper South has seven provinces; Chumphon, Krabi, Nakhon Si Thammarat, Phuket, Phang Nga, Ranong and Surat Thani The deep-south has seven provinces; Trang,.Phatthalung, Satun, Songkhla, Yala, Narathiwat and Pattani. In 2015, the total population of the Upper South and Deep South was 9,290,708 people. This research has focused on three of the southern provinces, Pattani, Yala and Naratiwat, which, in 2010, had populations of 609,015, 433,167 and 670,002 respectively.

Reliable data on the composition of ethnic groups in this area is scarce as Thailand's population census does not collect data on ethnic or racial composition (Committee on the Elimination of Racial Discrimination, 2011). According to the UN report (Committee on the Elimination of Racial Discrimination, 2011, pp. 5-6), Thailand's Department of Provincial Administration, Ministry of Interior, defines 'minorities' as 'probably groups of persons without Thai nationality, who are less in number than the original inhabitants of the country and have distinct cultures and traditions; have entered Thailand in different ways, i.e. as illegal immigrants, or granted

temporary shelter.' Ethnic difference is equated solely with migration and/or displacement and the possibility of ethnic diversity *among* Thais is implicitly rejected.

In general, ethnic groups in the Deep South of Thailand include Thai, Malayu, Sakai, Patan, Chinese, Moken, Moklen, Urak Lawoi. Indian and Burmese ethnic groups are mostly present as migrant workers. According to the Thai Government's National Statistics Office (2011), the majority religion is 94.6 percent Buddhist, 4.6 percent Islamic, and 0.7 percent Christian, with another 0.1 percent adhering to various other religions. As reported by Premsrirat (2004), 11 languages are spoken in the 14 southern provinces of Thailand including, Southern Thai (85%), Thai-Malayu (13%), Lao North east (0.5%), Tak Bai (1%), Central Thai (1 %), Chinese language group (0.17%), Urak Lawoi (0.1%), Mon (0.005%), Moklen (0.02%), Burmese (0.01%) and Sakai (0.001%).

Economy in the Deep South of Thailand

Since conflict broke out, the Deep South of Thailand's economy has been in decline and many businesses have closed. Tourism, in particular, has largely disappeared despite being the main source of income prior to the conflict. One local shop owner told me that during peace, when the economy reached a peak, her income was one hundred thousand baht a day. Nowadays, it is difficult for her to earn two hundred baht per day. Degradation of the environment has also causes economic losses (and, for some, psychological trauma). Diminishing fishing yields were a significant concern and stress for many villagers.

Business trade and services in Southern Thailand are now dominated by retail trade (except motor vehicles and motorcycles) about 46.2 percent, followed by accommodation, food and beverage and other services activities about 18.6 percent and 12.1 percent respectively (National Statistical Office, 2014). For Agricultural, most work at Para rubber, rice, permanent crop/forest, field crop, vegetable crop/herb/flower/ornamental plant and pasture (National Statistical Office, 2003). Marine fisher industry and aquaculture are also found in this region (National Statistical Office, 1995). People from the Deep South of Thailand also work abroad in countries such as Cambodia, Saudi Arabia, Japan, Brunei, Bahrain, Burma, Malaysia, Indonesia and India. The highest number of Southerners work in Malaysia, with the number of legal workers (36,478) dwarfed by an estimated 100,000 illegal workers in 2016-2017 (Ministry of Labour, 2017).

In 2005, the World Bank Thailand Office reported that tsunami (6 provinces), civil unrest (3 provinces) and drought in the Deep South had led to declines in tourism and crop production of six and ten percent respectively (Bhaopichitr, Atsavasirilert, Ruangrong, Luangpenthong and Matin, 2005). However, the same report also pointed to signs of recovery. By contrast, the Thailand

Economic Monitor Report 2017 did not discuss at all the effect of the tsunami, on-going civil unrest in three provinces or of drought on Thailand's economic growth (Ariyapruchya, Reungsri, Habalian, Latimer Julian and Kuriakose, 2017).

Cultural Differences

This section demonstrates cultural differences between Aceh and the Deep South of Thailand in order to analyze the role of culture in the creation and maintenance of psychological trauma through the action of social sanctions or expectations (Jobson and O'Kearney, 2008). Many research studies have found that ethnic and cultural differences correlate with psychological trauma (Engelbrecht and Jobson, 2014; Jobson and O'Kearney, 2008; López et al., 2017). For example, in Aceh and in the Deep South dancing and performance were found to be different but, in both contexts, dance and movement have an important role in communicating a suffering experiences. Performance also relieves psychological trauma such that due to as tsunami and violent conflict. This has also been found in other countries such as Taiwan that have experienced disasters (Lee etc., 2013).

The cultures of Aceh and the Deep South of Thailand are based on a diversity of historical influences. A lot of traditions and customs are closely related, such as Islamic culture. Both areas have shared some similar culture and have close relationships, especially through trade since the 14th century (Bradley, 2015a; Reid, 1993). However, both areas have some clear differences of social context in which people live and develop their own cultural values.

The physical appearance of buildings and motifs are the first differences between Aceh and the Deep South of Thailand that I see. Almost everywhere can be seen one common symbol used for decorations from the shirt fabric patterned to the gabled roof of the mosque. Later, I learned that it is called '*Pintu Aceh*' or 'Door of Aceh'. The shape is like two twin doors with intricate patterns and a linear cut in the middle. *Pintu Aceh* represents the Aceh people. Most Aceh people who are born here, no matter what ethnic or religious groups they belong to, are proud to present this item. Even though the majority of Indonesians are Muslim, the Acehnese are ethnically and culturally distinct which can be seen in the buildings and motifs. Most of the Muslims in the Deep South of Thailand are of the Melayu ethnic group and their identity can be seen through their own house patterns and motifs.

Acehnese dancing performances are also fascinating to watch during the peace event celebrations. Dhuhri (2015) found that a role of Acehnese dance is to present and explain Acehnese collective identity related to the fact that they had faced a period of conflict, especially during fighting against the Dutch. Most of the dancing is performed as a group, sitting in a row with shoulders

adjacent. Men and women dance separately, wear different clothes and execute different dances. Men show their strength by slapping their chest, rocking back and forth, moving from slow to fast and from soft to hard. Older men dance differently. They wear white dresses with a red strip on the head. The dance is more focused on snapping the fingers of both hands, from slow to fast, to show masculine identity. The lyrics talk about God, peace, life and Aceh regional autonomy. Some dances are different because they are presented by different ethnic groups such as the Gayo. In the Flying Dance, the dancer looks like a bird as part of their performance, while other dancers seem to be harvesting coffee beans. Aceh dance is similar to '*dikir hulu*' in the Deep South of Thailand, particularly in the way dancers sit in a row and slap hands.

Aceh is a part of Indonesia, which has a majority Muslim population. Most television shows have moderators who are Muslim but Indonesia is composed of many different ethnic groups, whose differences can be seen through their dress, culture and food. In contrast, there is little discussion of Islamic belief on mainstream Thai television because the majority of the population is Buddhist and television is mainly based on Bangkok culture. Indonesian TV programs are heavily influenced by films from neighboring countries like the Philippines, Malaysia, and Thailand, which are screened with subtitles. In contrast, most Thai television movies and series show a heavy influence from the USA with shows dubbed into Thai language. There are almost no programs from our neighboring countries or even the other Thai ethnic groups. Thai mainstream movies when they are related to other ethnic group are mostly focused on the war history between Thai and Burmese.

Most Acehnese who live in a remote area speak a local Aceh language that belongs to the same language group as the Cham language. Nowadays, the most significant Cham ethnic group is Muslim, in Vietnam. Their culture has similarities with those of Malaysia and Indonesia. In the past, Cham had their own kingdom named *Cham Pa* but later on it was annexed by Vietnam. As a result, many of the people from Cham seek asylum to Aceh Indonesia. Of course, their language is different from the Indonesian language. Only Acehnese who study in formal schools will learn the Indonesian language. During the conflict, many local Acehnese from rural areas discovered they could not communicate with the Indonesian military.

Many of my Melayu friends in the Deep South of Thailand acknowledge Acehnese as a Melayu ethnic group while my Acehnese friends know that they are different ethnically but share the same religion. Many Muslim Indonesians have negative perceptions of Melayu Muslims from the Deep South of Thailand because the latter mix other cultural beliefs with Islamic religion (for example, the ritual worship of volcanoes). However, the attitude of Muslim Indonesians towards Acehnese Muslims is positive as they seem to have the same, or even stronger, Islamic faith.

I come from an area where Muslim women and men do not greet non-family members with a handshake or touching with any part of their body. This does not seem to be the case in Aceh. Once, when I first arrived at Aceh city, I feel surprised when I saw men and women greeting each other by touching fingers. Only a few people who I met there did not greet by physical touching.

I have learnt of cultural differences between the Deep South of Thailand and Aceh from the Aceh War. War broke out between the Dutch and Acehnese on 26 March 1873. When Teuku Umar, a guerrilla leader, was killed, his wife, Cut Nyak Dhien, took over his role and is renowned as a heroine after fighting the Dutch for twenty-five years. Furthermore, Cut Nyak Dhien, is also well known as a woman who had knowledge of Islamic religious practice from teaching Islam to Acehnese jungle fighters during the war, as well as being a good mother and a good wife. At the end of her life, Cut Nyak Dhien became blind and was subsequently captured by the Dutch army. Her courageous deeds and her unflinching character still serve as a role model today for many Acehnese women.

Many war monuments can be found in public areas in Aceh. Between 1873 and 1904, approximately 2,200 soldiers and high commanders were buried in the city. They are buried in a large grave called Kerkoff Dutch Cemetery which is near a monument of a Douglas DC3, RI-001, located in a public park. The DC3 is a symbol of the contribution by the Acehnese people during the struggle with the Dutch during and after World War II.

Natural Disasters

Natural disasters in Aceh

At 7.58am on 24 December 2004, a magnitude 9 Richter scale earthquake struck just north of Simeulue Island off the western coast of north Sumatra, Indonesia (Levy and Gopalakrishnan (2005). This was, at the time, the largest seismic event on Earth for 40 years and the largest ever recorded with global digital seismometer. This earthquake generated three giant waves. The most severely affected area was Aceh city (Borrero, 2005a), along with other areas such as Lhoknga, Kreung Raya, Melaboh and Pidië (Borrero, 2005b; Liew, Gupta, Wong and Kwoh, 2010). Levy and Gopalakrishman point out that as a result of this natural disaster more than 283,000 Indonesia people were killed, which may be partly related to poor sanitation and poor preparation and poor humanitarian response. Not only were many people who lived near the coast vulnerable to natural disasters (Inter-agency secretariat of the International Strategy for Disaster Reduction (UN/ISDR), 2005), so too were coastal ecosystems such as coral reefs and soil. McLeod et al. (2010) stated that about 37,500 hectares of coastal farmland were severely affected by soil salinity. Even now, this area

cannot be planted with new crops. Fishers have also experienced difficulty using equipment such as fishing rods and nets because ruined buildings that sank into the sea damage their gear.

Many tsunami graveyards are evident across Aceh. Sites housing both cemeteries and monuments speak to an active remembering of the tsunami and its victims. Other material reminders of the tsunami such as evacuation buildings, plans, routes, signs and maps, are more evident in the city than in rural areas, speaking to where resources are concentrated. The continuing presence of houses left unfinished, along with abandoned evacuation buildings, illuminate spaces that lie unused because people no longer what to occupy them.

Zeccola (2011) states that during the conflict period, it was difficult for local and international NGOs to operate and to address human rights issues. He found that post-tsunami, many organizations including the Government of Indonesia (GoI), INGOs and Local NGOs had different perspectives about what to do to help people recover. He points out that natural disasters are acknowledged to be a 'purely' humanitarian problem while victims of violent conflict are perceived as 'political problems' by key players (Zeccola, 2011). Similarly, Waizenegger and Hyndman (2010) found that some Acehnese who were affected by the tsunami subsequently had better living conditions than ex-combatants (people caught up in social conflict) because the former received help from aid agencies for being the 'pure' victims.

The most controversial aspect of aid organizations is that even though they give food and medicine to many disaster victims they are also concerned with political issues, which limits their concern for the dead, injured and those tortured from the conflict. There is sometimes criticism about the 'well-fed dead' because aid organisations sometimes focus on providing food, medicine, and shelter to people affected by disaster, while ignoring the elimination of the root causes of conflict (Barnett, 2005; Cohen, 2006; DuBois, 2009). Waizenegger and Hyndman (2010) state that post-tsunami in Aceh, almost 75 percent of ex-combatants were unemployed after the peace process. This is because they did not have any other job skill except fighting. As the result, many social problems arose from their poverty, such as robberies, kidnappings, and extortion (International Crisis Group, 2007; Waizenegger and Hyndman, 2010)

To sum up, the people of Aceh experienced both a major natural disaster and a long violent civil conflict. Not only did many people lose their family members and property from the natural disaster but other people also lost the same things from the thirty years of violent conflict. Some Acehnese, who were victims of both the natural disaster and violent conflict, received hardly any help from aid organizations because they were perceived as 'political' problems. As a result, the 'trauma' experienced by the ex-combatants has expressed itself in socially disruptive behaviour, and impacted

the whole society in the form of robberies, kidnappings, and extortion as the ex-combatants struggle to survive.

Natural disasters in the Deep South of Thailand

Natural Disaster in Thailand

Thailand has a history of disaster experience. As shown in Table 4, the types of disaster include flood, tropical cyclone, earthquake, landslide and drought (Asian Disaster Reduction Center, 2004a). For example, in 2000, Hat Yai, a city in Songkhla province, southern Thailand near the Malaysian border was affected by flash flood and inundation which caused the death of at least 32 people and injury to about 1,700 (Assanangkornchai, Tangboonngam, Sam-angsri and Edwards, 2007; Supharatid, 2006; Tanavud, Yongchalermchai, Bennui and Densreeserekul, 2004).

Table 4: The level of disaster intensity, vulnerability, managing competency and risk levels of Thailand

Type of Disaster	Intensity Level	Vulnerability Level	Managing Competency Level	Risk Level
Flood	High	Moderate	Moderate	High
Tropical Cyclone	High	High	Moderate	Moderate
Earthquake	Low	Low	Poor	Moderate
Land slide	Moderate	Low	Poor	Moderate
Drought	High	Moderate	Moderate	Moderate
Fire	High	Moderate	Moderate	Moderate

Source: Civil Defence Plan 2005, Civil Defence Secretariat Office Ministry of Interior, Thailand

Until 2004, volcanic eruptions, tsunamis and earthquakes did not appear in the Thailand Disaster Country Report (Asian Disaster Reduction Center, 2004a; Potigavin, 1992). However, records from 2004 show that these types of disaster have occurred in many parts of Thailand. For example, on 26 December 2004, many parts in southern Thailand, six provinces namely, Phuket, Trang, Phang Nga, Krabi, Ranong and Satun were affected by the tsunami. This tsunami also affected 14 countries along with Indian Ocean border. Asian Disaster Reduction Center (ADRC) reported 8,345 people were killed and 67,007 people affected by the tsunami in Thailand (Asian Disaster Reduction Center, 2006). The numbers of deaths, injuries and missing are different by different sources and organizations (Asian Disaster Reduction Center, 2004b). Southern Thailand is a tourist

destination. Hence, over 1,600 to 5,395 foreigners were affected by the tsunami (Asian Disaster Reduction Center, 2004b; James, Ball and Benthaus, 2005). On 16 April 2012, an earthquake happened at Phuket, Thailand (Jitmahantakul, 2012, May 21; Vervaeck, 2012). No deaths were reported, but 20-30 whole houses were affected by this earthquake. Another earthquake occurred on Sunday 5 May 2014 which affected northern Thailand, Chiang Rai province (Foxnews World, 2014; Pananont et al.; Vervaeck, 2014). In consequence, one death and 32 injuries were attributed to this event.

Natural Disaster in the Deep South of Thailand

Storm Surge

The storm surge in the Deep South of Thailand was not on the scale of the tsunami in Aceh. While limited official information is available, fieldwork revealed that a number of people died as a result of the storm surge. Foreign aid agencies and Thai aid organizations that already work in this area offered help to victims of the natural disaster, however, without considering that they were also dealing with victims of civil unrest. Most people in this area are agriculturists, farmers, and fishermen. Their agricultural productivity and fishing equipment were damaged by the disaster including whole farms of chickens, goats, ducks, rubber trees, gardens, small fish factories and much more. Local villagers who lost agricultural productivity – loss of equipment and damage to farmland. – could be helped with aid, but then found themselves struggling to re-establish themselves when economic activity was depressed by civil unrest.

Under the violent conflict and diminishing natural resources, many heads of families, including the wife and/or some other family member, undertook work in Malaysia to obtain income for the family. Some households were severely disrupted by the civil unrest; some households had family members under arrest, and some members had fled to another country such as Malaysia. Hence, it was hard for remaining family members to recover after the natural disasters. After the storm surge event, it is not known how many people died or how much agricultural equipment was lost and how badly properties were damaged as a result of both natural disaster and violent conflict. It was certainly more difficult to maintain a cohesive family life, and to establish a livelihood because the agricultural equipment was expensive for local people to buy or repair and difficulties selling product during civil conflict conditions brought reduced incomes.

Other Types of Natural Disaster

In 1967, Tambon *Na Tham, Mueang Yala* district experienced heavy flooding of Pattani river. For many this was their first severe disaster experience. Most people above 50 years still remember this event. Marks on the wall by knife indicate water levels at the time, to remind themselves how high the water was. The head of this village, Chalong Thomtong stated that:

> Nobody prepared for anything because we never have this kind of experience. We lost our livestock, rice, home and others. Everyone evacuated into Wat Na Tham (Buddhist temple). The monastery has tall pillars. It is higher enough to escape from flood. We did not carry anything, just running to save our life (Community organization network on disaster management in three southern provinces of Thailand and Natural disaster management networks Nakhon Si Thammarat province, 2011b, p. 6).

Post-disaster, the core lesson learn from this disaster was 'learning and preparing'. This disaster union as villagers shared their experiences and information about recovery. A range of changes were implemented such as lifting the height of first floors in houses by 2.8 to 3 meters and undertaking livestock evacuation planning.

When heavy flooding occurred 38 years later (in 2005) the villagers were prepared. Although official responses did not go according to plan the people themselves experienced less suffering. They were more resilient and knew how to save themselves. When the floodwaters were gone, however, the elderly in this village still had anxiety due to natural disasters becoming more frequent. This happened all over Thailand and in other countries (Indian Ocean tsunami of 2004).

Elsewhere in the Deep South of Thailand, flash flooding that impacted a village about 40 years ago left those who were children at the time ready to prepare for disaster events without help from outsiders. Following this flood, the villagers almost starved to death. No one from outside the village was able to get in and the villagers could not go out to bring food back home. People learned to stockpile food supplies by preserving edible food forests and they purchased lifeboats (See Figure 6). Crops and other edible plants were cultivated within the old-growth forest that all villagers can still access. Children are growing up and taking jobs but do not need to spend money to buy food in an emergency. Meanwhile, leftover fruit and vegetables can be exchanged or sold for cash. Adults of working age do not necessarily leave home to work in Malaysia. The whole family can stay together and children are growing up together with the family members. As a result of doing this, they gain indirect benefits that no one in this village is involved in conflict. Peace happens in this area.

Figure 6: Edible forest foods, the Deep South Thailand

In 2009, the Community Organization Network on Disaster Management emerged including 17 Tambon in the Deep South of Thailand with supported from the Thai Health Promotion Foundation (ThaiHealth). The core members built on previous friendships to establish collaborative networks. They learned that after the area was hit by severe flooding there was a delay of aid delivery from the government sector, increasing suffering and disappointment. At the same time, a number of victims received no help as a majority of emergency aid bags were distributed to the family members and friends of officials. However, after three years of operation the pressures of ongoing armed conflict and cultural and ethnic differences contributed to the demise of this community organization.

Building Community Organization Network on Disaster Management in the Deep South of Thailand faced a number of obstacles. First, it has been suspected by officers of government as promoting separatist action through its activities. Second, people who did not get involved in the violent conflict feel isolated, abandoned, insecure, hurt, pained, disconnected and lacking in communication (Community organization network on disaster management in three southern provinces of Thailand and Natural disaster management networks Nakhon Si Thammarat province,

2011a). When the second factor was combined with the first, disaster management run by local communities was found hard to develop. Community leaders spent much time trying to clarify their activities with governmental staff. Even among local villagers there was suspicion that someone might be a member of a separatist organization.

A Brief History of Violent Conflict in Aceh, Indonesia and the Deep South of Thailand

To understand the violent conflicts in Aceh and the Deep South it is necessary to consider pre-colonial history including the relationships among cities and kingdoms in Southeast Asia. The histories of Aceh and Patani[1] are embedded within their nations' history (both Thailand and Indonesia). In the 13th or 14th Century, Patani already existed on the Malay-Thai Peninsula, east coast due to a migration of people who speak Malay (Bradley, 2015b). Patani was a commercial centre between the 15th and 17th centuries along with Aceh, Pasai, Melaka, Johor and Brunei (Andaya and Andaya, 2001; Reid, 1990).

Wars occurred many times in these areas. However, Southeast Asian history experts (Reid, 1990) argue that the purpose of war in Southeast Asia pre-colonization was principally the capture of people for slavery rather than the occupation of territory – as was the case in most European wars during this period (Reid, 1990). Even so, pre-colonial conflict between Siamese (Thai) and Patani (the Deep South of Thailand) included, in the 17th century, the use of elephants by the Siamese to kill Patani captives, old women and men and children, by trampling them to death (Bradley, 2015b).

Reid (1990) points out that Europe as an external influence in the region came after Indian, Persian, Islam and Chinese influences. Even today, many countries in Southeast Asia are Muslim, where previously people believe in animism, Hinduism and Buddhism (Arhem and Sprenger, 2015; Mabbett, 1977). Beliefs, faiths and cultures that had been brought from the group of people before Islam and colonization still have a great influence in many communities in the present day.

Aceh, Indonesia

The conflict history is significant for this research. First, Aceh has a long history of wars which happened before the colonization era. Armed conflict is evidently, at some point, a cause of psychological trauma. Second, the most destructive violent conflict area is Pidië regency. Hasan di

Tiro, Gerakan Aceh Merdeka (GAM) leader, recruited family, relatives, and friends from his village, in fighting with the Indonesian government. Consequently, people who lived in this area often became targets by parties in armed conflict. Many of them, civilians, were suspected of being insurgents and/or giving their economic and political support to GAM. Third, most of the mental illness patients who were admitted to the mental health hospital in Banda Aceh come from Pidië regency. Most of the medical staff believed that mental illness issues were caused by drug addiction only. Additionally, mental illness issues caused by drug addiction had been viewed as a personal problem. However, there is clearly a connection between the multiple sources of psychological trauma with other social problems such as armed conflict and poverty. Fourth, strong characteristic of war warrior ancestors led to expectations that Aceh people should not express their psychological trauma (as weakness).

Over the past few hundred years before the history of colonization, Aceh had been at war with at least three countries: Portugual, the Netherlands and Japan.

In the middle of the 16th Century, war broke out between the kingdom of Aceh and the Portuguese. Aceh, which had a long-established relationship with their rulers, the Ottoman Empire, asked the Sultan of Turkey, Aceh for assistance. After a year of war, two ships still remained in case the Portuguese returned (Basry and Alfian, 1990). Up until post-natural disaster, relationships between Turkey and Aceh have so far gone well. This can be seen when Turkish Red Cross donated hundreds of houses for tsunami victims (Lamb, 2014) and built new schools in many disasters affected areas.

Aceh was then colonized by the Dutch and Japan. The war between the Dutch and Aceh started in 1873 and lasted until 1917; approximately 100,000 from Aceh side were killed along with almost 16,000 on the Dutch side (Reid, 2004). At the Kerkhoff Dutch Cemetery in Aceh city, approximately, 2,200 bodies of Dutch military are buried. However, the Acehnese are still proud of being colonized for the shortest period of time by comparing themselves with the other provinces of Indonesia (Lindblad, 1989a; Sulistiyanto, 2001). Most Acehnese fighters used the short knife or *Rencong*, the traditional weapon, when fighting the Dutch soldiers with weapons such as guns and cannons, a fact that Acehnese are still proud of today.

In 1871, the Sumatra Treaty was signed by the Dutch and the British governments which gave authority to the Dutch East Indies Company to conduct business in Sumatra (The Dutch War Colonial in Aceh 1990). Due to this, spices, especially pepper from Aceh, were exported to many countries

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[1] Patani (with one 't') is the kingdom in the Deep South of Thailand before Siamese annexation.

around the world such as England, Turkey and India, during the 16th and 17th centuries (Reid, 2004). After, 1871, war began between Aceh and the Dutch. Several Acehnese fighters were recruited and trained by Acehnese commanders. One of them is the Prince of Pidië. In 1883, after the loss of Teuku Nya' Hasan, the religious leader Teungku Chi' di Tiro Syaikh Saman and others announced a Holy War between the Acehnese and the Dutch. He was successful in recruiting people, especially young religious school disciples and recruiting resources to fight the Dutch. Approximately 6,000 people joined this War. The interpretation of 'Holy War' based on the Qur'an can have two meanings. Holy War can mean a war to defend an Islamic country (Aceh) against the Unbelievers, that is the Dutch, and, a Holy War can also been seen as God punishing the Acehnese because they have sinned (Wieringa, 1998). One of the famous guerrilla leaders, Teuku Umar, pretended to join the Dutch in the tactic of 'Letting the Acehnese fight the Acehnese' in 1883 but, in 1886, he walked back and took Dutch weapons for Acehnese guerrillas. After he died on February 10, 1899, his wife, Cut Nya' Diën became a leader. Later, she was blind and disabled. The Dutch captured her on November 4, 1905 after which she became a role model of Acehnese women and her story later was made into a movie. Other Acehnese warrior women were common among the guerrillas, but only a few names have been recorded, for example, Cut Meurah Intan, Cut Mutia, Pocut Baren, Teuku Fakinah and Cut Gambang (Cut Gambang is Teuku Umar's daughter who died in the battlefield) (M. Hasbi Amiruddin 2010). During the war, some Acehnese worked on both sides by being spies. They were declared 'traitors to their own country'.

After WWII the word trauma was been introduced to Indonesia, with reference to Bali. In 1906, the Dutch army personnel identified trauma caused by the experience of a ritual suicide, *Puputan* which was led by *Buleleng* king and 400 Balinese followers. All of them decided to kill themselves rather than surrender to the army of the Dutch. Another significant event was war between the Dutch army and Acehnese guerrillas. Psychological trauma within the Dutch army was constructed from extreme fear of being killed by Acehnese guerrillas who were ready to murder everyone, especially a person wearing Dutch military uniform.

The beginning of a conflict between Aceh and the Indonesian government started in the period of Indonesia nation building. There are many causes for the eruption of violent conflict in Aceh between GAM and the Indonesian government. The roots of the conflict occurred after the end of Japanese occupation and the return of the Dutch. Before the Republic of Indonesia was born in the name of the country, in the transition era of decolonization, the areas which were in Dutch colonies came together under the name of Indonesia.

From 1945 to 1949, Aceh was an example of resistance against the Dutch, including contributions of gold that was abundant in Aceh. In addition, they delivered the first Indonesian

airplane for use during the war. Aceh is still proud of the key role it played in ending Dutch colonial rule.

Sukarno, the first Indonesian president, asked Aceh to join the Republic of Indonesia in 1947, promising to give Aceh special independent status. However, the promise was ignored and Aceh was incorporated into the province of Sumatra (Schulze, 2004; Sulistiyanto, 2001).

There are many other causes of tension between Aceh and the central government of Indonesia, including ethnic and cultural differences, disputes over natural resources, Islamic movement differences, human rights violations, the use of excessive violence against Acehnese by Indonesian government, the military response to GAM, anti-communist forces, and economic crises.

Aceh and Indonesia do share some similarities. Namely, most of their people are Muslim, their physical appearance is similar and they were both colonized by the Dutch and by Japan. However, significant cultural differences exist. So much so that by ethnicity and culture, most of the population in Aceh is viewed as of Acehnese ethnic group while the Indonesia's government and military had been seen as Javanese (Ross, 2005). Hence, many Javanese who live in Aceh have been thought of as Indonesian spies (interview, 2013).

In the 14th Century, the first Arab and Indian traders arrived in Aceh at Pasai from the Indian Ocean, bringing the Islamic religion with them. Hence, the economy of Aceh was driven by the Arab and Indian traders. Political, cultural and economic activities of Aceh were orientated to the Malayan Peninsula and focussed little on the Java Sea world. In addition, Acehnese wanted to be an Islamic State, whereas The Republic of Indonesia took issue with that concept following the declaration of independence.

The Anti-Jakarta uprising started in 1953 led by Teungku Muhammad Daud Beureu'eh. He was a military governor who had been born in Pidië and who had been a leader of the Islamic scholar association since 1939. Jakarta responded by sending troops into combat. The conflict continued until 1959 when Sukarno promised to give 'special region' (*Daerah Istimewa*) status to Aceh, for customary law, education and religion. However, the rioting and violence continued until 1962. The Aceh separatist movement was focussed on religion and national independence and, at this stage, did not have links with global jihadists (Aspinall, 2009; interview, 2013) or a particular focus on natural resources (Reid, 2004). In addition, opinions and actions of religious leaders supporting GAM or State and/or neutralization, also had significant differences amongst themselves (Barter, 2011; interview, 2013).

When liquefied natural gas (LNG) was discovered in Lhokseumawe, Aceh in 1971, the separatists claimed Aceh received an unequal share of these resources which became another cause of

violent conflict (Lindblad, 1989b; Robinson, 1998; Ross, 2004a, 2004b, 2005). Benefit and profits of resources are in the hands of the US Company Exxon Mobil and the Indonesian government. Resentment about this agreement appears to have led to escalation of conflict into the civil war. Exxon Mobil workers were subsequently threatened, killed, kidnapped and tortured, while the Exxon Mobil site was believed by GAM to be used as a military base of torture.

Teungku Hasan di Tiro announced Aceh independence on 4 December 1976. Initially, the group of GAM members numbered between 25 to 200 but grew to 27,000 after 1999. The first group of GAM's members were well-educated and included academics, doctors and businessman. From1986, he recruited family, relatives and friends from his village, approximately 300 of whom trained in Libya between 1986 and 1989 (interview, 2013; Schulze, 2004). From 1990 to 1998, the Indonesia government responded to GAM action by announcing Martial Law which became known later as Military Operation Zone (DOM: *Daerah Operasi Militar*).

The tactics of the Indonesian soldiers included slashing and burning to discourage people from joining the GAM. During sweeping operations that affected civilians along with guerrillas people were tortured, beaten, killed, kidnapped, raped and forced to rape their own family members (Good, Good, Grayman and Lakoma, 2006; interview, 2013). In turn, the same techniques were applied by GAM to anyone who was suspected of cooperation with the Indonesian government. Many children who lost their parents during this period become GAM members while still growing up. Torture houses were commonly found in the villages where suspected GAM members and supporters were tortured. A well-known house of torture was called *Rumoh Geudong* or the 'Tall House'. Later, it was burned to destroy evidence.

Teachers were killed and the houses of teachers, as well as schools, were burned because they were symbols of the state education system (See Figure 7). In addition, schools had been used as shelters for troops. Sixty teachers were killed between 1998 and 2002. Between 15,000 and 50,000 migrants from Java were also expelled from Aceh between 2000 and 2002 (Czaika and Kis-Katos, 2009; interview, 2013; Li, 2002; Ravich, 2000; Schulze, 2004). Some scholars argued that expelling Javanese was a part of a GAM plan to get international attention (Ravich, 2000).

Figure 7: A school that was burned down in Aceh, Indonesia

Chinese ethnic groups were impacted by the civil war, and when Indonesian troops withdrew from Aceh after anti-military riots in 1998, anti-Chinese riots took their place (Dexter, 2004). Previously, from 1965 to 1966, anti-Chinese rioting had broken out throughout Indonesia, including Aceh (Melvin, 2013). During this period, almost 500,000 people were killed (Cribb and Coppel, 2009). Today, many Chinese people in Aceh still teach their children to focus on their own business and not think about seeking a job as a government officer due to anti-Chinese prejudice. The fear of these past events is said to still affect the present generation (interview, 2013).

Following the 2004 tsunami, a peace agreement between the Government of Indonesia (GoI) and the Free Aceh Movement (GAM) was signed on 15 August 2005[2]. The agreement gave Aceh the right to have their own political party and their own flag, with the original party name *Partai Aceh* or

'Aceh Party'. Most of the leaders of this party were military personnel of the GAM. Later, the party was split into two groups, *Partai Damai Aceh* (PDA) and *Partai National Aceh* (PNA)[3]. Before the election date, the parties started bombing and killing each other, perhaps reflecting their life histories as warriors. Even though today Aceh is at peace as an autonomous state within the Republic of Indonesia, many Acehnese are still fearful and uncertain for the future.

Also following signing of the peace agreement, a large number of objects were eliminated from the conflict zone – objects, in particular, that might provide evidence of crimes or serve as reminders of the conflict. For example, the house of torture, *Rumoh Geudong* in Pidië, was destroyed while restrictions were placed on the use of military uniforms and flags in everyday life. Attempts, similarly, were made to redefine the roles of actors such as military rescue teams who are represented in the tsunami exhibition not as conflict actors but as aid players.

The Deep South of Thailand

History of the Deep South of Thailand

The history of the violent conflict in the Deep South Thailand always has been a sensitive political issue for the Thai state (Aphornsuvan, 2008). Documents in the National Library of Thailand related to the Deep South's conflict history are restricted, with readers unable to make copies. Readers must memorise the content, include taking notes, in the National Library Director's room. In the Deep South of Thailand, anyone holding a book related to the unrest risks arrest. Prior to the 21st Century, anyone who produced or owned Patani history books was charged as a separatist. Nowadays, the situation is getting better.

The causes of the violence are often seen to have arisen from the rebellion of Patani as discussed by Pongsudhirak, in *The Malay-Muslim insurgency in Southern Thailand.* Patani was once a part of Ayuthaya Kingdom (an ancient kingdom of Thailand) but after Burmese seized Ayutthaya in 1767, Patani rebelled against Siamese domination. However, in 1786 Siam ruled Patani again in the new Siam Kingdom led by King Rama I. Siam was divided into seven provinces administered centrally from Bangkok (Pongsudhirak, 2009). After that, violence periodically broke out between the Deep South of Thailand and the central Thai state.

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[2] See agreement online: http://www.ucdp.uu.se/gpdatabase/peace/Ind%20050815.pdf cited 29/02/2016.

The 'standard' history of Thailand always refers to the rule by four kingdoms: Sukhoothai (1792-2126/1219-1583), Ayatthaya (1893-2310/1350-1761), Thonburi (2310-2325/1761-1782) and Ratanakosin (2432-present/ 1889- present). It is generally accepted by Thai historians, general commanders (Patcharakanokkul, 2010) and Thai elites that the Deep South of Thailand - Pattani, Yala, Naratiwat, have been part of Thailand since the 14th Century, in the era of King Ramkhamheng of Sukhothai kingdom. This assumption is based on stone inscriptions, which the majority of Thai people had been educated to believe about this era. The evidence is based on the findings George Coedès (Baker, 2003; Coedès, 1968, 1969), a French scholar who confirmed that it had been built in the 14th century. Furthermore, the stone inscriptions have been recognised as the first Thai constitution, written in the reign of King Ramkhamheng who invented Thai script (The 6th Reginal Office of Fine Arts Department, Sukhothai 2016). However, other scholars, such as Michael Vickery (Vickery, 1987) have argued that the inscription was probably made in the 19th Century during King Rama the 3rd or 4th because the grammatical language used seems to have been written in the early Rattanakosin period and be part of a more edifying literature than 14th century. Wright's argument is similar to that of other scholars, such as Charles Keyes (Keyes, 1995), Sujit Wongthes (Wongthes, 2012), A.B. Griswold and Prasert Na Nagara (Griswold and Na Nagara, 1971), Amara Prasithrathsint (Prasithrathsint, 1997, 2006), Phiset Chiachanphong (Chiachanphong, 2012), Piriya Krairiksh (Krairiksh, 1991) who speculate that the stone inscription was probably made by King Rama the 4th (2394-2411) as a precaution to avoid colonisation. There is on-going academic debate about the dating of the inscription. In 28-30 August 2003, the stone inscription was registered as a 'Memory of the World Heritage' by United Nations Educational Scientific and Cultural Organization (2003) in Gdansk, Poland despite the disagreements of many Thai scholars. The dating of the stone inscription is still unresolved, and educational institutions have still not updated their texts.

At present, the argument is limited to archaeologists and historians. Also, the Thai constitution and legal penalties may stifle debate. Therefore, the current belief in Thailand is that the constitution of Thailand dated from the 14th century, Thailand is comprised of four kingdoms, replacing three, and that Thailand was never colonised by foreign powers because the previous kings, general commander and soldiers sacrificed life and blood for the nation. This sentence appears in Thai National anthem. Since I was young, I have to stand and singing this song every 8am and 6pm. Nobody can move, walk or talk. In theatre, Royal anthem (*Sansoen Phra Barami*) plays before movies. Everyone has to stand until the song finishes. The Thai constitution clearly states in sections

[3] Chairman of PNA is Irwandi Yusuf. He is the first Aceh governor and a lecturer at SKU.

1, page 11 that 'The United Kingdom of Siam is the one and inseparable'. There is a maximum penalty of death to life time imprisonment for anyone who acts, plans or thinks to create a separation within Thai territory.

In fact, the first Thai constitution was made when Thailand changed regimes on 24 June 1932, the King Rama the 7th era. In addition, Thailand has lèse majesté's law, section 112, 'the king is held in a position of revered worship shall not be violated whoever arraigned kings nor in any way', with violation punished by imprisonment of 3 to 15 years. The definition of 'be violated' is dependent on the court's opinion and judgement. This law covers the present kings, all kings in the past (who are already dead) and the monarchy as an institution. The forms of violation include speech, not standing for the National anthem, and posting a criticism in a statement on social media such as Facebook and YouTube. Some scholars, for example, Gile Ji Ungpakorn who have criticized the institution of the monarchy have been exiled from the country. He wrote a book in 2007, title, *A Coup for the Rich: Thailand's Political Crisis* (Ungpakorn, 2007). His argument is a coup had been support by King. Those who have criticized the institution of the monarchy have been exiled from the country (Walker, 2011) and some, for example, Somsak Jeamteerasakul, Professor, a history lecturer at Faculty of Liberal Arts, Thammasat University, were attacked by an anonymous group (Asian Human Rights Commission, 2014; Walker and Farrelly, 2009). On 12 February 2014, he was attacked by gunshots and bombs' homemade at his home. He was not injured even though he was at home on that day.

One consequence of all this is that Patani's history (the Deep South of Thailand kingdom) is largely ignored by historiography and subsumed within the broader history of Thailand (Bradley, 2015b). While the Patani kingdom emerged before Sukhoothai, Bradley (2015) argues that the violent conflict occurring in the Deep South of Thailand would potentially begin to unravel if it were understood that the root of conflict lay in history and Patani, as a region, was seen to have its own history.

Present Violent Conflict Situations

The separatist movement Barisan Revolusi Nasional Melayu Patani (BRN) has existed since 1974 (Askew, 2008; The National Reconciliation Commission (NRC), 2006) (See Figure 8). Nonetheless, 21th Century conflict commenced when Police Lieutenant General Dr Thaksin Shinawatra became Prime Minister, serving two terms, from 9 February 2001 to 19 September 2006. On 4 January 2004, approximately 400 gun barrels were stolen from the Pileng Narathiwat Rajanakarin military camp in Naratiwat province. On the same day, four soldiers were killed. The next day the government declared martial law in three Southern provinces and two districts, Chana and Thepha, in Songkla province.

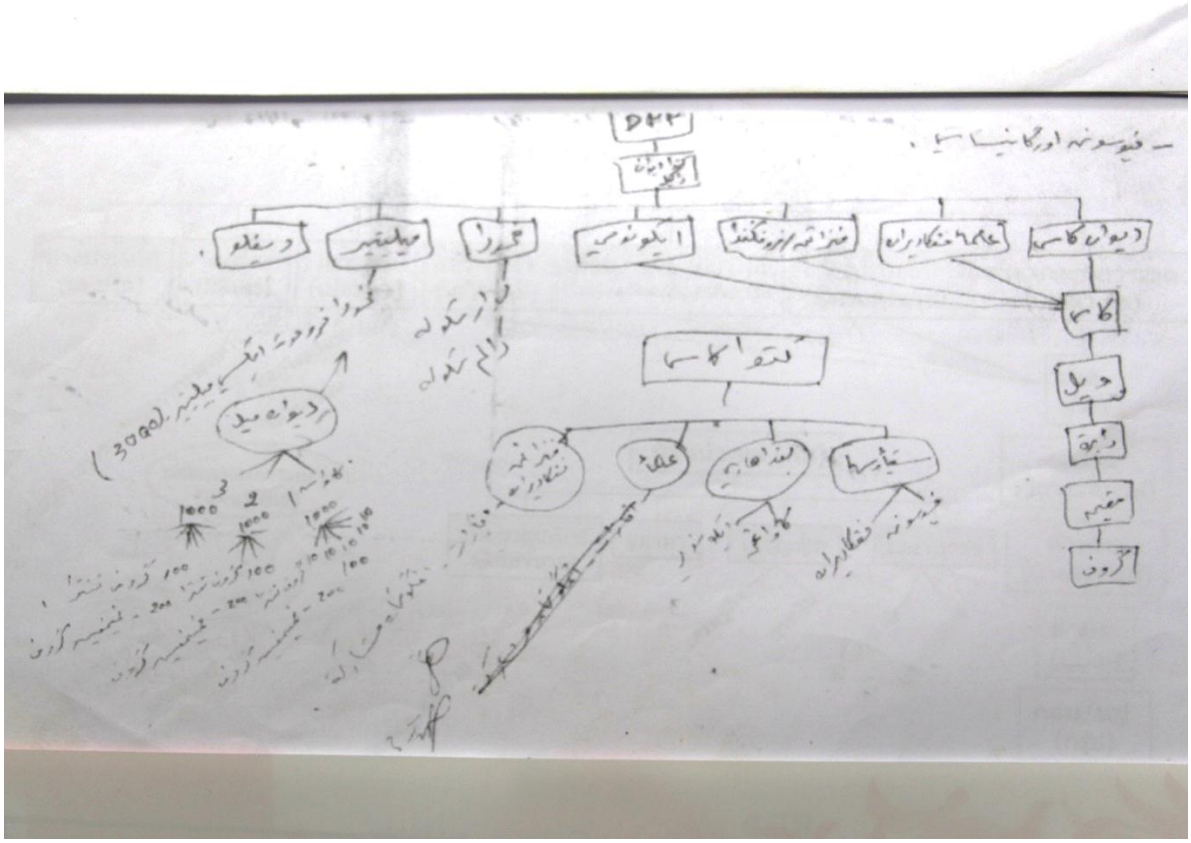

Figure 8: BRN organization flow chart (Melayu language)

At the commencement of the conflict, Thaksin Shinawatra called the rebels ‘petty thieves’. The government assumed that peace could be quickly restored once a core leader was killed. However, the conflict was not resolved and continues today despite Shinawatra’s own exile from the country. Extensive deaths, arson, and bombing of public building such as schools, have occurred. Between 2004 to 2013, there were at least 21,254 violent events (44% guns; 21% bombs; 15% guns and arson), as well as 945 schools destroyed through arson (See Figure 9), 593 government offices and 525 military barracks attacked. There were over 22,377 victims (more male than female), the majority of whom were ordinary people including 7,013 Muslim civilians and 5,672 Buddhist civilians, 304 teachers, 7,567 deaths (directly and indirectly), 553 disabled, 55 disappearances. Many more have been orphaned, widowed and/or displaced (Chongsuvivatwong et al., 2014; International Displacement Monitoring Centre, 2011; Kuning, Eso, Sornsrivichai and Chongsuvivatwong, 2014)

Figure 9: School was burned down in the Deep South of Thailand

As there are many separate violent events, to illustrate I have selected two events, 'Keresik Se Mosque Raid' and 'Tak Bai Incident', because they were discussed widely and have been resolved.

On 28 April 2004, an unknown number of people attacked from 13 points at military barracks and police stations in three Southern provinces of Thailand and one Saba Yoi, Songkla province, resulting in five police and soldier deaths and 22 injuries, while there were 108 insurgency deaths and six injuries. This event was known as the 'Keresik Mosque Raid', the fighting provoked by the use of heavy weapons to kill 32 insurgents in the Keresik Mosque following a nine hour siege. A crowd of approximately 1,000 witnessed the incident. The Keresik Mosque incident has drawn comments from Human Rights Watch which claimed human rights abuses occurred, particularly as the conflict impacted on a place of religious worship. Not only was the Keresik Mosque a symbol of religion but also it has a long local history. Some versions of history relate it to the history of Thailand with a story that this mosque had been burned by the Siamese army when Ayutthaya attacked Patani.

The 'Tak Bai Incident' occurred on 25 October 2004, resulting in deaths of 85 people, with seven shot and 78 suffocated. The event happened when six people, who worked in security positions

in the community, had been charged and then gave false testimony. They claimed their guns were stolen by the rebels. But the Thai police did not believe their claim, and they were brought to the police station at Tak Bai, Naratiwat province. Soon a large crowd (from 100 to 1,000 protesters) surrounded the police station, trying to pressure the authorities to release the suspects. The event exploded into violence when Thai police used the water hose from a fire engine to disperse the crowd and then began to arrest protesters. Those arrested had their hands tied behind their backs and they were stacked one on top of another, in layers of between three and four people, in police trucks. During the long, slow drive to the military camp, 78 people suffocated and were dead on arrival at the camp[4].

Many years later, when Yingluck Shinawatra was Prime minister, the government decided to give compensation to families who were affected by the violence, including the insurgency 'Krue Se Mosque Raid' and 'Tak Bai incident' [5]. Of the 32 families who had suffered losses from the 'Krue Se Mosque Raid', each family received 4 million Baht. For 'Tak Bai incident', 19 families of the deceased each received 7.5 million Baht (Askew, 2008; Bradley, 2015b; Croissant, 2005; McCargo, 2009; Srisompob and Panyasak, 2006; The National Reconciliation Commission (NRC), 2006)

Untold Violent Conflict Stories

Despite a long history of violent conflict, the Deep South has largely been ignored by Thai historiography (Bradley, 2015b). Human rights violations under martial law have not received widespread attention (Croissant, 2005), and nor have the contributions to conflict of poverty, poor access to education, globalization and cultural and linguistic differences (McCargo, 2009; Srisompob and Panyasak, 2006; The National Reconciliation Commission (NRC), 2006).

Most research, moreover, on conflict in the Deep South of Thailand focuses on conflict between Thai (Buddhist) and Muslim (Melayu) while the effect of war on other ethnic and religious minority groups receives little attention (Chaiwat, 2006; Chongsuvivatwong et al., 2014; Jitpiromsri and Watch, 2011; McCargo, 2015; Satha-Anand, 2009; Srisompob and Panyasak, 2006). Depicting the conflict as a struggle restricted solely to Thai-Buddhists and Melayu-Muslims is reflected in military strategies including recruitment. Ignorance, ambiguity and a desire to conceal the history of

[4] The trucks were covered with plastic because of the rain. Travel time from the scene of the military camp was longer than usual because the drivers feared an ambush. I got this information from the meeting that I arranged for investigating the situation by inviting two police officers who were in charge the situation.
[5] http://www.isranews.org/isranews-scoop/item/7115--q-q-75-4-5-.html

Thailand – including the history of conflict between Siam and the Deep South of Thailand – are all a part of the violent conflict, together with other social problems, including the delicate ethnic balance, development inequality, poverty and high impact incidents of violence. Although, many of the events seem to have been resolved in the form of giving indemnity it still does not make the violence in the Deep South of Thailand unravel. There is also no research on how compensation payments affect the unrest.

Historical and violent incidents have occurred and the incidents have been used as evidence to persuade the young Muslim generation to support the processes of separatism. Violent conflict agents in the area keep themselves as a secret organization, which contributes to the unrest in the southern border provinces continuing until today.

Conclusion

Shared history and my experience being born into two cultures gave me several advantages as a sociological researcher. I can cross cultural and religious boundaries because I have shared Muslim identity with Acehnese. In addition, I have the social skills to live sensitively among people who are from a different culture. Moreover, my knowledge of sociology and anthropology prepared me to respect and adapt myself to the community I planned to study. I was able to adapt to Acehnese culture, especially Islamic culture. I can participate in many activities such as Islamic rituals, along with my Acehnese friends. Even though Aceh food is different I happily ate together with them because it is correct by principles of Islam. When I met many Aceh people, most of them welcomed me when they found that I came from the Deep South of Thailand. They recognized me as a part of a Muslim minority and they were happy to meet me. Many of the people I interviewed had travelled to Thailand in their past before they met me. These people were familiar with the food, beautiful sea, well known medical treatment and generous Thai ways, and already felt a connection with me.

However, I was aware of the cultural difference that made me question my own culture. My concerns were mostly to do with what I should do and what I should not do in spite of sharing the same religion. Why were some aspects of the culture so different in Aceh relative to the Deep South of Thailand? For example, why had I never heard about the Muslim war heroine in the Deep South of Thailand? How is it that in the Deep South of Thailand there are no monuments built other than those built for religious purposes? The Deep South of Thailand has a long history of war with Siam, so where, also, are the cemeteries of the fallen from both sides?

Chapter 5

Families, Disasters and Conflict

This chapter discusses the relationships between psychological trauma, families, disasters and conflict in Aceh, Indonesia and the Deep South of Thailand. Psychological trauma both impacted and arose from the relationships among family members who lived through natural disasters and conflict. In this chapter, psychological trauma in families is conceptualized as a product of relationships between people, the roles they assume within families (namely protector, caregiver etc.), changing familial roles (e.g. single parent households) and the compounding effects of conflict and disaster. It is not surprising my research found that individual members of many families who lived through natural disasters on top of violent conflict experienced psychological trauma. Importantly though, the experience of trauma was most particularly associated with two things: separation from other family members and changing relationships among surviving family members. Almost every participant in this research said that the most traumatic moment for them was the moment of separation – whether temporary or permanent – from other family members. Many survivors felt guilty. They could not rescue family members or other victims when the disaster occurred.

The familial roles and responsibilities of survivors changed dramatically as a consequence both of the loss of family members and the acquisition of physical and mental disabilities. Many appeared to lack family support and to be poorly prepared for such changes as parenting and other roles were transformed following the death of a spouse and /or children. Many struggled to deal with their own psychological trauma (almost all the survivors had had a ‘near-death’ experience themselves), let alone the new role of taking care of survivor family member/s with a disability. They discovered their own limitations when unable to meet the roles of care provider, protect their family or cope with witnessing or hearing of the death of family members in the disaster events. Many participants were emotionally isolated and tended to hide their feelings from others. They appeared to be neglecting themselves and reluctance to share experiences of psychological trauma with relatives was evident.

Violent Conflict and Families

Most families living in the disaster affected areas were extended families. As individual family members, they provided many kinds of support, physical and psychological, when the members of the family were in need. Typically, living together were grandparents, children, grandchildren, and brother/sister-in-law. Grandparents were looked after by their children and grandchildren, at home. It was typical that within the family grandparents had a role of being a primary carer of the grandchild. In the Deep South of Thailand, for example, parents might go to work in Malaysia, leaving their children in the care of grandparents. Some family members might not live together in the same house; however, a common preference is to live next door or near their parents' house in the same village. For anyone who is located in a far province, reunion will be a very important social event, much like the family activities of holiday, wedding party, funeral, pregnancy, and birth.

For most of the non-Melayu Muslims in the Deep South of Thailand, such as Chinese-Buddhist, Thai-Christian, Mon-Buddhist/Ancestral Sprit worshippers, and Thai-Hindus, they did not feel threatened by the violent conflict. All of them said that they are not the main target because it is a conflict between the Thai state and Melayu Muslim insurgency. Taking care of themselves and keeping an eye on the situation when they enter the conflict areas was the main concern because accidents from gunshots and bomb explosions might happen at any time. All of the members of the Mani (Orang Asli or Sakai) ethnic group who lived at Amphoe Than To, Yala province, Thailand were moved out before the conflict occurred in 2004. Malaysia has become a new residence for them as they got support from the Malaysian government which gave them forest officers' positions together with salary and some amount of land.

Many more families, however, did experience violent conflict before they experienced the natural disasters discussed in this thesis. A key theme to emerge from interviews with members of these families was inability of failure to protect members of the family. Even with parents, brothers or sisters living next door, it was often impossible to protect each other. In fact, even attempting to help other family members often led to harm and even to their death. For example, one Acehnese woman explained:

> *My husband was accused of taking the side of GAM but he had been forced to provide food for GAM members. When the military came into my house my husband was not at home. Hence, I was arrested, interrogated and tortured by Tentara Nasional Indonesia (TNI). They were also looking for my parents. We were tortured. My Mom was forced to lie down on the*

stairs. Other people who were captured were forced to step on her head until her head was swollen. My parents died. Until now, I have not been able to locate my Mom's dead body.

Others, similarly, stated that:

Under violent conflict, no one can help anyone. Even the victims (the neighborhood) are your family members such as mother, father and sibling.

They (GAM members) were asking for money. My husband could not come back home. I had to stay with my four children.

This participant was unable to talk about details of her violent conflict experience. She kept repeating, with tears flowing, *'They were asking for money from us'*. A male head of family in the Deep South of Thailand told me *'I don't want to join BRN, but I have to. Otherwise, they will kill my family. BRN members and I are living in the same village'*.

In the armed conflict, a lot of young male adults ran away from home because they were suspected of being informants or separatists. Many adult males escaped from the village, a number of whom were arrested, tortured and/or killed. A lot more ended up in jail. In Aceh, when the tsunami occurred, between 700 and 2,000 GAM people in prison were drowned. Similarly, because many TNI high commanders had set the army camps near the beach, most of those army men and prisoners died in the tsunami. Some 'widow villages' have emerged, resulting from the effects of conflict during which female family members stayed at home whilst males left to hide, fight or be taken prisoner. Some wives and daughters become war warriors or *Inong balee* with the purpose of being a fighter to protect other family members in dangerous times. A daughter and *Inong balee* told me *'They (TNI and GAM) were fighting with each other. I heard the sound of the gunshots. It did not stop for two days'*. She decided to join GAM because she wanted to protect her family.

In Aceh, the military (of TNI and GAM) practiced violent actions towards women including sexual violence, torture and murder. The aim was to gain male family members' attention and drawing fathers, husbands or sons out of hiding. Moreover, female family members were used for exacting revenge on the opposite party. In the Deep South of Thailand, in relation to sexual violence during the conflict, one in two cases remain unsolved.

Similar conflict and natural disaster experiences can be found among the Mon migrant workers who work at the Fishery Port of Pattani, Thailand. One told me his story:

Since I was 13 years old, I started working at the Fishery Port of Pattani. At first, I came here illegally. I travelled with many migration workers. It was crowded in a car. But, if we had stayed living in Myanmar, we would have been forced to be unpaid labor … We were at risk

> *of being killed by the military … we felt safer when we met the Karen Army. They did not kill the villagers. Here, in Pattani, it is like my home now. One time, I went outside and I experienced the bomb explosion. I was really scared. After that, I went back home (at Port of Pattani) … I didn't want to go outside (the Fishery Port) again … When the storm surge was coming I was afraid. I called my ancestral spirit to save my life on that day*.

Among families that lost members during the violent conflict, the roles of parent, sibling, husband or wife and kin were all described to me as causes of death. During the massacre, some women refused to leave home only to become targets of mass murder. In Acehnese culture, property and land passes mainly on to women as future mothers. The homeowner is a woman. For other ethnic groups, women are found at home undertaking functions such as looking after elderly parents. There are those women in the Deep South of Thailand who said they were threatened (psychologically and physically) by both sides – government officers (police and military) and separatists – when male family members were not at home. Violent conflict often targeted husbands and other male family members, but if they were not found at their houses, the target of violent conflict shifted to female relatives. Nearly all women reported they had experienced a high risk of being killed, raped or tortured (gang rape was reported in Aceh) in the search for information about male family members – including spaces in which they may hide in the jungle or outside country.

Psychological trauma was often caused through being threatened by both government officers and separatists. It often happened when people were working in the garden or rice field or fishing. Often, they were forced not to work during military operations. If they disobeyed the order, death or torture could result. In a time of armed conflict, men faced internal conflict over their income-earning roles and family responsibilities and living with the fear of death while working away from the family. Some men had experienced torture and witnessed death during interrogations.

Many men also received death threats whether as part of a protection racket by separatists or from recruiting security services (working for the government), armed forces themselves, or others. Government workers were often targeted, as were gardeners and farmers who lack power and social status. Moreover, changing occupations was nearly impossible as many were unable to move or work outside their village due to the conflict. The burning of schools in the conflict zone amplified this problem as few were able to attain the education qualifications needed for other careers. Correspondingly, many males appeared to exhibit signs of severe psychological trauma. They were not able to work, think or communicate properly. Many feared meeting people and experienced panic attacks at the sound of a motor vehicle.

When men appeared to be suffering severe psychological trauma, wives or other family members were forced to take primary responsibility for earning money. Both women and children had to work in the garden and rice field to contribute to their families' income while, in some families, caring for mentally ill husbands, fathers and sons. Some women accompanied their husbands to receive medical treatment in other provinces. Hence, many women had to leave their own children at home either with relatives or to take care of themselves. Participants also reported instances of mental illness among men being associated with drug addiction.

In the case of children who witnessed parents having been killed and tortured, academic performance diminished. Many of them said that they could not read the letters on the whiteboard because of fear of being kidnapped like their parents during their study. They bore the burden of being targeted for recruitment and experiencing multiple threats from both sides – military and separatist. Tragically, many children (both boys and girls) who were witnesses to a parent being killed, kidnapped or tortured when they were growing up also joined the battle operations, with the aims of exacting revenge and/or protecting family members and protecting themselves under life and death conditions.

This study found that the role of protecting family members has changed as a result of male family members being absent (due to death or fleeing). Some women joined the separatist fighting because they wanted to protect family members. In the Aceh context, Acehnese females who joined Free Aceh movement (GAM) were called *Inong balee* Army. These women have been trained no differently to male soldiers – living in the jungle, carrying wood logs, learning to shoot and engaging in the battle. In some villages in Aceh, only women and children remain. While women in the Deep South who join the separatist movement are in smaller numbers, many of them become supporters of armed groups– sending news and supplies.

Most of the families that got involved in the violent conflict were isolated from other family members, relatives, neighbors and community. Their neighbors did not want to be implicated into the same situation. During the years of dealing with the traumatic event, the survivor partners and children were struggling to look after family members who lived in the same house. When more than one family member had been affected by more than one traumatic event, dysfunctional relationships among family members developed.

Natural Disasters and Families

When the tsunami hit Aceh at 7:59am on 26 December 2004, Acehnese people were mostly at home engaged in activities such as cooking and looking after their children/parent. Some were preparing to go outside or were already outside and others were visiting friends or just welcoming friends who had come to visit. The storm surge that struck the Deep South of Thailand occurred on 1 November 2011 arrived just before dusk after more than an hour of heavy rain. Most families in the disaster affected areas relied on fishing to earn income, but many residents were away working in Malaysia, and some working-age family members were in a prison, leaving children to be raised by grandparents in the village.

***Gempa*: The Earthquake and the Bomb Explosion Sound**

Gempa is an earthquake, in Indonesia language. Not everyone understood that an earthquake might generate a tsunami. But the magnitude 9 earthquake that shook Aceh on 26 December 2004 caused its own devastation – electric poles collapsed, as did houses and trees. All electricity was turned off and people were surprised. Some people thought they were seeing a moving picture and that the appearance of shaking scenery had happened because of personal sickness or waking up in the morning a little dizzy. Most family members who had other activities outside the home attempted to return home immediately to check the safety of their people.

One male head of household in a fishing village heard the screams of the monkeys from the forest. Even with his house located near the forest, he had never before heard the voice of the crying monkeys through the airspace. One wife in Meulaboh, who was sitting outside her house facing the sea, noticed her cat kept meowing and behaved anxiously. She also saw crane birds making unusual sounds and flying from the ocean to her direction and the mainland. When the earth stopped shaking, some people witnessed the cracked earth and smelled the odour of gas from the soil. Some key informants who were located in the violent conflict areas compared the sound of the earthquake with the sound of tanks firing artillery. Many of them said that the noise had happened many times, but the loudest sound occurred about three times before the earthquake occurred. Someone compared the sound of the explosion to a thunderstorm or volcanic eruption, but they did not know how it came from the ocean. A sixty year old woman who lived with her five children also heard a sound like bombs. She ran to the beach to check the situation and, to her surprise, saw that the water level had dropped so far it looked as though the sea had dried up.

In Kampung Jawa, Aceh city, a young Acehnese man stayed outside his house after he experienced the earthquakes. He just waited and evaluated the situation with his family – father, mother, brother, and his sister-in-law. His house was not damaged. The beach was only two kilometers away. At the Hotel Cakrdonya, he heard that some people got injuries from buildings that collapsed. However, because he did not see unusual things, all the family members went back inside the house once the earthquake stopped.

A forty-seven year old forge worker's wife was sitting at the front of the veranda with her son and other family members – grandmother, mother, and sister after they experienced the earthquake. All of them felt safe to stay at home. This was related to their experiences of violent conflict. When she heard a sound like exploding bombs from the sea just before the earthquake and the tsunami, she though it happened because GAM and TNI were fighting each other. She was wondering why they had not stopped battling even when the earthquake occurred. Hence, she thought that the house was the safest place for her and her family members. This was an example of how peoples' experience and response to the natural disaster was affected by previous experience of violent conflict. This woman and her family survived because her son requested food after the earthquake had stopped. Through the kitchen window, as she began cooking rice; she saw people running over the beach with the wave chasing them. She saw the wave was as high as the coconut trees (See Figure 10). The top of the wave looked like a haze. After that, she dropped the rice and started running and shouting, *'RUN! RUN!'*.

Figure 10: The coconut trees in Aceh, Indonesia located at the tsunami affected area

Air Laut Nike: The Sea Water Rise and Sense of Danger

People who lived near the sea in Aceh were yelling *Air Laut Nike* which means 'the sea water rise'. In some areas, the tsunami had been shaped in the form of a flood or *air bah* in Indonesian. However, these words did not have a sense of danger. Additionally, some people did not know the word 'tsunami'. Many did not even know what the formation of high waves in front of them was. When they heard people screaming *'the sea water rise'*, they wondered why river water rising would scare that person. Thirty minutes after the earthquake, the rising tsunami took a variety of forms – flooding, fountains, waves and, for people located at the riverside, a strong rushing stream. These different patterns caused people to have different experiences in different areas. One respondent, a woman of Chinese ethnicity who lost a husband and two children, one a high school daughter and the other, a son in fourth grade, told me:

After the earthquake, I saw people were running and screaming 'the sea water rise!' many times. But I did not have any idea what was happening? My first though was that the sea water rise was the same as with flooding?

Another woman explained:

I thought it was air bah*. We did not know what the tsunami was. Someone spoke up, 'The water is so big!', but I did not understand what he said. I thought the water flow was vast and everybody seemed very surprised*.

Most people realized that the big black wave was the sign of dangerous sea when they saw that it was higher than the coconut trees. Running for their life had usually begun before the water reached them but they did not have any idea in which direction they should go. At that time, Aceh did not have an evacuation sign. Some tried to run ahead of the waves and other people ran in other directions, some as much towards as away from the waves.

Many chose to run with family members - mother and daughter, sister and brother, husband and wife, grandparents and/or with their neighbours. A number of people had to decide whether to leave family members behind or die with them. A daughter who chose to stay with her disabled mother asked her own husband to flee with her four children so that they could be rescued or saved. A husband who found himself stuck in the wave asked his wife to run away taking their son.

One significant survivor story was from a Chinese woman who had multiple roles such as mother, daughter, and wife. Despite expecting to die, this woman and her disabled mother both survived, whilst her husband and their two children did not. She chose to run away with all her family members. This woman had a motorcycle but it was too small to carry all of them. Consequently, they decided to escape by running from the house, stopping at the big yard of one school. Not very long after the earthquake, the flooding had reached her and her family. They were stuck against an iron fence and they did not know where else to go.

I didn't know how I could do that (climb the fence) because I was fat and my Mom also did not know how to climb. At the same time, my husband was stuck in the torrential stream, holding both of my two children together with the door, trying to resist the fast-flowing water. I also held my mother, protecting ourselves so as not to drift away together with the water. Shortly, in front of my eyes, my husband and two children were swept away in the flood…I still remember how my children called me, 'Mama! Mama!' until they were gone from my searching eye.

At this time, she realized that her mother could not walk and that the muddy water had already covered them until they were struggling to breathe. She started to acknowledge a dangerous situation. She cried as she shared her story of the loss of husband and children. She continued her narrative even though her voice started shaking. She wiped her tears but they continued flowing and she could not hide the tear drop stains on her face. She said this event had happened a long time ago, and she did not often cry anymore because she had to stop thinking about the loss of family members. This tragedy causes her stress and she was afraid that it might cause her to become crazy. She then intermittently modified her mood to giggles and smiles.

Through the interviews, hardly anyone acknowledged they had thought to escape only for themselves, despite the tough situation and not having experience of a similar previous disaster. Many people witnessed the death of family members and became separated from them. During the interviews the survivors recalled their memories. Many said that if they had made another decision everyone (in their family) would still be alive now. However, with time unable to be reversed, mental wounds were evident. A Chinese respondent went on to tell me:

> *... if that day we had returned back to our house which has a second floor, all of them will be safe now ... [After the tsunami] I found only my daughter's dead body at Masjid Raja. But, I didn't know what to do. I left her there, buried with other people ... and we went to Medan*.

Knowing the Tsunami or *Ie Beuna*

Many Acehnese people said that they did not know the word 'tsunami', yet many Acehnese who were resident near the coast had previous experience or knowledge of giant waves. They named the huge sea waves *Ie Beuna* which, in Acehnese, means 'standing water' or 'wall of water'. *Ie* is water. *Beuna* is standing. There are a number of stories about *Ie Beuna* and people had different views, prior to the tsunami, of how dangerous the waves could be. The fishers' villagers trusted that *Ie Beuna* could be controlled – that when *Ie Beuna* approached they could read Al-Quran (Muslim bible) until the standing water disappeared. One male head of a fishing village, like many Acehnese, stated that he had believed that *Ie Beuna* never harms people. He and his villagers often saw *Ie Beuna* in the sea. By contrast, one young adult said his grandmother had told him that *Ie Beuna* does attack the people. Similarly, a local fisherman in Meulaboh remembered his grandmother telling him:

> *When the ground splits and water comes up from the ground that is split after the strong earthquake and people must run away to the highest place.* Ie Beuna *will come*.

The First Tsunami Wave

After he experienced the earthquake, the fisherman quoted above went home. He saw that the earth had split in his back yard and water was shooting up like a fountain. He began to run away and was trying to tell everyone to escape, and follow his lead. However, he said that no one believed him. Even his own brother thought he was crazy. Very soon he saw that *Ie Beuna* had been shaped. He described this:

> *The water was high; the crest of a wave was white while the other part of the wave was black. It was like a snake and it swept the area*.

He was able to run away and survived. However, not everyone knows about *Ie Beuna*, especially in Aceh city. Many people who lived there were non-resident and came from different areas of Indonesia.

One forty-seven year old forge worker who lost his grandmother in the tsunami and almost lost his younger son as well, shared his experience. He stated that after the earthquake had stopped, he went back home to check the safety of his family members – more than hundred year old grandmother, sixty-nine year old mother, his wife, sister and his little son. When he found no one was injured, he headed back to work which was located near the sea. Even though he saw the water come up from the ground like a fountain, he did not realise this was the sign of the dangerous sea. He said:

> *That day, I had to go to work, so I thought everything was alright and that it was safe to leave the house. I didn't know that the tsunami would happen. If I had known that the tsunami would happen like in Japan, I wouldn't have gone anywhere. My workplace is near the beach, so I actually saw the sea water rise up.*

He realized this was not an ordinary wave when he saw the water rise higher than the coconut trees. The color of the wave was black. He squinted and stared at the wave because he did not know what to do. Actually, he did not even know what it was that he saw in front of him. He wondered why the water was rising. Then, he started running together with the other people. However, he did not run away for himself. Home was his destination. He was thinking about his family members and their safety. He jumped on one police motorcycle that passed in front of him. After arriving at the junction, he was dropped off and went straight to his house. He met his family members. They were sitting together outside. He carried his grandmother and ran in the direction that he thought was opposite from the tsunami, but the water reached them and blocked them at some traffic signs.

While he was carrying his grandmother and running he often stopped and looked back for checking on his family members. He wanted to ensure all of them could flee together and waited until

they came closer before he started running again. The destination was the bridge but they did not make it. All of them were trapped in the middle of the water. He spoke of a life and death moment. He did not know what else he should do, one hand holding his grandmother and the other hand holding the traffic sign pole. Every family member was with him. The stream of water was strong and increasing. He was desperately worried about his family members – his wife, younger sister, his mother and his little son.

When he saw a table floating on the surface he decided to place his little son on top of it. Suddenly the table flipped. He grabbed his son so that he did not drown but his grandmother had dropped off from his arm and into the water. He pulled his grandmother back to the surface, holding both his son and his grandmother together on his chest, protecting them from being drowned. Suddenly the water began to recede. All of them started running again, heading to the main road. He did not know where he should go. He yelled for help but it did not seem that anyone could hear. Everyone looked busy with themselves. On the road, he saw many car and motorcycle accidents occur. Many people were injured. One military truck accelerated and hit people who were running on the same road and as a result there were many injuries.

One cycle passed in front of him and he asked help from the rider, sending his grandmother to the hospital. When he arrived at the hospital there were no doctors, nurses or any medical staff. Many injured people were there but everybody had to take care of themselves. He heard people screaming and shouting for medical treatment. Eventually, he saw some night-shift medical staff, but so many patients who needed help. The doctors and nurses were also panicking about trying to help too many patients who were wounded. He also had a head injury and had lost a tooth but he did not acknowledge his pain because he was focused on his grandmother's safety.

His wife's experience was different, as told in a separate interview. She said that after she saw people running away from the sea and also had seen the high wave she went to tell her mother and said *'Mother…Mother…run…sea water!'* However, she started laughing when she was remembering that she did not understand herself why she had to take some clothes with her when she fled on that day. She also searched for her money in the cupboard – money she thought she might need later. She realized that she would not have a chance to return home because the sea water was so high. She was panicking. She ran into the main road but then she returned home again to take some clothes with her. She recalled, *'I didn't know what I should take. I took my clothes. Why did I do that? I don't know. Then, we ran'*. She ran away because she heard her nephew tell her to run, *'Aunty Run! Run quickly!'* Hence, she and her family started running away together. When she went to the intersection, the water was coming from the direction of the city. It was high. She and her family members could not go anywhere. She was swept away by the water with her family. At that time when she was floating, she

thought she might be killed. All of them were flowing away until reaching a small mosque. They had not been taken far because the water was subsiding. Her grandmother got hurt after she had been dropped from her husband's arms. Suddenly the interviewee started crying when she remembered in this moment that her husband had been choosing between saving her son or the grandmother. She said:

> *The water came from the city. We were trapped. My son was put on the table, but the water brought the refrigerator and it hit the table. My husband grabbed him and dropped Grandmother; otherwise, my son would have been swept away. He rescued his son and sacrificed Grandma. If I think about it, it makes me sad. I feel sad when I remember it now. One of them must be sacrificed. If he catches Grandma, then my son will be drowned … my second son*.

However, they all survived and were safe when arriving at the mosque. Two of her younger relatives had been brought to the mosque by male family members. When she, her mother, the grandmother and her husband were united at the hospital. She said:

> *It was us, Mom and Grandmother. Grandmother is old. She is a hundred-year-old. But, we did not separate because we had no intention of that. But we ran without a clear destination because we were panicking. Some people went to a store's second floor, but we kept running on the ground*.

Here is another story about one young Acehnese man who lived with his father, mother, brother and his sister in law at Kampung Jawa, Aceh city. He is a tsunami survivor, but he lost his mother, his brother and his sister in law on that day. He said that he had been surprised by the flooding of the river which happened within several minutes of the earthquake. He described:

> *I was panicking because the water level was increasing very fast and massively, following by the big black wave. I estimated the height of a wave as almost two coconut trees. The wave slammed on me and my family. I was separated from all of them. I lost all of my clothes from my body… even my underwear. I was floating in the water. The condition in the sea was like water blended in the blender machine. It was going up and down. Even though I can swim, in this situation it was not important. Even Olympic swimmers could not swim in this kind of water because it had many things coming together with the wave – roof, cable, and even a spring bed. I was caught up by my neck in one spring bed, for about five to seven minutes under this condition. I was choking with the water*.

After the water level declined, he landed at Kampung Keuramat on the rooftop of one house. On the beach, he saw many survivors. He also collected some clothing articles from the ground and

wore them. He grabbed and ate the food from one refrigerator that he found. It had been floating with the water.

> *I was very hungry… I think when everyone faced with the same situation like me will grab anything. At that moment, we cannot say what is belonging to whom. No one will care. They care about their life*.

After the water reduced he saw many crops but all crops were naked. Then, he went back to his sister's house by walking and riding a motorcycle. He travelled about twenty kilometers. He rode with one stranger but walked about half the way. By nightfall his father had arrived but there had been no sign of his mother. He realized she had not survived. The next morning, he went to search for his mother's body with his father, sister, and brother-in-law. Not a single corpse among all those that lined on the beach looked like her. He never found his mother alive or dead.

Another story is of fifty-five year old woman who stayed at home with her mother, her husband, her younger sister and brother, and her child on this day. She started crying when she described her experience, especially when she recalled being separated from her siblings, her older sister and her brother, by the giant waves. Most of her family members are still alive, except her mother who drowned in the tsunami. With tears in her eyes and head bent down, she whispered:

> *Our houses were destroyed. Only my Mom passed away. But I can't eat. If I recall that day I become very sad. I can't sleep during the day or at night and I keep remembering when I was searching for my sister and brother … Where are they?*

As people yelled *'sea water rise'*, her child told her to escape with the motorcycle while her older mother went in a car. However, the motorcycle could not be started. Nonetheless, she stood and waited for the ride until the water arrived. Consequently, they were slammed by the giant wave. Both of them were drifting, but they were still trying to hold each other's hand. During this moment, she also witnessed her mother's car rolling in the water. It had her siblings and her mother sitting inside but within a few seconds they had been thrown out of the car. Her mother survived that initial event but as a result of choking on tsunami water she lived only another three days.

Actually, if the mother had departed when she first could she would have escaped but she was waiting for her neighbor who lived next door, so that they could escape together on that tsunami day. At Padang Tiji, the mother got slammed by the water and the car floated with the water stream. While the mother was floating, but the daughter was able to grab her mother's hand, rescuing her from drowning. The water level began decreasing until their feet were able to touch the ground. After that, they were able to run together with her siblings, to the road. Then the army truck came. The mother was sent to the hospital; however, the medical doctors and nurses were busy with an enormous

number of patients and consequently the mother did not receive any medical treatment. The family decided to bring their mother back to Pukat village. Later on, her condition kept getting worse. She could not eat and she was vomiting yellow water. Within three days she passed away. The daughter also vomited yellow water a few times. The water was rancid, full of rubbish that included household waste, tin roofing materials and all kinds of wood. She had been drowning many times because the massive water waves kept slamming on her.

After the life and death situation has passed she kept looking for family members. All of the family's houses were located near her place. When she arrived at one family member's space all that was left were the edges of house floor foundations. Three days later she met all of her family at the shelter. Even though they were still alive she teared at the memory of that psychological trauma.

The 2nd Tsunami Wave: The Killer Wave

In Aceh, the tsunami did not appear as only one giant wave. It occurred as three huge wave forms. Many tsunami victims stated that the second wave was the killer. It was stronger and higher than the first and the third. Many survivors who had been separated from family members after the first giant wave experienced and witnessed death after the second tsunami.

The water from the first wave had reduced for a while. Then, the second arrived, higher than the first. One key male informant who survived the first wave by evacuating with all his family members to the rooftop of a house was separated from his parents who were located a short distance away. He was desperately worried about the parent's safety but could not do anything at that time due to the sea water level after the second tsunami having reached the rooftop on his two-stories-high house. He was afraid for his newborn baby who was very sick and needed medical treatment. His wife, his two children and his brother in law were together with him. He stated that this was the most frightening experience in his life.

During this time, he saw one old lady flow with the water with another man and a girl of about six years of age. His family threw electric cable to the group. They grabbed the cable and were dragged to his house. The old lady had many injuries and wounds on her body, as did the young girl. But the girl was already dead. He also witnessed one man who was stuck in between rubbish bins. When the water was rising, the man was drowning and dying in front of the witness's eyes, but he could not help anyone under this situation.

The Third Tsunami Wave: Isolation

One female community mental health nurse (CMHN) reported having experienced all the three waves. Her psychological trauma stemmed from the loss, separation and death of her family members. Her husband, four year old daughter, father and one sibling survived, but her almost two year old son, mother and three siblings died. Only one body, one of the siblings, was recovered. Additional ongoing psychological trauma was related to her relationship with her surviving daughter. Until now, the mother has been blamed by her surviving child for being a bad mother. The daughter stated that she believed that the mother intentionally let her hand go and left her to die in the tsunami. The mother said she lost her grip on her daughter's hand when the first giant wave slammed on them.

The first tsunami wave separated the woman from her grandmother and her daughter but during her escape she was still holding a hand of her youngest son. After that first wave, for a period, her husband was not with her. He had gone to drive her housemate back home as she had requested after the first earthquake had stopped. This woman later reunited with her husband in the middle of the expanse of water. Her family members were floating in the water, except for her grandmother and her daughter, who had not been sighted after the first tsunami wave struck.

Then she was hit by the second killer wave and lost her son's grip. She watched him drowning, floating away, and calling for her *'Mother! Mother!'* until he was gone. Even though her husband ordered her not to look at him, she still wanted to see her son and watched him until he had disappeared in the expanse of water. When she shared this part of her story she covered her face and mourned heavily. Her friend who sat near her gave her a hug, trying to release the pain from her shaking body. It took a while before she was able to continue sharing her tsunami story. All of this is the experience of the first two waves. There was another wave that followed.

When the third tsunami wave came, again she was slammed by the mass of water and separated immediately from her husband and all other family members. She found herself alone in the middle of the expanse of water. Somehow, she climbed up to the top of a tree and stayed there until the water level had started receding. Her daughter was found alive in the mangrove forest by a rescue team that had heard her screaming for help. Her clothes had been stripped from her body by the force of the wave. Many physical wounds were found especially the scar on her neck caused by her necklace and a head injury that had become infected and had a very big abscess. Later, she was taken to receive medical treatment at Medan hospital.

Life After the Tsunami

The woman's situation became more complex when she found herself in the position of community mental health nurse (CMHN). Listening to the traumatic stories of her patients causes flash-backs to her own tsunami experience when she became separated from and lost her family members in the same situation. She stated that she had gained more knowledge from a short course in counseling and psychology and, as a result, knows better how to deal with her patients and also has gained benefits for coping with her own daughter's psychological trauma symptoms. The downside of being a counseling CMHN is that the patients' stories always are providing a trigger to her own experience as well. She stated that many times she cried together with them. She stated that placing her in a CMHN position was a wrong decision because she also has the psychological trauma condition that the patients have.

For two years after her daughter's experience of the natural disaster she always drew the colours black and white when drawing pictures related to the death of the tsunami victims. This had been interpreted as meaning that everyone had already become ghosts (*pocong*). The psychologist at the school told the mother that the girl's use of white and black could be interpreted as a sign of psychological trauma. Her daughter has many other symptoms of psychological trauma such as difficulty falling asleep and takes sleeping pills (Valium). The daughter has also exhibited memory problems – being able to remember material she has studied at school for only about two weeks – and will not let people touch the scar on her head. Her emotions have been intense – easy to anger and telling her mother *'I don't want to be friends with you. You let me go! You are bad!'* Yet, at the same time, does not want to be far away from her mother. Dealing with her daughter's psychological condition, the mother said to her daughter, *'I promise you that I will never leave you again if a next tsunami comes'*.

Family Gender Roles and Disaster

Gender roles in many families were challenged by the experience of disaster. Such roles are varied and complex, responsibilities of protector, caregiver and parent interacting with roles as 'in-laws' and grandparents and, in an extended family, multiple roles can be attributed to each person. Changing gender roles post-tsunami both reflected the psychological trauma associated with the experience of disaster and they were a source themselves of secondary trauma as people struggled with new responsibilities and contradictory expectations.

Protector

The role of the protector is occupied by both men and women. Male psychological trauma was associated with beliefs that men are physically stronger than women along with gender role expectations that a male should be protector of the members of the family. One male tsunami victim, for example, observed that the majority of tsunami corpses were identified as women and children. According to his opinion, maternal instincts may also relate to the death of female natural disaster victims. This quote is from a male as a husband, father, and tsunami and conflict survivor.

> *… every time when I heard about corpses floating in the sea or getting stuck on the Banyak Island…miles away from the sea shores. Most of them were identified as being women and children … Two months after the tsunami, I found my wife and daughter's dead bodies only six hundred meters from my house. They were in a position of my wife hugging my youngest daughter and my daughter's body was inside her arms… In the tsunami condition, women and children found it hard to help themselves… but women have a maternal instinct to protect their child*.

In his opinion, men are stronger. However, in the tsunami waters it is extremely difficult even for men to survive. He concluded that the cause of death among women and children related to the physical difference between men and women but he conceded that both men and women have protective tendencies. He explained the death of his brother in law, who was trying to protect his children.

> *You cannot say that only women die because of trying to protect their children from the disaster. Many males as fathers did too. Such as my brother in law who sacrificed his life trying to protect his children…It is very hard to find an explanation of how it happened. My brother in law refused to let his kids go while running away from the waves*.

Many women also accepted the belief that women are weaker in physical strength than men. However, in a time of disaster and certain social contexts, especially in a conflict, many Acehnese women became warriors for the protection of their own family members, just as many males did.

> Inong balee *is strong. I saw she carried logs the same as with men. They lived in the jungle and also did military practice*.

For women who lost their children in the disaster, psychological trauma was embedded in the role of mothers who should be able to protect their own children in any situation. The differences between female and male physical bodies are significant due to many women's experiences giving birth during the disaster and its aftermath. One woman gave birth on a roof during the tsunami, and

her husband helped by cutting the umbilical cord with his motorcycle key. Others suffered from the infection of wounds arising from caesarean sections. Lack of basic medicine in the disaster-affected areas and the limited number of medical doctors and nurses was one of the main uses of infection.

Many male disaster victims died or suffered injury when trying to protect family members from the disaster. Their story can be learned from female family members and friends who survived the disaster event.

Male survivors who failed to protect their family members experienced associated psychological trauma. One man who lost his wife and two daughters in the tsunami is now remarried and has two new sons. Even though he has a new family, he still remembers his previous family and stated that it is hard to forget the tragedy. On the tsunami day, he was slammed by the giant wave. He lost his grip on his daughter's hand. He was separated from his wife and another daughter. He claimed he survived because of the motivation of being a protector. Whilst struggling in the water, he was ready to die and surrendered himself to Allah. However, he changed his thoughts when he began thinking about his wife and children. He stated that he thought they might have survived from the waves and might need his help. He then pushed himself above the surface of the ocean and breathed again. He spent two months searching for his wife and daughters but he found later they were already dead. Because of his loss, he had no more purpose in his life. He could not eat properly. He had no spirit to move on. In a deep, low voice he told me:

> *I felt like someone who had a broken heart. My life was so devastating because my life with my wife and my children was ended*.

He had been born and raised near the beaches and had thought of the sea as his close friend, but now he felt hate and anger towards the sea because it had taken his loved ones. He said it was hard for him to adopt a normal life again, and to feel normal. By contrast, a number of other Acehnese referred to the tsunami as coming from God and spoke of *'surrendering to the tsunami'*.

In general, members of both of the societies expressed a belief that most of the widowers who lost their partner in the disaster did not appear to suffer psychological trauma. Evidence that they were quick to remarry was cited. However, immediate remarriage did not happen with everyone. Many widowers took years before agreeing to have a new partner. Some of them remain single fathers today. Even for many of those men who agreed to remarry, their sadness and psychological trauma did not disappear.

One man who agreed to remarry a new partner, who was introduced by his family, said that he is always sad and expresses his sadness to the new wife. His new wife told him not to feel sad. He frequently referred to his deceased wife. He thinks she might not like to see his weakness but he likes

to share his feelings among his friends at the tea shop. He believes there is nothing to be ashamed about when he shares his story of trauma with them.

Publicly expressing male psychological trauma caused by losing a wife and children often happens among male disaster victims with similar experiences. Another man did not shy away from describing his experience and he cried heavily when stating that he had thought he might lose wife and daughters. When he shared this story among his family members – his wife, his children, his mother, his nieces and his nephews, who sat together during the interview with the man, they were giggling after he described his crying reaction. Nevertheless, he proceeded with his account of the tsunami. He continued sharing his psychological trauma experience with a smile, at least superficially appearing to disregard their attitudes.

> *Yes, I'm a man. But, no one will understand how sad the situation is. No matter how strong they are. When I thought I might lose my wife and children ... it was a very sad situation. I had to cry*.

The perceived expectations of females were also related to emotional expressions of masculinity. Male weakness such as crying and expressing fear might not be accepted by every woman. One Acehnese daughter did not know of her father's feelings related to the disaster. She said that, with a man as a father, emotion associated with the disaster was not necessary for her to know. Moreover, she also expected that her father should not show his anxiety. She stated that:

> *He should not show his fear. Otherwise, as a role of the father and the leader of the family, if he fears how do we trust him?*

This stereotype is similar to one of this study's female interpreters. She told me after we finished interviewing that 'if a man has a wife, he should not express his fear in the public and friends'. One male as a husband, son, father, brother, and brother in law, when his wife went into the kitchen, quickly said that he still has psychological trauma.

> *In the conflict, I met GAM members in the forest. They asked for money and threatened to kill my boss by cutting off his head. But ... we have a permission letter. So, we survived ... I was in shock to hear them threatening ... I still have psychological trauma from the tsunami ... but please don't tell this to my wife ... I think Aceh does not have a future ... we have experienced natural disaster and conflict ... I want to move, leaving to live in another area, but I don't know how*.

The wife of this man expressed the view that this research might never be finished because no one has psychological trauma anymore.

Caregiver

Many families in the disaster/conflict areas studied look after their own family members in need. Besides grandparents, most of the caregivers are females, as a wife, mother or daughter. However, in a time of disaster, family members with disabilities are looked after by a wider range of family caregivers. The role of caregiver can be adopted by males such as a husband or a father who looks after children after the death of his spouse. A brother might take care of his niece or nephew after the death of their mother. A son might take care of his father, disabled in the conflict, and a father might take care of his disabled son. In many cases, a family member's physical disability pre-existed the disaster but, sometimes, the disaster caused the disability.

Grandparents in the disaster areas play an important role as primary caregivers, as discussed above. In many families in the Deep South of Thailand, grandparents rescued grandchildren from the storm surge because the parents were working (for example, in Malaysia). One grandfather who almost died evacuated his wife and five grandchildren (one of them had a disability before the natural disaster) by using a small boat explained how:

> *That day we almost died because I have asthma and the boat was overweight. On one side of the boat, I dragged all of them under a very dark night. I cannot see even a single light from a star. I did not even know where the direction to the main land was. With a strong wind and high level of sea [up to my chest] and heavy rain, I was worried that the sinking of the boat could happen anytime*.

The grandfather was not in the boat because it was already overloaded. Despite his exhaustion, he was lucky to make a guess and head in the right direction. Nowadays, he is older and weaker. His house is still located in the natural disaster area. He thinks that all of his grandchildren and his wife might not fit in the small boat if there is another disaster. His grandchildren are getting bigger every day. If storm surge happens again, he and his family members might not be able to survive. This family cannot move to live in another area due to poverty. In the Deep South of Thailand, many grandparents were affected by the storm surge. Their psychological trauma is related to the role of looking after grandchildren while their parents went to work in Malaysia.

One mother in the area affected by storm surge looked after her disabled daughter. The cause of the daughter's illness was swallowing dirty water during the escape from the surge. The mother said that the baby fell into the debris and water for only for a second. Her daughter did not appear affected during the first few days but her health deteriorated. The medical doctor said she had a serious illness and her brain was affected. The doctor did not know the cause of the contagion but the mother believed that it may come from when she dropped her daughter into the polluted water during

escape from storm surge event. Nowadays this mother's role involves caring for her disabled daughter and also taking care of her elderly diabetic father. The girl's father who had left her and has a new family came back to stay with his daughter and former wife after he was abandoned by his new wife. All the household income was sent by her husband who was working in Malaysia, leaving her alone for almost the whole year.

A wife of the head of a fishing village in the Deep South of Thailand almost lost her son to drowning. She exhibited much anxiety due to her husband being focused on helping the other villagers before his own family. As a wife of the head of the village, she said she understands her husband's action, however, she wanted to communicate with him about helping his family as a first priority.

> *... he went to rescue the villagers while I stayed at home with my son ... I was very scared too ... Even though I am a wife of the head of the village, so ... I have to save myself and my son because he went to help his village members.*

Many Chinese-Buddhist families who had been living in the Deep South were not affected by storm surge. Before the storm surge occurred, a lot of Chinese-Buddhist families who used to live in remote areas moved out when the conflict became more severe. Most of them relocated to cities in non-conflict zones. Their children were able to experience better living conditions there. Previously, the Chinese-Buddhist families had similar conditions to the Melayu-Muslims and Thai-Buddhists, such as poverty and a lot of children (8 to 10). However, the new generation generally has different conditions including being able to support their own family members.

In Aceh, especially in fishing villages, the role of caregivers is related to earning income. Most male fishermen went out to sea while most of the women who stayed at home were the caregivers. The responsibilities and duties were different for fishermen who worked the morning shift before sunrise and those who worked the night shift after the sun is down. The local fishermen who took a night shift died in the tsunami because they were home resting before dawn. For the fishermen who went to the sea in the morning, over three kilometers from shore, many of them survived in the ocean. From the long distance, they saw the tsunami wave sweep coastal villages and were thinking about their family members who stayed at home. After the wave had gone, not everyone had a chance to see their family members again.

Changing Roles

When a partner experiences the death or disablement of their partner parenting roles are inevitably changed. A single father and/or mother struggles to raise children. According to

participants, the effects on children from the death of a family member are often that the child's behavior is changed in a negative way. They were reported to act disobediently, aggressively, violently (e.g. throwing things at a sibling). Single parents did not know how to deal with their children's behavior. Moreover, many of them had a difficult time earning income to feed their children. Some families could not live in the old village (or house) due to fear and sought relocation to avoid the traumatic scene. Expected to settle down and start a new life again, the families who had experienced natural disaster with home, livestock, and fishery equipment damaged or destroyed, felt frustrated because they were struggling of look after themselves and surviving children earning, or trying to earn, income at the same time. Some single-parents remarried but, in such remarriages, there was often evidence of an unhealthy relationship, such as domestic violence.

Poverty, armed conflict and natural disaster could be factors in disability for a family member. For example, a male fisherman with scars from serious wounds on his face and body related that initially he had lost his left eye after using dynamite to catch fish in 1989. Then on 8 June 2010, he lost his right eye, right hand and hearing capacity from the same activity. As a result of the violent conflict, he had been too fearful to seek work outside his fishing village, as many people who had travelled for work in Aceh had disappeared – possibly being kidnapped or killed. On 24 December 2006, he lost his two sons, relatives and his property as a result of the tsunami. His wife and daughter survived.

Families have roles to care for family members, one widow still blamed herself as a cause of death of her husband in the conflict. Her husband disappeared on the way to exchange three chickens with medicine for treating his wife's illness. Hence, when this widow experienced the tsunami she was struggling by herself in a natural disaster (during and after). Moreover, post-conflict, post-natural disaster and on-going conflict are caused the problem of earning income.

> *I've already lost my husband to a conflict. On that (disaster) day, I was sick. He took three chickens for trading to get medicine but has never returned … My house and property were destroyed by the tsunami … and I did not have anyone.*

For some families that have limited financial support, they did not have any other choice than to live in the same village with extreme fear under violent conflict. When they experienced a natural disaster along with poverty it caused even more severe psychological trauma.

Some single parents decided to remarry but experienced domestic violence from a new partner. Moreover, some family members had negative experiences of interactions with their stepfather or stepmother. For example, one stepfather sexually assaulted a daughter, and other reports included psychological abuse and physical harm to a partner. However, this family was unable to

relocate and move out. They already had new land but this place had frequently occurring natural disasters including flooding.

Single Parent Households

The death of partner, as stated above, was widely seen as a primary source of psychological trauma. Beyond the immediate emotional impact of loss and grief at the death of a partner, single parents acquired additional responsibilities in relation to the material and emotional needs of their children – responsibilities they often struggled to meet.

Single fathers reported a lack of social support. They felt invisible, portraying a public face of household head and provider while struggling with unfamiliar tasks. One explained how he had never learned to cook or talk softly with children – how he cried in private and tried to heal himself with reading and prayer. He said:

> *I have four children, one son and three daughters… I lost my wife, my youngest daughter and nine family members. My wife didn't want to run. She didn't want to leave her mother who was very fat. I asked her to leave her and run with me, but my wife did not want to. She asked me to run with the kids. I got swept away and lost grip of my daughter while the other three ran in different directions. I got swept away two hundred meters. After the tsunami, our condition was so sad. An American boat dropped rice for us, but some of my friends who took the rice past the military post had the rice was taken by many soldiers. The road was blocked by many soldiers after the third day of the tsunami. I cooked food for my kids. Tasty or not they still eat it. Once I made sambal lado using turmeric, the children just laughed at me. We usually used the stove to cook but it did not have gas. And I am not good in cooking. Sometimes, I burn the cooking food. In 2011, I remarried*.

Single mothers faced similar but also slightly different challenges. I spoke with a number who lost husbands during the conflict only to experience trauma again during the natural disaster. Most of these women found it difficult to raise sons who had themselves been traumatized by these events. Some were even afraid of their sons who were often larger than them.

One Acehnese women told me how she not know how to deal with a teenage son who was ignoring his study and spending nights at internet cafes. She was constantly searching for him in order to take him back home. She complained:

> *My son is bigger than me, and I am afraid he will hurt me if I complain too much. If my husband was still alive my husband will teach my son*.

This widow, whose policeman husband had died unexpectedly during the conflict, had relocated herself and two children, one girl and one boy, to live near her mother's home. Her husband's boss had allowed her to continue to live in the same house (police camp), but grief from the death of her husband caused her to leave. She built her new house and cared for her children. All money that she spent on building the house was coming from her husband's salary. Only a few months after she built the house it was damaged by the tsunami, causing her to experience more grief. She wanted to move again but post-tsunami the value of the land declined. She could not afford to sell it and move to another area.

Some male children grew up with more aggressive behaviors including yelling and hitting. Single women told me about sons who threw things at their siblings or screamed at their mothers when they wanted new toys. One told me of an older son who, having witnessed his father's violence towards his mother when he was a child, emulated the behavior.

Single mothers told me of depression and sadness. One, for example, from the Deep South of Thailand described the difficulty of life as widow and mother of three children alone. The sounds of explosions and gunshots were common in the market, the only place she was able to earn an income after her husband died. These sounds drove her to stay at home out of fear despite the need to earn money. She feels great stress when the landlord comes to her house asking for the rent as she has no money and asks for mercy. She cried and mourned as she told me all this. She is worried about her second daughter who saw her father die. Yet the daughter exhibited no obvious sign of ongoing psychological trauma. The daughter had been witness to domestic violence before her father's death and appeared not be grieving his passing.

Remarriage was a solution for some single parents but not for all. One single father refused to remarry, for example, when a potential partner ask him to abandon his four children. One widow who did remarry found later her new husband had lied to her about having no children – hiding from her the fact he had six children of his own. Men, in general, appeared more likely to seek a new partner for the sake of helping to raise their children than did women. Also, it is worth noting that remarriage was not only about connecting with a sole partner but about connecting with family and society in new ways. After the death of a spouse, many found that their family, friends and neighbors took it on themselves to become matchmakers, looking for a new partner for the single person.

Compounding Effects of Conflict and Disasters

Compounding effects disasters are characterized by complex relationships and interactions between disasters and society (Weichselgartner and Bertens, 2000). The death of a partner in the

armed conflict was seen by many participants as the most severe cause of psychological trauma (indeed, more severe than the death of a partner during a natural disaster) but it is important nonetheless to understand the interaction of multiple sources of psychological trauma. Many key informants viewed armed conflict as being caused by human action that they wished to revenge (Gäbler and Maercker, 2011). They felt angry. In contrast, natural disasters were often termed acts of God and thus those people who had been affected by the tsunami were seen as pure victims (Korf, 2007; see also Chapter 7). This difference in attribution of cause and consequent reaction is evident when examining how conflict and disaster interacted in the two study sites. Aceh experienced peace after the tsunami, allowing survivors to reunite. Even though many families lost members and property in the tsunami, the experience of reuniting with surviving family members helped mitigate its impact. In contrast, violence continued in the Deep South of Thailand following the storm surge, reducing families ability to reunite with survivors, access relief and development projects by the government, or improve their livelihoods. Many had severe psychological trauma caused by violent conflict, natural disaster and poverty. Most key participants from both sites had a similar response to the violent conflict. They stated that living under on-going violent conflict and not knowing when the conflict would end caused considerable anxiety. On the other hand, many people believe that natural disasters will happen only one time, despite the reality that the strong earthquake and other weather events have occurred more often.

Different types of disaster have different effects on different families. Some families may experience domestic violence from their own partners. Witnessing domestic violence in turn has a different impact on a child than does the death of a family member who died because of a natural disaster. For example, some wives experienced domestic violence by husbands which affected their children by leading them to drop out of school. In one case, the husband later died during the natural disaster and one of the children displayed behavior change such as acting disobediently. Interestingly, only the mother appeared to display clearly obvious psychological trauma. Her daughter, who witnessed the death of her father, did not overtly display grief. This daughter witnessed the earlier violence against her mother and this may have affected her reaction to the sight of her father dying when a tree collapsed on him on the day of the storm surge (See Figure 11).

Figure 11: A house was abandoned after the death of the father who died when a tree collapsing on him on the storm surge, the Deep South of Thailand

This research found one key informant who felt glad when the tsunami occurred because he then felt more able to share his psychological trauma caused by the loss of his father in the conflict. He could talk about it with many tsunami victims who had lost their father in the tsunami. He explained:

> *When I was young, my father was kidnapped and disappeared during the conflict … I feel the benefit that the tsunami occurred. Every child who lost a father in the tsunami, they will know how I feel when I lost my father in the conflict*.

Many family members stated that after the strong earthquake the veranda was the reunion spot where family members waited to be reunited with those who were not at home. According to family relationship ideals they expected to be running away together, because each of the family members were required to remain loyal to their family. The battery of sounds – the sound of artillery fire, grenades and shooting – is the key link between tsunami and violent conflict behaviour. During the violent conflict, home is the safe place for them when they heard the sound of battle. On the

tsunami day, before and during the earthquake, more than three extreme artillery sounds arose then people thought, again, it had happened because of fighting between GAM and TNT. Peoples' reaction – to stay at home – reflected their experience of conflict as much as it did their lack of experience of tsunamis. Even today, the sound of thunderstorms reminds people of death, the loss of family, and traumatic experience.

Conclusion

Disaster victims experienced both different kinds of disaster events differently and different kinds of secondary traumatization arose from the restructuring of family relationships. Armed conflict on top of natural disaster affects both female and male family members. When more than one traumatic event occurs simultaneously, the first traumatic event influences the outcomes of the second disaster event. The most severe psychological trauma is thereby caused by multifactorial sources. This research found that psychological trauma effects were often associated with the roles of family member, the changing role of family members, types of disaster and societal response (before, during and after). Other social problems such as poverty and domestic violence added an additional layer of complexity. For families that had different social backgrounds such as ethnicity and socioeconomic status, the effects of psychological trauma were found to not have the same impact on each family member. Long-lasting repetitive traumatic events such as post-conflict (Aceh), on-going natural disaster (Aceh and the Deep South of Thailand) and on-going armed conflict (the Deep South of Thailand), were found to be experiences particularly harmful on mental health in families.

The restructuring of family relationships can be understood as a cause and consequence of cultural trauma. This is not to suggest that the collective norms and ways of life reflected in the institution of the family were fundamentally undermined by exposure to disasters and conflict. The roles ascribed to families of protector and caregiver remained intact. However, families faced great stress and individual family members experienced a high degree of cultural disorientation over changing gender role expectations. Single parents, in particular, struggled to find adequate social support. They were traumatized by the expectations of society as much as they were by unfamiliar tasks and stressed relationships with surviving children. People had not abandoned existing ideas of family or gender but attempts to reconnect with traditional understandings of the institution of family through remarriage were often unsuccessful.

Chapter 6

Disaster, Conflict and Young People

This chapter explores the relationships between psychological trauma, young people, natural disaster and violent conflict in Aceh, Indonesia and the Deep South of Thailand. The traumatization of young people occurred through changing relationships and through learning processes. Among young people, psychological trauma was a direct outcome of exposure to the threats of giant waves, earthquake shocks, firearms etc. and through exposure to the visible effects of these threats as evident in dead bodies and the reactions of adults. Psychological trauma was also evident though as a product of relationships between these experiences of natural disaster and violent conflict and other life factors including child exploitation and abuse. In other word, the sources of secondary trauma were found through many forms of violence. Consistent with the previous chapter, psychological trauma among young people was strongly associated with young peoples' experiences of separation and survival in natural disaster and violent conflict situations.

Previous disaster experience was a key factor in the ongoing traumatization of young people through exposure to multiple interacting threats. Young people interviewed for this research were exposed to violent conflict from their very earliest years. As children, they became familiar with the sounds of gunshots and exploding bombs. Those born in Aceh, Indonesia, then experienced the earthquake and the tsunami and those born in the Deep South of Thailand, several years later, the storm surge. Older adults, by contrast, generally had experience of natural disasters before the outbreak of violent conflict. In any case, it became apparent through this research that the emotional and psychological impacts of exposure to conflict and disasters were not the same for all young people. As time passed, some learned to manage their emotions better than others. While some were afflicted with severe mental illness, others were able to build their own way to resilience. This chapter will explore the varying experiences of psychological trauma of children and other young people through the stories: first, of young people who went through the disaster when they were children; and second, of parents caring for children both when they were affected by the disasters and then since then. Parenting, for many in this latter group, involved ongoing struggles to cope with the mental health impacts of conflict and disaster on young people.

Separation and Survival

As with other family members, separation from parents, grandparents and siblings was often a key moment in the traumatization of children. Interviewed as teenagers and young adults, they still recalled times spent together with family members in a normal situation. They remembered separation and the emotions experienced both in that moment and when seeking their parents and other family members following it. One young woman explained to me:

> *I cry because my father was not with us. I was worried about him. I wanted someone to pick him up at PT.SAI. (name of place). He was working there. I didn't know it was an earthquake. It happened when I was in Grade 3 of elementary school. My father survived. He climbed to the mountain near the factory. When I was running I was afraid, but I didn't know that it was a tsunami. I didn't understand yet.*

And others:

> *I am afraid that I would lose my parents (who are still alive). I thought that we would not be together again. I lost my aunt and grandparents. I cried. I was very sad because I was close with my grandma*.

> *[During the conflict] I was afraid I would get shot. I saw people bleeding. They might be persons that are close to me like uncles or my father's friends that had become the victims. Many innocent people were accused that they know GAM … Then, they will get shot and no one can help them. So, we can say that it was our friends that become victims. It will make you feel afraid, right?*

Enduring fears that might appear, at face value, associated with the disaster itself (for example, fears of the ocean) were, in fact, more directly related to the familial context in which the disaster struck. Several young people explained how their memories of separation leave them still fearful to swim in the sea:

> *I was afraid because my Mom was not with me … I was five years old … I was taking bath … Then, the earthquake happened. I was separated from my parent. My Mom just gave birth two days before. My baby sister was held by my Grandma. I ran with my neighbor. We ran to the mountain. I was questioning what was happening … Now, I am afraid to go to the beach. I went there only for sightseeing, but not swimming, I'm afraid to swim*.

Another young Acehnese experienced the tsunami sweeping him and other family members and the trauma of separation and loss of a father, leading him to feel jealous of other children whose

fathers were still alive. He remembered when his father spent time together with him. The loss of a sibling and grandparent intensified these emotions:

> *My Mom held me. We ran with my Dad, brother, younger brother and sister. During the time I was running I looked back, I saw the water and then we were swept by the water. I lost my father, my brother and younger sibling. The next morning, we knew that they had passed away. I felt sad. At Lam Paya, we found only my father's body. I'm not happy because other children still have a father. When my father and my brother were still alive we played together and we went to the beach. After that I didn't go to the beach by myself, only with Mom because I am afraid to see the waves at the beach*.

Again, the disruption of familial relationships was as central to this young man's ongoing fear of the sea as the tsunami wave itself. Here, traumatization is a concept to describe children who experience traumatic separation from parents and caregivers in the events. Neither natural disaster nor violent conflict is a trauma by itself. It is beyond dispute, young adults had learnt from the experience of the broken relationship between themselves and parents or caregivers in the disasters. This is harmful to their mental health. For young adults who lost their parents, they developed a painful emotional experience that encompasses feelings from experienced of losing their parents and caregivers, happiness childhood's memories to envy with the other children who parents still alive. Moreover, young adult developed a fear of objects, places or situations, for example, ocean and sea waves as it causes them to recall the memories of previous loss and separation. This all kind of triggers becomes an obstacle for other life skill development such as swimming. Avoidance from the disaster areas is a part of their behavior, based on this evidence, then, psychological trauma has a long-term impact on young adult.

After their homes were destroyed, many of the young people I spoke to live in poor conditions – exposed to mosquitos, centipedes and snakes, and deprived of toys, lighting and dry blankets. Nights were cold and wet. Aftershocks continued for many days and nights. However, those young people who did not lose their parents or guardian reported how they felt happy to see them survive. At the time, they were not able to understand why they could not go back to their own home – instead sleeping on the top of a mountain or at a temporary shelter. They remembered sleeping in beds and huts made from branches and leaves. Some had to sleep on the ground. Instant noodles and other kinds of food were brought by rescue organizations but some did not have anything to eat for the first three days. A month after the disaster, many still lived in temporary shelters and others moved to stay at relatives' homes. As a young woman explained, the presence of parents and other family alleviated the emotional impact of these deprivations:

During the time I was staying at my grandmother's house I felt both sad and happy. I was sad because we didn't have a house anymore, but I was happy because both of my parents survived.

Importantly, young people also commented on how the emotional impact of the disaster was mediated by the relationships they had with their parents and other adults before and since the event. Some, for example, felt more comfortable when being cared for by their mother than by their father. These particular young people thought their mothers more gentle and tolerant in their parenting. They were afraid of their fathers who, violent or not, appeared angry. One young man told me:

My Mom searched for Grandma's body. So, I had to look after by my Dad, but living with Mom is better. My Dad scolded me when he got angry because I was naughty. He just told me not to play too far away. He only raised his voice, but he never hit me.

Likewise, the process of traumatization of surviving young adults was influenced also by the poor conditions in which they lived following the disaster. Insufficient shelter, separation from their mother or father, uncomfortable experiences of living with surviving family and the anxiety triggered by aftershocks were all implicated in the traumatic stress experienced by young people.

Death through the Eyes of the Young

Too Young to Remember?

Many people in Aceh and the Deep South of Thailand believe those who were children at the time of disaster or exposure to conflict should not have been traumatized – that they were simply too young. Others question why the psychological impacts of these events would endure today. Indeed, most of the young people participating in this research could not narrate exactly what had happened on those days disaster struck. Certainly, it was hard to remember the detail. However, almost all were able to draw pictures – sketching their memories of people swept away by giant black waves and storm surges. They were able to render images of car accidents, houses and coconut trees dwarfed by the tsunami, the black clouds and/or the tornado shape of the sea. Throughout these scenes, they drew the disfigured bodies of victims (swollen, bruised and missing body parts). They drew scenes too of conflict – images of people being shot, injured, and of bloodied bodies lying on the ground. Whether or not they were able to verbalise their experiences, it was clear most of the young people I interviewed had lived through life and death situations as children that had left deep psychological scars. Young people who survived conflict have memories of events like running from the scene of

conflict, hiding, and trying to save their own life, even though they did not have a clear picture of what was happening in that situation at the time.

Young people reported they now panic, scream or cry when reminded of disaster or conflict – for example, by aftershocks, strong winds, heavy rain or the sounds of gun shots or explosions. They seek out family members (parents first) to ensure they are able, if necessary, to evacuate together. When young people in school feel earthquakes, they return home even though they have been trained to evacuate, follow emergency plans and gather together with other students at prescribed assembly points. They want to leave together with their parents. They believe that if they have to die, it is better to die together with their loved ones. Failure by adults and institutions to recognize these and other lifelong effects of disaster events experienced by children contributed to secondary trauma among those who were teenagers and young adults by the time of this study. The mental health challenges faced by young people appeared generally unacknowledged.

Before Separation

At the time of the disaster, many children were at home with parents and/or other family members. When the earthquake struck Aceh, they were carried by their mother, father, uncle or a stranger. At that moment, they did not know what was happening but all of them were running together with adults, evacuating into the safe zone. A young woman who was eight at the time explained:

> *When I was eating, the earthquake happened. I didn't know it was an earthquake, I asked my parent why the earth was shaking. My parent told me that it was an earthquake. Then my uncle came to our house. He said that the tsunami was coming. We ran with labi-labi (small car).*

Two others, a boy and a girl then five, told me:

> *I was still too young. So, I don't really know what exactly happened. I stayed at home with my parent. Then the earthquake happened, very strong. Then, I heard a sound like an airplane. After that, people said the water had gone up. I didn't know what water had gone up. It was the tsunami*.

> *I saw people swept by the water. The water was high. I didn't know about earthquakes, but on that day many people ran to save themselves*.

Witnessing Disaster

As described above, young people's experience of disasters as children left lasting emotional and psychological impacts. Traumatization among young people involved what they witnessed as much as what they experienced. They remembered how they were swept away by the giant waves and the taste of the tsunami water. Some remembered losing grip of their parents in the disaster while others lost their memory of the time they spent in the water. Importantly, watching family members and other people suffering and seeing the injured and the corpses of the dead after the event also contributed to psychological trauma. After witnessing the tragedy, even those young people whose parents survived report fear their parents and family members will be taken from them. Two young women recounted their experiences:

> *I saw people swept by the water [from the mountain point of view]. I was sad and afraid that I will lose my parents (who survived). I lose my aunt and my grandparents … only half of our relatives survived.*

> *… in front of a truck, I saw a kid crying. He loses his Mom and he didn't survive because he was struck down by electricity pole. I had psychological trauma to see that … I saw children crying. We were screaming for help … I often have bad dreams after the incident. When the earthquake happened again or I hear people talking about flood or disaster, the psychological trauma will come. I still have a bad dream sometimes. In my dream, I am drifting by the water. I drown. Many people also drown. They asked for help. It was very sad. In my dream, I was on a mattress and many people asked for my help, but I cannot help them because if I pull them on the mattress it will flip over. It was very scary … I am sad if I remember my brother, he was an athlete.*

Recurring nightmares were in fact common. These appeared within a few days of the initial disaster and were triggered again for a number of participants by the earthquakes that continue to affect Aceh in particular. A young man recounted:

> *Three weeks after the tsunami, I have a bad dream that tsunami happened again. In my dream, I saw people calling me from the middle of the sea. That person said, 'All of you must be careful, don't make tsunami happen again' I only dream once. I also have a dream about dead bodies, the hands and legs broke, the body was not complete. For two years, I didn't go to the sea after the tsunami. I feel afraid of water rising again.*

Same Psychological Trauma

When reflecting on childhood experiences of the tsunami and of violent conflict, young people saw little difference in the psychological trauma associated with both events. The interpretation of the second event was associated with their previous experiences. Many said that adults' reactions to natural disaster and violent conflict were not different from their point of view. Almost everyone was familiar with dead bodies, blood, corpses, and human organs during violent conflict. In the tsunami, flashback memories happened when they saw blood and human body parts during and following the event. For them, the defining features of these events were the ways in which people behaved, the impacts on other people and, as above, the disruption of familial relationships. In relation to secondary trauma, this suggests that societal reactions at the micro-scale of the family and local community are as important as societal reactions at the meso-scale of government and aid organisations. In relation to cultural trauma, it suggests that traditional family structures and functions are under stress. Young people recalled adults around them panicking, the sounds of people screaming, shouting and crying, the sight of dead bodies and the bloodstains and body parts that littered floors and roads. The sounds of gunfire and explosions may have been different to those of aircraft and thunder, but separation from and loss of family overrode the immediate physical experience of these different kinds of event in the shaping young peoples' emotional and psychological responses. Two young people shared their views:

> *There is someone who loses a husband on the conflict. It also happened on the tsunami … Children also become the victims.*

> *[The conflict panic and the tsunami panic], it was the same. With tsunami, people died, also they did during the conflict. After getting shot, people bleed. I saw it. I saw dead bodies and people bleeding from head to toe. I often saw this, sometimes in the morning or afternoon. They knocked on the door, did not say* Salam *(greeting). They asked for father or husband. If they didn't get an answer, they will shoot, just like that. People got killed by GAM and Army*.

A young man shared similar experiences where he also had to hide himself during a conflict situation.

> *Yes, my grandfather told me. If he wasn't at home or someone come, if he had already gone to the post alone, for example, and someone knocks the door or if anything happens, don't get out of the house, just hide in the barrel. Don't get out of the house*.

Whether in response to a natural disaster or conflict experience, the sounds of people running and screaming are much the same the same and generated the same type of psychological trauma.

At the same time, previous experience of conflict intensified the fear of losing loved ones in subsequent disaster events. From young peoples' perspective, the sight of dead bodies appeared to have a similar emotional impact regardless of what caused the deaths in questions but, for most young people participating in this research, exposure to conflict generally preceded the tsunami or storm surge. As these disasters unfolded young people were reminded of the conflict, the violence they had witnessed and the family members they had lost. Young people expressed fear of being orphaned during the disaster events and they expressed ongoing anxiety over potential loss. Everyday reminders such as water marks on the wall of buildings or earthquakes trigger fears the tsunami/storm surge will happen again.

Physical and Psychological Trauma Interactions

On the part of physical and psychological trauma effects of disasters, some young people were affected from both events, suffering from psychological and physical trauma. One young Acehnese woman was affected by pneumonia following submersion in the tsunami water. X-rays showed a needle-shaped object in her lung but she resisted hospitalization and the advice of her doctor – even refusing the medicine she was prescribed for fear it would make her sicker. This belief was encouraged by teachers suspicious of Western medicine and who recommended herbal medicines instead. However, she is still suffering from her syndrome and tires easily. While group activities (drum band and Boy Scouts) make her happy she still experience recurring nightmares and panic attacks.

During the conflict, the same young woman was wounded in the head, hitting it on a bed during a gunfight between GAM and the army. This occurred before she had even started kindergarten but the scarring is still visible. Her house was riddled with bullet holes and she saw her second brother shot in front of the house. During the conflict she saw and heard many other people shot:

> *I lived at Lam Paya, Pulo Racon. Mmmm … my second brother was also shot in front of the house … many people were shot. Their clothes were full of blood. At night … the babies can't cry. We can't go out at night. If we do, one of the sides, for example, GAM [or army] will kidnap, kill and throw away the body. We were not allowed to go out at night … if conflict happened, of course, everybody knows the gun shot … when GAM came to a house, the soldiers will come too. They attacked each other, shooting. When people heard a shot, they will run and hide*.

Interaction with healthcare institutions will be taken up in more detail in Chapter 7. Important to note here, in the process of traumatization, is the interaction of physical and psychological harm for young people. For this particular young woman, the childhood experiences of near-drowning, illness and injury were interwoven with the experiences of running in fear, hiding, losing a brother and witnessing people being killed – including a baby killed during the earthquake. Her father died a year later of exhaustion, she believes, from searching in vain for her brother's body.

Different Psychological Trauma

The above results notwithstanding, some young people did identify psychological impacts specific to the conflict situation. Almost all had seen people killed. Following shootings in Aceh, for example, the army would round up all men in the village. They would investigate and search for GAM members, ordering all the villagers to line up and open their shirts. If they found someone they were looking for they would shoot them immediately. One young man, exposed to such events, shared his experience:

> *On the tsunami, I felt afraid because I don't know where to run and hide. I'm afraid I will be a victim. On the conflict situation, I'm afraid of the shooting sound*.

This young man lost his father in the tsunami and witnessed tragedy in armed-conflict. Even though he said that he was too young to remember the conflict situation, in the first year of elementary school he was able to describe the first sound of gunfire. He said that during the time he was studying, he saw an army truck passing his school before the military started shooting people in the jungle. All the students had to lie down on the floor. After the gunshots, the entire group of students was sent home. On the next day, the school was open, but for three days he was afraid to go back for continuing his study.

Key features of the conflict, from the perspective of young people, included not only the role of people and institutions in creating the source of trauma, but of both sides of the conflict in generating that trauma. One young man remembered his family moving to Medan to escape conflict. He had been four years old when he witnessed his father nearly killed by GAM members – one of whom was his relative. He heard the sound of gunshots and saw GAM soldiers threatening his father outside the front door. His father tried to run but was surrounded by four armed men who demanded protection racket payments. On this occasion, the army came and GAM dispersed. His father was saved but suspected hereafter of being a GAM supporter and interrogated by the army. Eventually, the family moved back to Aceh but only a week later the earthquake and tsunami struck, although none in

the family were killed. Thinking back, this young man is still fearful of losing his parents and angry with the army for hitting his father on the neck during an interrogation (See Figure 12).

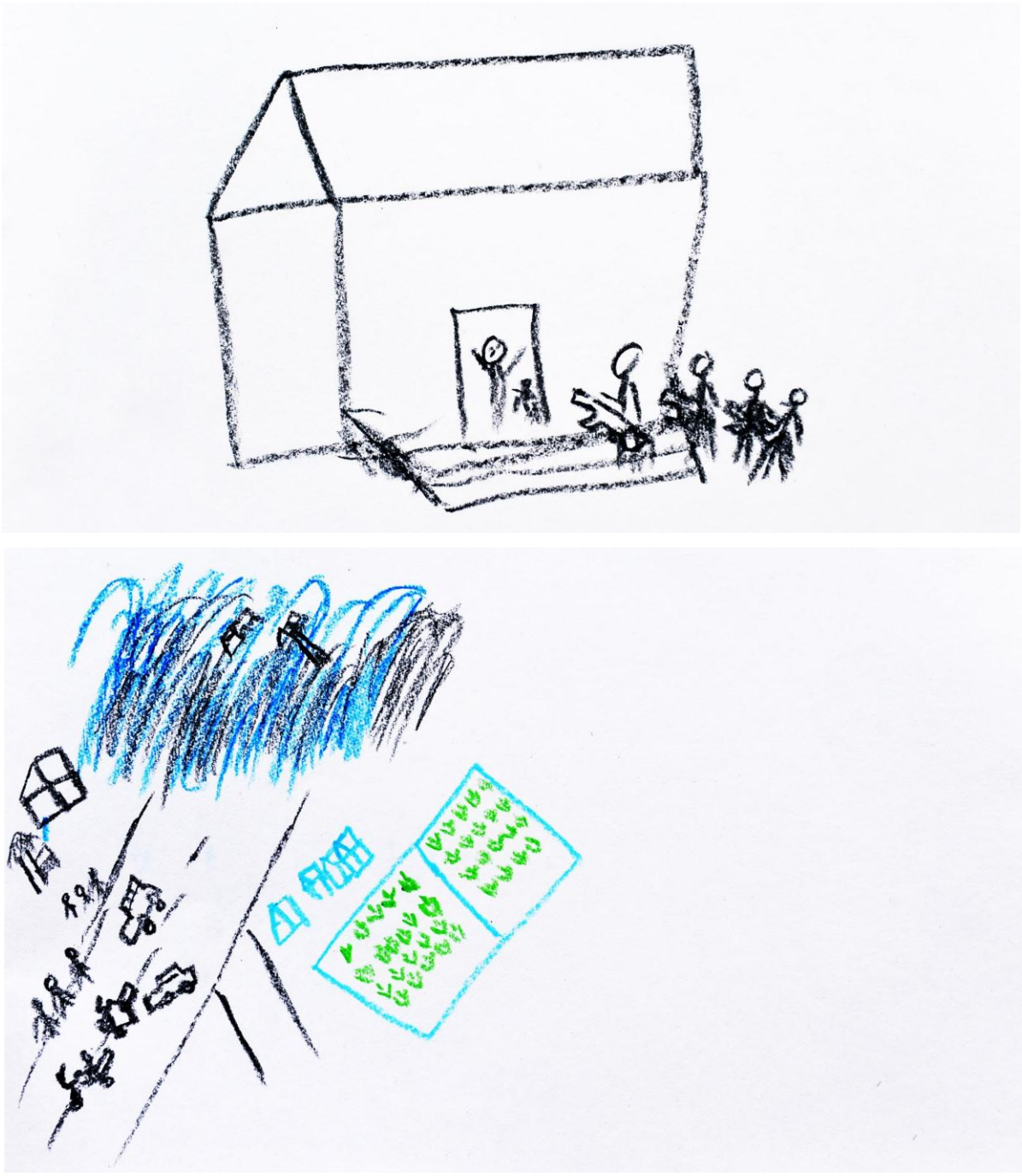

Figure 12: This picture was drawn by a 15 year old Acehnese male who was affected both by the tsunami and violent conflict in Aceh, Indonesia

Soldiers and separatists during the conflict in Aceh wore similar uniforms. Seeing army uniforms and check points became a trigger for symptoms of psychological trauma even when the

conflict passed. When soldiers walk past their home or asked for help, young people experienced intense emotions. Likewise, as the army's role post-disaster transformed into that of a humanitarian agency (evacuating and rescuing people), young people still felt afraid and often reluctant to accept aid because of previous direct/indirect negative experiences. A young Acehnese man and woman recounted the mixed emotions:

> *Soldiers come to the village after the tsunami, but I am afraid to get closer … [I heard] GAM shot brother of a solider … GAM didn't talk much and didn't get close with the community. The soldiers did come close to the community. Moreover, because there are soldiers' houses there, some in the community knew them, but GAM usually live in the jungle, so if we met GAM, we would avoid them*.

> *… there was sadness [after the tsunami] but also a happy moment [when we saw the army come to rescue people] because we were getting help. They played with us then, but during the conflict it won't happen. When people said the soldiers were coming to the village we got into the house or lay on the ground … everyone ran*.

A consistent theme across young peoples' narratives was the amplifying effect of exposure to multiple sources of stress. Secondary trauma associated with societal responses to disasters and conflict was equally, therefore, a function of how those responses were felt or understood by young people. Even the provision of ostensibly humanitarian relief was experienced as a source of secondary trauma, for example, by those whose exposure to conflict had left them afraid of military personnel and signifiers.

Learning from Traumatic Experience

The process of traumatization can, in some ways, be seen as a learning process. Previous experience clearly, as above, shaped the reactions of young people to new circumstances. However, while a number of the responses discussed so far were negative (e.g. refusing medical treatment or emergency assistance) other responses reflected learning from experience in a manner that helped young people both physically and emotionally.

One aspect of this was better appreciation of risk. Young people who had experienced conflict and disasters as children had knowledge of how their environment could change (e.g. sea water reaching the village, water wall, storm, and waterspout) and how their body responded to these changes (e.g. heart beating fast during escape). They reported developing some ability to manage their emotions and subsequent psychological trauma. This was not universal and young people did not all regulate their emotions the same way. Some explained how they will express their emotions freely

(e.g. by crying, screaming or telling adults such as teachers and parents), while others prefer to keep silent and not express their feelings directly.

One of young man told me he cried whenever he feels an earthquake. His younger brother – born one year before the tsunami – laughs at him. However, he explained his mixed feelings about expressing his fear to others:

> *I felt afraid and I cried because I am afraid the tsunami will happen again. (I did not tell anyone that I am afraid) I am afraid that my younger brother will laugh at me, because he doesn't afraid of earthquake. He was one year old when the tsunami happened. He will say you older than me, but you are afraid of earthquake. But, I don't care. I am shy to tell friends and teachers because the other doesn't feel scared of earthquake. When earthquake happened, I was at home not at school*.

Young people know a natural disaster might happen again if a strong earthquake, big storm or heavy rain hit. Even though many adults do not like to say the word 'tsunami' for fear of it coming back, young people recognize the signs of an impending event.

> *Now, I know it is called tsunami … People said that if something happens, it was* kiyamat *when everything was crashed. So, when tsunami happened, I thought it was* kiyamat.

Wherever possible though many try to avoid objects or situations that trigger anxiety and other symptoms of psychological trauma. For example, young people told me they avoided to go to the sea after a natural disaster event. Some young people needed to be accompanied by a parent, nonetheless, they were afraid of swimming in the ocean. Every time when the earthquake happened, many of them cannot stand being alone. Some of them may be avoided seeing crime scenes such as markets and checkpoints. Some young adult girl did not use the bathroom at her house for 3 months after her brother-in-law sexually abused her.

The Impact of Adult Psychological Trauma on Young people

As noted already, loss of parents and disruption of familial relationships were critical factors shaping the impacts on young people of disaster and conflict. Also important, in this context, were adults' own emotional responses. Children's understanding what was happening to and around them was mediated by adult reactions – crying, trembling, shaking, screaming, running and panicking, for example. These memories were stronger for most of the young people I interviewed than the memories of earthquakes, waves and fighting. According to one young person:

> *… psychological trauma caused by conflict and psychological trauma caused by the tsunami are the same … During the conflict, after we heard gun shots. People were running and screaming. It was the same on the tsunami day. People shouted, 'Allahu Akbar'. They also screamed. So when the tsunami happened, it was like conflict, the sound*.

Hence, the tsunami and storm surge reminded many young people of conflict. But young peoples' understanding of what was happening was shaped by more than their observation of adult behaviours. It was shaped too by their emotional and affective bonds with those adults. Young peoples' earliest memories of death were often not the sight of bodies but of emotional sorrow in an adult's expression or the grief and fear evident in an adult's behavior. They told me they cried because they saw their family members and parents crying. The physical contact, or loss of contact, between adults and children during disaster and conflict events also left its mark. Young people recounted their memories of being carried and hugged, of adults' bodies shaking in fright and the emotion they could feel transferred from adults' bodies to their own.

One young adult male in Aceh was six years old when the tsunami occurred. He described how his heart was beating fast when his Mom told him to run. He cried when he saw his mother crying as they ran. He described the fear and sorrow:

> *Everybody was panicking. We gathered. My grandma cried and so did my older brother. Everybody cried … how? What? People were panicking. I was panicking. Suddenly, my Mom dragged me to run … I cried also. I felt sad to see my Mom crying and my brother cried, everybody cried … I sat on my Mom's lap, my Mom told me not to cry, but everybody cried … [when she saw black water and people on the waves, including all the survivors on the mountain] . I felt sad. [I saw] that people cried. They didn't know what to do. They hit themselves … Some people heard that their mom died … maybe they made mistakes*.

The same young man described similar feelings that arose in context of the violent conflict which preceded the tsunami:

> *Many gunshots happened … My grandfather had just returned from the garden, planting cassava. Then, suddenly the soldiers came [in search of GAM]. They (GAM) hide in the garden. He asked [soldiers] what happened. They said Aceh would be bombed. My grandfather felt scared. He went back home and told us. We got panic. What will happen if all of us were bombed. Everybody will be dead. Then, we just kept silent and we didn't know what to do. My grandfather was a soldier. He told us if something happens, just run first, anywhere you can*.

Losing a child brought grief to parents that many struggled to overcome. A young woman (quoted already above) described how her father could not overcome his grief over the loss of a child and suffered until his own death. Even though two children survived the tsunami he bore an overwhelming guilt over the loss of his son. For over a year he searched for the body. In 2007, he planned to search again in the Indian Ocean but did not live to see the plan to fruition. The surviving daughter shared her story:

> *He was my father and earned money for the family. He also loved me very much. Before he died, he told my brother (2nd brother) to take care of me … My father kept searching for my brother until he got sick. My Mom told him not to look for my brother anymore. It was his fate. But, my father kept searching for him. My father believed that my brother was still alive. My brother always went to the beach on Sunday. He liked to play there. My father supported him, that's why he felt guilty. My brother relied on his father to take care of us, that's why he loved him so much … He posted his photo and asked people. He kept looking for my brother. He was sure that my brother was still alive. He also went to Medan. He also got sick with amnesia*.

Traumatization among young people was different from, but influenced by, the traumatization of adults – of importance here being the processes of learning, retaining and absorbing from adults' reactions to stress events. Again, this recalls the stress placed on traditional family structures and roles by failures of protect children and the potential, in this respect, for cultural trauma at the micro-scale of the family.

Child Exploitation and Abuse

Most of the stories recounted in this chapter portray close emotional and affective bonds between young people and their families. However, it is important to acknowledge too the occurrence of exploitative and abusive relationships between children and adults.

Conflicts in both Aceh, Indonesia and the Deep South of Thailand involved child soldiers recruited by separatists to fight government armies. As a result of the armed conflict, in Aceh, many children were forced to leave home long before they became adults, most of whom had limited further access to education. For example, a young adult was trained to be a separatist by his father. However, this young man of 16 years old who did not like the military practice was often absent. His father often physically abused him during the practice and punished him when he was not in the class. Also, he was not allowed to go to Thai school and speak the Thai language. He was beaten every time he went to study. Later, at the age of 17, his mother turned against her husband and took him to run away

from home. In Aceh, another young adult came back home after post-conflict. In the age of 14 years old, he did not have an education because he had escaped from home when he turned from a child to a young man.

Sexual abuse of (mostly) girls and young women can be found in the Deep South of Thailand. Three women offered their own stories of abuse during the interviews, all of whom were abused by a close family member such as a brother-in-law. One recounted how her brother-in-law molested her after she finished bathing. When she told her older sister (wife of the brother-in-law) the situation became worse. All three women described how other family members got angry, refused to listen or to take their accusations seriously, and offered no help. One of the women was not able to take a bath in the same house for two years. Eventually her older sister's family moved out after they found their own home and only then did her own emotional state return to something like normal again. Extended family households are the norm in Melayu Muslim culture, with all living together in the same roof. The family members usually include brother/sister in law. A partition may separate sleeping areas but they usually have to share the same toilet and bathroom.

Conclusion

As discussed in Chapter 5 and again here in Chapter 6, the moment of separation from family members was the most critical moment in the traumatization of many participants in this research regardless of whether that separation was caused by natural disasters or violent conflict, and regardless of whether the separation was temporary or permanent. Moreover, the behavior and emotional reaction of adults around them were critical mediating factors in young peoples' comprehension and memories of their own experiences. One difference between natural disaster and armed conflict, with respect to their impact on young people's psychological state, was the role of humans in triggering traumatic events. Young people were angry at the military and at separatists for harming members of their family, but they were not angry at the natural processes that generated storm surges and tsunamis despite their enduring fears. Some blamed parents for failing to protect them when the disaster occurred and some were subjected to other forms of exploitation and abuse. For the most part though, young people were sympathetic to the impact of these events on their parents and other family members and took on many of the same emotions. Again, this suggests that despite cultural trauma associated with stress on traditional family structures and roles, participants do not question the ongoing importance of family as an institution (in some form).

Young peoples' accounts of disaster and conflict further recall the concept of secondary trauma while also offering important caveats on the application of this concept. The reactions of other

people to events both amplified and attenuated negative emotional and psychological impacts on young people participating in this research. But this was not something that happened only after the events in question – generating second and third order impacts due to (generally a lack of) emergency relief and empathy. The reactions of other people to disaster and conflict events, and their victims, were central to how they were experienced and remembered by those who were children at the time, and to the subsequent embodiment of psychological trauma. Past experiences were also critical in how young people felt and understood societal reactions, meaning even ostensibly positive reactions (such as the provision of humanitarian assistance) could function as sources of secondary traumatization.

Chapter 7

Gender, Stigmatization and the Construction of Mental Health

This chapter explores gender-related stigma among disaster victims and the gendered experience of stigmatization and shame in relation to psychological trauma. It is perhaps not surprising that stigma and shame emerge as amplifying factors which contribute to secondary trauma, but it is important nonetheless to investigate the specific processes of traumatization and secondary traumatization in which stigma and shame are implicated. The gendered construction of mental health and of victimization in women and men were both an important part of this story.

At face value, some groups of people appeared much better able to cope with deeply traumatic experiences that did others. Male fishers, for example, evinced few signs of stress – the common-sense explanation for which was their experience of dealing with difficult and unpredictable storms when at sea. Female fishers with public leadership roles, on top of their experience at sea, appeared similarly to have better coping skills than did other women. Combatants in armed conflict suffered or witnessed many traumatic experiences and seemed to have excellent coping ability. Learning how to live in the jungle with limited resources provided survival skills when the tsunami occurred. Indeed, many non-combatant survivors told stories about receiving food from GAM following their escape to the mountains during the tsunami. Female GAM members, used to living in difficult circumstances, seemed more inclined to ask for women's rights. Faith and cultural norms shape stigma and the construction of mental health.

Even among these groups, however, symptoms of psychological trauma were evident – fear, anxiety, sadness, panic, dizziness, sleep disorders, depression, emptiness, hopelessness, weight loss, social withdrawal, thoughts of suicide and stress. While circumstances did certainly lead a number of people to develop considerable psychological resilience, also at play here in the accounts of research participants were highly gendered social constructions of mental health. This chapter will explore these constructions, highlighting a number of themes to emerge from the interview data including stigma (and associated feelings of shame and weakness), strained family relationships, dysfunctional sexual relationships and family violence.

Shame and Stigma

Psychological trauma may not be outwardly noticeable. Regardless, many people tried to keep symptoms of trauma to themselves due to feelings of shame and/or fear of being stigmatized by others. While some participants (particularly but not exclusively women) felt their own symptoms signified some kind of personal failing, participants more broadly spoke about the attribution of failure to those with visible symptoms of mental illness. Such personal failings included moral weakness, laziness, intellectual disability, drug addiction and psychiatric or genetic disorders. Mental illness was also, similarly, attributed to divorced women and unemployed men.

Health professionals interviewed for this study spoke about how the '*stigma with which females and males are labeled by disease and culture'* contribute to mental illness and other symptoms of psychological trauma. Two psychiatrists based on Thailand and Aceh respectively, for example, said that:

> *I found that some patients have continuing mental illness because of historical misconceptions. They feel frustrated and stressed, so I gave them medicines for the treatment. I also told them that everything that happens is decided by Allah*.

> *Until today, Acehnese people in general still have a stigma about people with a mental health problem, especially if people have a very early on-set mental problem … In one hospital, one of the main causes was identified as heritability, so 'they got it from their family'. The cause of the problem could be schizophrenia and psychotic condition, but for these the main cause is assumed to be drugs. The stigma is not only applied by ordinary people but also by the medical practitioners as well*.

A Community Mental Health Nurse made a similar point about the wide prevalence of stigmatizing attitudes among educated and uneducated community members alike:

> *The stigma in the community is very strong, coming not only from within the uneducated community but also among people who are generally well educated. There is not much widely shared knowledge about mental health. There is a stigma that mental health patients can't be cured, are unproductive, and are a burden*.

Education was identified though by one of their peers as an important asset in building psychological resilience:

> *Many people have experienced severe torture but still can have a healthy mental condition. That's why I say it really depends on each person's tendency … It depends on the pressure,*

> *the genetic factors and also the education system that people experience. Education influences ways of thinking and how people deal with stress and handle the pressure*.

It is possible to explain the amplifying effects of shame and stigma on psychological trauma in a number of ways. The reluctance to admit symptoms noted above may discourage people from seeking help. Social exclusion and lack of support from family members, friends, local community and society in general may reinforce these fears and intensify symptoms. As a senior medical officer from Aceh explained of men whose mental illness was associated in other peoples' minds with unemployment and drug addiction:

> *In general, they are not accepted in the family and community, even after they are healed. Those who have been returning to their family and community have become aggressive, because they did not have jobs. It made them stressed and likely to relapse*.

Moreover, there can be psychological trauma related to having a family member with mental illness. Then, family members (both female and male) have difficulties getting married or establishing other relationships. This can have profound effects on the entire family, especially siblings and extended family members, due to the widely-held belief that mental illness is an inherited disease.

Importantly, lack of knowledge and general misunderstanding of the causes of mental illness are not the only causes of shame and stigma.

Shame of Doing Wrong

A number of faiths can be found in Aceh and the Deep South including Islam, Buddhism, Hinduism and Christianity, along with ancestral spirit worship and animism. Many participants associated psychological trauma with insanity, acts of God, punishment by God, God's testing, lack of faith, end of the world, spiritual possession and karma.

Acts of God

The vast majority of people in Aceh and the Deep South believe natural disasters to be acts of God, and there is much in the culture, institutional fabric and build environments of these sites to reinforce this belief. There is a materiality to religious doctrine on this point. For example, in some locations natural disaster material items are displayed together with the God's name. Varieties of religious messages are presented in Friday teachings, tsunami museums, the list of dead on the wall with the name of Allah on top (See Figure 13), tsunami books, newspaper contents, tsunami monuments, natural disaster DVDs, and drama activities that are presented in public spaces,

television, and social media. Furthermore, believers interpreted the power of God through identifying the mosques that were left standing while other buildings/houses were wiped away by the giant waves. People believed that the mosque is a house of God and hence God protects believers who used this place for worship. Many pictures circulated that are claimed to show the tsunami waves formed in the name of Allah. Miracle stories were added, such as that the giant waves reduced in speed so as not to smash religious buildings. All of this is presented as actual evidence and supporting information for religious believers.

Consequently, it is hard for disaster victims not to believe natural disaster is due to God's action. Even among family members and friends, in condolence words given to the natural disaster victims the victims have been told to surrender everything to God. Most of the time when people met each other through social events, the same message was sent, with an expectation for them to accept God's power. It seems like everywhere there has been delivered the same content, telling people to accept their own natural disaster destiny.

Figure 13: The list of the tsunami victims inside the Tsunami Museum located in Banda Aceh

Beliefs concerning the causation of conflict, however, varied geographically. While most Acehnese Muslims believed conflicts are caused by humans, Melayu Muslims from the Deep South of Thailand believed that even conflict-related deaths reflected peoples' destiny as determined by God.

Punishment

Karma is a fundamental doctrine in Buddhism which can be found among the Buddhists in the Deep South of Thailand. One elderly Buddhist woman I interviewed blamed herself as the cause of the devastating storm surge. She thought bad luck was following her and, because of her, the natural disaster affected people in Pattani. Previously, in 2004, she lost her oldest son, 49 years old at the time, to the conflict. He was shot to death on the way back home after being sent by her to the market. The pivotal role of being a mother, but one who could not protect her own son, led to her blaming herself as cause of his death. Since then, her nieces and nephews had become her responsibility but, again in 2006, she lost her husband, age 81, to the conflict. Tragically, he was shot to death before his head was cut off, followed by the burning of his house and body. Intensifying the family's grief, everyone knew his wishes were not to be cremated and he had already prepared his own grave. When he was still alive, he often had a bad dream in which his body was burned. He told his family members it was hot and he was scared.

To save her remaining family members, the elderly woman decided to move from the village, renting a new house in Pattani city. She often said *'I do not have the energy to continue living'*. In the city, life changed dramatically as the cost of living increased, the family needing to purchase the rice, fruits, vegetables and eggs that, in the village, they could grow on her land or collect from the community forest. In the city, she felt trapped in a life of routine, struggling to adapt to the new condition. Moreover, she was not allowed to use a wood-burning stove but was afraid of the unfamiliar microwave and gas stoves commonly used. At the age of 80, was she still working to earn money by offering massage services – trying to earn enough to survive herself and support her orphaned grandchild.

In 2011, she experienced the storm surge in Pattani city. Alone at home, she feared death, her Buddhist belief in Karma and reincarnation providing no comfort as she believed she had brought bad luck to her new community. In February 2017, this elderly woman died from a heart attack. She had never had symptoms of heart disease and there was no history of heart disease in her family.

Some members of other religious groups also interpreted disasters as punishment for 'doing wrong'. Both the tsunami and storm surge were perceived by a number of Muslims as punishment by

God, their waters washing away human sinners and sin. Behaviours singled out as the likely causes of this punishment included Muslims killing Muslims, drug addiction, attending inappropriate music venues, and other social problems. Behaviours specific to women were also singled out including wearing inappropriate dress, listening to music and dancing. Importantly, however, some religious leaders openly rejected the view that women's sins or sins in general were causes of natural disaster.

Testing Faith

The view was more widespread that even devout, good people of strong faith experience disasters. This was interpreted by many as God testing the faith of believers. An Acehnese religious leader recounted:

> *We advised [disaster victims], you have to be patient. You have to see this as examination from God to see how you conduct [yourself] with this examination and also we advise them that what we have (family and property) actually is a gift from God. This is not belonging to us. So, when God wants to take them back we have to accept this with a patience*.

'Doing wrong' was also thus used as an explanation for peoples' inability to cope with disaster events. Within each religion, most believers drew on texts and doctrines to help cope with trauma and disaster. Some, however, struggled to practice conventional worship routines, having difficulty reconciling these with their emotions and behaviours. As a consequence, they were stigmatized or labelled as faithless. Religious leaders (mostly male) delivered the message that catastrophic events were acts of God, punishments for wrong-doing and tests of the faithful. For example:

> *We can claim in Islamic view, if anybody becomes a tsunami victim (and cannot return back to normal), we can see that their Islamic teaching is not good or he/she has not been a good believer … We as Islamic leaders in the communities, were invited to give sermons, giving speech after Magrib (around 6:00 pm) to Isya (around 7.30 pm) for the tsunami victims. So, we repeated to them the verses of the Al'Quran and Muhammadism tradition, all about the Islamic teaching and how to be a good Muslim to face the disaster. It is our praise to Allah. Because of strong iman (strong belief), they can sacrifice their family and their houses.*

It follows that believers of strong faith will not experience deep psychological trauma. Many people reason that God has already planned humans' destinies, that everything in human life belongs to God, so humans should not feel sad whenever God permitted everything to return. Natural disaster victims may feel sadness and other emotions over their losses, but believers should not succumb to

insanity or other mental illness. Indeed, as one Acehnese woman explained, disaster should bring the faithful even closer to God:

> *In my opinion, some of the victims become more obedient to Allah, while some others do not. They forget about the disaster … because they have lack of religious knowledge. That is why they can't take the lesson from the disaster*.

Some health professionals believed that faith interacted with other characteristics of victims to help protect against mental illness. For example:

> *I told you before that people in Aceh have very low PTSD. I don't know if you conduct your research on this. What will you find? My friends from … (name of the country) … did research and they found very low PTSD number among the tsunami victims … in my opinion, people who are affected by natural disaster have less fear compared to the man-made disaster. Man-made disaster is the worse … I think, because only some people experience it, maybe people in the villages, but not all people, but the tsunami struck both the Aceh city and people in the villages. They all had that experience and went to stay together in the shelters…and Acehnese have very strong faith*.

In both sites, religious convictions worked in a number of ways to discourage people from accessing those mental health services available to assist victims of conflict or disaster. First, people were suspicious of the seemingly mystical abilities of psychologists and psychiatrists to access their feelings and thoughts. One Acehnese man explained, for example:

> *I didn't go to meet psychologists or psychiatrists. The tsunami was made by God. So, we must accept it. We only have to pray. If we go to meet a psychologist, we will get confused. They said this and that, suffering from this and that. The psychologist is like a … a fortune teller, right [laughs]. If we didn't go to see them, we won't know what is in our brain, and our heart will still be calm. But when we know what they say, we will know we have the disease and can't do this. We will feel worried after we get tested*.

Second, trauma healing centers and other facilities established by foreign NGOs were regarded as unnecessary. It was held by many with strong religious convictions that disaster victims' faith protected them from trauma and, indeed, not long after the centers were established most were closed down for lack of patients. An Acehnese religious leader explained:

> *After the tsunami attack, many international NGOs built trauma-healing centres here. In their point of view, many Acehnese victims were expected of having trauma. However, the centres did not have people to be treated for the psychological trauma problem. After that, the*

centres were shut down. I heard that there are no people who experienced trauma. I don't find any in the community, I don't see it.

Third, the stigma of accessing assistance among mostly Muslim communities was amplified by the widespread provision of services by Christian aid organizations. Even working in paid employment with these organizations was interpreted by some to reflect lack of conviction. One Acehnese man told me that while he never lacked religious faith he enjoyed making friends with people of different ethnicity and religion. However, many Muslim Acehnese who worked with Christian overseas aid organizations post-disaster experienced ostracism and were denied assistance from local rescue teams.

Shame of Sharing Trauma Stories

Many Muslims believed that sharing trauma stories such as bad dreams, personal problems, and family problems (such as domestic violence and pregnancy before marriage) is prohibited. A number of participants said they felt guilty, ashamed and embarrassed about talking of their experiences. Sharing their problems with others was itself considered sinful. Thus, within the community it was widely believed that wives should not tell others – including psychologists or psychiatrists – about abusive relationships with their husbands. Expressing the same belief, some local psychologists, psychiatrists and other health professionals were reluctant themselves to hear this type of story. A male Acehnese nurse told me, for example, told me that consultation with psychologists or psychiatrists was not consistent with Islamic culture but derived from Christianity:

... sharing [trauma story] with other people is not a common habit, because counselling is new. In Islam, we don't know counselling. Counselling is used from Christian people.

A number of conflict and disaster victims consequently lacked experience telling others of trauma symptoms and were vulnerable to secondary trauma – caused by the reactions of others – when they did talk about those symptoms. One psychologist shared her views on how these beliefs increased vulnerability to mental health problems:

The community also thinks that sharing a problem is a sin ... Our society also feels ashamed to share their problem. During my field practice before getting my psychology degree, one of my patients came to talk to me for only a few counseling sessions [I'm trying to follow up, but with little success]. I got no information from the community because they didn't want to talk ... Another example – one of my patients is a second wife. She was sharing her problem with me but, at night, she called and apologized for telling me her story. She said that she committed a sin by telling the story and making her husband look bad. I told her that it would

be better if she didn't tell other people about her private life. In my opinion, this is the reason why our community is vulnerable to mental health problems … For the trauma because of the tsunami, the community will not hide it, but they don't know how to talk.

Reluctance to share bad stories is thus a factor in psychological trauma, leaving some mental health patients feeling 'trapped in their own sin'.

Different views on whether violent conflict stems from human or divine action might be expected to generate different attitudes and responses. It is important to note though that reluctance to speak was a common feature across both study sites despite different views on the causes of conflict. An Acehnese religious leader expressed the view that:

When conflict happens, people who are involved in the conflict don't care about the humanity, religious teaching, or social issues … Just like in Syria, when the conflict was between Muslim and Muslim, many Islamic leaders also were killed.

However, in a time of armed conflict, public and private speaking on any topics related to the conflict were considered dangerous. It was believed that with few exceptions, all who spoke in public about the conflict would sooner or later be killed, including religious leaders. A former military commander from the Deep South of Thailand explained:

Religious leaders cannot say anything. They know killing is wrong. During the time we had the discussion with members of BRN, the religious leaders just shook their head and used the hand signal (cut-throat). This meant that if they said anything related to the conflict they would be dead, even if they did not agree.

Weakness

As noted earlier in this thesis, many research participants insisted on sharing their stories with me despite the sadness they revisited in doing so and despite the powerful disincentives against such sharing already outlined in this chapter. As elsewhere, both Aceh and the Deep South are characterized by expectations that people who have experienced potentially traumatic circumstances ought to emulate the heroes and heroines of popular culture and be strong for their families. Importantly though, they are expected to be strong for their families in gender specific ways that shape the construction of psychological trauma.

Men were often scared to share their psychological trauma stories with their wives for fear this may lead to lack of respect. An Acehnese man asked me: *'Please don't tell my wife that I still have psychological trauma.'*

In general, a male who has a role of father, husband and leader of the community might have emotional vulnerability but is not expected to reveal this either to family members or to members of the community. The role of leadership involves avoiding displays of weakness and the ideal father and husband figure has been viewed as being emotionless. One young woman, for example, told me she did not know if her father had fear of disaster, and she did not expect any sign of weakness from him either. She stated, '*Father is the head of the family. How can I trust him if he is scared and shows his fears*?*'* Yet the responsibility of leadership, either family or community, is a key factor for many in their emotional response to disaster events. An informal community leader from Pattani recounted:

> *After the night of storm surge, I am crying because I feel sorry for the villagers. Flooding is everywhere. Even though I am a man, the situation makes me cry*.

Some men hid their emotional and psychological scars well. One woman expressed her opinion that I might struggle in my research to find anyone who had experienced psychological trauma while her husband had, in fact, just told me of his struggle with psychological trauma symptoms.

Despite expectations to the contrary, however, some men did share their stories and trauma with close friends and some family members. Some were willing to share their experiences with their wives but not with their children. One Acehnese single father (quoted in Chapter 5) who was living both guilt and grief following the death of his wife, asked me to keep his story and not to tell his children. Turning his face on the side (only a second) and trying to hide his pained face, he said he still had psychological trauma but he never let his children know:

> *Thank you for asking me this question (How to raise kids as a single father?). As an Acehnese man, I never learned how to cook. When I was young, housework was my mom's duty. After I married, caring for the kids is my wife's role. I just brought money back home and did nothing. My wife had always taken care of everything in the house. When my wife died, I had to look after four kids. After I lost my wife to the tsunami, I have been taking care of kids. I don't know how to cook. I burn the rice. I burn the fish. I burn it until it turns black. I don't know how to wash clothes. I don't know how to talk softly with my kids, but I never beat them. When I am very angry, I just quit, but my face is turning red. I just know my wife worked so hard. After the death of my wife, it is very difficult for me to raise four children who are very young. I still have psychological trauma until now*.

Another man, also Acehnese, was very willing to share his emotions with his children:

> *We sit together (father and kids), sharing the story, remembering their Mom and cry together. We feel sad about our conditions now because we have nothing*.

Corresponding to the discussion in above, psychological trauma can be found among female leaders in the Deep South of Thailand as well. A number I interviewed told me they had suicidal thoughts. These arose from a number of inter-related pressures such as the roles and responsibilities of leadership and parenting, the experience of losing family members to the conflict and natural disaster, domestic violence, and cultural expectations leading them to being unable to reveal their signs of weakness to their communities.

Gender and Caring for the Mentally Ill

For many, albeit a minority, psychological trauma manifests in more severe mental health conditions that require intensive care and/or treatment. The interaction of mental health patients with medical institutions will be taken up in the next chapter. This section, meanwhile, will examine what the experiences of families in providing care reveals about the gendered construction of mental health.

Caring for mental health patients was found to have a number of implications for family members – parents, partners, grandparents and siblings. Family members were affected by stereotypes leading to stigmatization and discrimination from the broader community. In most communities, there was shame in having mental illness in one's family. Due to beliefs about heredity, many mental health patients' families found it hard for other members to marry if people knew (or believed) a family member was 'insane' or 'unstable'.

Female and male mental illness patients were treated very differently at the family and institutional levels as a consequence of the ways people constructed gender and mental health. This was evident at the mental health hospital in Aceh, where male patients were admitted at a rate six times higher than for females. However, this cannot be interpreted as men having mental health problems at a rate six times higher than women. Many women with mental health issues were kept at home or offered home-treatment by health professionals.

The accepted view among research participants was that women had to be protected by their family members. The ways in which women were cared for differed between the two sites but, in both cases, women had primary responsibility for the domestic sphere. In Aceh, women are considered to be emotional and daughters are the centre of attention. One Acehnese man said *'I spoiled my daughter more than my sons'* because, in the future, they will be expected to take care of their own children. Being a mother is considering the hardest job. Transferring property to the daughter is a duty of the parents and, in Aceh, wives are the owners of the house. Raising a son is different. Sons are taught to protect the family but to create, at the same time, an adventurous life. Sons are taught to close the

doors and windows of the house and to look after female family members in preparation for their adult roles as husbands and income earners. Following the traditional way of life, parents build private rooms for their daughters but not for their sons. They sleep in a guest room, near the front door. In the Deep South of Thailand, many women are expected to earn household income, but they are still assigned responsibility to care for children and carry out the role of housewife.

Women, further, were seen as physically weaker and less aggressive than men, making it more feasible to care for female patients at home. Male patients admitted to the mental health hospital were generally seem to present with a high risk of aggressive behavior. This aggression, importantly, was seen to stem as much from a warrior image of masculinity common to both Aceh and the Deep South as it did from mental illness. Many psychiatrists, psychologists and other participants in this research believed 'hero culture' was deeply implicated in the relationship between aggressive behavior and psychological trauma among men.

However, caring for a woman with serious mental illness was not necessarily safe, all the time, for either the woman or for her family. One woman, for example, was raped and experienced two pregnancies while suffering mental illness.

A medical doctor expressed the view that women were actually no less aggressive than men when afflicted by mental illness, but differences in strength and the visibility of aggression affected peoples' perceptions of women's behaviour. They recounted how:

> *In the field, a lot of men were found with mental problems. That's why it seems like men are more aggressive. But women are also aggressive … but maybe different in [physical] strength, that's the only difference. For example, the woman wants to kill someone, but because she is weak, she can be defeated by a man. But women can't defeat men*.

Constructions of masculinity based on the celebration of heroic warriors offer additional insight into why men are reluctant to access support when symptoms of psychological trauma and mental illness first appear and the escalation of aggressive and violent behaviour. However, it is also important to acknowledge that symptoms of psychological trauma such as hypervigilance and fear may also promote aggressive behaviour. Many survivors of violence felt the need to carry guns or other weapons to provide for their own safety. The Thai government has given guns to Buddhist men for free (although they have to buy their own bullets). They have not given guns to Muslim men but, in any case, under conflict conditions weapons are easy to buy, with or without a licence (See Figure 14).

Figure 14: Male survivor of violent conflict and his illegal gun, the Deep South of Thailand

Further, female warrior heroines are also present in Acehnese culture and lack of visible aggression among women cannot explain why they are admitted to the mental health hospital in lower numbers than men. At least two more explanations are suggested by the data; namely, fear of sexual violence and cultural acceptance of female expression of emotion.

As reported in Chapter 4, rape and other forms of sexual violence were used against the civilian population by protagonists in the violent conflict affecting both Aceh and the Deep South. While I did not collect data on how many women experienced sexual violence, nearly all those

interviewed reported that they were at high risk of such violence. Fear of rape both during and after the armed conflict (in Aceh) would very likely have led families to care for mentally ill women at home.

At the same time, women were allowed to express their emotions and to seek the support of family when they are scared and feel fear. When life becomes challenging, women might receive the help that they are looking for. Variety of practice across genders has been expressed through their social connections. For example, mother and daughter relationships are close and they often share their emotional experiences. This is more acceptable for daughters than for sons. When a man experiences emotions such as fear, he is expected to deal with it on his own. The emotional support for men is often different to that for women. Family members and friends may not understand the kind of support that men need. Each gender experiences socialization during child-raising that reinforces the adoption and internalization of such socially constructed gender identities.

Disability and Care

Caring for the disabled poses a physical and psychological challenge for many families. In the Deep South of Thailand, for example, one man who looked after his disabled son told me he suffered depression and weight loss, struggling to eat or sleep. In just a few months he lost more than ten kilograms. He worried about the future, about getting older and about who will care for his son after he passes away. Caring for a disabled son was both emotionally and physically painful. He suffered back pain from daily carrying routines such as helping his disabled son to the toilet. The man's face expressed pain when he shared his story. He was thinking about the old days when he used to be a bus driver, traveling through the provinces of Thailand and making a good income. He had to stop this when his son was disabled and he became a rubber tapper – earning a comparatively low and irregular income (400 baht or AU$15 a day).

Other people spoke to me of the difficult of maintaining healthy sexual relationships when a husband or wife was affected by disability. Married men who were not able, as a consequence of disability, to have sex with their partner reported being asked for a divorce. Men with disabilities (or with disfigurement resulting from conflict or disaster) were fearful of their wives leaving them and, in general, it seemed that disabled men still capable of sex were more likely to be able to maintain marriage relationships.

Women told me about experiences of domestic violence involving disabled who felt insecure in their relationships. One woman, for example, told me of how her husband beat both her and her son

when in a bad temper. The woman said that her husband was afraid she will leave him due to his disability and sexual dysfunction. The son dropped out of high school after his father became disabled to help earn income. In another family, a man disabled by a violent attack fatally shot his wife and then killed himself.

A number of women also had to deal with the psychological trauma of their own disability and/or disfigurement. Examples included a woman left with severe scarring. She was still capable of having sex but believed her scars had been the main cause of her husband abandoning her (See Figure 15). The burns which left this scarring hampered her mobility but still she had to care for her four year old daughters by herself. Since becoming disabled, she had been in receipt of a monthly subsidy payment from the Thai government which she used to build her own house. However, she worried about the future. She did not know when the government will stop providing her monthly income.

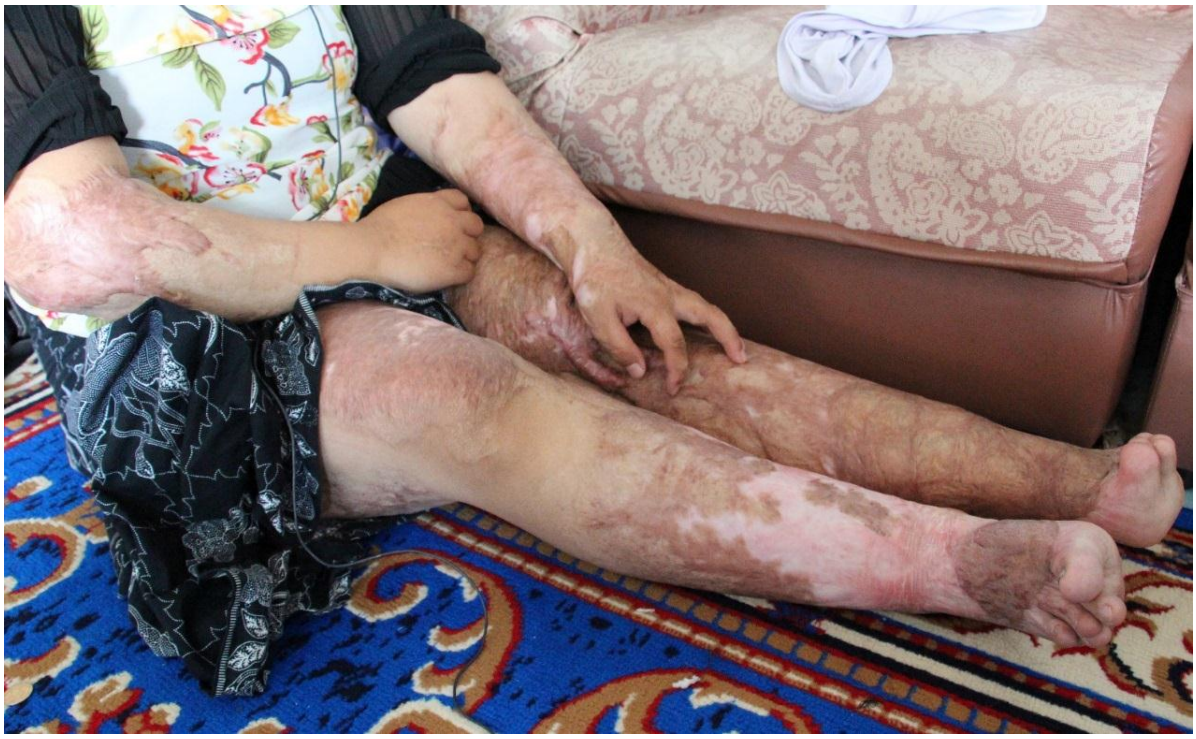

Figure 15: Female survivor of violent conflict and her scars

Self-harm

While this research did not collect data on suicide or other forms of self-harm, it did find that the combined impact of physical and psychological injuries, shame and stigma, responsibilities to care for others and interaction with other deeply traumatised people, led many to suicidal ideation. The

thought of suicide was particularly common among Melayu Muslim women – especially leaders who faced multiple pressures and lived in the most unpredictable of situations.

One woman who lost her husband during the conflict was abused, physically and emotionally, by a new husband. She had many roles including those of housewife, income earner and leader of women. Her responsibilities included the care of biological children from her first marriage and step-children from her second. She told me how her new, bad tempered, husband beats her on the face and body and tells her she is lazy and not a good enough wife. She took a self-portrait on her mobile phone showing the black eyes left after her husband punched her in the face. She told me how she worries about her daughter's safety and how she had recently noticed that her husband was sexually abusing her biological daughter. She wanted to divorce and to go to live with her ex-husband's family. They had already given her land, but it's located in a natural disaster area. She has had suicidal thoughts as the only way to end the problems.

Another female bombing victim related having feelings of guilt and suicide associated with the traumatic event. She said that she will kill herself if she became disabled and incapable of helping the victims of natural disaster. She does not live in the violent conflict zone but has experienced storm surge.

Conclusion

Secondary trauma refers to shame and stigma associated with community beliefs and attitudes, and it leads to lowered rates of access to mental health services. Stigma among health care professionals toward patients with mental illness is another barrier to treatment in medical care. Shame of having a family member with mental health illness relates to negative response on marriage relationship of the healthy family members. Gender differences connected to social stigma and the gender role. Masculine norms also lead to lowered rates of access in the early stages of psychological trauma. I found participants felt shame in acknowledging mental illness, even to their own partner, particularly among men. The partner's expectations of gender roles is a further source of psychological trauma. Feminine norms, particularly, wives would not be address their husband and wife relationship problem. Violent and abusive behaviour from those who are themselves physically and/or psychologically traumatized, can lead to domestic and sexual violence.

Cultural trauma is illustrated by religious leaders not able to show leadership during conflict for fear of speaking out. People told me about their shame of doing wrong and their fears of social sanctions if they spoke about mental illness. Gender differences in relationship of caring for family

members had been challenged by the event of disaster and social norms. Those who are physically weaker, particularly women, were viewed as needing support above men, meaning men often suffered from trauma without treatment. Other gendered differences in trauma experiences include the high risk of sexual violence facing women during conflict, and aggressive behaviour in men associated with hero culture. While Aceh has a culture of female warrior heroines, there is no social norm of female aggression. The Thai government amplified cultural trauma among other ethnic groups and religions by given guns to particular groups, especially Buddhist men. Physical disruption of people's disability related to psychological trauma of themselves and family member such as caring for a disabled family members, difficulty of maintaining healthy sexual relationship among partners and fear of being a burden.

Chapter 8

Disasters, Conflict and Healthcare Institutions

This chapter involves an investigation of the relationship between psychological trauma and healthcare Institutions in Aceh, Indonesia and the Deep South of Thailand. Psychological trauma is a product of the relationship between human experiences of natural disaster and violent conflict and other social life products – family, community organizations, the economy and culture, along with the complexity of healthcare systems that include modern healthcare as well as traditional and family healthcare.

In this chapter, modern healthcare is conceptualized as a product of the relationships between modern medical knowledge, medical and health professionals (including psychiatrists, psychologists, medical doctors, nurses and community mental health nurses), technologies (including medicines, instruments and case history protocols) and material objects (including hospital buildings, mental health clinics, community health centres, examination rooms and patient recovery rooms). Modern medical knowledge is itself conceived as a product of the relationships between medical professionals, technologies, materials and mental health patients.

Traditional healthcare, by contrast, is treated as a product of local knowledge and relationships. This chapter does not enter into debate over whether this is 'alternative' or 'complementary' to the science underpinning modern medicine. Instead it explores how and why people seek treatment both from modern healthcare institutions and from traditional healers known in Aceh as *Dukun* or *Tabib* and in the Deep South of Thailand as *Hmo Ban* (Thai language) or *Tok Bomo* (Melayu language). Other common elements of traditional healing for psychological trauma include: first, medicines based on things found in the home, such as water, rice, wood, branch, leaves and herbs (See Figure 16); second, methods that are inexpensive or free; and third, practice by religious leaders who have learnt how to treat people through relatives or others and who create medicines by chanting hymns over the items referred to above.

Accessibility, as will become evident through this chapter, is as important an issue as cost when people make decisions about the use of modern and traditional healthcare. Traditional healthcare is not only available close by from healers based in the village (except for some famous

healers), the cost of treatment is low and patients may pay for the service with food and fruits. Further, to receive treatment, patients do not need to present all the evidence of identity documents.

Figure 16: Traditional medicines – leaves and rice

Modern Healthcare and Diagnostics

Diagnosis of mental illness by modern healthcare workers and institutions was based primarily on observation of their behaviour, interviews at hospitals and/or clinics, and application of the health professional's personal medical treatment experience with mental health patients. Patients diagnosed with severe mental disorders were sent to be treated at the mental health hospital or mental health clinic. One psychiatrist stated that:

> *There are several indicators to know they have a mental illness. The first indicator is that they disturb themselves. The second, they disturb other people. For example, they throw rocks at the other person's house, doing violence, and harming other people. The third is that they need special treatment. We can hospitalize that person.*

But what causes mental illness? Nearly every mental health professional interviewed during this research stated that it is difficult to diagnose the main source of psychological trauma symptoms when people have been impacted by natural disaster and violent conflict along with other social problems. The overlapping of natural disasters and violent conflict events was a new phenomenon that highlighted a number of limitations in the knowledge and capacity of healthcare institutions.

Many healthcare professionals, including psychiatrists, believed there were no differences in the symptoms associated with various sources of trauma. One psychiatrist, working at a newly established mental health clinic in Aceh, shared the view that different sources of trauma had a cumulative effect:

> *For symptoms … actually it's difficult for me to differentiate the stressor, because here, we have a conflict and the tsunami … so when they come to me, I don't know exactly what the main stressor or problem is. Because if we searched from their background we can't say that the tsunami is more of a stressor than conflict … Some patients, if they suffer from mild mental health problems it's easy to diagnose, but some people have told me they suffer from the conflict which started in 1996 … and that then the disease was not so severe, so they thought that they didn't need to visit a psychiatrist and the patient was still at home … after psychological trauma caused by conflict. They suffered again from the tsunami, so … two dominant factors … two dominant stressors. Maybe the first symptom is mild and the second symptom that occurs is severe*.

In contrast with what I was told by community members, most of the mental health professionals I spoke to did not believe they had actually treated people with experience of both natural disaster and violent conflict. They believed conflict and natural disaster had effected largely different geographic locations and therefore different groups of people. Another psychiatrist thus told me:

> *I never had a patient who was affected directly by both tsunami and violent conflict. I knew some of them. But … their condition is getting better now. Here, we have the overlapping areas of different types of disaster between violent conflict and the tsunami. People may experience indirect conflict and also the tsunami such as in Banda Aceh, Meulaboh, Aceh Jaya, and Aceh Bersar. The violent conflict areas are Pidië, Aceh Utara and Aceh Timur. But … a few of my patients in Aceh Barat were affected by conflict. But … they were not the primary victims. I never meet primary victims of conflict.*

Yet another psychiatrist, by contrast, suggested that the symptoms of psychological trauma arising from exposure to conflict and disaster could be quite different, but difficult to disentangle in patients exposed to both:

> *… in the conflict they feared humans, while after the tsunami they became fearful of natural signs, such as strong wind, small earthquakes and heavy rain. From the conflict, they became fearful of strangers … they also feared very loud voices, such as people shouting their name, a truck passing by and making a loud noise … For the patients affected by both its too difficult for me to know what is the dominant factor.*

Importantly, the symptoms of most patients then receiving treatment in mental health facilities were attributed by healthcare professionals principally to drug addiction, schizophrenia and psychosis, followed to a lesser degree by violent conflict and personal problems (such as laziness, unemployment and divorce). Natural disaster events were seldom acknowledged as causes of psychological trauma in the medical conclusions.

Family history of psychiatric illness was a key factor in schizophrenia and psychosis. Some psychiatrists believed any mental health impacts arising from the tsunami or storm surge were indirect, the natural disaster triggering underlying genetic factors. Conversely, people who experienced disaster events but did not have family history and inherited mental illness genes should be free of mental illness or, at most, present with minor symptoms treatable at the general sub-district hospital or community health centre.

However, many community members who sought mental health treatment through modern healthcare services were not able to access that treatment. Modern healthcare services were faced with a variety of issues in providing help. First, a lack of specialist mental health clinics and mental health hospitals meant many potential patients reported problems with access to modern healthcare services. Second, large gaps were evident between the actual number of mental health workers and the number needed, and insufficient medical training of those who do exist. Third, as a consequence, many mental healthcare workers did not themselves know the symptoms of trauma. A large number of people thus struggled to find the right treatment, or even any treatment, increasing the suffering for those struggling with mental health and their families.

Here is the story from two local community mental health nurses (CMHN). They found that some mental illness patients did not recognize their own mental illness symptoms. They stated that many of them often had regular visits to the community health centre with a physical illness such as headache. However, for months to years of a long process of seeking medical services, their illness had never been cured. Some of them are more vulnerable than others. Even though these two CMHN

workers had been trained for work in mental health services they felt that it was not enough for dealing with mental health patients.

> *… we are a midwife but because this community health centre has lack of nurses, so we were appointed to be a nurse because we have experience in helping nurses … we got training for 7-12 days at the health department. The training was for basic level for CMHN … it is about mental health, the characteristic of mental health patients and how to take care of mental health patients…but we cannot prescribe the medicine because we are not doctors … the training is more about how to give counselling for the patients. The doctor in this community health centre comes to visit patients with us sometimes. If we cannot handle the patients, then we will refer the patients to a clinic (name) at the hospital. On the last day of the training, we also do practice in patients' houses. For patients with a severe mental problem it's easy to identify them, but for the patients with the first symptom of a mental problem, it is difficult to tell, we must do an interview, such as ask them how many times they have the sleep disorder and get digestion problems ... we feel very happy when one of our patients becomes independent, but when the patient's condition doesn't get better, we feel sad and think probably it's because we have a lack of knowledge.*

Hence, traditional healthcare was accessed by many mental health patients and their families, although not always to the exclusion of modern healthcare.

Traditional and Modern Healthcare

Patients or their families make choices about traditional and modern healthcare, often moving between the two. If treatment has been ineffective then choices may be changed. For some, early symptoms of psychological trauma may not be noticeable to either the mental health patient or to medical professionals. Many present with a physical illness such as headache or other unexplained physical illness. This may have happened long before going to receive medical treatment from the modern healthcare sector. In seeking to find the most effective care many patients switch from one type of treatment to another and back again. In many cases, the patients who have first sought traditional healthcare may go to receive treatment from modern healthcare with an intern, midwife or nurse at the private clinic, community health centre or general hospital. Transferring between modern healthcare professionals and traditional healers tends to happen when either has limited success in the eyes of the patient, or for a few, to simply 'multiply' the benefits of various treatments.

Traditional healers and medical professionals acknowledge and, at times, encourage movement between the modern and traditional sectors. One traditional healer, for example, explained how:

> *… after I cure the person, if the person is still sick, then I will ask them to go to see the doctor. Because* Syaitan *(Demon/Satan) lives in the vein, not in the skin, probably they leave scratches in the vein. So, the patients need vitamins and a check of their blood.* Insya Allah*, they will be healthy again. In other cases, they received medical treatment from the doctor and the doctor can't find the disease, but after being cured by me, the patients go to see the doctor again and then the doctor finds the disease. So, the patients must go to both of us.*

Similarly, a nurse who opened his own private clinic told me:

> *When* Dukun *cannot cure his patients, he will transfer the patient to me (nurse). At the same time, when my patients cannot be treated, I will recommend my patients to be treated by* [Dukun]. *But, when* [Dukun] *is sick, he will come to see me. Because, he cannot cure himself (laughing).*

Mental Healthcare and Social Stigma – Pasung

The signs of mental illness may be noticed through aggressive behavior, in particular, repetitively breaking things, self-harm or aggression. The first occasion of aggressive behavior may not be recognized as a symptom of trauma but if this behavior is repeated frequently then may be seen as sign of 'insanity' or 'craziness'. Whilst aggressive behavior is widely accepted as a sign of trauma, other warning signs of psychological trauma were found to commonly be ignored. Such commonly overlooked symptoms include social withdrawal, sleeping all day, insomnia, fainting (when watching tragic news from TV or hearing disaster news), being unproductive at work and breaking past patterns of worship. These symptoms were often viewed only as personal problems. At an individual level, signs and symptoms of psychological trauma were often attributed to unemployment, laziness, not being a 'good' person, lack of serious religious faith, black magic, *satan, dijinn* (bad genie), punishment by God and being divorced. Often, at the first sign of psychological trauma, the individual has been hidden and prohibited from talking. It may go on to have an effect on other family members. For example, they may find it hard to attract a marriage partner because of the shame and embarrassment of having mental illness among family members.

It is in this context, and with an inability to restore the mental health of the individual, that some families resort to confining (even caging) the person with the mental illness, in a controlled

space. *Pasung* is a set of practices adopted by some family carers of people with mental illness. This method has been used when family members have found that they have limited access to, or limited success with, modern healthcare and that the mental illness has not been cured by traditional medicine. If a family member with a severe mental disorder exhibits aggressive behavior then they may be caged in controlled spaces with a chain (on wrist, neck, arms, and feet), wood (on both feet), and/or placed under a floor or in a small dark room (See Figure 17).

In Indonesia, *pasung* is widely known. Also, similar practices can be found in the Deep South of Thailand. Long before people in these areas experienced natural disaster, it was used with people who appeared to have severe mental illness. *Pasung* has been seen as a sign of caring and love shown by the members of the families that practice it. *Pasung* has been seen as one type of medication. The belief is that *pasung* (wood) is a type of herb. It is made of *Bak Panjoe* or cotton tree. During the violent conflict, those with severe mental illness were likely to walk around without a destination. In addition, many of them were found unable to communicate and they may have had a high chance of being arrested, investigated, tortured or killed. Hence, families resorted to confining mentally ill family members with *pasung* for their safety.

Figure 17: A leg with chain of male pasung

People who had been locked up with *pasung* are called *orang gila* or crazy persons. *Pasung* has been used to avoid negative effects of a mentally ill patient's behavior on family and on others, especially when they destroy things and steal objects from their neighbours. Many families have restricted income and inability to pay for damages costs. Locking up *orang gila* according to *pasung* seems to many families to be an unavoidable choice.

Mentally ill patients who did not appear aggressive and/or were capable of taking care of tasks such as bathing, eating and taking medicine were not put in *pasung.* Their family would look after them without resorting to confinement.

At the same time, *pasung* cannot be separated from stigma and shame. Using the index finger to make a cross on the forehead is a gesture commonly used to communicate, 'this person is crazy!'. Confined for long periods of time in poor conditions the mentally ill come more and more to resemble the stereotypes people have of them. I found people with long dirty hair and nails, denied access to toilet or bath facilities, and with atrophied muscles, their mental illness compounded by physical disabilities caused by living in such unhealthy conditions.

Pasung, *orang gila* and trauma have been widely known in Acehnese society. It is important to note here that the practice of *pasung* was associated both with the protection of those with severe mental illness and with the shame and stigma of 'craziness' many believe hereditary. The contexts of violent conflict and natural disaster add more layers of complexity to the care of mentally ill and traumatized people by families and by traditional and modern health services.

Socioeconomic Inequality in Access to Mental Healthcare Services

People in poor mental health often have limited income. Transportation barriers include high-cost and inconvenience and there are many more life obstacles that limit access to mental healthcare services.

Poverty in conflict and disaster areas has been caused by violent conflict and mental illness but in a cyclical way the poverty can make the mental illness worse and the opportunities for healthcare more limited. Armed conflict is a major cause of poverty and barriers to education. Most of the schools and textbooks have been burned. Teachers have been shot dead. In the Deep South of Thailand, school teachers were viewed as soft targets and they were killed often to draw the attention of troops from other areas. Generally, school teachers and curriculum were derived from the central government. Most state schools in rural areas force their students to speak central languages (in Aceh, speaking Indonesian while, in the Deep South of Thailand, Thai). Hence, the education system has been viewed as a symbol of a state that brainwashes the children of ethnic minorities to forget their own roots. This is another reason why people in the remote areas did not have education or high education. Having limited education limits people's social mobility. People who live under war conflict conditions find it nearly impossible to change their career.

Living under war conditions as well as experiencing natural disaster is a major cause of poverty, unemployment and mental illness. Most farmers, gardener and fisherman in the studied areas

have been affected by war. In the agricultural areas, often, agricultural fields such as paddy fields (Aceh) were burned off and rubber trees (Thailand) were cut down. This action was taken (by others) to prevent goods or financial support being sent to support the enemy. Displacement, when villagers were driven from their land, could happen at any time. In uncounted incidents, people were not allowed to work in their fields because the armies were searching for their enemies. Whoever disobeyed during this period risked extrajudicial killing of themselves, their family (including women and children) and other villagers. Occasionally, they may have been given permission to work but for only a couple of hours per day – not enough to raise crops. Many chose to stay at home. Consequently, they could not feed themselves and nor could they sell their produce to earn an income.

In Aceh, post-natural disaster and post-conflict, the situation seems to have improved in a positive direction. For example, there has been a great reduction in burning agricultural products and in restricting access to fields. However, many areas that are located near the tsunami affected areas are contaminated by the seawater. The salt levels in the soil mean that it cannot be used for planting crops. For the local fishermen in Meulaboh, they found the wreckage of big blocks of cement, buildings and cars in the seabed, things that had been dragged by the giant waves and had sunk in the ocean. Some have been removed from the bottom of the ocean but many more still remain on the ocean bottom and so local fishermen cannot use equipment such as fishing lines and nets in affected areas (See Figure 18). In the Deep South of Thailand, of course, people still suffer the combined impact of violent conflict and natural disasters such as annual flooding.

Figure 18: Fishermen village, Aceh, Indonesia

Inaccessibility and Inequality of Mental Health Services

Limited mental health resources were found in both Aceh, Indonesia and the Deep South of Thailand. Inaccessibility and inequality in mental healthcare services were related to both the violent conflict context and to natural disasters.

Before 2004, Aceh had only one mental health hospital with three psychiatrists and 300 beds servicing a population of 4 million. The mental health hospital was located separately from the general hospital in Aceh city. Budgeting, less than half a percent of Aceh province was spend on mental healthcare, was clearly inadequate. The mental health hospital was named *Rumah Sakit Jiwa*, meaning home for treatment of mental health patients in Indonesian language (See

Figure 19).

Figure 19: Male mental illness patients at Rumah Sakit Jiwa, Banda Aceh, Indonesia

Mental health services in the Deep South of Thailand were similar to those found in Aceh. There is no mental health hospital at all in conflict areas but there is one facility, Songkhla Rajanagarindra Psychiatric Hospital, located in Mueang Songkhla District, outside the conflict zone. Additionally, there are only three psychiatrists servicing a population of more than one million and there is only one mental health clinic located inside the general hospital in each of three provinces. These clinics share their space and opening hours with other types of healthcare. This is not enough for providing medical services for people who need mental health treatment.

The inadequacy of facilities notwithstanding, people, especially from rural areas, reported that they struggled to access centralized mental healthcare services. People who had restricted incomes were forced to travel long distances on foot or bicycle or, if they could afford them, to use bicycle rickshaws, motorcycles or boats. Some were able to travel by car, bus or van but, for most, these options were expensive. The more significant issue, however, in accessing centralized mental health services was security. Even in the city, where people lived near healthcare services, travel was

difficult during periods of conflict. At the peak of the violence in Aceh, all forms of transport were targeted and public transport stopped working. Shooting after 4:00 or 5:00 pm became routine and, to avoid any kind of danger, most people chose to stay at home. Violence also hindered the development and maintenance of transport infrastructure. In the Deep South of Thailand, occasional gunfire and bombing are still happening in towns. Many people are afraid to go outside at night and on many roads it is hard to find a car at night.

Participants from rural areas in both Aceh and the Deep South reported having to pass through up to 50 or more military and separatist checkpoints during the violent conflict on the way to mental health hospitals, making it nearly impossible to access care regardless of the cost of transport. The aim of these checkpoints was to disrupt people and search for enemy combatants. Checkpoints were used to protect and expand territory and, hence, passing through was deliberately difficult and time consuming. Passing through a checkpoint required people to present identification documents complete with photo, full name, age, date of birth, address, an identification number, card number, gender, religion and citizenship. The only difference between Aceh and the Deep South of Thailand, in this respect, was that Acehnese ID cards included occupation and marital status. Anyone without adequate identification documents was unable to travel.

Participants believed, moreover, that anyone passing through checkpoints was at risk of detention, kidnapping, arrest, torture and death if government or separatist forces suspected them of belonging to, or sympathizing with, an enemy group. In Aceh, people who worked with the government were at particular risk when passing through separatist checkpoints. Meanwhile, anyone sharing a name or surname with suspected separatists was at risk when passing through military checkpoints. In the Deep South of Thailand, where some family names identify a person as being of a particular ethnic identity, Melayu Muslims were subject to suspicion they were opposed to the government.

Identity documents were also needed in order to be eligible to receive medical services. Patients and family had to present their identification card together with certificate of residency. Fake ID cards and house registration documents were often used to reduce the risks associated with travel, passing through checkpoints. However, these also contributed to overcrowding and confusion in psychiatric hospitals and other health services. Staff attempting to discharge patients would find inconsistencies in hospital records and no reliable home address or family contact details. False details were provided for security but also in a number of cases, to ensure a mentally ill family member was not able to return home.

Travel was also dangerous for medical staff, many of whom were kidnapped, threatened and forced to provide a medical care for TNI and/or GAM members. Some medical staff were killed after providing treatment to patients who were conflict actors. Some, conversely, survived because it was recognized that they had saved lives. Fear and the trauma of losing colleagues contributed to depression, insomnia and nightmares among a number of medical professional participating in this study. In recognition of the dangers, rules were implemented in some situations to improve the safety of medical staff; for example, by working only during official working hours, travelling only in hospital vehicles, and staying away from mental health patients who had been affected by violent conflict.

Acehnese participants reported that during the conflict it was normal to see rotting human corpses on roads and sidewalks, hanging from trees and mounted on crosses. Corpses were often found with missing parts – deliberately mutilated to sow fear and to threaten the general population. Under Islamic tradition, the bodies of the dead should be washed and wrapped in cloth and then buried within 24 hours of their death. But during periods of armed-conflict, often no one was brave enough to collect the corpses that littered roads and other public spaces. Family members were afraid that doing so would see them targeted as suspects. Even following the tsunami, many people were reluctant to visit sites where the military had collected the bodies of victims for identification for fear of becoming victims themselves. In my earlier research in the Deep South of Thailand in 2004, we found that a similar situation but with the difference that combatants allowed for the collection and management of dead bodies in accordance with funeral traditions.

Terrorization of the general population further discouraged travel and caused its own psychological trauma, one nursing student who lived in the violent conflict zone reported that every time when she saw the soldier's uniform (worn by GAM members or military) she began to stiffen, experience shortness of breath and other breathing problems, and her heartbeat almost stopped.

The story of Dr Fauziah helps to illustrate the complexity of these difficulties for healthcare professionals. Dr Fauziah was a female medical specialist at Bireun killed on 25 May 1999. On this day she was forced by TNI to treat a military commander who was wounded from the fighting outside the general hospital at the military camp. She was forced to travel with soldiers in a military vehicle. Her medical friends had reminded her of the regulations that limited what she was allowed to do. However, the situation was tense and she found it hard to resist the direction to sit inside the military truck. Dr Fauziah was not deliberately harmed by GAM but she was killed when the troop vehicle was attacked by GAM members. Her friends were safe inside the ambulance which was not attacked. Dr Fauziah's death shocked everyone, especially GAM members when they found she was two

months pregnant. When a new general hospital was built at Bireun, the building was named in her honour.

Risking loss of life was a very real price during periods of conflict for gaining access to modern medical treatment. This inaccessibility is a part of the disconnection between mental healthcare services and mental illness patients. When and where there is disengagement between people with mental illness and the access to healthcare services then mental illness seems to be a kind of disease that cannot be cured.

Mental Health Services, Post-Disaster and Post-Conflict

Rebuilding plans for Aceh were defined in a memorandum of understanding between the Governments of the Republic of Indonesia and the Free Aceh Movement on 15 August 2005 (United Nations, 2005). Both sides recognized that restoring infrastructure damaged by the tsunami would not happen without a peace agreement. Since then, many new mental health clinics have been built, across seven cities namely Sigli, Lhokseumawe, Tamiang, Kuala Simpang, Meulaboh and Calang. Each has one psychiatrist in charge. The number of psychiatrists in Aceh has increased from 3 to 15 with 8 working at the mental health hospital in Aceh city.

Despite progress, post-tsunami and post-conflict, the mental health hospital in Aceh has been in an overcapacity situation. Overcapacity mental health hospitals have high costs for looking after discharged mental health patients whose own family refuse to accept them. Before 2004, 373 beds was the real number that the mental health hospital was able to receive with 300 patients already admitted. Post-tsunami, in 2010, the number of mental health patients had been increased to 400 beds. In 2011, the mental health hospital was caring for 500 patients. On 14 November 2013, the hospital was accommodating 804 mental health patients. Mental health clinics have been faced with the same over-capacity problem – too many patients and not enough beds.

Lack of mental health professionals is a major problem. Scholarships have been offered to encourage doctors to specialize in psychiatry but few have been taken up. Psychiatrists were consequently overwhelmed with their workload – seeing more than 50 patients per day. A similar situation can be found in the Deep South of Thailand where overwhelming workloads affect psychiatrists and other medical staff. Ironically, this constitutes a major mental health risk for psychiatric staff.

The government has also tried to recruit and train other healthcare professionals. In Aceh, in the field of mental health, counselling has been provided for general practitioners, midwives and community mental health nursing. Motorcycles, boats, and ambulances were donated by countries

around the world with the aim of providing mental health services within their home for people affected by tsunami. For people who suffer from violent conflict and other social problems, they received indirect benefit from those donations. This can be compared with the Deep South of Thailand, where the government's plan is to grow the number of field nurses by 3,000 within three years. The aim is to improve medical services by increasing the number of nurses in the conflict zone. However there have not been enough teachers and education facilities and job positions for the new nursing students. The original proposal was for 300 nurses within 10 years, but the politics of interests have changed the original plan to improve access to health care in the Deep South of Thailand. Many more volunteer projects have commenced in this area but people with mental illness still have limited access to mental health services.

More positively, following the memorandum of understanding the first Aceh governor, Irwandi Yusuf, asked each government department to nominate an 'outstanding program'. The program 'Release Pasung Patient' was developed in the Health Department with the aim of improving mental health patients' quality of life. All mental health patients locked up by *pasung* were to be released and receive proper treatment by professional psychiatrists. This idea was based on information from the regional budget report on mental health patients which found that less had been spent on mental health care services than on rabies.

Release Pasung Patient was scheduled for implementation in 2010 but commenced in 2007 ahead of schedule. Many mentally ill Acehnese were subsequently released from close confinement by their family and sent to receive medical treatment at the mental health hospital. The qualifications and networks of the Director of the Release Pasung program has been key to the program's success. He is a nurse by profession, chair of the nurses' association in Aceh, Director of the mental health hospital, Director of the Release Pasung Program and Third Assistant of the Aceh Governor. He is able to connect every community health center and every mental health staff member involved in monitoring *pasung* patients. Everyone has his personal mobile phone number. When medical staff find people with mental illness they are able to send him a report directly. Many *pasung* patients have been sent to receive medical treatment at the mental health hospital after being picked up from the village and all the transfer costs have been supported by the new government. It seems that this program is successful but with mental healthcare in general it also seems that many things have still gone wrong. As noted above, the mental health hospital is over capacity. The number of people with mental illness is not likely to be reduced. Moreover, a hundred patients who have been healed but cannot return home have become homeless and still live at, or in the vicinity of, the mental health hospital. One medical staff said *that 'now, the mental health hospital is become a big* pasung*'*. Even

though the modern mental health services have been improving, social stigma toward mental health patients still exists.

In response to the issue of over-crowding in the mental health hospital a grant proposal was sent abroad, seeking funding support from international countries. To date, no response has been received. Nonetheless, a new mental health hospital is planned at Aceh Bersar and the land has already been bought. However, it awaits funding support from the government of Aceh.

It also needs to be acknowledged that the scale of the conflict and tsunami, and subsequent trauma, continue to present psychological challenges for those delivering and utilizing mental health services. One local researcher, a nurse and head of a healthcare research unit attempting to assess post-conflict psychosocial needs, admitted to experiencing vicarious trauma by the fourth day of her research, after listening to conflict and psychological trauma stories:

> *During the research, I interviewed conflict victims. In my opinion, as human and as a Muslim, what had been done to them was so inhuman. Even animals don't deserve to be treated like that. I cried during the interview. Never before had I cried while interviewing someone. The experience was a bit different than the tsunami. Their story also made me not know what I should ask next, I was stunned. One of the examples is a woman who was gang raped and then she had been dragged by motorcycle. Another example is people who were suspected by the military. They were placed overlapping and the person on the top was cut alive. Another example, someone was murdered by TNI and then the dead body was hung like a cross*.

Vicarious trauma in this case represents an enduring form of secondary traumatization.

Mental Health Services and Related Services Departments

The problem of over-crowding in the mental health hospital was acknowledged by staff of other departments but views differed on what could be done to assist. For example, the Social Welfare Department believed over-crowding was the mental health hospital's own responsibility. Some Social Welfare Department staff claimed over-crowding at the mental health hospital was not a major problem. It was pointed out to me by mental health medical staff that after much discussions and statements of commitment to solve the problem, still no memorandum of understanding between the two departments has been signed. The departments of Forestry, Agriculture and Labor have all identified actions to help address the problem but all await budget approval by the Government of Aceh.

Still, the Social Welfare Department is an important contributes to mental healthcare services. Services and social rehabilitation for people with disability, in particular, was intended to provide a job skills training program for patients discharged from the mental health hospital. The aim was to prepare them to be independent and to have life skills. The elements of the program combine three things: work skills such as clothes making training; professional equipment such as sewing machines; and a carer support fund. Keeping discharged patients busy was intended to prevent relapse among mental health patients. Having job security was valued both for themselves and to assist reunion with family members. With the help of this program, this department believes that patients can earn income and be welcomed back by their family. However, not every discharged patient has been able to attend a job skills training workshop.

Five-year budget plans of the social welfare department have been sent to the Government of Aceh. In 2013, this department expected to receive 21 billion rupiah (or 1,978,652 AUD). However, only 7 billion was approved. As a result of budget restrictions, only 10 people (instead of 15-20) have taken the rehabilitation workshop, and over only 20 days (rather than over a two month period). This is very much a minority of the 420 mental health patients who have already been discharged and there are 1,000 unemployed people also waiting for training. There are many more people needing job training, including 54,000 disabled people and more than 3,400 people who have psychological trauma caused by violent conflict (all Aceh districts). The over-crowding problem in the mental health hospital causes discharging of mental health patients who did not have the life skills to go back to their family members. Frequently, after one to three months with family, they relapse and have to be sent back to the mental health hospital. In relation to mental health patients who have been affected by tsunami, this department believes that there are not so many people who have had mental illness caused by natural disaster and been admitted to the mental health hospital.

The problem of restricted budget may be related to responses to other competing priorities beyond discharge of mental health patients. Here is the opinion by the director of Release Pasung Patients program on the budget used in this department:

> *A department budget deficit happened because it has been spent on the other purposes such as staff salary, uniform, tour of duty and staff training in Jakarta but not on job training for discharge of patients or solving problem of poverty that are related to mental health patients and others*.

General Healthcare Services after Disaster

The healthcare services system has been improving. Post-tsunami, the medical healthcare insurance was included in the services. Mental health patients who live in rural areas can be directed to access to mental health services in the city with a letter from the community health center. All the identification documents are still needed but they no longer have a problem of former dangers carrying their documents. This situation went well in the term of the first Aceh governor. However, the second governor has changed the name of medical healthcare. All documentation on medical treatments has to be recreated for supporting a new management system. This has brought a new complexity for modern healthcare services. Many patients have renewed difficulties in accessing mental healthcare treatment.

Living costs after the tsunami have been increasing. Many goods and food are more expensive than before the tsunami. Inflation happened when the international donors spent money in these areas, with most of them using international rates for services but many local villagers are still living in poverty and find difficulty with the higher prices, including difficulty in to accessing modern healthcare.

The Aceh Government has ostensibly free healthcare for disabled people. However, it covers only care at the main general hospital in the capital city. Additionally, health insurance provided by the Aceh Government is mainly given for ex-GAM members. They are able to access medical services in the city by bringing the approval letter from the local officer. The Minister of Health stated that this is the way to build trust between the governments of Indonesia and the ex-GAM members. Hence, the health and welfare of ex-GAM members is prioritized and the cost for them is subsidized. Sometimes they might have a normal flu but put pressure on medical staff to transfer them to the hospital in the capital city. A senior executive of the Health Department explained that most ex-GAM members graduated only from junior high school and they may want to receive better care. Some Aceh people did not agree with this special treatment. Some said that they should fight for Aceh people in general and that the benefits after war should be distributed to everyone. However, not all local people felt the same and some were sympathetic to former fighters because they have had a hard time, suffering, living in the mountain and having poor conditions during fighting with the TNI during war.

Post-conflict, people were able to travel more freely without fear. Checkpoints were removed. Weapons were repurchased and destroyed. Narrow dirt roads have been widened and paved. Bridges have been built. It is illegal for anyone (ex-GAM members and military) to wear military uniforms.

People are able to seek jobs. More motorcycles can be seen on the roads and traffic jams may be an indicator of higher incomes.

Yet political violence is re-emerging. In 2011, the Aceh Party (or *Partai Aceh*) has split into two groups – Aceh Peace Party (or *Partai Damai Aceh*) and National Aceh Party (or *Partai Nasional Aceh*) and incidents of shooting and grenade throwing have been reported. One new party leader experienced a car bombing caused by an unknown party. This conflict situation has been interpreted as Aceh not having a real peace. The effects of natural disaster required a long time for recovery, so perhaps the recovery time from violent conflict and associated trauma will also be extended.

In relation to economic condition in Aceh, the MoU number 1.3.4 states clearly that 70 percent of revenue from oil and natural resources will return to this region:

> *Aceh is entitled to retain seventy (70) per cent of the revenues from all current and future hydrocarbon deposits and other natural resources in the territory of Aceh as well as in the territorial sea surrounding Aceh*

The Aceh Government has the right to manage their own budget. From this entire contract, it seems Aceh economy should be improving in a positive direction. However, the conditions have not changed when all the budget has to be approved by the Government of the Republic of Indonesia. The budget process is complex and complicated. When the budget has been approved, a lot of money was found to have been left over but could not be spent the following year, causing resentment. In 2005, Aceh has become a special administrative region, however, using the budget is still restrained. Consequently, the opinions of Aceh people are split into two big groups. One side has accepted the MoU and seeks to use the benefits without any conflict. Another side wants to totally separate from Indonesia because they are not satisfied with merely a level of autonomy under the authority of the Indonesian government.

Conclusion

It is difficult to differentiate traumatization arising from conflict and disaster despite different symptoms being evident to at least some healthcare professionals. My research uncovered stigmas towards mental illness among health professionals. This influenced the way in which healthcare providers interacted with mental health patients. Personal issues and family history of mental illness patient was viewed as a personal problem, rather than a sociological issue. This has the effect of furthering secondary trauma. In particular, inadequate mental health services, dangers and other costs of accessing services, limited mental health professionals, and vicarious trauma from exposure to the

other peoples' stories of traumatization were all common experiences of secondary trauma. Poverty and unemployment related to war added a layer of complexity in psychological trauma. Mental health patients who belong to the minority groups experienced an inability to access healthcare. A further element of secondary trauma is the disconnect between mental health hospitals and the Social Welfare Department. The re-emergence of political violence affected on entire mental health care systems.

It is interesting that the Health Department is challenging *pasung*. If successful, this challenges cultural institutions but it is not clear whether the change would be traumatic. The scale of psychological trauma raises challenges for traditional healers and religious leaders, however, unsuccessful treatment was viewed as personal problems, such as sins listed in religious beliefs. Cultural trauma associated with mental patients living with sinful. Their illness had developed when the fear of being judge by healthcare provider. Because of incapacity of dealing with over-crowding in the mental health hospital, people have lost faith in the Health Department when mental illness cannot be healed.

Chapter 9

Conclusion

This chapter concludes the thesis through a summary of major findings relevant to the research questions that informed the study and through the identification of recommendations for future research. The thesis has explored relationships between psychological trauma, gender, natural disasters and conflict in Aceh, Indonesia and the Deep South of Thailand. In broad terms, the research aimed to investigate, from a sociological perspective, psychological trauma as experienced by persons surviving both natural disasters and violent conflict in the context of two sites where there was experience of both natural disasters and violent conflict. More specifically, the research aimed to, first, examine how people experienced and responded to the mental health and emotional impacts of natural disasters and violent conflict, linking with factors such as gender, ethnicity, age and institutional responses, which all play a role in the construction of psychological trauma. Second, by studying the people of Aceh ten years after the tsunami, the research aimed to discover how psychological trauma has been managed and the extent to which it has been resolved. Third, the research aimed to conduct comparative analysis of the different types of disasters (large-scale natural disaster – tsunami and earthquake; small-scale natural disaster – storm surge and others), and the different conflict contexts, taking into consideration sociocultural differences. A fourth aim was to explore the experience of psychological trauma in two geographical areas that have different social contexts. A fifth aim was to find out more about how psychological trauma has been influenced by other social problems.

In the beginning of this thesis, I started by describing how I become interested in this research topic through personal experience of natural disasters and violent conflict. I reflected on how my personal history influenced the research including my methodological and theoretical choices, and how I used these to take a reflexive and self-critical approach to the research. I discussed how people who experienced multiple varieties of disaster were more likely to become vulnerable and the importance, consequently, of ensuring scholarly and practical knowledge of disasters reflects the multiple potential sources of psychological trauma.

To meet the research aims, this thesis used three core concepts – traumatization, secondary trauma and cultural trauma for analyzing psychological trauma. Gill's concept of secondary trauma was used to conceptualize peoples' experiences of relief efforts and other social responses. Gill

(2007) argues that to study psychological trauma we need to understand how society responds to victims of different types of disaster. The thesis has extended this insight by considering not only different kinds of disaster but the more drawn out experience of violent conflict and its interactions with natural disasters, relief efforts and mental health services. Psychological trauma has been treated not as a straightforward outcome of individual stressful events but as a product of relationships between multiple stressors including a range of social institutions, such as family and also other form of social construct, namely, gender, age and ethnicity. These were found to intersect with social problems such as social inequality, poverty, domestic violence, sexual abuse, ethnic conflict and war.

Over time, the ways in which psychological trauma is understood has changed, culminating in the medicalized understanding institutionalized in the mental health field. In contrast, sociological arguments focus on the connections between psychological trauma and social relationships. The conceptual approach in this thesis has thus been developed by exploring how sociologists have conceptualized the relationship between disaster, conflict and psychological trauma. Many concepts such as mental alienation have been used by Durkheim (1952), and sociologists since, to understand why some groups of people cannot be integrated into their society. From such perspectives, psychological trauma is associated with relationships and social processes. Lack of social support and isolation experienced before, during and/or after disaster events can be causes of psychological trauma.

In order to answer my research question, the following section relates to the five key research aims and objectives.

1. Experience and Responses to Mental Illness

The question of what counts as a disaster is socially constructed in a number of ways, one of which is recognition by government and non-government agencies. For example, the December 26, 2004 tsunami in Aceh was acknowledged as one of the largest and deadliest in recorded history (Paris et al., 2009). Over 30 years of violent conflict in Aceh, many conflict areas were inaccessible to aid organizations. This lack of accessibility was changed fundamentally by the tsunami but victims of conflict were routinely ignored, nonetheless, by organizations responding to the disaster (Zeccola, 2011). Post-tsunami, Aceh received large amounts of money from international government and non-government agencies and million people around the world (Jayasuriya, and McCawley, 2010) along with the time and energy of thousands of volunteers (Clarke et al., 2010). Much of this aid attracted criticism for insensitivity to Acehnese culture and norms (Altay, 2008) but the more important issue

here is the role it played in the secondary traumatization of people who experienced both the conflict and the tsunami.

Acehnese survivors received several indirect benefits from tsunami, the first of which was peace following the signing of a Memorandum of Understanding between the Government of the Republic of Indonesia and the Free Aceh Movement. Second, and as a consequence of peace, people were able to travel more freely. Third, recovery money flowed into Aceh. This recovers money contributed, however, to secondary trauma. More expenditure was focused, for example, on ex-GAM members than on Acehnese's people in general, contributing to the difficulty experienced by many victims of conflict to deal with psychological trauma.

Exposure to conflict and to multiple types of disaster increased vulnerability to psychological trauma. Although faced with multiple sources of trauma, participants found some aspects of their experience ignored by their communities and by relief efforts. People who experienced symptoms of psychological trauma thus had a tendency to isolate themselves – avoiding interaction with others and disconnecting from the community and institutions because they felt judged and stigmatized. Social relationships among disaster victims and social responses to different types of disaster (here, the way in which society responded to the disaster victims) contributed to secondary traumatization.

Familial relationships were as important here as relationships at a community, institutional or macro-scale. Traumatization among those exposed to natural disasters and conflict was primarily associated with separation from other family members and secondary traumatization, subsequently, with changing relationships among surviving family members. The death of family members was of obvious importance here but so too was the impact of conflict and disasters on other family members' mental and physical health, leaving many in need of treatment and care. Familial roles and responsibilities underwent dramatic change for which many were poorly prepared, lacking both experience and family support (whether this be in relation to parenting, the care of disabled family members or simply coping with the death of a spouse and/or children). Many survivors struggled to help family members in need of care while suffering themselves from the emotional and mental health impacts of witnessing and/or hearing about the deaths of other family members. Feelings of guilt were expressed over peoples' inability, in the first instance, to protect family members during the conflict or disaster and, in the second instance, to care for other survivors afterwards. Unhealthy relationships, emotional isolation, and reluctance to share psychological trauma experience among family members illustrated the social nature of psychological trauma. Other social problems such as domestic violence and suicidal ideation added further layers of complexity to the psychological trauma stemming from conflict and disaster.

Secondary traumatization was clearly evident in family members' relationships. The direct impacts of conflict and disaster, restructured families and familial roles, exposure to additional disaster events and/or ongoing conflict, constituting both new and interacting sources of traumatization. The multiple stimuli of psychological trauma were consequently inseparable, and any distinction between primary and secondary traumatization largely heuristic. Just as societal responses influenced the long-term impacts on people of conflict and disaster events, so too did their prior exposure to such events. The social background of those experiencing traumatic events (their ethnicity, socioeconomic status and gender) also shaped both primary and secondary traumatization in complex and interacting ways. Gender role expectations that exposed a number of women to domestic violence and economic vulnerability simultaneously worked to leave men forced to take on new familial roles without acknowledgment or support from their communities or relief agencies.

Psychological trauma among young people was particularly shaped by moments of separation and loss from other family members. For this group, the sequence of events from exposure to armed conflict to living through natural disaster was particularly clear. Armed conflict left young people feeling hurt and angry with anyone who harmed members of their family while, following natural disaster, anger was directed towards parents. Witnessing adult reactions to conflict (for example, panicking, screaming or crying) was traumatizing in much the same way as hearing of the death of a family member during a natural disaster event. Emotional insecurity triggered by the loss of parents during conflict, or by parents seeming inability to cope with the stress of conflict situations, intensified the fear felt by many young people of further loss during natural disasters despite their lack of direct experience of such events. Sexual abuse and recruitment of child soldiers stood out as particularly egregious examples of exploitation impacting young people during and post-conflict.

The relationship between psychological trauma and gender has already been discussed with respect to imposed changes on familial roles and responsibilities. Responses to those exhibiting symptoms of mental illness or otherwise in need of healthcare support were also gendered, stigma here playing a major role. The gendered nature of stigma in relation to mental illness was evident in health professionals' attitudes toward mental health patients. Mental illness has been viewed as an individual problem. Both male and female mental illness have been seen in relation to moral weakness or sinfulness, intellectual disability, psychiatric and genetic deficiencies. For male mental health patients, common causes have been seen as laziness, unemployment and drug addiction while a female who has been through a marriage that ends in divorce has been seen as a cause of mental illness. The flipside to stigma is the shame experienced both by those who experience symptoms of mental illness and by their relatives – shame from being seen to do something wrong in the eyes of God, the shame of sharing trauma stories and the shame of exhibiting weakness.

Women and men with symptoms of mental illness were subject to different treatment by their families and communities. Women were generally viewed as being more need of support than men and were more likely to be cared for at home. Men were more often admitted to mental health hospitals and left homeless after they were discharged. People with symptoms of mental illness were often afraid to admit these symptoms due to fear of social sanction and families often hid mental illness among their members. Siblings, of the mentally ill, for example may experience difficulty finding a marriage partner if the illness becomes publically known. Reluctance to acknowledge the early signs of psychological trauma, particularly among men, meant treatment was often not sought and conditions worsened.

Disruption to familial roles and responsibilities – particularly those that challenge fundamentally traditional roles of protector and caregiver – can be interpreted as a form of cultural trauma. Frustrated single parents were overwhelmed by the task of raising children and sought any kind of social support. Most of the single parents described how they were struggling with their experience of the role change and with societal expectations concerning parenting. At issue here were both additional demands on single parents to undertake domestic labour, to secure accommodation and income, and the emotional needs of traumatized children who, in many instances, blamed their surviving parent, became disrespectful or even violent, and/or withdrew. For many single parents, the solution was remarriage but this solution was not always successful and, indeed, exposed a number of participants to exploitation and abuse.

2. Managing Psychological Trauma

Protracted conflict and multiple natural disasters challenged the capacity of institutions, modern and traditional, to manage psychological trauma. The authority and influence of religious leaders, for example, was compromised by their inability to act out leadership roles during violent conflict. However, many people continued to rely on religious leaders to interpret traumatic events and for healing when modern healthcare was inaccessible or ineffective. This is a source of secondary trauma.

The source of traumatization arising from disaster and conflict was often hard to diagnose for healthcare professionals. The bigger issue identified through this research, however, was the individualization and indeed stigmatization of mental illness by healthcare institutions and professionals. Mental health services were both inadequate (given the scale of psychological traumatization in both Aceh and the Deep South) and inaccessible (located in centralized facilities despite the expense and danger of travel as well as, importantly, the fear of travelling even when

immediate danger has passed). Inaccessibility and failures of modern healthcare and traditional healthcare in treating mental illness led some families to lock up the severely mentally ill with *pasung*. From a family perspective, *pasung* may be interpreted as a sign of love and care. While *pasung* may also be used by families to avoid stigmatization and shame, medical negligence and the inaccessibility of medical treatment was also justified through the stigmatization of individuals in need of care.

Secondary trauma was evident in the failure of emergency relief, social response, inadequate mental health services and community beliefs and attitudes. Shame and stigma lower rates of access to mental health services and the effectiveness of those services. Psychological trauma among families, young people, people who have different social backgrounds and socioeconomic status were all associated with and prolonged by these factors. Low levels of public awareness of mental health problems also impacted families, young people and people who are different by gender and social background. Masculine and feminine norms may a barrier to medical treatment in the early stages of psychological trauma. In male and female partner may not be acknowledged and found the difficulty of receiving a proper treatment in relation to gender roles expectation. Insufficient mental health services, limited mental health professionals, danger and other costs of accessing services and vicarious trauma from exposure to the other peoples' stories of traumatization were all common sources of secondary trauma.

3. Comparative Study of Different Types of Disasters and the Different Conflict Contexts

Socioeconomic status, gender, age and other socio-demographic variables may all be expected to influence peoples' vulnerability to traumatic events. In Chapter 8, I presented how socioeconomic inequality related to inaccessibility to mental health care service. Chapter 7, showed a lot of cases and evidence of how gender is associated with stigmatization and the construction of mental health. In Chapter 6, I provided information on how young people's psychological trauma is linked with disaster and conflict. In Chapter 4, I demonstrated how Aceh and the Deep South of Thailand are different by historical background, type of disaster and violent conflict. In Chapters 5 to 9, I presented how different types of disaster and different types of violent conflict have affected people in those areas.

This research shows, however, that the number and duration of events is also important in the construction of vulnerability. In short, those exposed to multiple traumatic events were more likely to suffer long-term psychological and physical harm as a consequence. Of less importance was the type of event. While it was true that armed conflict and natural disasters were interpreted differently in

each site, these interpretations were not consistent across sites, and there was no discernable variation in societal responses to those exhibiting signs of psychological trauma regardless of the cause of traumatization.

The attribution of responsibility for a traumatic event played a major role in the experience and interpretation of traumatization. A number of young people, for example, expressed anger towards the protagonists (government forces and separatists) in armed conflict and towards their own parents in relation to natural disasters. Again, however, there was no clear pattern beyond a tendency to blame a human agent for their traumatization, regardless of the kind of event.

4. Exploring Psychological Trauma in Two Geographical area

It is perhaps not surprising that the overt symptoms of psychological trauma were similar across both sites – participants reporting grief, nightmares, insomnia and panic attacks. After all, if they had not reported these symptoms, they would not be considered traumatized. However, the social context specific to each site shaped the incidence and experiences of psychological trauma at both the individual and collective level. The thesis has explored these specificities through four major themes – the relationships between disasters, conflict and families, the relationships between disaster, conflict and young people, the relationships between disaster, conflict, gender and health and, lastly, the relationships between disaster, conflict and healthcare institutions and practices.

In the Deep South of Thailand, the comparatively small size of the disaster in question led to comparatively little recognition by the wider Thai society and relief efforts. The Boxing Day tsunami that impacted Aceh, Indonesia, on the other hand, was well known at the international level. Across both sites, however, the impact of multiple types of disaster was not adequately acknowledged by most relief effort actors. Long-lasting repetitive traumatic events such as post-conflict (Aceh), on-going natural disaster (Aceh and the Deep South of Thailand) and on-going armed conflict (the Deep South of Thailand), were found to be experiences particularly harmful on mental health in families.

5. The Influence of Other Social Problems on Psychological Trauma

A range of other social problems that generate psychological trauma were found in this research. Many forms of violent and abusive behaviour including domestic and family violence, sexual violence against women and children, and recruitment of child soldiers were reported by participants. The violent and abusive behaviour of those themselves physically and/or psychologically

traumatized caused secondary trauma among other family members. Much of this violence can, of course, to attributed to the armed conflict with participants reporting, for example, rape and other acts of sexual violence perpetrated by military forces in order to terrorize populations and coerce relatives. However, violence against women, in particular, also preceded these conflicts.

Secondary trauma can be found from the other forms of social problems such as domestic violence and any kinds of abusive generated the different psychological trauma in young people. The experience of seeing other young people who lost their parents during armed conflict and the natural disaster evoked young adult psychological trauma. Many more young people, especially male were recruited as soldiers in armed conflict. Young peoples' psychological trauma also related to adults' life and their parents. Poverty and unemployment related to war added a layer of complexity in psychological trauma. Mental health patients who belonged to minority ethnic groups experienced an inability to access healthcare. Disconnection between institutions (e.g. the mental health hospital and the Social Welfare Department in Aceh) also contributed to traumatization. The re-emergence of political violence effected entire mental health care systems.

Future Research

Doctoral theses often conclude with calls to scale up the research – to expand it to new sites or to larger sample sizes. This thesis concludes with a call, rather, to explore the complex processes of traumatization and secondary traumatization of communities in Aceh and the Deep South in yet more detail. Understanding and responding adequately to the needs of people in these sites requires more thorough exploration of a range of issues that were not dealt with in detail during this research.

Mental illness, for example, is not the only healthcare challenge facing either Aceh or the Deep South. In Aceh, there is concern among many medical staff that the rate of newly diagnosed HIV infections has increased. Also of concern is what is perceived to be a fast-growing drug epidemic. Many medical staff stated they did not know why new problems were emerging or how to handle people who are HIV and AIDS infected. As well, they did not have any idea how to deal with the drug issue. Some medical staff said Aceh has experienced three types of disaster: first the conflict, then the tsunami, and now drug addiction. It is difficult in the Deep South of Thailand to know whether and how HIV and AIDS infections are changing as so much is hidden by the violent conflict situation. Anti-HIV education and healthcare are no longer available directly in the villages.

Psychological trauma among the young people of Aceh and the Deep South needs lifetime observation and study. Particularly, young people were exposed to other traumatic life events – on-

going violent conflict, on-going natural disaster, post-conflict and other forms of social problems such as abuse, sexual violent and others. In order to support young people who have experienced multiple sources of psychological trauma, it will be important to understand how their behaviour has developed, how they have psychologically adjusted to adult life and the people around, and how young people attempt to (re-)establish normal life routines despite on-going violent conflict and natural disaster conditions.

At the same time, such research needs to be deeply sociological. The complexity of mental health and illness throughout peoples' life cycles certainly demands medical and psychological investigation of the primary sources of psychological traumatization. However, it demands too sociological examination of secondary traumatization associated with societal responses in order to ensure that the many institutions and relief agents responsible for providing assistance attenuate, rather than amplify, the ongoing experience of psychological trauma.

References

Agustini, E., Asniar, I. and Matsuo, H. (2011). The prevalence of long-term post-traumatic stress symptoms among adolescents after the tsunami in Aceh. *Journal of Psychiatric and Mental Health Nursing, 18*(6), 543-549. doi:10.1111/j.1365-2850.2011.01702.x

Alcantara-Ayala, I. (2002). Geomorphology, natural hazards, vulnerability and prevention of natural disasters in developing countries. *Geomorphology*, *47*(2-4), 107-124.

Alexander, J. C. (2002). On the social construction of moral universals: the 'Holocaust' from war crime to trauma drama. *European Journal of Social Theory, 5*(1), 5-85.

Alexander, J. C. (2004). Toward a theory of cultural trauma. *Cultural Trauma and Collective Identity*, *76*, 620-639. In Alexander, J. C., Eyerman, R., Giesen, B., Smelser, N. J. and Sztompka, P. (Eds.) (2004). *Cultural Trauma and Collective Identity*: Univ of California Press.

Alexander, J. C., Eyerman, R., Giesen, B., Smelser, N. J. and Sztompka, P. (2004). *Cultural Trauma and Collective Identity*. Berkeley, California: University of California Press.

Allen, J. G. (2008). *Coping with trauma: Hope Through Understanding* (2 ed.). Washing, DC; London, England: American Psychiatric Publishing, Inc.

Allwood, M. A., Bell-Dolan, D. and Husain, S. A. (2002). Children's trauma and adjustment reactions to violent and nonviolent war experiences. *Journal of the American Academy of Child and Adolescent Psychiatry, 41*(4), 450-457. Altay, N. (2008). Issues in disaster relief logistics. Large-scale disasters: Prediction, control, and mitigation, 120-146.

Amaratunga, D., Haigh, R., Ginige, K., Amaratunga, D. and Haigh, R. (2009). Mainstreaming gender in disaster reduction: Why and how? *Disaster Prevention and Management: An International Journal, 18*(1), 23-34.

American Psychological Association. (2008). *Children and Trauma: Update for Mental Health Professionals*. Retrieved from http://www.apa.org/pi/families/resources/children-trauma-update.aspx

Ananta, A., Arifin, E. N., Hasbullah, M. S., Handayani, N. B. and Pramono, A. (2014). *A New Classification of Indonesia's Ethnic Groups (Based on the 2010 Population Census)*. Retrieved from http://citeseerx.ist.psu.edu/viewdoc/download?doi=10.1.1.734.5023andrep=rep1andtype=pdf

Andaya, B. W. (2007). Studying women and gender in Southeast Asia. *International Journal of Asian Studies, 4*(01), 113-136.

Andaya, B. W. and Andaya, L. Y. (2001). *A History of Malaysia*: University of Hawaii Press.

Andresen, D., Donaldson, A., Choo, L., Knox, A., Klaassen, M., Ursic, C., Vonthethoff, L., Krilis, S.,. Konecny, P. (2005). Multifocal cutaneous mucormycosis complicating polymicrobial wound infections in a tsunami survivor from Sri Lanka. *The Lancet, 365*(9462), 876-878.

Aphornsuvan, T. (2008). Origins of Malay Muslim 'Separatism'in Southern Thailand. In Michael J. Montesano and P. Jory (Eds.), *Thai South and Malay North: Ethnic Interactions on a Plural Peninsula* (pp. 91-123). Singapore: National University of Singapore.

Arhem, K. and Sprenger, G. (Eds.). (2015). *Animism in Southeast Asia*. London: Routledge.

Ariyapruchya, K., Reungsri, T., Habalian, R. A., Latimer Julian, C. and Kuriakose, S. (2017). *Thailand Economic Monitor Digital Transformation August 2017*. Retrieved from Bangkok: http://pubdocs.worldbank.org/en/823661503543356520/Thailand-Economic-Monitor-August-2017.pdf

Asian Disaster Reduction Center. (2004a). *Country Report 2004 Thailand*. Retrieved from http://www.adrc.asia/countryreport/THA/2004/page.html#Introduction

Asian Disaster Reduction Center. (2004b). *Thailand: Tsunami: 2004/12/26*. Retrieved from http://www.adrc.asia/nationframe.php?URL=./view_disaster_en.php?NationCode=andlang=enandKEY=790

Asian Disaster Reduction Center. (2006). *Natural Hazards in Thailand*. Retrieved from http://www.adrc.asia/countryreport/THA/2005/english.pdf

Asian Human Rights Commission. (2014). *Thailand: Danger to Political Freedom Following Attack on Historian*. Retrieved from http://www.humanrights.asia/news/ahrc-news/AHRC-STM-031-2014

Askew, M. (2008). Thailand's intractable southern war: Policy, insurgency and discourse. *Contemporary Southeast Asia: A Journal of International and Strategic Affairs, 30*(2), 186-214.

Aspinall, E. (2009). *Islam and Nation: Separatist Rebellion in Aceh, Indonesia*. Stanford, USA: Stanford University Press.

Assanangkornchai, S., Tangboonngam, S. n., Sam-angsri, N. and Edwards, J. G. (2007). A Thai community's anniversary reaction to a major catastrophe. *Stress and Health, 23*(1), 43-50.

Atkinson, J. M. (Ed.) (1990). *Power and Difference: Gender in island Southeast Asia*. Stanford, CA: Stanford University Press.

Aubert, V. and Messinger, S. L. (1958). The criminal and the sick. *Inquiry, 1*(1-4), 137-160.

Australian Government, Department of Foreign Affairs and Trade. (2018). *Thailand*. Retrieved from http://smartraveller.gov.au/Countries/asia/south-east/Pages/thailand.aspx

Badan Pusat Statistik. (2012). *Penduduk Indonesia menurut Provinsi 1971, 1980, 1990, 1995, 2000 dan 2010*. Retrieved from https://www.bps.go.id/linkTabelStatis/view/id/1267Bajunid, O. F. (2009). The conflict in Thailand's Deep South and its international implications. *Journal of International Studies*, 5, 40-56.

Baird, K., and Kracen, A. C. (2006). Vicarious traumatization and secondary traumatic stress: A research synthesis. *Counselling Psychology Quarterly*, *19*(2), 181-188.

Baker, C. (2003). Ayutthaya rising: from land or sea? *Journal of Southeast Asian Studies, 34*(1), 41-62.

Bandelow, B., Torrente, A. C., Wedekind, D., Broocks, A., Hajak, G. and Rüther, E. (2004). Early traumatic life events, parental rearing styles, family history of mental disorders, and birth risk factors in patients with social anxiety disorder. *European Archives of Psychiatry and Clinical Neuroscience, 254*(6), 397-405.

Banks, M. E. (2003). Disability in the family: a life span perspective. *Cultural Diversity and Ethnic Minority Psychology, 9*(4), 367.

Barnett, M. (2005). Humanitarianism transformed. *Perspectives on Politics, 3*(04), 723-740.

Barter, S. J. (2011). Ulama, the state, and war: community Islamic leaders in the Aceh conflict. *Contemporary Islam, 5*(1), 19-36.

Barton, A. H. (2005). Disaster and collective stress. In Perry, R. W., and Quarantelli, E. L. (Eds.) (2005). *What is a disaster?: New Answers to Old Questions*. Philadelphia, PA: Xlibris Corporation.

Basry, M. H. and Alfian, I. (1990). *The Dutch Colonial War in Aceh* (Muhamad Hasan Basry and I. Alfian Eds. 2nd ed.). Banda Aceh, Indonesia: The Documentation and Information Center of Aceh.

Becker, E. M., and Dochhorn, J. (Eds.). (2014). *Trauma and Traumatization in Individual and Collective Dimensions: Insights from Biblical Studies and Beyond. EBook* (Vol. 2). Vandenhoeck and Ruprecht.

Becker, H. and Geer, B. (1957). Participant observation and interviewing: A comparison. *Human Organization, 16*(3), 28-32.

Bensley, L. S., Spieker, S. J., Van Eenwyk, J. and Schoder, J. (1999). Self-reported abuse history and adolescent problem behaviors. II. Alcohol and drug use. *Journal of Adolescent Health, 24*(3), 173-180.

Berren, M. R., Beigel, A., and Ghertner, S. (1980). A typology for the classification of disasters. *Community Mental Health Journal, 16*(2), 103-111. doi:10.1007/BF00778582

Bertazzi, P. A. (1998). Stellman, J.M. (Ed). Disasters and major accidents. *International Labour Office(ILO) Encyclopedia of Occupational Safety and Health*. 4th ed. Geneva: International Labour Office.

Betancourt, T. S., Agnew-Blais, J., Gilman, S. E., Williams, D. R. and Ellis, B. H. (2010). Past horrors, present struggles: The role of stigma in the association between war experiences and psychosocial adjustment among former child soldiers in Sierra Leone. *Social Science and Medicine, 70*(1), 17-26.

Betancourt, T. S. and Khan, K. T. (2008). The mental health of children affected by armed conflict: protective processes and pathways to resilience. *International Review of Psychiatry, 20*(3), 317-328.

Bhaopichitr, K., Atsavasirilert, W., Ruangrong, T., Luangpenthong, A. and Matin, K. M. (2005). *Thailand Economic Monitor November 2005*. Retrieved from Bangkok: https://www.google.com.au/search?q=World+Bank+Thailand+Office+AND+resource+economic+monitor+2005andie=utf-8andoe=utf-8andclient=firefox-bandgfe_rd=cranddcr=0andei=PEXpWdzAFrTM8geQiJzYDA

Billings, A. G. and Moos, R. H. (1983). Comparisons of children of depressed and nondepressed parents: A social-environmental perspective. *Journal of Abnormal Child Psychology, 11*(4), 463-485.

Billon, P. L. and Waizenegger, A. (2007). Peace in the wake of disaster? Secessionist conflicts and the 2004 Indian Ocean tsunami. *Transactions of the Institute of British Geographers, 32*(3), 411-427.

Binder, D. K., Schaller, K. and Clusmann, H. (2007). The seminal contributions of Johann-Christian Reil to anatomy, physiology, and psychiatry. *Neurosurgery, 61*(5), 1091-1096.

Blackburn, S. (1999). Gender violence and the Indonesian political transition. *Asian Studies Review, 23*(4), 433-448.

Blackwood, E. (2000). *Webs of Power: Women, Kin, and Community in a Sumatran Village*. Lanham, MD: Rowman and Littlefield Publishers.

Blanc, V., Bohic, J.-Y., Lerousseau, L., Del Giudice, P., Rodríguez-Nava, V. and Boiron, P. (2008). Nocardia spp. wound infection in a tsunami survivor from Thailand, 2004. *Journal de Mycologie Médicale/Journal of Medical Mycology, 18*(2), 123-127.

Boin, A. (2005). From crisis to disaster: Towards and Integrative perspective. In Perry, R. W., and Quarantelli, E. L. (Eds.) (2005). *What is a Disaster?: New Answers to Old Questions*. Philadelphia, PA: Xlibris Corporation.

Bokszczanin, A. (2008). Parental support, family conflict, and overprotectiveness: Predicting PTSD symptom levels of adolescents 28 months after a natural disaster. *Anxiety, Stress, and Coping, 21*(4), 325-335.

Bolin, R. C. and Bolton, P. A. (1986). *Race, Religion, and Ethnicity in Disaster Recovery*. Boulder, Colo.: Institute of Behavioral Science, University of Colorado.

Borrero, J. C. (2005a). Field data and satellite imagery of tsunami effects in Banda Aceh. *Science, 308*(5728), 1596-1596.

Borrero, J. C. (2005b). Field survey of northern Sumatra and Banda Aceh, Indonesia after the tsunami and earthquake of 26 December 2004. *Seismological Research Letters, 76*(3), 312-320.

Boudon, R. (2002). Sociology that really matters: European academy of sociology, first annual lecture, 26 October 2001, Swedish cultural center. *European Sociological Review, 18*(3), 371-378.

Boulding, E. (1950). Family adjustments to war separation and reunion. *The ANNALS of the American Academy of Political and Social Science, 272*(1), 59-67.

Bradley, F. (2015a). *Forging Islamic Power and Place: The Legacy of Shaykh Daud bin'Abd Allah al-Fatani in Mecca and Southeast Asia*. Honolulu: University of Hawai'i Press.

Bradley, F. (2015b). Forging Islamic power and place: the legacy of Shaykh Daud bin ‘Abd Allah al-Fatani in Mecca and Southeast Asia. *The Contemporary Pacific, 27*(1).

Brent, D. A. and Mann, J. J. (2005). Family genetic studies, suicide, and suicidal behavior. *American Journal of Medical Genetics Part C: Seminars in Medical Genetics, 133*(1), 13-24.

Brewster, D. (2011). The relationship between India and Indonesia. *Asian Survey, 51*(2), 221-244.

Briere, J. and Elliott, D. (2000). Prevalence, characteristics, and long-term sequelae of natural disaster exposure in the general population. *Journal of Traumatic Stress, 13*(4), 661-679.

Broadhead, W. E., Kaplan, B. H., James, S. A., Wagner, E. H., Schoenbach, V. J., Grimson, R., Heyden, S., Tibblin, G., Gehlbach, S. H. (1983). The epidemiologic evidence for a relationship between social support and health. *American Journal of Epidemiology, 117*(5), 521-537.

Brown, P. and Mikkelsen, E. J. (1997). *No Safe Place: Toxic Waste, Leukemia, and Community Action*. Berkeley, CA: University of California Press.

Burgess, E. W. (1942). The effect of war on the American family. *American Journal of Sociology, 48*(3), 343-352.

Byrd, M. L. and Robinson, A. (1995). *Gender In Interviewing*. Retrieved from http://files.eric.ed.gov/fulltext/ED388928.pdf

Campbell, D. T. and LeVine, R. A. (1961). A proposal for cooperative cross-cultural research on ethnocentrism. *Journal of Conflict Resolution, 5*(1), 82-108.

Canfield, J. (2005). Secondary traumatization, burnout, and vicarious traumatization: A review of the literature as it relates to therapists who treat trauma. *Smith College Studies in Social Work, 75*(2), 81-101.

Carrera-Bastos, P., O'Keefe, J., Cordain, L. and Lindeberg, S. (2011). The western diet and lifestyle and diseases of civilization. *Research Reports in Clinical Cardiology, 2*, 15-35.

Caruth, C. (Ed.) (1995). *Trauma: Explorations in memory*. Baltimore and London: The Johns Hopkins University Press.

Catani, C., Jacob, N., Schauer, E., Kohila, M. and Neuner, F. (2008). Family violence, war, and natural disasters: A study of the effect of extreme stress on children's mental health in Sri Lanka. *BMC Psychiatry, 8*(1), 33.

Catani, C., Schauer, E., Elbert, T., Missmahl, I., Bette, J. P. and Neuner, F. (2009). War trauma, child labor, and family violence: Life adversities and PTSD in a sample of school children in Kabul. *Journal of Traumatic Stress, 22*(3), 163-171.

Cavallo, E. A., and Noy, I. (2009). The economics of natural disasters: A survey. *International Review of Environmental and Resource Economics*, 5, 63–102.Chaiwat, S.-A. (2006). The silence of the bullet monument: Violence and "Truth" management, Dusun-nyor 1948, and Kru-Ze 2004. *Critical Asian Studies, 38*(01), 11-37.

Chatani, K. (2010). *Skills Gap Analysis in Aceh From Reconstruction to Sustainable Growth through Skills Development*. Retrieved from http://www.ilo.org/wcmsp5/groups/public/@asia/@ro-bangkok/@ilo-jakarta/documents/publication/wcms_143374.pdf

Cheers, B., Binell, M., Coleman, H., Gentle, I., Miller, G., Taylor, J. and Weetra, C. (2006). Family violence: An Australian Indigenous community tells its story. *International Social Work, 49*(1), 51-63.

Chen, C.-H., Tan, H. K.-L., Liao, L.-R., Chen, H.-H., Chan, C.-C., Chen, C.-Y., Wang, T.-N., Lu, M.-L. (2007). Long-term psychological outcome of 1999 Taiwan earthquake survivors: a survey of a high-risk sample with property damage. *Comprehensive Psychiatry, 48*(3), 269-275.

Chiachanphong, P. (2012). *Meung rad khong phokhun pha meuang krung sukhothay lea roy cheuxm ni prawatisastrthai [The town of Sukhothai and the welds of Thai history]*. Nonthaburi, TH: Thaiphumpublishing.

Chongsuvivatwong, V., Boegli, L. C. and Hasuwannakit, S. (Eds.). (2014). *Healing Under Fire: The Case of Southern Thailand*. Bangkok: The Deep South Relief and Reconciliation (DSRR) Foundation and the Rugiagli Initiative (tRI).

Clark, C. D. (1999). The autodriven interview: A photographic viewfinder into children's experience. *Visual Studies, 14*(1), 39-50.

Clarke, H. and McKay, S. (2008). *Exploring Disability, Family Formation and Break-Up: Reviewing the Evidence* (1847124003). Retrieved from http://www.equality-ne.co.uk/downloads/274_rrep514.pdf

Clarke, M., Fanany, I., and Kenny, S. (Eds.) (2010). *Post-Disaster Reconstruction: Lessons from Aceh*. London and Washington, DC: Earthscan.
Cobb, S. (1976). Social support as a moderator of life stress. *Psychosomatic Medicine, 38*(5), 300-314.
Cockerham, W. C. (2014). *Medical Sociology*. (n.d.): John Wiley and Sons, Ltd.
Coedès, G. (1968). *The Indianized States of South-East Asia* (S. B. Cowing, Trans. W. F. Vella Ed.). Honolulu: University of Hawaii Press.
Coedès, G. (1969). *The Making of South East Asia* (Vol. 20). Berkeley and Los Angeles: University of California Press.
Cohen, R. (2006). Strengthening Protection of IDPs: The UN's Role. *Georgetown Journal of International Affairs*, 101-109.
Cohen, S. (2004). Social relationships and health. *American Psychologist, 59*(8), 676.
Cohen, S. and Hoberman, H. M. (1983). Positive events and social supports as buffers of life change stress. *Journal of Applied Social Psychology, 13*(2), 99-125.
Cohen, S. and Wills, T. A. (1985). Stress, social support, and the buffering hypothesis. *Psychological Bulletin, 98*(2), 310.
Coker, A. L., Davis, K. E., Arias, I., Desai, S., Sanderson, M., Brandt, H. M. and Smith, P. H. (2002). Physical and mental health effects of intimate partner violence for men and women. *American Journal of Preventive Medicine, 23*(4), 260-268.
Coker, A. L., Smith, P. H., Thompson, M. P., McKeown, R. E., Bethea, L. and Davis, K. E. (2002). Social support protects against the negative effects of partner violence on mental health. *Journal of women's Health and Gender-Based Medicine, 11*(5), 465-476.
Committee on the Elimination of Racial Discrimination. (2011). *First to third Periodic Reports of States Parties Due in 2008 Thailand* (GE.11-46262 (E) 141011 181011). Retrieved from http://www.rlpd.go.th/rlpdnew/images/rlpd_1/HRC/CERD%201_3.pdf
Community Organization Network on Disaster Management in Three Southern Provinces of Thailand and Natural Disaster Management Networks Nakhon Si Thammarat Province. (2011a). *Operation and Lesson Learned*. Thai Health Promotion Foundation. Nakhon Si Thammarat, Thailand.
Community Organization Network on Disaster Management in Three Southern Provinces of Thailand and Natural Disaster Management Networks Nakhon Si Thammarat Province. (2011b). *Tambon Na Tham Mueang Yala District Local Disaster Management Centre: Outstanding stories of natural disaster management by three southern provinces*. Thai Health Promotion Foundation. Nakhon Si Thammarat, Thailand.
Conigrave, K. M. and Lee, K. K. (2012). Smoking or alcohol dependence among indigenous Australians: Treatment may be needed, not just education. *Heart, Lung and Circulation, 21*(10), 626-631.
Connell, R. W. (1998). Masculinities and globalization. *Men and Masculinities, 1*(1), 3-23.
Connell, R. W. and Connell, R. (2005). *Masculinities* (2nd ed.): Cambridge, Polity Press; Sydney, Allen and Unwin; Berkeley, University of California Press.
Conrad, P. (1979). Types of medical social control. *Sociology of Health and Illness, 1*(1), 1-11.
Cooper, D. (1972). *Psychiatry and Anti-Psychiatry*. London: Paladin.
Cordain, L., Lindeberg, S., Hurtado, M., Hill, K., Eaton, S. B. and Brand-Miller, J. (2002). Acne vulgaris: a disease of Western civilization. *Archives of Dermatology, 138*(12), 1584-1590.
Cribb, R. (1990). *The Indonesian Killings of 1965-1966: Studies From Java and Bali*. Victoria, Australia: Centre of Southeast Asian Studies, Monash University Clayton.
Cribb, R. (2001). Genocide in Indonesia, 1965-1966. *Journal of Genocide Research, 3*(2), 219-239.
Cribb, R. and Coppel, C. A. (2009). A genocide that never was: explaining the myth of anti-Chinese massacres in Indonesia, 1965–66. *Journal of Genocide Research, 11*(4), 447-465.
Croissant, A. (2005). Unrest in South Thailand: contours, causes, and consequences since 2001. *Contemporary Southeast Asia*, 21-43.

Crossley, N. (1998). RD Laing and the British anti-psychiatry movement: a socio–historical analysis. *Social Science and Medicine, 47*(7), 877-889.

Cuny, F. C. (1983). *Disasters and Development* (S. Abrams Ed.). New York: Oxford University Press.

Curran, S. R. (2006). Research ethics are essential: Ethical consideration for research in cross-cultural settings. In E. Perecman and S. R. Curran (Eds.), *A Handbook for Social Science Field Research: Essays and Bibliographic Sources on Research Design and Methods* (pp. 197-216). California: Sage Publications.

Cutter, S. L. (1995). The forgotten casualties: Women, children, and environmental change. *Global Environmental Change, 5*(3), 181-194.

Czaika, M. and Kis-Katos, K. (2009). Civil conflict and displacement: Village-level determinants of forced migration in Aceh. *Journal of Peace Research, 46*(3), 399-418.

Dalgard, O. S. and Tambs, K. (1995). Social support, negative life events and mental health. *The British Journal of Psychiatry, 166*(1), 29-34.

Das, V. (2010). The empire of trauma: An inquiry into the condition of victimhood. By Didier Fassin and Richard Rechtman. Translated by Rachel Gomme. Princeton, NJ: Princeton University Press, 2009. Pp. 305. *American Journal of Sociology, 116*(2).

Delica, Z. G. (1998). Balancing vulnerability and capacity: Women and children in the Philippines. In E. Enarson and B. H. Morrow (Eds.), *The Gendered Terrain of Disaster: Through Women's Eyes*. Westport, CT: Praeger.

Denzin, N. K. and Lincoln, Y. S. (1994). *Handbook of Qualitative Research*: Sage Publications, Inc.

Department of Disaster Prevention and Mitigation, Ministery of Interior, Thailand (2018, May 29). Minister of Intertior Executive. Retrieved from http://www.disaster.go.th/th/about-about04/%E0%B8%9C%E0%B8%B9%E0%B9%89%E0%B8%9A%E0%B8%A3%E0%B8%B4%E0%B8%AB%E0%B8%B2%E0%B8%A3%E0%B8%81%E0%B8%B2%E0%B8%A3%E0%B9%80%E0%B8%A1%E0%B8%B7%E0%B8%AD%E0%B8%87

Derluyn, I., Broekaert, E., Schuyten, G. and De Temmerman, E. (2004). Post-traumatic stress in former Ugandan child soldiers. *The Lancet, 363*(9412), 861-863.

DeWalt, K. M. and DeWalt, B. R. (2011). *Participant Observation: A Guide For Fieldworkers*. Plymouth, UK: AltaMira Press A Division of Rowman and Littlefield Publishers, Inc.

Dexter, P. (2004). *Historical Analysis of Population Reactions to Stimuli-A Case Study of Aceh*. Retrieved from http://dspace.dsto.defence.gov.au/dspace/bitstream/1947/4094/1/DSTO-TR-1592%20PR.pdf

Dhuhri, S. (2016). Art as a cultural instrument: The role of Acehnese art in resolving horizontal conflict. *Journal Ilmiah Peuradeun*, 4(1), 89-102.DiCicco-Bloom, B. and Crabtree, B. F. (2006). The qualitative research interview. *Medical education, 40*(4), 314-321.

Dirkzwager, A. J., Bramsen, I., Adèr, H. and van der Ploeg, H. M. (2005). Secondary traumatization in partners and parents of Dutch peacekeeping soldiers. *Journal of Family Psychology, 19*(2), 217.

Double, D. (2002). The limits of psychiatry. *BMJ: British Medical Journal, 324*(7342), 900.

Downey, G. and Coyne, J. C. (1990). Children of depressed parents: An integrative review. *Psychological Bulletin, 108*(1), 50.

Drabek, T. E. (1970). Methodology of studying disasters: Past patterns and future possibilities. *American Behavioral Scientist, 13*(3), 331-343.

Drabek, T. E. and Stephenson, J. S. (1971). When disaster strikes. *Journal of Applied Social Psychology, 1*(2), 187-203.

Dressler, W. W. (1985). Extended family relationships, social support, and mental health in a southern black community. *Journal of Health and Social behavior*, 39-48.

Dube, L. (1997). *Women and Kinship: Comparative Perspectives on Gender in South and South-East Asia*. Tokyo: United Nations University Press.

Dube, S. R., Felitti, V. J., Dong, M., Chapman, D. P., Giles, W. H. and Anda, R. F. (2003). Childhood abuse, neglect, and household dysfunction and the risk of illicit drug use: The adverse childhood experiences study. *Pediatrics, 111*(3), 564-572.

DuBois, M. (2009). Protection: The new humanitarian fig-leaf. Paper presented at the conference P*rotecting People in Conflict and Crisis*, Refugee Studies Centre, Oxford University (22–24 September), http://www. rsc. ox. ac. uk/pdfs/endnotemarkdubois. pdf.

Dubos, R. (1969). The diseases of civilization. *The Milbank Memorial Fund Quarterly, 47*(3), 327-339.

Duraiappah, A. K. (1998). Poverty and environmental degradation: a review and analysis of the nexus. *World Development, 26*(12), 2169-2179.

Durkheim, E. (1952). *Suicide. A Study in Sociology* (J. A. Spaulding and G. Simpson, Trans. G. Simpson Ed.). New York: The Free Press.

Dynes, R. R. (1970). Interorganizational relations in communities under stress. In Quarantelli, E. L., *Disaster Theory and Research*. California: SAGE Publications Inc.

Ely, M. (1991). *Doing Qualitative Research: Circles Within Circles* (Vol. 3). London and New York: Routledge Falmer.

Calgaro, E. (2015). If you are vulnerable and you know it raise your hand: experiences from working in post-tsunami thailand. *Emotion, Space and Society*, 17, 45-54. doi:10.1016/j.emospa.2015.09.003

Enarson, E. (1998). Through women's eyes: A gendered research agenda for disaster social science. *Disasters, 22*(2), 157-173.

Engelbrecht, A. and Jobson, L. (2014). An investigation of trauma-associated appraisals and posttraumatic stress disorder in british and asian trauma survivors: The development of the public and communal self appraisals measure (PCSAM). *Springerplus*, 3(1), 1-18. doi:10.1186/2193-1801-3-44

Erikson, K. T. (1976). *Everything in its Path*. New York, NY: Simon and Schuster.

Etzioni, A. (1993). A socio-economic perspective on friction. *Institutional Change: Theory and Empirical Findings*, 47-60.

Falk, R. A. (2003). What future for the UN Charter system of war prevention? *American Journal of International Law, 97*(3), 590-598.

Fassin, D. and Rechtman, R. (2009). *The Empire of Trauma: An Inquiry Into the Condition of Victimhood*. Princeton, NJ: Princeton University Press.

Feldman, R. and Vengrober, A. (2011). Posttraumatic stress disorder in infants and young children exposed to war-related trauma. *Journal of the American Academy of Child and Adolescent Psychiatry, 50*(7), 645-658.

Felten-Biermann, C. (2006). Gender and natural disaster: Sexualized violence and the tsunami. *Development, 49*(3), 82-86.

Finkelhor, D. (2009). *Children's Exposure to Violence: A Comprehensive National Survey*. Couverture: DIANE Publishing.

Finkelhor, D., Ormrod, R. K. and Turner, H. A. (2007). Poly-victimization: A neglected component in child victimization. *Child Abuse and Neglect, 31*(1), 7-26.

Fontana, A. and Frey, J. (1994). The art of science. In N. a. Y. L. Denzin (Ed.), *The Handbook of Qualitative Research* (pp. 361-376). Thousand Oaks: Sage Publications.

Foucault, M. (1988). *Madness and Civilization: A History of Insanity in the Age of Reason* (R. Howard, Trans.). New York, NY: Vintage.

Foxnews World. (2014). *Strong Earthquake Shakes Northern Thailand, Myanmar*. Retrieved from http://www.foxnews.com/world/2014/05/05/strong-earthquake-shakes-northern-thailand-myanmar.html

Freidson, E. (1962). The sociology of medicine. *Current Sociology, 11*(3), 123-140.

Fritz, C. E. and Williams, H. B. (1957). The human being in disasters: A research perspective. *The ANNALS of the American Academy of Political and Social Science, 309*(1), 42-51.

Fritz, C. E. (1996). Disasters and mental health: Therapeutic principles drawn from disaster studies. Historical and Comparative Disaster Series #10, University of Delaware, Disaster Research Center.

Gaillard, J.-C. (2010). Vulnerability, capacity and resilience: Perspectives for climate and development policy. *Journal of International Development, 22*(2), 218-232.

Galovski, T. and Lyons, J. A. (2004). Psychological sequelae of combat violence: A review of the impact of PTSD on the veteran's family and possible interventions. *Aggression and Violent Behavior, 9*(5), 477-501.

Garbarino, J., Dubrow, N., Kostelny, K. and Pardo, C. (1992). *Children in Danger: Coping With the Consequences of Community Violence*. San Francisco: Jossey-Bass.

Garzoni, C., Emonet, S. P., Legout, L., Rilliet, B., Hoffmeyer, P., Bernard, L. and Garbino, J. (2005). Atypical infections in tsunami survivors. *Emerging Infectious Diseases, 11*(10), 1591-1593.

Gäbler, I., and Maercker, A. (2011). Revenge after trauma: Theoretical outline. In *Embitterment* (pp. 42-69). Springer, Vienna.

Giddens, A. (1993). *New Rules of Sociological Method: A Positive Critique of Interpretative Sociologies* (2nd ed.). Cambridge: Polity Press.

Gilbert, C. (1998). Studying disaster: Changes in the main conceptual tools. *What is a Disaster*, 11-18.

Gill, D. A. (2007). Secondary trauma or secondary disaster? Insights from Hurricane Katrina. *Sociological Spectrum, 27*(6), 613-632.

Gill, D. A. and Picou, J. S. (1991). The social psychological impacts of a technological accident: Collective stress and perceived health risks. *Journal of Hazardous Materials, 27*(1), 77-89.

Goddard, J. L. (1973). The medical business. *Scientific American, 229*(3), 161-166.

Goldstein, R. D., Wampler, N. S. and Wise, P. H. (1997). War experiences and distress symptoms of Bosnian children. *Pediatrics, 100*(5), 873-878.

Good, B. J., Good, M.-J., Grayman, J. and Lakoma, M. (2006). *Psychosocial Needs Assessment of Communities Affected by the Conflicts in the Districts of Pidië, Biereuen, and Aceh Utara*. Retrieved from https://scholar.harvard.edu/files/maryjo_good/files/good_m_pna1.pdf

Goodman, L. A. and Fallot, R. D. (1998). HIV risk-behavior in poor urban women with serious mental disorders: Association with childhood physical and sexual abuse. *American Journal of Orthopsychiatry, 68*(1), 73.

Goudy, W. J. and Potter, H. R. (1975). Interview rapport: Demise of a concept. *The Public Opinion Quarterly, 39*(4), 529-543.

Grant, H. (2015). UN agencies 'broke and failing'in face of ever-growing refugee crisis. *The Guardian, 6*.

Green, B. L., Korol, M., Grace, M. C., Vary, M. G., Leonard, A. C., Gleser, G. C. and Smitson-Cohen, S. (1991). Children and disaster: Age, gender, and parental effects on PTSD symptoms. *Journal of the American Academy of Child and Adolescent Psychiatry, 30*(6), 945-951.

Griswold, A. and Na Nagara, P. (1971). The Inscription of King Rama Gamhen of Sukhodaya (1292 AD). *Journal of the Siam Society, 59*(2), 208.

Habermas, J. (1975). *Legitimation Crisis* (T. McCarthy, Trans. Vol. 519). London: Heinemann.

Halbwachs, M. (1992). *On Collective Memory* (L. A. Coser, Trans.). Chicago and London: University of Chicago Press.

Haraguchi, M. and Lall, U. (2015). Flood risks and impacts: A case study of Thailand's floods in 2011 and research questions for supply chain decision making. *International Journal of Disaster Risk Reduction, 14*, 256-272.

Harrell, M. C. and Bradley, M. A. (2009). *Data Collection Methods. Semi-Structured Interviews and Focus Groups*. Santa Monica, CA: RAND Corporation.

Hasamoh, A. (2008). Reginalism and Inter-Ethnic Relations: The Case of the Acehnese in Indonesia *Are We Up to the Challenge?: Current Crises and the Asian Intellectual Community*. Abeno Printing Co., Ltd: The Nippon Foundation.

Herod, A. (1993). Gender Issues in the Use of Interviewing as a Research Method. *The Professional Geographer, 45*(3), 305-317.
Hiransuthikul, N., Tantisiriwat, W., Lertutsahakul, K., Vibhagool, A. and Boonma, P. (2005). Skin and soft-tissue infections among tsunami survivors in southern Thailand. *Clinical Infectious Diseases, 41*(10), e93-e96.
Holt, S., Buckley, H. and Whelan, S. (2008). The impact of exposure to domestic violence on children and young people: A review of the literature. *Child Abuse and Neglect, 32*(8), 797-810.
Horton, J. (1964). The dehumanization of anomie and alienation: A problem in the ideology of sociology. *The British Journal of Sociology, 15*(4), 283-300.
House, J. S., Landis, K. R. and Umberson, D. (1988). Social relationships and health. *Science, 241*(4865), 540.
Hughes, D. (2004). An attachment-based treatment of maltreated children and young people. *Attachment and Human Development, 6*(3), 263-278. doi:10.1080/14616730412331281539
Hull, H. G. (2008). Electroconvulsive therapy: Baby Boomers may be in for the shock of their lives. *University of Louisville Law Review, 47*(1), 38.
Hunter, B. (2000). *Social Exclusion, Social Capital, and Indigenous Australians: Measuring the Social Costs of Unemployment*. Canberra: Centre for Aboriginal Economic Policy Research.
Huntington, S. P. (1971). The change to change: Modernization, development, and politics. *Comparative Politics, 3*(3), 283-322.
Ingram, J. C., Franco, G., Rumbaitis-del Rio, C. and Khazai, B. (2006). Post-disaster recovery dilemmas: Challenges in balancing short-term and long-term needs for vulnerability reduction. *Environmental Science and Policy, 9*(7), 607-613. doi:10.1016/j.envsci.2006.07.006
Inter-agency Secretariat of the International Strategy for Disaster Reduction (UN/ISDR). (2005). 10 preliminary lessons learned from the Indian Ocean tsunami of 26 December 2004 Retrieved from http://www.unisdr.org/files/5605_ISDR10lessonslearned.pdf
Internal Displacement Monitoring Centre. (2011). *Buddhist Minority Declines the 'Deep South' Due to Protracted Armed Conflict*. Retrieved from http://www.internal-displacement.org/south-and-south-east-asia/thailand/2011/buddhist-minority-declines-the-deep-south-due-to-protracted-armed-conflict
International Crisis Group. (2007). *Aceh: Post-Cconflict Complications*. Retrieved from Jakarta/Brussels: https://d2071andvip0wj.cloudfront.net/139-aceh-post-conflict-complications.pdf
International Displacement Monitoring Centre. (2011). Buddhist minority declines the 'deep south' due to protracted armed conflict. *South and South-East Asia Thailand 2011*. Retrieved from http://www.internal-displacement.org/south-and-south-east-asia/thailand/2011/buddhist-minority-declines-the-deep-south-due-to-protracted-armed-conflict website: http://www.internal-displacement.org/south-and-south-east-asia/thailand/2011/buddhist-minority-declines-the-deep-south-due-to-protracted-armed-conflict
interview. (2013).
Jacobs, J. (2008). Gender and collective memory: Women and representation at Auschwitz. *Memory Studies, 1*(2), 211-225. doi:10.1177/1750698007088387
Jacobs, N. (1971). *Modernization Without Development*: New York, USA: Praeger Publishers; London, UK: Pall Mall Press.
Jacobson, S., Fasman, J. and DiMascio, A. (1975). Deprivation in the childhood of depressed women. *The Journal of Nervous and Mental Disease, 160*(1), 5-14.
James, H., Ball, J. and Benthaus, S. (2005). Thai tsunami victim identification overview to date. *Journal of Forensic Odonto-Stomatoly, 23*(1), 1-18.
Janik, J. and Kravitz, H. M. (1994). Linking work and domestic problems with police suicide. *Suicide and Life-Threatening Behavior, 24*(3), 267-274.

Jayasuriya, S. K., and McCawley, P. (2010). *The Asian Tsunami: Aid and Reconstruction After a Disaster*. Cheltenham, UK and Northampton, MA, USA: The Asian Development Bank Institute and Edward Elgar Publishing.

Jeney-Gammon, P., Daugherty, T. K., Finch Jr, A., Belter, R. W. and Foster, K. Y. (1993). Children's coping styles and report of depressive symptoms following a natural disaster. *The Journal of Genetic Psychology, 154*(2), 259-267. doi:10.1080/00221325.1993.9914739

Jensen, P. S. and Shaw, J. (1993). Children as victims of war: Current knowledge and future research needs. *Journal of the American Academy of Child and Adolescent Psychiatry, 32*(4), 697-708. doi:10.1097/00004583-199307000-00001

Jitmahantakul, S. (2012, May 21). แผ่นดินไหวภูเก็ต 16 เมษายน 2555 [Phuket earthquake 16 April 2012]. Retrieved from http://www.geothai.net/2012-phuket-earthquake/

Jitpiromsri, S. and Watch, D. S. (2011). *The Protacted Violence Amidst the Unstable Political Situation After 2011 Elections*. Deep South Watch Center for Conflict Studies and Cultural Diversity. Retrieved from https://www.deepsouthwatch.org/sites/default/files/92_Analysis__eng_.pdf

Johnson, L. J. and Travis, A. R. (2006). Trimidal Death and the Injuries of Survivors in Krabi Province, Thailand, Post-Tsunami. *ANZ Journal of Surgery, 76*(5), 288-289.

Jobson, L., and O'Kearney, R. (2008). Cultural differences in personal identity in post-traumatic stress disorder. *The British Journal of Clinical Psychology*, 47(Pt 1), 95-109. doi:10.1348/014466507X235953

Kaniasty, K. and Norris, F. H. (1993). A test of the social support deterioration model in the context of natural disaster. *Journal of Personality and Social Psychology, 64*(3), 395. doi:10.1037/0022-3514.64.3.395

Kawachi, I. and Berkman, L. F. (2001). Social ties and mental health. *Journal of Urban health, 78*(3), 458-467.

Kenardy, J., Le Brocque, R., March, S. and De Young, A. (2010). *How Children and Young People Experience and React to Traumatic Events*. Australian Child and Adolescent Trauma, Loss and Grief Network. Retrieved from http://earlytraumagrief.anu.edu.au/files/ACATLGN_TraumaResources_Booklet_D1%282%29.pdf

Kenny, S., Clarke, M., Fanany, I. and Kingsbury, D. (2010). *Deconstructing Aceh's reconstruction* ([Ebrary version] ed.). London, England: Earthscan.

Keyes, C. F. (1995). Who are the Tai? Reflections on the Invention of Identities. In Lola Romanucci-Ross and G. A. D. Vos (Eds.), *Ethnic identity: Creation, Conflict, and Accommodation* (3 ed., pp. 136-160). Walnut Creek, Calif: Altamira Press.

Khondker, H. H. (2002). Problems and prospects of disaster research in the developing world: A case study of Bangladesh. *Methods of Disaster Research.* Xlibris Corporation, Philadelphia, 524.

Killian, L. M. (1956). *An Introduction to Methodological Problems of Field Studies in Disasters*. Washington: National Academy of Sciences National Research Council.

King, L. A., King, D. W., Fairbank, J. A., Keane, T. M. and Adams, G. A. (1998). Resilience–recovery factors in post-traumatic stress disorder among female and male Vietnam veterans: Hardiness, postwar social support, and additional stressful life events. *Journal of Personality and Social Psychology, 74*(2), 420.

Kinzie, J. D., Sack, W. H., Angell, R. H., Manson, S. and Rath, B. (1986). The psychiatric effects of massive trauma on Cambodian children: I. The children. *Journal of the American Academy of Child Psychiatry, 25*(3), 370-376.

Kirk, J. and Miller, M. L. (1986). *Reliability and Validity in Qualitative Research*: Sage.

Kirmayer, L. J. (1996). Landscapes of memory: Trauma, narrative, and dissociation. *Tense Past: Cultural Essays in Trauma and Memory*, 173-198.

Kiser, L. J. and Black, M. M. (2005). Family processes in the midst of urban poverty: What does the trauma literature tell us? *Aggression and Violent Behavior, 10*(6), 715-750. doi:10.1016/j.avb.2005.02.003

Kleinman, A., Das, V. and Lock, M. M. (1997). *Social suffering*. Berkeley: University of California Press.

Korf, B. (2007). Antinomies of generosity: Moral geographies and post-tsunami aid in Southeast Asia. *Geoforum*, *38*(2), 366-378.

Krairiksh, P. (1991). Towards a revised history of Sukhothai art: A reassessment of the inscription of King Ram Khamhaeng. In J. R. Chamberlain (Ed.), *The Ram Khamhaeng Controversy: Collected Papers*. Bangkok: The Siam Society.

Kristensen, P., Weisæth, L., Hussain, A. and Heir, T. (2015). Prevalence of psychiatric disorders and functional impairment after loss of a family member: A longitudinal study after the 2004 Tsunami. *Depression and Anxiety, 32*(1), 49-56. doi:10.1002/da.22269

Kuning, M., Eso, M., Sornsrivichai, V. and Chongsuvivatwong, V. (2014). *Healing Under Fire: The Case of Southern Thailand* V. Chongsuvivatwong, L. C. Boegli and S. Hasuwannakit (Eds.), *Epidemiology of the Violence in the Deep South* (pp. 41-48). Retrieved from http://dsrd.pn.psu.ac.th/webnew/images/healing.pdf

Kupersmidt, J. B., Shahinfar, A. and Voegler-Lee, M. E. (2002). Children's exposure to community violence. In A. M. La Greca, W. K. Silverman, E. M. Vernberg and M. C. Roberts (Eds.), *Helping Children Cope With Disasters and Terrorism* (pp. 381-401). Washington, DC, US: American Psychological Association.

Laing, R. D. (1990). *The Politics of Experience and the Bird of Paradise*. London UK: Penguin Book.

Laing, R. D. and Esterson, A. (2016). *Sanity, Madness and the Family*. London and New York: Routledge.

Lamb, K. (2014). Banda Aceh: where community spirit has gone but peace has lasted. *theguardian.* Retrieved from https://www.theguardian.com/cities/2014/jan/27/banda-aceh-community-spirit-peace-indonesia-tsunami

Landis, J. T. (1960). The trauma of children when parents divorce. *Marriage and Family Living, 22*(1), 7-13. doi:10.2307/347395

Lang, G. (2002). Deforestation, floods, and state reactions in China and Thailand. In A. Mol and F. Buttel (Eds.), *The Environmental State under Pressure* (pp. 195-220). Amsterdam: Elsevier/JAI.

Lawrence, D., Johnson, S., Hafekost, J., de Haan, K. B., Sawyer, M., Ainley, J. and Zubrick, S. R. (2015). *The Mental Health of Children and Adolescents: Report on the Second Australian Child and Adolescent Survey of Mental Health and Wellbeing*. Retrieved from http://www.health.gov.au/internet/main/publishing.nsf/Content/9DA8CA21306FE6EDCA257E2700016945/$File/child2.pdf

Lee, T. C., Lin, Y. S., Chiang, C. H., and Wu, M. H. (2013). Dance/movement therapy for children suffering from earthquake trauma in Taiwan: A preliminary exploration. *The Arts in Psychotherapy*, 40(1), 151-157.

Lerias, D., and Byrne, M. K. (2003). Vicarious traumatization: Symptoms and predictors. *Stress and Health: Journal of the International Society for the Investigation of Stress*, *19*(3), 129-138.

Levy, J. K. and Gopalakrishnan, C. (2005). Promoting disaster-resilient communities: The Great Sumatra–Andaman earthquake of 26 December 2004 and the resulting Indian Ocean tsunami. *Water Resources Development, 21*(4), 543-559. doi:10.1080/07900620500363297

Li, T. M. (2002). Ethnic cleansing, recursive knowledge, and the dilemmas of sedentarism. *International Social Science Journal, 54*(173), 361-371. doi:10.1111/1468-2451.00388

Liebenberg, L. (2009). The visual image as discussion point: Increasing validity in boundary crossing research. *Qualitative Research, 9*(4), 441-467.

Liew, S. C., Gupta, A., Wong, P. P. and Kwoh, L. K. (2010). Recovery from a large tsunami mapped over time: The Aceh coast, Sumatra. *Geomorphology, 114*(4), 520-529. doi:10.1016/j.geomorph.2009.08.010

Lindblad, J. T. (1989a). Economic aspects of the Dutch Expansion in Indonesia, 1870–1914. *Modern Asian Studies, 23*(01), 1-24. doi:10.1017/S0026749X00011392

Lindblad, J. T. (1989b). The petroleum industry in Indonesia before the Second World War. *Bulletin of Indonesian Economic Studies, 25*(2), 53-77. doi:10.1080/00074918812331335569

Lindell, M. K. and Prater, C. S. (2003). Assessing community impacts of natural disasters. *Natural Hazards Review, 4*(4), 176-185. doi:10.1061/(ASCE)1527-6988(2003)4:4(176)

Lindgaard, C. V., Iglebaek, T. and Jensen, T. K. (2009). Changes in family functioning in the aftermath of a natural disaster: The 2004 tsunami in Southeast Asia. *Journal of Loss and Trauma, 14*(2), 101-116. doi:10.1080/15325020802537138

Liss, C. (2007). *The Roots of Piracy in Southeast Asia*. Retrieved from https://nautilus.org/apsnet/the-roots-of-piracy-in-southeast-asia/

López, C. M., Andrews,Arthur R., I.,II, Chisolm, A. M., de Arellano, M. A., Saunders, B., and Kilpatrick, D. G. (2017). Racial/ethnic differences in trauma exposure and mental health disorders in adolescents. *Cultural Diversity and Ethnic Minority Psychology*, 23(3), 382-387. doi:http://dx.doi.org.elibrary.jcu.edu.au/10.1037/cdp0000126

Luecken, L. J., Rodriguez, A. P. and Appelhans, B. M. (2005). Cardiovascular stress responses in young adulthood associated with family-of-origin relationship experiences. *Psychosomatic Medicine, 67*(4), 514-521. doi:10.1097/01.psy.0000160466.10397.18

Luttrell, W. and Chalfen, R. (2010). Lifting up voices of participatory visual research. *Visual studies, 25*(3), 197-200. doi:10.1080/1472586X.2010.523270

Mabbett, I. W. (1977). The 'Indianization'of Southeast Asia: Reflections on the historical sources. *Journal of Southeast Asian Studies, 8*(02), 143-161.

MacDonald, R. (2005). How women were affected by the tsunami: A perspective from Oxfam. *PLoS Med, 2*(6), e178.

Machel, G., Salgado, -., Sebasti o, Klot, J. F., Sowa, T. and UNICEF. (2001). *The Impact of War on Children: A Review of Progress Since the 1996 United Nations Report on the Impact of Armed Conflict on Children*. Hurst: London.

Macksoud, M. S. and Aber, J. L. (1996). The war experiences and psychosocial development of children in Lebanon. *Child Development, 67*(1), 70-88.

Malinowski, B. (1930). 17. Kinship. *Man, 30*, 19-29.

Margolin, G. and Gordis, E. B. (2004). Children's exposure to violence in the family and community. *Current Directions in Psychological Science, 13*(4), 152-155.

Maruyama, M. (1996). Post-totalitarian deconversion trauma. *Human Systems Management, 15*(2), 135.

Maxwell, J. (1992). Understanding and validity in qualitative research. *Harvard Educational Review, 62*(3), 279-301.

McCargo, D. (2009). The Politics of Buddhist identity in Thailand's deep south: The Demise of civil religion. *Journal of Southeast Asian Studies, 40*(1), 11-32. doi:10.1017/S002246340900002

McCargo, D. (2015). *Tearing Apart the Land: Islam and legitimacy in Southern Thailand*. (n.p.): Cornell University Press.

McCarthy, J. F. (2007). The demonstration effect: Natural resources, ethnonationalism and the Aceh conflict. *Singapore Journal of Tropical Geography, 28*(3), 314-333. doi:10.1111/j.1467-9493.2007.00304.x

McCracken, G. (1988). *The Long Interview* (Vol. 13): Sage.

McLeod, M., Slavich, P., Irhas, Y., Moore, N., Rachman, A., Ali, N., Iskandar, T., Hunt, C., Caniago, C. (2010). Soil salinity in Aceh after the December 2004 Indian Ocean tsunami. *Agricultural Water Management, 97*(5), 605-613. doi:10.1016/j.agwat.2009.10.014

Medway, F. J., Davis, K. E., Cafferty, T. P., Chappell, K. D. and O'Hearn, R. E. (1995). Family disruption and adult attachment correlates of spouse and child reactions to separation and reunion due to Operation Desert Storm. *Journal of Social and Clinical Psychology, 14*(2), 97-118.

Meltzer, H., Gatward, R., Goodman, R. and Ford, T. (2000). *The mental health of children and adolescents in Great Britain*. London: The Stationery Office.

Melvin, J. (2013). Why Not Genocide? Anti-Chinese Violence in Aceh, 1965–1966. *Journal of Current Southeast Asian Affairs, 32*(3), 63-91. Memorandum of Understanding between the Government of the Republic of Indonesia and the Free Aceh Movement. (n.d.). Retrieved from *http://www.acehpeaceprocess.net/pdf/mou_final.pdf*

Mendenhall, T. J. and Berge, J. M. (2010). Family therapists in trauma-response teams: Bringing systems thinking into interdisciplinary fieldwork. *Journal of Family Therapy, 32*(1), 43-57.

Meštrović, S. and Glassner, B. (1983). A Durkheimian hypothesis on stress. *Social Science and Medicine, 17*(18), 1315-1327.

Meštrović, S. G. (1985). A sociological conceptualization of trauma. *Social Science and Medicine, 21*(8), 835-848. doi:10.1016/0277-9536(85)90139-X

Meyer, I. H. (1995). Minority stress and mental health in gay men. *Journal of Health and Social Behavior, 36*(1), 38-56.

Michalos, A. C. (2014). *Encyclopedia of Quality of Life and Well-Being Research*. Dordrecht, Netherlands: Springer.

Ministry of Labour. (2017). Important Labour information August 2017. Retrieved from http://www.mol.go.th/sites/default/files/downloads/pdf/10._khmuulsamkhay_s.kh_.60.doc.pdf

Mitchell, J. K. (1989). *Hazards Research*. Columbus, OH: Merrill Publishing Company.

Mitchell, J. K., Devine, N. and Jagger, K. (1989). A contextual model of natural hazard. *Geographical Rreview*, 391-409. doi:10.2307/215114

Moniruzzaman, M. (2010). "The ripples changed our lives": Health in post-tsunami Thailand. *Disaster Prevention and Management: An International Journal, 19*(3), 333-344.

Morgan, L., Scourfield, J., Williams, D., Jasper, A. and Lewis, G. (2003). The Aberfan disaster: 33-year follow-up of survivors. *The British Journal of Psychiatry, 182*(6), 532-536. doi:10.1192/bjp.182.6.532

Myers, M. (1994). 'Women and children first' Introducing a gender strategy into disaster preparedness. *Gender and Development, 2*(1), 14-16.

Nash, W. P. and Litz, B. T. (2013). Moral injury: A mechanism for war-related psychological trauma in military family members. *Clinical Child and Family Psychology Review, 16*(4), 365-375.

National Health and Medical Research Council. (2007). National Statement on Ethical Conduct in Human Research (2007) (Updated May 2015). Retrieved from https://www.nhmrc.gov.au/guidelines-publications/e72

National Health and Medical Research Council, Australian Research Council and Australian Vice - Chancellors' Committee. (2007). *National Statement on Ethical Conduct in Human Research 2007 (Updated May 2015)*. Retrieved from National Health and Medical Research Council: https://www.nhmrc.gov.au/_files_nhmrc/publications/attachments/e72_national_statement_may_2015_150514_a.pdf

National Reconciliation Commission. (2006). *Report of the National Reconciliation Commission (NRC): Overcoming Violence through the Power of Reconciliation*. Retrieved from http://thailand.ahrchk.net/docs/nrc_report_en.pdf

National Statistical Office. (1995). *The Marine Fisheries Census*. Retrieved from http://web.nso.go.th/en/census/marfish/cen_marfish95.htm

National Statistical Office. (2003). *2003 Agricultural Census Southern Region*. Retrieved from http://web.nso.go.th/eng/agriculture/agri_south.pdf

National Statistical Office. (2014). *Business Trade and Services Survey*. Retrieved from http://web.nso.go.th/en/survey/bts/bts_a_total2014.htm

Neal, A. G. (1998). *National trauma and collective memory: Major events in the American century*. Armonk, NY: M.E. Sharpe.

Nettleton, S. (2006). *The Sociology of Health and Illness* (2nd ed.). Cambridge, UK.: Polity Press.

Neuner, F., Schauer, E., Catani, C., Ruf, M. and Elbert, T. (2006). Post-tsunami stress: A study of posttraumatic stress disorder in children living in three severely affected regions in Sri Lanka. *Journal of Traumatic Stress, 19*(3), 339-347.

Newman, E. and Kaloupek, D. (2009). Overview of research addressing ethical dimensions of participation in traumatic stress studies: Autonomy and beneficence. *Journal of Traumatic Stress, 22*(6), 595-602.

Newman, T. and Blackburn, S. (2002). *Transitions in the Lives of Children and Young People: Resilience Factors* (0969-613X). Retrieved from http://files.eric.ed.gov/fulltext/ED472541.pdf

Norris, F. H. (2006). Disaster research methods: Past progress and future directions. *Journal of Traumatic Stress, 19*(2), 173-184. doi:10.1002/jts.20109

Norris, F. H., Friedman, M. J., Watson, P. J., Byrne, C. M., Diaz, E. and Kaniasty, K. (2002). 60,000 disaster victims speak: Part I. An empirical review of the empirical literature, 1981–2001. *Psychiatry: Interpersonal and Biological Processes, 65*(3), 207-239.

Norris, F. H., Perilla, J. L., Riad, J. K., Kaniasty, K., and Lavizzo, E. A. (1999). Stability and change in stress, resources, and psychological distress following natural disaster: Findings from Hurricane Andrew. *Anxiety, Stress and Coping*, *12*(4), 363-396

Norris, F. H., Galea, S., Friedman, M.J. and Watson, P. J. (Ed.) (2006). *Methods for Disaster Mental Health Research*. New York, NY: Guilford Press.

Noy, I. (2009). The macroeconomic consequences of disasters. *Journal of Development economics*, *88*(2), 221-231.

Nunan, D. (1992). *Research Methods in Language Learning*. New York: Cambridge University Press.

Ogburn, W. F. (1957). Cultural lag as theory. *Sociology and Social Research, 41*(3), 167-174.

Orcutt, J. D. (1976). Ideological variations in the structure of deviant types: A multivariate comparison of alcoholism and heroin addiction. *Social Forces, 55*(2), 419-437. doi:10.2307/2576233

Osofsky, J. D. (1995). The effect of exposure to violence on young children. *American Psychologist, 50*(9), 782.

Øyen, E. (2004). Living with imperfect comparisons. In P. Kennett (Ed.), *A Handbook of Comparative Social Policy*. Cheltemham, UK; Northampton, MA, USA: Edward Elgar Publishing.

Pananont, P., Herman, M., Pornsopin, P., Furlong, K., Habangkaem, S., Waldhauser, F., Wongwai, W., Limpisawad, S., Warnitchai, P., Kosuwan, S. and Wechbunthung, B. (2017). Seismo-Tectonics of the 2014 Chiang Rai, Thailand, Earthquake Sequence. *Journal of Geophysical Research: Solid Earth*. doi:10.1002/2017JB014085.

Paris, R., Wassmer, P., Sartohadi, J., Lavigne, F., Barthomeuf, B., Desgages, E., Grancher, D., Baumert, P., Vautier, F., Brunstein, D. and Gomez, C. (2009). Tsunamis as geomorphic crises: lessons from the December 26, 2004 tsunami in Lhok Nga, west Banda Aceh (Sumatra, Indonesia). *Geomorphology*, *104*(1-2), 59-72.

Patcharakanokkul, S. (2010). *Rethinking Strategy Policy of Counter Insurgency in Southern Thailand*. Retrieved from Defense Technical Information Center: http://www.dtic.mil/docs/citations/ADA518347

Peacock, W. G. (1997). Cross-national and comparative disaster research. *International Journal of Mass Emergencies and Disasters, 15*(1), 117-133.

Peek, L. (2008). Children and disasters: Understanding vulnerability, developing capacities, and promoting resilience—an introduction. *Children Youth and Environments, 18*(1), 1-29.

Peek, L. and Stough, L. M. (2010). Children with disabilities in the context of disaster: A social vulnerability perspective. *Child Development, 81*(4), 1260-1270.

Person, C. and Fuller, E. J. (2007). Disaster Care for Persons With Psychiatric Disabilities Recommendations for Policy Change. *Journal of Disability Policy Studies, 17*(4), 238-248. doi:10.1177/10442073070170040701

Perry, R. W., and Quarantelli, E. L. (Eds.) (2005). What is a disaster?: New answers to old questions. Philadelphia, PA: Xlibris Corporation.

Peterson, Y. (1979). The impact of physical disability on marital adjustment: A literature review. *Family Coordinator, 28*(1), 47-51.

Pfefferbaum, B., Weems, C. F., Scott, B. G., Nitiéma, P., Noffsinger, M. A., Pfefferbaum, R. L., Varma, V. and Chakraburtty, A. (2013). Research methods in child disaster studies: A review of studies generated by the September 11, 2001, terrorist attacks; the 2004 Indian Ocean tsunami; and Hurricane Katrina. *Child and Youth Care Forum, 42*(4), 285-337. doi:10.1007/s10566-013-9211-4

Phillips, D. L. (1964). Rejection of the mentally ill: The influence of behavior and sex. *American Sociological Review*, 679-687.

Phillips, B. D. (2003). Qualitative methods and disaster research. *International Journal of Mass Emergencies and Disasters*, 15(1), 179-195. In Stallings, R. A. (Ed.) (2003). *Methods of Disaster Research*: Xlibris Corporation.

Picou, J. S., Marshall, B. K. and Gill, D. A. (2004). Disaster, litigation, and the corrosive community. *Social Forces, 82*(4), 1493-1522. doi:10.1353/sof.2004.0091

Pikoulis, E. A., Petropoulos, J. C., Tsigris, C., Pikoulis, N., Leppäniemi, A. K., Pavlakis, E., Gavrielatou, E., Burris, D., Bastounis, E. and Rich, N. M. (2004). Trauma management in ancient Greece: Value of surgical principles through the years. *World Journal of Surgery, 28*(4), 425-430. doi:10.1007/s00268-003-6931-x

Pini, B. (2005). Interviewing men: Gender and the collection and interpretation of qualitative data. *Journal of Sociology, 41*(2), 201-216.

Pittaway, E., Bartolomei, L. and Rees, S. (2007). Gendered dimensions of the 2004 tsunami and a potential social work response in post-disaster situations. *International Social Work, 50*(3), 307-319. doi:10.1177/0020872807076042

Piyasil, V., Ketuman, P., Plubrukarn, R., Jotipanut, V., Tanprasert, S., Aowjinda, S. and Thaeeromanophap, S. (2007). Post traumatic stress disorder in children after tsunami disaster in Thailand: 2 years follow-up. *Journal of the Medical Association of Thailand, 90*(11), 2370.

Piyasil, V., Ketumarn, P., Prubrukarn, R., Pacharakaew, S., Dumrongphol, H., Rungsri, S., Sitdhiraksa, N., Pitthayaratsathien, N., Prasertvit, J., Sudto, K., Theerawongseree, S., Aowjinda, S., Thaeramanophab, S., Jotipanu, V. and Chatchavalitsakul, W. (2008). Psychiatric disorders in children at one year after the tsunami disaster in Thailand. *Journal of the Medical Association of Thailand, 91*(Suppl 3), S15-S20.

Polkinghorne, D. E. (2005). Language and meaning: Data collection in qualitative research. *Journal of Counseling Psychology, 52*(2), 137.

Pongsudhirak, T. (2009). The Malay-Muslim insurgency in Southern Thailand. In A. T. H. Tan (Ed.), *A Handbook of Terrorism and Insurgency in Southeast Asia* (pp. 266-278). Cheltenham, UK; Northampton, MA, USA: Edward Elgar Publishing.

Potigavin, N. (1992). *The 1988= mil novecientos ochenta y ocho landslide in southern of Thailand [The 1988 landslide in southern of Thailand]*. Paper presented at the Seminar in Technology for Disaster Prevention, 16, Japan.

Prasithrathsint, A. (1997). The emergence and development of abstract nominalization in standard Thai. *Southeast Asian Linguistic Studies in Honour of Vichin Panupong*, 179-190.

Prasithrathsint, A. (2006). Development of the thùuk passive marker in Thai. In Michael Noonan and L. Leisiö (Eds.), *Passivization and Typology: Form and Function* (Vol. 68, pp. 115-131). Amsterdam, John Benjamins Publishing Co.; Philadelphia, John Benjamins North America: John Benjamins Publishing Company.

Premsrirat, S. (2004). *Ethnolinguistic Maps of Thailand*. Bangkok, Thailand: Committee of Cultural Commission of Thailand.

Pronczuk-Garbino, J. (2007). Children's health and the environment. A global perspective. *Int J Public Health, 52*, 67-68. doi:10.1007/s00038-006-6100-8

Punch, S. (2002). Research with children: The same or different from research with adults?. *Childhood*, *9*(3), 321-341.

Pynoos, R. S. and Nader, K. (1990). Children's exposure to violence and traumatic death. *Psychiatric Annals, 20*(6), 334-344. doi:10.3928/0048-5713-19900601-11

Pynoos, R. S., Steinberg, A. M. and Piacentini, J. C. (1999). A developmental psychopathology model of childhood traumatic stress and intersection with anxiety disorders. *Biological Psychiatry, 46*(11), 1542-1554. doi:10.1016/S0006-3223(99)00262-0

Quarantelli, E. L. (1978). Some basic themes in sociological studies of disasters. In E. L. Quarantelli (Ed.), *Disasters: Theory and Research* (pp. 1-14). Oxford, England: Sage.

Quarantelli, E. L. (1987). Disaster studies: An analysis of the social historical factors affecting the development of research in the area. *International Journal of of Mass Emergencies and Disasters, 5*(3), 205-310.

Quarantelli, E. L. and Dynes, R. R. (1977). Response to social crisis and disaster. *Annual Review of Sociology*, 23-49.

Quarantelli, E. L. (2005). A social science research agenda for the disaster of the 21st century: Theoretical methological and empirical issue and their professional implementation. In Perry, R. W., and Quarantelli, E. L. (Eds.) (2005). *What is a Disaster? New Answers To Old Questions*. Philadelphia, PA: Xlibris Corporation.

Rabalais, A. E., Ruggiero, K. J. and Scotti, J. R. (2002). Multicultural issues in the response of children to disasters. *Helping Children Cope With Disasters and Terrorism*, 73-99.

Ravich, S. F. (2000). Eyeing Indonesia through the lens of Aceh. *Washington Quarterly, 23*(3), 5-20. doi:10.1162/016366000560999

Reid, A. (1980). The structure of cities in Southeast Asia, fifteenth to seventeenth centuries. *Journal of Southeast Asian Studies, 11*(2), 235-250.

Reid, A. (1990). An 'Age of Commerce'in Southeast Asian History. *Modern Asian Studies, 24*(01), 1-30.

Reid, A. (1993). *Southeast Asia in the Age of Commerce, 1450-1680: Expansion and crisis* (Vol. 2): Yale University Press.

Reid, A. (2004). War, peace and the burden of history in Aceh. *Asian Ethnicity, 5*(3), 301-314.

Rentea, A. (2009). *The Nature and Treatment of Trauma*. Retrieved from http://www.healingeducation.org/uploads/2/1/6/7/21671438/trauma.pdf

Resick, P. A. (2001). *Stress and Trauma*. New York, NY: Psychology Press Ltd.

Rice, S., Graff, C. and Lewis, J. I. (2006). *Poverty and Civil War: What Policymakers Need to Know*. Washington, DC: The Brookings Institution.

Richards, R. J. (1998). Rhapsodies on a cat-piano, or Johann Christian Reil and the foundations of romantic psychiatry. *Critical Inquiry, 24*(3), 700-736.

Rigg, J., Grundy-Warr, C., Law, L. and Tan-Mullins, M. (2008). Grounding a natural disaster: Thailand and the 2004 tsunami. *Asia Pacific Viewpoint, 49*(2), 137-154.

Rittichainuwat, B. (2011). Ghosts: A travel barrier to tourism recovery. *Annals of Tourism Research, 38*(2), 437-459. doi:10.1016/j.annals.2010.10.001

Robinson, G. (1998). Rawan is as Rawan does: The origins of disorder in new order Aceh. *Indonesia*(66), 127-157. doi:10.2307/3351450

Rolland, J. S. (1993). Mastering family challenges in serious illness and disability. *Normal Family Processes*, 444-473.

Rook, K. S. (1984). The negative side of social interaction: Impact on psychological well-being. *Journal of Personality and Social Psychology, 46*(5), 1097. doi:10.1037/0022-3514.46.5.1097

Rorty, M., Yager, J. and Rossotto, E. (1994). Childhood sexual, physical, and psychological abuse in bulimia nervosa. *American Journal of Psychiatry, 151*(8), 1122-1126.

Rosaldo, M. Z. (1974). Woman, culture, and society: A theoretical overview. *Woman, Culture and Society*, 17-42.

Rosaldo, M. Z. (1980). The use and abuse of anthropology: reflections on feminism and cross-cultural understanding. *Signs, 5*(3), 389-417.

Rosen, G. (1959). Social stress and mental disease from the eighteenth century to the present: Some origins of social psychiatry. *The Milbank Memorial Fund Quarterly, 37*(1), 5-32. doi:10.2307/3348745

Ross, M. L. (2004a). How do natural resources influence civil war? Evidence from thirteen cases. *International Organization, 58*(01), 35-67.
Ross, M. L. (2004b). What do we know about natural resources and civil war? *Journal of Peace Research, 41*(3), 337-356. doi:10.1177/0022343304043773 ISSN 0022-3433
Ross, M. L. (2005). Resources and rebellion in Aceh, Indonesia. In Paul Collier and Nicholas Sambanis (Eds.), *Understanding Civil War: Evidence and Analysis* (pp. 35–58). Washington, DC: World Bank.
Ryff, C. D. and Singer, B. H. (2001). Introduction: Integration Emotion into the Study of Social Relationships and Health. In C. D. Ryff and B. H. Singer (Eds.), *Emotion, Social Relationships, and Health* (pp. 3-22). New York: Oxford University Press.
Sabin-Farrell, R., and Turpin, G. (2003). Vicarious traumatization: implications for the mental health of health workers?. *Clinical Psychology Review*, *23*(3), 449-480.
Salloum, A. and Overstreet, S. (2008). Evaluation of individual and group grief and trauma interventions for children post disaster. *Journal of Clinical Child and Adolescent Psychology, 37*(3), 495-507. doi:10.1080/15374410802148194
Satha-Anand, C. (Ed.) (2009). *Imagined Land?: The State and Southern Violence in Thailand*. Tokyo: Research Institute for Languages and Cultures of Asia and Africa, c2009.
Saylor, C. F. (Ed.) (1993). *Children and Disasters*. New York, NY: Springer Science and Business Media.
Sayre, S. (2006). Using video-elicitation to research sensitive topics: Understanding the purchase process following natural disaster. In R. W. Belk (Ed.), *Handbook of Qualitative Research Methods in Marketing* (pp. 230-243). Edward Elgar: Cheltenham, UK; Northampton, MA, USA.
Schippers, M. (2007). Recovering the feminine other: Masculinity, femininity, and gender hegemony. *Theory and Society, 36*(1), 85-102.
Schulze, K. E. (2004). The Free Aceh movement (GAM): Anatomy of a separatist organization. *Policy studies*(2), I.
Seeman, T. E. (1996). Social ties and health: The benefits of social integration. *Annals of Epidemiology, 6*(5), 442-451.
Shepard, M. F. and Campbell, J. A. (1992). The Abusive Behavior Inventory: A measure of psychological and physical abuse. *Journal of Interpersonal Violence, 7*(3), 291-305. doi:10.1177/088626092007003001
Shuval, J. T. (1957). Some persistent effects of trauma: Five years after the Nazi concentration camps. *Social Problems, 5*(3), 230-243. doi:10.2307/798965
Simoni, J. M., Sehgal, S. and Walters, K. L. (2004). Triangle of risk: Urban American Indian women's sexual trauma, injection drug use, and HIV sexual risk behaviors. *AIDS and Behavior, 8*(1), 33-45.
Singer, M. I., Anglin, T. M., yu Song, L. and Lunghofer, L. (1995). Adolescents' exposure to violence and associated symptoms of psychological trauma. *Jama, 273*(6), 477-482.
Singleton, P. (2012). Insult to injury disability, earnings, and divorce. *Journal of Human Resources, 47*(4), 972-990.
Smith, C. (2012). *War, Medicine and Morality in Aceh: An Ethnography of'trauma'as an Idiom of Distress.* (Unpublished doctoral dissertation), Australian National University, Canberra, Australia.
Smith, J. K. (1983). Quantitative versus qualitative research: An attempt to clarify the issue. *Educational Researcher, 12*(3), 6-13. doi:10.3102/0013189X012003006
Smith, P., Perrin, S., Yule, W. and Rabe-Hesketh, S. (2001). War exposure and maternal reactions in the psychological adjustment of children from Bosnia-Hercegovina. *Journal of Child Psychology and Psychiatry, 42*(3), 395-404.
So, A. Y. (1990). *Social Change and Development: Modernization, Dependency and World-System Theories*: Sage.
Sorokin, P. (1967[1928]). *The Sociology of Revolution.* New York, NY: Howard Fertig.

Solomon, S. D., Bravo, M., Rubio-Stipec, M. and Canino, G. (1993). Effect of family role on response to disaster. *Journal of Traumatic Stress, 6*(2), 255-269.
Solomon, Z., Waysman, M., Levy, G., Fried, B., Mikulincer, M., Benbenishty, R., Florian, V. and Bleich, A. (1992). From front line to home front: A study of secondary traumatization. *Family Process, 31*(3), 289-302. doi:10.1111/j.1545-5300.1992.00289.x
Soutis, M. (2006). Ancient Greek terminology in pediatric surgery: About the word meaning. *Journal of Pediatric Surgery, 41*(7), 1302-1308. doi:10.1016/j.jpedsurg.2006.03.011
Spradley, J. P. (2016). *Participant Observation*. Long Grove, Illinois: Waveland Press.
Srisompob, J. and Panyasak, S. (2006). Unpacking Thailand's southern conflict: The poverty of structural explanations. *Critical Asian Studies, 38*(01), 95-117.
Stallings, R. A. (2003). Methods of disaster research: Unique or not? In R. A. Stallings (Ed.), *Methods of Disaster Research* (pp. 21-44). Philadelphia, PA: Xlibris Corporation/International Research Committee on Disasters.
Steedly, M. M. (1999). The state of culture theory in the anthropology of Southeast Asia. *Annual Review of Anthropology, 28*(1), 431-454.
Steinberg, F. and Smidt, P. (2010). *Rebuilding Lives and Homes in Aceh and Nias, Indonesia*. Mandaluyong City, Philippines: Asian Development Bank.
Steiner, R. (1948). *Spiritual Science and Medicine*. London: R. Steiner Publishing Company.
Steinglass, P. and Gerrity, E. (1990). Natural Disasters and Post-traumatic Stress Disorder Short-Term versus Long-Term Recovery in Two Disaster-Affected Communities. *Journal of Applied Social Psychology, 20*(21), 1746-1765. doi:10.1111/j.1559-1816.1990.tb01509.x
Stoll, C. S. (1968). Images of man and social control. *Social Forces, 47*(2), 119-127. doi:10.2307/2575141
Strauss, C. C., Last, C. G., Hersen, M. and Kazdin, A. E. (1988). Association between anxiety and depression in children and adolescents with anxiety disorders. *Journal of Abnormal Child Psychology, 16*(1), 57-68.
Stuart, E., Bird, K., Bhatkal, T., Greenhill, R., Lally, S., Rabinowitz, G. and Samman, E. (2016). *Leaving no one Behind: A Critical Path for the First 1,000 days of the Sustainable Development Goals*. Retrieved from https://www.odi.org/sites/odi.org.uk/files/resource-documents/10692.pdf
Sulistiyanto, P. (2001). Whither Aceh? *Third World Quarterly, 22*(3), 437-452. doi:10.1080/01436590120061697
Summerfield, D. (2000). Childhood, war, refugeedom and 'trauma': Three core questions for mental health professionals. *Transcultural Psychiatry, 37*(3), 417-433. doi:10.1177/136346150003700308
Sun, Y. and Li, Y. (2009). Parental divorce, sibship size, family resources, and children's academic performance. *Social Science Research, 38*(3), 622-634. doi:10.1016/j.ssresearch.2009.03.007
Supharatid, S. (2006). The Hat Yai 2000 flood: the worst flood in Thai history. *Hydrological Processes, 20*(2), 307-318. doi:10.1002/hyp.5912
Szasz, T. S. (1960). The myth of mental illness. *American Psychologist, 15*(2), 113.
Sztompka, P. (1993). Civilizational incompetence: The trap of post-communist societies. *Zeitschrift für Soziologie*, 85-95. doi:10.1515/zfsoz-1993-0201
Sztompka, P. (1999). *Trust: A Sociological Theory*: Cambridge University Press.
Sztompka, P. (2000). Cultural trauma: The other face of social change. *European Journal of Social Theory, 3*(4), 449-466. doi:10.1177/136843100003004004
Sztompka, P. (2000). The Ambivalence of Social Change Triumph or Trauma?. *Polish Sociological Review*, 275-290.
Sztompka, P. (2004). The trauma of social change. *Cultural Trauma and Collective Identity, California University Press, Berkeley*, *6*, 155-197.
Taanila, A., Kokkonen, J. and Järvelin, M. R. (1996). The long-term effects of children's early-onset disability on marital-relationships. *Developmental Medicine and Child Neurology, 38*(7), 567-577. doi:10.1111/j.1469-8749.1996.tb12121.x

Talley, R. C. and Crews, J. E. (2007). Framing the public health of caregiving. *American Journal of Public Health, 97*(2), 224-228. doi:10.2105/AJPH.2004.059337

Tanavud, C., Yongchalermchai, C., Bennui, A. and Densreeserekul, O. (2004). Assessment of flood risk in Hat Yai municipality, Southern Thailand, using GIS. *Journal of Natural Disaster Science, 26*(1), 1-14.

Tedlock, B. (1991). From participant observation to the observation of participation: The emergence of narrative ethnography. *Journal of Anthropological Research, 47*(1), 69-94.

Thabet, A. A. M. and Vostanis, P. (1999). Post-traumatic Stress Reactions in Children of War. *Journal of Child Psychology and Psychiatry, 40*(3), 385-391. doi:10.1111/1469-7610.00456

The National Reconciliation Commission (NRC). (2006). *Overcoming Violence Through the Power of Reconciliation* (pp. 1-147). Retrieved from http://thailand.ahrchk.net/docs/nrc_report_en.pdf

Thienkrua, W., Cardozo, B. L., Chakkraband, M. S., Guadamuz, T. E., Pengjuntr, W., Tantipiwatanaskul, P., Sakornsatian, S., Ekassawin, S., Panyayong, B., Varangrat, A., Tappero, J. W., Schreiber, M. and Griensven, F. v (2006). Symptoms of posttraumatic stress disorder and depression among children in tsunami-affected areas in southern Thailand. *Jama, 296*(5), 549-559.

Titchener, J. L. and Kapp, F. T. (1976). Family and character change at Buffalo Creek. *The American Journal of Psychiatry, 133*(3), 295-299. doi:10.1176/ajp.133.3.295

Tracy, S. J. (2010). Qualitative quality: Eight "big-tent" criteria for excellent qualitative research. *Qualitative Inquiry, 16*(10), 837-851. doi:10.1177/1077800410383121

Trowell, H. C. (1981). *Western Diseases: Their Emergence and Prevention*: Harvard University Press.

Tumarkin, M. (2004). First as a tragedy, second as a farce: Traumascapes, memory and the curse of indifference. *Overland*, (175), 22-26.

Turner, H. A., Finkelhor, D. and Ormrod, R. (2006). The effect of lifetime victimization on the mental health of children and adolescents. *Social Science and Medicine, 62*(1), 13-27. doi:10.1016/j.socscimed.2005.05.030

Umberson, D. and Karas Montez, J. (2010). Social relationships and health: A flashpoint for health policy. *Journal of Health and Social behavior, 51*(Suppl), S54-S66. doi:10.1177/0022146510383501

Ungpakorn, J. G. (2007). *A Coup for the Rich: Thailand's Political Crisis*. Bangkok, Thailand: Workers Democracy Publishers.

UNICEF. (1989). Convention on the Rights of the Child. *Child Labor*, 8.

UNICEF. (1996). *The Trauma of War*. Retrieved from http://www.unicef.org/sowc96/7trauma.htm

UNICEF. (2004). *Tsunami Press Room*. Retrieved from https://www.unicef.org/media/media_24628.html

United Nations. (2005). *Memorandum of Understanding between the Goverment of the Republic of Indonesia and the Free Aceh Movement*. Retrieved from https://peacemaker.un.org/sites/peacemaker.un.org/files/ID_050815_Memorandum%20of%20Understanding.pdf

United Nations Educational Scientific and Cultural Organization. (2003). *'Memory of the World' Programme*. Retrieved from http://www.unesco.org/fileadmin/MULTIMEDIA/HQ/CI/CI/pdf/mow/6th%20Meeting%20of%20the%20International%20Advisory%20Committee%20of%20the%20Memory%20of%20the%20World%20ProgrammeEN.pdf

Van Ijzendoorn, M. H., Bakermans-Kranenburg, M. J. and Sagi-Schwartz, A. (2003). Are children of Holocaust survivors less well-adapted? A meta-analytic investigation of secondary traumatization. *Journal of Traumatic Stress, 16*(5), 459-469.

Van Praag, H. (1978). The scientific foundation of anti-psychiatry. *Acta Psychiatrica Scandinavica, 58*(2), 113-141. doi:10.1111/j.1600-0447.1978.tb06927.x

Vervaeck, A. (2012). *(Major) Earthquakes list April 16, 2012 - Phuket, Thailand earthquake mystery solved*. Retrieved from https://earthquake-report.com/2012/04/15/major-earthquakes-list-april-16-2012/

Vervaeck, A. (2014). Very strong deadly earthquake close to Chiang Rai, Thailand - At least 1 dead and 32 injuries + huge number of aftershocks. Retrieved from https://earthquake-report.com/2014/05/05/strong-earthquake-thailand-on-may-5-2014/

Vickery, M. (1987). *The Ram Khamhaeng Inscription: a Piltdown Skull of Southeast Asian History?* Paper presented at the Proceedings of the International Conference on Thai Studies, The Australian National University, Canberra.

Vogt, T. M., Mullooly, J. P., Ernst, D., Pope, C. R. and Hollis, J. F. (1992). Social networks as predictors of ischemic heart disease, cancer, stroke and hypertension: Incidence, survival and mortality. *Journal of Clinical Epidemiology, 45*(6), 659-666. doi:10.1016/0895-4356(92)90138-D

Waizenegger, A. (2007). Armed separatism and the 2004 tsunami in Aceh. *Canada Asia Commentary, 43*, 1-10.

Waizenegger, A. and Hyndman, J. (2010). Two solitudes: Post-tsunami and post-conflict Aceh. *Disasters, 34*(3), 787-808. doi:10.1111/j.0361-3666.2010.01169.x

Walen, H. R. and Lachman, M. E. (2000). Social support and strain from partner, family, and friends: Costs and benefits for men and women in adulthood. *Journal of Social and Personal Relationships, 17*(1), 5-30. doi:10.1177/0265407500171001

Walker, A. (2011). *Ji Ungpakorn on lese majeste*. Retrieved from http://www.newmandala.org/ji-ungpakorn-on-lese-majest/

Walker, A. and Farrelly, N. (2009). *Special Interview: Giles Ungpakorn, Part 1*. Retrieved from http://asiapacific.anu.edu.au/newmandala/2009/02/20/special-interview-giles-ungpakorn-part-1/

Wall, R. B. (2008). Healing from War and Trauma: Southeast Asians in the US: A Buddhist Perspective and the Harvard Program in Refugee Trauma. *Human Architecture, 6*(3), 105.

Weick, K. E. (1993). The collapse of sensemaking in organizations: The Mann Gulch disaster. *Administrative Science Quarterly*, 628-652. doi:10.2307/2393339

Weichselgartner, J. and Bertens, J. (2000). Natural disasters: acts of God, nature or society? On the social relation to natural hazards. *WIT Transactions on Ecology and the Environment*, 45.

Weissman, M. M., Gammon, G. D., John, K., Merikangas, K. R., Warner, V., Prusoff, B. A. and Sholomskas, D. (1987). Children of depressed parents: increased psychopathology and early onset of major depression. *Archives of General Psychiatry, 44*(10), 847-853.

Wenger, D. E., Dynes, R. R. and Quarantelli, E. L. (1986). *Disaster Analysis: Emergency Management Offices and Arrangements*. Retrieved from http://udspace.udel.edu/bitstream/handle/19716/1138/FPR34.pdf?sequence=1

Wessells, M. G. (2006). *Child soldiers: From violence to protection*. Cambridge, MA: Harvard University Press.

Wickrama, K. and Kaspar, V. (2007). Family context of mental health risk in Tsunami-exposed adolescents: Findings from a pilot study in Sri Lanka. *Social Science and Medicine, 64*(3), 713-723. doi:10.1016/j.socscimed.2006.09.031

Wickrama, K. and Wickrama, K. T. (2008). Family context of mental health risk in tsunami affected mothers: Findings from a pilot study in Sri Lanka. *Social Science and Medicine, 66*(4), 994-1007.

Wieringa, E. (1998). The dream of the king and the holy war against the Dutch: The koteubah of the Acehnese epic, Hikayat Prang Gompeuni. *Bulletin of the School of Oriental and African Studies, 61*(02), 298-308.

Willmott, D. E. (2009). *The National Status of the Chinese in Indonesia 1900-1958*: Equinox Publishing.

Wongthes, S. (2012). *Suk sila charuk sxang trakulrath Sukhothai khaeng barami thangkarnmeung [Thailand Inscription war of two Sukhothai's family fight for political position]*. Retrieved from http://www.sujitwongthes.com/2012/06/weekly22062555/

World Health Organization. (2002). *Gender and Health in Disasters*. Retrieved from http://www.who.int/gender/other_health/genderdisasters.pdf

World Health Organization. (2006). *The World Health Report: 2006 - Working Together for Health*. Retrieved from http://www.who.int/whr/2006/en/

Yoon, S.-J., Choi, D.-C. and Park, J.-W. (2007). Service orientation: Its impact on business performance in the medical service industry. *The Service Industries Journal, 27*(4), 371-388. doi:10.1080/02642060701346375

Yumarni, T. and Amaratunga, D. (2015). *Resource Capability for Local Government in Mainstreaming Gender Into Disaster Risk Reduction: Evidence From Indonesia*. The United Nations Office for Disaster Risk Reduction. Retrieved from https://www.unisdr.org/campaign/resilientcities/assets/documents/privatepages/Resource%20capability%20for%20local%20government%20in%20mainstreaming%20gender%20into%20disaster%20risk%20reduction%20evidence%20from%20Indonesia.pdf

Zeccola, P. (2011). Dividing disasters in Aceh, Indonesia: separatist conflict and tsunami, human rights and humanitarianism. *Disasters, 35*(2), 308-328. doi:10.1111/j.1467-7717.2010.01213.x

Ziabari, K. (2011). *The United Nations Security Council: An Organization for Injustice*. Retrieved from https://www.globalresearch.ca/the-united-nations-security-council-an-organization-for-injustice/22875

Zimet, G. D., Dahlem, N. W., Zimet, S. G. and Farley, G. K. (1988). The multidimensional scale of perceived social support. *Journal of Personality Assessment, 52*(1), 30-41.

Appendix 1 Semi-structured interview questions

Objectives	Main questions	Following questions
1) How are people affected by natural disasters on top of violent conflict? How do they construct and experience trauma?	1.1) Could you please tell me what happened on that day? 1.2) How have disaster and conflict contexts affected individuals/ communities/organizations? + observe trauma through material objects as evidence from a researcher's perspective (the cause from the disaster and violence from each society which is difference meaning and expression form each culture) ●Property damage (house, agricultural areas, school, belongings, and/or pets) ●Disaster monuments/museums ●Documentary records – pictures, video, dance, song ●Loss of a family member or friend, including multiple losses ●Observing serious injury or dead bodies ●Family members who remain missing after the disaster, including instances when their body has not been recovered, but presumed dead ●Becoming hurt or sick ●Being unable to evacuate quickly in the disaster ●Trapped or delayed evaluation ●Previous experiences with loss or other stressful times in their lives	a) What are the natural disaster's meaning from your point of view? [tsunami, earthquake, storm surge] b) What is the conflict situation? c) How has the conflict situation affected your natural disaster experiences? e) Has anyone you know been affected and/or involved with the situation? family, relative, friends, and organizations [physical-deaths, injuries, disabilities/psychology behavior and/or mood, sleep and/or eating, family and/or friends, school/ home/community/activity, other possible changes] f) Why do some have trauma while others don't? [Having trauma – lack of social support, nuclear family, ethnic minority, marginal people, no access to aid, experiencing conflict prior to the natural disaster including the death or disability of the head of the family, periods in jail or under arrest, escape during the conflict, head of family working overseas / Didn't have trauma - all members in the community are family, relative, and neighbours, helping each other during the natural disaster, having outsider social network, creating new security social network, perceived cause of natural disaster (act of god?)] g) Were there any aid organizations who offered aid to the community after disasters? Who? What organizations? How? [Individual, organizations, NGOs, INGOs, government, local government, family, friends, relatives] h) What kind of resources did you and community receive? [aid

Objectives	Main questions	Following questions
		package, social support] f) Are you satisfied with their help? Why? Why not? [yes-got basic needs, expected some organizations to help but they didn't come/no-didn't receive aid help, food from aid package is against religion beliefs, political conflict is restricted aid in some cases] g) What resources were available to the community pre and post disaster? h) What communication systems are/ were used? Are these different pre and post disasters? – portable radio, radio communication, telephone, internet Others: items to note / suggestions
	1.2) What is the role of the organizations?	a) How have organizations, leaders being involved with the natural disaster and conflict? b) What is your organization duty/job description that related to natural disasters? How? Why? c) What did your organization do and what was it unable to do to respond to the natural disaster? Why? How? can-related to previous experience, it exists in the job description etc. cannot- didn't have clear job description, limited budget, under conflict situation, bureaucratic systems, hierarchy, personal characteristics, impacted from the natural disaster d) How did you /your organization get involved in these events? 1.6) What has been role of these organizations/individuals following the disaster and conflict contexts? e) How many individuals/ organizations were involved in the natural disaster and conflict contexts? (disaster service, support, work together or separated/why? why not?)

Objectives	Main questions	Following questions
		f) What did you/ your organization find when you interacted with the people who affected by natural disasters? g) What were their reactions, responses, actions, and activities? h) What did they need? i) Did you think you/your organization covered all their needs? Why? Why not? j) How did you/ your organization prepare for possible future disasters? k) Were there any problems? l) What are their key concerns in the post disaster and conflict contexts? m) Have they undertaken preparation for possible future disasters? (individuals, social systems, structures, institutes, organization, knowledge and training)
2) How have gender roles interpreted traumas by natural disasters on top of violent conflict in different way?	Could you please tell me how women were affected by the natural disaster on top of violent conflict?	a) What does the natural disaster mean from your point of view? b) What is your role in the family? c) What happened on that day? fear, alone in the house because husband went to work or under arrested or disability from the conflict, worry about children and elderly, overwhelm with cooking, cleaning but didn't have cooking equipment and enough food / not fear, having outsider social network, receive aid and social support from family members and friends d) Has your role have changed? How? Why? Why not?
	Could you please tell me how men were affected by the natural disaster on top of violent conflict?	a) What does the natural disaster mean from your point of view? b) What is your role in the family? c) What happened on that day? Lost properties – fishing

Objectives	Main questions	Following questions
		equipment, house; recovery but limited resources – no money, cannot find a job, too many check points and too much searching by the authorities d) Has your role have changed? How? Why? Why not?
3) How people who are different by ethnic group and age construct and experience trauma?	[Ethic minority] Could you please tell me what happened on that day?	a) How did you define yourself and/ or your ethnic group in this society? Chinese, Javanese, Sakai b) What does the natural disaster mean from your point of view? c) What happened on that day? aid, social support, help other, receive and/or not receive aid? How do you feel? How your friends feel? d) Other items to note
	[Young adults assisted by a psychologist or psychiatrist] Could you please tell me what happened in that day?	a) What do you think happened? b) How has this affected your family/ community? c) What do you think about what is happening now? What do you think about the response to the disaster? d) What is it that you are most upset or worried about? e) Is there anything else you would like to tell me or that you want to know more about? f) Other items to note