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SYIAH KUALA UNIVERSITY
(AIC - UNSYIAH)
IN CONJUNCTION WITH
The 9th ANNUAL INTERNATIONAL WORKSHOP AND EXPO ON SUMATRA TSUNAMI DISASTER AND RECOVERY
(AIWEST-DR)

A.A.C. Dayan Dawood, Darussalam - Banda Aceh, Indonesia
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MESSAGE FROM THE RECTOR

Assalamualaikum wr wb.

On behalf of Syiah Kuala University, I would like to extend my warmest welcome to all participants to the 4th Annual International Conference of Syiah Kuala University 2014 (AIC-UNSYIAH 2014) in conjunction with the 9th Annual International Workshop and Expo on Sumatran Tsunami Disaster and Recovery 2014 (AIWEST-DR 2014).

Syiah Kuala University is the largest and the oldest university in Aceh Province, Indonesia. The university was established on June 21st, 1961. Establishment of UNSYIAH was driven by a strong spirit to form an institution to bring the Acehnese become more educated, knowledgeable and pious to God Almighty. UNSYIAH has a vision to establish itself as an innovative, independent, and outstanding university in term of the development of science, technology, humanities, sports and arts, in order to produce qualified graduates who have highly honour moral and ethical values. Currently, UNSYIAH has over 1,500 staffs and 30,000 students.

This year, UNSYIAH has hosted a series of events commemorating the 53rd anniversary. As part of the celebration, UNSYIAH has held an interdisciplinary academic conference on October, 22nd-24th, 2014. The conference has a plenary address, oral and poster parallel sessions, social programs, and a tsunami/historical sites tour.

Finally, I would like to take this opportunity to thank our keynote and invited speakers for their time and support for this conference. Moreover, I would also like to thank the Organizing Committee of the conference for their hard work in making this event successful. To all participants, I wish you have fruitful interactions with your peers and to our foreign friends, an enjoyable stay in Banda Aceh.

Thank you
Assalamualaikum wr. wb.

Prof. Dr. Ir. Samsul Rizal, M.Eng
Rector of Syiah Kuala University
MESSAGE FROM THE CHAIRPERSON

Assalamualaikum wr wb

I would like to extend a very warm welcome to all of the distinguished participants, local as well as overseas especially those who have travelled long distances to be present here today. My thanks are also due to all members of the organizing committee and students volunteer for having worked very hard to make this event a reality and the various companies for their support and generosity.

I would also like to record my thanks to our four keynote-speakers Prof. Yasuo Tanaka, Prof. Anthony Kuo, Prof. Dr. Zahari Taha, and Prof. Fumi Kumata who have kindly agreed and come to share their knowledge and experience with all of us.

Today we have delegates from 10 countries namely Indonesia, Malaysia, Taiwan, Thailand, Singapore, Australia, Japan, United State of America, Germany, and Swiss. To all these delegates once again I welcome you with open arms to savor and enjoy the Acehnese hospitality. Among the delegates, there are not only experienced experts and researchers but also postgraduate students from emerging areas such as biology, agriculture, marine and fisheries, chemistry, medicine, engineering, law and politics, education, history economics, disaster sciences and management. The presented papers will be published in proceedings of AIC Unsyah & AIWEST-DR 2014.

I hope that all the delegates will not only benefit from the excellent scientific programme that has been lined up four you but also enjoy the local food and wish you a pleasant and enjoyable stay in Banda Aceh.

Thank you,
Wassalamualaikum wr wb.

Muhammad Bahi, Ph.D
Chairperson of AIC Unsyah & AIWEST-DR 2014
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BARRIERS TO INDIVIDUALS ACCESSING PSYCHOLOGY SERVICES IN COMMUNITY HEALTH CENTERS — A QUALITATIVE STUDY INTO PSYCHOLOGISTS’ EXPERIENCES OF PROVIDING SERVICES TO PUSKESMAS OR COMMUNITY HEALTH CENTERS (CHCS) IN BANDA ACEH

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Abstract
Aceh was devastated by the 2004 tsunami with over 170,000 people killed along the coast of the Indian Ocean. Frankenberg et al. (2008) claims that in the wake of the tsunami post-traumatic stress disorders have manifested along Aceh’s coastal line. High rates of psychopathology, including symptoms of anxiety, affective disorders, and post-traumatic stress symptom have been reported amongst survivors of the earthquake and tsunami in Aceh and Nias (Chandra, Pandav, & Bhugra, 2006; Frankenberg, Nobles, & Sumantri, 2012; Frankenberg et al., 2008; Irmansyah, Dharmono, Maramis, & Minas, 2010; Prasetyawan, Viora, Maramis, & Keliat, 2006; Setiawan & Viora, 2006). Prior to the 2004 tsunami there existed a long running military conflict between the Aceh separatist group (GAM) and the Indonesian government taking place between 1967 and 2004. This also had psychological impacts including depression, anxiety and trauma symptoms (Souza, Bernatsky, Reyes, & Jong, 2007) for the larger Acehnese community (Prasetyawan et al., 2006). Prior to the Tsunami 2004, there was little or no attention to mental health in the health system both nationally and locally. Mental health conditions following the Tsunami 2004 has brought opportunity for national and international agencies to initiate the establishment of a mental health care system. Mental health specialists have been limited in Aceh, although since the tsunami mental health training has been provided to the health department staff whose services are in primary care. In addition, to reach the community, mental health approaches based on community interventions have been established and funded by some agencies in terms of assessment and treatment or intervention. However, there continue to be substantial barriers to accessing mental health care in CHCs in Aceh. As international funding has declined, local initiatives between university and CHCs discontinued, psychology services continue to be stretched and those psychologists who provide these services do so on a voluntary capacity. This research has sought to develop understanding into the experiences of those volunteer psychologists who provide mental health care services in CHCs in Banda Aceh in order to gain knowledge for the improvement community mental health provision in Aceh. The design of this research is qualitative as this is considered the most appropriate method to address the research question that seeks an in depth understanding of the experiences and opinions of a small group of Clinical Psychologists working in Aceh. Six clinical psychologists responded to an email advertisement forwarded through a clinical psychologist contact person in Aceh (see Appendix 1 for email advertisement) and participated in this study. The interviews were conducted in Indonesian language, recorded, transcribed verbatim in Indonesian and translated to English by the researcher. Each interview was of approximately 60 minutes duration. The semi-structured interview schedule was intended to explore these aspects of participants’ experiences. Data was analysed inductively, which is a “process of coding the data without trying to fit into pre-existing coding frame, or the researcher’s analytic preconceptions or called data-driven” (Braun & Clark, 2006, p. 83). This theme describes the community beliefs, stigma, taboo and perception toward mental illness and person with mental illnesses that prevent individuals and their family within the
community in Aceh from accessing mental health services.

Keywords:

INTRODUCTION

Aceh was devastated by the 2004 tsunami with over 170,000 people killed along the coast of the Indian Ocean. Frankenberg et al. (2008) claims that in the wake of the tsunami post-traumatic stress disorders have manifested along Aceh’s coastal line. High rates of psychopathology, including symptoms of anxiety, affective disorders, and post-traumatic stress symptom have been reported amongst survivors of the earthquake and tsunami in Aceh and Nias (Chandra, Pandav, & Bhugra, 2006; Frankenberg, Nobles, & Sumantri, 2012; Frankenberg et al., 2008; Irmansyah, Dharmono, Maramis, & Minas, 2010; Prasetyawan, Viora, Maramis, & Keliat, 2006; Setiawan & Viora, 2006). Prior to the 2004 tsunami there existed a long running military conflict between the Aceh separatist group (GAM) and the Indonesian government taking place between 1967 and 2004. This also had psychological impacts including depression, anxiety and trauma symptoms (Souza, Bernatsky, Reyes, & Jong, 2007) for the larger Acehnese community (Prasetyawan et al., 2006).

Moreover, a study 5-years after the Tsunami into the prevalence of long-term post-traumatic stress symptoms among adolescents reported that 63.1% of adolescent participants stand to have moderate to severe PTSD symptoms (Agustini, Asnir, & Matsuo, 2011). Another study one year following the Tsunami revealed that only six out of fifty affected children show no indication of trauma-related symptoms (Hestyanti, 2006). A current study has suggested that the prevalence of psychological disorders such as depression, anxiety and stress affects 50% of the survivors following the disaster (Musa et al., 2013).

In the context of this recognition of psychological trauma caused by the longstanding conflict and the 2004 tsunami on the larger community in Aceh, it has become necessary to focus on community mental health service provision (Souza et al., 2007). Therefore, this research seeks to explore clinical psychologists’ perspectives and experiences of delivering mental health services in Banda Aceh. The results of this study hope to contribute to the improvement mental health service provision in Aceh.

RESEARCH METHODOLOGY

Design

A qualitative design based on a thematic analysis approach was used for data collection and analysis. Thematic analysis is a method for identifying, analysing, and reporting themes within data (Liamputtong, 2009) through minimally organising and describing the data set in rich detail (Braun & Clark, 2006). Specifically, the design of this research is qualitative as this is considered the most appropriate method to address the research question that seeks an in depth understanding of the experiences and opinions of a small group of Clinical Psychologists working in Aceh.

Ethical considerations

All participants were informed about the purposes and the methods of the study. They were informed that participation in the study was voluntary and that they could decline to participate or withdraw from the study at any time without penalty. Moreover, the participants were reassured that their responses would be confidential and that their identities would not be revealed in research report and publication of the study through use of pseudonymous and removal of any part of the interview transcripts that they selected out as potentially identifiable. Because there are few clinical psychologists in Aceh, confidentiality was
discussed with each participant including that confidentiality could not be guaranteed. Nevertheless participants chose a pseudonym and were given interview transcripts to remove any information that they did not wish to be included in this thesis or any publication of this research.

Participants
Six clinical psychologists responded to an email advertisement forwarded through a clinical psychologist contact person in Aceh (see Appendix 1 for email advertisement) and participated in this study. The purposeful selection of this group of participants was to address the research questions that sought to understand clinical psychologist perspectives and experiences in working in mental health services in different primary or community mental health centres in Aceh. All these psychologists were Acehnese, female, bilingual in English and Indonesian, with post-graduate degrees in Psychology, aged between 30-34 and had worked as psychologists between 3 and 9 years.

Interview transcription and analysis
The interviews were conducted in Indonesian language, recorded, transcribed verbatim in Indonesian and translated to English by the researcher. Each interview was of approximately 60 minutes duration. The main focus of the interview was to find out whether there are barriers that may impact on professional provision of services. The semi-structured interview schedule was intended to explore these aspects of participants’ experiences. A selection of these interview questions was used with further exploration of participants’ experiences from their responses. Therefore each interview was unique and sought to provide a context of participants to richly describe their experiences and perspectives. Data was analysed inductively, which is a “process of coding the data without trying to fit into pre-existing coding frame, or the researcher’s analytic preconceptions or called data-driven” (Braun & Clark, 2006, p. 83).

The following steps were taken when analysing interview transcripts- Familiarising with data: transcribing data, reading and re-reading data, noting down initial ideas.

Generating initial codes: inductively and descriptively through labelling groups of words, phrases and paragraphs of the transcripts. Searching for themes: collating codes into potential themes, gathering all data relevant to each potential theme. Reviewing themes: checking if the themes work in relation to the coded extracts and the entire dataset. Defining and naming themes: ongoing analysis to refine the specifics of each theme and the overall story the analysis tells, generating clear definitions and names for each theme.

The data was analysed to identify and categorise initial codes, then the codes and their latest development as themes were compared. Credibility of the data was established through participants’ revision of their interviews and the researcher summary of the interview as a check (Holloway, 2005). The data analysis was finalised with emerging themes and sub themes to describe the participants’ experiences, meanings and perspectives regarding mental health services needs in Aceh.

The limited research was of a significant concern for the researcher and inspired this research to review and evaluate areas for improvement.
RESULTS
Bars to individuals accessing psychology services in CHCs
This theme describes the community beliefs, stigma, taboo and perception toward mental illness and person with mental illnesses that prevent individuals and their family within the community in Aceh from accessing mental health services.

a. Community beliefs about the causes of mental illness
Therapists asserted that there are a number of common community perceptions about the cause of symptoms of mental illness that may act as barriers to individuals both seeking and referring to psychological therapy services.

EXTRACTS 1
Bunga: Thus, the people cannot find, access, or use the professional service in CHCs because of the difference of understanding.

Cinta: The people [community] still believe in black magic, when someone has mental disorder and begin to disturb the neighbourhood, commonly people in the village will thing it was because of black magic or a kind of voodoo or being possessed. Community tends to ask for help to a shaman.

Permata: Some [Nurses in CHCs] think that mental disorders are triggered by magical witchcraft [pause] which happens suddenly [...].

Cinta identified community beliefs that link mental health problems to supernatural causes ("being possessed") as posing a barrier to persons seeking psychological counseling. From her experiences, this alternate way of understanding symptoms results in communities seeking healing through shamans, or religious people that use traditional methods of medicine and healing. Many people in Aceh and other Asian cultures continue to believe that mental illness is rooted in supernatural causes (Boothby et al., 2011; Lauber & Rossler, 2007) and consequently seek help from traditional healers before approaching modern medicine (Al Krenawi, Graham, Dean, & Eltaiba, 2004; Botross, Atalla, & Al Islam, 2006). Consistent with Cinta’s identification, Lauber & Rossler (2007) have suggested that there is strong resistance and delay in seeking psychiatric help when traditional healers and medicine are available.

Permata experienced these attitudes from nurses who work in the CHCs who, despite their knowledge of mental health issues, hold onto the beliefs that magical forces are the cause 24 of symptoms. This would suggest that traditional beliefs about mental illness may be established to the extent that Western medical perspectives may not be adopted even by some people who work in these organizations. Consequently, mental health services in CHCs are unlikely to be considered as a place to seek help for psychological problems for people within the community. In the event that a person does seek assistance in the CHCs, there also exists a risk that these beliefs will be transmitted from health professionals to their patients (Lauber & Losser, 2007).

EXTRACTS 2
Permata: Some people [community] still consider that their problems should be kept for themselves, there is no need to share with others. And they indeed believe that the God will give them solution. This behavior is very common among people.

Permata spoke about her experience with members of the Acehnese community who were reluctant to share their problems and understood the solution to their problems to be generated from transcendent forces. Permata also identified particular religious beliefs where God will
intervene on behalf of individuals and their families in providing an alternative to the services provided in CHCs. People who take up this perspective that God will intervene and cure their problems are less likely to seek out treatment services for themselves. Consistent with this, Yip (2004) has described these religious beliefs as one component of the Asian culture leading people to seek assistance through religious avenues rather than through health care professionals.

**EXTRACTS 3**

Cendana: [Pause][…] they [community] still consider that [...]mental illness is untreatable [...] what do you call it heredity disease[...].that what some people assume I think.

Cendana suggested that the belief that mental health problems are not only hereditary but also untreatable may impact individuals and families behaviour in seeking mental health care services. Similarly, research in Asian traditional culture confirms that the belief of mental 25 illnesses are hereditary may stigmatize individuals with mental health problems and their family and these beliefs produce scepticism about the usefulness of mental health services (Lauber & Rossler, 2007). This may impact upon an individual’s hope for their future. The situation may become worse if the family holds the same belief and may result in a loss of support. In addition to this if an individual fails to recover from their illnesses, this situation may be seen as evidence to support the idea of mental illness as hereditary and untreatable (Phelan, Cruz-Rojas, & Reiff, 2002).

**b. Stigma related to attitudes towards persons experiencing symptoms of mental illness**

**EXTRACTS 4**

Cendana: I assume it is because of stigma, in which if one comes to a hospital, he or she must be ill, isn’t it?, go to a psychiatrist or psychologist. It was as if "people might say that they are crazy. . Maybe the stigma should be [...] [pause] changed a little! [...]?, So they [patients] do not want to be considered mad people.

Cinta: [...] many nurses do not want to be trained or recruited by CMHN (community mental health nurse) program to learn about the mental health problem in the community. [...] they [nurses] afraid to learn about mental health, do not want to deal with the patient with mental health. Actually [these nurses] do not really understand about the mental health. [...] consider mental health as crazy people.

Half of the psychologists in this research identified community perception that equate understand symptoms of mental health with signs of madness ("crazy people"). Psychologists accounted for people’s avoidance of their services because of the stigma linked to these community attitudes. Research in Indonesia has found that rejection of an individual with mental health problems from family members is related to the shame experienced by a family where one of their members is seen as crazy (Fitriawan, 2005, ). Likewise, Nurjannah, FitzGerald, & Foster (2009) in their study about psychiatric patients’ experiences in Indonesia have found that when a person shows symptoms of mental illness both they and their immediate family frequently experience rejection, discrimination, stigmatization, and isolation from society. Perhaps to avoid community rejection some families first reject their immediate member in an effort to maintain their status in the community, which may be perceived as important among many Acehnese people (Gryse & Laumont, 2007). Similarly, research in rural India has reported that most individuals keep their problems to themselves in
order to protect their families from the stigma that mental disorders pose, not only for the individual, but also their whole family (Kermode, Bowen, Aroie, Joag, & Jorm, 2009). Consequently, it is understandable for people with mental problems to avoid seeking assistance from psychologists, particularly when this may result in stigma, discrimination, rejection and isolation. Not only this, but Cinta has also met nurses in the CHCs that avoid training with mental health patients because of their fear of working with such people. This fear may be related to an assumption that has been found in research in Asia that people struggling with mental health issues are dangerous (Ng & Chan, 1996; Lauber & Rossler, 2007). For these psychologists perspectives, it individuals delay seeking help from mental health specialists due to the stigma of being perceived crazy or mad that is attached to seeing psychologists. For individuals to seek their services, psychologists argued that the person and/or their family would need to overcome not only such stigma but also the taboo and shame of sharing personal or family problems with a person outside their family.

c. Taboo and shame in sharing personal or family problems

**EXTRACTS 5**

Bunga: There is also cultural belief that it is embarrassing to share problems with others. Acehnese people are supposed to be strong and able to solve their own problems.

Cahaya: Acehnese people are [pause] supposed to be strong. 27

Bunga and Cahaya suggested that the cultural pressure on individuals to be “strong” and the assumption that sharing problems is a sign of weakness means that there is an expectation for people to show strength by solving their own problems. From research in Acehnese society individual strength is valued, especially in men, where being strong is viewed as normative (Gryse & Laumont, 2007). Within this cultural context, sharing feelings or emotions particularly with those outside family & intermediate social networks may be understood as proof an inability to function as a strong individual. Also, for a person to experience extreme emotional states may not be acceptable within the Acehnese community because it may indicate disrespect, frustration or stress in relation to what is understood as God’s plan (Gryse & Laumont, 2007). In addition, Gryse & Laumont (2007) claimed in their study that most people in Aceh prevent being disrespected by their community by avoiding both sharing their problems and the demonstration of extreme emotional states.

**EXTRACTS 6**

Bunga: Psychologist even fail to address the real problems at the first session because the patients still hesitate to talk about their problems.

Cendana: It is taboo to share family problems with others because of her embarrassment to share her problems; she keeps the problem for herself and avoids sharing it with others.

Cahaya: Culture has really significant influence on individual of what I have seen [...]. Therefore [...] to share personal life among Acehnese is recognised as “aib” or disgrace/ dishonourable.

Three of the six interviewees described sharing problems for Acehnese people as “taboo” as this risks disgrace and/or dishonor for the person. The cultural taboo to disclose difficulties may influence how Acehnese people behave in terms of seeing psychologists or other mental health professionals. Gryse & Laumont (2007) have claimed that embarrassment and shame hinders Acehnese people from talking about personal struggles and family problems. Cultural expectations to be strong and the stigma of mental illness may culminate not only in
reluctance of Achenese people to seek mental health care services but, even when 28 they do, Bunga argues that these barriers may also act to restrain them from disclosing the extent of their difficulties.

d. Perceptions about mental health

**EXTRACTS 7**

Bunga: So, what people consider as mental disorder is only schizophrenia. [...] They believe that they need to see mental nurses only for serious mental health problem. On the other hands, they do not know much about going to psychologists. Most of them see the psychologist to ask about their children learning difficulties. So, the community perception about Mental Health and the professional is not clearly understood.

Permata: [...] they [community] consider a problem is indeed a problem when someone already suffers from psychological disorder, chronic mental disorder [...] schizophrenia. But other problems are not [pause] considered as mental health problems.

Cinta: [...] many patients do not know that they have a disorder. [...] neurotic or anxiety disorders, etc, actually patients do not understand what happened to them...This kind of patients does not know that they have psychological disorder or problem so they will not take a treatment. This kind of thing is essential [...] What they know is just go to the medical doctor. They do not know about psychologist, such as what does the psychologist do.

Two of the six interviewees identified that the understanding of mental disorder within the Achenese community is frequently confined to serious mental illnesses such as schizophrenia and that this belief works to perpetuate more negative attitudes towards those who experience mental health symptoms within the community (Lauberr & Rossler, 2007). This understanding may pose as a barrier for those in seeking help for psychological problems because first, they may not see their struggles as serious enough to see a psychologist and second, they may not want others to assume they have schizophrenia. Cinta argued that many people may not understand their symptoms as a psychological problem and, compounding this, is an absence of understanding into what services a psychologist provides. Consistent with this, a vignette case study in Hong Kong suggests that psychotic symptoms are 29 considered normal by the community, thus the treatment needs were perceived less importance by this community (Chung, Chen, Lam, Chen & Chan, 1997).

Psychologists are therefore caught in a gap between not only a lack of knowledge about symptoms of psychological distress (outside those experiencing schizophrenia) and a corresponding absence of knowledge about the services that they provide, by both persons within the community and other health care providers. The difficulties they report are consistent with research in other parts of Asia (Bhugra & Mastrogiani, 2004) where seeking help for psychological problems is depended upon to knowledge about symptoms of mental illness.

**EXTRACTS 8**

Cinta: People have negative perspective to the people who has recovered from mental illness. [...] some [people] feel embarrassed if their family member has mental disorder [...] hesitate to bring their family member to the mental hospital. For example, there is an economy empowerment in village[...]. The family who has the psychotic patients in their family will be granted some money [...] to
produce crispy chip or to plant chilli, etc. if there is profit, the money will be given to the patients. But the patient is not allowed to help family […] in the process of the making the crispy chip, because most people in the community, who do not want to eat something what the ex-patient [recovered patient] made.

Cinta identified that once individuals are diagnosed with mental illness especially psychosis, they are forced to deal with shame of having mental illness, family isolation and social discrimination. According to Tew et al. (2012) there is strong evidence that persons with mental health problems commonly face social sanction through discrimination. For example, research in rural Turkey and China has shown that most people are likely to show their negative, discrimination and rejection attitude to individuals with mental illness through avoidance of working with a person with mental illness, and refusing to rent their house to an individual with mental illness (Taskin et al., 2003; Ahmed, 1995; Tsang, Tam, Chan & Cheung, 2003). 30 Also, Cinta identified that family members feel embarrassed that a member suffers from psychological problems. Consistent with this picture, a study in Hong Kong has found through interviews and questionnaires that families seek to hide any knowledge that a family member is struggling with mental illness (Lee, Lee, Chiu, & Kleinman., 2005) due to the shame that this may carry for the entire family.

To avoid the shame of having mental illness, family isolation and social discrimination may have implications for individuals with mental health problems. Individuals may avoid seeking services, engaging in therapeutic conversations and following on from this, their recovery process. Consequently, an individual’s mental health problems may risk becoming worse (Van Zeltst, 2009).

CONCLUSION
Community Mental health services in Aceh are new and were initiated following the 2004 Tsunami. Research in Aceh has argued for the importance of long-term mental health services for the community (WHO, 2005). This is to respond the psychological impact of not only the catastrophic effects of the tsunami but also the prolonged military conflict on the community in Aceh. Therefore, to understand the mental health status in Aceh is important toward the improvement of community mental health in the Aceh province.

In this research, psychologists from Aceh shared their experiences as mental health professionals treating the community. This study located three major themes that were presented by research participants regarding mental health and psychological services status in the CHCs. The first theme addressed barriers to individuals accessing in the CHCs. These barriers were identified by psychologists as related to stigma of mental illness in the community in Aceh ranging from beliefs about causes, taboo and shame in sharing personal or family problems, and perceptions, about mental health.

Implications for mental health service provision

There is a significant need for mental health programs are targeted at reframing the views of mental illness in Acehnese society. This is important in order to challenge the existed mental illness stigma and the values owned by the Acehnese people. Particularly, psychologists have an ethical obligation to examine the role of culture in their conceptualizations, assessment and practice (APA, 2002). With regard to mental illness stigma, this means emphasizing how culture influences patients’ stigma, patients’ evaluation of stigma and the public expression of
stigma. There is a significant need for deeper, more nuanced understandings of the cultural factors that are salient with regard to stigma and the ways stigma shape attitudes toward mental illness in order to develop methods of change. In addition, identified cultural values, where individuals are expected to be ‘strong,’ may also be addressed in different psychological approaches. This is a way to implement cultural sensitivity into professional practice. Conversely, this brings implications for psychologist to provide cultural sensitive approach, as well as to value community’s assets, talents and skills that can contribute to improvement mental health service provision.

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