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CULTURE AND PTSD

Trauma in Global and Historical Perspective

Edited by

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and

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CHAPTER 11

Culture, Trauma, and the Social Life of PTSD in Haiti

Erica Caple James

The massive shock experienced by millions in Haiti and the Haitian diaspora during and after the January 12, 2010, earthquake has provoked numerous psychosocial rehabilitation projects in response to this emergency. International medical missions, faith-based, humanitarian relief, and development aid organizations (among others) have inaugurated a variety of trauma treatment programs in Haiti that offer competing and sometimes conflicting interventions. Each also arises from distinct views of the relationship between personhood and embodiment and produces modalities of redressing suffering that are rooted in particular cultures, histories, and clinical perspectives. For example, the Israel Center for the Treatment of Psychotrauma (ICTP) has launched an elementary school–based program, Project Resilience Haiti: Rebuilding Community,[1] which uses cognitive behavioral therapy, eye movement desensitization retraining (EMDR),[2] somatic experiencing,[3] and other therapeutic methods to identify and treat posttraumatic distress in Haitians. In another example, the Unitarian Universalist Service Committee sponsored representatives from the U.S.-based Trauma Resource Institute (TRI),[4] an organization established in 2006,[5] to train Haitian caregivers in "somatic trauma-healing techniques."[6] The TRI's trauma resiliency model (TRM), assumes that trauma is a universal physiological phenomenon and claims that its treatment—an amalgam of somatic-based therapies like Jane Ayres's sensory integration theory, Eugene Gendlin's focusing, and Peter Levine's somatic experiencing—has been substantiated by current research about the brain.[7] Another psychosocial intervener after the earthquake—the

Center for Mind-Body Medicine, founded by James S. Gordon, M.D., in 1991—launched a local version of its Global Trauma Relief (GTR) program in Haiti. GTR "pioneers," as its website describes them, train "local healthcare professionals and educators to teach children and adults simple, powerful self-care and self-awareness techniques that can relieve stress and suffering, using the Center's unique small group model."[8] According to Dr. Gordon, the goal of the program is "to create an organization that will respond as Doctors without Borders does to the physical . . . to the psychological and emotional needs of whole countries."[9] Underlying these globalizing mental health treatment ventures is an assumption that trauma, and specifically posttraumatic stress disorder (PTSD), are universal conditions that can be ameliorated through each brand of treatment.[10]

As I have documented elsewhere (James 2010), the inauguration of mobile mental health therapeutic programs in response to social disruption and states of emergency in Haiti is not a new phenomenon. The rapid propagation of psychosocial interventions in the aftermath of the earthquake suggests that now is the time to return a critical eye to the subject of PTSD and its controversial social life in the troubled nation. Haitian mental health professionals concur with this cautionary stance. In response to the onslaught of requests from "relief organizations, missionary groups, and others with disaster counseling skills" seeking information on how to implement mental health treatment programs in Haiti, Dr. Guerda Nicolas, a psychologist with long-standing experience conducting clinical work both in Haiti and with diaspora Haitians in the United States, warned prospective interveners: "Please stay away—unless you've really, really done the homework. . . . Psychological issues don't transcend around the globe. . . . People fail to recognize that it's not going to work the way you think it's going to work, it's not just an issue of being trained as a psychologist. . . . The kind of treatment model developed for PTSD doesn't integrate folk medicine, it doesn't take into account cultural aspects, and it makes the assumption that people have the wherewithal to avoid traumatic events."[11] Dr. Nicolas's statements raise provocative questions regarding the universality of PTSD and, if the disorder truly does manifest globally, whether cultural, material, and structural conditions are factors that shape its occurrence. A subtle tension implied by this statement (the exploration of which is beyond the scope of this chapter) is the extent to which the development of PTSD is a biological universal or the product of "local biologies" (Lock 1995; Lock and Nguyen 2010)—"the way in which biological and social processes are inseparably entangled over time, resulting in human biological difference . . . that may or may not be subjectively discernible by individuals" (Lock and Nguyen 2010:90).

The DSM's PTSD construct implicitly assumes a set of psychosocial and material conditions that may produce individual behaviors of avoidance of contextual and environmental triggers (among other responses). For many in Haiti, however, avoidance of settings or contexts that evoke past traumas may be difficult, if not impossible, because of complex phenomena comprising *ensekirite*. Since the late 1980s, the term "ensekirite" (Haitian Creole for "insecurity") has indexed the ontological uncertainties and dangers of an everyday political, criminal, and interpersonal violence that has flourished amidst growing risks of environmental and infrastructural harm (James 2008, 2010). In my usage of the term, ensekirite describes the experience of living at the nexus of multiple uncertainties[12]—political, economic, environmental, interpersonal, physical, and spiritual—and as I will discuss later, ensekirite is mediated through the body.

Given such circumstances, what severity of symptoms and evidence of debilitating experience meet criteria for PTSD, especially in contexts in which ruptures in daily life are routine? Although imported brands of trauma therapy may prove efficacious in ameliorating the struggles of Haitians in the aftermath of psychosocial ruptures, there may also be impediments to effective treatment that result from reliance on the DSM's PTSD criteria to diagnose traumatic sequelae. For example, Dr. Nicolas's work with Haitian immigrant woman has shown that cases of severe depression have been missed because patients did not display disturbances of weight, sleep, attention, or mood that met DSM criteria. According to Nicolas, "You can have a Haitian who is very, very depressed and they get up in the morning, they take care of their kids, they still get dressed, they go to work . . . [b]ut they still have this sense of emptiness that they cannot describe."[13] The example of the "underdiagnosis" of depression among Haitian immigrant woman in the United States raises questions of whether the DSM's PTSD diagnosis might also be underdiagnosed, not only among Haitian immigrants but in Haiti itself—especially given the variability and specificity with which trauma manifests cross-culturally, and the routine occurrences of ruptures of varying magnitudes that are characteristic of ensekirite.[14]

In this essay, I raise questions about the PTSD diagnosis and its social life in Haiti. I argue that the efficacy of mobile modalities of mental health treatment depends on the extent to which these models take into account how Haitian traditional understandings of personhood, embodiment, and trauma

are complex and dynamic. Customary or vernacular methods of care for emotional and physical distress can provide a language through which many Haitians understand and express their trauma. Nevertheless, even these culturally based methods of care may fail to repair the ruptures wrought by devastating social experiences. Organized efforts to address and redress psychosocial trauma must also respond to the phenomena of ensekirite. It is important to note, however, that just as the PTSD diagnostic criteria have changed (see Good and Hinton, the Introduction to this volume), the contours of ensekirite and its psychosocial sequelae have also transformed over time. As the stories in this chapter demonstrate, the conditions of rupture that occur cyclically in the nation may provoke the irruption of past traumas (and affect the experimental or improvisational manner of its treatment) in unanticipated ways.

This essay is a meditation on more than twenty-seven months of field research I conducted in Haiti between 1995 and 2000, tracing the international-, national-, and local-level responses to traumatized victims of human rights abuses from the 1991 to 1994 coup periods. In 1996, I was invited to volunteer[15] at a women's clinic that Haitian and U.S.-based women's rights organizations had founded that year in Martissant, a highly populated *bidonvil* (shantytown) just outside Port-au-Prince. I worked there regularly until spring 1999. Between 1998 and 1999, I also trained with Haitian mental health practitioners at the Mars/Kline Center for Neurology and Psychiatry at the State University Hospital to understand better the subjective experience of psychosocial trauma in Haiti. Moreover, between 1997 and 2000, I worked at the Human Rights Fund, a political development assistance program funded by the United States Agency for International Development that housed a rehabilitation program for torture survivors and their dependents. In addition to providing a number of other medical, legal, and social services to victims and their dependents, the Rehab Program, as it was called, held therapy groups for its beneficiaries in which I participated. I also analyzed hundreds of client dossiers that represented the traumatic experiences of nearly twenty-five hundred beneficiaries of the program.

Throughout these ethnographic fieldwork and therapeutic activities I witnessed how ensekirite was becoming both a material and ghostly presence that affected many people physically, emotionally, and even spiritually. Acts of violence were visible but complex—simultaneously displaying motives of personal vengeance, economic profit, and political threat. I also learned that ensekirite indexed the uncertainties and risks of life in a nation hampered

by a succession of natural disasters, and technological and industrial accidents—routinized ruptures that make the resumption of normal life difficult, if not impossible. In response to such conditions, numerous international (and national) mental health interveners like those described above attempted to redress the long-term effects of psychosocial trauma in everyday life, but to varying degrees of success.

In the remainder of this chapter, I describe the relationship between ensekirite and psychosocial trauma as articulated in a variety of therapeutic contexts in which I was a participant in the late 1990s and analyze how the dynamics I observed challenge conventional understanding of PTSD and its contemporary treatment in Haiti. I have selected two cases from my fieldwork that have troubled me in the years since I left Haiti. Each in different ways illustrates the complex experiences of ontological insecurity and the disordered subjectivities that such states may produce. The story of a young man whom I call Jean-Robert Paul, whose parents were targeted for political violence during the 1991–94 coup years, provides context for conceptions of personhood, embodiment, and emotion in Haiti. Not only does his case illustrate how the experience of ontological insecurity may fracture individual subjectivity, it also shows some of the unintended negative consequences of improvisational treatment that well-intentioned national and international interveners provided to Haitians both within and across national borders.

A second story, of a woman whom I call Odette Jean, raises several questions about the subjective experience of trauma, the ways in which PTSD may or may not manifest, and the efficacy of mobile mental health interventions currently being implemented in post-earthquake Haiti. Through these examples this chapter offers the following main points: First, interventions focused on the psychosocial effects of the earthquake must also track the ways in which traumatic experiences sustained during past periods of acute ensekirite (and as a result of human-authored, rather than natural disaster) may complicate how trauma manifests in response to subsequent ruptures in routine. Second, either in cases of human-authored or natural disasters, the lack of knowledge about missing persons and the inability to observe customary mortuary rites for those lost and presumed dead are among the most devastating experiences for Haitians, which, when unresolved, can contribute to posttraumatic stress.[16] Third, there remains a risk that in acknowledging the cultural and temporal specificity of Haiti trauma in climates of ensekirite, Haitians may be viewed as not meeting criteria for PTSD and be denied treatment that would provide a standard of care in settings of greater security.

Conversely, under conditions of social instability and rupture, international (and even national) interveners implementing a variety of brands of mobile trauma therapies may inadvertently perpetuate a situation in which care is experimental, unregulated, and unsustainable—placing further at risk already vulnerable Haitians. Finally, psychosocial treatment programs focusing on acute *individual* traumatic suffering will not be effective in the long term unless *collective* security—political, economic, and social—is established and sustained in Haiti.

Ensekirite and Trauma in Haiti

Between 1957 and 1986, the Duvalier dictators inculcated a climate of terror in Haiti by deploying the military to target particular kinds of violence against individual enemies of the state and civil society associations. The *tonton makout*—armed paramilitary forces that mobilized the baneful power of the occult to threaten, extort, and repress fellow citizens—instilled fear in and controlled communities across the nation (Trouillot 1990). The methods of "necropolitical" terror (James 2010; Mbembe 2003)—acts that subjugated life using the power of death to violate moral, social, and physical boundaries—were rape, disappearances, murder, display of corpses, and other egregious acts. This style of violence was first used systematically during the presidential administration of physician and ethnologist François "Papa Doc" Duvalier (1957–71) and continued under the reign of his son, Jean-Claude "Baby Doc" Duvalier (1971–86), until his ouster and exile in 1986. Between 1986 and 1990, reciprocal violence occurred between members of a reactionary military that reproduced "Duvalierism without Duvalier" with impunity, and the militarily weaker prodemocracy sector—some members of which attempted to "uproot" (*dechouke*) individuals known to be Duvalier loyalists or tonton makout. During this period Haitians began to use the term "ensekirite" to characterize the violence throughout the nation, but especially to connote how the repression was especially acute for the poor who remained targets of Duvalierist forces.

Despite the overarching atmosphere of fear and uncertainty, on December 16, 1990, Haitians elected to the presidency former priest Jean-Bertrand Aristide, a staunch advocate for political and economic justice who gave voice to the frustrations of the poor. Hopes for democracy were short-lived: on September 30, 1991, the Haitian military usurped power and forced Aristide into exile after less than eight months in office. During the three years of ensekirite that followed, the coup apparatus—composed of members of the army, civilian paramilitary attachés, and *zenglendo* (armed bandits or criminals)—deployed necropolitical violence on a widespread scale in attempts to destroy systematically the physical, social, kinship, and moral foundations of their opposition. While the international community debated whether or not to intervene militarily to restore democracy, the strategies of detention and disappearances, gang rape, repeated rape and forced incest, murder and mutilations of corpses, and theft and destruction of property, were directed against those individuals and neighborhoods held to be loyal to President Aristide. The U.S.-led Multinational Force (MNF)—a coalition of military units from twenty-eight nations authorized by U.N. Security Council Resolution 940—intervened in September 1994 to restore Aristide to the presidency (on October 15,1994), thereby inaugurating the postcoup era of "democracy." During this time of entrenched economic stagnation, ensekirite continued unabated but in altered form. It began to refer to the proliferation of political, criminal, and gang violence that could occur at any moment and without a predictable pattern, as well as to the everyday crimes the political motivations of which were less clear. The combination of these forms of violence and social and material uncertainty hindered the nation's attempts to consolidate democracy, rule of law, and sustained economic growth.

The climate of fear inculcated by state-sponsored violence and the widespread material fragility of life in contemporary Haiti is but one aspect of a broader, collective sense of "ontological insecurity" (Giddens 1984) that especially characterizes the life of the poor. In his complex structuration theory, the sociologist Anthony Giddens defines ontological security as "confidence or trust that the natural and social worlds are as they appear to be, including the basic existential parameters of self and social identity" (1984:375). The *sense* of security generated by the routinization of daily life is integral to and engenders the existential foundations of self and body, social action, and, ultimately, the reproduction of the structure of society. As the foregoing discussion shows, the reality of ensekirite in Haiti, especially among the poor, is that there can be no presumption of stability, security, or trust for the individual or collective group. On the contrary, "ontological insecurity" (Giddens 1984:62) forms the existential ground of day-to-day life in Haiti, where disruptions and fluctuations in social institutions and practices may be the norm. In post-earthquake Haiti, even the sense of security

that the physical geography may have once provided (despite recurring fluctuations in the sociopolitical sphere) can no longer be presumed.

To some extent, PTSD, a psychiatric diagnostic category utilized in Haiti only relatively recently, has been useful to describe the profoundly disruptive impacts of ensekirite and can assist in describing what for many Haitians has been a paradigmatic shift in the mode of being-in-the-world. But PTSD still fails to capture the complex effects of ongoing uncertainty in Haiti. In my discussions and physical therapy with women of Martissant, their suffering corresponded to continual stressors, rather than a single etiological traumatic event from which there was now a "post"—as is commonly conceived of PTSD (Basoglu 1992; Herman 1992; van der Kolk et al. 1996; Marsella et al. 1996; Young 1995).

Furthermore, the conception of trauma or the traumatic memory as residing in the individual sufferer and originating in the past was belied by my experience of everyday life in the Martissant bidonvil. There the literal ghosts of the past are very present in mundane reality and irrupt into conscious awareness from both within and without the individual (James 2008). States of ensekirite force us to ask the following question: when ruptures in the fabric of social life are routine, of what use is a concept of *post*traumatic stress? What threshold or boundary exists between normal mourning and grief and pathological responses to traumatic events? When ruptures become routine, what possibility is there for sustained hope, or for a sense of ontological security? In what social institutions or actors can Haitians invest as guarantors of public health and security?

The Social Life of PTSD in Haiti

The DSM's PTSD construct has been influential in the development of what I have called elsewhere the "political economy of trauma" (James 2004). PTSD was exported to Haiti in the 1990s through multiple international humanitarian relief efforts following both human-authored and natural disasters. During my ethnographic study of rehabilitation programs aiding survivors of organized violence, I learned how trauma treatment practices transformed the political subjectivity of both providers and recipients of care. Haitian psychiatrists and psychologists who had trained abroad adopted the DSM-IV PTSD diagnostic category in their clinical work and teaching at the State University Hospital's Mars/Kline Center for Neurology and Psychiatry. In our

discussions between 1998 and 1999, many clinicians felt the PTSD category was superfluous and claimed that its features could be encompassed by depression and anxiety. Many also felt that the diagnosis failed to address the particular cultural ways that Haitians experienced emotional distress after a shock. In a context in which international humanitarian aid organizations wielded and continue to possess tremendous power over Haiti and its citizens—a form of humanitarian governance that has expanded exponentially since the earthquake—Haitian mental health practitioners deployed PTSD to demonstrate their own clinical competence (Good 1995, 1999) and to access both national and international resources for the public and private institutions with which they were affiliated. The technologies of trauma used to aid Haitians to render inchoate experiences of victimization discursive and legible contributed to the commodification of their suffering. An unintended consequence was that formerly independent activists (*militan*) adopted new identities as patient-clients of the aid apparatus.

This political economy of trauma notwithstanding, the PTSD construct can provide tools for understanding the extreme suffering of Haiti's victims. Some Haitians manifest posttraumatic stress in ways that resemble biomedical conceptions of PTSD; however, their so-called symptoms are frequently interpreted through other moral meaning systems. For example, one woman with whom I worked closely between 1997 and 1999 in administering a Haitian Creole translation of the Clinician-Administered PTSD Scale remarked that she frequently saw *vizyon* (visions)—a term that typically refers to religious visions—on a "screen" in front of her. These images, however, were of her own victimization by members of the coup apparatus rather than of explicitly religious content. That religious discourses would provide a structure or framework through which to interpret extraordinary experiences is not surprising. Proponents of evangelical Protestantism have traced the roots of Haiti's individual and collective traumas to historical involvement with the widespread religion of *Vodou*, from the purported diabolical pact that Haitians made with Satan in 1791 to attain the powers required to overthrow French colonial forces (McAlister 2012) to contemporary practices of ancestral and family religious traditions. Understandings of suffering arising from and linked to the epistemology of the Vodou tradition may also identify the ultimate etiology of affliction in the moral realm, for example, the failure to uphold kinship and other spiritual obligations, or—particularly with respect to the baneful practices of sorcery—as the result of another individual's jealousy or malediction (Brodwin 1996; Farmer 1992; James 2012). In these

cases, conversion to Protestantism has become a means by which some Haitians sought psychosocial healing, and economic and spiritual security, as well as immunity from vulnerability to others' occult practices (Conway 1978).

As I observed during my fieldwork, these religious perspectives operated alongside the secular theodicies of feminism and human rights. Haitian *viktim*—self-named "victims of human rights abuses"—whom I encountered at the women's clinic and Human Rights Fund reinterpreted the ultimate causes of their suffering through a political lens as the result of gender inequalities and a predatory state. But these secular interpretations were often insufficient to mitigate the ongoing subjective experience of trauma.

Personhood, Embodiment, and Emotion in Traditional Haiti

My understanding of Haitian traditional conceptions of embodiment derives in no small part from the clinical and therapeutic work in which I participated among the poorest residents of Port-au-Prince and the provinces and from analysis of the testimonies and other documentary evidence contained in the case files at the Human Rights Fund.[17] From these qualitative and archival methods I learned that several cultural components influenced the subjective experiences of emotion, illness, and suffering: the religious beliefs and ritual practices of Vodou—comprising a mélange of European Catholic, Masonic, indigenous, and African traditions that fused during the colonial period; the crafts of bonesetters (*doktè zo*), midwives (*fanm saj*), and other manual therapists; and, in many cases, the theologies of the evangelical Protestant denominations that understand everyday life in Haiti as subjected to the struggles between unseen forces.[18] I also came to understand that many Haitians experienced the circulation of substances like blood, heat, and cold in the body; the unpredictability of environmental forces; the acts of invisible spirits and ancestors; and the benevolent and malevolent magical practices of occult actors, as factors affecting the relationships between psyche and soma.

In Haitian traditional culture, the "self" or "person" is located at the nexus of relationships among the living, the ancestors, and the divine spirits (*lwa*) (Brown 1989:257; 1991). In order to maintain balance among the person, family, and larger community, individuals must honor the duties and obligations that accompany each relational linkage between the living and the

dead. Although personhood and identity are indelibly tied to the lwa for ritual practitioners of Vodou (Dayan 1991:50), I found that even for Haitians who did not explicitly admit to or describe service to the divine spirits, their understandings of the embodied self were inextricably linked to the folk religion's theology. The embodied person comprises multiple parts. The *kò kadav* is the material body. It is separable from the complex soul and decays after death (Brown 1989:265–66; Dayan 1991:51). The *gwo bonanj* (the big guardian angel), is a nonmaterial "metaphysical double of the physical being" (Deren [1953] 1970:226) that detaches from the body during sleep (Brown 1991:351–52; Dayan 1991:51; Deren [1953] 1970:25–26; Larose 1977:92; Métraux [1959] 1972:120, 303) and in the course of ritual spirit possession—returning after the lwa has completed its intended action (Bourguignon 1984:247). An individual experiencing emotional distress may say that his or her "big guardian angel" is upset (Brown 1989:264). Vulnerable to sorcery and magic, the gwo bonanj can be especially defenseless at death, when it may become a "disembodied force wandering here and there"—a *zonbi*[19] (Larose 1977:93). Somewhat like the lwa, the detached zonbi can possess individuals; but rather than manifesting in a circumscribed ceremonial context, the zonbi acts as an unruly and malevolent force seeking a permanent home until it can be detached through ritual means. A captured zonbi can also be sent by a relative to avenge an injustice before the mortuary rituals have dispersed it (Larose 1977:95; McAlister 2002:102–11). In addition to the gwo bonanj, the *ti bonanj* (little good angel) is a force that is deeper than consciousness, acts as a conscience, and can enervate the individual in times of stress (Brown 1989:265; Deren [1953] 1970:26; Larose 1977:94). The *nanm* is the animating force that disappears after corporeal death (Brown 1989:264). Finally, the *zetwal* (star) is a celestial component of the self that resides outside the body and relates to the person's destiny.

The seat of the gwo bonanj is the head (*tèt*), an important component of Haitian ethnophysiology that links psyche and soma, as well as the material and spiritual dimensions of many emotions, illnesses, and diseases. Disorders of the tèt give rise to a number of bodily afflictions like *tèt fè mal* (headache, migraine), *tèt vire* (dizziness, vertigo), and others to be discussed below. As a result of a variety of psychic, social, spiritual, and material (etc.) imbalances, the tèt may become the repository of excess bodily substances or forces: "When an individual is worried, his or her head is said to be 'loaded.' In excitement, the head heats up; when the head cools, the individual becomes calm, also sad" (Bourguignon 1984:262). The substance that regulates

the circulation of hot and cold in the body is *san* (blood); imbalances in its flow render individuals vulnerable to illness (Laguerre 1987:70). Foods that one eats, individual acts, and environmental and the aforementioned spiritual factors influence the balance of heat and cold in the blood (Laguerre 1987:70–71). The permeable boundaries of this embodied self render subjectivity and life itself as relational, but also subject to the precarities of local behavioral ecologies (or local biologies).

The foregoing discussion presents an image of an embodied subject whose social relationships and environment are also constitutive aspects of subjectivity, of the self, and of personhood.[20] For Haitians who become possessed by divine entities while serving the spirits, or furthermore, who are slain in the Holy Spirit in Protestant and Catholic charismatic worship services, dissociative states are not necessarily alien or pathological; rather, they are desirable. However, ruptures in the linkages among the individual, community, ancestors, and the lwa can cause emotional disorders, illness, and other material and spiritual problems, not only for the individual, but also for the extended family, both living and dead.[21] Given these complexities, how do Haitians define trauma? How should it be treated? Does the narration of suffering necessarily facilitate healing at either individual or collective levels?

I raise these questions knowing that I cannot answer all of them in this short essay but offer now the case of Jean-Robert Paul as one that offers some troubling answers. In this example, Jean-Robert is situated at the nexus of the encounters among Haitian traditional understandings of emotional and physical distress (and their remedy), and a bricolage of pharmacological treatments proffered by international biomedically trained clinicians in the United States and their expatriate and Haitian counterparts in Haiti.

Jean-Robert Paul

I met Jean-Robert in 1998 at the Human Rights Fund Rehabilitation Program, "the Fund," as the program was called informally. He was a twenty-one-year-old man who worked now and then as a groundskeeper, primarily to "hang out" with staff in the *lakou* (courtyard) inside the walled campus. Of slight but not frail build, he had a mischievous grin and sunny disposition, always smiling at me when I arrived each day. At times he was the object of ribbing, especially when he tried to banter with the armed private security guards and drivers who congregated on the verandah at the entrance to the gingerbread-style building. Jean-Robert had been a beneficiary of the Rehabilitation Program since April 1997. He was considered an indirect victim of politically motivated violence because his parents, pro-Aristide activists, were direct victims of human rights abuses. They had been murdered in 1994, just prior to the restoration of constitutional order. Gaining beneficiary status provided Jean-Robert a small stipend, housing assistance, medical care, and other social support.

However, Jean-Robert may also have had a liminal status at the Fund because he was also perceived to be *fou* (insane). When I inquired about him at the Mars/Kline Center for Neurology and Psychiatry and among the facilitators of the therapy groups for viktim at the Fund, both the international and Haitian mental health specialists had labeled him schizophrenic. They told me that his memories of the circumstances engendering his beneficiary status were disjointed and tremendously distressing. I would eventually witness directly what I interpreted as the irruption of the traumatic past into the present. The incident caused me to question further the concept of PTSD and how it might manifest in cross-cultural contexts.

One day inside the Human Rights Fund building, Jean-Robert suddenly became angry and aggressive toward staff members. He had come to request additional financial support, but at the time program funds were diminishing. The program director denied his request and in response, Jean-Robert became agitated. Then, something shifted, transforming Jean-Robert's usual demeanor and seemingly allowing another "persona" to speak the frustration of his condition. This shift was alarming, a stark contrast to his customary "presentation of self in everyday life" (Goffman 1959). His face changed, becoming taut and drawn with tension. His gaze no longer focused on the physical space around him. Rather, he seemed to be peering into the distance, perhaps recalling the past, but not seeing those of us physically near him. He started breathing heavily and was clenching and unclenching his fists. He began speaking strongly and with a deeper voice that was quite different from his usual soft-spoken tone. It was one with eloquence and passion, but also pathos. He said, "Look at me. Look at my body. Look at how I've shrunk in size. I used to be a man. I don't have anywhere to sleep. I don't even have a bed." The two nurses who staffed this program quickly approached Jean-Robert to calm him down. One wiped his forehead, attempting to cool him down. He seemed shaken by the force of emotion that had overcome him and by his own utterances, but was eventually soothed, returning to the placid individual to whom I had become accustomed.

Later, the nurses explained that his head (tèt) had become hot (*cho*) and that their ministrations had been meant to reverse the flow of excess blood to the head that caused his outburst. Building on the discussion above of traditional understandings of embodiment in Haiti, the condition of *tèt cho* (hot head) or *move san* (bad blood) (Farmer 1988), could cause *endispozisyon* (indisposition)—spells of falling out or fainting and weakness—as well as other disordered states. Jean-Robert's condition of tèt cho was common among the Rehabilitation Program clients. Many Haitian mental health practitioners told me that a heightened emotional state and propensity to eruption in aggression was characteristic of viktim, a pattern that accords with DSM-5's criteria for PTSD. However, the moment Jean-Robert's behavior and speech changed also resembled the way that the lwa, the Haitian Vodou spirits, entered the head of a supplicant and began communicating through the devotee's body. Although in ritual circumstances the entrance of the divine spirits is desired (Brown 1991), in this case, possession by the specter of a traumatic past was an unwelcome intrusion, despite its prophetic, revelatory nature. But such a manifestation of distress might also be interpreted through the DSM-5's description of dissociative reactions.

Jean-Robert's status in relationship to this U.S.-funded trauma treatment program raises larger questions about the moral and political economy of PTSD in Haiti that I can only gesture toward here. How had Jean-Robert become the ward of an international nongovernmental organization and a patient of international and national psychologists, psychiatrists, and other humanitarian aid workers in Haiti? What happens when a succession of biomedically trained caregivers attempt to treat conditions with which they possess little familiarity and experience, not to mention, cultural competency, and the care is perceived as harmful rather than palliative?

Jean-Robert's past can be reconstructed only in part. Its ghostly traces existed in fragments contained in his "trauma portfolio"—the case file containing affidavits and medical records documenting his past experiences of rupture—and in the memories of the caretakers who had provided him asylum. As mentioned above, in June 1994, just prior to the restoration of democratic order by international military intervention, the young man became what the Rehab Program characterized as an "indirect" victim of organized violence. He had been seventeen years old, an only child, and residing with his family in a small, isolated coastal town near the westernmost tip of Haiti's southern peninsula. On that fateful day in June, members of the military murdered Jean-Robert's parents on the street in a quintessential example of

necropolitics. One of his psychologists told me that soldiers wielding machetes beheaded his parents directly in front of him. The killing ruptured the ties between him and his natal family, and subsequently, to his country.

After the decapitation of his parents, Jean-Robert fled Haiti with hopes of attaining asylum in the United States. I do not know if he was able to perform customary mortuary rites to lay the souls (zonbi) of his parents to rest or if he left immediately. Customarily, funerary rites would have included more than a week of activities immediately after death and would comprise a "wake, funeral (in a chapel, if possible), procession to the cemetery, and burial" after which "the nine-day mourning period begins, in which relatives and neighbors of the deceased gather nightly to mourn, chant Catholic texts, socialize, recreate, and cajole the dead (with food) to take leave of the living for the world of the ancestors" (Richman [2005] 2008:124).[22] As I have documented elsewhere (2008, 2010), the failure to perform customary mortuary rites—whether from lack of the body or of means to conduct these time- and resource-consuming practices of sociality—could be devastating socially, emotionally, and spiritually. Angry spirits can even torment survivors, leaving what one woman with whom I worked described as stigmata on her body after nightly struggles with the spirit of her deceased husband (James 2008).

It is doubtful that the then seventeen-year-old young man, fleeing for fear of further persecution, had the financial means or the time to arrange these mortuary practices. Jean-Robert most likely left immediately after the murders to seek sanctuary outside Haiti. What is certain is that he disembarked on a perilous journey by boat with hopes that refuge lay in the United States. Such sea journeys are hazardous and frequently result in interdiction, immediate repatriation, or even death by starvation or drowning. Jean-Robert was fortunate to have landed in south Florida, but he was apprehended and then detained at the notorious Krome detention facility in Miami while his asylum request was pending. In the 1980s, the conditions at Krome were deplorable, leading one writer to compare the adult facility to a "theater of the absurd" and to a concentration camp (Nachman 1993:251, 254). Conditions in the early 1990s provoked hunger strikes among inmates and protests by human rights activists outside its walls.[23] But as an unaccompanied minor, Jean-Robert did not remain there long. In September 1994, he received asylee status and was sheltered in a program for unaccompanied minors in Boston, Massachusetts. There he began to unravel.

Jean-Robert's trauma portfolio provides some information about the onset of psychosis. After arriving in the U.S., he began recalling how his

parents had been murdered, and a note in his case file says that from that moment of recall his "disorder was unleashed" (*la maladie est déclenchée*). He suffered visual and auditory hallucinations and paranoid thinking and was violent toward others. Psychiatrists diagnosed "subchronic schizophrenia" and prescribed antipsychotics and antidepressants. During one acute psychotic episode, Jean-Robert was hospitalized and injected with antipsychotic and antispasmodic drugs. Presumably, he had not been compliant with his treatment and the injections ensured that his symptoms would be managed. Jean-Robert felt that the medications were too strong, and he reported that they "hit him in the head." That he experienced medical treatment as blows suggests that their intent was to pacify and subdue him, rather than to relieve his suffering.

In October 1996, despite receiving political asylum, Jean-Robert was repatriated to Haiti. Upon his arrival in Haiti the United Nations International Civilian Mission processed Jean-Robert's case without providing treatment; its victim assistance services had been suspended earlier that year. His trauma portfolio was next transferred to Médecins du Monde (Doctors of the World), whose Spanish psychiatrist examined him and diagnosed schizophrenia, but otherwise good health. She proposed psychotherapy and a new course of antianxiety and antipsychotic medications.

Throughout these travails and shifts from one institution and organization to the next, Jean-Robert had not asked for treatment but rather, amelioration of the structural conditions that prevented him from living. His report states that as he was unemployed and that he desired social assistance and return to the United States. Unfortunately, in 1997 Médecins du Monde also ceased providing treatment to victims of human rights abuses. Jean-Robert was next transferred to the Human Rights Fund, receiving eligibility in April of that year. In 1999, a few months after I witnessed Jean-Robert's dissociative outburst, the Rehabilitation Program would also cease providing services, leaving its beneficiaries to seek support from the fragile Haitian state or to negotiate the cycles of insecurity on their own.

How are we to interpret the fragments of Jean-Robert's case? Certainly, these rehabilitative measures transformed Jean-Robert's disordered subjectivity in both positive and negative ways, offering care on the one hand and a measure of security, but also the "pharmaceuticalization" of self and bodily experiences on the other (Biehl 2010). Nonetheless, the national and international charitable, human rights, religious, and medical groups intervening to aid Haitians during its persistent states of emergency had limited

capacity to provide sustainable assistance. As each organization lost funding, it transferred its collective trauma portfolios and the work of care to other organizations with means. Unfortunately, Haitians with chronic disordered conditions received less social and material support to rebuild their lives and find paths toward sustainable security. But it is important to note how many of these institutions medicalized, and in large part, depoliticized the grief and feelings of loss (and righteous indignation) that Jean-Robert suffered when he desired social support, the right to work, health, justice, and security.

Odette Jean

My work with Odette Jean raises additional provocative questions about how to address complex posttraumatic stress in situations of chronic insecurity and the gendered ways in which Haitian trauma and mourning manifest and are mitigated. In February 1999, I interviewed Odette, then a fifty-eight-year-old woman, in the clinic at which I had voluntarily been providing physical therapy to rape survivors and other women patients. In the small room where we worked, Odette spoke about the violence in the neighborhood as a component of her life story. A few days prior to our meeting a brutal murder had taken place in the mountains above the clinic. Odette heard about the killing from other women who lived near the murder site—a section of the deforested mountain called the Zòn (zone) Siyon. During the coup years, the *siyon*, an open-air evangelical Protestant church, had sheltered many internally displaced Haitians. The mountain was now freckled with makeshift shacks and one-room cinderblock homes with tin roofs, where large families of squatters had built permanent homes.

Odette described how gang members killed the young man, the son of a friend of hers, for unknown reasons. The murderers drowned him, submerging his head in an oil drum that stored rainwater. Residents of the neighborhood were too frightened to bury the body or to report what had happened to the police, as the perpetrators lived in the same neighborhood. Eventually, a couple of women who were also clients of mine went to the police to report the death, and the young man was eventually buried. The story was extremely distressing for Odette because it reminded her of when her own family members were attacked roughly eight years prior to our interview while living in the same vicinity.

Although I had heard many disturbing stories about violent crime in Martissant during and after the coup years, and witnessed its effects on the women I saw at the clinic, what struck me on this occasion was *how* Odette recounted the story. At the time her words came in halting fragments and erupted into the narrative of the recent murder in disjointed elliptical phrases. She then slipped into a description of her embodied shock (*sezisman*) and feelings of resignation after her own past losses, then a few words later returned to the story of the recently drowned young man. Odette appeared to be moving in and out of intrusive memories, at times whispering and gazing off at a distance then returning to the present. I then asked her if we could use a diagnostic interview schedule, the Clinician-Administered PTSD Scale for DSM-IV (CAPS) (Blake et al. 1998)—in which I had received training in 1998 at the National Center for Posttraumatic Stress Disorder from the authors of the instrument—as a means to provide a structure through which to approach these distressing biographical details.[24] She agreed, and over the course of a two-hour interview we attempted to reconstruct some tragic events of her life history. Throughout the interview, the events of 1990—when her family members were raped, murdered, and disappeared, and her house was destroyed—and the murder in 1999 of the young man, erupted into the narrative, as did descriptions of the bodily suffering such events caused her. These traumas were the center around which her narrated life history pivoted.

Odette was born in Aux Cayes du Fonds in the southern peninsula of Haiti. Her mother died from an unnamed illness and her father took care of her and her brother until he remarried. When her father died, her stepmother mistreated her and forced her to work from morning until night, denigrating her verbally, and withholding food, soap, and clean clothing. Like many young women who lived in perilous domestic conditions Odette escaped to the capital at the age of sixteen to seek a better life. She began living in the slums of La Saline and later found some security working as a maid for a French family. At around twenty years of age, she fell in love with a young man and became pregnant; however, the young men left her as soon as he learned of the pregnancy. (It's not clear whether she was still working for the French family at this point and was ejected from the household or if she was living on her own.) She described being homeless during her pregnancy and malnourished, and she lacked funds to pay for medical care for the delivery. The General Hospital charged 10 gourdes at the time (approximately US$2) and she had no means of obtaining the sum. So when Odette went into labor, she spent four days attempting to deliver the child on her own without support. Upon returning to the hospital she was admitted and the doctors attempted to remove the child from her body alive, but her little boy had already died.

In the years after this loss, Odette went on to have five more children and described some success as a *madanm sara*, a market woman. She was living with her brother, a sister, and three of her children until that fateful day when her family was attacked because of their prodemocracy activism. Antidemocratic forces in her neighborhood had pressured them to vote against Jean-Bertrand Aristide, but her family remained loyal.

Odette could not give me the exact date of the tragedy that befell her family but stated that the attacks came prior to Aristide's taking power in 1991. As previously discussed, the necropolitical style of violence resembled what would later become a systematic and widespread pattern of terror used against poor Haitian activists both during and after the coup years. Not long after Aristide was elected president, members of the coup apparatus murdered one of her sons at the local market. Others entered her house, burning birth certificates and other identification cards, destroying all that she owned. Her daughter was gang raped. Another son fled the house. During the course of the attack, Odette also escaped and stayed in the unpopulated wilds of the mountains and ravines south of the squatter settlement. Although on October 15, 1994, the U.S. and UN military forces restored constitutional democracy, the intervention failed to disarm the coup apparatus fully. Many of the prodemocracy majority continued to live in the same neighborhoods as their still armed perpetrators. The political and criminal insecurity that ebbed and flowed as a result contributed to Haiti's ongoing economic stagnation and instability. Eventually she returned to living in the Martissant area, but at a much lower elevation than the Zone Siyon.

Odette felt deep remorse about not having prevented her daughter from being raped. Her daughter had become pregnant from the rape and had had a little girl, whom she had abandoned. The girl now lived with another family in the area. The little girl knew that Odette was her grandmother and occasionally approached her to ask for food or other support. This inability to help her granddaughter, because of her own poverty and ambivalent feelings, caused her tremendous suffering.

Most distressing was her son's disappearance. Odette had not heard from or seen the young man in almost ten years. He was presumed dead. It was the lack of knowledge about this missing son that tormented her. Not only was she unable to perform roles as parent and grandparent as would be

expected in this moral economy, the absence of his body prevented the fulfillment of customary mortuary rites enabling his soul's passage from living kin to the realm of the ancestors. But while describing how these distressing events dominated her thoughts—a pattern of uncontrollable rumination that Haitians called *dominasyon*—she abruptly returned to describing the conditions of insecurity in 1999, which included gang members who controlled when and how residents of the zone moved through public space.

She also told of her suffering from *tansyon* (literally, "tension"), a condition similar to high blood pressure, referring to a disorder of the blood that resulted from emotional distress. Throughout the interview she stated that she had problems in her head (*mwen gen pwoblèm nan tèt mwen*), and that since the recent murder of the young man was so close to where she once lived, it was as if the murder of her friends' son was also a loss for Odette to bear. It reminded her of how she fled her house when the attack occurred during the coup years and of her inability to protect her children.[25]

As I moved through the CAPS symptom checklist, Odette's negative responses to questions asking whether she experienced hypervigilance, negative affect, feelings of emotional isolation, startle response, or dissociation were surprising to me. Her ruminations on failing to fulfill expected kinship roles could easily be labeled survivor's guilt; she felt profound remorse because of her inability to take care of loved ones. She deliberately chose to reside in an area more distant from the site of her family's attack, as much to avoid the perpetrators who continued to patrol the zone as to avoid triggering horrific memories of that day. Was her posttrauma experience PTSD? Although she did not verbally state having symptoms that corresponded exactly to the DSM-IV criteria, she was among the most troubled individuals whom I encountered in therapeutic contexts in Haiti and seemed unmoored in time, space, and speech. Perhaps, like the women Dr. Nicolas described above as living with unrecognized depression, the traumatic sequelae of the ruptures Odette exhibited could not be captured as PTSD using the CAPS diagnostic instrument.

It may also be that her efforts to find relief through faith—a source of sustenance and resilience for many Haitians, but especially for women who had been targets of violence (Rey 1999)—provided means for coping with the unwelcome memories of her own losses amidst the ongoing insecurity of the zone. To a question that asked about intrusive memories, Odette said that for her the best way to survive was by forgetting. She said, "If you remember, you can't live." These unwanted memories were described as an oppressive

domination (dominasyon), and were said to hit her head (*frape tèt ou*). Too much rumination on the past (*kalkilasyon*) would kill her. Instead, her salvation lay in becoming another person through her faith in God and through religious conversion. By forgetting the past and what she could not control in the present, she had begun centering herself in the conversion experience, exercising agency, and perhaps, a modicum of control, through the disciplines of prayer and fasting for others, for Haiti, and for the world. Although Odette's life history contained a seemingly incessant chain of deeply distressing events, her strategies for survival and hope challenge contemporary conceptions of posttraumatic stress that would view avoidance of distressing thoughts as pathological, and would pose treatments that would encourage greater confrontation of and engagement with traumatic memories.

How should we interpret the fragments of this story, especially in light of the collective trauma that Haiti suffered on January 12, 2010? On that fateful day over two hundred thousand people died during the earthquake, and many were buried in mass graves without the mortuary rites that would be customary in Haitian culture. Odette's case suggests how the lack of knowledge of those who are missing may also traumatize thousands of Haitians over time, but especially those who are most vulnerable, the poor. Furthermore, about five thousand inmates escaped from damaged prison facilities and remain at large (BBC News),[26] and many have resumed former careers in fomenting ensekirite through violent crime, extortion, and patrolling of social space both within and outside the internally displaced persons camps. In the years after the earthquake, Haiti has confronted the resurgence of gang violence and sexual violence and the concomitant spread of infectious disease, especially in the camps. There has been an exponential increase of kidnappings of both Haitians and international humanitarians by these nonstate actors. Another unanticipated disaster is a devastating outbreak of cholera carried to Haiti by UN troops from Nepal.

The most pressing task at hand continues to be how to meet the basic needs of Haiti's citizens while also creating and sustaining collective security—a prerequisite, I argue, for aiding Haitians to come to terms with traumatic losses. As they had done during and after the 1991–94 coup years, and as described above, a plethora of organizations have established trauma treatment programs and other mental health initiatives around the nation. Although the various trauma treatment modalities that are currently being offered to Haitians may provide tools that aid in resolution of the psychosocial sequelae of ensekirite, one wonders whether and how successful

imported brands of therapy may be in the long term, especially if their techniques do not take into account traditional conceptions of embodiment and the complex self/soul. In addition to this, are the interventions offered sustainable—inculcating in patient/clients durable practices of self-care that may be employed to mitigate past and future ensekirite?

Effective programs must focus their interventions beyond the immediate effects of the earthquake in Haiti. These programs must be comprehensive, accounting for the ongoing effects of routines of rupture in the past, as well as current structural socioeconomic challenges. Nevertheless, international relief funds only trickle into Haiti and have limited effects on the lives of those most in need. But as both Jean-Robert and Odette's examples suggest, by focusing on treating trauma or PTSD to the exclusion of remedying ontological insecurity in Haiti, clinicians, mental health practitioners, missionaries, and other interveners may be medicalizing or pathologizing forms of mourning and grief that are becoming routine given Haiti's ensekirite rather than addressing its historical and (infra)structural roots. Without collective security, how effective can these programs be? Will they merely expand and sustain the political economy of trauma in Haiti, one in which the treatment of trauma aids the interveners as much, if not more, than Haitians?

Notes

1. The ICTP website asserts, "Children in Haiti are suffering from post traumatic distress that manifests itself both in psychological symptoms such as fear and anxiety as well as day to day functioning in school. Our resilience building interventions have been implemented in post-war and post-disaster environments in different cultures and countries and will be adapted to the language and culture of Haiti." See their website at http://www.traumaweb.org/content.asp?PageId=434&lang=En, last accessed January 29, 2014. Treatment modalities are described here: http://www.traumaweb.org/content.asp?pageid=113, last accessed January 29, 2014.

2. See http://www.emdr.com/, last accessed January 29, 2014.

3. See http://www.traumahealing.com/somatic-experiencing/, last accessed January 29, 2014.

4. According to the TRI's website (http://traumaresourceinstitute.com/trauma-resiliency-model-trm/, last accessed January 29, 2014), "Trauma Resiliency Model (TRM) Training is a program designed to teach skills to clinicians working with children and adults with traumatic stress reactions. TRM is a mind-body approach and focuses on the biological basis of trauma and the automatic, defensive ways that the human body responds when faced with perceived threats to self and others, including the responses of 'tend and befriend', fight, flight and freeze. TRM explores the concept of resiliency and how to restore balance to the body and the mind after traumatic experiences. When the focus is on normal biological responses to extraordinary events, there is a paradigm shift from symptoms being described as biological rather than as pathological or as mental weakness. As traumatic stress symptoms are normalized, feelings of shame and self-blame are reduced or eliminated. Symptoms are viewed as the body's attempt to re-establish balance to the nervous system."

5. See http://traumaresourceinstitute.com/history/, last accessed January 29, 2014.

6. http://www.uusc.org/content/trauma-recovery_group_continues_work_haiti.

7. See http://traumaresourceinstitute.com/history/, last accessed January 29, 2014.

8. See http://cmbm.org/global-trauma-relief/about-gtr/, last accessed January 29, 2014.

9. See *Healing Trauma, Restoring Hope*, http://cmbm.org/global-trauma-relief/the-campaign/, last accessed January 29, 2014.

10. Although the outpouring of assistance to the nation and its people is laudable, a troubling dimension of the expansion and proliferation of these treatment programs is the possibility that Haitian trauma—whether individual, collective, or even national—poses, for those who consider themselves mental health pioneers, a terrain that is ripe for cultivation and transformation through experimental measures, the efficacy of which may not be tracked or regulated by the state (Petryna 2009).

11. See http://www.huffingtonpost.com/erin-marcus/ptsd-manifests-differentl_b_580825.html, last accessed January 29, 2014.

12. While it has become common to refer to the term "structural violence" in order to explain the pernicious effects of poverty, I have found that such a term tends to leave unexamined the complexity of situations of vulnerability that simultaneously involve international, national, and local relations of power, economy, politics, race, gender, and other factors. While naming structural inequalities "violence" can assist in drawing attention to the everyday misery of the disenfranchised individual, community, or nation, it may do more harm than good by crystallizing violence in a fetishistic manner.

13. See http://www.huffingtonpost.com/erin-marcus/ptsd-manifests-differentl_b_580825.html, last accessed January 29, 2014.

14. On the other hand, the recent influx of international mental health workers seeking to ameliorate trauma in Haitians might also produce an overdiagnosis of the condition.

15. I provided physical therapy service to rape survivors and other patients in my capacity as a practitioner of a mode of manual therapy called the Trager Approach, see http://www.trager.com/approach.html, last accessed January 29, 2014.

16. Hinton et al. 2013 have observed similar responses among Cambodian refugees.

17. As discussed elsewhere (James 2010), trauma portfolios were assembled in several periods—the America's Development Foundation staff members had compiled one archive during the early years of the coup period prior to the inauguration of the first iteration of the Human Rights Fund (HRF) project in 1994. These files were stored on-site but were not in the best condition. With the advent of the new HRF Rehab program in 1997, its program directors, upon questioning the authenticity of another second set of case files that had been assembled under HRFII, launched a new system for documenting cases of prospective beneficiaries to which I had full access. In everyday communications the HRF program was called Fon Dwa Moun (Haitian Creole for "Human Rights Fund") or "the Fund."

18. While none of my clients admitted to serving the spirits, the broad formulation of a sociocentric "self/body" (Becker 1991), which follows, was commonly expressed regardless of their stated religious practice.

19. A sorcerer can capture the gwo bonanj when a person is alive. Although this entity is also called the zonbi, in this case, it can be used to force the material person to whom it belongs to labor for the sorcerer as what has conventionally has come to be understood as the living dead. Note, however, that some scholars of religion in Haiti ascribe to the ti bonanj (little good angel) the vulnerability to capture and forced labor as a zonbi (Davis 1988:187–91).

20. As noted elsewhere (James 2008), Brown describes the consequences of the complex components of identity and body on subjectivity, but especially for ritual practitioners: "for the Vodou worshipper, each person is at the core of his or her being, a multiplicity of beings, a polymorphous entity and that it is only at the periphery of life, in areas less important to that person, that he or she adopts clearly definable, and consistent roles or modes of being" (Brown 1979:23). See also Boddy 1988, Brown 1991, Antze 1996, and Lambek 1996 for discussions of how the expression of alternate selves through either spontaneous possession or multiple personality disorder can be considered creative presentations of self in everyday life, regardless of whether such manifestations are willed or involuntary.

21. Even as they are also sources of blessing and healing, relational obligations are sometimes sources of threat to the self. Illness or misfortune can befall the person who is directly culpable for failure to uphold these obligations (Métraux [1959] 1972:256) or other persons within the community.

22. See also Smith 2001:128–32 for a detailed description of the funerary practices of Haiti's Sosyete Ann Leve Ansanm (Let Us Rise Up Together Society).

23. See Patrick Reyna, "Haitian Hunger Strikers Say They Will Die If Not Released," Associated Press, January 4, 1993.

24. I was testing whether the CAPS for DSM-IV could be used in a cross-cultural context.

25. On how rumination on past and present events (often cast in the trope of "thinking too much"), as well as the experiencing of somatic symptom and cultural syndromes, are at the core of the trauma presentation in many cultures, see Hinton and Good, Chapter 1 of this volume.

26. Nigel Pankhurst, "Haiti Earthquake: Did Appeal Money Make a Difference?" *BBC News*, January 11, 2012, http://www.bbc.co.uk/news/uk-16283942, last accessed February 16, 2014.

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CHAPTER 12

Is PTSD a "Good Enough" Concept for Postconflict Mental Health Care? Reflections on Work in Aceh, Indonesia

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In November 2005, eleven months after a devastating tsunami and barely three months after the signing of the Helsinki accords, which brought to an end nearly two decades of fighting between the Indonesian military and Gerakan Aceh Merdeka (the Free Aceh Movement or GAM), the International Organization for Migration (IOM) in Indonesia invited us to provide consultation concerning mental health strategies in previously high-conflict areas of Aceh (Aspinall 2005, 2009, Reid 2006, Drexler 2008). By February 2006, we were accompanying IOM research teams into villages of three districts of Aceh to conduct a major psychosocial needs assessment, a survey designed to guide IOM in launching postconflict psychosocial or mental health programs, to which we were deeply committed for more than five years.[1]

The survey we helped lead, which included both quantitative and qualitative interviews, produced an outpouring of stories of violence and torture, enacted primarily by the Indonesian military against civilian communities. In one village, interviewers left in such shock that Jesse Grayman, then working for IOM, arranged for the organization to send a mobile mental health team to this village.[2] On February 15, 2006, we joined a group of Acehnese doctors and nurses, including a brave and committed psychiatrist, and a guide who was a former leader of GAM in the area, in a caravan of four-wheel-drive vehicles, marked with the blue and white symbols of IOM, up into the hills of North Aceh. We passed untended rice fields, overgrown pinang (areca nut)