Harvard Guide to Khmer Mental Health

by Harvard Program in Refugee Trauma

Edited by

James Lavelle, LICSW
Svang Tor
Richard F. Mollica, M.D., M.A.R.
Kathleen Allden, M.D.
Lynne Potts

Translated by

Kowith Kret

Dedication

This guidebook is dedicated to the 57 Khmer men and women who underwent three months of training in the Khmer Mental Health and Certification Project on the Thai-Cambodian Border. With instructors from a number of different countries providing cross-cultural instruction for Khmer mental health, these students became equipped to support others during the upcoming period of repatriation and reconstruction. Their certification from the Harvard School of Public Health and letter of acknowledgement from the World Federation of Mental Health recognized their commitment and outstanding achievement.

Introduction

Various writers of this volume have called it a guidebook, but its contents and purposes go far beyond simply being a collection of general principles for applied mental health in Cambodia. Indeed, the book, by its very international authorship, suggests a new way of approaching refugee (and displaced person) mental health on a more global basis and in a manner which is a radical departure from the traditional paradigm of "food, shelter, clothing."

Although the book is written by a variety of writers, addressing the problems of a dislocated and traumatized population, each brings his or her own particular perspective to the chapter's topic. Many of the writers are displaced persons from the Thai-Cambodian Border and ex-patriate Khmer. Others are from the international community, with experience either in the Thai border camps, in Cambodia, or in countries of resettlement. For example, the author of the chapter on "Spiritual Diagnosis and Healing Practices of Buddhism" is a monk who resettled in Canada; the author of the chapter on "Psychosis and Head Injury" works with resettled Khmer in Australia; and the Cambodian author of the chapter on "Rape Trauma and Sexual Violence" is presently developing a human service initiative in Cambodia.

The content is idiosyncratic in that it reflects the personal experiences and perspectives of its authors – a new synthesis of outsider and insider approaches to mental health. Some writers, for example, describe methods and practices of folk healers as they can be applied to relieve emotional suffering. Others describe more universal applications of counseling, self-help and community support. Still others introduce the use of Western medicines as they can be administered with other possible therapeutic interventions.

The book is also about partnership – the effort to sustain dialogue between people with differing approaches to mental health. It presents different points of view in order to stimulate ongoing discussion in the field of cross-cultural mental health. The book advocates a bicultural approach; it shows how an expanded lexicon of methods and practices more effectively reaches individuals, families and children who have been profoundly affected by war trauma and torture. The authors hope that the book may be used as a teaching guide in schools of medicine, nursing schools, teacher-education settings, and other social and human service settings.

This volume is a result of fifteen years of a bilateral partnership with the Cambodian community. In 1981, the Indochinese Psychiatry Clinic (IPC) established a team approach to working to meet the psychosocial needs of the Cambodian people resettled in Massachusetts USA. IPC's partnership model encouraged a combination of Western psychiatric interventions which matched traditional approaches to Khmer emotional and family problems. As the IPC service worked in collaboration with the Cambodian community, a deep appreciation and understanding of the cultural meaning of trauma developed. Khmer patients and their families taught the IPC how they could be more effectively supported with useful interventions which made sense.

Over time IPC and the Harvard Program in Refugee Trauma (HPRT) were encouraged by Khmer colleagues to explore the growing mental health crisis which was emerging in the Khmer camps along the Thai-Cambodian border. Between 1988 and 1991, HPRT conducted secondary key informant surveys and a one thousand household epidemiological survey in the largest camp, known as Site Two. The knowledge gained from these investigations revealed new information which promoted a family and community-based approach to the Cambodian health-care system after repatriation of the border camps, and during the reconstruction period which followed national elections. In preparation for this larger challenge, HPRT (with funding from

an anonymous foundation in New York) trained 57 family-child mental health counselors during repatriation. Although their newly acquired skills were subsequently under-utilized by the humanitarian community, the lessons learned from this initiative laid the ground work for longer-term approaches. As a result, the Harvard Training Program in Cambodia (HTPC) emerged as a pilot program to address the mental health and trauma-related problems of the Cambodian people.

Why is this brief overview relevant to the current situation in Cambodia? First, this historic experience produced Khmer and Western professionals who felt the need to address the mental health crisis on the Thai-Cambodian border. The model generated was specifically geared to people living in the dependent condition of camps served by Western humanitarian assistance. Now that HTPC has had the benefit of two years of training and related mental health services through the Minister of Health to the Siem Reap community, the limitations of previous intervention strategies have become apparent. While many basic principles still apply, a new model of community-based health care and mental health is already evolving in Cambodia. As this public health model emerges, it is the opinion of HPRT that a great deal of work needs to be done in understanding more fully the common symptoms of everyday life in Cambodia.

HPRT is against the simplistic introduction of Western criteria for diagnosis (e.g. DSM-IV) and believes that this may be inappropriate in Khmer society. While it has many diagnostic strengths, it also has many weaknesses, particularly around the cultural meaning of these diagnoses in Khmer society. Also, the so-called "atheoretical" model of DSM-IV has little capacity to prescribe the social interventions which will be helpful to Khmer patients and their families.

It is important to reflect to Khmer society, through this text, the mental health concept that Cambodia needs to avoid the social stigma and ostracism of people with serious mental illness. The Khmer capacity for compassion toward those individuals

who suffer from serious mental illness is well known and should be fostered.

This text should be used by Khmer medical practitioners and traditional healers who work in and with the community to provide mental health care as a normal and essential part of the primary health care system. So many Khmer people, who have developed emotional distress and can benefit from mental health care, are having normal responses to their past trauma and problems including poverty. All practitioners must guard against using Western labels to set these people apart from their fellow citizens who have been more fortunate than themselves.

In the next few years, we look forward to a major revision of this book as Khmer doctors, nurses, and social scientists clarify the nature of suffering and healing within the Cambodian context.

The editors would like to acknowledge those individuals and agencies who made this guide possible. So many helped that it would be difficult to name them all. Yet, there are some persons and groups without which this enterprise could never have been achieved. The Pew Charitable Trusts and an anonymous donor from New York believed in the feasibility and importance of this effort and subsequently provided significant fiscal support and guidance. Within the past year, The Nippon Foundation (Tokyo), with its contribution, guaranteed that this volume could come to fruition. United Nations staff and organizations provided invaluable assistance, in particular, Mr. S.A.M.S. Kibria, Mr. Dennis McNamara, and Mr. Patrick Van de Velde, former Director, United Nations Border Relief Organization (UNBRO). The current Royal Cambodia Government has been extremely supportive of this mental health guide as well as our other psychiatric activities in Cambodia. Dr. Chhea Thang, Minister of Health and his staff have played a critical role in fostering the general acceptance and use of this volume by the Cambodian medical community. The office of the Ministry of Foreign Affairs and the offices of both Prime Ministers have been receptive and encouraging of a mental health program for Cambodia. In the local community of Siem Reap, the HTPC team has appreciated the support of the governor and his colleagues.

The graphic design of this volume was done by Ms. Annie Grear; photographic contributions were made by Ms. Leah Melnick, Mr. Marcus Halevi, Mr. Dam Nang Pin and Ms. Kari René Hall. The photographs were computer enhanced by Mr. Marcus Halevi so that actual individuals could not be identified. Illustrations were provided by Ms. Jill Frazier. Secretarial assistance was provided by Ms. Donna Bolles. We would like to thank Mr. Sothea Chiemruom for production of the Khmer version of this book.

Finally, we would like to thank all of those Cambodian and non-Cambodian mental health advocates and community workers who responded (and who are still responding) to the mental health needs of their fellow citizens in spite of few available resources. This volume is a celebration of the great compassion of Cambodians throughout the world who are working to improve the well-being of their nation.

It has been an honor for the editors to be involved in such a special project.

Harvard Program in Refugee Trauma
8 Story Street, Third Floor
Cambridge, MA 02138
USA
Tel: 617 496-5550
Fax: 617 496-5530

CONTENTS

1. Khmer Mental Health in the Border Camps

by Nee Meas

This chapter provides background on the Thai border camps — describing the development of mental health services and the particular problems faced by a population that was displaced for many years.

Khmer Mental Health in the Border Camps

by Nee Meas

INTRODUCTION

During the period of 1979-1991, when Cambodia was ravaged by civil war, a number of humanitarian aid and international organizations helped to establish mental health centers in Site II, a Thai border camp for displaced Cambodians. The one in the north part of the camp was called the Mental Health and Traditional Healing Center (MHTH) and the one in the south was called Khmer People Depression Relief (KPDR). Both of these centers relied on a combination of traditional folk medicine and Western psychiatry to help people who were suffering from emotional and mental illnesses. The purposes of the mental health centers included:

- providing support to people who suffered from domestic violence, family conflict, depression, and other personal and social problems;
- providing traditional treatment to all patients who needed or believed in traditional ways of care by combining Kruu Khmer, Buddhist monks, and counseling with Western psychiatry.

HISTORY OF CAMP LIFE

Site II was the largest of seven refugee camps located in Thailand. It had a population of 190,000 at one time and was subdivided into six smaller camps: Rithysen, Nong Chan, Ampil, San Row, Nam Yoeun, and O'Bok. The camp was built in 1985 after other Thai-Kampuchean border camps were destroyed in a Vietnamese offensive. It was located in Tapraya district, Prachinburi Province, Thailand—just 200 meters inside Thai territory. Most of the people in the camp had been living at the border since 1979.

Site II was a closed camp; no one was allowed to enter or leave. For more than 13 years the people of the camp depended on the United National Border Relief Operation (UNBRO) for supplies. These included: 3–3.5 kg. rice per person per week; one small tin of fish per person per week; 10–15 litres of water per person per day; .5 kg. vegetables per person per week; 3 pieces of fire wood for each family per month; one set of clothing per person per year; one blanket for 2–3 people per year.

Because of the extreme stress of crowded living spaces and lack of needed goods, people often got into conflicts with one another. Sometimes there were even murders over very small issues.

MENTAL ILLNESSES

The problems people faced in the camp affected them physically and emotionally. Life in the camp was very tense and violent — with hand grenade explosions, banditry, shelling and internal camp tensions affecting everyone. People often came to the health clinic with complaints of headache, tiredness, insomnia, poor appetite, and other vague symptoms. They did not have anything physical causing these symptoms; they were suffering from the effects of trauma. Many people suffered from a condition called Post Traumatic Stress Disorder (PTSD).

THE SPECIAL PROBLEMS OF CHILDREN IN THE CAMP

According to statistics, 60% of the people in the camp were children; 90% of these born in the camps. There was an education system in the camp that went from kindergarten through high school, but unfortunately many children quit before completing what was available. It is not difficult to understand why. Since most of the children were born in the camp and had seen only the dusty road in front of camp houses, they could not imagine a world outside. School seemed unnecessary. They could not imagine that studying and finishing school would help them in their lives.

Furthermore, parents sometimes discouraged children from studying. They were afraid that if their children were educated, they would be killed if there was another regime like the Pol Pot.

Because they were (and still are) so poor, the children decided to quit school and leave camp to illegally pick up extra food such as vegetables, snails, and crabs outside. However, many were wounded or killed by land mines when they did this.

In the future, many of the camp children will end up being farmers, but they do not know how to farm. What will happen to them?

THE SPECIAL PROBLEMS OF WOMEN IN THE CAMP

According to observations and interview data, approximately 85% of the patients who came to the Site II mental health center were women.

In the traditional Khmer family, the man is considered the head of the family and therefore responsible for the safety and economic stability of the family. The woman is considered a housewife and as such is responsible for taking care of the house, children, and food preparation. She is also the banker of the family so that while her husband earns the money, she is still in charge of financial affairs.

During the war in Cambodia, many men were killed and many were conscripted into the army which meant the women and children were left alone. The majority of women left behind had no job to support their families; however, as sole heads of household, they had both economic and domestic responsibilities.

Supplies in the camps were extremely sparse. For example, a woman got only 15 litres of water per person and this had to be used for drinking, bathing, cooking, and washing clothes. The firewood stipend only lasted for 3–4 days out of the month.

To get more firewood, a woman or her children would have to leave the camp, but when they did so, they were often raped, robbed, or injured by land mines. The trade-offs were apparent. Either a woman did not boil her water (in which case the family may have become sick) or she risked her life outside the camp. Furthermore, when she or the children got sick, they had to wait in line for medicine, and if they were waiting when the water was delivered, they would miss receiving their quota of water. So the choice was between the medicine or the water — but the family needed both.

Khmer women suffered the additional burden of being poorly educated. There is a Khmer proverb that says, "The woman should not be away from the kitchen." This means that a woman does not need to learn anything beyond reading and writing because she must always come back and work at home. Hence, parents do not encourage their daughters to be educated. Furthermore, they fear their daughters will come to some unexpected harm (such as rape or falling in love) if they are away from home.

There was an adult literacy program in the camps that was supported by a humanitarian organization, but many of the women did not go to classes. They seemed to feel, "We need to fill up the stomach first and the knowledge can come later."

Finally, there was very little security for the women. The houses were made with thatch; a thief could see through from one side to the other, and easily break in and steal. They were always afraid that their houses would be burned, or their belongings (which they saved for repatriation) would be stolen.

DOMESTIC VIOLENCE

According to MHTH and KPDR health workers, many women in Site II were mistreated or beaten up by their husbands. Some of these women suffered and were mistreated for many years, and they carried the signs of their beatings.

There is an attitude that men have about women in Khmer culture that goes far back to the past. In Khmer culture, if a man wants to be married to a woman, he has to have money first and then pay it to the parent of the girl. According to the custom, after they are married, the money is given back to the couple. Some men, however, do not acknowledge this; they say, "She is my wife. It is up to me to do what I want."

This attitude gives men the power to be very brutal to women. Some beat their wives so severely the wives die. The woman cannot temporarily run away or get help because if she leaves home, her husband will accuse her of committing adultery or being a "bad woman" and beat her more.

TRADITIONAL AND WESTERN TREATMENT TOGETHER

Integrating traditional care and Western medicine seems the best way to treat patients but almost all who are considered mentally ill prefer to see a traditional healer or Buddhist monk before seeing a Western health worker. Here is why: Khmer people still believe that their daily life is under the spiritual care of an ancient spirit or a spirit who takes care of the house. When people have mental health problems, they believe the spirit is angered or wishes to punish them. They may believe a ghost came into the ill person's body and made them confused. As a result, Cambodians believe their problems can only be solved by monks or traditional healers who can address these spirits. When they are not cured by these healers, however, they may turn to Western psychiatry for help.

THE FUTURE OF INTEGRATED HEALTH CARE

Until recently, it has been difficult to integrate traditional practices and Western psychiatry. Doctors who have been trained in the Western style are developing new treatments; traditional healers have a different method based on the past.

The two can better integrate their services if they learn to understand the other's strengths as well as limitations, share knowledge, skills and values, and cooperate with one another by resisting the temptation to force an either-or choice on the patient.

2. A Model Called KCBM

by Svang Tor

As a result of collaboration between Khmer and Western health professionals, Cambodian health care providers have developed a comprehensive treatment program that emphasizes Khmer traditions and practices but includes Western mental health. This chapter describes this bicultural health care program.

A Model Called KCBM

by Svang Tor

INTRODUCTION

KCBM (standing for Kruu Khmer, Counseling, Buddhism, Medication) is a mental health treatment model which grew out of a collaboration between the Indochinese Psychiatric Clinic in Boston, Massachusetts and the Khmer People Depression Relief (KPDR) project in Site II on the Thailand border. The model integrates Khmer and Western practices for the treatment of mental illness.

The KCBM model has helped Khmer people who were traumatized by the civil war of the late 1970s and 1980s for a number of reasons. First and foremost, it uses and builds on traditional beliefs and practices that are respected by the Khmer people. It also treats Buddhism and counseling as different but compatible means of enabling traumatized and emotionally ill people to get help from others in the community. Finally, it makes use of Western medications to treat patients with particular symptoms so they can have immediate relief.

Since the beginning of the KCBM project, we have strongly argued that Khmer people must be trained to provide services to their own people. We know from experience that the Khmer people (and all peoples) are more receptive to treatment when it is provided in the context of their belief systems and cultural practices — by their own countrymen. Hence, we knew that we needed to train Cambodians to work in Cambodia.

Our project seeks to use both Khmer and Western treatments, but insists they be described in the constructs of Khmer culture and thought.

DEFINITION OF KCBM

The KCBM model is explained in more detail as follows.

K= KRUU KHMER

The Kruu Khmer is a traditional healer who uses various methods such as herbal medicine, massage, steaming, and other practices to treat physical and emotional disorders. He diagnoses his patient by conducting a physical exam and by asking about symptoms and feelings. Then he identifies the disease by name and asks the patient about her or his personal and medical history.

Kruu Khmer differ according to the roles they play described below:

Kruu Tnam Sangkov: a person who performs diagnosis and treats illness much like a modern doctor;

Kruu Robien or *Kruu Moen Akom:* a person who makes a kind of rolled-up gold or silver plate charm on which a *Kruu Robien* has been inscribed with *Pali* to protect the wearer against evil spirits, wounds, accidents, and even visibility to his enemy;

Kruu Snae: a specialist in love charms and potions;

Kruu Bangbat: a person who diagnoses through meditation and then gives advice or makes a referral.

C = COUNSELING

Counseling refers to a Western practice applied to Khmer culture. In counseling, a health worker (or anyone who has the sensitivity and understanding) allows a person who is suffering to speak about his or her problems.

A counselor is someone who listens to another person's story with patience and sympathy. In Cambodia, this person may be an elder, a monk, a relative, or a friend, but it must be someone who is respected and trusted.

In working with people who are upset and troubled, a counselor asks questions that will help the individual speak about his or her experiences. Sometimes the counselor asks the person what he or she plans to do; sometimes the counselor offers advice. The counselor always reminds the person, however, that he or she must make a personal decision, and not rely on others to make choices. If the person does not know what to do, the counselor encourages him or her to wait until it seems right to decide.

Counseling must occur within the context of complete confidentiality. The patient must be able to discuss thoughts and feelings without worrying that these will then be discussed with others.

B = BUDDHISM

Khmer Buddhism employs religious rituals and chanting to help relieve individuals and families of emotional distress. Cambodian Buddhists believe in the fundamental principles of dharma and karma representing good and bad, heaven and hell. These principles are related to the idea of the "wheel of life" that stands for birth, aging, illness and death. Cambodians believe that karma is the repercussion from a bad deed—either in this life or a previous one.

The Brahmin tradition teaches that the reciting of incantations and spitting bettel saliva on a sick person can cure a disease. Brahmanism also teaches that a tattoo has the magical power to protect its bearer from bullet or knife wounds.

M = MEDICATION

The Khmer have found Western medication useful for individuals who have not been helped by traditional remedies such as herbal medication or Buddhist rituals. Western medications have proven especially effective for individuals diagnosed as psychotic.

TYPES OF THERAPY

At the Indochinese Psychiatry Clinic (IPC) in the Boston area, we have individual, family, and group therapy. Sometimes a combination of these is used. Because extremely traumatic events may be hard for a patient to talk about in front of other family members, we often see these patients without their families. It may take months for a traumatized patient to get the courage to talk about the past.

At IPC we have women's therapy groups where women come together to share their thoughts, worries, family problems, and parent–child relationships. Because children can adapt more easily to the American way of life, parents often find they are in a

generation gap and cannot easily communicate with their children. When the parents have experienced torture and great loss , it makes it even harder. In the women's groups, patients learn to share their thoughts and feelings with each other.

Finally, at IPC we have what we call a co-therapy team which links up a bilingual mental health worker with a Western therapist. Before each meeting with a patient, the two therapists discuss what will be asked and prepare for the session. Sometimes during the session, there is a brief break when the mental health worker and the Western therapist discuss what is happening and what the patient is saying. During the therapy sessions, the bilingual mental health worker functions not only as an interpreter, but as a co-therapist with knowledge of the patient's cultural background. The worker and the therapist collaborate and work with the patient so there is a triangle of communication.

THE ROLE OF THE BI-CULTURAL WORKER

Western mental health clinicians need to recognize that Cambodian patients do not clearly delineate between emotional and physical illness. Khmer people seek medical help for headaches, blurry vision, dizziness, and nightmares and sometimes do not see that they may be symptoms for psychological problems. For example, a Cambodian woman complained of worsening headaches, dizzy spells, and shakiness, insisting that her problem was a low blood count. She paid no attention to the fact that she had lost all of her children under the Khmer Rouge government.

Cambodian patients also go to clinics seeking medicines because that is what they think will cure them. They often feel disappointed or mistreated if they are not given a prescription in their first meeting.

If a Western–trained person wishes to be helpful to a Cambodian, trust is the key to success. Patients do not want to share their stories with a Westerner (especially if it is rape) and they do not believe they are being helped unless there is a deep

feeling of trust. The clinician must show an interest and willingness to listen to the horrifying story of the past.

The bicultural worker has a key role to play in providing mental health services because she or he knows and understands the patient's culture and also recognizes complaints that come from a patient's life events. A patient, for example, complained of frequent headaches dating back to the time when her husband was killed and her son died of starvation. The bicultural worker knew the cultural meaning of these events and how the patient used the concept of "karma" as a way of understanding suffering or misfortune. Knowing this background made the bicultural worker able to help the patient cope.

The bicultural worker also has an insider's understanding of the culturally acceptable way to interview the patient. She or he knows that direct questions and overt displays of emotion so common in the West are intolerable to most Southeast Asian patients. In fact, this is how the bicultural worker can be most valuable — in filling the gap between the Westerner's clinical style and what is tolerable to the Asian patient. The bicultural worker helps to form a trusting therapeutic relationship with the patient. Once this trust is established, this worker can help the Western clinician begin to establish relationships with patients.

It is extremely important that the Westerner learn about Southeast Asian thought and culture when working with Indochinese. It is extemely important that all counselors learn to listen, to understand, and to have deep appreciation of the person and the value of life.

KHMER APPROACH TO MENTAL HEALTH

Cambodians focus on the symptoms of a problem (chronic headaches, dizziness, eye problems, achy body, chest pain, stiff neck, low back pain) rather than on the causes because mental illness brings shame and humiliation to the patient's family. Family members usually want to keep the illness a secret whenever possible. Psychosis is the only mental disorder for which a person

would be hospitalized. Up until the Communist take-over in 1975, there was only one psychiatric hospital and only one psychiatrist in all of Cambodia. This hospital was used primarily by poor or rural families because city dwellers treated their psychotic family members at home. Other patients, suffering from less serious or non-psychotic mental disorders, were turned over to monks or Kruu Khmer or village elders. Family problems (including those that are a result of forced marriages) were dealt with by family members.

Now it is becoming clear that many people suffer from mental illnesses as a result of traumatic life events. Furthermore, clinical experience has shown that it is helpful to try to understand the nature of these experiences (including torture experiences) in order to help patients. There is considerable evidence that encouraging people to give detailed documentation of their torture or other traumatic experiences helps them.

It is also very clear that a clinician needs to understand a person's problems in the context of the culture in which they are being presented. Clinicians must learn the skills that have to be applied in situations of crisis such as suicidal and homicidal behaviors, domestic violence, sexual abuse, and others. They must learn the skills necessary for minimizing disability and improving the individual's potential for psycho-social rehabilitation and self-reliance.

KHMER FOLK SYSTEMS OF PROVIDING EMOTIONAL AND SPIRITUAL SUPPORT

Buddhism has a great impact on the daily lives of the Khmer people. Its teachings of loving compassion influence almost every aspect of daily social interaction. Buddhism has been described by various scholars as a system of thought, a way of understanding life, an analysis of mental processes, and a series of well-constructed arguments which point towards the adoption of certain attitudes, values, and practices.

Buddhist doctrines speak to the role of sadness and suffering

in life, and argue for an acceptance of relationships and the effect of a past action on present existence. The Khmer people's Buddhist beliefs do not foster a strong sense of collective social responsibility. On the contrary, they teach that a person's present status in life is the result of past actions. According to this belief, only one's individual actions in the present are useful—and only for a future life. This belief gives little incentive for improving one's immediate living conditions.

In the traditional Buddhist model, patients account for their present tragedies with the explanation of "individual karma." The Buddhist concept of karma may often help diffuse a personal sense of survivor guilt or shame. They believe that they should suppress their anger, worries and desires because these events are the fateful result of past events. For example, a woman who has lost her child may attribute the tragedy to her own karma, believing that it is her repayment for some terrible things she did in her past life. In a way she is telling herself to relax—that she has no control over her life.

Buddhism teaches that holding suffering inside is a normal part of existence; it is important to accept your karma and not worry about what has happened. In the unfortunate event of a woman who has been raped, the family will send her away to a place where no one knows her background. They blame the victim and say that it is her fault. She is made to suffer and to submit to her fate.

Meditation can be a way of getting release from sadness and tension. It helps us accept our karma.

3. Khmer Traditional Healing

by Soeurn Hem

Efforts to help mentally and emotionally ill people go back many centuries in Khmer history. This chapter describes traditional ways of categorizing illnesses and their most common folk treatments.

Khmer Traditional Healing

by Soeurn Hem

INTRODUCTION

The Khmer folk healer may be a layman (man or woman) or a monk with knowledge of treating various illnesses according to Cambodian traditional ways. The folk healer possesses knowledge on many different levels and understands a variety of treatments and techniques. Folk healers learn their skills from ancient manuals or from others who pass knowledge down orally from generation to generation.

When treating illnesses, Cambodian traditional healers use natural materials such as vines, leaves, fruits, flowers, seeds, resins, barks, different woods, roots, bulbs, and even parts of animals. Some healers weigh out the quantities of materials according to formula and others mix their amounts by guess work.

Besides medicines, folk healers use religion, magical incantations, tattooing, burying magical objects under the skin, pouring holy water, inscribing handkerchiefs with magical scriptures, making raw threads to be worn around the waist, spitting chews of betels and areca nuts, calling souls with magic formulas and other such practices.

Traditional healers also use pinching the skin, coining, glass suction, herbal steaming, massage, bed heating and other treatments. Finally, Cambodian folk healers treat patients by making offerings to the ancestors or spirits, appeasing angry ghosts, ghouls, or the devil. They may use mediums to contact the water spirits, the male spirit, or others. Sometimes they use magical Pali words to "tie" the spirits. They may also "whip" a spirit through the patient's body in order to chase out the illness caused by evil spirits or the devil.

FOLK TREATMENT OF COMMON ILLNESSES

Folk healers are not much different from Western doctors when it comes to general practice and specialties. Some traditional healers can treat all kinds of illnesses; some can treat only one or two. Some Cambodian folk doctors can treat broken bones by using only herbal medicines and magical incantations.

Most Cambodian people recognize a kind of digestive disorder which they call *Toah*. Cambodian traditional healers divide this condition into several different categories, but for practical purposes it contains three groups.

◆ *Toah Camney:* an illness caused by eating inappropriate foods (pig's head, chdoa fish or game meat) and after giving birth to a baby.

symptoms: lock jaw, stomach cramps, vomiting, diarrhea, seizure

treatment: the food which is believed to have caused the problem is administered to the patient; for example, healers take meat from a pig's head and cook it to a crisp and mix it with rice wine to give to a person thought to be sick from eating pig's head.

◆ *Toah Sarsay:* illness caused by heavy work, anger, trauma, torture, sexual intercourse too soon after childbirth.

symptoms: lock jaw, body aches, dried breast milk, fever, arm and leg spasms, weakness, chest pain, blackouts, disorientation

treatment: varies from village to village; generally porcupine stomach and spikes are rubbed on stone and soaked in rice wine and given for the patient to drink; also parasitic plants or moha cumpou leaves are rubbed on a stone and mixed with rice wine to give to the patients; sometimes khtum bark is boiled until a 1/3 of the liquid is left and the patient drinks the mixture.

◆ *Toah Min Doeung Mouk, Toah Ring Rey, Toah Beak Sror Ka:* chronic illness that lasts a long time and is caused by nerves and food poisoning together; without treatment patients with this illness gradually waste away until they die.

symptoms: weight loss, lethargy, loss of appetite, insomnia, low grade fever, dry skin, scaly skin

treatment: varies but one medicine used most often: strychnine plant seeds, angkunhs or slaks rubbed on a stone apparatus for seven strokes and mixed with rice wine.

MEDICINES

Medicines used by folk healers may come in different forms: boiled, soaked, powered, or mashed. Sometimes the medicines are breathed, sometimes rubbed on the skin, sometimes applied as massages, and sometimes swallowed. The healers often accompany these medicines with magical incantations.

When Cambodian folk doctors mix medicines, they use a scale with a handle at the top and weights in chi (3.75 gr), damleung (37.5 gr.), or neal (600 gr.).

1 neal = 7 khams
1 kham = 2 damleung and 7 chi
1 damleung = 10 chi

The process of preparing the medicine actually begins when the healer sets out to look for the herbs. In some regions, according to the custom, folk healers light up three joss sticks and walk toward the herbal plants, push the joss sticks into the ground at the base of the plants, then walk backward three steps, sit down, and speak to the plant. The healer is praying to the tree when he does this so healing powers will be activated. After the prayer, the healer picks the leaves or bark or whatever part of the tree is going to be used.

According to some old traditional medicine manuals, there are certain times of the day when each medicine material should be gathered because there are peak times when the leaves, fruit, bark or branches reach their greatest strength.

KHMER CHIROPRACTICE

Bone and joint aches, back aches, dislocated joints, sprained shoulders, sore muscles, sprained ankles and elbows are treated by Cambodian chiropractors who push on muscles to move the nerves and get blood circulating more freely in the veins. Joints and bones are twisted or pulled to get them to move better. Cambodian chiropractors describe ten important nerve systems in the human body: *sommenia; piing khalia; ettha; kalha thari; sahasag raeng sei; thav ri; lavug sngang; ug lanka; nantak karak roat; kich chaneak.*

OTHER TREATMENTS

A number of complaints which people have, including motion sickness, dizziness, headaches, blackouts, cold sweat, nausea, weakness, palpitation of the heart, stomach aches and diarrhea are caused by the "catching winds" and may be treated with one of the following:

- *coining:* a method whereby the thighs, calves, arms, forearms, or neck are covered with coconut oil and then rubbed with a coin in long strokes until the skin gets red; if the skin gets a dark red, this means the patient's condition is serious;
- *pinching the skin:* in this method the healer wets the skin with water, and using the knuckles of the index and middle fingers, pinches and pulls the patient's skin until it gets red;
- *suction:* an inch-long candle is placed on a palm leaf, lit, and covered with a suction glass placed on the skin; when the skin under the glass becomes dark red, the suction cup is removed;
- *pulling strands of hair:* the folk doctor parts the hair in the middle, then takes a bunch of hair from above the forehead and, moving down the length of the strand, jerks the hair until there is a "prep" sound; the doctor rubs the temples using both thumbs and moves to the middle of the eyebrow (especially effective treatment for headache and blackouts).

The folk healer often follows these treatments with a drink of powdered or fresh ginger steeped in hot water.

FORTUNE TELLERS

Fortune tellers can tell people about their life cycle — if the person is fortunate or unfortunate, both in the past and in the future. Some fortune tellers work by looking at fingerprints and reading

palms. Others use mediums such as *koun krawk* (dead fetus smoked and wrapped with special cloth) or *neak ta's* (spirit or power). Some use objects such as bowls of water to call out spirit culprits. Some traditional healers are able to treat a problem by touching the patient while he or she is meditating. This last method can be especially effective with mentally ill patients.

KRUU KHMER

All of the Kruu Khmer study the same Pali, learn the same magic formulas and charms (made of rolled gold or silver plate inscribed with a prayer). However, some turn out to be good healers who try to undo voodoo and save patients while others work evil. This is because of karma and what the person has merited from a previous life. The ones who do evil have a shadow cast from a past life that makes them do evil. Others are generous and good as a result of a good previous life.

MENTAL ILLNESS TREATMENT BY TRADITIONAL HEALERS

There are two kinds of illness: one is physical and the other is mental. Mental illness cannot be seen or touched; it is invisible.

There are three main categories of mental illness and each has its treatment as outlined below:

LEVEL I: worries, unhappiness, pain, distress

symptoms: lost or lonely feelings; patient doesn't want to eat, cries easily or does not want to do much; at a more advanced stage, patient loses weight, cries very loudly, beats the chest, throws himself on the ground and acts suicidal.

treatment: patients are treated with traditional Buddhist ceremonies and counseling; some patients are guided to take up religious meditation; others are simply given much attention to help them feel better.

LEVEL II: confused mind; loss of memory

There are four types of Level II illnesses. They are the following:

A. normal mental aging

B. mental illness as a result of premature birth or a mental handicap (caused by a solar eclipse birth) treated with magic incantation, making offerings to angry spirits or to the moon during a lunar or solar eclipse

C. emotional problems of the kind listed below:

- *psychological crisis*—treated with holy water ceremonies, counseling on buddhist ways, and/or meditation
- *possession by flying ghouls, spirits, ghosts, demons or male-spirits (Neak Ta Chaul)* treated by praying, trying to appease the spirits, and making offerings (rice wine, bananas, sweet sticky rice, fermented fish etc.), tying the soul to the body with magical threads, or scaring the evil spirits out of the body by beating them with magical or powerful whips.
- *Mor Baing-Kamrol Chaul*—treated by using the manuals to liberate the bad luck; sometimes holy water ceremonies are used, but sometimes the traditional healers have to act out certain terrible deeds such as killing, hacking with a knife, or shooting to snap the patient from the unconscious and wake her or him up; afterwards the monks and achars come and sweep the dead person and pour holy water to exorcise the spirits; they also tie magical thread around the patient's wrist to ward off the evil spirit—all done with utmost care so the patients are not hurt
- *extreme fright (Phey Klaing; Bak Sbart)*—treated in a ceremony where monks gather the evil spirits into a basket or treated by mediums who evoke the spirits and call for the patient's soul to return to the body.

D. disruption of the sensory nerves (paralysis) untreatable by traditional methods.

LEVEL III: specific disorders

- *insanity or craziness*
- *womanizing* — treated by having monks or folk doctors pour holy water or having wise elders counsel the patient
- *alcoholism* — treated with Cambodian folk medicine, counseling, and getting the patient to receive spiritual guidance from monks

◆ *gambling* — treated with counseling and guidance on the dangerous consequences of gambling

◆ *insanity by poison* — treated early with steamed medicines; if left too long until symptoms include swelling of bitten area, gnawing own hands or legs, drooling and convulsion, it is untreatable

◆ *insanity by studying magic formulas* (either learning too much or going against what is taught causing the patient to make senseless talk, cry, run away, or refuse to eat or sleep) — treated by finding the healer who taught the student to help or by making offerings (banana trunks and leaves, flowers, areca nuts, incense, candles), using magical formulas, or pouring holy water to counteract the magic formulas

◆ *insanity by charms* — treated by drawing the bad spirit out, pouring holy water, having the patient wear raw thread around the waist, having the folk healer recite magic formula, using folk medicines, making a wax figure, or by putting magic objects under the skin.

◆ *insanity from childbirth (Phrey Kola Phloeung)* caused when a birth has not been properly managed, making the patient pick at things, laugh, cry, mumble, or roll the eyes) — treated with steam under the bed or by putting a raw thread around the bed to chase off the bad spirit or to keep the bad spirits away; also treated by the folk doctor using magic power and reciting magic formulas to chase off the flying ghouls; or treated by having the Buddhist monk ward off the evil spirits; or by having the midwife push on the patient's tummy (to expel clots in the uterus) and giving a medicine that has something to warm the blood and expel the spirit.

◆ *serious mental illness* — treated by the Cambodian folk healer with medicines to make the mind peaceful or the patient sleep

◆ *hereditary mental illness* — treated by fortunetellers who try to determine the root of the problem (father's or mother's side), then conduct a ceremony to worship the devil, make offerings, ask the spirit to possess the medium so that the person can plead

to the spirit; invite monks or achars to have a holy water ceremony or tie raw threads; (in some regions the folk doctors pretend to give the patient off to the monk or change the person's name; the folk doctor separates the patient from others with the same disease)

◆ *epilepsy* — treated (four or five times to be effective) by cupping the skin and giving herbal medicine while the patient is having the convulsion.

4. Counseling as Mental Health Treatment

by Barnabas Mam

This chapter describes how people with mental health problems have traditionally found help in Khmer culture. It also describes how these traditional methods of healing can be blended with clinical counseling and medication to provide greater support and relief to people suffering from a range of mental and emotional disorders.

Methods Of Khmer Counseling

by Barnabas Mam

INTRODUCTION

Khmer traditional counseling is neither academic nor clinical. It is practiced by people who have the skills as a result of their natural ability, received wisdom (learned from others), intellectual wisdom (gained from intellectual analysis), experiential wisdom, cultural sensitivity, and/or creativity. The Khmer counselor volunteers to help the patient develop his abilities to solve physical, mental, emotional, social, learning and work problems.

DHARMA COUNSELING

Mahayana Buddhism was first introduced to the Kingdom of Cambodia (called Funan) in the first century, and Theravada Buddhism to the Angkor Empire in the 13th century. Since the reign of King Jayavarman VII (1181-1218 AD), Buddhism has played a major role in Khmer traditional healing.

Dharma counseling is based on a belief in the Four Noble Truths: the truth of suffering, the origin of suffering, the cessation of suffering, and the Eightfold Path that leads to the end of suffering. The Eightfold Path has three main concerns: moral conduct, concentration, and wisdom. Dharma counselors help the patient experience peace of mind.

ANIMIST COUNSELING

Animism is the belief that a spirit may get angry at a person and cause him to be sick, to die, or to return to health again. An animist counselor may diagnose a suicidal patient as "spirit possessed" or "under a magic spell." In order to treat the patient, the animist counselor asks for background information (birth and lunar system; marriage date; etc.) and recent activities, behaviors, and symptoms such as frequent crying, poor appetite, poor sleep, little or no talking, the desire to run away or attempted suicide. If the patient's wife has left him for another man, the animist counselor will say the person is "magical spelled" by a *Kruu Tmoob* (magician) hired by either the wife or her new lover. The treatment for the latter is as follows: the patient is given a redemption-from-danger shower, redemption-from-power chanting, and/or a redemption-from-danger offering as an appeal to the spirit of the Great Master — and kept under observation in his home surrounded by magic protection boundaries. He may also be given a traditional sedative.

STORY-TELLING COUNSELING

Khmer stories are not intended for pleasure only. They are also used to transfer wisdom, life skills, coping skills, religious beliefs, cultural traditions, and problem-solving skills. A story-telling counselor (usually a teacher or an old person in the village) uses his story-telling skills to identify a problem, to explore it, and to help solve it. The story-teller discusses a case with the patient to help him solve his own problems.

KHMER CLINICAL COUNSELING

Between 1979 and 1985 thousands of Khmer people fled Cambodia and took refuge in camps that were set up along the Thai border. Site II, the largest camp, became the place where many people lived who had experienced rape, grief, depression, domestic violence, acute psychosis and/or mental disorders. Many of the people had also been the victims of beatings and a host of emotional traumas. To help these people, a Khmer People's Depression Relief (KPDR) Center was established in 1987 and a Mental Health and Traditional Health (MHTH) Center in 1989. Counselors in both health centers were trained to treat grief, depression, post traumatic stress disorder, and marital problems. They were also trained to provide counseling for sexually transmitted diseases and AIDS.

KHMER CLINICAL COUNSELING

Khmer clinical counseling is a process of empathetic discussion or conversation between counselor and patient in order to achieve a specific goal. The object is to build a strong positive working relationship between counselor and patient so the patient can express feelings and relieve fear. Counseling is a means to help the patient gain skills and learn how to make decisions that will help him or her solve personal problems.

A counselor may be male or female, young or old—a professional, a paraprofessional, or a volunteer. The counselor may be in the field of medicine, social work, or psychology. He or she may be a teacher or a manager.

FIVE PRINCIPLES OF KHMER COUNSELING

Successful counseling depends on the following five principles:

- The counselor must guarantee the patient complete confidentiality. Patients should be interviewed in a private place and promised that no one else will hear their stories without permission.
- The counselor should have an in-depth understanding of the patient's values, experiences, behaviors and feelings. The counselor's empathic behavior (listening and questioning) is what helps the patient share his deep and most personal concerns.
- The counselor must be non-judgmental, refusing to consider the patient either right or wrong in the disclosures that are made.
- The counselor must respect the patient, accepting him or her as a person of value and dignity, worthy of care without criticism or labels.
- The counselor must respect the cultural sensitivities of the patient, accepting her or his traditional beliefs, faiths, and practices. (The counselor, for example, should learn if the patient has been helped by traditional healers).

Example: If a Buddhist patient blames himself for having bad fate or bad karma, the counselor should explain that a person can become master of his fate by taking action. The patient can understand that he is responsible for the actions and therefore can end the suffering. This is the teaching of Buddha as well. The patient can learn to give up the feeling of bad karma by becoming responsible.

WESTERN MODEL OF COUNSELING

In the Western model of counseling the health worker talks to the patient in order to identify problems and establish an achievable goal or outcome. It may take several sessions to do this, but the counselor can be flexible in covering topics over time. The following are the basic phases of the initial interview(s):

- introduction: greeting the patient, ensuring confidentiality, and developing a working relationship
- identifying concerns: getting the person to talk specifically about presenting problems. (For example, the counselor may ask questions such as "Do you have nightmares?" The counselor should not ask a woman if she has been raped; after there is trust, this information will come out.)
- exploring more completely the patient's background including current stresses, self-concept, coping abilities, relationship with others, health and mental health history, family background, work problems, daily life activities and other matters regarding the patient's personal life.

At the end of each session, the counselor can summarize what was covered, arrange the next appointment, and thank the patient for coming. Later it may be good to invite the patient's family and friends to join in sessions for the patient.

Sometimes the counselor may refer the patient to another helper such as a Kruu Khmer or a religious leader. The counselor may also make home visits. These help the counselor better understand the patient's living conditions, family issues, and other relevant matters that may affect how she or he is feeling and functioning.

CRISIS INTERVENTION

When a patient calls on a counselor in the midst of a crisis, the counselor needs to be aware of safety above all. If the patient is violent, the counselor should call the police; if she or he is suicidal, the person should not be left alone. The counselor should

arrange for immediate medical attention if the patient has overdosed on drugs or been wounded.

Steps to follow in cases where there is an immediate crisis are similar to those outlined above. The counselor needs to get background information, assess the case by looking at symptoms, and evaluate risk factors such as a immediate need for medical assistance or other help.

Then the counselor should look for possible resources and solutions that can help the patient gain control of herself or himself. Finally the counselor should summarize the situation, make a next appointment for follow-up, or make a referral for other help. Regardless of what is done, the patient should be assured she or he can return if there is need for more help.

PROSPECTS FOR FUTURE KHMER MENTAL HEALTH

After repatriation, KPDR teams from Site II plan to continue to provide clinical assistance to Khmer mental health patients, integrating the best that is known of both traditional and modern medicine. KPDR teams will continue to rely on traditional health, counseling, psychiatric care and training.

To organize and form coalitions during reconstruction, KPDR wishes to establish a Khmer Mental Health Association (a body of different grass roots groups) to collaborate with the World Federation for Mental Health for future services, training, and research activities.

5. Healing Practices of Buddhism

by Venerable Hok Savann

This chapter presents fundamental beliefs of Buddhism that affect the Khmer understanding and treatment of mental illness. Using depression and grief as an example, it sets forth concepts that prescribe right living.

Healing Practices of Buddhism

by Venerable Hok Savan

INTRODUCTION

Buddha defined two types of illnesses: physical illness and mental illness. The first, he said, could be treated medically; the second had to be treated through Buddhism and meditation (chanting and praying).

Buddha said that as long as there is life, there will be illness. The only variance is in degree: some illnesses are severe and others are mild. When a person is sick, she or he should pray to the Veda, angels, ghosts or to Buddha himself for a blessing to take away the illness. Buddha also said that medicines can help, but only to regulate the body's chemical balance or to treat symptoms of a virus or bacteria. Medicines do not permanently cure because human beings will always get older and die. If life is not ready to end, medicines can help temporarily.

In keeping with the idea that prevention is better than medical treatment, Buddhism stresses personal hygiene.

PSYCHOLOGICAL ILLNESS

The mind, while not seeable, has its own existence affecting a person's moods and feelings. In Buddhism, physical and mental capacities grow and diminish at different rates. Very often the mind is quicker to react to an external event than the body. The mind will react to a difficult situation, and then the body will have a reaction later. In turn, mental suffering can actually cause a physical condition. People often pay more attention to physical reactions, however, than to the underlying psychological causes.

People can recover from physical illness sooner than they can from mental or emotional problems.

DEPRESSION

There are four basic kinds of grief or depression in Buddhism: grief from being born; grief from getting older; grief from getting sick; grief at facing death. From these, others develop. A person may also become depressed by societal problems such as the lack of human rights.

The Buddha taught that depression is closely connected to love. When a person loses a loved one, she or he feels sad and depressed. Buddha taught that grieving indicates closeness between two people. If someone dies and the other person does not grieve, this means there was not a deep connection between the two people.

Depression can also be caused by disappointment at not reaching a life wish or goal. In the case of Cambodia, many people became depressed because they lost their families and their homes during the war years. Their experiences were extremely traumatic and the ones who were fortunate enough to survive became depressed. When people were repatriated in 1979 they hoped their could resume their normal lives; when war broke out again, many experienced great disappointment and depression.

Buddhism teaches that life is made of extremes: happiness and sadness, good fortune and bad fortune, fame and dishonor, criticism and praise. When people experience one of these extremes, they can be sure they will experience its opposite to the same degree at some other time. Of course, when life seems to be going well, people feel happy and when life is not going well they feel bad — but life never stays consistent, and circumstances and feelings will always change. Buddhism also teaches that some people are simply born under better circumstances and are more fortunate than others. This is the way life is.

People who are depressed will often turn to addictive substances or alcohol to forget their problems. Some even try suicide. Buddhism, however, teaches that none of these help. The suffering person always has to wake up in the morning and face the problems anew, and the soul of the person who commits suicide continues to the next life, leaving the problem still unresolved.

The Buddha taught that suicide is only a temporary escape from a problem. If a person has a problem and tries to escape it through suicide, that person will carry the problem to the next life. Some people do commit suicide; others pray to their ancestors or good spirits to relieve the distress. Others go to a fortune-teller or to the monks. No problem is solved, however, forever. No state is permanent.

TREATMENT

KEEPING BALANCE

Buddhists believe that the mind and body are very inextricably linked. Physical symptoms such as headaches and fainting spells can be caused by grief and sadness. When a person learns to relax enough from thinking and worrying, the physical symptoms can disappear.

A person can develop physical symptoms from a single thought. For example, if a person is bit by a snake but thinks the snake is not poisonous, that person does not get sick and faint. If the person thinks the snake was poisonous, she or he can become faint and ill.

The Buddha cautioned that when people become extremely happy, they are over excited and their own energy causes sadness. The Buddha taught that it was best not to be either happy or sad, but to keep emotions in balance.

LIVING WITH PROPER PERSPECTIVE

Buddha taught that if you have a problem you should solve it. If you are not able to solve it, you should forget it. For example, if you are doing business and you go bankrupt, you should find a new way to continue the business. If you fail all experiments, you should not feel bad but try something else. If you have lost an object, you should search for it. If you cannot find it, you should try to forget about it. If your relatives or parents get sick, you should take them to a doctor. If the doctor is not able to cure them, you have to accept the fact that they may die.

On the same subject, the Buddha taught that people should try to solve problems as soon as possible. It is a mistake to put them off or repress them until they eventually become worse.

Wealth does not necessarily bring peace and happiness, and poor people are not always unhappy. Buddhism teaches that people need to learn to live with forgiveness and not wish for too much because grief can come from greed and excessive expectations.

The Buddha said that life is dictated by past action: if a person does good, then that person will receive good. The same is true for bad. When things happen, they are a result of karma established by past actions. Hence, people should not blame themselves. Many things are inevitable as a result of the past. Buddha taught that it is a waste of the mind to cloud the mind with regret and suffering.

HANDLING CONFLICT

There are two kinds of conflict: conflict between people and conflict in the mind. Winning in human conflict is not satisfying because the winner has to face the resentment and possible revenge of the loser. It is good, however, to resolve mental conflict. If you wish to win over others in the right way, you must win over yourself first. Meditation is a means of conquering the mind and accepting reality. Monks are able to teach different meditations for different situations. For example, the monk may give a patient who has a physical illness one meditation and a person who is depressed, another one.

STORIES THAT ILLUSTRATE BUDDHIST PRINCIPLES

BONDA CHA

There is a story about a woman named Bonda Cha who was the daughter of a millionaire. This young woman fell in love with her servant and ran away to live with him in a small village where, even though they were poor, they were very happy and had two children. One day, the husband was bit by a snake and died. Bonda Cha did not know what to do except try to go back to her

parents. On the way, she had to cross a river, and when she did, she lost her first son as a huge bird snatched him from her arms. Then she lost the second son as he drowned trying to reach her.

Soon after, Bonda Cha learned that her parents were killed in a hurricane. Grief so overwhelmed her that she no longer cared about life. One day she came upon a crowd of people listening to the Buddha. While they tried to keep her away, the Buddha encouraged her to come forward and speak to him. He told her that she had to accept death. He told her she had to take care of herself and stop punishing herself. The deaths of her loved ones, he said, were a result of their own karma, and she must accept her own as well. Bonda Cha was cured by the words of the Buddha. She was able to recover from her deep depression and grief, and to accept reality and continue her life. She became a great follower of the Buddha.

NEANG KEISA GOTMEY

A woman by the name of Neang Keisa Gotmey was taking her dead child to a Kruu Khmer to have the child brought back to life when she ran into the Buddha. He told her he would bring the child back to life if she would go get a cabbage seed from a family who had no dead relatives. Neang Keisa Gotmey came back to the Buddha and said she couldn't find such a family. The Buddha told her every child is born and every child dies and there is not anything she can do. She must learn to accept death.

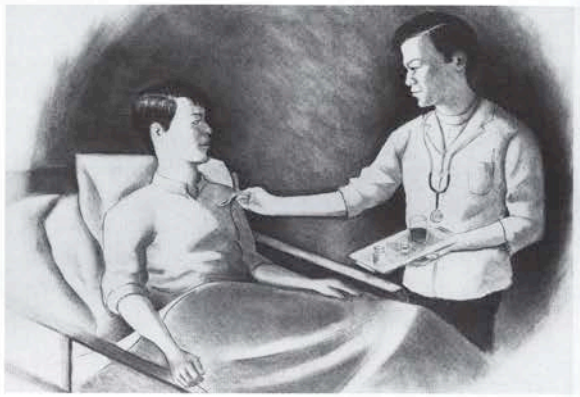
BESIKA THIDA

The Buddha once asked a girl named Besika Thida where she came from and when she would return home. Twice she said she didn't know. Then she told the Buddha she knew, but later confessed that was a lie to distract the crowd. When asked again, she told Buddha, "I say I don't know because I don't know where I came from in the past life and I don't know where I will go in the next life. That is why I answered I don't know."

CONCLUSION

As Buddhism teaches, everyone must try to do good deeds. Everything on earth is always changing, but human beings can act according to their own perceptions. Even though happiness and sorrow comes and goes, each person can learn to cope with what comes along. If the person does good deeds, she or he will be respected by society and feel good. Buddhism teaches that those who do good receive good and those who do bad receive bad.

The Cambodian people have suffered greatly as never before in their history. They suffered from separation and lost lives. They must now try to forget all the painful events and make themselves strong and the future bright. They must live with hope.



6. Use of Psychiatric Medications

by Kathleen Allden

This chapter reviews the basic principles for the use of psychiatric medication. Outlining various psychiatric conditions, it describes which medications are appropropriate for use. Special consideration is paid to medication use in the newly emerging mental health system in Cambodia.

General Principles of Psychiatric Medication

by Kathleen Allden

INTRODUCTION

Major changes in the treatment and prognosis of mental illness came about in the late 1950's with the introduction of two medications to treat psychosis and depression. The discoveries of chlorpromazine to treat psychosis and imipramine to treat depression allowed thousands of mental patients across Europe and North America to be released from mental institutions and to lead functional lives in the community. Since these were discovered, many more medications have been found to help patients who were formerly doomed to spend most of their adult lives in mental hospitals. Psychiatric medications do not solve all of an individual's problems but they can significantly decrease symptoms which interfere with normal healthy living.

Cambodia can expect to benefit from the discoveries of psychiatric medications in the same way that Western countries have. As a new mental health system is developed and implemented, most Khmer patients will be treated in their local communities, within their own families. The KCBM approach, blending traditional Khmer and Buddhist practices with modern Western methods, will provide a rich, culturally sensitive healing experience and allow patients to have productive lives.

The helpfulness of psychiatric medications for Cambodian patients has been demonstrated by the positive experience using the KCBM model at the Indochinese Psychiatry Clinic (IPC) in Boston, Massachusetts, the Khmer People's Depression Relief Center (KPDR) in Site II South and the Mental Health and Traditional Healing Center (MHTH) in Site II North at the Thai border.

PSYCHIATRIC DIAGNOSIS AND MEDICATION

In order to appropriately use psychiatric medication, the mental health practitioner and physician must carefully evaluate the patient and make a proper psychiatric diagnosis. The patient's complaints, symptoms, history, observable behavior, physical exam results and information provided by family members must all be considered. The major psychiatric diagnostic categories that are commonly used today were developed in the West. It is not yet clear to what extent these categories are relevant to other cultures and societies. Disorders may exist which are unique to a particular culture. (The World Health Organization and researchers worldwide are investigating this issue). Nevertheless, basic diagnostic groups have emerged which appear to be generalizable across cultures. These include:

1. thought disorders (psychosis or *Ckuot*)
2. mood disorders
3. Post Traumatic Stress Disorder and other anxiety disorders
4. mental problems related to brain injury or disease.

THOUGHT DISORDERS

Psychosis or *Ckuot* is characterized by auditory or visual hallucinations, unreal and bizarre beliefs, disorganized or irrational thinking, bizarre behavior, and/or excessive fear and suspiciousness. Psychosis can be severe and disabling; however, with the use of "anti-psychotic" medications, the condition of a patient with *ckuot* can dramatically improve. The two most commonly prescribed anti-psychotic medications are *haloperidol* and *chlorpromazine*. Both of these drugs diminish or erase the severe mental disturbances found in patients suffering from *ckuot*. These medications also sedate the patient and restore a normal sleep pattern. In most cases hospitalization can be brief or prevented entirely.

Scientific research and clinical experience show that Asian patients require a lower dose of anti-psychotic medication to obtain the same clinical benefit that a Caucasian might obtain. Asian patients are also more sensitive to the side effects of these drugs. To avoid as many side effects as possible, the patient should

be given the smallest clinically-effective dose of anti-psychotic medication.

In the West, a medication called *benztropine* is commonly prescribed to prevent or minimize side effects of anti-psychotic medication. A patient taking anti-psychotic medication, for example, may experience a sudden alarming muscle spasm in the tongue, jaw or neck which can be immediately relieved by benztropine. Other common side effects such as tremors, muscle stiffness or rigidity, stooped posture, a mask-like facial expression, drooling, or reduced spontaneous body movement can also be prevented or reduced with benztropine.

Patients on anti-psychotic medication often complain of agitated restlessness. This problem can be manifested in symptoms ranging from minor muscular discomfort or leg jiggling to agitated pacing. Benztropine does not help this problem but a tranquilizer such as *diazepam* may provide some relief.

The most worrisome side effect of anti-psychotic medications such as haloperidol and chlorpromazine is brain damage causing movement disorder. The longer a patient remains on an anti-psychotic medication (or the higher the dose), the greater the risk of developing the movement disorders particularly, abnormal tongue movements. The movement disorder can be permanent even if the medication is stopped; nevertheless, some chronically ill patients will require the anti-psychotic medication.

In spite of the risk of side effects, the benefits of anti-psychotic drugs are impressive. Other psychiatric medications do not produce as dramatic a benefit for the other categories of mental disorders.

Traditional healing has not produced the marked positive benefit for *ckuot* or psychosis that psychiatric medication has. It is extremely important to refer a person suffering from psychosis to a medical or psychiatric physician in order to obtain the proper medication. Family members of people with *ckuot* should be urged to bring their relative to the physician for proper diagnosis and medication treatment in order to prevent a severe and possibly chronic mental illness requiring hospitalization.

MOOD DISORDERS

Depression is the most common mood disorder, characterized by a deep sadness which is often accompanied by sleep disturbance, poor appetite, decreased interest in daily activities, decreased interest in sex, low energy levels, suicidal thoughts, poor concentration, and decreased ability to enjoy life or find meaning. People who have suffered significant trauma and loss are at risk for developing depression.

Symptoms often interfere with the person's ability to function in the family or the community. For example, the depressed patient may not have the energy or interest to work; he or she may withdraw from the family; his/her self care and personal hygiene may suffer; he or she may often cry for no apparent reason.

When a person's symptoms of depression interfere with functioning, "antidepressant" medication such as *imipramine* and *amitriptyline* can provide relief. When used in combination with supportive counseling and other KCBM modalities, imipramine and amitriptyline can improve sleep and increase energy, concentration, appetite, and the ability to find pleasure in life.

The common side effects of imipramine and amitriptyline include dry mouth, constipation, and sedation. These medications can also affect the heart, especially in patients with a previous condition. For this reason imipramine and amitriptyline should be used with caution. To minimize side effects the patient should always be given the lowest effective dose of antidepressant medication. As with anti-psychotic medication, Asians require a lower dose of antidepressant medication than Caucasians to achieve the same results.

Another form of mood disorder, known as *bipolar disorder*, is characterized by wide swings in mood and energy levels. Those suffering from this disorder experience episodes of depression and episodes of mania. Mania is characterized by euphoria, increased activity, increased talkativeness, irritability, rapid thinking, exaggerated sense of self importance, decreased need for sleep, distractibility, and grandiose or reckless behaviors. The episodes of wide mood swings tend to recur throughout a person's life.

Lithium is the medication of choice for this disorder. Lithium will gradually diminish the excited, sleepless, hyperactive, grandiose states. Before lithium takes full effect, it is usually necessary to prescribe an anti-psychotic medication to sedate the manic patient, allow him/her to sleep, and diminish the hyperactivity. Once the patient is stable, the anti-psychotic medication can be withdrawn and the patient can be maintained on lithium alone. If the patient takes lithium every day over the long term, future episodes of mania and depression can be prevented.

Most people taking lithium experience side effects; these may include: mild tremor, nausea, diarrhea, mild weight gain, increased thirstiness, increased frequency of urination (total daily volume of urine increases), and mild skin rash. The patient can develop thyroid gland problems if he/she takes lithium for a long time. The symptoms are usually mild, however, and the benefit of lithium is well worth any minor discomfort. Side effects get worse as the dosage of lithium gets higher. Asian patients require a lower level of lithium than Caucasians to achieve the same benefit. Lithium must be given under the strict direction of a physician.

Post Traumatic Stress Disorder (PTSD) is characterized by the development of mental and emotional symptoms after a person experiences an extremely traumatic and terrifying event. The types of trauma which bring on PTSD usually involve a serious threat to the life or safety of one's self, family members, or friends, the sudden destruction of one's home or community, rape, or the witnessing of violence. The symptoms which some people may develop after severe trauma include: intrusive memories of the event, nightmares, intense distress when reminded of the event, avoidance of persons and places which remind the individual of the event, memory problems, poor sleep, angry outbursts, irritability, poor concentration, and feelings of being jittery and/or on guard. People suffering from PTSD often suffer from depression as well.

Many Cambodians have experienced severe trauma but most have not developed PTSD. It is not yet clear which individuals

are most at risk for developing PTSD, but in general, the greater the severity and/or duration of the trauma, the higher the risk. There is no doubt that there are cultural variations in the psychological response to trauma because there are unique meanings attached to traumatic events in each society.

Psychiatric medication can help the symptoms of PTSD. Antidepressant medications (imipramine and amitriptyline) can improve sleep disorders, concentration, nightmares, and anxiety, and at the same time treat the patient's concurrent depression. Tranquilizers (diazepam and chlordiazepoxide) improve sleep and decrease the level of anxiety and the easy-startle response. Tranquilizers are habit forming, however, so their use should be monitored carefully.

Many patients with PTSD complain of memory problems. The causes of the memory problems remain unclear; there are probably both physical and psychological factors playing a role. No one medication has been found for this problem. The best approach is to provide the patient with a thorough medical evaluation, then to provide good medical treatment for medical problems, reassuring supportive counseling and family support, and appropriate psychiatric medication and treatment for mental problems. As the patient's general physical and mental health improves, his/her memory may gradually improve. Memory impairment that is caused by permanent brain damage will not improve much.

Other anxiety disorders are characterized by the following typical symptoms: excessive worry about life circumstances, muscle tension, shakiness, restlessness, shortness of breath, palpitations, dizziness, trouble swallowing. The person may experience discrete episodes of anxiety which last for several minutes, or the symptoms may be present to some degree most of the time. Antidepressants (imipramine and amitriptyline) can prevent the recurring discrete episodes of anxiety. Tranquilizers (diazepam and chlordiazepoxide) diminish anxiety symptoms which persist throughout the day.

MENTAL PROBLEMS RELATED TO BRAIN INJURY

The brain can be injured by head trauma, severe starvation, infection and disease. Head injuries sustained during combat, beatings, torture, and accidents are common among Cambodians. Also common is a history of starvation.

Brain injury can lead to changes in the individual's personality, behavior and memory. The person may show signs of wide mood swings from euphoria to apathy, temper outbursts, and poor control of his/her impulses (causing the person to make inappropriate comments, have inappropriate sexual behavior, fighting, destroy property, or assault others). The individual may have a diminished ability to judge or anticipate the consequences of his/her behavior. Brain injured people often complain of poor memory, forgetfulness, difficulty learning, and poor concentration. These patients may require close supervision to meet their basic daily needs, to avoid repeat conflict with other people, and /or to protect them from others who may react with hostility to the patient's inappropriate behavior. The diagnosis of this problem is frequently complicated by co-existing PTSD and/or depression.

Head–injured patients can be treated with medication if mood swings, temper outbursts, and/or violent behavior significantly interfere with the individual's ability to live peacefully with family members and within the community. Several medications have been found to be helpful.

Carbamazepine is an anti-seizure medication which has been found to be helpful in treating the behavior problems of some head–injured patients. It can stabilize the patient's mood, and decrease irritability and temper outbursts. *Lithium* may stabilize the mood and diminish irritability as well. Some patients benefit from a trial of the anti-high blood pressure medication clonidine. *Clonidine* can decrease the patient's level of arousal, diminish the heightened startle response, and decrease the physical symptoms of anxiety such as rapid heart rate, shakiness, and sweating.

Headache is a very common complaint among brain injured patients. *Ibuprofen* or aspirin will provide some relief. Low dose *amitriptyline* taken daily can decrease the frequency and severity of chronic headaches.

Memory problems do not respond significantly to medications.

SOME PRECAUTIONS

The use of any medication requires the supervision of a medical doctor. Mental health workers can provide important information and observations which, in turn, aid the physician in prescribing the proper medication. Mental health workers also perform the essential direct interventions and support needed by the patient and his/her family.

All psychiatric medications can cause side effects. Most side effects are minor (such as dry mouth or constipation); however, some medications cause serious side effects. Because of the potentially serious side effects, the patient must be under a physician's care while taking these medications. As stated above, antidepressant medications (such as imipramine and amitriptyline) can effect the functioning of the heart. For this reason antidepressants can be lethal if taken in an overdose. It is very important not to store unused or old medication around the house. Children may accidentally eat it, or a depressed individual may impulsively try to commit suicide by overdosing on the medication.

People should not use the medication prescribed for their friends or family members. One person's problem may be different from another's, requiring very different medications.

It is important for the patient to take the medication exactly as prescribed by the physician. The patient should be instructed not to change the dosage him/herself. Not only can such changes endanger the patient, but the medication will not produce the desired benefit if taken improperly.

It must be determined whether a patient is a danger to him/herself or others. If the patient is extremely depressed and suicidal, he/she must be prevented from killing or harming him/herself or others. A careful assessment of the patient's mental

ability to think rationally, make judgments, and control his/her behavior will determine the risk of danger to self or others. If the risk is determined to be high, the patient may require hospitalization or close supervision by family or professionals. This may be needed until psychiatric medication and treatment is underway.

CONCLUSION

Integrating the use of modern psychiatric medication into a practice of healing based on traditional Khmer methods, Buddhist philosophy, and sympathetic listening will enhance the outcome for people who are mentally ill and emotionally distressed. When used with caution and proper supervision, psychiatric medication can restore seriously mentally-ill people to a state of rational thinking and allow them to live relatively normal lives with their families. The benefits of psychiatric medications are maximized when a patient is treated with kindness by an understanding family and community. Traditional healers and Buddhist philosophy can strengthen the healing process by supporting the individual and his/her family.

7. Causes and Treatment of Depression

by Sokhom Chan &
Richard Mollica

This chapter describes a mental condition called depression. Presenting both the kinds and causes of depression, and then setting forth measures to manage the condition, the chapter shows health workers how to recognize depression and provide protection and relief to its sufferers.

Causes and Treatment of Depression

by Sokhom Chan and Richard Mollica

INTRODUCTION

Many Cambodians suffer from depression, an illness which can be very serious and may even lead to suicide. The symptoms of depression can be so disabling they inhibit work, study, and pleasurable experiences.

The most common causes of depression are the loss of a family member or friend, sickness or death of a child, loss of valuable property, extreme poverty, a shameful or embarrassing event within the community (such as an unwanted pregnancy), break-up of a marriage, or job loss. Hurtful and terrifying experiences such as rape or robbery by bandits can also cause depression. In some cases, however, depression just happens and there is no external explanation.

Almost all people who have been traumatized feel sad at times and hopeless. Yet, even with these feelings, most are not suffering from the mental illness called depression. Depressed patients feel very sad and hopeless for months; nothing seems to give them pleasure. They believe that no one or no thing can relieve their suffering. They may not seek help because they believe their situation cannot improve due to their bad karma from a past life. They believe they cannot change their own destiny or suffering.

CATEGORIES OF DEPRESSION

The Khmer people distinguish between three major types of depression. The first is called *Pibaak Cit*, a feeling of deep sadness caused by a tragic event in a person's life. People with *Pibaak Cit* often do not express this feeling in any external way. The second is called *Pruoy City* which manifests itself more as worry and anxiety.

The third is *Srangoot Srangat*, a very deep depression which others can readily recognize because the person shows outward despair.

SYMPTOMS

The following are symptoms of depression:

- sadness and deep sorrow
- hopelessness
- thoughts of self–harm
- constant desire to cry
- constant worry
- anxiety and tenseness
- lack of joy or pleasure
- low energy and fatigue
- physical complaints (such as headaches) that do not go away
- poor sleep
- weight loss
- disinterest in sex or daily activities
- poor concentration and/or memory
- feelings of uselessness
- absence of self-esteem and self-respect.

Depressed patients often complain of physical symptoms. Appropriate medical attention should be given to these complaints, but the health professional should remember that physical discomfort can be caused by emotional and psychological distress.

IDENTIFICATION OF ILLNESS

In dealing with depression, the health worker must try to understand the condition from the patient's point of view. The goal is to have the person discover and be able to talk about the cause.

The health worker can begin by asking how the patient is feeling. This may follow with questions about how things are going at home, work, etc. The patient should be allowed to

explain this in her/his own words. The health worker should explore the following:

- if all the other symptoms of depression are present and how long they have lasted
- the symptoms have interfered with the patient's activities at home, school, or work
- the patient has any false beliefs such as having cancer or a disease that is killing them
- any close or distant family members were depressed, suicidal or had a mental illness
- the patient has received a bad spell or is possessed by an evil spirit.

The counselor should not be afraid to ask if the person is hearing voices, if the voices are ordering the patient to kill him or her self or someone else, and if the patient can resist what the voices are saying to do. Some depressed patients will describe upsetting sensations they have that are associated with death; for example, they may smell dead bodies or think they are infested with snakes or worms.

The most important thing to remember in dealing with depressed patients is that life situations brought on these feelings. The patient needs to be able to say what she or he thinks is causing the depression. Then it is the task of the health worker to try to intervene in very concrete ways. For example, the counselor may want to call a family meeting.

SUICIDE

Khmer people have a cultural prescription against suicide. They believe that suicide is the intervention of evil spirits and that the suicidal person is not really acting on his own. While believing that the Buddha will not revive you if you kill yourself, many Khmer, nevertheless, succumb to suicide as a final escape from suffering.

MANAGEMENT OF DEPRESSION

SAFETY

The first step in managing depression is to assess the patient's safety and the safety of the community. When a patient indicates he/she has suicidal thoughts, the mental health worker needs to pursue this issue by asking if the patient:

- has attempted to kill her/himself in the past
- has a plan for killing himself or members of his family, owns a weapon, grenade, or poison, or has easy access to dangerous objects
- hears, smells, or sees things that do not exist, especially if voices are telling him or her to commit suicide or harm others
- lives alone and has no one to observe or offer protection
- drinks alcohol or uses drugs.

If the patient has access to weapons, the worker must ask the family to remove these from the home. If the mental health worker determines that the patient is a serious danger to him/herself or others, the worker must admit the patient to a safe, supervised setting. If hospitalization is not possible, the patient should be maintained in a supportive home environment where family members can closely monitor behavior and provide care and reassurance.

MEDICATION

The depressed patient can often benefit from physician-prescribed medications such as imipramine and amitriptyline. If the patient does get a prescription from a doctor, he or she must be monitored for potential drug side-effects such as dry mouth, blurred vision, irregular heartbeat, light-headedness or dizziness Dizziness is especially a problem when the patient is getting out of bed in the morning.

SUPPORT AND COUNSELING

The health worker must realize that the patient will solve his problems slowly. The worker should not blame or criticize the patient. This will only make matters worse. The role of the health

worker is to encourage the patient to return to work or school as soon as possible. The health worker can explain that once the depression goes away, the patient will feel well again.

The health worker should ask traditional and religious healers to help the patient get over feelings of hopelessness, guilt, and shame — especially if the patient indicates these are caused by a bad spell or evil spirit. Religious healers can be helpful in many cases. However, a woman who has been raped may be reluctant to go to a monk, if so she should be encouraged to go to a counselor she trusts instead.

SPECIAL CONSIDERATIONS

Individuals who are depressed and suicidal as a result of rape and/or sexual violence need special counseling and should be referred to counselors who have these skills. The health worker needs to be cautious if the depression does not improve with counseling and medication. If this is the case, the patient should be examined by a doctor or nurse for physical causes of the symptoms.

CONCLUSION

There is a Cambodian saying that captures the essence of despair that many people who have been through the civil war era feel. The saying is: "The cup is full and another drop can make it overflow." It reflects the kind of fatalism that is also at the heart of the Buddhist idea of kharma. People will suffer until they finally collapse.

Counselors can help people with this kind of great despair by acknowledging its legitimate causes and by helping the patient accept what has happened and still have hope.

8. Trauma Related Illness

by Lany Lang

This chapter discusses the traumas experienced by people who suffered through the Cambodian civil war. It describes the physical and psychological effects of trauma, and presents both traditional and Western methods of providing relief to victims.

Trauma Related Illness

by Lany Lang

INTRODUCTION

Traumatic–event illness occurs when life experiences have destroyed psychological and physical resistance, leaving a person weak and unable to function normally in every day life. All Khmer people who have survived the past couple of decades (either as victims or perpetrators) have been traumatized by their experiences. Those who lost families or who were targeted because of their education were especially affected.

Among the terrible events that many people experienced (and still suffer from the memories of) are the following:

- being forced to leave homes and properties
- being deprived of food and water
- being separated from loved ones
- being fearful that authorities will find true identities
- being forced to work at gun point
- being robbed or raped
- being brainwashed
- being tortured (beaten, kicked, knifed, axed,smothered)
- being imprisoned
- having to run from place to place to avoid shelling, bombing and grenade attacks.

SYMPTOMS

People who suffer from these traumas often experience some or all of these mental/or physical symptoms:

MENTAL

- reoccurring frightful memories including nightmares and flashbacks
- feelings of guilt about being alive when friends and relatives have died

- preoccupation with the smell of gun smoke, shelling and human blood (as if there were real blood on their hands or bodies)
- feelings of despair, hopelessness and entrapment
- forgetfulness
- mood swings, anger and depression
- fear of leaving the house or being in crowded places

PHYSICAL

- severe and persistent headaches
- shortness of breath and rapid heart beat
- numbness (feels like "dead person")
- aches and pains in the joints, back and neck
- sweating or cold hands, hot flashes and chills (shaking)
- nausea, diarrhea
- panic: feelings of extreme nervousness, shortness of breath ("no air to breathe") and feeling out of control or that they are going to die.

Sometimes the patient will talk to her/himself or get violent.

TREATMENT

Many patients resist help until their symptoms have reached crisis proportions. This is particularly true when their problems are especially difficult to resolve or when the usual support system is no longer available. At first the patient is caught in a state of great emotional upset and feels helpless. She or he may think that bad things have happened as a punishment for wrong doings in the past. The patient may become extremely nervous and feel that anything could become overwhelming. He or she may feel the illness is inevitable and the suffering deserved.

The health worker or counselor has to try to be both realistic and hopeful. The process of recovery may take a long time; the counselor needs to be patient and reassuring. It is good to remember that the patient has been severely traumatized and that his or her identity has been weakened by horrible experiences. When the patient regards the illness as inevitable or feels

deserving of punishment, she or he cannot be an active partner in the fight for health.

Nevertheless, the ultimate goal is to help the patient regain the emotional stability he or she had before the trauma. The counselor must educate the family and patient about the effects of trauma, share decision-making, and help find community support such as community elders, spiritual healers, monks, priests, doctors and nurses.

The counselor should not promise to solve the patient's problems. He or she should sympathize with the patient and express regret, but also assure the patient there is a chance that things will work out. The counselor should reassure the patient that he/she will not be abandoned, listen to the patient without making moral judgments, and strive to treat the patient with courtesy and respect.

The overall goal is to help the patient and his family understand causes of the symptoms and to ensure that there is on-going help.

ROLE OF THE COUNSELOR

The counselor should make a treatment plan with the patient and family members which outlines how often and when the counselor will visit. As much as possible, visits should occur on a regular basis for at least the first six weeks. This will help the patient get on a schedule and feel assured that she or he is getting help. It will also help the counselor build an alliance with the patient and family members.

During the visits, the counselor should let the patient tell his/her stories. While not pushing the patient to talk, the counselor should ask questions such as "Did you have a good night's sleep last night?" or "How do you feel when you wake up?" or "Is anything frightening you?"

The counselor may make comments such as "You look worried," or "You seem to be losing weight." The counselor should find out how long the patient has had the symptoms, how often, and if they interfere with daily activities. The counselor

should get the patient to talk about the symptoms, suspected reasons for the suffering, and any other related comments.

The counselor should tell the patient that it is all right to cry or shout — that there is "nothing to be ashamed of." The counselor should not argue or disagree, but simply be receptive. The counselor should listen as long as possible and even repeat stories that are important to the patient. The goal is to help the patient express and release painful emotions.

The counselor should keep the following questions in mind:

- How important are related events to the patient?
- What exactly do they mean to the patient?
- Who does the patient trust among his family members?
- Which family members does he feel close to?
- Have other crisis situation happened before?
- How did the patient resolve problems in the past?

Finally the counselor should try to get other people involved in helping the patient. For example, some may take the patient to the temple, get the patient to go for a walk, prepare a meal for the monks, or even share a meal with family and friends. While doing this, the focus should be on healthful food, exercise and deep breathing.

OTHER TREATMENT CHOICES

Traumatic–event illness is sometimes so severe that its effects cannot be relieved in a short time, even with emotional support and medication. If the patient's symptoms are out of control, the counselor should take him to a hospital for evaluation. Doctors or nurses may be asked to prescribe medication.

A physician can prescribe minor tranquilizers such as *benzodiazepines* to relieve anxiety and decrease fear. However, one should be careful as these are extremely habit forming. Antidepressants (such as a *imipramine*) are useful if the trauma-related illness is compounded by unending grief or chronic depression. These drugs may make the patient fatigued so the patient should be warned regarding driving a motorbike or bicycle.

The counselor may also want to suggest a *Kruu Khmer* who can offer support and comfort as well. The Kruu Khmer cannot take care of psychosis (loss of mind), but can be effective with nervous disorder, fear, sorrow, sadness, and other symptoms. The fortune-teller can help relieve anxiety or depression by telling the patient why he has had to suffer now and by predicting when the problems will be solved.

Traditional methods include those of the fortune teller, Buddhist monks, sorcerers, *Neak Ta*, *Chol Rup Arak*, and others. In general, traditional treatment consists of protective magic designed to conciliate the good spirits and drive out the evil ones. The good spirits, though mainly beneficent, are believed to be sensitive about their rights and capable of causing illness to persons not showing proper respect. They may cause mental disturbances which can be driven out only by a sorcerer. Prevention or treatment can combine magic and prayer as well as the use of magical charms and spells.

The Kruu Khmer is a practitioner of magic who has a number of talents. He is believed to be able to inject supernatural power into an amulet by drawing on his secret magic formula. He can also prescribe traditional herbs, roots and folk remedies.

The *Achar Wat* has the ability to intervene with the spirits. Because there is a belief that some mental disturbances are caused by offending a spirit or by not being a devout Buddhist, the Anchar Wat can be useful in performing the necessary ceremonies to placate the spirits.

The *Chol Rup Arak*, usually a woman, acts as a spiritual medium. This person occasionally becomes possessed by spirits and has the ability to communicate with the spirits on the patient's behalf.

Note: It can be very hard to work for a counselor with a trauma patient, especially if the counselor has lived through similar traumatic events and/or been a victim of the patient's political group. Talk to someone trustworthy about these feelings. There is a saying, "When your enemy is thirsty, give him water. When your enemy is hungry, give him food. Some day, he will feel ashamed of himself."

9. Domestic Violence: Consequences and Treatment

by Malis Oeur-Chum

This chapter describes why domestic violence occurs in Khmer culture, and what mental health workers can do to address the problem. It points out how domestic violence has been misunderstood in the past, and proposes education for both men and women on the subject.

Domestic Violence: Consequences and Treatment

by Malis Oeur-Chum

INTRODUCTION

Domestic violence is customarily defined in Khmer culture as physical abuse within a family; however, domestic violence may include verbal abuse as well. There may even be sexual abuse or rape within a family.

HISTORICAL BACKGROUND OF DOMESTIC VIOLENCE

Before the Khmer Rouge takeover of Cambodia in 1975, domestic violence usually occurred as a result of various stress factors in the family, most notably financial problems and alcohol abuse. Although domestic violence was seen as shameful, families suffering from its consequences sometimes sought help from extended family members, monks, Kruu Khmer, or elders in the community.

During the Khmer Rouge takeover from 1975-79, traditional family relationships were destroyed and family members separated from one another. Unmarried woman and widows were left unprotected. Frequently they became the charges of the Khmer Rouge who arranged marriages (often in mass ceremonies) and permitted new husbands to take control over them. Since women who protested this arrangement were threatened with violence or death, few, if any, ever spoke of the physical violence, emotional abuse, or rape they experienced.

Following the invasion of the Vietnamese in 1979, many Khmer people fled to refugee camps along the Thai border. For many of these people, domestic violence became a commonplace way to express anger and frustration. Men who had lost control of their lives sought to regain it by physically abusing wives, children, or stepchildren. Many mothers became violent with their children.

War, expatriation, and social upheaval may all precipitate domestic violence, but there are other conditions that may cause it as well: poverty, prior rape experience, abuse as a child, physical handicaps or injuries, substance abuse, depression or psychosis. Any one or more of the above can disrupt healthy relationships in a family, and cause domestic violence to occur.

SIGNS OF DOMESTIC VIOLENCE AMONG FAMILY MEMBERS

In Cambodia, the husband is considered the head of the family and he learns from a very young age not to show his feelings. It is difficult for him to speak about his problems. Furthermore, the family unit is considered sacrosanct. Families do not want outsiders to know about their problems, making it even more difficult to seek help.

In Khmer culture, there is a great cultural stigma for the woman who leaves her husband, and many women are very afraid of being considered "bad wives." Women who try to leave their husbands often return to the same abusive situations simply because they do not want to carry the stigma of being "bad."

When there has been violence and abuse among family members, generally all will finally indicate it in one way or another. The victim may express feelings ranging from depression and shame to distrust, anger, and self-blame. The perpetrator may also express a lack of self-worth and shame. He may also overcompensate for his guilt by increasing the abuse and exacerbating contributing destructive factors (alcohol and drug abuse).

Frequently other family members withdraw and become depressed. As they seek to isolate themselves from others, the community senses their shame and may either pity or blame them for their problems. Sometimes members in the community seek to help; others simply gossip and avoid the family. Very often community people do not interfere because they fear retaliation from the perpetrator.

VICTIM SYMPTOMS

Because domestic violence is regarded as a taboo in Khmer culture, victims often suggest that its physical signs (bruises, fractures, and other body marks) are due to an accident. However, emotional signs are not so easily disguised. Mental health workers can suspect domestic violence by noticing the presence of one or more of the following:

- depression: insomnia, poor appetite, tiredness, memory loss, poor concentration, ideation/attempted suicide, feelings of hopeless or worthlessness
- agitation: irritability, heightened reflexes, nightmares, flashbacks
- anxiety: shortness or breath, palpitations, chest pain, extremity tingling, hot flashes, cold sweats, jelly legs, panic
- psychosomatic complaints: headaches, dizziness, stomach aches, fever, blurred vision, and other unexplainable physical pain

MYTHS ABOUT VICTIMS AND PERPETRATORS OF DOMESTIC VIOLENCE

For a long time, people tended to blame the woman when it was discovered that she was beaten by her husband. They thought she was not being a "good wife."

Now, however, mental health workers and others know that the problem does not lie with the victim, but with the person who is doing the abusing. In fact, it is clear that men who abuse their wives need help as much as the women themselves.

It is no longer considered true that:

- domestic violence is very rare and affects only problem families
- women who get beaten are the kind of women who "ask for it"
- women get beaten by men because they have failed to be good wives
- women stay in domestic violent situations because "it isn't really that bad"

- men simply need to learn how to control their anger (most violent men control their anger in other settings, but not with their wives).

Mental health professionals who have studied domestic violence in many countries say that the most common underlying cause of domestic violence is the idea that the man owns the woman and has a right to do what he wants with her.

Men who harm and beat their wives frequently blame the woman by saying "she made me do it." They say that the woman was at fault. Often the abuser does not even realize there are other ways he can act. He does not know he has options of asking and negotiating for his needs and for taking responsibility for his own behavior.

AIDING FAMILIES INVOLVED IN DOMESTIC VIOLENCE

Traditionally, when there is domestic violence in a family, family members turn to other members of the family to help. The wife is usually the one who seeks help, or the husband may go away to stay with relatives.

The Kruu Khmer sometimes helps in cases of domestic violence by inviting the husband to stay in the company of the Kruu Khmer until there appears to be possible change. The Kruu Khmer can treat the husband with herbal remedies, massage, or coining.

Families can also go to Buddhist monks who are regarded as powerful influences in the community. The monks may counsel the family and provide religious training. Because domestic violence is sometimes seen as the temporary result of spirits inhabiting either the house or the perpetrator, monks may perform ritual cleansing of the individual or the home.

In recent years mental health workers have begun to help families involved in domestic violence as well. The emphasis of the clinical approach is on individual counseling and group therapy. Families (including the husbands) are encouraged to speak about

their feelings and encouraged to take personal responsibility for what is going on. Husband and wife are encouraged to focus less on blame or shame, and more on him getting outside help and finding a new perspective on their problems.

Husbands who beat their wives often feel threatened themselves. (Usually a woman's independence makes them afraid.) They know the woman may go to other people, and they are afraid of losing control over their wives. Sometimes the men will threaten the counselor or try to retaliate against the wife for "betraying" the family.

Husbands need to be asked questions that will cause them to examine their own actions and fears. They are often very angry inside and need to talk to someone about their feelings. They need understanding, but they also need to realize they do not have the right to harm their wives or regard them as their personal possessions.

CRISIS INTERVENTION

The health worker can assist the family on both an immediate and long-term basis. In the early stages of intervention, the health worker should see that everything possible is done to maintain the safety of the victim and children. This may mean the victim or the abuser needs to move away to the home of a relative or friend.

Very often the victim will want to talk to extended family members. For example the wife may go to stay with her family or her in-laws. If the husband has friends or neighbors he knows well, the wife may go to them. She may ask them to counsel her husband. Sometimes she will say she won't go back with her husband unless he comes with his family to speak to her and sometimes she has other conditions. These should be respected.

If the wife definitely wants to leave the husband, every effort should be made not to separate her from her children.

MENTAL HEALTH WORKER'S ROLE

The health worker must be careful not to interfere too much so that the husband and wife become afraid of social pressure and act too quickly on reconciliation. It takes time to work with a woman who has suffered violence, and she may often change her mind about what she wants to do. The health worker has to be patient, to ask questions many times, and to be sure that the patient does not return to her husband while she is still afraid. The woman may go back and forth between wanting to run away (feeling embarrassed before family and neighbors) and wanting to stay with their husband.

The health worker needs to continually reassure the woman that she can always ask for help and that she can return if she is in further danger.

When the health worker counsels the woman, it is important to:

- develop trust and confidentiality with the family
- ask for some history on the family (the wife's and the husband's)
- form a therapeutic alliance with the victim and the perpetrator
- refrain from being judgmental or blaming
- recognize the value and importance of traditional beliefs
- work with traditional healers to help the family.

The members of the family should begin to receive counseling as well.

10. Alcohol and Substance Abuse: Symptoms & Treatment

This chapter describes a number of addictions and their symptoms at various stages. It also discusses crisis interventions for people who are ill from alcohol and drug overuse and the management of disease for those wishing to recover.

Alcohol and Substance Abuse

by Sokhom Chan

INTRODUCTION

Cambodian culture and Buddhism stress high moral standards and good citizenship. Buddhism, in particular, emphasizes practicing good moral standards and avoiding bad habits — particularly the three "madnesses": alcoholism, promiscuity, and gambling. Nevertheless alcoholism and drug abuse are as chronic and widespread problems in Cambodia as they are throughout the world.

The reasons that people turn to alcohol and drugs are very apparent. Individuals who have experienced war, mass murder, sexual and physical assault, separation from families, destruction of property, loss of family and physical functions feel personally powerless and victimized. They turn to alcohol and drug abuse as a means of "medicating" themselves to get relief from physical and emotional suffering.

Teenagers, in particular, often rely on drugs to get relief from feelings of sadness, loneliness and grief. Sometimes they use alcohol to express anger they feel over being victimized or treated unfairly. Their reliance on alcohol and drugs may be a result of exposure to violence and traumatic events or it may be a result of depression or other mental illness.

Alcohol and drug abusers are frequently unable to make use of family or community support to cope with their past trauma or current stresses and hardships. Since the civil war, the use of alcohol and drugs has been on the rise in Cambodia. In fact, it is their abuse which causes many personal, family, and societal problems. The cost of alcohol and drug abuse is measured in higher medical expenses, greater absenteeism, lower work efficiency, poorer family production, and a weaker national economy.

The most commonly used drugs in Cambodia can be divided into two groups: 1) legal drugs such as alcohol and tobacco; 2) illegal drugs such as marijuana, opiates, amphetamines, and barbiturates.

ALCOHOL AND NICOTINE

Many Cambodians drink alcohol. It is estimated that 10% of all who drink, have drinking problems, and it is thought that more men have alcohol problems than women. This may not be true, however, because many women are secret drinkers. Society is much more critical of women drinkers and consequently they try to hide their problem. (Women are usually allowed to take traditional medicine containing alcohol solution for two or three months after delivery of the baby but this is the only time it is considered acceptable.)

Alcoholism is notorious as a cause of violence, broken marriages, lost jobs, legal problems, destitution, and despair. It can decrease a life span from 12-15 years and even kill a person if not treated.

It is feared that many young people in Cambodia today may be turning to alcohol. Mirroring adult behavior they see all around them, teens use alcohol to show off, to increase pleasure while socializing, to relax, or to prove they are members of a group.

Nicotine from cigarette smoking is another common drug in Cambodia. Use of cigarettes can cause heart attacks, lung cancer, gastritis, bladder cancer, head and neck cancer, and infant low birthweight.

IDENTIFYING ALCOHOLISM

There are three progressive stages of alcoholism. They are often marked by the social behaviors exhibited by people who are abusing alcohol.

The first stage is marked by the ability of the person to drink more and more before becoming affected by the alcohol.

The person may find him or herself drinking more to relieve tension and pressure. She or he may promise to quit drinking and then be unable to keep the promises. Personality changes such as increased irritability and forgetfulness (due to black-out).

The middle stage is marked by cycles of isolation, and guilt. Other signs include drinking to feel alert and less shaky in the morning; a decreased ability to work, and drinking more than intended.

The final stage is marked by disintegration of family life and decline in functioning. The person is likely to experience an inability to work. Drinking may become uncontrolled and tends to increase isolation from friends and family as does greater tension and irritability. Finally, signs of deteriorating health become apparent: tremors, hallucinations, weakness from malnutrition.

The medical consequences of alcoholism can include: cirrhosis of the liver, peripheral neuropathy, brain damage, heart disease/failure/attack, gastritis and gastric cancer, pancreatitis, and infant brain damage (due to mother's drinking during pregnancy).

DRUGS

Many people, when exposed to certain drugs in moderate doses, cannot control their use and become addicted. Once they are addicted, they show any of the following symptoms: take more than intended; cannot stop use; spend much time obtaining the drugs; cannot fulfill other obligations; give up other activities and focus only on the drugs.

The following is a synopsis of commonly abused drugs and their side effects:

Amphetamines cause mood elevation (a feeling of being "high"). Side effects include: loss of appetite, anxiety, irritability, rapid speech, sleeplessness, tremors, disorientation, severe depression, paranoia, hallucination, increased blood pressure and fatigue.

Morphine/Heroin brings insensitivity to pain, euphoria, and sedation. Users often have needle marks on their arms. The side effects include: lethargy, weight loss, itchiness and watery eyes, runny nose, slow and shallow breathing. Their use may also cause hepatitis and, if used with barbiturates, possible death.

Marijuana (hashish, gancha) causes lack of concentration and coordination, craving for sweets, increased appetite and laughter. Side effects are: dilated pupils, increased heart rate, impaired short-term memory, anxiety, lung damage, and possible psychosis.

Cocaine causes short lived euphoria (rapidly changing to depression or suicidal ideation. The side effects include nervousness, irritability, tightening of muscles, shallow breathing, fever, anxiety, tremors, and possible death from convulsion or respiratory arrest.

It should be noted that people who use (or even experiment with) some of the above mentioned drugs while using "dirty" needles are at extremely high risk for HIV infection and the AIDS virus.

DRUG WITHDRAWAL

Heavy drug users have a dramatic reaction when they stop because their brains have become adapted to a chemical substance and they can no longer function normally without it. All drugs have their withdrawal symptoms which are summarized below:

- *nicotine:* anxiety, hunger, irritability
- *caffeine:* headache, sleepiness
- *alcohol:* tremor, headache, nausea, weakness, sweating, depression, irritability, agitation, delirium tremors or seizures (unsupervised withdrawal can cause death)
- *barbiturate:* seizures and cardiovascular collapse which can cause death
- *opiate: (morphine, heroine):* anxiety, restlessness, diarrhea, muscle spasm

Withdrawal is not only uncomfortable, but can be dangerous enough to require medical treatment in a hospital. People in withdrawal are always tempted to return to their habits when they are exposed to others who are either using or discussing the

drugs. Alcoholics may feel the need for a drink when passing a favorite bar; recovered drug addicts may have an urge for drugs when they see a hypodermic needle or hear someone talk about morphine/heroine.

MANAGING ALCOHOLISM AND DRUG ADDICTION

Most alcoholics and drug addicts are reluctant to quit for fear of withdrawal symptoms. Others are resistant because they have used these substances for relief from their problems and emotional stresses. Both these reasons make it difficult to treat people with these dependencies.

Mental health workers can help, however, by showing concern and lending support. Users can stop their habit if they are determined, and if they get the support they need.

Medical treatment for withdrawal is not necessary unless the individual is a chronic user and strongly addicted. Mental health workers should be aware of various local traditional sources for help including traditional healers, Kruu Khmer, the Buddhist monk and local health workers. People who have dangerous withdrawal symptoms and complications should be referred immediately to the district health center or province hospital.

RECOVERY

The goal of alcohol and drug detoxification is to cleanse the body of the substance and its harmful side effects. Detoxification can be achieved in 1-4 weeks (but at the patient's pace) with the support of a counselor and others of the community. Sometimes the patient must be taken to a detoxification center or health care facility to prevent serious withdrawal symptoms.

KCBM can be applied as a useful means of preventing relapse. Kruu Khmer or traditional healers can help with medicinal herbs, roots or fish mucus which have emetic effects and cause nausea or vomiting when the patient uses alcohol or drugs. Cambodian counselors or family elders can use the concept of shame, fear of family stigma, and loss-of-face to help the users

control their addiction. Buddhist monks can use religious concepts based on moral ethics (honor, pride, and honesty), and employ blessing and chanting when there is personal or familial conflict. They can help to chase away the evil spirits which the addict feels intend harm to the user or the family. Finally, mental health workers may contact physicians to evaluate the patient for adequate nutrition, vitamin intake, and appropriate medical care. A physician may administer the following medications:

- chlordiazepoxide or diazopam to manage alcohol withdrawal
- phenytoin or diazopam to prevent seizure from alcohol discontinuation
- disulfiram to prevent relapse by causing vomiting if alcohol is ingested
- methadone to help morphine/heroin addicted people stabilize their symptoms of dependence.

Research in cognitive behavioral therapy has shown that alcohol and drug users need to be encouraged to identify the situations and feelings that cause them to relapse. When they are taught how to avoid those situations and feelings and substitute other more positive ones, they have a better chance of recovery.

Mental health workers can take advantage of this cognitive behavioral theory by educating the patient, family, and friends on alcoholism — including explaining the negative effect of protecting the alcoholic or drug user from the problems caused by the addiction. Workers can help with counseling, vocational rehabilitation, support to the family, and the use of free time with non-drinking peers. The worker should keep in touch with the patient and the family for a minimum of six months after abstinence is achieved.

Most alcohol and drug abusers seem ungrateful, demanding, and manipulative. They often enter treatment only when compelled and they seem to resist help. In many countries, people with alcohol and drug abuse problems form self-help groups where people come together to discuss their lives and problems. These groups provide a place where abusers can learn social skills and develop self-motivation.

CRISIS INTERVENTION

Some individuals become aggressive after using alcohol or drugs. When violent behavior occurs, it is best to isolate the person or persuade the family members and other people to go away. It is not good to attempt to challenge a violent alcoholic or addict except when there are enough people or force to restrain the person. It is not possible to order the person to stop the behavior; the mental health worker should try to "get along" with the violent person and get him away from the provoking situation.

A crisis may also occur when a person overdoses and becomes unconscious. In this case, the mental health worker should pay special attention to cardiovascular and breathing status and get the person to a health care facility or hospital as soon as possible. If possible, Cardio Pulmomary Resuscitation (CPR) should be administered.

11. Rape and Sexual Violence

by Phaly Nuon

This chapter describes the emotional consequences of rape and sexual violence against women. It describes how a woman may feel and act after such a trauma, and suggests ways a health worker can offer comfort and support.

Rape and Sexual Violence

by Phaly Nuon

INTRODUCTION

The emotional consequences of rape and other sexual violence are extremely traumatic. Many Khmer women who sought to escape to the border during the Khmer Rouge regime were violently assaulted and abused — without recourse of protection or justice. In fact, their abusers often committed the acts simply to have power over another person, making it all the more oppressive for the innocent women. The psychological damage was severe.

BACKGROUND ON THE PROBLEM

During the political upheaval and war in Cambodia, many women were raped by assailants when they sought to escape to the borders. Frequently the women were gang-raped, sometimes to the point of death. When women tried to hide in the woods to survive, the attackers would take them to the bunkers at night and force them to have sex. If they tried to escape after that, they were often murdered.

There have been other conditions under which women were raped as well. Sometimes a man who wanted a particular woman would have her arrested as a spy and then make an agreement with the police to release her under the man's custody. He would then take her home and rape her, hoping to get her pregnant so she would not leave.

Sometimes men stole women and raped them to be sold as prostitutes. When they did, the men invariably stole the women's possessions and money as well. Men also bribed young girls (ages 9-12) with money or food and then took them away and raped them. The girls did not suspect what the men intended to do.

SYMPTOMS

Women who suffer from the horrifying experience or rape and sexual violence manifest symptoms ranging from physical pain to extreme depression. The physical signs include cuts or bruises, internal injuries and hemorrhaging, sexual diseases, and pregnancy. The emotional signs, which sometimes can be hidden for years, include the following:

- nightmares
- fear and distrust of people
- depression, melancholy, loneliness
- uneasiness, anxiety
- guilt feelings and low self-esteem
- restlessness, a desire to run away
- a desire to commit suicide
- aggressive behavior
- clumsiness.

TREATMENT

Treatment for rape and sexual violence victims encompasses traditional methods of healing as well as Western medications and counseling. By observing the severity of the victim's physical, psychological and emotional condition, the mental health worker can determine the appropriate treatment. Most victims need the combined skills of a doctor, counselor and Kruu Khmer.

People who work with rape victims must be very understanding and sympathetic to the patient's feelings and disposition. Sometimes it is helpful if the counselor shares her or his own similar experiences.

It is important to promise confidentiality to the victim and to assure her that private information will be kept secret from others. However, if the victim is so depressed that she is suicidal, the health worker must inform others that she is suicidal in order to ensure her safety.

WHAT TO DO

In treating a rape victim, the health worker needs to be kind and to show respect for the victim. If the young woman is unmarried and a virgin, she needs to be told over and over that she should not blame herself. She needs to be reassured that her honor will not leave her, and her life is not destroyed. She needs to see that her inner self is still intact.

The worker should meet with the victim at least five times to learn about her and her family. If the young woman is poor, the health worker may have to help her find a place to stay and help her find a job. Sometimes the women or girls are sent by the relatives to live in another province. The health worker may have to help with this move.

If the victim has been physically injured, the counselor should be sure she is taken to a doctor. (Since many young girls are ashamed and afraid to do this, the counselor should offer to go along with the victim.) If the victim is a girl raped before puberty, she may become unconscious and bleed a lot. She should be taken to get emergency help and later to be checked for disease. If she is beaten up or kept as a prostitute, the health worker must contact the police or an agency that will protect her.

The counselor should also contact neighbors to ask them not to say bad things about the girl. The parents should be told that their daughter is not to blame.

Rape is very serious for a married woman as well. The married woman fears being disgraced and that her husband will abandon her. She may be afraid that the family will blame her as well.

In this case, the health worker needs to contact the husband and the family members and explain that the wife did not want this to happen. She did not mean to betray her husband; she was forced to have sex against her will. The counselor should see the patient several times, and watch the family to see that she is not abused for what happened. She should also be watched for suicide attempts using a knife, medication overdosing or trying to hang herself.

MENTAL HEALTH WORKER'S ROLE

Mental health workers assisting those who suffer from rape and sexual violence need to provide a safe and secure setting. In establishing a proper therapeutic atmosphere, the worker must also:

- promise strict confidentiality to ensure patient trust
- act friendly but not patronizing toward the patient
- remain non-judgmental at all times
- encourage the victim to be confident
- assure the victim of on-going services until the patient feels stable

When actually providing services to the victim, the mental health worker should seek to do the following:

- welcome the victim and assure her that she will be heard
- counsel the patient in a non-threatening way that helps her cope with her anxiety
- arrange for the patient to have a safe living environment
- contact other agencies who can provide services such as food rations and supplies
- make arrangements for follow-up counseling when the patient leaves treatment.

MEDITATION

Victims of rape can often benefit by meditation therapy. In meditation, the patient practices mental tranquillity and right thinking. She learns to concentrate and develop her mental powers.

Buddhist meditation can help the patient to see and understand truth, and to regain inner stability and a sense of inner strength. At first the patient may feel suicidal or very depressed. Sometimes the patient has outbursts of anger and feels like she is going crazy. Meditation helps the patient calm herself and feel less depressed. It can keep her from feeling like she is losing her mind.

The following are seven main types of meditation, many of them with a number of variations. For example there are ten kinds of Kasina meditation, ten Asubha and ten Anussati; there are four Brahma Vihara and four Arupa.

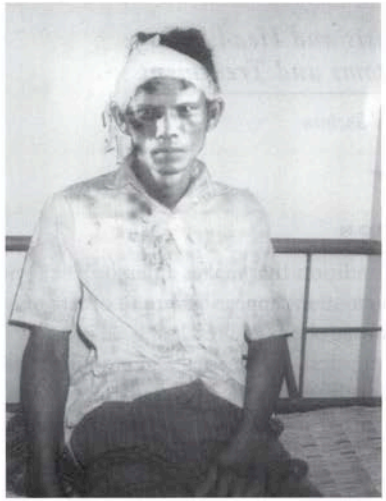
The following is a list of the seven main types:

- *Kasina:* meditating on an object or device to achieve a mystical state
- *Asubha*: meditation through concentrating on something unclean or impure such as a corpse or skeleton
- *Anussati:* meditation involving remembrance of the Buddha's good deeds
- *Brahma vihara:* meditation on the basic attributes of a pure and noble nature (compassion, pity, joy at other's happiness, sincerity); contemplation of a sublime or divine state of mind along with pious conduct
- *Arupa:* meditation on something abstract, formless, and bodiless
- *Ahara pali kula sahha:* meditation based on sensory perceptions
- *Veak Thaan:* meditation on the four natural elements of earth, water, wind and fire.

CONCLUSION

Rape is such a terrible thing for a woman in Cambodia that sometimes it takes a very long time for the victim to feel she can continue with her life. Sometimes the only thing that other people can do is to wait for time to pass. It should be noted that although it occurs less frequently, men sometimes are victims of rape and the above–suggested principles should be followed as well.

After repatriation, Khmer People Depression Relief (KPDR) will continue using a combination of traditional healing with Western counseling and medications to help rape and sexual abuse victims.



12. Psychosis and Head Injury: Symptoms and Treatment

by Chris Sochan

This chapter describes the symptoms and management of mental illness caused by psychosis and head-injury. The chapter tells how a health worker can provide crisis intervention and some long-term relief for patients suffering from these conditions.

Psychosis and Head Injury: Symptoms and Treatment

by Chris Sochan

INTRODUCTION

Psychosis is a condition that makes a person's behavior, beliefs, experiences and emotions appear bizarre to others of his/her own culture. Brain damage occurs as a result of head injury or suffocation. It can result in physical, intellectual and emotional impairment. People suffering from either of these conditions are often neglected, stigmatized and isolated by their communities.

PSYCHOSIS

A psychotic person can have behavior that ranges from being immobile or mute to being aggressive, and/or "out of control." A person's symptoms can come on suddenly (within hours or days) or subtly and slowly over months or years. The symptoms may be brief, intermittent, or on-going. Psychotic people who are depressed, in a delirium, aggressive, or suicidal can be dangerous. Long-standing psychosis can suddenly change and a person may experience "loss of control."

It is difficult to know what causes psychosis. Life experience, genetic inheritance and brain damage may all contribute to a person's vulnerability. Some women are vulnerable at the time of childbirth. In other cases, there seems to be no explicable cause. Traumatic events (e.g. loss of one's child, the experience of violence or rape) can precede a sudden psychotic episode.

On the other hand, people who are suffering from a medical illness, caused by a high fever, fluid loss, intoxication or drug overdose, head injury, epilepsy or brain diseases (such as meningitis) may appear as if they are psychotic. However, they are suffering from a confusional state which is different in origins from psychosis. Their problem is considered medical.

SYMPTOMS OF PSYCHOSIS

The following are indicators of individual psychosis:

- inability to cope with the normal demands of work, family and community
- change in energy, interest and pleasure
- change in sleeping patterns and the ability to sleep; agitated sleeping
- change in eating habits
- difficulty thinking and expressing thoughts clearly
- false, bizarre beliefs (e.g. others are controlling, hurting or tormenting them)
- hallucinations (voices, visions, body sensations and smells); belief that a device, machine or spirit has come into their body and is controlling the person
- rapidly altering emotions (no feelings, excessive irritability, depression or euphoria, sudden laughing or crying)
- use of drugs to cope with life.

IDENTIFICATION OF PSYCHOSIS

When a person has been brought to a health center for help (by friends, family, neighbors, people in authority or the patient himself), the health worker needs to get answers to a number of questions including the following:

- if the person has changed and if that change is "bizarre"
- how long the change has been obvious and if it is associated with an event
- if medical attention is required
- the severity of the crisis and if supervision is required
- how the family is being affected and if members are frightened, angry, or distressed
- How many of the above listed symptoms are present.

Before making any further decisions, the mental health worker needs to establish the degree of dangerousness (possibility of suicide, harmful intentions to self or others, assaults or threats,

voices ordering harm to others) and determine if there is a medical illness where the patient is found to be vague, drowsy, disoriented, or has difficulty with concentration or memory.

MANAGEMENT OF PSYCHOSIS

If the patient is not in crisis (see section on crisis below), then the mental health worker should provide the opportunity to have a private, uninterrupted meeting alone with the person in order to discuss confidential matters. The mental health worker may also want to meet with family members or identified supporting people to discuss related problems, needs and treatment. If there is a physical problem or "confusional state," then it should be brought to the attention of a medical doctor immediately.

Home treatment is possible if the patient is cooperative, willing to take medication, unlikely to injure himself or others — and if the patient can have supervision and sufficient support by the treating person.

Hospitalization may become necessary if restraint is required, medication is ignored, support is lacking, if the person becomes threatening or suicidal or cannot be treated anywhere else. The person may also need to be hospitalized if there is no support at home, or if children and family are being threatened.

Western medications such as chlorpromazine or haloperidol may be helpful to a psychotic person — larger doses being given to those more uncooperative and "out of control." If psychosis is accompanied by depression, the mental health worker may give imipramine or amitriptyline.

The treating worker must keep a written record of the following: identification, history of the problem and past treatments, past history of other problems and trauma, observations from others, and the worker's own observations and opinions of the case. All changes in the patient, both deteriorations and improvements, should be recorded as well.

A person who is treated can normally return to work when the crisis is passed and medication comfortably tolerated. Symptoms such as distressing voices may be heard as pleasant and comforting, or may disappear altogether.

HEAD INJURY

Most head injuries do not cause long-term problems. Knocks to the head or suffocation may cause a confusional state or unconsciousness, but people can recover from these. If, however, a person has prolonged loss of consciousness (hours or days), risk of brain damage increases.

Symptoms of brain damage include drowsiness, speech problems, deafness, loss of vision, loss of muscle power or movement, loss of balance, and loss of sensation. People with brain damage may also have seizures.

Frequently people with brain injury undergo a personality change. It may be very gradual, but eventually family and friends will notice one or more of the following: unprovoked anger or aggression (shouting, hitting); socially unacceptable behavior in public places; easily stimulated laughing or crying; difficulty organizing; suspiciousness; inability to enjoy sex, games and family activities; neglected self-care; alcoholism or drug abuse; problems with authorities; depression, anxiety and psychosis; lack of recognition and acknowledgment of problems; isolation from family and friends.

BRAIN DAMAGE MANAGEMENT

People who are brain damaged need medical assessment. Since brain–damaged people have a high incidence of depression, anxiety, and psychosis, they can benefit from Western medications. Epilepsy is a brain condition which can also be treated with Western medicines.

Brain damaged patients require a great deal of support, as do their families. Mental health counselors need to explain what is involved with a head injury and how it can affect the patient. Since in Khmer culture, there are strong feelings about the importance of touching the head, brain damaged patients and their families can benefit from support groups where their problems are recognized and discussed.

CRISIS MANAGEMENT

Crisis is defined as a time when an "out of control" or "confused" person needs outside control. It is also defined as a time when extremely withdrawn persons can no longer care for themselves or their families. In a crisis situation things happen quickly and there is a possibility of harm, injury or damage if the person is left unattended.

In a crisis, the mental health worker needs to first determine if the "out of control" person is approachable. It may be necessary to use restraint such as an injection to calm the person. (*Haloperidol* is the medication of choice in such a situation. See chapter on medications.) Only trained persons should give injections. Generally the person in crisis needs to stay under medical supervision.

ON-GOING TREATMENT

Patients who have personality change due to brain damage or psychosis need continuing treatment. Psychotic people who continue to have symptoms even when on medications or after they are withdrawn also need continued treatment.

Such individuals are best served by one person who is able to give them long-term support. The patient needs to build trust with this person over time. How often the patient meets with the care-giver depends on the individual's needs, although periods of stress usually require more frequent meetings. The care-giver should inform the person and the family regarding the patient's condition and medication — and should ensure that neither the patient nor the family is isolated from the community. It is helpful when the patient can be useful and participate in family and community life.

INTEGRATED SERVICE

The mental health care worker needs to establish a working relationship with the Kruu Khmer, Buddhist monks and other respected individuals to whom patients may go for help. All counselors should share information and experiences to ensure that patients receive care that addresses their needs.

13. Special Problems of the Handicapped

by Kowith Kret

This chapter describes the trauma and difficulties experienced by individuals and families coping with the consequences of physical and emotional handicaps. It describes how Khmer people have traditionally regarded people with physical handicaps. Finally, the chapter discusses the predictable psychological sequelae people with handicaps experience and ways others can help them.

Special Problems of the Handicapped

by Kowith Kret

INTRODUCTION

Great value is placed on the Cambodian family — the center of a person's identity within the smaller community — and within the context of surrounding communities. Each family has a hierarchical order with the parents at the top and the oldest child next in line to the parents.

The father is considered the head of the household and as such must protect, feed and oversee all the others. The mother, who is equally important in another way, raises and nurtures the children, keeps the house, and budgets the family's expenses. The actions of each family member are a reflection on all the others; hence, the bonding between each is very strong. If a crisis occurs in the family, each of the other members provides support. Last but not least, the family tries to keep its problems within the family, and not speak of them to others.

CAMBODIAN VIEW OF HANDICAPS

Khmer people consider there to be two types of disabilities. The first of these is mental illness, considered a disgrace in Cambodian culture. A person who has symptoms of mental illness can be cast out of the community. This brings shame to other family members as well. Cambodians believe that mental illness is caused by one or more of the following: genetic or hereditary causes, inadequate post-natal care, curses or black magic spells, and/or stress from "over studying" (or poor preparation before reading) religious texts.

The second type of disability is a physical one which the Cambodians also regard with suspicion, but less harshly. People tend to sympathize with someone who is mute, deaf, blind, or has

some form of birth defect, but they are less sympathetic with people who have been disabled by man-made weapons. This is because they believe wounded people suffer from an unfortunate life as a result of a reincarnation (as taught in the Buddhist religion). The family is disgraced as well and the wounded person has to beg for a living.

LEARNING HOW TO COPE

Physical and mental handicaps bring great hardships to both the individuals and their families. However, they seem more devastating for women than for men. The children have it the hardest. It is not uncommon for a child who is handicapped to be abandoned by his or her family and left to beg on the streets.

The following are some examples of concrete situations:

CASE 1

A father and mother had six children, two of whom died of malnutrition during the Civil War. The father had been a farmer and the mother a housewife, but when they resettled in a refugee camp, they lived on the charitable contributions from the international community. The rations, however, were not enough, and the father decided to smuggle goods from the border for extra financial support.

On two occasions, when he left the camp, he was robbed and tortured by border bandits. One day he was caught in a guerrilla fight and ran over a land mine near the camp. As a result he was hospitalized for six months and had to have a surgical operation on his right leg. His right hand became paralyzed due to a shrapnel injury in his back.

Consequently, the father became extremely depressed and alcoholic. He began to abuse his wife and children almost daily. Fortunately, a Khmer health worker started to intervene and the father received counseling from a Buddhist monk as well as herbal medication treatment from the Kruu Khmer. The wife's role was changed and she had to take on much more responsibility, but she was willing to stay with the family and stand by her husband.

CASE 2

A couple had been married for six weeks when the young bride stepped on a land mine in 1991 and lost her left foot. She had scars from shrapnel. Another mother of seven children stepped on a land mine while walking to work in the rice paddies. Both of these women were considered "undesirable" as wives after the accidents.

CASE 3

A six year old boy was an orphan. He was physically handicapped and his parents left him roaming the streets with a pair of crutches. This "no name" boy had polio as well as scabies all over his body. He was helpless and hopeless, begging for food in the hot monsoon weather, but no one cared. His sad eyes said that he saw no light at the end of the tunnel. This tragic story shows how the community does not understand the needs of such a child.

SOURCES OF SOCIAL SUPPORT

It is important to understand that in Khmer culture, the treatment of physical and mental illness are dealt within the larger context of cultural beliefs. Cambodians believe that the individual is comprised of four vital elements: earth, water, fire and wind. These elements interact with one another through the intervention of an outside force, and when a certain chain reaction begins (as at conception), life begins. This outside force could be a reflection of the human being's previous life in which case it is often called a "reincarnation." When the body dies, it decomposes and resumes its initial composition of the four elements.

Khmer people also believe that sickness can be interpreted as a visitation by spirits, and that a great deal can be cured through self-care and self-medication. In spite of the belief that causes of illness may come from the outside, mental health problems, in particular, carry a heavy stigma. Furthermore, family structure is strict and hierarchical — and parents, having the greatest authority, determine what is done within the family.

The religious Buddhist embodies the inner soul of Cambodian dignity, faith, spirit, and good action. Buddhist institutions provide the entire community with access to education in the arts, religion, and vocational training. In Buddhism, elders find the tranquillity they have sought, providing them with the wisdom to support and counsel other members of the family.

The Buddhist monk plays a major role in community healing. In the Buddhist tradition, the Kruu Khmer practice health traditions that have been handed down through the literary works written in Pali and Sanskrit.

Western medical practice is accessible only in the big cities and is not affordable to farmers and their families. There are no existing social services in Cambodia.

The civil war in Cambodia has left many people traumatized and vulnerable. People suffered from psychological and physical torture and suffered great losses. Furthermore, they were taken from their homes and familiar environments. They not only suffered physical and mental anguish, but they had to change their roles in the community, and many lost social status by having to live in the border camps.

TRADITIONAL MANAGEMENT OF EMOTIONAL CRISES OF THE HANDICAPPED

Cambodians tend to focus on presenting problems rather than underlying causes. Traditionally, the Kruu Khmer is the primary clinical coordinator, but he works with the Buddhist monk and the Khmer mental health worker as well. The mental health worker can help traditional healers by explaining concepts such as low self-esteem and even self-destructiveness felt by those who become handicapped. These health workers, however, should always work hand in hand with the Kruu Khmer, Buddhist monks and traditional healers. The mental health worker can also help by exploring the strength and the connection of the patient and family.

Example: A handicapped refugee in the camp reports that he is very worried about his family's welfare when he repatriates to Cambodia. He enrolls in a vocational training program and becomes skilled in pottery, but he is still worried that when he leaves the camp he will no longer be able to provide for his family. He has had psychiatric problems and is currently on an anti-psychotic medication. He sees a Buddhist monk daily for support therapy while relying on his wife and three children for emotional and physical support.

This man and his family are typical of many who face the trauma of repatriation. As handicapped people have returned to Cambodia, they have taken on new roles. Like this man, they face feelings of frustration, anxiety and disorientation. Many need medication and psychotherapy to be able to function but these services were not available.

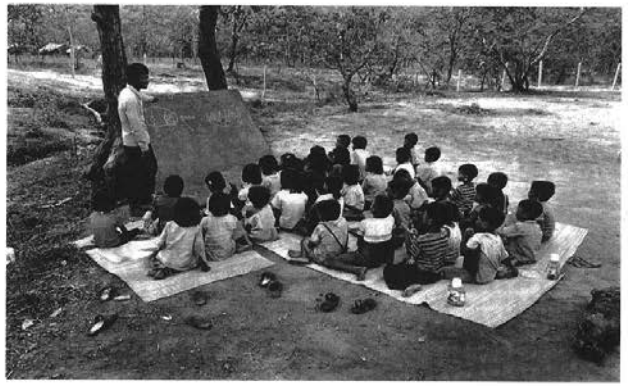
THE FUTURE

The civil war left physical and emotional scars on the Khmer people. Many Cambodians are in a constant psychological struggle as a result of this human catastrophe.

The "Kruu Khmer, Counseling, Buddhism and Medication" model is helping to bring therapeutic support services to those who have become handicapped and mentally ill as a result of the traumas they experienced. By putting therapy into the context of people's own culture and beliefs, it is possible to manage some of the emotional crises that are being experienced, especially by those who have been physically handicapped.

The emphasis of crisis management therapy, however, should be the family. The family is the main support system for the individual patient. Maintaining the dynamic of traditional family values and personal beliefs helps establish a trusting relationship between the mental health worker and the patient.

The goal of helping physically disabled people is to empower the patient to test his ability to function in the world. By doing this, the patient will learn to cope with the challenges before him.



14. Children and the Family

by Richard F. Mollica

This chapter outlines the particular problems of traumatized children — and what helping adults need to know about the way children cope and develop.

Special Issues of Children and Families

by Richard F. Mollica

INTRODUCTION

Children in all societies are dependent on the social and political context of their lives. They live in relation to their environment — the people, the physical setting, and the day-to-day experience of their families and communities. Because children are reliant on these factors, they are especially impacted by powerful experiences such as violence and war. Children of all ages, even small infants, are aware of their experiences, and have an age-appropriate response to what happens to them. If they have experienced trauma (seen the murder of their parents, torture, or other violence), they will eventually "record this" in the form of physical pain, smells of death, recurrent dreams, day memories and/or other symptoms.

It is important to note, however, that trauma experience, because it is contextual, may not be the main concern for a child. Not all children who have been traumatized will be affected the same and not all will have major impairment. Children may have other demands such as hunger or the need to find a parent, and these may take precedence over other experiences. The children may worry more about a missing family member or about school problems than about physical violence occurring around them.

In spite of the propaganda, the abuse, and/or the violence that children have experienced, they will always crave to know what is good and bad. Children live in a world of moral dichotomy, one where people and actions are categorized as right or wrong. In fact, most children (especially adolescents), while seeming self-centered and self-absorbed, are obsessed with fair play and justice. They seek a moral framework. In trying to establish one for their actions, they will look to the adults around them to provide it. When adults fail to supply one, the children become angry.

Last and not least, no matter how difficult life has been, children need to have fun and be involved in play. It is not good for a child to become an adult at a young age (at ten years, for example), with adult responsibilities of work and care-giving. Children need to have a period in their lives when they are free to have fun and enjoy themselves. They need to play as an essential part of their healthy growth and development.

CHILDREN OF CAMBODIA

During the last two decades of political upheaval and civil war in Cambodia, approximately 80% of the people were displaced from their homes. Close to a million were either murdered, died or disappeared. The resulting social disruption profoundly affected Cambodian families. During the Pol Pot period, in particular, families were torn apart, parents separated from children, family members lost, loved ones gone and never returned.

Children suffered as members of these families and communities, but many suffered personally as well. Many had no shelter for periods of their lives. Countless children were shot or hit by rockets or land mines. Many had their limbs blown off.

As a consequence of the war trauma they experienced, many children and adolescents of Cambodia express symptoms of physical and emotional distress. They do so, however, in the context of their own Khmer culture — in the ways they see their parents and other adults express emotional pain. Generally, they present somatic complaints such as stomaches, headaches and other physical pain just as the adults do.

Children, however, if asked, will be more forthright in talking about what is bothering them on an emotional level. While they talk about their physical discomfort, they will also open up regarding the stresses and experiences that have affected them. For this reason, it is extremely important that health professionals ask children directly what they are feeling.

CHILD SYMPTOMS OF EMOTIONAL STRESS

A small percentage of Cambodian children who have been through the country's recent events may be disturbed. If medically diagnosed, they fall into three main Western diagnoses: attention-deficit disorder, depression, and PTSD. Unfortunately, equivalent Khmer folk diagnoses for children are not known. These children may be described as *tweur oiy sma ra dei min mool*; and *prouy chet*. No folk terms are known for PTSD.

Cambodian leaders who have worked with Khmer refugee children have observed that children who have the greatest stress express it by an inability to concentrate and sit still. This has been affirmed by lay workers and border officials in the camps. All felt that the most disturbed children had the following symptoms: poor concentration, distractibility, inability to focus on learning, nervousness, constant movement, and anxiety.

Children who are "depressed" appear withdrawn and sullen; they look sad and cry easily. These children have trouble sleeping at night and frequently wet the bed.

Those with symptoms of PTSD have frequent flashbacks, nightmares, and daytime memories that become obsessive. They are unable to put the trauma behind them, and it continues to interfere with their ability to function. Of course all children who have been through the kind of traumas experienced by Khmer youngsters show some of these symptoms. In fact, many of the symptoms listed above are a normal response to the trauma experience. It does not mean the children are "sick" or permanently damaged if they express one or more symptoms during given periods. But there is a small percent of Cambodian children who are "disabled" by their symptoms and may need treatment.

In order to live with the trauma they have experienced, Cambodian children make "personality adaptations." The most commonly used by Khmer children is the effort to please others and to be perfect. The children try hard to be better and better all the time, putting an enormous burden on themselves to achieve, to accommodate, and to gain approval. On the other hand, there are those who become so pessimistic, so demoralized they simply give up. They no longer feel emotionally invested in their lives.

PARENTS AND CHILDREN

Cambodian parents routinely under-report the trauma of their children — failing to acknowledge their child's most traumatic experiences and minimizing the child's emotional upset and stress. Furthermore, because of their own trauma and shattered lives, the parents are extremely pessimistic about the future of the children.

Children, however, are never as pessimistic as the parents. They have not lived out their lives and are not carrying the burden of great disappointments, traumas, and losses of their parents.

INTERVENTIONS

The physician or health professional's best course of action in working with children is to speak directly to the child. No matter how old or young the child is, the clinician needs to observe the child, talk to the child personally, and have the child say what she or he thinks or feels. After speaking with the child, the health professional can speak with the parents, teachers and others. The child is the most important source of information about herself or himself. Before therapy begins, the clinician must hear the voice of the child. (Parents may be brought into the therapuetic process later, but at first, they may only present conflict for the child. Furthermore, the child may be afraid to talk about her or his own experiences in front of the parents because it could upset them. Frequently, a child will not discuss anything sexual in front of parents .)

By directly communicating privately and showing interest, the health professional establishes a trusting bond with the child. The first step in intervention, therefore, is to speak with the child privately and build this bond. Talking to the child in a personal and dignified manner establishes the trust that is the key to therapy.

Once there is a relationship with the child, the physician or counselor needs to evaluate the family to establish its resiliencies and strengths and to determine how to build on these for supporting the child. Poverty levels, religious beliefs, education, and

cultural/traditional practices should all be a part of this evaluation. If there is a crisis in the family, it will not be possible to help the child without calming the family first.

The first task of the health professional is to identify the cause(s) of the child's symptoms or obsessions. In the case of Cambodian children, one major factor may be malnutrition. It is important to determine the general health of the child in order to be able to address other issues. The next task is to identify the life situations or specific event that precipitated the child's "illness."

Once an honest and trusting relationship has been established, the physician or counselor can begin to look at causes. If the child had a specific personal trauma, the physician or health professional can determine much of what has happened either by direct questions or by extrapolating from what is revealed through nightmares or daytime images. After identifying the cause of upset, the physician or counselor should gently engage in child play or other activities (cooking, sports, etc.) to encourage the child to open up and speak of his or her bad experiences. It is not necessary to create a cathartic experience for the child, or to insist the child speak at length about these horrible events. The goal is to help the child "open up" at his own pace.

Next, the therapist must increase the security of the child by strengthening family cohesion and improving the resources of the family. The physician or counselor may have to help the parents stabilize the situation for the child, and learn ways of nurturing him or her. Parents will (and should) always act out of their own cultural patterns of behavior, but the counselor can make them more aware of the useful roles they can play in relation to the child.

The health professional will usually need to help the family find supporting resources. For example, relatives, NGOs and social service providers can be mobilized to help relieve the impact of poverty.

CONCLUSION

All professionals working with children need to remember that it is extremely important to speak to a child directly, and to let that child express his or her thoughts and feelings at their own pace. The child will also want to have answers from the counselor about value judgments in his or her life, and the health worker needs to prepare to provide clear and honest answers to these questions. The child will be confused and angry without them.

The most important thing in helping children is to affirm their strengths and idealism. It is less important to focus on their medical conditions than it is to affirm their dignity, identity, their beliefs in Cambodian culture and tradition, and to give them realistic hope about their future. Remember — they live in a world where the adults may be more pessimistic about their future than the children.

15. Importance of Education

by Anne H. Dykstra

This chapter describes the current status of education in Cambodia and discusses steps that need to be taken during the reconstruction period to improve attendance in school and the quality of instruction on varying educational levels.

Importance of Education

by Anne H. Dykstra

INTRODUCTION

In the neighboring countries of southeast Asia and throughout the world, it has been shown that primary school education yields significant return on investment. Primary school education brings a stronger economy, better agricultural yields, better nutrition, and increased health. What better gift to give children than an education! Cambodian children deserve the best educational foundation possible as they begin to claim a new future for their country.

THE CURRENT EDUCATION CRISIS

It is estimated that 20.5% of Cambodian's population is under age four and approximately 24.4% are 5-14 years. The population is 9.3 million and rapidly growing. In fact, Cambodia will need twice as many teachers in the year 2,000 as it has right now just to maintain the current system of three instructional hours per day.

Adult literacy is only an estimated 45%. In small villages, in particular, there is little incentive to read. Newspapers are available only in large cities and there is no publishing industry.

Many of the children who start school do not continue. In 1992, there were 1.3 million children in primary schools, but only 207,000 in lower secondary and only 47,000 who actually made it to secondary school.

There is also very little public funding for education in Cambodia. Schools have, in a sense, become privatized, with parents paying school fees to cover instruction, books, supplies, tutoring for exams, snacks and uniforms. The government pays for some teacher salaries, but funds are grossly inadequate. Many times teachers come to the classroom burdened by their own poverty.

Higher learning institutions have survived in Cambodia, but they are poorly supplied. Most instruction is theoretical as opposed to practical because science and other departments have little or no equipment.

BACKGROUND ON THE PROBLEM

Normal family life in Cambodia has been torn apart and the formerly closed social structure no longer exists. Traditional ways of living have been disrupted by the influx of foreigners, the resettlement of refugees, and economic chaos. There are few national or local administrative systems in place for establishing a free market economy.

The changes in social systems have changed the role of parents, teachers, and community leaders. People cannot predict what they may have to do on a day to day basis in order to support their families and communities. In the past, if they worked hard, they were guaranteed rice; now, no one knows what will happen.

Furthermore, Cambodia's devastation and isolation has diminished the ability of adults to dream about the lives of children. Children themselves lack role models of leadership and vocation. Boys don't think about what they may become; girls want to marry in order to feel safe and protected. (The girls do not see the possibilities of education. They have little or no understanding about ways women can support an economy as they do in so many other countries.)

Uncertainty and hardship have made Cambodian adults more rigid in their discipline of children. Because adults are seeking order in their own lives, they try to impose it on the lives of their children. It is not difficult to see why many children have difficulty learning fundamental concepts of living, why they feel insecure, and why they are not acquiring academic skills as they should.

A PLAN FOR ACTION

The greatest need in Cambodia now is for the children ages 5-14 to become competent in the Khmer language and in basic mathematics. Children are the human resources for the economic recovery of Cambodia. If they are illiterate, Cambodia's economic growth and stability will be severely impaired.

In order to establish an adequate education program, however, the country needs money for books and supplies. At the moment, teachers need everything from the basic paper and pencils to resource books.

Administrators and educational planners in Cambodia need to provide both the vision and the means to reform education. One is empty without the other.

Below are some things that can immediately be done:

- printed materials, education campaigns and the media can be developed to expose children to vocational opportunities in a new economy
- educational planners can support the development of more educational materials
- books and other printed materials can be produced on the local level
- parents and teachers can help local school official rebuild school systems
- officials can develop fair, parent-paid fees to cover school costs.

All information about the schools (their fees, the delivery of supplies and books and other information) should be posted so that all members of the community have it.

POLICY CHANGES

Cambodia should ensure that all 5-14 year old children have access to primary school regardless of race, color, creed, handicap or minority affiliation.

Cambodian education could be updated as follows:

1. Children should learn to master the Khmer language and math at levels that meet international standards. Children must be taught to comprehend, analyze, synthesize, evaluate, and apply knowledge. Rote learning is not enough. Children must acquire skills to think and make decisions.

2. Administrators and teachers must establish basic minimum competences to help parents know what their children should be learning at each level. In fact, parents need to be more involved in the schools, and they need to follow more closely what their children are learning. In the past, parents have not communicated much with teachers. This needs to change in order for schools to get better.

3. Teachers must learn teaching methods that foster student participation and build student confidence. Student-centered classrooms are the best for helping children learn skills and build self-esteem, but teachers need training to know how to establish these kinds of classrooms and how to try new activities and learn from other teachers.

4. Teachers and administrators must work together to make a viable educational system. Teachers need to express their needs, and administrators need to support teachers.

5. Administrators must ensure that teachers are paid enough to support their families and on an equitable basis with professional peers.

CONCLUSION

There are many things that can and must be done to restore and improve Khmer education during the reconstruction. Undoubtedly, those in charge will have to begin with the basics. Among these is good nutrition. Administrators must be sure that children and teachers have the proper nutrition to be able to work. Using the produce grown by children as part of the school breakfast and lunch program can help in this regard, but administrators must make nutrition a priority if they want education to succeed under the new government.

16. AIDS: Support of People and Families with AIDS

by Kathleen Cash

This chapter describes the virus that produces AIDS and how it is being transmitted around the world. The chapter also discusses AIDS prevention and what both men and woman can do to avoid contracting this fatal disease.

AIDS: Support of People and Families with AIDS

by Kathleen Cash

INTRODUCTION

Over the past ten years the world has witnessed the rapid spread of the HIV virus which causes AIDS, a fatal disease that can live in the human body for many years before the victim knows she or he has it. Because of this long period (sometimes up to 12 years) during which symptoms are not obvious, AIDS is often referred to as the "silent disease." It can be transmitted to another person, however, within a few days of when the individuals first contracts the virus.

Most people who are infected with the HIV virus become sick within a five year period. Because there is no known cure for AIDS, once a person is HIV-infected, he or she will eventually succumb to AIDS and die.

THE CAUSE OF AIDS AND ITS TRANSMISSION

The HIV virus attacks the immunological system, the body's mechanism for fighting off disease. Therefore, when a person is infected with HIV, he or she cannot resist other infections. For example, many people with AIDS die of tuberculosis which they contract and cannot fight.

While the symptoms of AIDS differ from person to person and between males and females, usually they are persistent and defy treatment. Typically symptoms include: night sweats, fever, persistent diarrhea, skin cancers, tuberculosis, persistent reproductive-tract infections (for women), and respiratory infections.

The HIV virus lives in blood, semen, and vaginal fluids. It is mainly transmitted:

- in sexual intercourse
- by injections or transfusions with unsterilized needles and syringes
- from infected mother to unborn child (in the womb or during childbirth)
- in homosexual activity that is sexual.

Babies born to HIV-infected mothers have a 30-40% chance of being HIV positive.

CAMBODIA AND THE AIDS EPIDEMIC

The AIDS epidemic has already begun in Cambodia. There is now a danger that its spread will be accelerated by the problems that have come during and in the aftermath of the civil war: low literacy, family disruption, drug abuse, alcoholism, poverty, rape, and sexual abuse.

The poverty in the Cambodian countryside has caused many people to migrate to the cities. In doing so, they increase the risk of AIDS. Women drift into prostitution when they have no other means of support. Married men migrate temporarily and seek quick sexual experiences with strangers. Adolescents have temporary sexual relations and experiment with drugs while they are looking for work. Abandoned, orphaned, or abused children seek life on the streets to survive.

All of these factors mean that more and more Cambodians are exposed to conditions that spread AIDS. It is therefore very important that every health worker know how the HIV virus is transmitted and the symptoms of AIDS. Health workers need to know how AIDS can be prevented, and how people and families with AIDS can be supported.

PEOPLE AT RISK FOR AIDS

The most common way for people to get AIDS is through sexual intercourse with a person who has the HIV virus. Everyone who is sexually active may be at risk for AIDS if they do not use a condom properly. (See section on condom use.)

The following are groups of people considered at high risk for getting AIDS:

- people who have multiple sex partners or consecutive sex partners over short periods of time
- people with a history of sexually transmitted diseases (because they may have lesions or openings where the HIV virus can enter the body)
- people engaging in unprotected anal intercourse which can cause bleeding
- young people experimenting with sex without a condom
- single or married women who are afraid to ask their partners to use condoms
- people who associate condoms with promiscuity, disease and distrust and therefore go without protection.

Street children who have been victims of sexual abuse and rape are at greater risk as are prostitutes, migratory workers (who live away from home) and others whose life styles or experiences cause them to have many sexual partners. Drug addicts who share needles or people who get tattoos are at risk for getting AIDS because of the danger of infected needles. Many people get AIDS from an infected blood transfusion.

PROBLEMS IN THE MANAGEMENT OF AIDS

It is difficult to prevent the spread of AIDS. People do not have the appropriate or accurate information. They often indulge in risky behavior even when they have the facts. Sometimes people know they should behave one way, but alcoholism or other behaviors prevent them from doing what they know is best. Many people simply don't have the money for condom or other preventive measures.

In Khmer society people are concerned with "losing face" because someone in the family has done something wrong. If a family member is HIV positive, people assume the person is promiscuous and judge the family. They begin to isolate and ostracize family members as well.

Women are especially victimized by the AIDS epidemic. They are usually the caregivers if someone in the family has AIDS, but they often suffer rejection if they themselves are HIV-infected. A woman who gives birth to a child with AIDS may be deserted by her husband and ostracized by her family. If her husband dies of AIDS, she may be isolated and cut off from any means of support.

MISCONCEPTIONS

The following are a number of incorrect assumptions about AIDS and about people who have it:

- AIDS can be transmitted through saliva
- AIDS can be transmitted from mosquitoes
- People with pimples or bad skin problems have AIDS
- Only promiscuous people get AIDS
- AIDS can be cured by drinking one's own urine
- Good women should not talk about AIDS, STDs or condoms
- Good women do not know or ask questions about a man's sexual behavior
- If a person gets AIDS, its is because of his/her karma.
- AIDS is an exaggeration by the government to stop people from enjoying sex.

AIDS PREVENTION

AIDS prevention is the responsibility of both men and women. Men must realize that using a condom is a way of protecting both partners. Using a condom shows caring for the other person.

The single most important means of AIDS prevention is information. People, both men and women, young and old, need to know the following:

- how AIDS is transmitted and who is at risk
- how to use condoms and how they prevent AIDS
- other means of prevention such as abstinence and monogamy
- how bodies work and the functions of various sexual organs

- how to insist that the man use a condom
- how the man can use a condom to demonstrate his caring for the woman
- how needle and syringe sterilization is accomplished
- about the risks of infected blood
- about HIV testing.

Past experience in AIDS prevention has shown that information by itself is not enough to change people's behavior. The health worker needs to make use of local networks, local media, and local health providers and counselors for repeating the message in several different contexts.

The following are some ways health workers can get the word out about the risk and prevention of AIDS:

- use of stories (both tragic and humorous), puppetry, drama and music
- use of Kruu Khmer and Buddhist monks to counsel individuals at risk
- use of local groups and peer groups to discuss AIDS.

The health worker needs to be sensitive to the age, sex and education level of people being educated about AIDS. Women, for example, may try to hide or deny their sexual activities in an effort to appear "good women." But the health worker needs to look at the "real" needs of the population, not just deliver moral talk.

STRATEGIES FOR INDIVIDUAL AND FAMILY SUPPORT

Because the information received can be so devastating, a person who decides to be tested for AIDS should first receive counseling. If the person then tests HIV positive, he or she should receive further support. It can be extremely traumatic for a person who has received a positive test to face what is ahead. That person may experience feelings of hopelessness, sadness, denial, stress, anxiety and/or depression. Sometimes the person is suicidal.

Because clinic or hospital resources are often not available,

most people with AIDS receive home care from their family members. For this reason, health workers must learn to work with families and support them. The family has to learn how to take care of the patient and how not to spread the infection.

Health workers who are working with AIDS patients and their families can keep in mind the following guidelines:

- Aids is sexually transmitted and therefore requires that patients receive the assurance of confidentiality from health workers.
- Having AIDS does not have to do with a person's morality; health workers should be non-judgmental in dealing with patients.
- Patients should be protected from misinformation, negativism, and talk that produces excessive fear.
- All local people who can be supportive should be enlisted to help the patient: health providers, Kruu Khmer, Buddhist monks and others.
- Patients should be protected from false medicines and therapies claiming to cure AIDS. Because it is an infectious disease, false curses can put the person and others at greater risk.
- Therapies that help people relax can be very beneficial because living with AIDS causes stress and anxiety.
- Compassion and loving kindness which are important parts of Buddhist teaching can be a great comfort to AIDS patients.
- Small discussion and therapy groups with people of the same age and sex and be helpful to patients, families and friends.

Health workers who are counseling individuals with AIDS and their families need to provide a safe, private environment where people can relax , talk and feel free of worries about what others will say. They need to provide positive action-orientated therapy so that individuals and families do not become fatalistic and pessimistic. The goal is to help people confront the illness and to teach them effective and positive ways to live with AIDS.

17. An Emerging Model of Mental Health Care in Cambodia

by James Lavelle
& Savuth Sath

This chapter reviews the evolution of Khmer mental health care in Boston, USA, psycho-social interventions on the Thai border and a new emerging model of mental health in Cambodia.

An Emerging Model of Mental Health Care for Cambodia

By James Lavelle & Savuth Sath

Every society and culture has its own medical system and/or community traditional healing system for addressing the physical and emotional suffering of its people. In societies that have been devastated by mass violence, customary systems have been destroyed or greatly diminished, and many of the traditional healers have been eliminated. This is the case in Cambodia, where the medical system was devastated, the mental health folk system fragmented, and the community of Buddhist monks and temples almost annihilated. The people in these systems were those who helped solve human problems and safeguarded the well-being of the whole society. Because of their deaths, the present generation of Khmer has been left without sufficiently trained community workers to meet the problems of the present and the challenges of the future.

Between 1980 and 1990, over 400,000 Cambodians came into the United States. Once they arrived it was discovered by American health providers that the Cambodian way of expressing illness and of seeking medical care were different from those of American patients. Acknowledging this reality, a model was developed by the Harvard Program in Refugee Trauma and the Indochinese Psychiatry Clinic (HPRT and IPC) in which a Western doctor and mental health professionals (such as a social worker and a nurse) teamed up with trained Cambodian mental health counselors to develop diagnosis and treatment interventions for the new Khmer-Americans. Over the past fifteen years this model, called the "bicultural partnership," has been developed, implemented, and systematically studied. The bicultural partnership is defined as "two medical world-views (sometimes very different in nature) integrated into a single approach for evaluating and caring for emotionally ill patients."

For example, when a Khmer patient and his/her family is evaluated at IPC and meets the members of this bicultural partnership for the first time, it is important to clarify the roles of the people attempting to support the patient. Often the patient will want to know from the Khmer mental health counselor if the Western doctor and nurse can be trusted; many ask if the non-Khmer professionals understand the recent history of the Khmer people. At the same time, since the Khmer mental health counselor often does not possess formal degrees and Western training in mental health, the Western professionals give a clear message to the patient that their Khmer colleague is a competent, experienced member of the team. This first meeting with the bicultural team has the potential to send a positive message to the new patient and his/her family that all members of the team trust in themselves to provide needed medical care and counseling.

In this model the Western doctor provides modern medical knowledge and skills (particularly from the field of psychiatry) and the use of psychiatric medication. He/she promotes the team approach by utilizing the expertise of other non-medical professionals as well as the valued skills of the Khmer mental health counselors. The Khmer mental health counselors bring to the therapeutic process their strength as "natural" healers and as survivors of Cambodia's civil war. They contribute useful support to fellow Khmer who are in need of both emotional and social assistance.

It should be noted that this physician-counselor partnership is only as strong as the individuals who are part of it. Occasionally, non-Cambodian physicians have great difficulty working out a democratic partnership with Cambodian mental health counselors untrained in Western medicine. The physician's blind faith in the hierarchy of modern medicine and his/her professional insecurity (often surfacing from the difficult challenges of the work) can reduce the efficiency of the partnership and cause the doctor to underutilize the multiple skills of Khmer colleagues. Similarly, the Khmer bicultural counselor, due to his/her own insecurities about a lack of formal medical training may under-

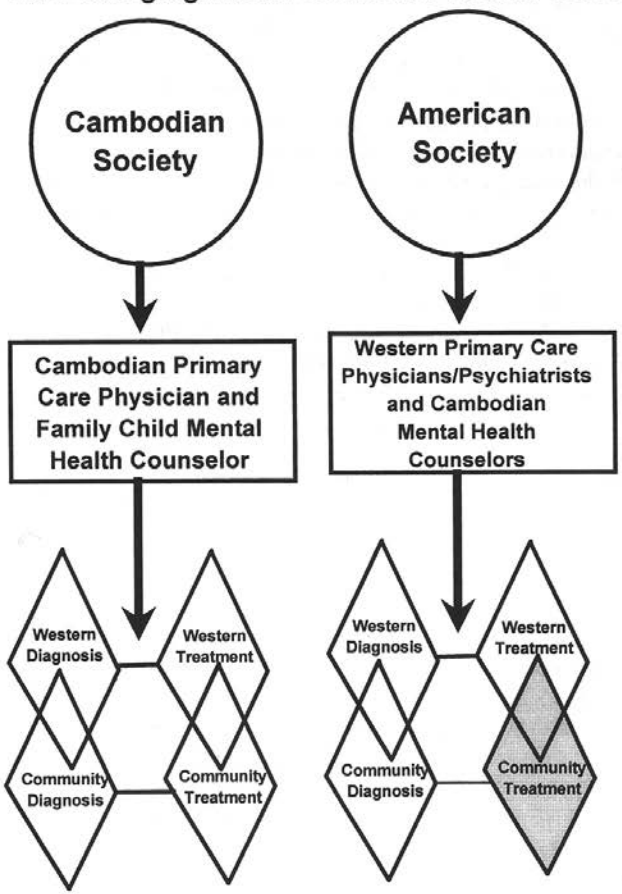
mine the partnership by being unwilling to work out a rapport with their medical colleague. Whatever the cause, the Cambodian patient can quickly perceive a lack of trust between these two helping partners and become unwilling to express his/her confidential life stories to receive the genuinely needed care.

The bicultural partnership generated by U.S.–based teams over the past fifteeen years was first brought to the Thai-Cambodian border when fifty-seven Khmer mental health counselors were trained in community mental health principles and crisis theory. The training occurred so that counselors could bring mental health expertise to the thousands of people repatriating to Cambodia in the early 1990s. Since a previous HPRT study in a border camp (Site II) revealed the importance of reinforcing both the Cambodian family as well as developing special services for vulnerable groups such as children and teenagers, it was decided to call these newly trained individuals Family-Child Mental Health Counselors (FCMHC); in essence the FCMHC idea also evolved from the model of HPRT and the IPC which promoted the Khmer mental health counselor as the keystone of the team approach. Although there were problems in actually securing positions for these counselors in the months to follow, these workers offered the promise of bicultural relationships for delivering mental health services in Cambodia.

A CURRENT PARTNERSHIP IN CAMBODIA

Today teams from the HPRT and the IPC partnership are working with primary-care physicians (PCPs) and FCMHCs in the primary health care settings in Cambodia (see Figure 1). The partnership also works with the human service providers in the local communities as well as with those who practice traditional and/or spiritual healing. Different from the U.S.-based bicultural model, this one requires sensitive integration of Buddhist and Khmer traditional healing concepts and practice in treatment as well. In Cambodia, these human resources at the community level have great potential to offer more educational and population-

Figure 1
Partnership in Cambodia:
An Emerging Model of Mental Health Care

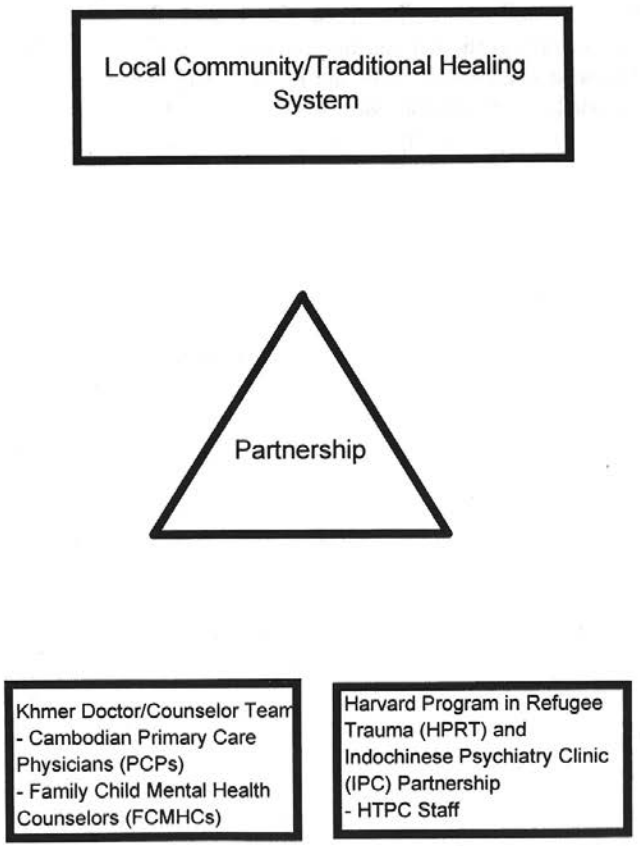


based help to fellow Khmer. As these resources become strengthened in Khmer society, both PCPs and FCMHCs need to continue to develop effective working relationships with individuals from the local community and the traditional healing system.

The Cambodia-based partnership between the PCPs and FCMHCs works in the following manner. The PCP in his/her daily practice sees many very sick individuals and their families. Many of the cases presented to the PCPs reflect more emotional symptoms and serious psychological (including family) problems than they do physical illness. By teaming with FCMHCs on whom they can rely, the PCPs can supervise the medical aspects of the case (i.e. the use of psychiatric medications), while the counselors can make home visits, meet other significant individuals in the family and offer counseling for both psychological and family problems. The treatment team, after it evaluates a new case, is able to share responsibility for the care of the patient. This strategy of community care is useful to the PCP who usually doesn't have sufficient resources to accomplish this range of care alone. Furthermore, most Cambodian PCPs are overworked and simply do not have the time to interview patients with serious mental illness or multiple family problems. The FCMHCs, as full partners, can do much of the community outreach and support required by these complex cases. They can compliment the effectiveness of the community doctor and produce an excellent therapeutic response for the patients and their families.

FCMHCs receive supervision and training in collaboration with the PCPs on a weekly basis through the technical assistance of the Harvard Training Program in Cambodia (HTPC) (see Figure 2). As a team, they receive individual and group consultation on their cases as well as ongoing training on mental health issues such as depression, trauma-related illness, and the special problems of families, for example, domestic violence and child abuse. They also learn how to intervene with other high risk groups (e.g. handicapped, widows, elderly). Above all, this Khmer team approach can offer hope and encouragement to patients while understanding the direct relationship between community

Figure 2
Harvard Training Program in Cambodia



mental health and the many factors (such as poverty, violence, and the lack of sufficient education and nutrition) which pose a threat to their well-being.

Before the PCP/FCMHC partnership, it was thought that pre-existing barriers might prevent the development of an equal exchange of ideas. This did not occur, however, and in fact, there has been genuine acceptance and sharing of ideas and skills in both directions. The resettled Cambodians appreciate the important work that the Khmer doctors and counselors are doing. Likewise, Cambodian PCPs and FCMHCs appreciate the new knowledge and technical assistance being brought by their expatriate partners to address the psychosocial medical needs of Cambodia's population.

FUTURE PARTNERSHIP IN CAMBODIA

There is an emerging new partnership built upon the strong foundation of the above-described model in Cambodia which seeks to offer specialized mental health training to the primary care doctors. This future working relationship is based on the fact that Cambodian medical practitioners are the main port-of-entry and source of care for their society. The anticipated model is one in which PCPs will be selected to participate in a one year training in community mental health principles (sponsored by the HPRT/HTPC). As PCPs and some health officers (HOs) receive certification from the training and return to work at the province level, they will be developing partnership teams with designated local nurses. It is hoped that these teams will eventually provide each province with a capability to integrate mental health concepts and treatment practices into the Khmer primary health care sytem. By working in collaboration with the Ministry of Health, it is also expected that another outcome will be the establishment of a national network of primary health-care providers with the capacity to receive ongoing continuing education and preventative mental health skills.

This new partnership relies on a model of community diagnosis that includes the following four components:

1. The cultural meaning of trauma which describes the cultural social and political meaning of traumatic life experiences;
2. The cultural specific symptoms which include the manner in which members of the society express their emotional suffering and upset;
3. Disability which describes the social and behavioral changes that result from traumatizing life experiences; and
4. Community support which identifies those community interventions which reduce symptoms, minimize disability and promote social and economic autonomy.

Both the community mental health treatment system and education activities which emerge from the philosophy expressed in this model of community diagnosis encourage a human development approach to the psychological, social and economic challenges of Cambodia.

CONCLUSION

There may always be a tendency for a new health system in Cambodia to try to copy the Western model, considered by some, to be a more modern mental health system. However, the HPRT bicultural partnership (in cooperation with Khmer doctors and counselors, traditional healers and local communities) is trying to produce a system in which modern medicine does not have hegemony over other healing traditions. Rather, HPRT believes that the emerging model of mental health care in Cambodia can only succeed if the opposite is true. A new model must prevail — one in which the limited resources of Cambodia are acknowledged and respected, where Cambodian expatriates are recruited to participate in training fellow Khmer, and, lastly, one which encompasses the philosophy of community diagnosis — the four components of which summarize the impact on the individual's work, family life, and community involvement.