

CHAPTER FOUR

Healing Trauma in Cambodian Communities

Willem. A. C. M. van de Put and Maurice Eisenbruch

Civil war and ruthless experiments in social engineering have created terror for decades in Cambodia. The population was largely uprooted and displaced, one in four Cambodians died, and when the worst of the conflict was over, 20 more years of low-intensity warfare followed. Amidst all this the international community expects the Cambodians to rebuild their country. The mental scars left by organised violence and abuse prevent many from participating in social processes, and the culture of Cambodia has to be reinvented for a globalising world. Nevertheless, at the core of Cambodian communities traditional ideas and healing methods still exist and are still relevant. It is from these kernels of culture that it is possible to start to design meaningful and effective interventions that can help people to help themselves.

BACKGROUND

The history of Cambodia unfolds as a complex mixture of conflict and violence, picturesque peasant life and colorful ceremony, religious rhythm and international interference. Towards the end of the nineteen sixties, external events such as the Vietnam war and internal power abuse drove the country into civil war. The subsequent rule of the infamous Khmer Rouge is described as being of a different quality to anything before or after. It brought with it the 'Cambodian holocaust', a total disruption of anything that had ever constituted normal life in Cambodia.

The Khmer Rouge tried to completely remould Cambodian society and its institutions with a radical experiment in social engineering. Every aspect of daily life was disrupted. Monks were defrocked, cities emptied, and villages replaced. Ritual life was halted, Buddhism denied, and family life disrupted. The first victims were those living in the cities, the *new* people, who were seen as needing re-education to fit them into the pastoral ideal. Driven into the countryside, they were forced to share every aspect of life with the rural peasants, known as the *old* people, and no escape from the grip of the *Angkar* (Organization – the Khmer Rouge system) was possible. After three years, eight months and twenty days of Khmer Rouge rule – all Cambodians can quote these figures by heart - the three-quarters of the population that survived found themselves scattered over the countryside or in refugee camps on the Thai side of the border. Then came the invasion of Vietnamese troops in 1979 and even after a peace was brokered in 1991 low intensity warfare continued. In 1993 the United Nations intervened with a massive peacekeeping force to oversee elections but armed factions continued to roam the countryside and the coalition between former enemies arising from the election blew apart in July 1997. The UN mission did succeed, however, in repatriating some 1,5 million Cambodians who had spent up to 14 years in the Thai border camps. Pol Pot, leader of the Khmer Rouge did not die till April 1998. His followers militarily defeated, new elections were then held that concentrated power in the hands of one party and a period of relative political calm has ensued. Reforms in the public sector, covering macroeconomic and public finance management, civil service restructuring and military demobilization have gained momentum. State reforms laid the foundation for the first ever local commune elections in February 2002 which confirmed the power of the ruling Cambodian People's Party.

The Cambodian population of 11.5 million is growing at about 2.5% per year, and one third continues to live below the basic needs poverty line. Income inequalities continue to be much higher than in most other Asian countries. Women represent 53% of the active labor force and head 25% of Cambodian households. The high rate of HIV/AIDS incidence (169,000 cases reported in 2000 - UNDP Global Human Development Report 2001) poses a major threat to development.

While the mental health problems of the hundreds of thousands of Cambodians who fled to other countries have been documented (Boehnlein *et al.*, 1985; Eisenbruch, 1990a; Eisenbruch, 1990b; Eisenbruch & Handelman, 1989; Kinzie *et al.*, 1990; Mollica *et al.*, 1990; Mollica, 1994), less is known about how those who remained in Cambodia coped with psychosocial and mental health problems. A program to implement the community mental health approach of the Transcultural Psychosocial Organization (TPO) (de Jong, 1997) began in 1995, with the aim of identification, prevention and management of psychosocial problems. The program developed interventions to enable people and communities to overcome the effects of traumatic events.

In this chapter we describe the community aspects of the TPO intervention – how psychosocial problems and coping strategies were identified and interventions designed to bring relief to the stress being experienced at community level. We begin by discussing the concept of community in Cambodia.

COMMUNITIES IN CAMBODIA

Many mental health and psychosocial interventions focus on the individual, but earlier investigations, as well as our ethnographic experiences in Cambodia, encouraged the authors (Eisenbruch and van de Put), in designing the program proposal, to believe that a community approach would be more effective. Some of the related assumptions for this approach had already been tested in 1993 before the program was launched. The first was that traumatic experiences were widely shared in the population at large; the second, that in the expression of the effects of these experiences there was a need to understand something of the Cambodians' own larger cosmology and taxonomy of suffering. Rather than assessing the psychosocial and mental health status of individuals as if all assumptions implied in Western nosology together with Western assessment tools could be applied, we felt that an approach in which we would allow people to express themselves in terms that were meaningful to them, rather than us, would be more useful. We needed to know more about the way people expressed distress, and how they coped with their problems. As we went along interpreting the data from the initial assessment through group discussions and focus group interviews, we discovered that in addition to scarce resources (Cambodia had almost virtually no trained health staff or functioning health system) there were other basic epistemological considerations urging us to go beyond an individual clinical approach. To really comprehend what was keeping people from coming to terms with their experience we had to understand not only how they defined themselves as individuals, but how they functioned in their communities and what exactly constituted a community. The latter point is now discussed.

DEFINITIONS OF COMMUNITY

'Pre-Revolutionary Cambodia was 80 percent peasant, 80 percent Khmer, and 80 percent Buddhist. First, it was an overwhelmingly rural economy. Its village society was decentralized, its economy unintegrated, dominated by subsistence rice cultivation. Compared to Vietnam, its villagers participated much less in village-organized activities. They were often described as individualistic; the nuclear family was the social core' (Kiernan, 1996), p.5. In a nutshell, such was traditional Cambodian life. But for planning and development purposes, officials

had always experienced difficulties trying to find a 'unit of analysis' for community-based work.

On the administrative level, a Cambodian district is divided into *khum*, which in turn are subdivided into anything between 4 and 20 *phum*. May Ebihara, an anthropologist who wrote about Cambodian rural life in the 1960s, described a *phum* as a social unit, an "aggregate of known and trusted kinsmen, friends, and neighbours. Within the realm of social relationships, family and kinship were of great importance. There were several types of families to be found (nuclear families, stem families and extended families). Apart from the family/household, there were no organized groups, whether formal associations, clubs, political parties, or the like. Neither were there major class strata within the community' (Ebihara, 1987). This lack of integration had earlier been noted by Chandler, writing about nineteenth century Cambodia: 'In ... Cambodian villages in the nineteenth century, there were no durable functionally important groups or voluntary associations aside from the family and the Buddhist monastic order or Sangha' (Chandler, 1983).

By the early 1990s the majority of families that lived in a *phum*, most readily translated as 'village', would have been much more scattered only a few decades previously, when clusters of 8 to 12 houses, inhabited by matrilineal relatives, had been organized into '*kroms*' or hamlets. Government decrees, warfare and insecurity forced people together, but many still carry a nostalgic and perhaps idealised notion of their original 'homeland' as a tiny hamlet separated from other such clusters by patches of forest. They will point to a small mound in what is now a rice field and say that is where their family lived. When, in the past, people had been forced to combine for defence or for festivals into larger groups these units rarely endured beyond the specific need for which they had come into being. *Krom* dwellers' relations with outsiders and with government authorities were sporadic and unfriendly. Quarrels were settled by conciliation rather than by law, and they often smouldered for years {Chandler1983A}. Given this history, it is not surprising that avoidance proved to be a common coping mechanism when trauma hit and that rural social organization has not traditionally encouraged community initiative.

On top of these historic patterns of social fragmentation, the Pol Pot regime relocated the whole Cambodian population. *Phums* were rebuilt on the orders of the Khmer Rouge cadres, only to be moved again when new cadres were appointed. People were forcibly relocated or fled from their homes and often had no means to return after the war was over. So different types of *phums* have come into existence. In some, a number of kin have managed to stay together over time. They have experienced the hardships as a group and have some sense of belonging. Such *phum* typically consist of three or four clans, headed by the older men and may be called 'old' *phum*. When reference is made to 'new' people in such *phum*, these turn out to be the husbands who have moved in from other *phum* and other families, no matter how long ago. 'Mixed' *phum* consist of

a number of related families who can be seen as a core of the community, who have been joined over time by influxes of refugees from the border camps unable to trace their original *phum* and others dislocated at various stages of the lengthy conflict. A third type of *phum* is the 'new *phum*.' These were created either in the 1990s specifically for returnees, or earlier for families in need of new land, or as a result of government efforts at control. In these villages people may or may not be related and their capacity to create a sense of community and stabilise sufficient income for basic needs has varied considerably.

It was obvious that greater political and economic security and emergence from isolation were not alone going to lead to the repair of a shattered cosmology that had defined peasant social relationships in terms of close family bound to small, well-defined geographical sites. When the TPO commenced its community health program, traditional views on life, moral conduct, relationships and health, had been threatened by events that shook the foundations of Cambodian society to its very core. Yet at the same time the memories of what had constituted traditional order and outlook was often all that was left, all that had kept Khmer identity alive amidst terror and social destruction. In order to understand the problems of Cambodian communities it was necessary to know how things had once been, and whether any traditional avenues of healing could be called upon. The team set about identifying potential resources to help with healing.

IDENTIFYING AVAILABLE RESOURCES

PAGODA COMMITTEES

The most respected villagers in any *phum* were members of the 'pagoda committee', and together with the *paaca*, the ritual assistant of the monks, plus the head of one of the more important families in the village, these men were important in the village associations that were the blueprints for organizing mutual support. Examples of associations and ways of working together included the 'pots and pans group' (*samakum chaan chhnang*); the funeral association; construction associations; rice bank groups, and parents associations. The presence and functioning of these was closely related to the type of *phum* (see above): the closer the relationships between the people who made up a community (the 'old' *phum*) the higher the level of functioning associations. Another avenue for social support was provided by the custom of reciprocal work, usually called '*provas dai*' (giving a 'helping hand'). In addition there were formal authority figures such as the village chief (*meephum*) and members of various village committees. There were also informal leaders, people who were respected, and who acted as patrons for others (e.g. the *meekchal*). All these local people had well defined roles in traditional Cambodian society, and even though the social situation had

been severely disrupted, they still enjoyed some authority which gave them a capacity to alleviate some of the villagers' psychosocial distress.

Pagodas have always been the center of religious life in Cambodia, the place where milestones in life are to be marked by appropriate ceremonies. They are to be found all over the countryside, usually located between villages. Several villages use the same pagoda, and in some sense such a group of villages can be viewed as making up a community. The pagoda is a place of worship, of education, of meetings and rituals. In the pagoda, one finds monks, novices, and sometimes nuns (*doon cii*).

The importance of a pagoda for the community depends largely on the activities of the monks present, and these are not the same everywhere. There are many pagodas where there is hardly any activity outside the fortnightly prayers and the large annual ceremonies. Activities of monks may be strictly religious. A monk may restrict himself to explain to people the "*toah*", the code of conduct according to the Buddhist principles. This may help people understand and accept their suffering. There are also pagodas where monks help people with social and health problems. Some of these are famous for their capacity to deal with specific problems, such as mental health problems (e.g. *Wat Andouk* in Battambang). And some monks have earned a reputation for initiating community development work, e.g. in Battambang, Svay Rieng and Siem Reap. A prior study of traditional healers had revealed their potential to contribute to the community healing approach that informed the TPO intervention and this is now discussed.

TRADITIONAL HEALERS

During the early 1990s Eisenbruch (Eisenbruch, 1992) had carried out an ethnographic study of several hundred traditional healers in Cambodia and identified three main groups.

- 1) *Mediums* had no formal training but acted as vehicles for healing forces. This group included mediums possessed of healing powers through healing spirits – the latter could be ancestral spirits or guardian spirits from the forest. The mediums were known as *kruu cool ruup*. These 'informal' healers, mainly women, had become healers after perhaps a single episode of possession, and from then on acted as mediums. Not only did the mediums act as general psychosocial supports, they also helped to ameliorate the problems of patients afflicted by serious and acute psychiatric derangement such as 'magical human intervention' and spirit possession. Mediums were often women who had gone through a particularly difficult period, or illness, and found at some point that a spirit had come to help them as long as they in turn would help the spirit to help others. The "*baarea?mə*", the spirit that

was the actual healing power and used the *kruu cool ruup* as a medium, thus really chose its own time in staying with the person it had chosen.

- 2) *Kruu Khmer*: these were the trained traditional healers. Whereas the mediums described above had no training or defined codes of behavior the traditional healers had years of study behind them and followed a strict code. The *kruu Khmer* had been apprenticed and acquired formal knowledge of healing theory and ritual. There was at least one *kruu* in every village. The *kruu*, like the monks, were an integral part of the community, highly respected among most villagers. If monks and *kruu* carried out similar healing rituals, the monks were seen to be spiritual healers, the *kruu* the medical ones. The *kruu* treated people who suffered from physical illness and mental disturbances; the latter included *ckuət*, the vernacular term for serious behavioral disorders and insanity. The *kruu* also dealt with psychosocial problems. They carried out a range of work that included magical healing (*mɔən ʔaakum*). *Kruu* worked in their homes, where they grew their medicinal plants, saw their patients, and taught their disciples.
- 3) *Buddhist monks* who were known as *preah saɲ* and their ritual assistants the *ʔaaca*. Most villages had their own Buddhist pagoda, the *wat*, a community place with moral, educational and social functions. These were the places where the Buddhist monks did their work, though in the 1990s some noteworthy monks broke out of the pagoda-based tradition to set up training and support elsewhere in the community. Behavior towards the monks was even more tied to rules of conduct than with the *kruu*. Monks could treat more patients at the same time, and a personal relationship between the monk and his patient depended entirely on the personality of the monk. The ritual assistants described and analyzed the technical details of healing rituals that the monks performed. Not constrained to the same extent as the monks, they were sometimes a freer source of information about the magical aspects of Buddhist healing practiced in the pagoda.

In some villages there were exceptionally effective healers. Some based in Buddhist pagodas enjoyed nationwide fame. Some managed up to ten or fifteen inpatients at a time, and their outpatient clinics could handle more than one hundred patients per day. The healers did not claim that they could cure all serious psychiatric illnesses, but they believed they could ameliorate symptoms in a majority of cases. For the most part patients did not pay more than they would have paid to visit the local hospital.

THE PUBLIC HEALTH SYSTEM

When the TPO 1995 intervention began public systems of care were weak in all respects. Ministries of women's affairs, social welfare and veterans affairs, culture and religion, and rural development had existed since the United Nations

Transitional Authorities in Cambodia were installed in 1992. It would be beyond the focus of this chapter to give a detailed overview of the efforts in all these ministries to set up systems of care for the most vulnerable groups in society. What they all had in common, however, was a fundamental lack of means to effectively cater to the large size of the target groups. One exception were the allopathic health services of special interest to the TPO project in view of its aim to contribute to *sustainable* solutions for psychosocial problems.

When the Khmer Rouge seized power in 1975, the only existing mental hospital, *Takmou*, providing mainly custodial care, was closed, as were most other medical services. Few traditional healers and monks who had provided some care for the mentally ill (Eisenbruch, 1994), were allowed to continue. After the fall of the Khmer Rouge regime in 1979, public health care was modelled on that of Vietnam. This effort to introduce a nationwide system resulted in a situation where too many staff had had too little training, and were scattered too thinly throughout the country with neither the means nor the supervision needed to deliver effective care. The traditional healing sector, though affected by years of war and terror, was able to regain a central place in the options for health care after 1979. In 1995, at the time the project started, psychiatric care was simply nonexistent.

Low salaries not only make it difficult for health workers to devote themselves fully to their public duties but also severely limit the impact of training efforts to bring about behavioral change in them. The efforts of the project to help install basic mental health skills in integrated primary and secondary care (Somasundaram *et al.*, 1999) are now described and the need for the project to incorporate traditional forms of healing will have become apparent. There were no viable alternatives. There was simply no public health system in place able to address the massive traumatisation that had occurred.

PROBLEMS IN CAMBODIAN COMMUNITIES

ASSESSING THE LEVEL OF DYSFUNCTION

Small communities in Cambodia have the kind of problems common to all developing countries. A fragile economic system, lack of job opportunities and chronic poverty are the most obvious and beneath these lie a score of related issues such as domestic violence, alcohol abuse and poor health. Many of these difficulties are viewed simply as part of everyday life and villagers know that only a dramatic and unlikely income increase would alleviate them. In a similar way, after the terrors of genocide and a long war, dysfunction was so much part of Cambodian life it had ceased to be thought of as a changeable condition. When the project team went into the villages to assess the level of dysfunction, symptoms like sleep disruption with recurrent nightmares were so common they

were not considered worth reporting. Families with more severe problems had in many cases lost all their possessions in their search for help. Approximately 20% of families in the villages assessed by the project team were considered to be dysfunctional by their fellow villagers, and this included anything from alcoholism to extreme poverty, from not being able to take care of children in the household to recurrent violence, abuse or chronic disease.

USING THE CAMBODIAN TAXONOMY

The team decided to use the indigenous taxonomy in order to obtain a better grasp of the problems as perceived by the Cambodian people themselves. Violations of moral codes proved to be an important category of problems for them. Examples of these included madness of the dhamma (*ckuBt thoa*) stemming from wrong thinking about the Buddhist dhamma and ‘wrong healer’ (*ckuBt khoh kruu*) where the culprit was a *kruu* who had violated his code (Eisenbruch, 1992). In a world so devastated by conflict, illnesses which Western health workers might call psychosomatic disorders, sorcery or paranoid psychosis were seen by the Cambodians as caused by the interference of supernatural agents and known as ‘magical human intervention madness’ (*ckuBt ?AmpBB*). ‘Lovesickness’ or *ckuBt snae* was a related disorder and appeared to be exceedingly common in the villages. In ‘sorcery madness’ (*ckuBt tmup*), for example, it was the intention of the sorcerer to make the victim die a horrible death, and the patient's symptoms often suggested catastrophic physical injury such as shattered bones or dangerous foreign bodies that hit the victim with the force of a missile.

Workers familiar with Cambodian refugees in the 1980s were accustomed to the complaint ‘thinking too much’, sometimes called simply ‘the Cambodian sickness,’¹ though it does in fact share similarities with a mental disorder described throughout Southeast Asia. Of all the types of mental disorders, this illness known in Khmer as ‘madness of the *sa?te? ?aarAm*’, seemed to be most closely linked to the stress, loss, bereavement, social and economic deprivation and family disruption that the villagers had endured in relation to the war. All of these factors were named as contributing causes to the slow destruction of the mind that ‘thinking too much’ progressively entailed. There were terms for each stage of this illness. It began with demoralisation, literally ‘small heart’ (*tooc cBt*). This progressed to worries causing broken thoughts known as *khooop cBt*, literally ‘broken down heart-mind’. This then progressed to *lAp*, a term implying mental distraction, and later its more serious version *lAp lAp*. Further deteriora-

¹ *ckuBt sa?te? aaram*. Here the question is what causes the thinking. Many people who have been in group sessions organized so far, felt better when they has an opportunity to talk about what they had been thinking. Monks are important to help people understand what they are thinking.

tion led to utter muddling and 'lost and confused intellect or cognition', *vCBEv-eeE smaardBy*. Anyone might have this mental state and not yet be counted as mentally ill (Eisenbruch, 1999b).

USING THE WESTERN TAXONOMY

The assessment using the indigenous taxonomy was backed up by appraisals using the Western classification of emotional disorders. In a sample of 610 randomly selected and interviewed Cambodians aged between fifteen and sixty-five, lifetime prevalence of post-traumatic stress disorder (PTSD) was 28% and 11.5% were found to suffer major depression. In 9% of the sample, PTSD and major depression were present together. Disorders were more common in people who were exposed to war events in the past or current family and community violence. The effects of stress, grief and cognitive impairment caused by trauma were found to be an important risk factor for disorders. The prevalence was higher in geographic areas that had witnessed more social upheaval due to war events, or that were undergoing social structural change at the time of the assessment. Forty percent of the sample showed anxiety disorder (14.4% for men, 49.1% for women), and more than half of all people interviewed (53.4%) had either anxiety disorder, PTSD, mood disorder or somatoform disorder. These rates of dysfunction meant that every household bore the scars of warfare, violence and repression. It was striking to hear so many people say that the only hope they had left was not to be born a Cambodian in the next life. More worrying still was the fact that 14% of all respondents had actually attempted suicide in a country where it is generally believed that suicide engenders negative consequences for the following five hundred lives.

THE INTERVENTION

THE APPROACH ADOPTED BY THE TPO TEAM

POINTS OF DEPARTURE

While traditional views on the world and related life perspectives were severely shaken, Cambodians still had some framework of meaning that incorporated ancient explanations for illness and evil and attributed specific significance to birth and death. Behavior, and therefore health, was embedded in beliefs about natural and supernatural forces in the environment of the village itself and the surrounding fields and forests. The worldview of Cambodians stresses the continuous cycle of lives, the importance of *b'aap bon* (good karma) in reincarna-

tion, and the reality of the impact of spirits and ancestors on the environment. The importance of conducting the right rituals for the dead and the need to restore disturbed relations with the spiritual world were always essential elements of coping and there was evidence that these mechanisms were still playing a role in controlling distress. They could be tapped into and used as points of departure for an attempt to find a sustainable way to treat trauma at community level. The respect and familiarity given to traditional healers in Khmer society, the continuing relevance of ancient explanatory belief systems and cosmology, the wide coverage offered by traditional healing options - even the most remote villager could access some type of healer - were obvious inducements to the team to take advantage of traditional sector resources in setting up their community PTSD program.

Another reason for focusing on a non-clinical approach to healing PTSD was that this disorder does not usually produce the severe, incapacitating dysfunction of psychotic illness and a mental health clinic was unlikely to be seen by the sufferers as an appropriate venue to seek help. It could be expected that many with PTSD manifesting through somatic complaints (Kirmayer, 1996) would seek help in the traditional sector. The team also knew that PTSD diagnosis in the usual public health services was likely to be overlooked because of inadequate training and experience and the possible role of transference as an obstruction in asking about trauma.

The challenge then became how to devise interventions at the community level that would complement and not 'corrupt' existing coping styles. Traditional ways to deal with the effects of trauma at the community level are revealed in the following analyses of sorcery and infractions against ancestral spirits.

At the level of the village and community, individuals and groups inevitably come into conflict, and conflicts are given the label of 'magical human intervention'. This is the same phenomenon as what is commonly described as sorcery (Eisenbruch, 1999a) and is not unusual in Southeast Asia. Sorcery has not waned with modernization which brings in its wake complications in work, marriage and sexual relations and induces its own forms of social strain. 'Referrals' to traditional healers because of sorcery are as numerous as ever and sorcery is a key marker of social and domestic disharmony whose ritual treatment is geared specifically to restoring social harmony. In Cambodia, sorcery leads to the acute onset of bizarre and socially disruptive behavior in the victim that healers appear to be able to ameliorate. Cambodians may blame sorcery that they believe was instigated by human hands, as opposed to spirit intervention, for the breakdown of community relationships. Various types are distinguished on the basis of agent (non-human or human), mechanism (invading spirits, a spell, or projected foreign bodies) and physical effect (disrupted body elements, causing swelling; pain, caused by the effects of foreign objects).

One can see that sorcery traditionally was a fairly violent form of coping with community strain, not too different in style from the indiscriminate violence facing the society in the wake of war – two friends playing cards, or a married couple, suddenly in disagreement, and one blowing the other to bits at point blank range with a B-40 rocket launcher. The other feature affecting the victims of sorcery – peculiar somatic symptoms – could be (mis)interpreted by psychiatrists as psychosomatic or somatoform disorders and experienced by the patient and family as a sign of a community disorder. We had to train our core group to understand and work with the two points of view.

‘Ancestral spirit disorder’ is another example of a traditional affliction that reflects community disruption and is treated by a community intervention. Ancestral spirits function as ‘regulators’ of social conduct and in their capacity as moral policemen, when they are not properly treated they withdraw protection and leave the descendant open to sorcery attack, initiated by the aggrieved family against him. In this way, the person’s ancestors act in concert with the community (Eisenbruch, 1997). The spectrum of ancestral spirit disorders can be treated by a ritual sequence: the calendrical ritual offerings to the ancestral spirits, performed on behalf of the whole community, in a ritual known as ‘erecting the pavilion’, can be seen as a ‘general vaccination’ of the whole community. This ceremony, rather than curing an individual patient, helps everyone: the emphasis is on the periodic ‘vaccination’ of the whole community. The *kruu* and the medium may collaborate to treat the individual patient and, at the same time, they ‘inoculate’ the community against harm. Impoverished people, preoccupied with eking out an existence and avoiding landmines, can forget these ceremonies – and the affliction could reflect their sense of moral negligence. Again, the core group needed to know how to link this idiom of distress with trauma therapy.

DEVELOPING COMPLEMENTARY INTERVENTIONS

The TPO intervention made use of both explanatory models of people in distress and the existing ethnographic data on the healing rituals of traditional healers, mediums and monks. The explanatory models pointed the way to the right resources for help. Identifying these resources, and knowing what they did and how they could be approached, helped bridge the gap between a family in distress and the community. Knowledge on the role-play and hierarchy informed us about thresholds in accessing various resources. The characteristics of a mixed *phum* helped in realizing why in this community a special intervention was needed to restore age-old Cambodian community relations.

The benefits of working with the healers were obvious. They were successful as counselors (the mediums), and in providing a productive link between the cosmological framework of meaning and the daily suffering of families (the

kruu and the monks). But social change triggers a mismatch between the problems people face and the capacity of traditional healers to ameliorate them. A lesson learned in Cambodia was to experiment with the composition of the teams of phum volunteers used for psychosocial work. Their outreach activities – from finding the families at risk to organizing group sessions and psycho-education campaigns, needed to be carried out by those who had easy entry into homes including those of the most marginalized. They were modest people, often widows who themselves had been diagnosed as in need of help and who had been convinced of the profound difference that could be made by ‘connecting’ distressed people to existing resources. The stumbling block was that such people lacked authority – and therefore, in Cambodia, lacked security! The solution lay in teaming them with monks or ritual assistants who provided the necessary authority.

Nevertheless, with the passage of time health beliefs were changing as were patterns of health seeking behavior. The healers began to face competition from other sectors that offered help. Both their explanatory models and their livelihoods came under threat. They had families to maintain and like other small time entrepreneurs in a rapidly globalizing society they faced economic annihilation and were forced to try and adapt. Those that were able changed along with their clients. Their taxonomy of disorders proved to be neither frozen or fossilized. Their treatments could be extended to cover the new range of personal problems that modernisation triggered. As the project developed, we heard both from healers who felt at a loss trying to ease the contemporary emotional problems of their clients and those adept at expressing their classifications and explanations in the contemporary idiom.

Despite the adaptive powers of some healers it became clear that new interventions, complementary to the traditional healing system, were needed. The team sought to find culturally appropriate solutions aimed at:

- 1) Strengthening local resources to identify and manage psychosocial problems, by offering training
- 2) Creating awareness concerning psychosocial and mental health problems, by producing appropriate materials and training local health workers and NGO staff in psycho-education
- 3) Adding appropriate new skills at different levels, including mental health clinics at the provincial and district level;
- 4) Forming villagers, chosen from those who had been trained and proved most effective in the pilot phase of the project, into teams, to refer families and provide psycho-education;
- 5) Forming self-help groups, where women and men could find a “niche” in village life and a safe place talk about their emotions.

The following section describes the approaches adopted by the intervention and discusses their effectiveness.

TRAINING

This step aimed at enable the Cambodians themselves to identify and manage psychosocial problems.

In first entering a phum or village, contact was sought with the local authorities, respecting the existing local hierarchical order. The team explained the idea of psychosocial work, as trying to address the problems of the ‘heart-mind’ (paññyehaa plBv cBt). If a traditional phum with a majority of related people was encountered, it was easy to contact healers and other resources for help, and to organize group sessions where the problems of the ‘heart-mind’ were discussed. Materials for psycho-education developed in the project, posters, videotapes and presentations on particular themes, allowed people to shift the angle of interpretation of their daily problems. Building on the existing relations in the village, the team would begin organizing training for interested helpers in the community, and group work (see below) came almost automatically.

In mixed villages the approach had to be more careful. The different groups were best approached separately, and the team took pains to discover through interviews of key informants (teachers, village leaders, monks) the social history of the group. In these phum building individual relationships between healers or helpers and people in need meant building up a sense of mutual trust that is the essential basis for group sessions. In ‘new phum’ the most effective approach was for the team to start individual casework and identify individuals who had common interests. Once brought together, the various groups were given psycho-education and relationships began to seem and to be possible.

In all villages, people agreed with the suggestion of the project team to visit families that were known to be in need. At the house of one of the identified families, the discussion about the problems and their causes would be pursued along the following lines. The family was asked what was done to find solutions, then asked to come along to the house, market, or hospital where help was found. There the healer, health worker or any other resource was asked to comment upon the problem and give her/his views about the causes and potential healing chances. Since the overall majority of people had visited several health sectors, it was often possible to reconstruct the health-seeking path and see the reported problem from several angles.

The next step was defined by the type of village entered, and consisted of either psycho-education for anyone interested, and/or individual case work aimed at strengthening local resources for help, or individual casework to build a basis for a group approach.

The people who were already “in position” to assist families in distress were identified. They were teachers, village chiefs, monks, ?aacaas, some of the traditional healers, staff of government agencies, NGOs, the public health sector,

and ordinary villagers. They were offered training. Curricula developed on different levels were developed especially for the Cambodian situation, and laid an emphasis on realistic possibilities.

COUNSELING

The elements of communication detected in traditional healing helped the team to see that there was common ground to build on. Counseling training could be used as a way of improving communication with and within the team itself, and counseling could be a start for developing a common language for describing helping activities. It would offer the core group a set of basic social skills, like listening skills, for helping in general. Furthermore, the very basics of counseling were expected to be of use for people working with vulnerable clients.

The therapeutic value of talking with, or even just listening to people about the problems they face was not readily accepted. Healing was traditionally seen as a process requiring specific activity from the healer. The role of the Cambodian team members was at stake when they were asked to visit people and families in distress, in order to just listen to them or talk with them. As educated people and NGO workers they felt they had to live up to the expectations people would have, and either give material support or sound and clear advice. To their surprise, many people actually liked being offered a chance to talk about their problems. The notion that a counselor does not solve the problems of a client for him/her appears to have been more difficult to accept for the counselor than for the client.

In the interactions between patients and healers in the traditional sector, advice is at the center of the transaction. People come to ask for advice, and expect clear answers. The answer partly points at the cause of the problem, and always gives clear guidelines on what to do. In the modern health sector the answers are less important. The causes are incomprehensible anyway, as long as the biomedical view on the human body is incompatible with people's beliefs. The guidelines are usually limited to advice on how to take the drug. Here people come to collect medicines, which in the modern sector are answer and treatment at the same time.

Training the core group of the project in counseling turned out to be a time-consuming affair. After two years the core group members had developed self-confidence in this new role, and they saw that there are many shades between the extremes of 'telling people what to do' and a completely passive role.

In describing common factors in the many brief psychotherapeutic approaches, Bergin and Garfield (1994) list the following basic general therapeutic factors: helping the client to understand his problem, the therapeutic relationship, emotional release, reinforcement of client responses, helping clients to confront a problem, giving information, reassurance of the client, promoting

successful coping, and emotional involvement of the client. The Cambodian caseload shows that these same factors apply in Cambodia, and the team members could make use of them all.

This does not mean that counseling has yet proved itself an effective tool in addressing the psychosocial problems of so many people. Training undertaken by the team to start spreading the counseling skills was difficult – especially because of the difficulty of the concept of ‘talk-therapy’, the need for a new role to be created for the counselors-to-be, and the actual time counselors were required to invest in their clients. The work done by mediums is probably more efficacious, definitely more cost-effective, and already in existence and readily accessible throughout the country.

SELF-HELP GROUPS

‘Group therapy is defined as a professionally led therapeutic activity occurring in a group setting employing techniques varying from educational to those in which specific inter-actional and dynamic issues are examined’ (Kinzie 1997). Group sessions were the first step in developing self-help initiatives at the community level. The group approach was firstly a response to the sheer quantity of people needing help. But it was also a chance to reinforce an important message, namely that people can actually help themselves and do not need an extra layer of “psychosocial workers” to do it for them. Group work also provides an opportunity to search for some kind of meaning, or acceptable explanation, for the events of the past and the present. Exchanging opinions on this fosters cohesion and becomes a force for and mutual empowerment.

In preparatory discussions of group sessions with Cambodians, it had been remarked that difference in cultural values, such as respect for authority, the need for smooth relationships, traditional interdependent family relationships, and harmonious living with nature, are important in the psychotherapeutic relationship and could pose difficulties for a positive outcome (Kinzie 1997). There is certainly no cultural analogue to the type of self-disclosure required in individual psychotherapy in any of the Asian healing ceremonies.

The team attempted to steer around these obstacles with the following measure. People were selected from the same social strata. Women in comparable positions discussed their problems, often for the first time in their lives, because they found themselves in a safe setting that was not automatically available in communities marked by displacement and isolation. All women experienced the groups as a welcome possibility to discuss problems which they had thought other women in the same situation would not have been willing to listen to. The introduction of these female self-help groups revealed some surprises. It was sometimes hard for outsiders to believe that female kin from the same phum and with a shared history of traumatic events, had never broached the subject of

their sufferings with each other despite daily contact. Discussion of trauma was avoided partly because of the strict hierarchical organisation of society which impedes free talk with those who are in a superior or a lesser position and partly because the culture had never explored the therapeutic effect of talking to people who share your dilemmas and pain. This was a totally new experience for participants. Cambodian villagers did not traditionally seek or expect help or advice from people at the same level in the hierarchy, and even more significantly did not generally indulge in in-depth discussion of emotional problems. This was not a society where some had suffered and others had not, and many felt it was difficult enough to avoid “thinking too much” about their own problems and the connotations this held for going down the path to losing one’s mind. The prevailing attitude was that one should try not to think, enjoy life as it is, ‘be happy you are still alive’.

In one of the group sessions we organized for widows, we asked them what they thought they would need to have a better life. They answered that first of all, there should be no more war, second, they should have enough to support their families, and third, what they needed was more friendly relations with other people. It turned out that they felt they were being looked down upon, that their poverty excluded them from friendly contacts with other people.

The behavioral changes among group participants showed that something important was happening to them. In many cases women insisted on continuing their weekly sessions, and rejected suggestions to start planning other activities such as income generating initiatives. Rejection of income generating activities was admittedly partly a result of memories of the pernicious experiments in communal work of the Khmer Rouge era but it was also related to the sheer relief of talking for first time about their daily emotional problems and the reluctance to put this at risk by embarking on potentially disruptive communal economic enterprises. Women were at a stage, one that cannot be rushed, where repetition of their life stories served the purpose of giving meaning to what had happened and rebuilding mutual trust. As the project developed women increasingly revealed the profound relief they experienced in sharing similar problems and their consequences with others. Other self-help groups began to emerge, for example for male alcoholics.

From today’s perspective it is evident that short-term mutual interest between individual families is acting as an organizing principle for community life and that this has replaced older systems as a practical survival mechanism. Widows in the same position, with small children, lack of income, and living outside their original phum were often isolated. But, as some of the self-help groups have shown, they are able to create a network of friends in the same position that stretches much farther than the phum. These networks eventually link up and criss cross communities, so that the whole community comes to function as a mutual support group.

CONCLUSIONS

Psychosocial problems in Cambodia had and continue to have a paralyzing effect on social rehabilitation. Although mental health clinics are helpful for individuals that need medical treatment and for their families, their coverage is limited and the treatment they offer does not relate to the problems most people experience. Certain characteristics of Cambodian society are causes as well as effects of what happened there and the challenge, as shown by this chapter, was and is how knowledge about the traditional functioning of Cambodian society might be harnessed to develop interventions aimed at reconciliation and rehabilitation.

The work of the 1995 TPO intervention is still going on in Cambodia. A team of Cambodians formed an organization to take over the original project tasks and extend the work all over the country. At community level, however, there is still evidence of dysfunction. The ongoing lack of cohesion between groups is readily detectable. Returnees are often among the most vulnerable. Refugee literature commonly refers to the phenomenon of resettlement not necessarily bringing relief (Muecke & Sassi, 1992). Neither is the process of rebuilding Cambodia a short-term project. It is more likely that it will take decades for the Cambodian people to recover from the civil war and the genocidal Khmer Rouge regime. Public mental health programs will need to give careful consideration to the consequences of the conflict for years to come.

The first generation that has not been through a series of traumatic events is now coming of age but what is striking is their continuing sense of cultural and personal loss (Lipson *et al.*, 1995; Schindler, 1993). From the perspective of our experience, we would urge those who try to help them to stress the importance of retaining a grip on their cultural identity as there is evidence that those who do so fare best in post-conflict situations (Berry, 1991; Cheung & Spears, 1995; Eisenbruch, 1986; Moon & Pearl, 1991).

In addressing the problems in Cambodia through the community, we tried to make use of the hidden reserves at that level. An individual approach would neither have coped with the numbers nor addressed the need to restore the bonds of trust between people. Beneath the nationwide destruction of social 'infrastructure' some tenuous and fragile threads of trust and respect had been preserved. The traditional healers had safeguarded them and when the cataclysm lifted the healers were there to bear witness that the core of traditional Khmer society had not been completely broken.

We learned that interventions to complement the traditional system were not easy to develop. The assumption in successful complementarity is that the other party needs additions. The Cambodian villagers did not automatically see this need. We had to demonstrate that our self-help groups could ease distress and build trust and that counseling could help individuals to regain function.

Only then were we able to add to the work already done by traditional healers whose value as trauma therapists could not be denied and indeed had to be built upon (Bracken, Giller, & Summerfield, 1995; Gibbs, 1994; Wilson, 1989). They provided and continue to provide a therapeutic mode that for some is simply more agreeable than those of the classical public health system and Western psychiatry.

In contrast to the villagers, the traditional healers did early on see value in adding new techniques and ideas to their repertoire. The community turned out not only to be a useful 'unit of analysis' to discover how a complex history of warfare and terror had affected the personal and social functioning of the individuals that formed it. It also proved to be the reservoir of potential solutions – solutions that were valid and in harmony with the context in which people are having to rebuild not only their own lives, but also the world that they live in.

REFERENCES

- Bergin, A. E. & Garfield, S. L. 1994, *Handbook of psychotherapy and behavior change*, 4th edn J. Wiley, New York.
- Berry, J. W. 1991, "Refugee adaptation in settlement countries: An overview with an emphasis on primary prevention.," in *Refugee children: Theory, research, and services*, L. A. Frederick, Jr. & L. A. Jean, eds., Johns Hopkins University Press, Baltimore, MD, US, pp. 20-38.
- Boehnlein, J. K., Kinzie, J. D., Ben, R., & Fleck, J. 1985, "One-Year Follow-Up Study of Posttraumatic Stress Disorder among Survivors of Cambodian Concentration Camps", *American Journal of Psychiatry*, vol. 142, no. 8, pp. 956-959.
- Bracken, P. J., Giller, J. E., & Summerfield, D. 1995, "Psychological responses to war and atrocity: The limitations of current concepts.", *Social Science & Medicine*, vol. 40, no. 8, pp. 1073-1082.
- Chandler, D. P. 1983, *A History of Cambodia* Westview Press, Boulder, Colo.
- Cheung, P. & Spears, G. 1995, "Psychiatric morbidity among New Zealand Cambodians: the role of psychosocial factors.", *Soc.Psychiatry Psychiatr.Epidemiol.*, vol. 30, no. 2, pp. 92-97.
- Ebihara, M. M. 1987, "Revolution and reformulation in Kampuchean village culture," in *The Cambodian Agony*, D. A. Ablin & M. Hood, eds., M.E. Sharpe, Armonk, N.Y., pp. 16-61.
- Eisenbruch, I. M. 1999a, "Culture and illness - Clinical presentation and management of somatoform disorders in Cambodia," in *Somatoform disorders: A worldwide perspective*, Y. Ono et al., eds., Springer-Verlag, Tokyo, pp. 153-162.

- Eisenbruch, M. 1999b, "Culture and illness - Clinical presentation and management of Somatoform disorders in Cambodia," in *Somatoform disorders: A worldwide perspective*, Y. Ono, A. Janca, & N. Sratorius, eds., Springer Verlag, Tokyo.
- Eisenbruch, M. 1986, "Action research with Vietnamese refugees: Refugee, be-friender and researcher relationships", *Journal of Refugee Studies*, vol. 7, no. 2, pp. 30-51.
- Eisenbruch, M. 1990a, "Cultural bereavement and homesickness," in *On the move: The psychology of change and transition*, S. Fisher & C. L. Cooper, eds., John Wiley & Sons Ltd, New York, pp. 191-205.
- Eisenbruch, M. 1990b, "The cultural bereavement interview: A new clinical research approach for refugees.", *Psychiatric Clinics of North America*, vol. 13, no. 4, pp. 715-735.
- Eisenbruch, M. The ritual space of patients and traditional healers in Cambodia. *Bulletin de l'Ecole Française d'Extrême-Orient* 79[2], 283-316. 1992.
- Eisenbruch, M. 1994, "Mental Health and the Cambodian Traditional Healer for Refugees Who Resettled, Were Repatriated or Internally Displaced, and for Those Who Stayed at Home", *Collegium Antropologicum*, vol. 18, no. 2, pp. 219-230.
- Eisenbruch, M. 1997, "The cry for the lost placenta: Cultural bereavement and cultural survival among Cambodians who resettled, were repatriated, or who stayed at home," in *Home is where the heart is: The psychological aspects of permanent and temporary geographical moves*, M. van Tilburg & A. Vingerhoets, eds., Tilburg University Press, Tilburg, pp. 119-142.
- Eisenbruch, M. & Handelman, L. 1989, "Development of an Explanatory Model of Illness Schedule for Cambodian refugee patients", *Journal of Refugee Studies*, vol. 2, no. 2, pp. 243-256.
- Gibbs, S. 1994, "Post-War Social Reconstruction in Mozambique: Re-Framing Children's Experience of Trauma and Healing", *Disasters*, vol. 18, no. 3, pp. 268-276.
- Kiernan, B. 1996, *The Pol Pot Regime: Race, Power, and Genocide in Cambodia under the Khmer Rouge, 1975-79* Yale University Press, New Haven.
- Kinzie, J. D., Boehnlein, J. K., Leung, P. K., & Moore, L. J. 1990, "The prevalence of posttraumatic stress disorder and its clinical significance among Southeast Asian refugees.", *American Journal of Psychiatry*, vol. 147, no. 7, pp. 913-917.
- Kirmayer, L. J. 1996, "Confusion of the senses: Implications of ethnocultural variations in somatoform and dissociative disorders for PTSD," in *Ethnocultural aspects of posttraumatic stress disorder: Issues, research, and clinical applications*, J. M. Anthony et al., eds., American Psychological Association, Washington,DC,US, pp. 131-163.

- Lipson, J. G., Hosseini, T., Kabir, S., Omidian, P. A., & Edmonston, F. 1995, "Health issues among Afghan women in California.", *Health Care Women Int.*, vol. 16, no. 4, pp. 279-286.
- Mollica, R. F., Wyshak, G., Lavelle, J., Truong, T., Tor, S., & Yang, T. 1990, "Assessing symptom change in Southeast Asian refugee survivors of mass violence and torture", *The American Journal of Psychiatry*, vol. 147, no. 1, pp. 83-88.
- Mollica, R. 1994, "Southeast Asian refugees: Migration history and mental health issues.," in *Amidst peril and pain: The mental health and well-being of the world's refugees*, J. M. Anthony et al., eds., American Psychological Association, Washington,DC,US, pp. 83-100.
- Moon, J. & Pearl, J. H. 1991, "Alienation of elderly Korean American immigrants as related to place of residence, gender, age, years of education, time in the U.S., living with or without children, and living with or without a spouse.", *International Journal of Aging and Human Development*, vol. 32, no. 2, pp. 115-124.
- Muecke, M. A. & Sassi, L. 1992, "Anxiety among Cambodian refugee adolescents in transit and in resettlement.", *West J Nurs.Res.*, vol. 14, no. 3, pp. 267-285.
- Schindler, R. 1993, "Emigration and the Black Jews of Ethiopia: Dealing with bereavement and loss.", *International Social Work*, vol. 36, no. 1, pp. 7-19.
- Somasundaram, D. J., van de Put, W. A., Eisenbruch, M., & de Jong, J. T. 1999, "Starting mental health services in Cambodia", *Social Science & Medicine*, vol. 48, no. 8, pp. 1029-1046.
- Wilson, D. 1989, "African contributions on AIDS/HIV", *AIDS Care|Aids Care: Psychological & Socio-Medical Aspects of AIDS/HIV*, vol. 1, no. 2, pp. 195-198.