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Starting mental health services in Cambodia

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Abstract

Cambodia has undergone massive psychosocial trauma in the last few decades, but has had virtually no western-style mental health services. For the first time in Cambodia a number of mental health clinics in rural areas have been started. This experience is used to discuss the risks and opportunities in introducing these services in the present war-torn situation. Basic statistics from the clinics are presented in the context of the historical and traditional setting, and the effort to maintain a culturally informed approach is described. The contrasting results in the clinics are analyzed in relation to factors intrinsic to the health care system and those related to the local population in order to highlight the issues involved in establishing future mental health services, both locally in other provinces and in situations similar to Cambodia. The efficacy of introducing low-cost, basic mental health care is shown, and related to the need to find solutions for prevailing problems on the psychosocial level. They can be introduced with modest means, and can be complementary to local health beliefs and traditional healing. In introducing mental health services, an approach is needed which adapts to the absorption potential of the health system as well as to the patients' need to find meaningful help. Existing resources, from the traditional healing sector to rudimentary village structures, cannot be neglected in the rehabilitation of the community, or in interventions to help the individual patient. © 1999 Elsevier Science Ltd. All rights reserved.

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Introduction

The recent history of Cambodia is one of war, auto-genocide, massive trauma and displacement of people (Vickery, 1984; Bit, 1991; Chandler, 1993). As a result, the country suffered a destruction of its social, economic, educational, political, cultural, religious, village and family structures. When the Khmer Rouge took over in 1975 the one mental hospital, *Takmou*, provid-

ing mainly custodial care, was closed, as were most other medical services. The traditional healers, like the *kruu khmer*, and monks had been providing some care for the mentally ill (Eisenbruch, 1994a) but only a few *kruus* were allowed to continue. Although western medical treatment became available after 1979 with the overthrow of Pol Pot by the Vietnamese, psychiatric care was never restored. The traditional healing sector was affected, but was soon able to take a central place in the options for health care after 1979. Starting in the 1990's, the international community, in a concerted effort at 'rebuilding war torn societies' (United Nations Research Institute for Social Development, 1993),

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attempted to reconstruct basic structures and institutions in Cambodia. The health system too had to be rebuilt, and since 1995 the first western mental health services have been introduced.

Cambodia has a pluralistic health care system. On the district level, health care is obtained through self-medication, the private sector and the official public health care system. All this takes place in the context of four 'sectors of health care', when one adds the traditional system. Health seeking behaviour is based primarily on self-medication, and then on the private and traditional sectors rather than on government health services (Van de Put, 1992). Cambodia has the lowest health services utilization in the region, with only 0.35 contacts per year per inhabitant (Ministry of Health, 1996; UNDP, 1996). At the same time, government hospitals function under severe constraints, both in terms of lack of skilled personnel and economic resources in the form of poor salaries (doctors salaries are on average US\$20 per month), and a shortage of materials and drugs. These services are therefore unable to provide quality care (Van de Put, 1992)¹.

Since the United Nations Transitional Authority in 1993, Cambodia has seen numerous international aid, development and training programs, including a few mental health related initiatives. The Canadian Marcel Roy Foundation for the Children of Cambodia in 1994 started a child mental health clinic at the Takmou Hospital. In the same year, the International Organization for Migration (IOM) supported by the Norwegian Council for Mental Health, started the Cambodian Mental Health Training Project (CMHTP) to train 10 Cambodian doctors as psychiatrists. Psychiatry was only included from 1995 in the medical curricula for doctors and nurses. In 1996, the Harvard Training Programme in Cambodia (HTPC) started an Outpatient Department (OPD) for the mentally ill at Siem Riep Provincial Hospital, followed one year later by mental health training for 48 doctors and medical assistants.

Some of these essentially 'western biomedical approaches' with emphasis on centralized, specialized, drug dispensing services have been criticized as inappropriate for Cambodia (Boyden and Gibbs, 1997). There has been recognition by the World Health

Organization (WHO) that adequate health care for all can be provided only by shifting the emphasis to primary health care (WHO, 1975, 1990, 1994). The Ministry of Health (MOH) accepted this approach in its new 'health coverage plans' (Ministry of Health, 1995) as the best option for a developing country like Cambodia, with 85% of its population living in rural areas (Ministry of Planning, 1996). With no structures and resources other than in the traditional sector, a community-based programme with a policy of decentralization and integration of services (WHO, 1981; WHO, 1990) would be best for mental health as well. Such an approach has been tried, for example, in a WHO collaborative attempt to extend mental health in Brazil, India, Egypt, Columbia, Philippines (WHO, 1981) and Guinea-Bissau (de Jong, 1987) and has been found to be effective (Sartorius and Harding, 1983; de Jong, 1996).

Following preliminary anthropological work in Cambodia by two of the authors on the traditional healing and indigenous beliefs concerning mental health (Eisenbruch, 1990, 1994a,b,c, 1997) and the utilization of health care services (Van de Put, 1992), a programme to implement the community mental health approach of the Transcultural Psychosocial Organization (TPO) (de Jong, 1997) was started in 1995. The TPO, based in Amsterdam and a collaborating center of the WHO, is involved in similar work in nine centers around the world where there is war or conflict with the 'aim of identification, prevention and management of psychosocial problems'.

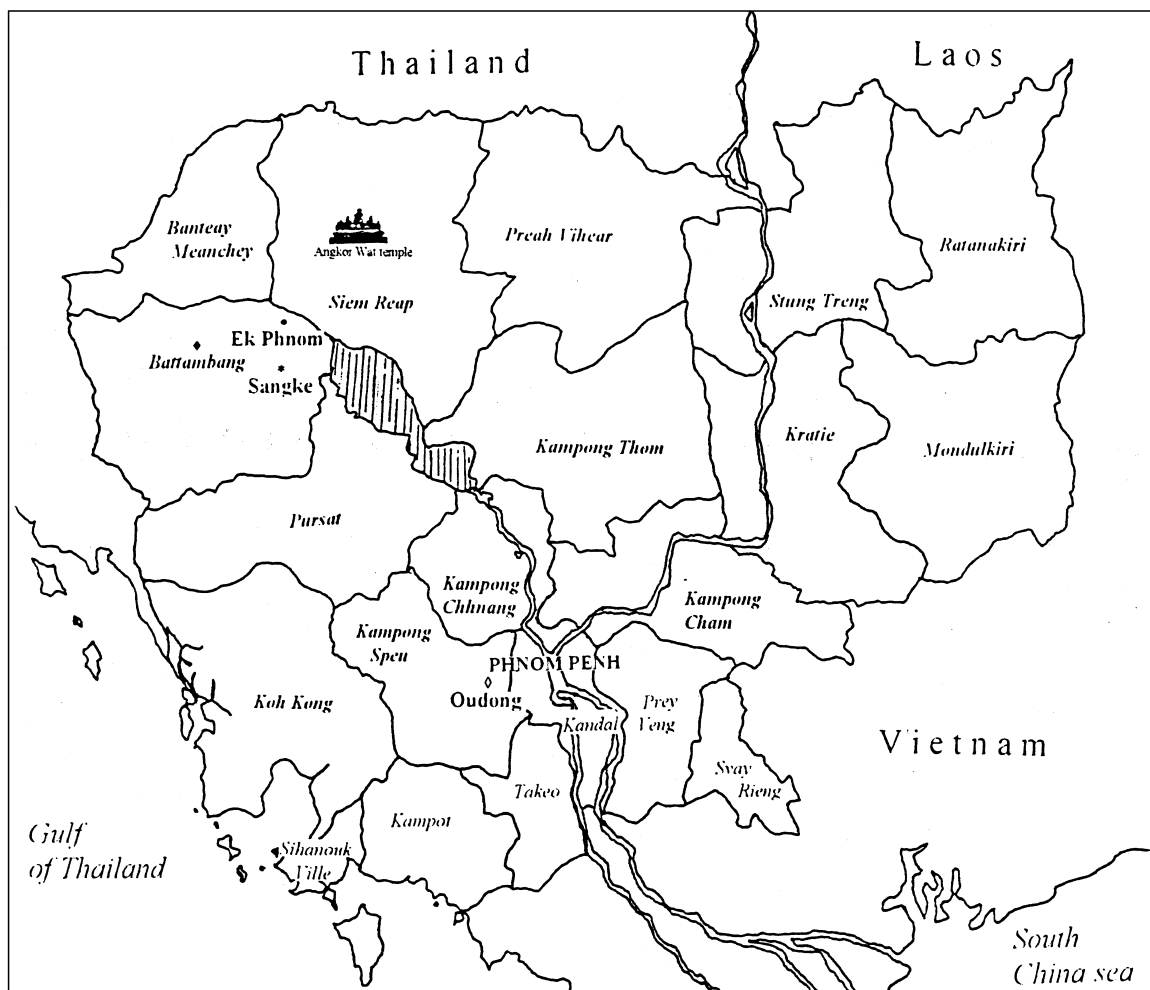
A core group (CG) of 12 Cambodians was trained, in the theory and practice of community mental health, by an expatriate multidisciplinary team with relevant experience in Cambodia. The CG of trainers then started interventions at the individual, family and community level, and trained villagers with special positions of responsibility in their communities, governmental and NGO workers to deal with community psychosocial and mental health issues. The villagers were people such as monks, members of pagoda-committees, village chiefs, elders, leaders, monks, nuns, *achaas* (learned religious persons), village development committee (VDC) members, primary health care workers and school teachers². A book, *Community mental health in Cambodia* was developed in Khmer and English (Somasundaram et al., 1997). Initially, this effort started as an adaptation of the WHO manual, *Mental health of refugees* (WHO, 1996), which describes common mental health problems in refugees and advises on how to help. However, the text had to be rewritten, reorganized and considerable new material introduced, for example from research into the traditional beliefs and healing systems, to make it appropriate and meaningful for the local sociocultural context and situation.

¹ In these circumstances, it is not difficult to understand that government staff have to find other means of supplementing their income. As a measure to increase hospital and staff income and motivation, the Ministry of Health has recently allowed the charging of fees from patients under the 'user fee system' to be shared by the hospital and staff.

² By the end of the first phase of the program in September 1997, 460 community workers had been trained by the core group.

As part of the initial practical training of the CG, three communes (*Khums*), that is 18 villages (*Phums*) in Kandal, Kampong Speu and Battambang provinces (Fig. 1) were selected for community mental health fieldwork. Selection was based on vulnerability to mental health problems in view of the commune's recent history (see below) and preliminary assessment, as well as on accessibility and relative security. At the start, the main problems presented by the villages to the CG were patients with psychotic disorders, causing considerable distress to themselves and their surroundings. Faced with many who were severely deteriorated,

sometimes chained up, the programme had first to attend to these, who were seen by communities as a priority and a test for the new workers' credibility. As there were no existing psychiatric referral services, it was decided to begin mental health clinics in the district hospitals of these areas. The staff at the local hospitals were trained in basic mental health care, which they would do in addition to their other duties as envisioned in the health reforms of the Ministry of Health under the minimum package of activities (Ministry of Health, 1995). In each hospital, around 10 medical staff were given training in basic mental health care.



- ◆ Battambang Provincial Hospital
- Ek Phnom District Hospital
- * Sangke District Hospital
- ◇ Oudong District Hospital

Fig. 1. Map of Cambodia.

Psychiatric specialist supervision, support from the TPO team and supply of psychotropic drugs were provided. The mental health clinics were run by the local health staff on one day a week, under supervision by expatriates and the CG.

In view of the lack of western medical services, and the important role of the traditional and popular sectors in dealing with common psychosocial problems and eventual reintegration of mentally ill patients back into the community, the TPO programme set out to interfere as little as possible with existing traditional healing networks and, indeed, sought to encourage their use while offering its own treatment. Western biomedicine is capable of recognizing and effectively treating severe neuro-psychiatric disorders, such as schizophrenia and major affective disorders as well as epilepsy. Primary health workers can be given basic training to manage the majority of mental health problems with a few inexpensive drugs³ (WHO, 1990; de Jong, 1996). The more experienced traditional healers know their limitations and avoid treating cases of what would be called chronic psychoses in western nosology (Eisenbruch, 1994b). Instead, they help the family to understand why a person may have developed *çkuet* (literally 'mad') and in this way, open the door for reintegration of the patient into the community. The 'category fallacy' (Kleinman, 1980), in which indigenous diagnoses are overlooked and western categories imposed where they have no cultural validity, could be avoided by working within the local cultural belief system, offering medical treatment only for the more severe symptoms or illnesses that have not found help elsewhere. The TPO programme trained the CG to respect cultural beliefs and explanations in order to enhance patient compliance and satisfaction with the treatment.

Paradoxically, some of the CG members, who would have been quite familiar with traditional beliefs and practices, initially resisted such an approach. Those that were from an urban background and had had western style education tended to view traditional practices in a negative way, at least while working

within a 'western' programme. Part of the training was in fact a form of 'reeducation' where traditional beliefs, explanations, practices and systems had to be explained, their function demonstrated and their efficacy in many conditions established. This approach helped to bridge the splitting in the minds of the CG members who used to attend the folk sector when they were confronted with illnesses. Advocacy for the best use of local resources went along with creating referral possibilities at the district level for drugs and other treatment for severe cases. Further referral for specialized assessment and care should be available at the provincial (referral) hospital. Once seen and treatment stabilized, the patients should be referred back to the health centre and primary (community) health worker for follow-up.

This paper describes an attempt to introduce mental health services into Cambodia within the health system. An analysis of this experience should prove helpful for future planning of mental health services not only in this country but also for attempts to introduce mental health services in low income, war devastated situations elsewhere. This paper focuses on the clinical level starting mental health clinics at the district (future health centers) and provincial levels for the first time in Cambodia. Community mental health interventions and the research into the social context and traditional sector are reported separately.

Materials and methods

Battambang province (Fig. 1)

Battambang province, with a population of 660,000⁴ in the northwest of Cambodia, is an area where the civil war continues to the present day. Many have fled their homes many times over, living as refugees or 'internally displaced persons'. The mixed population reflects the total upheaval of local society. Life under the Khmer Rouge (KR) was hard, but the hardest was yet to come: most at the commune level report that the most difficult time was after 1979, when warfare between KR forces and the Vietnamese troops and famine caused families to flee the area.

The TPO programme began work in Sangke district of Battambang province, with a population of 83,612 in October 1995. The district hospital with 32 beds is designed to be a health centre in the new coverage plans of the Ministry of Health. In 1996, 10,509 new general patients or 44 per day came to the outpatient department (OPD) held every weekday. There were 2102 follow-up visits or nine per day. In the Ante Natal Clinic there were 603 new patients or 2.5 patients per day while there were 787 follow-up visits or three per day. The mental health clinic started func-

³ The costs of a basic health program are low, provided that a functioning primary health care system exists and that building and salaries are already funded. US\$1 meets the needs of 54 inhabitants per year (de Jong, 1996).

⁴ Most of the statistical data given in the paper are taken from the survey done by the Ministry of Planning (1996) and the 1995 National Health Statistics report of the Ministry of Health (1996). Basic statistics for Cambodia are difficult to come by. Maintaining reliable, regular statistics and records is only now being slowly instituted. A recent survey estimates the current population to be 10.7 million (Ministry of Planning, 1996).

tioning from April, 1996. It grew rapidly, and over 50 patients were treated on a weekly basis by the last quarter of 1997. Patients started coming from neighbouring districts and provinces, sometimes travelling more than 300 km to reach the clinic.

In view of the increasing demands, a tertiary referral mental health facility at the provincial hospital was begun eight months later. This hospital had 407 beds in 1997 and a catchment population of 383,445. In 1996, there had been 17,048 first visits or 72 patients per day for general consultation at the OPD. In the dermatology clinic, which includes patients with leprosy, there were 989 first visits or 4.5 per day and 50 follow-up visits or less than one a day. The mental health clinic, started at the end of December 1996, quickly became very busy, and eventually patients were also seen on other days. Another two months later, a mental health clinic begun in the Ek Phnom District Hospital. This district has had a particularly traumatic history during the Khmer Rouge period when many civilians were detained at the historic Wat Ek Phnom and later massacred in caves nearby. Ek Phnom District has a population of 62,409 and the district Hospital 30 beds. In 1996, 12,626 new general patients or 53 per day had come to the OPD. There had been 1261 follow-up visits or five patients per day. In the Mother and Child Clinic (MCH), there had been 422 first visits or 1.8 patients per day and 320 follow-up visits or 1.4 per day.

Kompong Speu province (Fig. 1)

The majority of the population of 533,00 in Kompong Speu is of local origin, though some have moved in since 1970. The area has seen continuous civil warfare from that time, until Khmer Rouge troops defected to the government in mid-1996. Shelling, carpet bombing and direct fighting between the Lon Nol government forces and the Khmer Rouge had been daily fare up to 1975, and the Khmer Rouge regime and atrocities were followed by the Vietnamese occupation in 1979. Contrary to Battambang, Kompong Speu has poor soil and several years of flooding have left the population impoverished.

According to the Ministry of Health plans, Oudong District Hospital with a catchment population of 41,000 is to be a model provincial referral hospital. The hospital has 32 beds and is 45 km from the capi-

tal, Phnom Penh. Some general figures for the hospital include 8651 general patients seen for the first time in the OPD in 1996 (36.5 new patients per day), 1107 follow-up consultations (4.7 per day), 599 first visits and 665 follow-up visits at the MCH clinic (2.5 and 3 per day, respectively). The provincial health authorities selected this hospital to begin mental health services. A series of key informant and focus group interviews (de Jong, 1997) also showed the need for a local facility to treat severe neuro-psychiatric illnesses. As a result, a mental health clinic was opened in April, 1996.

The monthly attendance at Mental Health Clinics in the Sangke, Ek Phnom and Oudong District and Battambang Provincial Hospitals are reported up to August 1997. Other statistics are reported for the total patients together, but where there were significant differences between the hospitals, these are indicated. The statistics were obtained mainly from the patient records, but attempts were made to obtain additional information or clarification from the patients and the staff. Some were followed-up at home. The social class was approximated by taking into account the patient's or the head of the household's occupation, income and traditional status. The Cambodian medical staff running the clinic were asked to classify patients into three groups: the elite, normal peasants owning their own land and the landless, poor⁵ or returnees without permanent dwelling. The diagnosis was made by the Cambodian doctor or medical assistant in charge of the clinic based mainly on broad categories described in the ICD-10 primary care version (WHO, 1996) and the TPO book, *Community mental health in Cambodia* (Somasundaram et al., 1997). Patients given an appointment, but who did not come for two months were taken to have 'dropped-out'. The dropouts at Sangke District Hospital were further analyzed.

Results

Attendance

The Mental Health Clinics were held weekly at Oudong, Sangke, Battambang and Ek Phnom. The monthly attendance for each clinic is shown for first visits (Fig. 2) and follow-up (Fig. 3). A total of 839 first visits and 4342 follow up visits were seen.

The Oudong clinic started in March 1996. Three or four patients attended each of the first few clinics, and the attendance remained much the same with one or two new patients and five follow-up patients on average. At times the clinic did not open and attending staff eventually dwindled to one medical assistant and nurse. In October the staff were again given training and efforts were made to open the clinic regularly with TPO support. Attendance and the functioning of the

⁵ Poverty is the inability to attain a minimal standard of living, typically taken to imply adequate income to consume a food basket that provides at least 2100 calories of energy per person per day (with a small allowance for nonfood consumption, like clothing and shelter) This is roughly US\$15 per person per month in the areas TPO worked (UNDP, 1996).

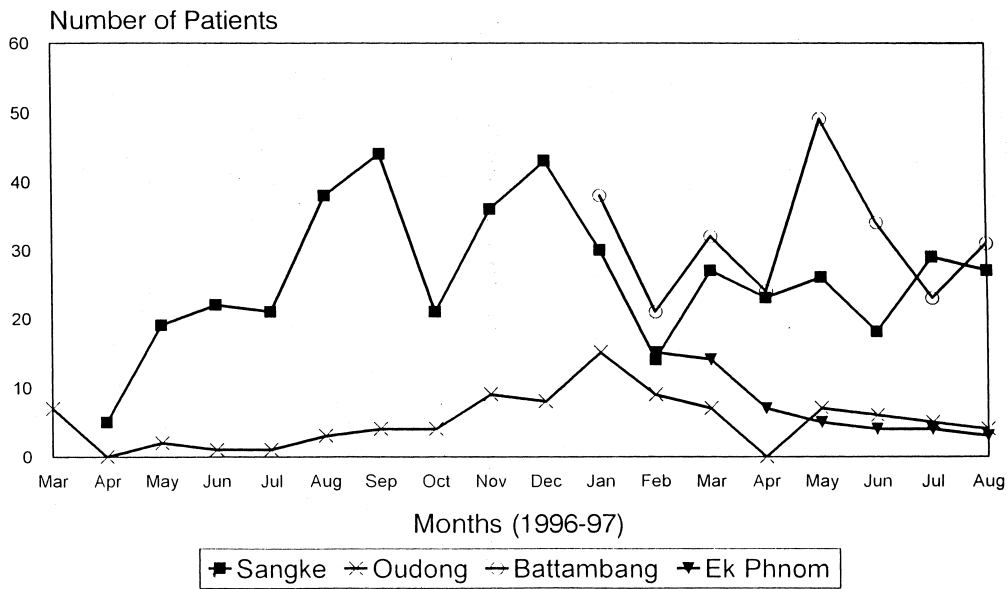


Fig. 2. First visits to TPO Mental Health Clinics in Cambodia (1996-1997).

clinic was then seen to improve to reach a stable point of, on average, two new patients and 10 follow-up visits each time. Up to August 1997, a total of 92 first visits had been seen with 569 follow-up consultations.

The Sangke clinic started functioning in April 1996. Three patients came to the first clinic and, in contrast to Oudong, the attendance grew rapidly to an average of 10 new patients and 50 follow-up patients coming

to each clinic. The original hospital staff trained to run the clinic continued to work regularly up to August 1997 a total of 443 new patients and 2617 follow-up patients had been seen.

The Battambang Provincial Hospital clinic started functioning from the last week of December 1996. First visits soon settled down to an average of seven to eight new patients per clinic. Follow-up consultations

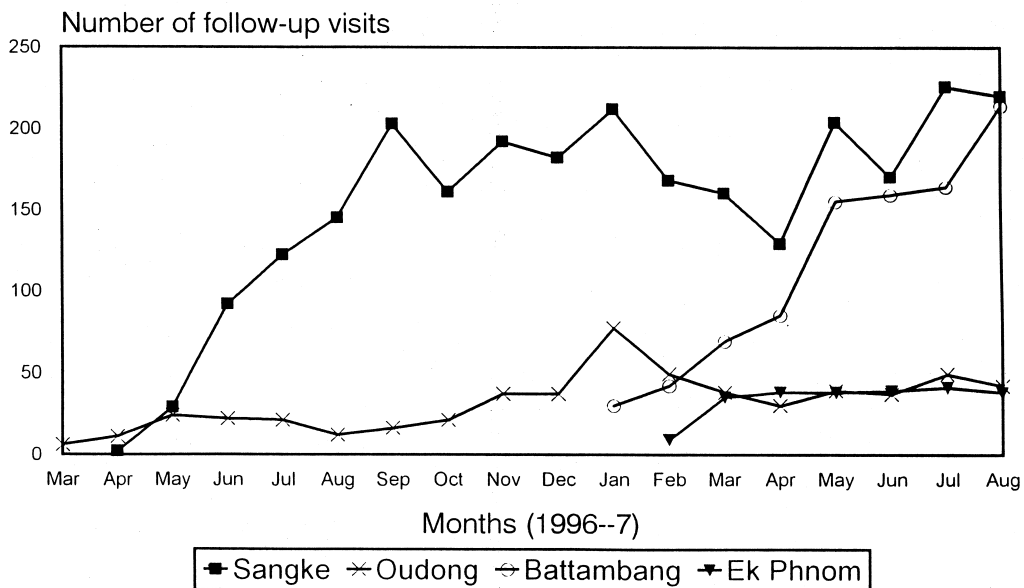


Fig. 3. Follow-up visits to the TPO Mental Health Clinics in Cambodia (1996-1997).

have kept increasing gradually to about 50 each week. As a result, the clinic has now been expanded to function on two days of the week and a separate afternoon session for counselling has also started. Up to August 1997 a total of 252 first visits and 918 follow up visits had been seen.

The Ek Phnom clinic started functioning in the middle of February 1997. After an initial spurt of attendance of new cases there has been a gradual decline. Altogether 52 first visits and 238 follow-up visits have been seen up to August 1997. Follow-up visits have remained stable at an average of 10 per clinic. The overall pattern of attendance and follow-up suggest similarities between Sangke and Battambang, which have been more heavily attended between Oudong and Ek Phnom.

Age

The age range and the average age of the patients attending the different clinics are shown in Table 1. Overall the age ranges in the clinics were similar. However, the averages showed that much younger patients were seen at Ek Phnom.

Comparison of the age distribution with national averages shows underrepresentation of children in the clinic population as shown in Table 1. Overall there were 74 (9%) children, while they form over 50% of the national population. The majority of patients were young adults between the ages of 19 to 45 years with an overall average of 33.6 years. This age group forms 34% of the national population.

Gender

Females formed the greater part of the patient load (see Table 1), with an overall 522 or 63%. Nationally, women form 52% of the population.

Marital status

As shown in Table 1, there were more single patients (45%) compared to the total national population where only 28% are single in those above 15 years. There were also slightly more widowed, separated or divorced patients (13.4%) compared to 10.8% in those above 15 years in the national population.

Occupation and social class

An approximate assessment of the social class of the patients showed that the lower social classes were well represented. The poor, landless and labouring class formed 59% (494 patients). Small farmers, businessmen and fisherman, government servants, teachers, military and police formed 37% (307).

Diagnosis

The common diagnoses in the patients included schizophrenia, 154 (18%), psychosis, 128 (15%), epilepsy, 123 (15%), anxiety, 151 (18%), depression, 119 (14%). Less common were, posttraumatic stress disorder (PTSD), 28 (3%), somatization, 19 (2%), mania,

Table 1
Demographic data of patients attending the TPO Mental Health Clinics in Cambodia (1996–1997)

	Sangke	Oudong	Battambang	Ek Phnom	Overall (all clinics)	National population
<i>Age (years)</i>						
Range (years)	5–77	5–70	8–78	9–70	5–78	
Average (years)	32.1	37.5	35.33	21.65	33.6	
<i>Children</i>	32 (7%)	22 (24%)	15 (6%)	5 (10%)	74 (9%)	53.2%
<i>Gender</i>						
Male	181 (41%)	38 (41.4%)	77 (33.1%)	21 (40.4%)	317 (37%)	48%
Female	262 (59%)	54 (58.6%)	175 (69%)	31 (59.6%)	522 (63%)	52%
<i>Marital Status</i>						
Single	214 (48%)	42 (45%)	84 (33%)	29 (56%)	369 (44%)	28% ^a
Married	166 (37%)	44 (48%)	129 (51%)	18 (34.6%)	357 (42.6%)	61%
Widowed	57 (13%)	3 (3%)	25 (10%)	4 (8%)	89 (10.6%)	9.4%
Divorced/separated	6 (1.4%)	14 (5.5%)	1 (2%)	24 (2.8%)	1.4%	

^a Above 15 years. In all ages, 60% are single, 34% are married, 5.3% are widowed and 7% are divorced or separated.

22 (3%), mental handicap 17 (2%), organic psychosis, 33 (4%) and 41 (5%) having other diagnosis.

The high number with epilepsy is noteworthy, 62 patients (14%) in Sangke, 31 (34%) in Oudong, 25 (10%) in Battambang and five (10%) in Ek Phnom, totalling 123 patients (15%). What was called epilepsy referred to the Grand Mal type of generalized tonic clonic seizures, though a few had partial seizures. In Cambodia, as in many developing countries, this condition, especially the Grand Mal form, is considered a mental illness, and is termed 'pig madness' or *ckuet cruk* (Eisenbruch, 1994b). Some traditional healers attribute the brain pathology to bad action in a previous life, consider it to be inherited from parents; or as a residue from epileptiform illnesses in childhood known as *skan* (Eisenbruch, 1994b). There is no absolute cure according to them, and the treatment, usually medicinal, is directed towards alleviating symptoms and preventing further complications.

From the point of view of western nosology, the two most common psychiatric conditions treated in the clinics were schizophrenia and anxiety (both 18%). Psychosis was diagnosed in 128 patients (15%), This included both acute psychosis and many who would be later rediagnosed as schizophrenia on long-term follow-up. Those receiving the diagnosis of schizophrenia had obvious chronic symptoms of self-neglect, deterioration in functioning, loss of touch with reality, withdrawal or grossly abnormal behavior, hallucinations in the auditory or visual modality and strange beliefs of persecutory or religious nature. The hallucinations and delusions were often related to local events and culture but with bizarre twists and no longer shared by others, showing the pathoplastic effect of the psychosis on the sociocultural context. Thus much of the paranoia involved the Khmer Rouge, Vietnam or security forces. Ideas or experiences of spells or black magic corresponded to cultural beliefs. Hallucinations were often of spirits known locally or ancestors. Some believed they were Buddha. The diagnosis of psychosis was based more on abnormal, disorganized behavior.

There is a marked difference between Sangke and Battambang, the two more successful clinics, in the diagnosis of major mental illness or psychosis in general and minor mental disorders or neurosis. In Sangke, 46% were diagnosed to have a psychotic illness while 31% had a neurotic illness. In Battambang

it was almost the reverse, with only 24% having psychosis and 56% having a neurosis.

Interventions

The therapeutic interventions (Somasundaram, 1997) that were used in the clinics were as follows:

1. Pharmacotherapy
2. Crisis intervention
3. Counselling
4. Referral to traditional resources like Kruu Khmer, monk, village elder or medium.
5. Behavioural-cognitive methods
6. Relaxation-techniques
7. Psychoeducation
8. Group therapy
9. Family therapy
10. Emotive methods⁶
12. Rehabilitation
13. Community approaches

The majority of patients, 744 (89%), received medication. The psychotropic and anticonvulsant drugs: Chlorpromazine, Haloperidol, Imipramine, Amitriptyline, Phenobarbitone, Phenytoin and Benzhexol, were supplied to the clinic by TPO as they were unavailable through the Ministry of Health. In keeping with the differences in diagnostic patterns between Sangke and Battambang, the major tranquilizers were used much more in Sangke as compared to Battambang (about five times more in Sangke), while antidepressants were used more commonly in Battambang (twice as much) during 1997.

Two hundred and eighty-one patients (33%) received counselling, while 287 (34%) were taught relaxation exercises. Counselling consisted mainly of active listening, supportive techniques, symptomatic relief and problem solving as described by van der Veer (1993) who also trained the CG in these techniques. Based on Jacobson's relaxation techniques, culturally acceptable methods can be quite effective for minor mental health disorders, namely states of arousal, anxiety, PTSD and somatization. Four basic methods adapted to the Cambodian culture and religion were developed.

1. Breathing exercises: Buddhist mindful breathing or *Ana Pana Sati* was taught. The popular idiom, *Puthoo* was repeated, that is *Puth* while breathing in and *thoo* while breathing out, or mindful observation of regular abdominal breathing was explained.
2. Muscular relaxation: for most clients, a variation of Jacobson's progressive muscular relaxation, the technically similar Yogic exercise, *Shanti* or *Sava*

⁶ Emotive methods aim at emotional release through artistic or creative expression through drawing, story telling, drama, play, writing, music, carving, clay modeling, etc. This is particularly helpful in children particularly play. In the clinic, encouragement was given for patients to do whatever they were talented in or liked to do.

Asana or the Buddhist mindful body awareness was used.

3. Repetition of word: in this method similar to the relaxation response of Benson (1975), a meaningful word, phrase or verse is repeated over and over to oneself. In Cambodia, repetition of *Keatha*, words (*mantra*, *Angkam*), idiom (*Puthoo*) or the phrase, *Buddhang Saranang Gachchami* is well known.
4. Meditation: various meditation practices known in Cambodia, such as *Samadhi* and *Vipassana meditation* were used.

Using traditional methods of massage like *Thveu Saasay*, to produce profound relaxation was both culturally familiar and effective.

Although all the patients received some amount of general psychoeducation, 169 patients and their families (20%) were given more specific psychoeducation and explanations about behavior modification techniques such as simple positive and negative reinforcement to shape behaviour. Psychoeducation included giving basic information, culturally sensitive explanations, advice on what to do and what not to do and creating awareness. The interventions were often used in combination as the case below.

Case example: T.P. was a 44-year old married lady with six children from Oudong. She complained of having a headache for the last 10 years due to 'thinking too much' (*kit chraen*). When asked about what she thought too much about, she recounted a traumatic incident that happened in 1973. She had been carrying food for some combatants when she had suddenly seen 'big' tanks coming towards her. There had been heavy shelling with death and destruction all around her. Many of her relations and friends were killed. She saw dead bodies, parts of bodies like hands and fingers, blood and people crying out in pain. Heavy (carpet) bombing had followed and she had taken shelter in a bunker, which collapsed under the bombing. She had been buried under the sand, suffered head injury and lost consciousness. She came to in the hospital but could not remember for how long, she had been unconscious. She had difficulty in remembering many of the details of what happened. She tried not to remember and often suppressed her memories ('forced them out of her mind'). At times she had no memory of what happened. At other times she had vivid recollections of the scene, particularly when she saw military personnel or heard loud explosions. At these times she became very frightened. She had frequent nightmares of the event both at night and when she slept in the day. She became markedly distressed when recounting her past experience, her hands shaking visibly. She resisted trying to recall the details, saying she did not want to remember. She had been given a responsible position during the Khmer Rouge

regime. She had been in charge of the Children's unit in her area and had been unusually harsh towards the children in her care. She admitted during subsequent counselling sessions that she feared retributions from those who had been affected in her village. She did not wish to talk about this time. In 1979, Vietnamese soldiers had come, fired some shots in the air and taken her husband away. She had become severely frightened, her body shaking terribly. Now her appetite is poor and she is not able to work as before. She had attacks of fainting lasting 2 h or more, a few times every month. She often had chest pain, with a heavy pressure as if a heavy weight was on her, making it difficult to breath (she said that this had started after she had been buried in the sand). She had started neglecting her self-care, sometimes crying and feeling sad. She was started on Imipramine, counselling, relaxation exercises and participation in a women's group was arranged. She improved quickly, her appetite and sleep returning to normal and the frequency of reexperiencing decreased markedly. However she remained very sensitive and vulnerable to reminders of the trauma, becoming distressed whenever it was brought up.

Outcome

Overall, 421 (50%) patients showed clear improvement after treatment. However there was a high number of drop-outs, 328 (39%), particularly in Oudong 48 (52%). Sixty-eight patients (8%) remained the same, although none became worse during treatment. Seventeen (2%) patients relapsed and five (0.6%) patients died. It is significant that three deaths occurred in epileptic patients, one due to drowning during a seizure, another apparently due to side effects or toxicity of the drugs and one due to suicide. Two deaths in patients with schizophrenia were due to suicide.

Drop-outs

The diagnosis of the 144 dropouts at Sangke included 20 (14%) who had epilepsy, 26 (18%) with psychosis, 15 (10%) with schizophrenia, 32 (22%) with anxiety, 14 (10%) with depression, six with PTSD and six children with mental handicap. The parents of the six children with mental handicap had actually come expecting curative treatment, but did not return after the child's condition and simple behavioural modification techniques were explained to them. Eleven patients had been referred to another hospital, six to the Provincial Hospital on the same day as their first visit for a medical condition and three to the mental health clinic near their home. They had been asked to come back to confirm that they were being cared for.

Looking at it another way, 32% of the patients with epilepsy, 25% with psychosis, 18% with schizophrenia, 53% with anxiety, 26% with depression, 35% with PTSD and all the children with mental handicap had dropped out. Nevertheless, 11 of those with psychosis and five of those with schizophrenia improved with treatment and had come several times average of 10 consultations) before dropping out. Of the rest who had dropped out with psychosis or schizophrenia, six were from very far and one had started buying Chlorpromazine directly.

In general, at the other clinics, long distances and difficulties in travel, other work, no relation to accompany the patient, side effects from drugs, no improvements with first few doses or improvement that was taken as cure were often cited reasons for dropping out. Many patients seen in the community said that they had felt better and so had not bothered to return.

Discussion

There are many pressing problems in Cambodia and resources are severely limited. Poverty, floods and drought are perennial, falciparum malaria is rampant in areas adjoining the forests, dengue haemorrhagic fever is a yearly epidemic, tuberculosis is endemic, HIV/AIDS is a looming catastrophe, low intensity conflict, danger from land mines and political instability continues and the national budget is exhausted. Against this, there is in place a backdrop of traditional healing services. In these circumstances where does mental health fit in?

A global perspective shows that mental health problems the world over produce 8.1% of the burden of disease, measured in disability adjusted life years (DALYs), while 34% of all disability is due to behavior related problems, including violence, exploitation, and AIDS (Desjarlais et al., 1995). In Cambodia, these problems are rampant, and to not include basic mental health care in the minimal activities of the public health sector therefore does not seem a serious option. The health care reform plans of the Cambodian Ministry of Health (1995) include mental health in the 'minimal package of activities'. The question is how these services should be introduced and made effective, not whether services should be introduced at all.

The results reported in this paper point to some marked differences in the attendance at different mental health clinics. In analyzing these differences, it is necessary to analyze factors in Cambodia in general and local differences in context, staff and patient population in each setting. Particular attention will be paid to Sangke and Oudong clinics which have been the longest running and show the most marked contrast in utilization.

The utilization of health care services in any sector is defined by characteristics of the services on the one hand, and socio-cultural characteristics of the population on the other. The quality of services depends on factors such as salaries, availability of medicines and materials, quality of management and motivation and skills of personnel. In deciding where to seek help, health beliefs define the perceived needs, and the available information about the quality of services is combined with the accessibility in terms of costs, time and distance (Van de Put, 1992).

Characteristics of the public health sector

The motivation and enthusiasm shown by the staff in the different clinics were dissimilar. The staff in the Battambang province were receptive to psychiatric notions. Thus, local resources and health center staff were eager to receive support and training, and the referral system was installed. These clinics quickly became a model for the future development of mental health care services in Cambodia, of just the sort envisioned in the draft national plan for mental health drawn up by the Ministry of Health (1995) in conjunction with WHO.

The staff were keen to learn psychiatry, asking expatriate staff penetrating questions and requesting lessons and literature. The doctor at Sangke undertook to admit emergency psychiatric patients to his general medical wards, the only western psychiatric inpatients in the whole country (some traditional healers also have psychiatric inpatients). The situation was different at Oudong clinic, where staff did not show much interest or enthusiasm (TPO, 1996). The clinic, soon staffed by only one medical assistant and one nurse, did not function regularly. Patients sometimes travelled long distances, but returned home disappointed and without medication. Further, attendance at the mental health clinic appeared to have a seasonal variation. Low attendance during the planting and harvesting season reflected the high number of farmers coming to the clinic.

It is interesting that most district hospitals are facing changes as a consequence of the health reform plans. Sangke hospital is expected to scale down to a health center, while Oudong needs to develop into a model referral hospital. Both hospitals have been supported for years by international organizations, which provided training and material support. As shown below, Oudong district has a strong presence of the traditional sector, which causes extra competition in the private health care market. Being the place exploited by public health staff to accumulate necessary income, this may account for the apparent low interest in investing more time in the public hospital. The weaknesses of the public health system in Cambodia

strengthen the importance of personal motivation of the staff, the level of performance varies from clinic to clinic, from person to person.

This effect is strengthened by the fact that whereas the traditional sector has its own supply of materials needed for treatment, psychotropic drugs are not readily available in the pharmacies outside, and patients or doctors do not obtain them abroad. The Ministry of Health started to supply a limited quantity of essential psychotropic drugs to central hospitals only from September, 1997. Drugs and minimal other requirements, such as buildings, extra furniture, stationery and per diems, had to be provided by TPO.

The population

In Battambang, the local health authorities, aid agencies and people themselves expressed a need for mental health services, perhaps accounting for the relative ease and success of the programme there. This seems to be related in the first place to the high number of returnees from the Thai border camps (more than one third, 117,000 of the 360,000 in the camps returned to Battambang), who have been exposed to mental health projects there. Another factor is the continuation of low-intensity warfare. Fighting seemed to stop after the breakaway of an important Khmer Rouge faction under Ieng Sary, the former foreign secretary of the Democratic Kampuchea regime, in 1996, but flared up again after the military confrontation between two government parties in July 1997.

In Oudong, there is a strong presence of the traditional healing sector. A survey in 1993 found 459 traditional healers (268 *kruu*, 191 traditional birth attendants), 338 private practitioners and drug sellers, and 1339 unpaid village health volunteers in the district (monks are excluded, but their number should be added to the traditional sector). Per 1000 inhabitants there were five traditional healers, 2.8 drug sellers, 1.5 private practitioner and 0.55 commune health workers, of whom 66% receive no salary at all (Australian Red Cross, 1994). The fact that Oudong has a reputation for its range and quality of traditional healers, whereas Battambang has more displaced people who have lost touch with their original community and the healers in

it, may account for a difference in need for as well as awareness of western mental health services.

The past history of Battambang also differs from the Oudong area. In Battambang, the most traumatic and difficult episodes reported are the DK regime (1975–1979) and the years following it. People in Oudong suffered more from the civil war and carpet-bombing before 1975. The Khmer Rouge regime proved to be a very hard life for everyone, but is by no means the only time to still haunt people (Shawcross, 1983; Vickery, 1984). The actual traumatic periods were at different times, and the structures of the different communities have responded to these.

Social scientists who have worked to any extent in Cambodia agree that the level of social integration in Cambodia is unique (Delvert, 1961; Ebihara, 1968; Van de Put, 1992; Chandler, 1993; Thion, 1993; Ovesen et al., 1995). The range of people, families, communities with whom a given family needs to maintain relationships has always been small in Cambodia in comparison with surrounding countries. Families could live relatively separate lives due to the structure of land ownership, low population density and huge forest habitat. Public space was limited to the pagoda and the market. This society, where social relationships were clearly defined but loosely maintained⁷, was then hit by Khmer Rouge totalitarian terror, aimed at the very roots of communal life. Trust between people was shattered, and a collective loss of meaning and social structure resulted. Areas where one would feel safe and secure became smaller and smaller, leading for some to a point where the family itself lost its role as a safe haven,

In Oudong, people who survived the DK regime were able to remain together as groups of families. Although many still express the wish to go back to their original homestead, people feel at ease in villages made up of long-known, and usually related, families. The social network, including healers and other local resources, has managed to survive. In Battambang this is much less the case. Many people who were living in Phnom Penh when it was taken in 1975 were sent to different parts of the country, but ended up in Battambang, as 'new people' (Vickery, 1984; Kiernan, 1996). In the early 1980's families split up in order to find enough food. People were displaced due to warfare between Vietnamese troops and the Khmer Rouge and later between other groups. Many people spent years in the camps. Later on, returnees, not able to go back to their old villages, set up residence along new roads, with no Wat (pagoda), healer, village network or resources where they could get help.

Thus the marked difference in the use of the mental health services by the population in Battambang and Oudong could be due to their differing past history, the presence of traditional healers, and different levels

⁷ Many elements in Cambodian society are reminders of the debate about the 'loosely structured society' in Thailand (Evers, 1969, 1980). If it is true that Cambodian community is shattered, it must be hard to find the remains of a loosely structured society, and this has implications for community and social rehabilitation. The danger of accepting the idea of a loosely structured society in Cambodia is in the potential confusion of identifying aspects of a 'loosely structured society' with effects of trauma on the collective level.

of knowledge about and experience with western psychiatric services.

Women

In most developing countries, males are more common in psychiatric clinics (German, 1972; Islam, 1977; Ihezue, 1983). The high number of women attending the mental health clinic calls for an explanation. In the national population, women predominate due to death or migration of male members during the war. Women are heads of many households (UNDP, 1996) that also tend to be large, and many are 'widows' (Bit, 1991; UNICEF, 1996). In Cambodia, the Khmer term *mee maay* is translated as 'widow' but indeed means any woman whose husband has died, left her or divorced her. In the villages where the TPO team work, 40% of those identified as having psychosocial problems by the village authorities were widows (Van de Put et al., 1996).

The sex ratio (males to females) for different age groups shows that for every 10 women older than 40 there are six men of the same age⁸. In this age group are the older widows, who lost their husbands during the earlier times, or whose husbands have abandoned them more recently. Younger widows, often abandoned but still regularly harassed by their husbands, have to take care of young children by themselves. They bear the consequences of some of the changes due to the breakdown of old village structures and social codes. The endemic domestic violence (Project Against Domestic Violence, 1996) is linked to these changes, such as the disappearance of the rule on where a new couple will live. Whereas this used to be the village of the woman, thus offering her some protection from her kin, many young women now find themselves abandoned in a 'strange village' where they have very limited access to the traditional sectors for help. And even in their original villages, social control, which used to be exercised by monks or the *achaa*, cannot compete anymore with the liberty men feel of using their power over women.

It is traditionally accepted that women should carry the consequences of 'bad actions' of others. If, for example, the husband forces himself sexually on his wife too soon after delivery, it is she who has to carry the burden of '*toah damneek*' (White, 1997). AIDS is seen as given by women, and received by men. The

Khmer saying, "*pros chea meas teuk dop...*" (which is understood to mean men are gold, women are cloth) is an apt illustration of the position women take in society. The added responsibility for widows of running the home single-handed and taking on many traditional male roles would put an extra burden on them, making them more susceptible to mental breakdown.

Age

Children, particularly under 12 years, were not commonly seen in the clinic population. In some ways, this was expected as severe psychotic illness, which accounted for the majority of patients, is rare in childhood. Most of the children who were brought had either epilepsy or mental handicap, similar to the situation at the Child Mental Health Clinic at the *Takmou* Hospital where 50% had epilepsy and 30% had mental handicap (Subcommittee of Mental Health, 1997). An adult has to be available to take the child to the health center. A low level of social integration, and absence of trust, means for many families that a parent cannot take a child to a health center because there is nobody available to look after other children or the house.

In the TPO community work it was found that many Cambodians, as in other developing Asian countries (Malhotra et al., 1977), seemed unaware that their children could have mental problems and that a mental health clinic was in any sense an appropriate facility to seek help. There is no reliable study of the prevalence of psychosocial problems in children in Cambodia, but the past history of war, displacement, separations, famine and other hardships is likely to have considerable impact on children's mental health which is not being addressed in any systematic way (Boyden and Gibbs, 1997).

Most patients (70%) were young adults (19–45 years). This being the most productive age, relations and patients would have tried to remedy the situation as soon as possible so that the person could get back to work. In addition, the overall average was 33.6 years, indicating an age group that would have been teenagers during the Khmer Rouge regime and would have gone through considerable hardship.

Social class

Traditionally, rural Cambodians consider themselves to be farmers. Those who are not farmers are looked upon as 'being not Cambodian'. The upper class would come from the nobility and ruling elite. The bigger business entrepreneurial class and to some extent, officials, have usually been from other ethnic groups and are often targeted during wars and social upheavals (Kiernan, 1996).

Forty percent of the Cambodian population lives below the poverty line (UNDP, 1996), and the poor

⁸ Sex ratio (males for females): 25–29: 0.84, 30–34: 0.82, 35–39: 0.81; 40–44: 0.66; 45–49: 0.77; 50–54: 0.76. Hundreds of thousands of young males who would have now been in the 40–44 year age group perished in the Pol Pot years. This gives the marked difference in sex ratio for this age group. (UNDP, 1996).

are to be found mainly in the rural areas. Poverty rates are relatively small for civil servants and public employees (UNDP, 1996), and these often belong to what could be called a 'middle class' in Cambodia. The landless peasants and returnees can be assumed to be poor. Plans by UNHCR to resettle returnees in cultivable land did not succeed due to numerous landmines and the returnees were left with no source of income (Davenport et al., 1995).

The higher classes are hardly present in the Sangke and Oudong districts and would normally seek help in the private sector, Phnom Penh or abroad. The absence in the patient population of the very few people, if any at all, who would meet the criteria to be included in the top group, is therefore not surprising. In the largest group in the district, the small farmers, are the clients who use the public health sector when expectations are raised by a new service, provided by an external organization. The population of Sangke and Oudong district is predominantly made up of small farmers. They make up 158 (30%) of the patient population. In Battambang, many of the returnees are without their own land and thus very poor. This poorest group will only come when they live very close, or if a new service provided by a new group raises expectations. It is noteworthy that a relatively large number of poor people came to the mental health services. These high expectations are probably the reason for this.

Diagnosis

Among the diagnoses, it is significant that, in the light of the history of massive trauma, post traumatic stress disorder (PTSD) was not more common, accounting for only 3% of the diagnosis. As PTSD usually does not produce severe, incapacitating dysfunction in quite the same way as a psychotic illness, a mental health clinic would not be seen as an appropriate place to seek help. With the social stigma attached to mental illness, most would be reluctant to come to a psychiatric clinic where the 'mad' are treated. Instead it could be expected that many with PTSD manifesting through somatic complaints (Kirmayer, 1996) would seek help in the traditional sector, as well as western health services.

It takes considerable skill to recognize PTSD when the complaints are not directly related to traumatization. Thus it is possible that PTSD diagnosis was missed in the clinics. Further, the important issue may not be whether PTSD is cross-culturally valid (Bracken et al., 1995) in Cambodia, but that we are dealing with a much deeper collective traumatization that may not be expressed as individual complaints.

Trauma tends to be pervasive, massive, chronic, complex and multilayered, as the case example shows.

Given the widespread nature of the traumatization due to war, the reactions would have come to be accepted as a normal part of life (Somasundaram and Sivayokan, 1994). The prevailing cultural idioms of distress including tiredness (*ohkumlang*), thinking too much (*kit chraen*) and flashbacks of past traumas in the form of dreams and imagery which spill over into waking life (*srAmay*), were so common as to be considered normal (Eisenbruch, 1996, 1994a). Similarly the common occurrence of nightmares (71%), and what was termed depression or *pibak cet* in 83% of Cambodian refugees in a Thai border camp (Mollica et al., 1990) in apparently functioning adults cannot be considered pathological.

As Bracken et al. (1995) comment in relation to symptoms of PTSD in a similar context in Nicaragua, "in this situation the people were clearly, not psychological casualties, they were active and effective in coping with new and difficult circumstances in the face of the continuing threat of further attacks". Indeed, it would be more appropriate to talk of collective trauma (Somasundaram, 1996) or cultural bereavement (Eisenbruch, 1991), and to look at how the community as a whole has responded, how the community coped, and what can be done at the collective level (Somasundaram, 1996). For example, it may be more beneficial to consider strengthening and rebuilding the family and village structures and to encourage rural development, as well as finding a common meaning for the immense suffering. Bracken et al. (1995) conclude their analysis of the 'psychological responses to war and atrocity' with the suggestion that "the most fundamental principle is that recovery over time is intrinsically linked to reconstruction of the social and economic networks, cultural institutions and respect for human rights".

The high number of epilepsy cases in Oudong (34%) is particularly significant, perhaps confirming that traditional healers may have difficulty in treating this chronic neurological problem. On the other hand, there were no acute psychosis seen at Oudong. Patients with acute psychosis would have first gone to the *kruu*, who are quite competent in managing this condition (Eisenbruch, 1994c). Further, those with this transient, good prognosis condition would have recovered within the period that usually lapsed before their health seeking behaviour would bring them to Oudong District Hospital. This was not the case in Sangke, where patients with acute psychosis were brought early (sometimes within days of the onset) to the clinic.

The marked difference in the diagnostic categories of major and minor mental health problems between Sangke and Battambang is noteworthy. It was apparent from the distances people were traveling to come to Sangke that it had become more established and well known for successful treatment of mental illness

as it had been functioning from 1996. As a result, the clinic attracted all the more severe mental patients from the region and outside. Battambang only started functioning from 1997, and in addition had referrals from the medical wards and other specialties that would account for the higher number of somatization and other conditions at the neurotic end of the spectrum.

A diagnosis of organic psychosis (chronic) mainly referred to those patients who had developed various behavioural disturbances following head injury and senile dementia, but also included two in Sangke who had developed paranoid psychosis after being given amphetamine while working as migrant labourers in Thailand (Somasundaram et al., 1997).

Interventions

It is notable that a mental health clinic can be reasonably managed with relatively few, cheap drugs (de Jong, 1987, 1996). Chlorpromazine, Haloperidol, Amitriptyline and Imipramine cover most serious mental disorders, while Benzhexol will be needed for the side effects. As epileptic patients also came in large numbers to the mental health clinic, Phenobarbitone and Phenytoin was also needed. Not all patients respond well to the basic front-line drugs. Some situations, such as where a chronic schizophrenic refuses treatment and the relations have washed their hands off the patient, may benefit from injectable long-acting depot preparations.

Psychological forms of treatment like counselling, relaxation exercises and other nonpharmacological forms of therapy were encouraged for appropriate conditions, particularly minor mental health disorders (Somasundaram, 1997). The use of nonpharmacological forms of treatment continues to be an unresolved contentious issue between the TPO and health workers. Health workers insist that when patients come to a western medical facility they expect drugs. It is reasoned that as such, all patients need to be given some drug, even if it is a placebo. However, the TPO position has been that by giving drugs where they are not needed, emphasis is shifted from the real psychosocial causes for the problem and suggests to patients that this is an illness to be cured by drugs. Particularly, in a situation where there is shortage of drugs, the unnecessary use of drugs cannot be warranted.

The situation usually arises in cases of minor mental disorders like anxiety, mild depression, PTSD and somatization where the medical staff tend to prescribe antidepressants. The TPO argument has been that the original objective of starting mental health clinics in the districts was to deal with severe, major mental health disorders and epilepsy that needed medication

and for which no facility existed. Now patients with other mental health problems have also started to come to the clinics, due to the clear success with the treatment of major mental illnesses, but the psychiatric clinic may not be the appropriate place for minor mental health problems. Most of them can be managed in the community, by the traditional sector or through health education and the psychosocial skills being imparted there.

It would not be a big tragedy to 'lose' these categories of patients from the clinic. In fact it may help to decongest the overcrowded clinic and make the services better. However, the medical staff are comfortable in the medical role of prescribing and dispensing drugs, and for reasons mentioned above, the motivation to invest in often time-consuming new forms of treatment is limited. As a compromise in many cases, to satisfy patient and staff expectations, a placebo is given while nonpharmacological forms of treatment are also started concurrently, with the intention of stopping the drug once trust and understanding was built up in the patient.

The Buddhist form of mindful breathing (*Ana Pana Sati*), body awareness, repetition of *Keatha* and meditation have been culturally acceptable and found effective for minor mental health disorders (Somasundaram, 1997). Mental distress in Cambodia, as well as in other developing countries, are often experienced and expressed in somatic terms (Kirmayer, 1996) and will benefit from interventions structured initially in physical terms (Bracken et al., 1995). The benefits of these traditional practices are not confined to producing relaxation. When methods are culturally familiar, they tap into past childhood, community and religious roots and thus release a rich source of associations that can be helpful in therapy and the healing process. Mindfulness and meditation draw upon hidden resources within the individual and open into dimensions that can create spiritual well-being and give meaning to what has happened. Although these techniques involve no formal psychotherapy, they may accomplish what psychotherapy attempts to do by releasing cultural and spiritual restorative processes.

Drop-outs

Despite the gratifyingly high attendance and marked improvement in 50% of cases, some questions remain, such as the high drop-out rate (39%) from the mental health clinic. Together with low utilization of health services in general, health seeking behaviour in Cambodia rarely includes a follow-up visit to the same place or person. This is shown by the very low number of follow-up patients generally in Cambodia (Ministry of Health, 1996) and in the hospitals TPO worked in. This is true even for chronic conditions like TB and

Leprosy. Thus, the fact that so many patients return regularly to the clinic is in itself a remarkable achievement.

Comparison with other mental health services in Cambodia is also instructive. In 1996, 1347 first visits and 13,921 follow-up consultations were done at the CMETP psychiatric clinic at Sihanouk Hospital. At the Canadian Marcel Roy Foundation child mental health clinic at Takmou Hospital, there were 101 first visits and 1937 follow-up consultations (Subcommittee of Mental Health, 1997). This shows, on the average, a ratio of first visits to follow-up of 1:10 at Sihanouk and 1:20 at Takmou, while at the TPO clinics it is approximately 1:5. The high turnover at the TPO clinics could indicate that the customers are not satisfied and services are poor. However, the different clinics are not strictly comparable. The first two are specialized clinics in the capital, Phnom Penh, with better facilities and range of drugs, run by specialists and open on all week days. The TPO clinics are in the periphery with limited facilities and drugs, run by ordinary medical staff who do this work in addition to other general medical duties on one day of the week. Thus, the level of care would be less (for example, management of troublesome side-effects less finely tuned) and patients may have difficulties in attending a clinic that is held only once a week.

Further, the above-mentioned policy of TPO to use nonpharmacological forms of treatment whenever possible (particularly for minor mental health disorders) could result in more patients not returning when their expectation for the 'strong medicine' is not fulfilled. The high drop out for anxiety (53%) is significant in this respect. In those who do receive treatment with drugs, it is possible that, after receiving a tangible treatment, a series of pills, the patients and their families had 'got what they were looking for', that is, the modern western 'strong medicine'. In Cambodia, as in other developing countries, patients are inclined to take medication only while they feel or look sick and, once that stage is passed, they lose interest in going on with a treatment, especially if it is seen to induce unpleasant side effects. In treating the more disabling symptoms, TPO may be fulfilling its primary objective of helping the person to return to his or her normal role in the community. The initial reason these clinics were started by TPO, a community mental health programme, was to deal medically with those more severe mental health disorders that could not be managed within the community without drugs.

The high drop-out rate at Oudong (52%) was notable. In many patients, it was found that coming to the mental health clinic at Oudong was part of a complex health seeking behavior. Patients had over the years been to many healers, traditional as well as western. The high drop-out rates in epilepsy (14% in

Sangke and much more at Oudong), which needs long-term treatment and where stopping suddenly can be dangerous, is worrying. This may be a reflection of the beliefs and attitudes in the community which sees it as an incurable mental illness. For epileptic patients to have to come to psychiatric clinics to receive their drugs and to sit and wait with other patients with severe behavioural disorders, does not help at all. If the epileptic patients could be shifted to other clinics, at least for their follow-up treatment, it will help with their self-image and the attitude of others towards them. An attempt to organize this is being made at Sangke District Hospital psychiatric clinic, as part of a general move to refer all stabilized chronic patients to their local hospital for follow-up. The lowest drop-out rate was for schizophrenia (18%) which is perhaps the only other condition, with epilepsy, that needs and benefits immensely from long-term follow-up and drug treatment.

Conclusion

It is difficult to evaluate the outcome in a community mental health programme such as the one described in this paper. The preliminary results suggest that after the first flush of treatment, most patients improved to the extent that they could lead reasonably productive lives. Whereas earlier these patients had been a severe burden to their families and their community, not to mention their own suffering, they were now working and leading a satisfactory family life. That this could be done with cheap drugs and a mental health clinic that, so far, functions only once a week, shows what can be achieved with such little input.

The difficulties in starting mental health services in a low income country are well illustrated by the experience in the different hospitals. The experience reported in this paper demonstrates how the motivation of the staff running the clinic and the awareness of the local population are equally important determinants in the use of effective western psychiatric services. One evident outcome of starting western psychiatric clinics with the objective of providing a source of medication for the more severe mental illnesses in the community was that the clinic soon outstripped this basic function and began to attract all types of psychosocial problems.

The introduction of these psychiatric services needs to be seen from the framework of the Cambodian villager. When western-style psychiatry is added to the differing traditional resources already available, it offers solutions for some problems which the traditional healer could not remedy. The utilization of the service depends largely on the information people in the area have regarding mental health care. Local

health beliefs define health seeking behavior as much as other factors do. For some, such as in Oudong, the presence of a strong traditional sector excludes, at present, the clinic as a viable option for healing. For others, such as in Battambang, experience with previous mental health programs in the Thai border camps seems to have added the clinical approach to the range of resources for help. The fact that this added resource proves to be useful should not be taken hastily as a disqualification of the other resources. This new medical resource is in itself only a very modest beginning in the search for solutions for psychosocial problems in Cambodia.

People are trying to cope with the traumatic experiences of the past 25 years. In coming to terms with what happened to Cambodia and its people there are no clear-cut explanations, and much of the individual suffering does not fit in any of the existing 'explanatory models' used by patients and/or healers, in any sector. The individual and communal search for meaning was prevented by the uninterrupted sequence of events, from civil war, to Khmer Rousie terror, to Vietnamese occupation to continuing internal infighting. Correctly understanding the past became a political topic, where one man, Pol Pot, was made responsible for all that had happened, and a standardized view of events (Vickery, 1984) was seen as an efficient tool to manage emotions. Finding meaning for the events is still a problem for everyone — common villagers as well as the people who make up the different sectors of allopathic or traditional health care. At the commune level, this search for meaning is essential to come to terms with the past, and to prevent psychosocial and mental health problems from developing in the future. The toll of behavior-related problems on disability (Desjarlais et al., 1995) is threatening Cambodia perhaps more than anything else.

The problems people face are complex, and have many different aspects. A clinic can offer some relief for the mentally ill. If mental health services are integrated in a primary health care approach and strengthening of the public health services is successful, a useful addition to potential solutions can be created. The preliminary experience of the work in Cambodia supports the growing literature attesting the value of traditional healers as 'trauma therapists' in countries recovering from war (Taussig, 1986; Wilson, 1989; Gibbs, 1994; Bracken et al., 1995). It seems that they provide a means that for some is more agreeable than the methods brought by classical public health and psychiatry. Eisenbruch (1997) has described a classic sign of posttrauma among Cambodians, termed *kit craen* ('thinking too much') which can lead to *ckuet satey aarom* ('madness of the feeling') and, as many healers believe, rooted in a web of losses — of life and family, possessions, status. The explanatory models

used by the various healers, and the rituals used in the healing sessions of monks and *kruu khmer*, can show the links between illness and personal and community stresses like poverty, loss and hopelessness. We believe that when people are helped to find meaning for what has happened, they are better able to select the right resource for the right part of their problems. Clinical mental health services are one of many ways to help people find solutions.

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