Counselling in Cambodia: cultural competence and contextual costs

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The term 'counselling' is often used to describe psychosocial interventions. The concept appears to have different meanings to different people. In this contribution to this journal, we will describe an attempt to introduce a classical type of counselling, 'individual talk-therapy', in a psychosocial and mental health program in Cambodia. We use this example to explore two different aspects. First, we show how talk-therapy can be effective in a cross-cultural setting. Overcoming cultural barriers is possible, and in this sense we want to make a case for a 'culturally informed' design of intervention. Then, we will discuss the relevance of this intervention in the context of other interventions in the same setting. We shall also argue that this intervention is often not applicable for practical reasons, rather than cultural ones.

Psychological relief is becoming a normal part of the package offered in humanitarian aid. One finds group work, sports initiatives, education and teacher oriented interventions, creative and art-therapy, narrative theatre and exposure therapy interventions. There are also more clinical approaches, and a huge variety of other psychologically based therapeutic interventions. Current debate, about which interventions should be seen as 'psychosocial', and an increasing number of guidelines, are produced. The effects of the wide range of interventions offered by numerous organizations are not yet clear. One of the interventions most often discussed is counselling, as a form of brief supportive therapy based on verbal communication between individuals. The concept of counselling is becoming increasingly vague, as the core skills ascribed to counselling are also seen as essential for group work, psycho-education, and clinical care. While at the same time, practical lessons are learnt about the viability of individual, time-consuming therapies in situ with large numbers of potential clients.

In this paper we use the 'classical' concept of counselling, as 'talk therapy' between two individuals, as a point of departure. In the beginning phase of a mental health and psychosocial care programme in Cambodia we offered training in counselling skills to a core group of twelve Cambodians. This group were trained to be trainers. We were hesitant about the validity of the concept of non-directive talk therapy in Cambodia. Yet, we were also dissatisfied with the (sometimes) assumed inapplicability of the concept, based as it was on assumed cultural differences that had not been tested. In this paper we describe four social, cultural and historic reasons why counselling might not work in Cambodia. We then describe some aspects of the relationship between

traditional healers and mediums and their clients, in order to show how an understanding of these relationships was helpful in developing counselling as a new and effective intervention. The training for the Cambodian counsellors-to-be is described, their functioning and effect, as well as the insights we have generated from the overall experience.

'April 1, 1998. After two and a half days, that means 18 hours, of teaching on the subject 'psychological consequences of armed conflict' to fourth year students at the Royal University of Phnom Penh, I have started to discuss counselling with them. I just told them that in Western countries people were helped in overcoming their psychological problems through talking with a counsellor, e.g. a psychologist. They had heard about that. One of them said there was even a counselling centre in the university, staffed by teachers of their faculty who are also members of the core-group.

I told the students that I wanted to show them how counselling worked by doing a role-play. Then I asked for a volunteer who would play the role of someone having a personal problem. It did not take much time before one of the students accepted the invitation and came to the front. I played the role of a bad, dysfunctional counsellor. I behaved in a way that was disinterested, aloof, impatient and rather rude.

At first, the students stared in disbelief at my performance. Then smiles appeared on their faces. The interpreter, whom I had informed before about the way I would play the role, had trouble keeping a poker face. At that point I stopped the role-play. I explained that I had played the part of a very dysfunctional counsellor. The students obviously had guessed that already. Then I asked if some of them would try to improve my performance. Three students gave it a try. They demonstrated an attitude of patience. They showed sincere interest to the student playing the role of the client. They were very kind and respectful to him. So these students had a first, basic understanding of what it takes to be a

counsellor, before I had given any explanation about counselling' (Van der Veer, 1998a).

Psychosocial problems in Cambodia

The citizens of Cambodia have lived through years of horror. The Khmer Rouge period (1975-1979) is only one in a succession of extremely difficult times. The carpet-bombing in 1972 and 1973, and the continuous warfare and famine into the 1980s, are remembered by some as worse than the 'Pol Pot' years. Presently, landmines and poverty still pose severe problems for many. However, things are changing; the political situation is more stable than in decades before, and one could see the fact that corruption is being accepted, as an increasingly important problem is also a clear sign of relative normality returning to the country. Cambodians are looking forward to the possibility of an international tribunal – not because they expect justice to be done, but because such an event would finally mark the beginning of a period where they can try to come to terms with the past.

Practically every Cambodian family lost relatives and material possessions. Almost all citizens experienced relentless fear. People were systematically terrorized, social structures were destroyed and people learned not to trust others. The Buddhist clerics, the sangha, were ridiculed. Educational, economic and administrative systems had broken down abruptly. Year zero, as the anonymous '*angka*' ('organization') called it, was to be truly a start from scratch.

Those born after civil war and social terror are now growing up in a society where practically everyone has to cope with the continuing impact of these terrifying events. In communities where the psychosocial team has been active, no less than 10% of,

and often one out of five, families were dysfunctional according to the self-defined standards of the same community. Families were considered dysfunctional if the parents were unable to care for themselves and their children. Most people experienced overwhelming feelings of hopelessness and were caught in a vicious cycle of depression, poverty, and more depression (Van de Put et.al. 1998b).

A community mental health program

In order to deal with these problems, the Transcultural Psychosocial Organization (TPO) implemented a community mental health program. The program was to identify psychosocial problems and design appropriate interventions for primary, secondary and tertiary intervention. TPO started with a group of 12 Cambodian women and men in March 1995. In this article, this group of people are referred to as 'the core-group' (Van de Put et.al, 1996, 1998b; Somasundaram, 1997).

Counselling was one of the interventions developed by this core-group. It was defined as a form of brief supportive therapy, aimed at people burdened with psychosocial problems, or minor mental health problems, including post-traumatic complaints and symptoms. Counselling, as a form of therapeutic intervention based on verbal communication between individuals, was viewed as an approach that might, or might not, be relevant or appropriate in the Cambodian setting.

Counselling in Cambodia: would it work?

Counselling might not work in Cambodian society for several reasons (Van de Put et.al. 1998a). The first reason has to do with the possibility to talk about emotional experiences. Although life in small communities (*phums*) provides many opportunities for people to meet and talk, they also avoid talking about the emotions that haunt them. Entire communities had gone through similar experiences. Traditionally, help could only be asked from, and expected of, those in a more powerful position (the formal, or informal, community leaders). Social uprooting had taken place to such extent that the basic trust between ordinary villagers and these local powerbrokers had often been destroyed. The attitude is: one would not bother others with emotions which all shared. The historical potential of avoidance and denial in a country with low levels of social integration made it all the more difficult to open new avenues to new coping styles.

The traditional attitude towards dealing with conflicts was limited to preventing conflicts from going too far. Finding acceptable, 'face-saving' ways for all parties to let the conflict rest is still considered a more important goal than to 'track down the roots of the problem', and remove them.

The second reason to worry about the effectiveness of counselling in Cambodia has to do with the function of stories in Cambodian culture. During counselling, the client is invited to tell stories from his personal life. Oral legends and stories have always been important in Cambodia. Usually, stories are told again and again, and during this process they are reshaped. People tend to reconstruct the story of their own lives until it fits a socially desirable, standard story. The communist ritual of creating false autobiographies is also possibly reinforced in this tendency: in self-criticism sessions, or worse, in prisons under torture. A counsellor would have to be able to detect a personal truth behind the construction that was made to fit the prede-

fined, politically safe, and socially acceptable, repertoire. The 'obsession with truth', as some Cambodians qualified our expatriates wish to 'be clear', was not mirrored in the Cambodian versions of reality.

A third factor is the lack of social networks in Cambodian society. Stimulating the client to use resources in his social network was difficult. Traditional networks before 1970 did not extend very far, and political turmoil after 1970 included the deliberate destruction of these networks. Not only religious life and traditional rituals, but also social relations and family life, were disrupted. The loss of trust in other people that occurred after 1970 makes it hard to rebuild these contacts.

A fourth factor impacting applicability was the combination of fear of the consequences in being outspoken, and the fear of belonging to any group, be it only the group that was seeking counselling. This seemed a logical barrier to any new intervention. The suspicious aspect of entering into a healing relation that is new, and that lacked those elements of all known healing relationships such as: location, clear roles and expectations, confidentiality, and at least the beginning of a shared cosmology and understanding what would constitute a problem and a solution, was difficult to overcome.

Traditional 'counselling' and its limits.

These known healing relationships were found in the traditional resources for help and support. These include a range of religious, traditional and folk healers. Monks, *kruu khmer*, and mediums are the most common forms of healers, and the intervention of the mediums comes closest to what we define as counselling (Eisenbruch, M. 1992, 1994a, 1994b, 1996).

Mediums, often women but sometimes men, are sought for their advice on a wide range of problems. The more successful the medium is, the wider the range, but their expertise is clearly in relational problems. They help people find out the cause of their problem, and they offer advise for action. The medium stands out from other traditional, or religious, healers in verbal interaction with the client as they allow the client to speak at length about her/his problem. The medium is the way for the 'spirit', who represents the real healing power that works through the body of the medium to freely speak in response to the client's problems. Strict traditional hierarchy and related codes of conduct in speech do not apply to the spirit. This may lead to a 'breakthrough' in communication when a family situation seems hopelessly blocked.

The sessions are not expensive and may take up to an hour or more. When not in trance, before or after the session, the medium talks with the client in a relaxed way.

Given this variety of traditional resources, one might question the need for new interventions. But there are various limits to the healers' effects.

One of these is the fact that healers may themselves be severely traumatized. People providing help have themselves been part of the same history as their clients. For some of the healers, the events of the past decades have been especially difficult, because they were targets of prosecution, especially monks and traditional healers. For mediums, one could assume that because of the particularities of their 'vocation', they are even more likely to have the same emotional problems as their clients.

The traditional classification of personal problems used by the healers is also ill suited for dealing with problems arising in a rapidly changing society. In many discussions with different kinds of healers, we

were told that some healers are at a loss as to how to deal with the contemporary emotional problems they encounter. Within a small category of problems presented to the healer, the traditional taxonomy can be used to 'label' the patient. Then, by providing the treatment that fits the label, the patient is offered a framework of reference that helps in (perhaps temporarily, but renewable) coping with the problem. However, many problems in present-day Cambodia do not fit traditional Cambodian cosmology.

Also, there is the limited access for Cambodians to traditional healers. The composition of society has changed. Many people have been displaced, and continue to live in villages that are not their 'home ground'. In those villages, people have less access to local helpers.

These limitations of traditional 'counselling' show the need for new, effective, and culturally appropriate interventions. The elements of communication we detected in traditional healing helped us see that there was common ground that could be used to build. Apart from that, training people in counselling skills was a useful way of opening discussion with, and within, the core group. Issues such as: 'being a helper', limits to problem-solving capacity, labelling psychological distress, and manoeuvring between the explanatory models of clients, local resources available, and added value of psychosocial intervention were discussed. Counselling 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, such as listening skills, for helping in general.

Introducing counselling

One of the first barriers to overcome was the 'poverty trap', as we called it. In Cambodia, a helper is seen as somebody that gives material help or clear directives that are beyond discussion. Given the fact that many of the clients were desperately poor, the core group saw this as the first priority. Talk seemed cheap. Single headed households with a depressed mother needed urgent material help. The question centred on the circular relationship between poverty and depression, the potential for resilience, and the bare, basic fact that no help could ever be sufficient to deal with large numbers in this way.

In discussions with villagers, the members of the core-group began to see the multiple, mutually enhancing causes for problems. Poverty proved to be an effect as often as it was a cause. We saw how some clients' problems, such as poverty, depression, sick children, hopelessness and more were all intertwined.

We were beginning to realize that one could relate all the different problems of any client to different type of resources in the community. NGOs working in the area, covering such fields as health education, health care, family spacing, food programs, or initiatives on income generation. These do not yet exist everywhere, but what is available in every Cambodian community are the pagodas, the traditional healers, older people, teachers, and *phum* leaders. Reconnecting isolated clients to the available resources turned out to be not only possible, but also actually helped people reverse the cycle of increasing problems.

Another way of showing the core-group alternatives to material support was to start group sessions. Listening proved to be a very effective tool and a new experience for many of the core group members. The group setting allowed participants, often literally for the first time in their lives, to talk freely about their emotional problems. Life

stories were told over and over again. For many participants the possibility to talk, and being listened to, was the first and primary goal of the group sessions.

After these initial steps TPO invited the second author to provide further training for the core group members. Three conditions made this a strenuous process. First, most core group members did not feel as safe in a teaching situation that included activities such as group discussion of personal experiences and physical exercises for relaxation. Second, many of them showed strong resistance towards new, unfamiliar ways of looking at reality. Third, they had difficulty in accepting an approach toward helping that did not offer them a clear protocol, i.e. telling them exactly what to do under which circumstances.

When the trainer arrived, the core-group members had already seen the value of a few separate counselling skills, like listening and probing for information. These skills were used within the context of group-work, or in the provision of psychiatric care. However, there was still a high level of difficulty accepting that counselling in itself could be a healing activity. The expectation was focused on 'therapeutic tricks' that guaranteed instant results; in a similar way as some well-prescribed drugs can cure a psychosis within a few days. There was a demand for unambiguous, straightforward instructions. The trainer tried to convey the message that the counsellor offers his capacity for experiencing feelings and coping with emotions, in order to help the client face his own feelings. At the same time, he tried to make clear that counselling, at some level, is a planned and systematic activity.

The trainer presented a program based on international literature as well as his/her own clinical experiences as a psychotherapist with refugees. This program had been tried out before in various areas of armed conflict including: Sarajevo, Bosnia, and Jaffna, Sri Lanka. It focused on discussing the psychological consequences of traumatisation and uprooting for individuals and families. It was aimed at developing a common language for discussing both the psychosocial problems of Cambodian people and counselling techniques that could work in Cambodia. Last but not least, the training was aimed at promoting body-awareness and encouraging the use of body-oriented techniques, like relaxation and breathing exercises, within the context of counselling.

During the training, short informal lectures were alternated with structured group-discussions and practical exercises. The members of the core-group reacted with a waiting attitude. They seemed to be reluctant to enter into group discussions. They would follow the trainer's instructions to do the exercises, but initially in a manner that could be described as passive resistant. A few showed an attitude that seemed to be determined to prove that the trainer's knowledge and experiences were irrelevant for Cambodian daily life. Whenever the trainer tried to introduce a little piece of psychological theory, some of the core-group members showed reactions he had not experienced in other countries. This happened especially whenever he introduced a theoretical concept they did not know, or a set of theoretical categories. This always led to a seemingly endless series of questions in an attempt to formulate a precise and rigid definition of the concept in question. The core-group members seemed to be afraid to use the concepts in a 'wrong way', and that they might to be severely punished for being a dissident. They seemed to see theoretical concepts as traps one should map carefully, and then avoid.

They had difficulty seeing theoretical concepts as useful tools for a more detailed observation of reality. An additional problem was that the members of the core-group were not very eager initially to discuss personal experiences, personal feelings or personal opinions. If one of them overcame this hesitancy, he ran the risk of being ridiculed by the others.

It took about a week before the majority of the core-group members became really involved in the training. In other countries, this usually takes no more than one or one-and-a-half days.

The first training lasted two weeks. There were follow-up courses of one week every six months. During these courses a lot of energy was invested in promoting reflection on their work, in the core group, as counsellors through role-play, by discussing both successful and unsuccessful cases, and by writing reports.

Counselling in Cambodia: the state of the art

In order to describe how core-group members are using the skills they acquired, the follow quote is offered from a report on a follow up training presented in October 1998.

'Today I interviewed one of the senior core-group members on a case he considered to be successful. It was about a woman in her forties. The chief of the village introduced the counsellor to her, because she had done something that the villagers considered crazy. Some days ago she had jumped from the first floor while shouting, as if she were completely out of her mind. Before that no one had noticed anything was wrong with her. The counsellor had visited her in her house. On that occasion she had given the impression of being quite worried and dejected. The village chief suggested that she might need some medication. Her husband was worried that she might kill herself.

'I was wondering', the counsellor said to me, *'whether she was in a depressive episode and if I should take her to the psychiatrist for medication. On the other hand, jumping from the first floor does not really seem to be a serious attempt to kill herself. It looks more like a panic attack. I thought she might have had a flashback of some traumatic event. She made me think of another client that acted in a similar way. So I asked her what she had been doing just before she ran and jumped'.*

'She did not remember. But her husband did: he told me she had been watching television. He thought that maybe something she saw had scared her. I had to go back to the office then, but I promised to come again the next day'.

'When I saw her again, I suggested that she had been very afraid when she jumped. She said that was true. Then, I suggested that she might have been afraid like that before and asked her about her life in the Pol Pot time'.

'She told me that she had been working in a group of young women, digging trenches for irrigation. They had to work long hours, continuing after dark, digging with a hoe. She had been very afraid of demons, which according to local belief were hiding in the ground at night time. One night her hoe hit a stone that sent up sparks. It stuck to her hoe. She remembered the stories about evil spirits. In panic, she tried to get the stone from her hoe with her hand. But then it stuck to her hand. She managed to throw it off, but then it hit the clothes of another woman. The clothes caught fire. Then she had fallen unconscious. Later the people in her brigade had been very angry with her''.

'It must have been a piece of phosphorus', the counsellor said, 'after we had talked about this the lady seemed to be very relieved. I explained her that probably something on television in a way had reminded her of the Pol Pot time, and that therefore she had panicked. I told her that this can happen to anyone and that it does not mean that she is crazy. I explained this also to her husband. When I came to see her the following week, she had started working again in the paddy field. She did not look depressed at all' (Van der Veer, 1998a).

This example shows some of the abilities of the core-group. The counsellor was thinking in terms of psychiatric classification, and was actively excluding the possibility of Major Depression. He was comparing the pattern of the symptoms of the client to those of another client he had seen before, which is a traditional scientific activity of psychologists. He consciously reviewed the indications for referral to the psychiatrist. He also was thinking about the psychological background of the symptoms of the woman in question in terms of traumatic events. He was aware of the relation between present symptoms and experiences many years ago. He obviously also understood that present day events can trigger traumatic memories.

His counselling techniques included problem analysis, situation analysis, incident exploration, detailed discussion of a traumatic memory, and giving reassurance through psycho-education (Van der Veer, 1998b).

This is only one example. If one discusses cases with core-group members, they appear to use a much wider variety of counselling techniques. Moreover, they are now able to reflect on the causes of counselling contacts not being effective. For example, they understand very well why some clients did not return after an initial interview (Van der Veer, 1998a). They are not afraid to admit mistakes and are also very professional. Thus, they are able to learn from their mistakes.

Core-group members today are involved in counselling contacts of up to about 15 sessions, with frequencies varying between twice a week and once a month. TPO Cambodia organizes referral of clients to doctors for medication or a second opinion. They discuss cases in regular team meetings, and have access to regular professional support by psychologists and psychiatrists. Some have further specialized in attending special categories of clients including: landmine victims, terminal aids-patients, homeless women, and so on.

Discussion

Introducing counselling skills to the core group proved to be successful after four years. All members were tested by international, independent experts, and passed strict tests. Senior core-group members now function as adequate professional helpers. They are effective in supporting clients with a variety of complaints, symptoms and problems, such as: physical complaints without an identifiable physical cause, post-traumatic symptoms, depressive complaints, marital problems, substance abuse, and so on. Also, they have been able to share their knowledge with new, 'junior' members of the core-group who seem to acquire counselling skills quicker then the senior members themselves did. Last, but not least, all core-group members seem to be better equipped to deal with their own problems related to traumatic experiences in the past. Most of them are able to discuss their own traumatic experiences, without getting overwhelmed by emotion. This ensures they are also able to cope with the emotional stories of their clients.

There is no doubt that 'individual talk-therapy' works in Cambodia. The barriers that we encountered were successfully overcome. But the overall cost-effectiveness needs to be measured according to a broader set of criteria. General public health criteria are similar to any public service. If we want to introduce counselling as an intervention that is used in any public service delivery system, we need to think about the availability, accessibility, affordability, accountability and acceptability of this service for the clients of the public sector.

The availability poses the first problem. To make the counselling service available to the population at large – which is justified on the basis of the epidemiological data (De Jong, Komproe, van Ommeren, El Masri, Araya, Khaled, van de Put, & Somasundaram, 2001), massive numbers of people would need to be trained. There are no means to do this. The accessibility is therefore limited. In general terms, accessibility should be easy established: we have taken counselling sessions into the villages, using any public space that would offer a minimum of privacy for client and counsellor. That is not the problem, it is the sheer lack of trained counsellors, and the cost of training larger numbers, that will keep quality counselling accessible to only a small minority of the population. The affordability can be looked at from a supply and the demand perspective. Training and salary of counsellors, administrative and organizational costs, are impossible to add to the already insufficient budgets of the public health sector. Social services are even lower on funds. One could also question the moral value of training people in skills, which they will never be able to use in a professional, independent setting (that is, after the external funding has dried up). Content-wise, accountability remains a problem as long as correct supervision and monitoring is limited to those programs that have staff available to carry out the work. Acceptability has proven to be within reach in cultural terms - but as long as the service is provided for free, we cannot really be sure whether it has a chance to become a sustainable intervention.

Conclusions

Introducing counselling, in the sense of a healing relationship through 'talking and listening' between a counsellor and an indi-

vidual patient, can be an effective therapy in countries such as Cambodia. It is possible to cross cultural boundaries, but there are other elements that pose problems in implementing the technique of individual counselling. It is not easy to measure the effects of individual counselling. It is very difficult to install sustainable public counselling services. Also, with a limited number of counsellors, few people can be helped and mechanisms for selecting these few have not been developed. What can, for example, four trained counsellors accomplish in a refugee camp with 100.000 traumatised inhabitants?

Individual counselling as an intervention needs to be studied in its feasibility as a sustainable element within a public or private service, before relatively large sums of money and time, are spent on training people to be counsellors.

That does not undermine the value of certain important 'counselling-skills' that are – or should be – part and parcel of any training for psychosocial workers. The skills of active listening and the ability to reflect on one's own thoughts, feelings and personal history (including their alarming features) are essential for psychosocial workers involved in group work and community interventions. Expatriate trainers that introduce local psychosocial workers to these skills need to be aware of the cultural barriers they may encounter. In working with their trainees to develop a locally valid, culturally informed curriculum and training modules, these trainers will need all the listening skills and self-reflection they can muster to come to effective results.

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