A Qualitative and Quantitative Investigation into Ethno-Cultural Framing of Trauma in Cambodia: *Baksbat* (broken courage), a Cambodian Trauma Syndrome akin to PTSD

Sotheara Chhim
MD, MPM, Senior Consultant Psychiatrist

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School of Social Sciences
Faculty of Arts, Monash University, Melbourne, Australia
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Abstract

The impact on the human psyche, body and emotions in those who endure major traumatic events is well documented, regardless of whether trauma is human induced or the result of natural disasters. In particular, symptoms leading to depression, anxiety, and posttraumatic stress disorder (PTSD) have been linked to traumatic events. PTSD was developed in the United States initially following the documentation of traumatic symptoms in Vietnam veterans after they returned home from the war. Similarly, the diagnosis of PTSD is widely used across Asian countries, and in Cambodia specifically. PTSD diagnoses are reinforced in medical, clinical and academic training programmes, as well as in research designs and outcomes. More profoundly, the diagnosis of PTSD was highlighted by foreign experts after their psychiatric, forensic evaluation of survivors of the Khmer Rouge genocide; their findings underscored testimonies during hearings in the Extraordinary Chambers in the Courts of Cambodia (ECCC). This study set out initially to determine the discrepancy between descriptive analyses of PTSD, and lived experiences of Cambodian survivors of the Khmer Rouge. Despite studies on idioms of distress in non-Western cultures, few ethno-cultural studies capture fully the trauma response set of symptoms in the context of Cambodians' post-genocide history. Given the dearth of assessment infrastructure for the Cambodian context, this study was designed with three objectives: 1) to explore the meaning of trauma and the ethno-cultural range of responses to distress, including *baksbat* (broken courage) for those living inside Cambodia; 2) to develop and validate an inventory to measure ethno-cultural conditions and expressions of *baksbat*; and 3) to increase the cultural competency in particular on *baksbat* to local and foreign mental health workers who are practicing and researching in Cambodia.

This study used a progression of qualitative and quantitative mixed-methods that started with ethnographic interviews and focus groups in order to unfold the ethno-cultural meaning of trauma; validation of the inventory followed. The focus group discussions were conducted with 53 experts in order to understand the *baksbat* domain from their overlapping and individual perspectives of context, content, and process. Thematic analysis of the interview data assisted

the item development of the first inventory designed to measure the *baksbat* complex. That inventory for *baksbat* was administered to a clinical sample inside Cambodia in order to validate the clustering of items. Cambodian psychiatric research is validated mostly on former refugee populations residing outside Cambodia, so a baseline sample taken from inside the country was essential to its cultural reliability.

From these objectives, the author published three related articles in peer reviewed journals that are attached inside the thesis. The first article was about the understanding and the analysis of the ethno-cultural concept of *baksbat* from a social, historical, political, medical and etymological perspective. The author also compared the overlapping symptoms between *baksbat* and PTSD in terms of symptomatology, causation, and treatment. The second article described the development and validation of the *baksbat* inventory using statistical measures, exploratory factor analysis (EFA) to explore the factor loading, and confirmatory factor analysis (CFA) to confirm the validity of the inventory. This article establishes the development and validation of the *baksbat* inventory. The third article was written about the application of *baksbat* as an ethno-cultural condition. Herein, its use offered real practice potential in forensic, clinical, research, and education about transcultural trauma in Cambodia. The author cautioned that foreign experts used PTSD criteria to support their forensic evidence, but because of the lack of cultural sensitivity of PTSD criteria, it may have failed to capture trauma symptoms among survivors. In his third article, the author recommends the use of *baksbat* together with PTSD criteria in giving forensic evidence; also, the author demonstrated its use when testifying as an expert witness on psychological trauma on survivors of the Khmer Rouge regime at the Extraordinary Chambers in the Courts of Cambodia (ECCC) on the 4th and 5th June 2013.

The three published articles presented in this thesis correspond to the three broad aims of this study. This study was exploratory and confirmatory, as there have been no prior systematic and in depth studies conducted on this topic among the Khmer population in Cambodia. The findings show that PTSD and *baksbat* criteria combined represent better Cambodian survivors

descriptive symptoms of trauma. This ethno-cultural syndrome, *baksbat* provides new knowledge for application on cultural aspects of trauma and mental health in Cambodia. In addition, there is broad scope for other former Cambodian refugees who are living abroad, and for others living in non-Western or Buddhist contexts. These findings bring us another step closer to representing human experience more fully in this long journey across the fields of transcultural psychiatry and traumatic studies.

Papers published during the candidature:

1. Sotheara Chhim, Psychiatry, Psychology and Law (2013): A Place for *Baksbat* (Broken Courage) in Forensic Psychiatry at the Extraordinary Chambers in the Courts of Cambodia (ECCC). *Psychiatry, Psychology and Law*, DOI: 10.1080/13218719.2013.809652.

2. Chhim, Sotheara. (2013). Baksbat (broken courage): A Trauma-Based Cultural Syndrome in Cambodia. *Medical Anthropology*, 32(2), 160-173.

3. Chhim, Sotheara. (2012). Baksbat (broken courage): The development and validation of the inventory to measure baksbat, a Cambodian trauma based cultural syndrome of distress. *Culture, Medicine and Psychiatry*, 36, 640-659.

While conducting this research, several book chapters and journal articles were co-authored.

Meyer, R. S.; Robinson, C.W.; Chhim, S.; & Bass, J.K. (2014) Labor migration and mental health in Cambodia: a qualitative study. *The Journal of Nervous and Mental Disorder*. DOI:10.1097/NMD.0000000000000101.

1. Poluda, J., Strassor, J., and Chhim, S. (2012). Justice, Healing and Reconciliation in Cambodia. In B. a. P. Charbonneau, Genevieve (Ed.). *Peace Building, Memory and Reconciliation: Bridging Top-Down and Bottom-up Approaches*. Montreal: Rutledge.

2. Stammel, N., Heeke, C., Bocker, E., Chhim, S., Taing, S., Wagner, B., and Knaevelsrud, C., (2012). Prolonged Grief Disorder Three Decades Post Loss in

Survivors of the Khmer Rouge Regime in Cambodia. *Journal of Affective Disorders*. 144(1-2), 87-93.

3. Strasser, J., Poluda, J., Chhim S., Phuong, P. (2011). Justice and Healing At The Khmer Rouge Tribunal - The Psychological Impact Of Civil Party Participation. In: Van Schaak, B., Reicherter, D. & Chhang, Y. (ed.). *Cambodia's Hidden Scars: Trauma Psychology in the Wake of the Khmer Rouge*. Documentation Centre of Cambodia.

4. Nigel P. Field & Sotheara Chhim (2008). Desire for Revenge and Attitudes Toward the Khmer Rouge Tribunal Among Cambodians. *Journal of Loss and Trauma: International Perspectives on Stress & Coping*, 13:4, 352-372, DOI:10.1080/15325020701742086

5. Field, P.N., Strasser, J., Taing, S., Horiuchi, S., Chhim, S., and Packman, W., (2014) Prolonged grief following the recent death of a daughter among mothers who experienced distal losses during the Khmer Rouge era: Validity of the prolonged grief construct in Cambodia. *Psychiatric Research*. DOI:10.1016/j.psychres.2014.05.014

6. Stammel, N., Bocker, E., Neuner, F., Chhim, S., Taing, S., and Knaevelsrud, C. "The Readiness to Reconcile Inventory: Assessing Attitudes Toward Reconciliation in Victims of War and Conflict". This manuscript is submitted to the *European Journal of Psychological Assessment* in June 2014.

Award received during the candidature

Dr. Chhim Sotheara received the *Annual Human Rights Award for 2012* from the Leitner Center's for International Law and Justice at Fordham Law School, Fordham University in New York City, USA. The Award recognizes the exceptional work of Dr. Sotheara and his team at TPO Cambodia in working to address the needs and rights of those suffering from the aftermath of trauma and compromised mental health. This Human Rights Award encourages Dr. Sotheara and TPO Cambodia to continue to strive toward helping Cambodians achieve the highest attainable standards of mental health and to better their quality of life.

General Declaration

Monash University

Monash Research Graduate School

Declaration for thesis partially based on conjointly published work. In accordance with Monash University Doctorate Regulation 17/ Doctor of Philosophy and Master of Philosophy (MPhil) regulations the following declarations are made:

I hereby declare that this thesis contains no material which has been accepted for the award of any other degree or diploma at any university or equivalent institution and that, to the best of my knowledge and belief, this thesis contains no material previously published or written by another person, except where due reference is made in the text of the thesis.

This thesis includes three original papers that have been published in peer-reviewed journals. The core theme of the thesis is the study on ethno-cultural responses to trauma in Cambodia – a trauma based cultural syndrome call *baksbat* literally translated as 'broken courage'. The ideas, development and writing up of all the papers in the thesis were the principal responsibility of myself, the candidate, working within the School of Social Sciences, Faculty of Arts, Monash University, under the supervision of Associate Professor Peg LeVine, and Emeritus Professor David Chandler.

I myself am the sole author of the three articles, however, my work has been completed in consultation with my supervisors, who assisted me in the following areas: design of the study, review of the literature, obtaining approval from relevant ethics committees, collection of data from the first group participants, feedback on writing of articles and chapters of this thesis.

The extent of my contribution to each publication is reported below.

Article	Publication title	Publication status	Extent of candidate's contribution
Article 1	*Baksbat* (Broken Courage): A Trauma-Based Cultural Syndrome in Cambodia	Published	100%
Article 2	*Baksbat* (Broken Courage): The Development and Validation of the Inventory to Measure *Baksbat*, a Cambodian Trauma-based Cultural Syndrome of Distress	Published	100%
Article 3	A Place for *Baksbat* (Broken Courage) in Forensic Psychiatry at the Extraordinary Chambers in the Courts of Cambodia (ECCC)	Published	100%

Signed:…  …… .

Date:……14 July 2014……

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I love Australia! Australia and Australian people are always in my heart!

Thank you very much.

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OVERVIEW OF THE THESIS

This thesis is presented as a collection of three inter-related articles published in juried journals in the fields of trans-cultural psychiatry and legal studies. In this regard, the reader is invited to review briefly the titles and abstracts of the articles in Section Two of this thesis at the onset. Such an initial overview of the key themes under study assists in integrating the three sections as well as the conclusion. An overview of Section One, Two and Three is described below.

SECTION ONE: This section is compiled into four chapters.

Chapter One presents the historical context from which this study emerged as well as the geopolitical background of the genocide in Cambodia. Suffering is on-going across generations and mental health and psychosocial problems are acute and chronic. To date, psychosocial problems among Cambodians are rarely captured fully by the internationally standardized criteria of diagnoses found in the United States and Europe. Delegates of the United Nations and foreign university researchers often impose the boundaries of trauma symptomology. As background for discussion, a brief review of criteria normed in Asian countries is presented.

Chapter Two provides a review and analysis of the literature on the history of trauma, Post Traumatic Stress Disorder (PTSD), and the national and international prevalence of PTSD. The discrepancies between the prevalence of PTSD amongst the Cambodian Diaspora, the Cambodian population in Cambodia and its prevalence in the mental health clinics will also be discussed and analysed. A discussion is taken on different types of cultural syndromes, internationally. In addition, the author provides an overview of a Cambodian domain of trauma responses, *baksbat*, and a rationale for its use as a trauma-based cultural syndrome akin to PTSD that emerged initially from a male sample in the United States. The author uses multiple sources of explanations across etymological, social and historical contexts to describe what *baksbat* means to Cambodians.

Chapter Three presents research methods that informed outcomes in the thesis journal articles; these were based on a mixed research method and grounded theory. An ethnographic approach assisted an understanding of the concepts under study, from which an inventory emerged for the *baksbat* cultural syndrome.

Chapter Four presents the study's findings and descriptions of the trauma-related syndrome, *baksbat*, while revealing the relationship between *baksbat* and other disorders, such as anxiety, depression, and PTSD.

SECTION TWO

Chapter Five Published articles that emerged from findings in this study are collected in this section for the reader's review.

SECTION THREE

Chapter Six This chapter presents the conclusions and closing notes. It brings the trauma syndrome, *baksbat*, into the mental health field in Cambodia, with prospects for international use. Conclusions, limitations and recommendations are presented for future research consideration.

SECTION I:

This section is compiled into four chapters.

Chapter 1: Contextual background and rationale for the study

1.1. Cambodian tragic history

Several factors influenced and motivated me towards this study. The most lingering of these has been the tragic history of war and genocide in Cambodia since the late 1960s. Secondly, my personal experiences as a child slave in the children's work camps under the Khmer Rouge and as a survivor of the Khmer Rouge regime provided a unique insight into the ways culture interfaced with the experienced depths of trauma. Finally, my professional experiences as a psychiatrist in Cambodia who has been providing mental health care for survivors of the Khmer Rouge regime moved me to become more knowledgeable of the trauma literature. That said, I became sensitised to the absence of culturally-reliable research that informs treatment of trauma in the Cambodian context. The intersection of these three factors led me eventually to this research study.

More personally, I had never wanted or intended to become a doctor. Indeed, since my childhood I had always dreamt of becoming an architect or perhaps a construction engineer who could design or build beautiful tall buildings in Phnom Penh. I admit that the Khmer Rouge changed my dream forever. The regime systematically targeted and killed many physicians as well as other professionals. Those who did survive physically lived and survived most often inside deeply-gouged psychological and emotional scars. All Cambodian survivors have strong memories and images of members of their families, villages and communities dying needlessly – by starving, working to death, being tortured, killed, or mistreated medically. Those who returned home alive did so in great despair, desperately shocked, hungry, and sick. The hospitals rapidly filled with patients where few 'professionally trained' medical staff available to take care of them. It is estimated that only about 43 medical doctors out of 450 existed before early 1975s survived the regime in the whole country (Chy, 2007).

While they were sick and traumatised themselves, they tried to care for the millions of other Cambodians who were ill.

Most personally, it was my mother who insisted that I follow a career as a doctor because she thought that, in the extremely difficult times that followed the Khmer Rouge years, at least I would be able to help our family members as well as others when they were sick. I could not disobey my mother's advice, and so I pursued her dream. I began my study in medicine in 1986 and graduated as a medical doctor in 1992. Two years later, in 1994, I enrolled in a post-graduate training program on psychiatry organized by Oslo University, Norway and the University of Health Sciences of Cambodia. I became one of the first ten graduating psychiatrists in Cambodia in 1998.

I have no doubt that Cambodia's turbulent past influenced my decision to pursue psychiatry, instead of another specialty of medicine. In the 1960s, Cambodia was named, 'Island of Peace' when other countries in Indochina were engaged in war. Such a title had little meaning for me, since Cambodia was dragged into the Vietnam war in the early 1970s, an event which was associated directly with the genocide committed by the Khmer Rouge communist regime. As a result, perhaps as many as two million people, approximately 25% of Cambodians at that time, were killed or died from malnutrition, forced work, illnesses, torture and systematic execution and about half a million more scattered into exile as refugees in other countries (Chandler, 1998), (Kiernan, 2002). Cambodian people call this period the *Mahantdori*, meaning the time of great destruction. In Khmer, the word *Mahantdori* denotes a complete loss of all of one's reality, which is greater than the loss of institutions and material possessions. Experiencing *Mahantdori* changed the face of the Cambodian family and nation, permanently (Kuoch, Miller, & Scully, 1992). Many Cambodians relate events that subsequently happened during the Khmer Rouge period to the prophecy of *Pûtth tûmneay* (prediction or prophecy of the Buddha) I heard of *Pûtth tûmneay* when I was a young boy, but I

only remembered it vaguely before the fall of the country in 1975. The *Pûtth tûmneay* makes the following prediction.

"The darkness will settle on the people of Cambodia, there will be houses but no people in, roads but no travellers upon, the land will be ruled by Barbarians with no religion, the blood will be so high to touch the belly of the elephants, only the deaf and mute will survive" (Kuoch et al., 1992, p. 334).

A Khmer Rouge spokesperson said in the radio broadcast in the morning of 17 April 1975 that "over two thousand years of Cambodian history" had ended (Chandler, 2000), with everything successfully destroyed by the Peoples' Revolutionary Forces. The Khmer Rouge communist regime ruled the country for three year eight months and twenty days. This period has been known in the media as the "Killing Fields". All in all, the Khmer Rouge behaviour matches that predicted by the *Pûtth tûmneay*. Even after this regime was defeated in 1979 by Vietnamese forces, the Khmer Rouge retained a strong guerrilla force, which continued to fight with the government for more than twenty years.

1.2. Brief History and the Mental Health Aftermath of the Khmer Rouge

The legacy of the Khmer Rouge and civil war has left Cambodian survivors suffering from various psychosocial and mental health problems. Cambodia and its people have had to rebuild their nation from the ashes of the genocide. Cultural infrastructure, family, community, religious, economic, health, education and ecological systems were destroyed or severely damaged under the Khmer Rouge regime. Even today land-mine deaths accidents are reminders of the disruptions. Intellectuals, people living in urban areas or under the government controlled areas were referred to often as 'new people', while educated professionals and Buddhist monks were subjected to execution by the Khmer Rouge who

considered them to be leeches that suck the blood of society and to be the enemies of the revolution.

People were forced to evacuate from all towns and cities to live in the rural areas and work in extremely harsh conditions as slaves in exchange for a very little food. Torture and systematic execution were rampant so that people lived in constant fear. Everyone in Cambodia who has lost family members and survivors can give vivid descriptions of Cambodia as a country that is full of blood, bones and tears: 'the blood flowed like a river stream and bones were piled like mountains,' and the whole population became 'prisoners in the prison without walls'.

The magnitude of the *Mohandori* extended in Cambodian society from micro to macro levels. In a study of 650 families with approximately 1,400 people in 3 districts in Cambodia, van de Put and Eisenbruch (2002) found that many suffer from a variety of many health problems including psychoses, depression, alcoholism, domestic violence, marital problems, sadness and anxiety. It is estimated that one out of five Cambodians suffer from mental health and behavioural problems, ranging from mild to severe (van de Put & Eisenbruch, 2002). Domestic and community violence are widespread and relate often to alcoholism. One study on domestic violence by the Cambodian NGO (non governmental organization), Program Against Domestic Violence, found that one out of six Cambodian women experience domestic violence perpetrated by their husbands who abuse alcohol (PADV, 1996). Similarly, A ten year follow-up study conducted by the Ministry of Women's Affairs (2005) showed that 64 % of the population knows of a man who physically abuses his wife. A more recent study shows a 16 % decrease in families experiencing domestic violence (Bihler, 2010). Even with a recorded improvement, these statistics indicate that the level of violence in Cambodian society is still quite high even decades after the Khmer Rouge. This violence can easily be attributed to the

past turmoil in Cambodian history and the aftermath of people being unable to lead productive lives within their families or communities.

In a post war reconstruction process, there were many efforts to rebuild mental health systems in Cambodia. International NGOs (INGO) started a range of mental health services to address the on going trauma in our country. During the Khmer Rouge, the only two psychiatrists who existed before 1975 were killed along with other mental health professionals. Also, the only Mental Hospital called Prek Thnoat Hospital (located in Takhmao Town, Kandal province) was used as "Re-education Camp" by the Khmer Rouge. Re-education meant brainwashing, and this was a prison camp under the Khmer Rouge). And while it was reopened as a general hospital, there were no mental health services provided.

In order to address the dire need for training of mental health professionals, the University of Oslo in Norway began a program inside Cambodia through the International Organization for Migration (IOM). This initiative was led by Professor Edvard Hauff (currently the Head of the Institute of Psychiatry, and Dean of Oslo University). IOM organized a postgraduate training programme in psychiatry in 1994, which was previously known as the 'Cambodian Mental Health Training Program' (CMHTP) when it was an institute that trained medical doctors in psychiatric medicine (Hauff, 1996). This author was included in the first group of doctors trained under this program. The Transcultural Psychosocial Organization (TPO, 2008) began through the support of the organisation based in Amsterdam, the Netherlands. TPO has implemented community mental health and psychosocial programs since 1995 (Somasundaram, 1999). In addition, since 1992 the Social Service of Cambodia (SSC) formerly known as Khmer Buddhist Society (KBS) that was based initially in Seattle, USA, has provided social services to mentally and socially compromised and traumatised people.

This author was among the first players in the field of mental health within Cambodia. In this way, a lived history provides insights into the on-going challenges for survivors. The author was fortunate to study under the CMHTP's specialist training program of the University of Oslo This gave him insights into the cultural challenges for service delivery in Cambodia as poverty and other realities are rarely considered in most medical programs. Most of the lecturers and professors were Western scholar-practitioners who introduced biomedical models in psychiatry (called the bio-psycho-social model) as the basis for the program. This biomedical model consists of symptom-based criteria that describe symptoms/problems experienced by people in the USA and Europe in particular. Although this gave the author and other psychiatric residents a sound foundation for assessing and treating the spectrum of mental health problems, the assessment criteria lacked transfer for identifying and treating trauma-based syndromes of people living in the context of Cambodia. And though the training program was Cambodian based, there was little supervision and training that adequately addressed indigenous psychosocial health.

Despite the effectiveness of this programme in treating hundreds of thousands of psychiatric patients from all over the country, most patients from those early years continue to receive treatment up to the present day. These patients have seldom been discharged and the numbers of patients continues to grow every year. This may be because therapists only deal with biological parts of the problems, which reduce symptoms through the prescription of medication, but they rarely look into how to deal with complex issues of psychosocial, cultural and spirit-related components and deal with them accordingly. It may also be that, because the approach that therapists are trained to use in the Western contexts shows reduction in symptoms, without being culturally sensitive to Cambodian patients' experiences. Also, many Cambodian psychiatrists, through their Western training, have begun to see their patients' stresses and treatments for such through Western lenses (Aleshire, 2007).

When Cambodian psychiatrists and psychologists are trained in the Western methods of assessment and treatment, they may not have learned how to adapt culturally responsive methods to the local context. In this regard, Huot and LeVine, (2000) stated that foreign countries have been assisting the education and training inside and outside the country, but that this assistance may be culturally compromising, particularly when foreign trainers are fully aware of the Cambodian culture, and over or under estimate indigenous understanding of dis-order. In particular, researchers and practitioners may not account for ordering and disordering phenomena in these environments, including the power of spirit phenomenon and protective rituals.

The above statements are supported by other experts in transcultural psychiatry such as De Jong (2001) and Littlewood (1991). They contend that we may all agree that western psychopathologies play an important role in helping people with mental health problems, but various idioms of distress, as well as illness factors, are culturally specific and better explained within a socio-cultural paradigm. In addition, other authors agree that the international standardisation of diagnoses conceals cultural and historical specifics of psychiatric classification and undermines the validity of non-western culture (Brody, 1994).

In order to deal with these issues, it is necessary to study the cultural aspects of mental health and psychological responses to trauma in the Cambodian context in order to understand the cultural issues of illnesses and disorders that would help people to find better ways to cope, and to treat mental health problems in Cambodia. Patel (2007) suggests that learning about ethno-cultural aspects of mental health can allow us to identify the factors which promote mental health and prevent illness.

Overall, people with different cultural and geographical backgrounds have varied ways of relating to their social and physical environments, and experiencing emotions and expressing feelings and thoughts. Also, some psychological disorders tend to be identified and treated

according to cultural influences. Thus in order to understand health and illness behaviour in any group, we must study such health, illnesses and disorders within their cultural context.

For these reasons, the author set out to study collective and individual experiences and expressions of trauma within the Cambodian cultural context. This study was designed to advance an understanding of the Cambodian peoples' references to trauma in Khmer language. Overall, Cambodian survivors of the genocide refer often their suffering of *baksbat*, which has been determined to be a Cambodian trauma syndrome. This thesis has been formatted around three published journal articles in the areas under investigation. The contents of this thesis are presented in the following ways:

Chapter 2: Review and analysis of literature

There have been increasing interests in the intersectional studies in anthropology and medicine, across mental health topics in recent years. More and more scholars are challenging the notion of the universality of the psychiatric diagnosis, Post Traumatic Stress Disorder (PTSD). Summerfield (2000), for example, contends that Western diagnostic criteria do not capture adequately the range of human responses to traumatic events outside Western contexts. In this regard, social and cultural contexts influence symptom presentations, as well as the experience and expression of suffering across different cultures and geographies. This chapter examines research that shows variations across Western and non-Western diagnostic categories with regard to trauma aftermath. Alongside a brief review of the history and conceptualisation of trauma and PTSD, international prevalence of occurrence will also be highlighted.

To date, much of comparative research related to this study was derived from Cambodian refugees living overseas who have been surveyed by Euro-American researchers who use Western criteria. Additionally, trauma-based studies on Cambodians livening inside Cambodia have been mostly designed and evaluated by USA and European academic teams. This review

of literature aims to take these comparative limitations into account. The discrepant cultural reliability within and between the prevalence studies is noted. It is only recently that increased efforts to develop culturally sensitive tools for non-Western culture have been reported. This author outlines various cultural syndromes reported outside Cambodia. From such a review, the Cambodian concept of trauma responses called *baksbat* is highlighted for discussion. Its etymological, ethno-medical, social and historical origins and its impact on Cambodian society today are discussed. This literature review supports the author's efforts in designing a study to assist the reliable and valid development of *baksbat* as a Cambodian ethno-cultural syndrome of distress.

2.1. Historical Origins of Trauma and Post Traumatic Stress Disorder (PTSD)

According to the New Oxford American Dictionary, the notion of trauma drives from a Greek term, *'τραῦμα'* which means 'a wound'. While the term 'trauma' is widely used by the medical profession to refer to physical injuries, it is only since the 1980s that psychological trauma has been included. Psychological trauma is an experience that includes emotional pain and distress, or neurological and psycho-emotional shock, which may result in lasting mental and physical effects. Psychological trauma is essentially a normal response to an extreme event. It involves the creation of emotional memories about the distressful event that are stored in structures deep within the memory sites of brain. In general, it is believed that the more direct the exposure to the traumatic event, the higher the risk for emotional harm (Mollica, McInnes, Poole & Tor, 1998; Hollick & Cornelly, 2010).

PTSD is a condition marked by the development of symptoms after exposure to traumatic life events. The person reacts to this experience with fear and helplessness, persistently relives the event, and tries to avoid being reminded of it.

During the American Civil War, the trauma-based condition was first called "*soldier's heart*" because of the presence of autonomic cardiac symptoms suffered by soldiers who witnessed and experienced horrifying events. Jacob DaCosta described soldiers with the syndrome as "Irritable Heart" (Sadock, 2007, p. 612). In the 1900s, due to the strong influence of psychoanalysis, particularly in the United States and its connection to Europe, clinicians applied the diagnosis of traumatic neurosis to the condition. In World War I, the syndrome was called *shell shock* and was hypothesised to result from brain trauma caused by exploding shells.

World War II veterans, survivors of Nazi concentration camps, and survivors of the atomic bombs in Hiroshima and Nagasaki had similar symptoms related to *combat neurosis* or *operational fatigue*. However, those surviving the European Holocaust and the atomic bombings in Japan have had the resonance of "generational trauma' akin to that suffered by those of the Cambodian genocide.

It was not until American researchers focused formally on the psychiatric symptoms of American Vietnam War veterans that the concept of PTSD was introduced as a psychiatric diagnosis in 1980 in the Third Edition of the Diagnostic and Statistical Manual of Mental Disorder (DSM-III) by the American Psychiatric Association (APA, 1987). Although a controversial diagnosis when first introduced, PTSD has come to fill an important gap in psychiatric theory and practice. From an historical perspective, the significant change made by the inclusion of a formal trauma category was the stipulation that the etiological agent of harm was outside the individual (i.e., the traumatic event) rather than an inherent individual weakness or disturbance (i.e., a traumatic neurosis). The key to understanding the scientific basis and clinical expression of PTSD is the concept of "trauma."

In its initial DSM-III formulation, a traumatic event was conceptualized as a catastrophic stressor that was outside the range of usual human experience. The framers of the original PTSD diagnosis had in mind events such as war, torture, rape, the Nazi Holocaust, the atomic bombings of Hiroshima and Nagasaki, natural disasters (such as earthquakes, hurricanes, and volcanic eruptions) and human-made disasters (such as factory explosions, airplane crashes, and automobile accidents). They considered traumatic events as clearly different from the very painful stressors that constitute the normal vicissitudes of life such as divorce, failure, rejection, serious illness, financial reverses and the like. This dichotomization between traumatic and other stressors was based on the assumption that although most individuals have the ability to cope with ordinary stress, their adaptive capacities are likely to be overwhelmed when confronted by severe traumatic stressors.

The DSM-III diagnostic criteria for PTSD have been revised across time, such as in the DSM-III-R (1987), the DSM-IV (1994), and the DSM-IV-TR (2000), and the DSM-V (2013). A very similar syndrome is classified in WHO's International Classification of Disease 10th Edition (ICD-10). Diagnostic criteria for PTSD include a history of exposure to a "traumatic event" and symptoms from each of three symptom clusters: intrusive recollections, avoidant/numbing symptoms and hyper arousal symptoms. There are very few changes in the recent and DSM-V (2013), other than a fuller description of accompanying dissociative symptoms and revisions to childhood trauma symptoms. It remains unclear how the diagnostic criteria of PTSD will evolve in the upcoming ICD-11, which will be ready by 2015.

2.2. Challenges in Diagnosis of Complex PTSD Across Cultures

There are specific time criteria in assessing PTSD that may be suggestive of cultural influences. For instance, the diagnosis requires evidence of symptoms lasting for more than a

month after the event and must significantly affect important areas of life, such as family and work. It is noted that spirit and ancestral influences are omitted from any criteria consideration. Revisions in the edition of DSM-IV coincide with the former version wherein symptoms of a disorder that is similar to PTSD called acute stress disorder, occur earlier than PTSD (within 4 weeks of the event) and remits within 2 days to 4 weeks. If symptoms persist after that time, a diagnosis of PTSD is warranted (Please see appendix for the diagnostic criteria of PTSD). In the DSM-5, however, the diagnosis of PTSD includes dissociative symptoms, but specifies that individuals must meet criteria for posttraumatic stress disorder, and in addition, in response to stressor, the individual must experience persistent or recurrent symptoms of 'depersonalization' (such as, feeling detached from or feeling as though one were in a dream; feeling a sense of unreality of self or body or of time moving slowly) and 'derealisation' (which is the subjective experience of unreality or sense of unreal surroundings, or feeling as if the world around oneself is dreamlike, distant, or distorted) (APA, 2013). It is noted that these surreal symptoms are as subjective as those found in this study within the criteria for *baksbat*.

The lifetime incidence of PTSD is estimated to be 9-15 % and the lifetime prevalence of PTSD is estimated to be about 8% of the general population, although an additional 5-15% may experience subclinical forms of the disorder. Among high-risk group whose members experienced traumatic events, the lifetime prevalence rates range from 5-75 %. About 30% of the American Vietnam veterans experienced PTSD, and an additional 25 % experienced subclinical forms of the disorder. (It is noted that the author has found no studies that compare Vietnamese and American veterans of the Vietnam War). The lifetime prevalence range from about 10-12 % among women and 5-6 % among men. Although PTSD can appear at any age, it is most prevalent in young adults, because they are researched more often as permission and self-report criteria is easier to manage (Sadock, 2007).

2.3. Prevalence Studies of PTSD among Cambodians Inside and Outside Cambodia

2.3.1. Prevalence of PTSD among Cambodian Refugees Living Overseas

Given the on-going nature of turbulence in Cambodian history, ranging from civil wars, the Khmer Rouge genocide, and continuing socio-political unrest, and the plight of poverty, and lack of basic health and mental health services in Cambodia, it is predictable that many Cambodians suffer from traumatic stress (PTSD) symptoms, and other physical and mental health compromises. Many Cambodians escaped to refugee camps along the Cambodia-Thailand border, and later gained passage to the United States, Canada, Australia, New Zealand, France and other countries in the late 1970s and 1980s. Many of those settling after the1980s were given PTSD diagnoses in accordance with the DSM-III criteria. Cambodian refugees were studied in the United States in concentrated communities in California and the Boston area of Massachusetts. Related studies showed that the rate of PTSD in the Cambodian population is probably one of the highest among Southeast Asian refugees (Kinzie, 1990) when compared to other Southeast Asian groups. Psychological compromises stemmed from the accumulation of traumatic experiences and adjustments among Cambodians across horrors they experienced during the Genocide and civil war, the dire conditions in refugee camps, and culture adjustments in the host countries were they resettled (Mollica, Wyshak & Lavelle, 1987).

While most studies on trauma responses found in Cambodian survivors have been conducted with refugees in transitional camps or host countries, results show similar trends in symptomatology. For instance, the study by Mollica, McInnes, Poole, & Tor (1998) with Cambodian refugees along the Cambodia-Thailand border shows that there are dose-effect relationships between the severity of traumatic events the people experienced and the symptoms of depression and PTSD among Cambodian survivors of mass violence. This study

provides insights into the relationship between extreme trauma and the psychological and physical symptoms such traumatic experiences may produce. One can logically assume that psychological and mental health problems among Cambodian people would be high given the severity and the prolongation of trauma in Cambodia over the past decades. The quantitative study by Cheung (1994) on PTSD among 233 Cambodian refugee adults aged over 18, in New Zealand showed that approximately 21% of respondents met criteria for PTSD. Similarly, the study by Kinzie (1990) on PTSD among Southeast Asians found that the rate of PTSD among Cambodian patients (92 %, N=84) were among the highest. It is noted that at the time these studies were conducted, Cambodian, Laos, and Vietnamese refugees were clumped together as Southeast Asian refugees. The reader is cautioned that this geo-cultural clumping may not fully represent the Cambodian trauma aftermath.

Many studies on the mental health status of Cambodian refugees conducted two decades after their resettlement in the United States, found that the rate of mental health dysfunction remained significantly high. The study by Marshall, Schell, Elliott, Berthold, and Chun (2005) was conducted on 586 Cambodian adults aged between 35 to 75 years who lived in Cambodia during the Khmer Rouge reign and immigrated to the United States prior to 1993. The study shows high rates of PTSD (62%, weighted), major depression (51%, weighted), and low rates of alcohol use disorder were found (4%, weighted). PTSD and major depression were highly comorbid in this population (n = 209; 42%, weighted) and each showed a strong dose-response relationship with measures of traumatic exposure, which is similar to the study by Mollica et al., (1998) described above. In general, it is clear that mental health adjustments and trauma aftermath remain challenging for Cambodian refugees living in a Western, host country.

2.3.2. Prevalence of Cambodian Trauma Studies Inside Cambodia

It is unwise culturally to compare prevalence rates of trauma and adjustments inside and outside the country of Cambodia for genocide survivors in particular. Those who leave Cambodia may have access to health, education and an economy, but in the process they lose access to familiar language and expression, ancestral support, Buddhist rituals and spirit resources, familiar sounds, smells, tastes, and community support. On the other hand, those who remain in Cambodia are reminded every day of the aftermath of the regime and face political unrest and oppression, and related health and safety erosion. For the purpose of this study, this author has attempted to put comparisons aside or judgments about whose plight is easier or more difficult as the adjustments are incomparable.

To date, there is no reliable study available on mental health and/or PTSD inside Cambodia during the period of the civil war between early 1980s to early 1990s. After the end of civil conflict, and after the first UN sponsored general election in 1993, international sanctions against Cambodia were lifted and Cambodia was opened to the outside world. There were a few international organizations that started mental health services in Cambodia (Hauff, 1996; Somasundaram, 1999) but the aims of those organizations were to research and provide mental health services to Cambodian people after the civil war. For instance, a study on the prevalence of PTSD among Cambodians residing inside Cambodia by De Jong, Komproe and van Ommeren (2003), in collaboration with the Transcultural Psychosocial Organization (TPO), compared the prevalence of common mental disorders in post-conflict settings on a sample of people who experienced armed-conflict and non-armed conflict in Algeria, Cambodia, Ethiopia and Palestine. The rank-order results showed that within the Cambodian sample, 28.4% (N=610) met criteria of PTSD according to the DSM-IV criteria, while the Algerian, Ethiopian and Palestinian samples had 34.7 % (N=653), 15.8% (N=1,200) and 17.8% (N=585) respectively for PTSD. Meanwhile, the household survey of psychiatric morbidity in Kampong Cham province of Cambodia by Dubois, Tonglet, Hoyois, Ka, Roussaux and Hauff (2004) found that 7% of the sample of 769 adults over 20 years of age met criteria for PTSD (from the

DSM-IV criteria). The most recent quantitative survey by Sonis, Gibson, De Jong, Field, Hean and Komproe, (2009) on the mental health status of 1,017 Cambodians prior to the start of Khmer Rouge Tribunal found that 14.2% of those aged above 35 (a cohort that directly experienced the Khmer Rouge) and 7.9% of those aged between 18-35 (too young to have experienced the Khmer Rouge time directly) have probable PTSD. It is essential to account for the probability of transgenerational trauma in the younger sample.

2.3.3. Prevalence of PTSD in metal health clinics in Cambodia

While reported studies show high prevalence of PTSD and other mental disorders, compromising social factors (such as poverty or forced migration) are rarely included as contributing aftermath factors for trauma priming. Yet despite the lack of extends, there seems to be a large contrast in the prevalence of PTSD in research findings and the prevalence of PTSD in clinical settings in Cambodia. The prevalence of PTSD ascertained by checklist criteria across outpatient clinics in Cambodia is consistently low with the figure of 2-3 % of the total number of patients admitted to the Mental Health Clinics (Bernsen, 2005). The prevalence of PTSD in most Mental Health Clinics in Cambodia in the subsequent years has not shown an increase (TPO, 2008). The rate of mental disorders among 430 patients admitted to the Mental Health Clinic of TPO Cambodia in Phnom Penh in 2010 shows that 2.96% of the patients was diagnosed with PTSD, 26.20% with Depression, 18.91% with Anxiety Disorder, 21.87 % with psychosis and/or schizophrenia, 7.97% with epilepsy, with bipolar affective disorder, 2.96% with organic disorders and 16.40% with other diagnoses (TPO, 2010).

It is noticeable that the prevalence of PTSD in Cambodian samples inside Cambodia across both general population and the clinics are generally lower than results from studies on Cambodians residing as refugees overseas.

2.4. Factors contributing to differences in prevalence inside and outside Cambodia

This section highlights probable reasons for a discrepancy in trauma outcomes between research and clinical practices inside and outside Cambodia. One mediating factor tends to be a dynamic of silence and avoidance, which exists between Cambodian therapists and their patients. Within Cambodia, therapists and patients have both experienced the wrath of the Khmer Rouge genocide and its aftermath. From this shared experience, they tend to avoid talking or discussing Khmer Rouge issues together as doing so brings up too much of the painful past. De Jong and colleagues found a higher degree of avoidance in the Cambodian sample when compared to samples from Algeria, Ethiopia and Palestine (De Jong et al., 2003). To avoid such discussion on traumatic pasts is to avoid allowing painful memories to resurface. In addition, traumatised survivors tend to isolate themselves socially and withdraw from participating in social and community activity. Therefore they may be disabled in their own village or home which in the Cambodian village context, is a place where they feel safe and protected. They find their own home and/or environment more comfortable, predictable and safe; also they may not seek treatment from public health clinics but may be more likely to seek treatment from traditional healers (*Kru Khmer*), mediums, monks, *Kru Arak* etc… in their villages. Also, many survivors do not like to talk about their traumatic memories or about their suffering because they consider it was a problem of the past. Some believe according to the retired King Norodom Sihanouk of Cambodia, "Let bygones, be bygones". Many Cambodians still believe that no matter what they do, it will not bring back the lives of their deceased relatives, so they prefer not to speak about what happened to them.

The lack of culturally valid instruments could be another cause of this discrepancy. Many researchers who have studied Cambodian refugees or Cambodian patients in the clinic inside Cambodia use instruments that were developed in the United States, or were developed on refugees who have been hosted and re-socialised in Western cultures. Also, PTSD as a

diagnostic category may not be a culturally valid indicator of the complexity of trauma suffered by Cambodians after the past atrocities. Measures of trauma used in making the 'post' trauma diagnosis often lack cultural sensitivity, and most items in the formal surveys have not been developed with local Cambodian people (Kohrt, 2010). In particular, there is no appropriate Khmer vocabulary that can describe trauma or emotional complaints in Western terminology and some of the meanings may have been lost in translation when translating Western terminology into Khmer language. In addition, some of the measures have not been properly validated in Cambodia and the PTSD criteria itself may not capture the trauma symptoms expressed by Cambodian patients. Many other researchers have also questioned whether the notion of trauma and particularly PTSD is a universal response (Braken, 1998; Marsella, 1996; D. Summerfield, 1999).

2.5. Cultural, spirit-based and linguistic influences on mental health

Cultural, spiritual, language, geographical differences, indigenous access to ritual and national politics, and the nature of trauma experienced by Cambodians could also be operating factors in the differences in the prevalence of PTSD and other mental disorders. This section references the overlap between culture, spirit practices and beliefs, and language and mental health complexities within Cambodia. LeVine (2010) notes that the concept "spirituality" is derived from a Judeo-Christian world view; the term spirit-based represents better the impact of spirit forces, places and ancestral influences exert on a Cambodian person's wellbeing.

Culture is defined traditionally as 'integrated pattern of knowledge, belief, and behaviour that is both a result of and integral to the human capacity for learning and transmitting knowledge to succeeding generations'. It consists of language, ideas, beliefs, customs, taboos, codes, institutions, tools, techniques, work of art, rituals, ceremonies, and symbols. It is also

the totality of habits, ideas, beliefs, attitudes and values, as well as the behaviours that spring from them which includes language, arts, marriage patterns and eating habits and so on. It is also the 'blueprint-for-living that is non-genetically transmitted from one generation to another' (Patel, 2007). In the Cambodian context, spirit phenomena hold a powerful presence in the cultural landscape and day-to-day life.

Other notions of culture include a shared learned knowledge that people in a society hold, collectively. It guides how people live, what they generally believe and value, how they communicate, as well as their habits, customs, and tastes (Loustaunau, 1997). Culture acts as a risk or protective factor, and influences the way people cope with problems (De Jong, 2007). Collective beliefs and perceptions in/of spirit phenomena and supernatural forces, for example, can be a risk or protective factor. For example some spirit beliefs may delay psychiatric patients from receiving medical treatment and that could result in severe consequences or death, such as a person who believes a seizure is evidence of possession when it may be evidence of a brain lesion. On the other side of the coin, someone with anxiety might find relief by enacting spirit-ritual practices.

In addition, some spirit beliefs enable survivors to make sense of what has happened to them, including past karmic forces or a pre-determined destiny. Karma is related to 'action', or the actions one enacted or did not enact in the past or present life, which can impact a person's luck or health in this life or the next life. This firm belief in karma can have positive and negative effects on one's mental health. For example, a Cambodian survivor of domestic violence told me, "Khmer women must endure according to their karma" (Bhuyan, 2005). Herein, their understanding of suffering from trauma is viewed as the result of their bad action in their past, which effects their present life. They would accept their sufferings because they believe that their past action has now returned to them. However, this could have negative

effects. One women comments, “if we endure according to our karma we will certainly die” (Cambodia Survivors of Domestic Violence).

The Buddhist concept of “impermanence” also impacts on community beliefs and perceptions Basically, everything is not going to stay the same, the belongings we own now will go away from us in the future. People are born with nothing, they didn’t bring anything with them into this life; therefore when they die, they will not be able to take anything with them. Ultimately, our body does not belong to ourselves; therefore, we should not regret losses, as nothing belongs to us anyway. We come to this world with nothing and we must return with nothing. In conversations with elderly men and women at Buddhist temples in Cambodia, I have heard them say that that they often have back pain, body pain or illnesses; they relate that it is now time that their own properties (parts of their body) have to gradually be returned, so they do not regret anything. They focus on making merit (*tveu bonn*) by sharing/donating part of their belongings or by doing the right thing, save it for a better future in their next life. An elderly man who has recently just lost his 40-year-old son said that he can only be the father for this son up until the day he died, now he “can no longer the father of his son anymore because his son has to return to where he belonged”. By such views, suffering can have a cushion.

Reasey a concept that literally means ‘luck or fortune’, is a belief held by many Cambodians. Cambodians believe in *reasey* in order to predict their wellbeing and/or future. Mediums or fortune tellers or traditional healers often use *reasey* as a way to predict the health status of the people. High *reasey* means that individual is in good health, physically and psychologically, low *reasey* means there may be an impending problem (D. Hinton, and Good, B., 2009). Once a person has low *reasey*, mediums or monks or traditional healers can perform some sort of ritual ceremony in order to raise *reasey* back to normal in order to avoid potential problems to

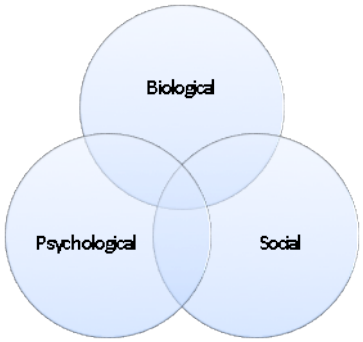
individuals. This belief leads individuals to seek help in order to prevent illness from happening, so it is a protective factor for Cambodian people.

Loustaunau (1997) wrote, “in order to understand and analyse health and illness in any society, they have to look at individual behaviour, interactions and social structures within its cultural context”. Culture differs from one ethnic group to another, and from one geographic place to another within an ethnic group, particularly within a spirit-based country such as Cambodia (LeVine, 2010). Also, culture influences beliefs, ways people think, ways people communicate and relate to each other and the phenomenal realm (De Jong & van Ommeren, 2001). Culture also influences and impacts upon the mental health of the people in each ethnic group, it determines the roles of individual or group in dealing with problems, it defines what an illness is, it influences symptoms of mental illness and the way people seek help. De Jong (2007) states that cultures influence problem-focused and emotion-focused coping. Traumatic life events can be simple or complex in nature and therefore result in simple or complex forms of posttraumatic adaptation. Cultures are complex in nature with different roles, social structures, authority systems and mechanisms for dealing with individual and collective forms of trauma (Wilson, 2008). Different cultures contribute to individual and collective coping strategies to deal with extreme stress. These culturally specific coping strategies can be protective mechanisms but can also represent risk factors for some people in developing mental health problems as well as illustrated above.

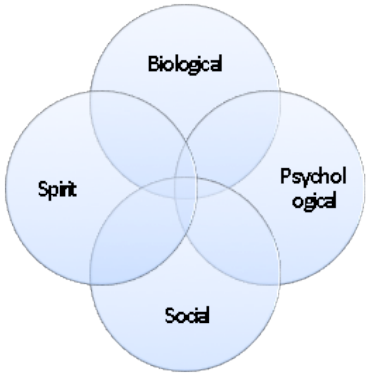
Eisenbruch (1992) suggests that clinicians in Cambodia and elsewhere may misinterpret cultural presentations of their patients if they give too much stress to the criteria of diagnostic categories developed in Western cultures. He adds that the high rate of PTSD that appears in many research studies in Cambodia flows from systematic but unintentional misinterpretations, of the Khmer idiom of distress.

Spirit-based beliefs and access to rituals for Cambodians are significant to trauma studies. LeVine (2010) found that the more Cambodians had access to traditional spirit protective rituals, the more their anxiety was contained or relieved. In particular, there is less panic over the potential harming by roaming ancestors, or unresolved karma for ancestors when rituals are accessed. Huot & LeVine (2000) found that most foreign educators who train mental health workers in Cambodia do not take the spirit domain into account, even though these activities are important in their daily lives to secure protection and feelings of safety from unknown sources of harm. Since Cambodia is a spirit-based country, it is important to take into consideration beliefs and perceptions among its people whose lives are interdependent with spirits. According to Cambodian beliefs, spirits live in many places such as in houses, buildings, trees, hills, and in the water, disturbing or upsetting those spirits may result in sickness or problems (Thompson, 2005). At the same time, evidence suggests that ritual ceremonies enacted to appease angered spirits can lead to collective recovery from fear and psychological suffering.

With regard to cultural factors, instead of taking refuge in the bio-psycho-social model of mental health that responds to Euro-American contexts that highlight 'spirituality', a model is needed that includes spirit-related beliefs and practices that represents Cambodians' experiences, and others in the Southeast Asian region and beyond. The terms 'spiritual practices' or 'spirituality' are reflected in the passage, "universal dimension of human experience…concerned with matters of meaning and purpose in life, truth and values" (Cook, 2004, pp. 548-549). In the Cambodian context, however, this spirit domain involves a complex cosmology that includes ancestral and fateful (*reasay*) influences on people's collective sense of wellbeing.



Bio-Psycho-Social Model of Mental Illness



Bio-Psycho-Social-Spirit Model of Mental Illness

Besides understanding the spirit-based dimension in a cultural model, the understanding of the Khmer language and specifically verbal expressions of the Cambodian people would assist an understanding of the dimensions of suffering. The Khmer words discriminate experiences differently than words in English do; the Khmer descriptors of taste are used often to express emotions (Huot, 2000). Huot and LeVine (2000) found that the majority of Cambodians living in Melbourne described their experiences living under the Khmer Rouge as *lvin-chu-chot* (bitter-sour-bitter); metaphorically these experiences of taste give a visceral feel to emotion akin to 'something that is so painful and overwhelming that one could find it hard to swallow' (LeVine, 2007).

The Khmer descriptions of pain and suffering are significantly different from Western concepts (Morelli, 1996). In Khmer culture, the concept of pain is part of a larger process of suffering and healing, which continually contributes to kinship and familial solidarity and reciprocity, and ethnic identity (Marcucci, 1994). The Khmer explanation of pain is also often linked to spirit-based aspects of pain derived from Buddhism. The vast majority of Cambodians practice Theravada Buddhism with a philosophy of pain that runs through *'life'* itself with *'suffering'* that is unavoidable. By contrast, in Euro-American culture, meaning of

life is highlighted with goals for happiness. Coping abilities of Cambodian people with mental health problems and trauma is supported by Buddhist systems on the meaning of suffering. Relatedly, standard bio-psycho-social models fail to fully capture symptoms related to experiences and idioms of suffering that Cambodian people endure (Tseng, 2007).

2.6. Culturally sensitive instruments previously developed

Because the presentation of mental health and trauma symptoms differ from culture to culture, many of the internationally standardized diagnostic criteria that were developed in Euro-American contexts are less valid in Southeast Asian cultures. Brody (1994) states that international standardized diagnostic criteria conceal cultural and historical specifics of present psychiatric disorders and undermines its validity in non-Western contexts. Due to such the differences, any attempts to identify the presence of PTSD in Cambodian refugees who resettled in the United States were hampered by difficulties in cross-referencing cultural psychiatry (Bit, 1991). Other authors who worked with Cambodian refugees overseas and in the United States most often have proposed the integration of anthropology and medicine in understanding both the longitudinal life experience of individual patients and the collective experience of a collective group. They have argued that if such integration takes place, it could lead to a high prevalence of PTSD and trauma related disorders among survivors of the Khmer Rouge genocide noted in the psychiatric literature over the past decades (Boehnlein, 2001).

Realizing such differences, some researchers have developed tools to measure trauma symptoms for specific populations. Mollica (1991) developed the Harvard Trauma Questionnaire (HTQ) to measure trauma and mental health symptoms for the Indochinese (Cambodian, Laotian and Vietnamese) population. Later on, Marwa and Mollica (2007) developed a new version of HTQ for Iraqi refugees who resettled in the US. The Indochinese version does not include many idioms of distress as it does in the Iraqi version. Therefore, the Cambodian version of HTQ may not be culturally sensitive enough for Cambodian population

because it may not capture many idioms of distress that the Cambodian population express (Rechtman, 2000; Hinton & Lewis- Fernández, 2010).

There have also been other initiatives to enhance the cultural sensitivity of western diagnostic measures for use among the Vietnamese. Examples include the translations of the Diagnostic Interview Schedule (DIS) (Helzer, 1989) into Vietnamese language, the translation of the Composite International Diagnostic Interview (CIDI) (Wittchen, 1991) cited in Phan (2004) and the development of the Hopkins Symptom Checklist 25 (HSCL-25) to detect anxiety and depression for Indochinese refugees living in the US by Mollica, Wyshak, de-Marneffe, Khuon and Lavel (1987). However, these checklists were developed among Indochinese refugees in the US and have been used in Cambodia and elsewhere and have been referenced as culturally reliable instruments but the concerns about the cultural appropriateness of such approaches still continue (Ahmad, 1989). There are many other experts in transcultural mental health expressing similar ideas that the International classification of diseases in DSM-IV (APA, 1994) and ICD-10 (WHO, 1993) are very helpful to detect and treat mental health problems, but that discrepancies exist between these classifications and experiences within local culture which continue to evoke discussion, research and diagnostic paradigms (Mezzich et al., 1999; De Jong & van Ommeren, 2001).

This indicates that culture, spiritual, and language have a very important role in the expression and the presentation of mental health problems in specific culture groups. No disorder is immune to cultural shaping (Draguns, 1980) therefore; it is necessary not to overlook the local culture when applying the Western concepts to people from a non-Western background.

2.8. DESNOS (Disorder of Extreme Stress Not Otherwise Specified) – Complex PTSD

Aside from cultural, spiritual, and language issues mentioned above, the nature of traumatic events could be one of the reasons why the responses to trauma are different and that could be the cause of rates of PTSD among Cambodian people and in mental health clinics there. Wilson (2008) has written that traumatic life events can be simple or complex in nature and result in simple or complex forms of posttraumatic adaptation. As far as the nature of traumatic events is concerned, Herman (1992) argued that PTSD criteria do not fit with survivors who experienced prolonged trauma and therefore cannot capture trauma symptoms experienced by those people. This is particularly true for the Cambodian population who experienced prolonged and repeated trauma during the Khmer Rouge time and the years after the fall of the regime. Van der Kolk, Roth, Pelcovitz, Sunday, and Spinazzola (2005) found that children and adults exposed to chronic interpersonal trauma consistently demonstrate psychological disturbances that are not captured in the PTSD diagnosis. Herman proposed another diagnostic criteria called "Disorder of Extreme Stress Not Otherwise Specified (DESNOS)" with five components: (a) regulation of affect and impulses, (b) memory and attention, (c) self-perception, (d) interpersonal relations, (e) somatization, and (f) systems of meaning (van der Kolk, 2005), in order to capture other symptoms of trauma expressed by survivors who are exposed to cumulative and prolonged trauma.

2.9. Idioms of distress

The term 'idioms of distress' describes specific expressions of disorder that occur in some societies, while recognized by members of those cultures as expressions of distress. Idiom of distress has been a relevant topic for discussion among scholars in the field of anthropology, psychiatry and psychology especially in relation to research on culturally informed assessment and treatment of various illnesses. According to Mark Nichter (2010), primary idioms of distress, referenced often as somatic-based disorders in Asia, have been in circulation for 30 years and have clearly taken on a life of their own. The term is used in the DSM-IV and it is

likely to be used again in the upcoming DSM-V. Idiom of distress has refined global understanding of psychological, social and somatic expressions of distress, while providing a blueprint for researchers and clinicians across countries to account for the phenomenology of distress specific to cultural settings.

Scholars define idioms of distress in different ways but with similar themes. Hollan (2004), for example, regarded idioms of distress as culturally shared symbols, behaviours, and language that express, explain and/or transform peoples' experience of distress and suffering. In some cases, idioms of distress are culturally and interpersonally effective ways of expressing and coping with distress, and in other cases, they are indicative of psychopathological states that undermine individual and collective states of well-being (Nichter, 2010). There are many types of idioms of distress studied across cultures, such as somatic-based (Nichter, 2001, 2002, 2008a, 2008b); *Kiyang-yang*, a West-African post-war idiom of distress by De Jong and Reis (2010); and *Llaki* and *Ñakary* references suffering among the highland Quechua in the Peruvian Andes (Pedersen, 2010). Hinton and Lewis-Fernández (2010) classified idioms of distress and related prototypes, which include psychological or somatic complaints, eating abnormalities, cultural illness syndromes, zealous-religious involvement, and acting-out behaviours.

These idioms of distress help clinicians and researchers to understand the presentation of symptoms experienced by local people. Misunderstanding such idioms of distress could result in over diagnosed or neglected problems experienced by people from the local culture.

2.10. Cultural syndromes

Cultural syndromes have been actively studied in the fields of ethno-psychiatry in many cultures. There are certain types of cultural syndromes previously studied in different cultures around the world. The following cultural syndromes are examples from Latin America, Southeast Asia and Cambodia.

2.10.1. Hwa-Byung:

Due to the significant importance of the combined study of culture and mental health, some mental health experts in several East Asia countries such as Korea and Japan have developed checklists to detect the culturally bound syndromes in their countries.

Robert, Han and Weed (2006) developed a standardized assessment scale to measure symptoms of the Korean culture-bound syndrome called *Hwa-Byung,* based on a Western instrument, the Minnesota Multi-phasic Personality Inventory (MMPI-2). *Hwa-Byung*, is a Korean folk illness ordinarily understood by patients and families to be a physical affliction despite the fact that its manifestations include both physiological and psychological symptoms. In addition, the patient often recognizes interpersonal conflicts and anger as precipitating factors. There were many circumstances where Western instruments were used to assess this culture-bound syndrome in Korea but there were no previous efforts made to develop a local scale that can measure this *Hwa-Byung* syndrome from a Korean perspective.

2.10.2. Shinkeishitsu and Taijinkyofusho

Similarly Japanese psychiatrists had also discussed and developed the nature of trauma-based fears in the Japanese diagnostic category of *Shinkeishitsu* and *Taijinkyofusho* (Morita, 1928/1998; LeVine, 2000). *Shinkeishitsu* (constitutional neurasthenia) is a widely used diagnostic term in Japan that represents a particular kind of anxiety where a sensitive disposition makes one more sensitive to body sensations. This diagnostic category and used by lay people to describe somatic distress. In fact in Japan, Shoma Morita (1874-1938) developed a therapy to assist those struggling with neurasthenia and *shinkeishitsu*-based symptoms (Morita, 1928/1998). A subcategory of *Shinkeishitsu* is *Taijinkyofusho* has been roughly referred to as ‘social phobia’ or ‘anthropophobia’ in the Western diagnostic terms. In Japan, however, social expectations for harmonious exchanges increase sensitivities not found in other cultures, wherein “fear of interpersonal relationships” and “interpersonal situations” gets heightened

(Russell, 1989). Both *Hwa-Byung* and *Shinkeishitsu* are types of mental health problems that are not standard disorders found in mental health nomenclature (DSM-IV or ICD-10). Hence it is very important for mental health professionals to understand cultural influences on symptom presentation so that treatment considerations are most responsive.

2.10.3. Ataque de Nerviose

Nervios and Ataque de Nervios is considered often as a 'folk illness' shared among many Latin American cultures. *Ataque de Nervios* (attack of nerves) is an illness category used by many Puerto Ricans and other people of Hispanic background. The typical symptoms include "shaking, heart palpitations, a sense of heat rising in the head, and numbness of the hands. Behaviourally, the person begins to shout, swear and strike out at others. The person then falls to the ground and either experiences convulsive body movements or lies as if dead" (Guarnaccia, Rubio-Stipec, & Canino, 1989). Such attacks often occur at funerals, accidents, or family conflicts and call for the family or other social supports, suggesting that they may be culturally shaped and sanctioned response to severe stress.

However, case reports revealed some attacks in which recurrent symptoms were unprovoked by immediate stress (Guarnaccia, DeLaCancela, & Carrillo, 1989). Further, the individuals in these cases then developed fear of going out unaccompanied, suggesting a relation to the unexpected panic attacks, panic disorder and agoraphobia (Leibowitz, 1994).

2.10.4. Susto and soul loss

Susto and soul loss is also a Latin American so-called folk illness, which involves frightening experiences, often including 'soul loss' as part of the aetiology. It is attributed to a fright resulting from an accident or other unexpected occurrence. In *Susto* an "immaterial substance or an essence" leaves the body because it has been captured by spirits or other forces. Symptoms reported by those exhibiting this disorder include restlessness during sleep, listlessness, loss of appetite, and depression (Rubel, 1964). Approaches to treatment focus on

restoring the equilibrium between the "essence" or "soul" and the body and returning to the body what has become detached. *Susto* also has attracted attention because of its association with stress, morbidity, and mortality and has been included in the DSM-IV (Glazer, 2004).

2.10.5. Kesambet

Kesambet is a common cause of child mortality and adult sickness in North Bali, Indonesia; if a child cries inexplicably and persistently, the mother is likely to think of it as "*Kesambet*" and rushes the child off to traditional healers. *Kesambet* refers to illness from shock, fright or soul loss, which is not to be taken lightly. It is the illness most commonly attributed as the cause of death in children where aetiology is unknown; adults are known to die from it as well. The traditional healer (*balian* or *dukun*) focuses the treatment on mother or child, depending on whether the child is breastfeeding age, as well as when the fright is believed to have originally struck. In the case of a child believed to be sick because the mother was startled, it makes no sense by Balinese conceptions to direct treatment towards the child. The child received its vital nourishment through the mother's milk; hence its vitality and balance depend on *her* condition rather than that of the child. From her blood, in which flows her spiritual essence, she makes the milk that sustains the soul essence of the child (Wilkan, 1989). It is worth noting that mother's breast milk has protective properties in Cambodia as well.

2.10.6. Hikkikomori

Hikkikomori, a form of acute social withdrawal, is becoming a silent epidemic in Japan. As it has not been reported from other parts of the world, *hikikomori* fulfils the criteria for "a culture-bound syndrome." Its symptoms present with fear in social situations, when coupled with shyness, can lead to behavioural inhibition. This condition is also characterized by antisocial and avoidant behaviours leading to school non-attendance or withdrawal from society (Sakamoto, 2005).

2.10.7. Khyal attack

In many part of Southeast Asia, there are local ethno physiologies that feature a pathological wind-like substance. This substance is often described by the same local word for external wind (Hinton & Good, 2009; Hinton, Pham, Chau, Tran & Hinton, 2003; Muecke, 1979). In Khmer language *khyal attack* or *khyal chab* is literally translated as 'caught up by the wind' (*khyal* = wind) is a key idiom of distress experienced by many Cambodians. Hinton, Pich, Marques, Nickerson, & Pollack (2010) found that *khyal attack* was often complained about by many traumatized Cambodian refugees with the diagnosis of PTSD. It was found to have correlation with PTSD and it was triggered by various processes such as worry, trauma recall, standing up, going to a crowded place, having conflict and *khyal attack* often met panic attack criteria. Its aetiology is caused by excessive amount of wind substance inside the body and sometime it becomes overload, which is called in Khmer as "*khyal kor*" or *khyal goeu* (Hinton, Un, & Ba, 2001). According to Cambodians' belief, *khayal kor* is the most severe case of *khyal* attack, which is similar to syncope in biomedicine. Every Cambodian knows very well how to treat *khyal attack* which involved using coining (*kaus khyal*), cupping (*chub khyal*) or pinging (*chab khyal*) but not everyone who experienced *khayl attack* likes to be treated by coining because this method is so painful and it leaves many bruises on the body for 3-4 days afterward. In Cambodia, coining is common; in addition, while medically trained, this author uses coining to treat certain conditions, too.

2.10.8. Weak heart

Weak heart syndrome is known as *ksaoy beh daung.* Cambodian people often complain with a local syndrome called '*ksaoy beh daung'* or 'weak heart' in which the patients often have episodes of palpitations on a slight provocation (Hinton, Hinton, Um, Chea, & Sak, 2002). The sufferers often attributed their problems to cardiac dysfunction because it was the first symptom present with palpitation, chest pain, shortness of breath, fatigue and orthostatic dizziness. They often fear that their heart may stop working and lead to their death by heart failure. Symptoms of *ksaoy beh daung* are very much overlapping with generalized anxiety

disorder, panic attack, and PTSD. Patients with *ksaoy beh daung* suffer often from *khayl attack*; both conditions are treated often by coining in Cambodia.

2.10.9. Baksbat (Broken courage): Cambodian cultural syndrome of distress

Over the past 19 years, this author has worked directly with trauma survivors of the Khmer Rouge genocide and with people who suffer from various mental health and psychosocial problems in both urban and remote rural communities of Cambodia. He has found that many survivors expressed more symptoms than are described in the diagnostic criteria of PTSD in the DSM-IV and ICD-10. In addition to describing physical and psychological symptoms, survivors express their inabilities to trust others, while becoming more submissive, feeling more cowardly, becoming '*bak'* (broken) or *baksbat* (broken courage), and being mute and deaf (*dam doeum kor or planting a mute tree*). The term *baksbat* has been described by Kong (2003) as well as Huot and LeVine (2000). However, there has never been any systematic study into its phenomenological description or its influence on people's wellbeing. *Baksbat* appears to be an idiom of distress, cultural syndrome that shares some of the features with Post Traumatic Stress Disorder, Anxiety and/or Depression with Dissociative features (which requires further research for fleshing out). *Baksbat* is observed to be unique within the context of the Cambodian population, with complex appearances and phenomenal experiences for those surviving the Khmer Rouge regime (1975 - 1979), while it is noted that elders in this study indicate the presence of *baksbat* before the 1970 warring period.

This *baksbat* concept expresses most fully the fear that follows a distressing or life-threatening situation. Chourn Nath (1967), the late Supreme Head of Monks and the author of the first Khmer Dictionary, wrote that '*baksbat'* comes from the word *bak* (noun) which means break/broken and the word *sbat* (noun) means the body or form. Therefore, *baksbat* literally means broken body or form. In Khmer language, people like to use compound nouns or combined rhymed words in order to make the meaning of their experiences stronger and flow smoother. The word *Sbat* can also be used as *sbat-sbov* and in this instance *sbat* (adjective)

means thick or dense whereas *sbov* (noun) means thatch or the type of grass that rural people use for roofing. The combination of these words therefore means thick thatch. Choun Nath gives an illustration that once an elephant steps on this *sbat-sbov* (thick thatch), its form is broken and its original form is broken forever. So, *baksbat* is literally translated as a 'permanent' breaking of the body or spirit. The late Supreme Head of Monks referred to this as 'psychological break down of courage', which may be called broken courage. This etymological explanation uses purely lay terms such as *sbov* (thatch), and elephant, both of which are commonplace in the daily life of Cambodian villagers thus it makes it easy to understand.

Sos, Kheang, and Erham (1994) translated *baksbat* into English as 'being afraid forever' which suggests that people who suffer from this will never get back to their previous level of calm or functioning. In lay terms, *baksbat* refers to fear following bad experiences, meaning that *baksbat* sufferers would never dare to do something again, or would be so afraid that one would never dare to begin anything. This means that *baksbat* or broken courage is a condition that has broader meaning than the *baksbat* concept as indicated in everyday spoken language. *Baksbat* has collective meaning in Cambodia as well. For instance, a group of villagers who experience the same terrible event may dare not do something or dare not take action. Some of the terrible events significant to this study are sudden loss of a loved one, combat shock, a landmine accident, being frightened by spirits or ghosts, or being chased by wild animals. People with *baksbat* have a feeling of *reang-charl* or a sense that they will not or dare not do something ever again.

2.10.10. Ethno-medical aspect of baksbat

Some traditional healers in Cambodia refer to *baksbat* when describing an illness in which symptoms relate to intense *phey-khlach* (fear-fear)*, or khlach* (fear) that leads one's soul to get

lost, or leads one to scream out in the night when having a bad dream. “Soul loss” is categorized as (1) *Lours-praling* (some of the souls jump out of the body): or (2) *Praling-chong-sak* (souls run to the extremity of the hair) (Ly, 2006). According to Ly (2006) and Thompson (2005), and in personal communication with elderly Cambodians, there are 19 small souls and 1 big soul (or crystal soul) in our body. When the majority of these 19 souls are lost, or the big soul is lost or *lours-praling*, people’s consciousness is partly or completely lost as well. As a clinical note, this lost soul / lost consciousness phenomenon resembles the DSM-IV text revision’s definition of dissociation which means a ‘disruption in the usually integrated functions of consciousness, memory, identity or perception of the environment’ (APA, 2000). According to Ly and Thompson, the lost soul can be regained through a method that is called *hav-praling* (calling back the soul). The lost big soul may lead to individuals becoming mad with symptoms that appear psychotic, or look like someone is dying. These kinds of symptoms occur more often after someone experiences an extremely and sudden frightening situation or is shocked instantly by an experience. This clinical *baksbat* condition is more serious than the *baksbat* concept used in everyday language. Someone may tell a friend that he/she was *baksbat*, while clinicians would see *baksbat* condition as a condition akin to PTSD or acute stress reaction in DSM or ICD criteria.

In some contexts, the *baksbat* condition is described as an illness (*chumgneu*) when it is more severe. In the Khmer language, when emphasis is placed on something more severe or more enduring, people usually attach the prefix *chumgneu* (illness or disease) onto a word in order to make the meaning stronger. Examples are *chumgneu kcheul* (lazy illness), *chumgneu puk-rolouy* (rotten illness or corruption illness), *chumgneu sangkum* (social illness). People call *chumgneu baksbat* (*baksbat* illness) to emphasize that *baksbat* has caused a severe, debilitating form of illness after experiencing fright. In personal communication with a Cambodian scholar, Dr Meas Nee in 2008, he said that *baksbat* has two forms, normal reactions or pathological, exaggerated reactions. In normal *baksbat*, symptoms relate directly to a particular situation or

event. With pathological *baksbat*, the symptoms become more enduring and behaviour becomes more maladaptive over time, lasting long after the event itself has been resolved. Some Cambodian psychiatrists and psychologists equate the condition of *'baksbat'* to that of PTSD because there are some overlaps in features related to psycho-emotional distress. This practice is similar to that of psychiatrists in Colombia and Peru who found other symptoms of trauma responses among their patients yet they included everything into PTSD criteria (Elsass, 2001). Nevertheless, Cambodian psychiatrists acknowledge that there are underlying differences culturally, such as easily giving in, being submissive, being mistrustful of people, or being mute in someone with *baksbat*. Again, to date there has not been any study about this idiom of distress or any ethnographic study that compares PTSD, anxiety and/or depression to *baksbat*.

For this reason, the author's rationale for conducting this study is to explore the ways in which trauma symptoms or responses manifest themselves in Cambodia (while accounting for urban, rural and remote regional variables), and begin to establish norms for ethno-cultural problems related to trauma and *baksbat*. Of course it is well known that Cambodia has been emerging from genocide, which has impacted the whole of society, and it is likely that the threshold for anxiety has been adversely impacted. The study was designed to seek Cambodians' descriptions of their own phenomenological experiences of distress using the local idiom of distress *'baksbat'* (broken courage, never dare to do something again) rather than using the term 'trauma'.

This proposed research project about the ethno-cultural responses to trauma in Cambodia, and, in particular, the study of *'baksbat'* will, in many ways, assist the 'preservation' of indigenous health methods and contribute to developing and updating knowledge of mental health compromise in Cambodia.

Chapter 3: Research Methodology

3.1. Research aims:

The aims of this research are:

1. To explore the meaning of trauma, ethno-cultural range of responses to distress in Cambodia as a way of developing a culture based syndrome of trauma, called *baksbat* (broken courage) that may be fruitfully compared to trauma syndromes classified in the International Classification of Mental Disorders of DSM-IV or ICD-10.

2. To develop an inventory to measure *baksbat* and validate this inventory against internationally standardized instruments such as PTSD Checklist (PCL-C) and Hopkins Symptoms Checklist-25 (HSCL-25)

3. To increase the cultural competency of local and foreign mental health workers who are practicing and researching in Cambodia. In this sense, the author wishes to apply this newly developed ethno-cultural syndrome of trauma responses, *baksbat*, as forensic evidence of psychological impact from the Khmer Rouge genocide among civil parties and witnesses who testify at the Extra-Ordinary Chambers in the Courts of Cambodia (ECCC).

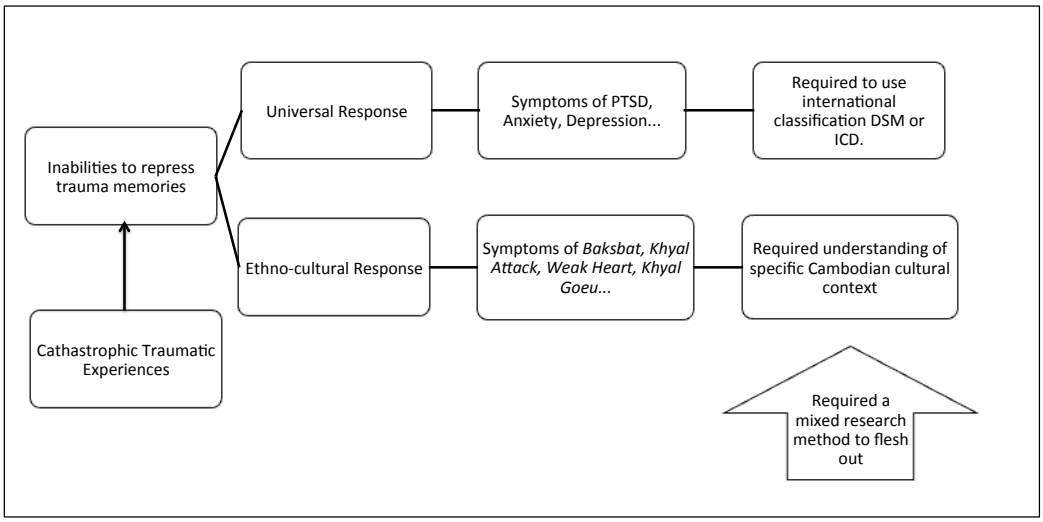
3.2. Theoretical framework

Every research project may be conceptualized as the end result of a sequence of choices, beginning with the broad and basic choices of the research paradigm and theoretical frameworks and concluding with the narrow and specific choices of sampling strategy and data analysis procedures (Auerbach, 2006). First is the choice of research paradigm, whether positivism underlies what are called quantitative methods, or constructivism underlies what are called qualitative methods (Drummond, 1997; Finkielkraut, 2000; Kirmayer, Rousseau &

Lashley, 2007; Kymlicka, 1995; Lincoln, 1985; Monstakas, 2001; Ross, 1996) or pragmatism (quantitative plus qualitative) (Boehnlein, Schaefer, & Bloom, 2005; Dencan, 1990; Ignatieff, 2000; Kirmayer, 2003). The pragmatism paradigm has been developed in what follows in an attempt to make peace war between the two major paradigmatic positions. Pragmatically oriented theorists and researchers now refer to "mixed method" (or mixed methodology or methodological mixes), which contain elements of both quantitative and qualitative approaches (Hunter, 2003; Tashakkori, 1998). According to Tashakkori and Teddlie (2003), a mixed methodology is defined as "a type of research design in which QUAN and QUAL approaches are used in types of questions, research methods, data collection and analysis procedures, and / or influences". Mixed methods research involved the combined use of quantitative and qualitative methods in the same research study, and it is becoming increasingly important in several areas (Tashakkori, 2003, p. 711). This author has chosen a mixed method of 'combined qualitative and quantitative approaches' because the goal of his research is to gain an understanding of a local concept through qualitative interviews. The author uses information from these quantitative interviews as a basis to develop a culturally appropriate inventory through a quantitative validation survey. This combined qualitative and quantitative method enables the author to understand the concept of *baksbat* from the qualitative interviews and develop a valid inventory for measuring the symptoms of *baksbat* in a quantitative survey.

The diagram below shows the conceptual framework of ethno-cultural responses to trauma called *baksbat* and Western responses to trauma called PTSD.

Figure 1: Conceptual Framework for Ethno-Cultural Response to Trauma



In this design, the author divided the study into qualitative a quantitative phases. In the qualitative phase, the author has to decide which form of qualitative research method should be used. There are many qualitative research methodologies but this author chose an ethnographic method because it is the most general of all of methods and serves as the basis for understanding the concept to be studied. According to Goldbart (2004) and Lopez-Fernandez (2011a, 2011b), the word ethnography literally means 'writing about people'; … 'people as meaning makers', around emphasis on understanding how people interpret their worlds, and the need to understand the particular cultural worlds in which people live and which they both construct and utilize. Ethnography attempts to be holistic – covering as much territory as possible about a culture, subculture, or program and the ethnographer's task is to collect information from an emic or insider's perspective.

The author has used ethnography in order to capture the concept of Cambodian trauma responses, *baksbat,* from the perspective of the Cambodian "experts" who have knowledge or experience of *baksbat* themselves. These experts include traditional healers, mediums, religious people, elderly people, mental health professionals, victims of torture or people who may have *baksbat* themselves, historians, linguists and academics. The experts were

interviewed on multiple occasions, using information from previous informants to elicit clarification and deeper responses upon re-interview.

This process is intended to reveal common understandings related to the phenomena under study. The data gathered will be analysed to cluster the patterns of phenomena that emerge from the interviews and then set up the criteria for *baksbat* syndrome which will lead to developing an 'inventory of *baksbat* syndrome'. The author also applies peer debriefing, triangulation techniques to ensure trustworthiness of the data as described in naturalistic inquiry by Lincoln and Guba (1985) (Fetterman, 1989).

Triangulation involved combining data sources to study the same social phenomenon. The author uses a variety of data sources (data triangulation), use of different researchers (investigator triangulation) and multiple methods such as ethnography, naturalistic inquiry, focus group discussions (methodological triangulation) in order to ensure validity of the study. Peer debriefing was also done when the author sought questions from peers, which aimed at probing biases and clarifying interpretations.

Following Greene, this research which uses a mixed-method approach to social inquiry, is better able to generate understanding than studies bounded by a single methodological tradition. Similarly, Strauss and Corbin (Greene, 2004) affirmed that combined qualitative and quantitative methods can be used effectively in the same research project. One might use qualitative data to illustrate or clarify quantitatively derived findings; or, one could quantify demographic findings. Or, use some form of quantitative data to partially validate one's qualitative analysis. Therefore, this proposed methodology for this study is in line with the existing theory.

In summary, based on the above theoretical and conceptual framework, this study combines both qualitative methods, for the development of the inventory of *baksbat* syndrome, and quantitative methods, for the validation of this inventory. The inventory development phase begins from quantitative ethnographic methods in order to understand the phenomenon of *baksbat* from the perspectives of experts. From this, criteria by which to measure *baksbat* syndrome was generated and the inventory of *baksbat* syndrome was developed. Then the validation phase starts with a quantitative survey by comparing the inventory of *baksbat* syndrome with the internationally standardized scales such as PTSD Checklist (PCL) and Hopkins Symptoms Checklist-25 (HSCL-25).

Table 1: Conceptual framework for mixed methodology research on baksbat

Conceptual Framework for Mixed Methodology Research on Baksbat
Formulation of research objectives and methodology
Literature review
Inventory Development Phase:
Qualitative Method: ▪ Ethnographic interview and FGDs, ▪ Purposive and convenience samplings, ▪ 53 experts were involved ▪ Explore the meaning of *baksbat* (emic) ▪ Clarify range of symptoms, and idioms of distress ▪ Develop initial inventory for *baksbat* (56 items)
▪ Second consultation with the experts (FGD) to remove irrelevant, duplicate items, and/or merge similar items. The items were reduced

from 56 to 32, thus initial inventory for *baksbat* was developed
Quantitative Method: Survey 1 ▪ Administer the 32 item inventory for *baksbat* syndrome to 390 consecutive patients ▪ Exploratory Factor Analysis (EFA) was used, the number of items reduced to 28 ▪ Develop a 28 item inventory for *baksbat* (consist of 3 clusters)
Inventory Validation Phase
Quantitative Method: Survey 2 ▪ Administer the 28 item of inventory for *baksbat* syndrome, PTSD checklist, HSCL-25 to 77 victims ▪ Confirmatory Factor Analysis (CFA) was used to confirm the factor loading of survey 1 ▪ Final inventory of 24 items was developed
Data analysis: ▪ Open coding for data from ethnographic interview and FGDs ▪ Factor analysis ▪ Internal consistency, reliability, correlation, multiple regression, EFA and CFA.

3.3. Research questions

In order to capture the meaning of *baksbat* from different perspectives, the author asked participants questions that would highlight the experience and operation of this term in their lives.

The early part of the interviews centred on respondents responding to the following questions: "What is *baksbat*? Please tell me about a person you know who has *baksbat,* without identifying her or him in any way. By beginning with these two questions, the respondents did not feel being intimidated; they were free to describe their own experiences through people they knew. Confidentiality was maximised at all times.

In addition to the main questions, the researcher sought ascertains details of trauma responses. So, these subsidiary questions assisted the researcher to better develop criteria for *baksbat* for comparison to PTSD.

Exploring ethno-cultural range of responses to distressing events

- What do you consider to be the 5 most challenging stressful events in your life?
- What senses have been impacted the most for you (sight, hearing, smell, touch, taste)?

Explore the meaning of 'trauma' in Cambodian context

- What Khmer words or expressions (metaphors) do you used to describe suffering? What Khmer words or expressions (metaphors) do you used to describe trauma?

Explore phenomenon of *Baksbat*

- Have you ever experienced *baksbat* in yourself? If so, what did it feel like?

- What made it better? And what made it worse?
- What do you think causes *baksbat*?
- What do you think can happen if someone with *baksbat* does not get help?
- Can someone get infected with *baksbat* by associating too much with someone who has it?
- Can it be transmitted from one generation to another?
- Who can best help someone with *baksbat*?
- Have you helped anyone with *baksbat*; if so what did you do?)
- How can someone be helped?

3.4. Inventory development phase

3.4.1. Sampling Methods

- ***Purposive sampling****:* Purposive sampling involves the selection of individuals/groups based on specific question/purposes of the research in lieu of random sampling and on the basis of information available about these individuals/group (Strauss, 1990). The main objectives were not to gain representativeness but to maximize sample variability by targeting those who have an understanding of the concept of *baksbat* and trauma-related issues from different perspectives while at the same time maintaining a reasonable level of convenience. Snowball sampling was also used in addition to the purposive sampling in order to find more .who have the knowledge of *baksbat* and to have their different points of view. Snowball sampling select individuals on the basis of information obtained from other selected sample member or from other individuals. Because each new person has the potential to provide information regarding more than one other suitable case, the sample mushrooms as the study continues (Tashakkori, 1998).

- ***Convenience sampling:*** is used with the first survey of participants. Convenience

sampling is a type of nonprobability sampling, which involves the sample being drawn from that part of the population, which is close to hand. That is, a population is selected because it is readily available and convenient (Tashakkori, 1998).

3.4.2. Participants

There were 2 groups of participants recruited for the inventory development phase:

- The first consisted of 53 experts who were selected for ethnographic interviews and focus group discussion (FGD) in order to come to consensus on their understanding of *baksbat* from their perspectives and to develop an initial inventory for *baksbat*. The details of the participants are included in the published article 1.

- The second group of participants consisted of 390 consecutive patients who received mental health services from the Mental Health Clinic of the Transcultural Psychosocial Organization Cambodia (TPO Cambodia) in Phnom Penh and other areas including Pursat, Battambang, Banteay Meanchey, Siem Reap, Preah Vihear, Kampong Thom, Kampot and Takeo provinces. These sample groups were recruited to develop the final inventory for *baksbat*. They were selected from a broad range of socio-demographic variables across geographical location, and the details of this sample are included in the manuscript.

3.4.3. Procedures

- The first group of participants was interviewed by the researcher using the ethnographic method developed by Hubbard (Babbie, 2011) which is not intrusive because participants were asked to tell about the problem of a person whom he/she knew; and he/she does not need to tell the name of that person. For example, the participants were asked to answer one main question: What is *baksbat*? Please tell me about symptoms of *baksbat* of persons

you know (you don't need to tell me the name) (e.g. their behaviour, attitude, relationship, function)? And subsidiary questions such as, What are the causes of *baksbat*? Is *baksbat* transmitted to the next generation? What can be done to prevent *baksbat*? The information from this ethnographic interview was coded and grouped to form an initial inventory for *baksbat* on a 5-point Likert scale (0-4). The interview lasted from 60-90 minutes. (Please see the questionnaire in the appendix).

- The second group of participants was administered with the initial inventory for *baksbat* refined from ethnographic interview in order to develop the final inventory for *baksbat*. This group of participants was interviewed by 4th year students of who were studying psychology at the Royal University of Phnom Penh. They were supervised by TPO's Research Assistant who was constantly in consultation with the researchers.

3.5. Inventory validation phase

3.5.1. Sampling

Purposive and convenience sampling method was used to identify participants who experienced and / or witness the tragic event of the stampede on the bridge in Phnom Penh.

3.5.2. Participants

The third group consists of 77 participants who are the neighbours of the family who lost their children or relatives during the stampede on the bridge in Phnom Penh in November 2010 during the annual Traditional Water Festival in Cambodia. A total of 350 people died in the stampede on the bridge, most of them young adults who came from rural areas to take part in the festival. The author used the neighbours as participants for the study because they did not have direct impact from this event, and also the author wanted to avoid overlapping symptoms of *baksbat* and grief. Respondents were interviewed one year later in order to understand their psychological responses to the tragedy based on both the newly developed inventory for

baksbat syndrome and the Western PTSD developed scales. Please see the details in the manuscript.

3.5.3. Procedure

Participants were interviewed by the final year (4th year) students from the Psychology Department of the Royal University of Phnom Penh. The researcher trained these interviewers on the use of questionnaires, including case examples and role-play in order to ensure that everyone understood the items the same way in order to increase consistency and inter-rater reliability. Interviews lasted approximately one hour, and were conducted in Khmer language. Verbal informed consent was obtained prior to the interviews. Due to the high rate of illiteracy and local customs, these people were never expected to sign any documents such as a consent form. No incentives were provided to participants of this study. The interviewers were also trained in mental health first aid and how to identify signs and symptoms of distress among people they interviewed, so that they could assess for referral if needed. The interview participants were also provided with a list of mental health services available including the hotline telephone number of TPO Counselling Center where they could seek help in cases of distress caused by the interview.

3.5.4. Instruments

- **TPO Baksbat Inventory (TPO BI)**

A 24-item inventory consists of three symptom clusters (1) broken courage, (2) psychological distress and (3) erosion of self. Respondents were rated on the extent to which they experienced each problem itemized on a 5-point Likert scale (0=not at all, 4=extremely). This inventory has 3 symptom clusters, psychological distress symptom cluster measures distressing symptoms which is a mixture of anxiety, depression and arousal, broken courage symptom cluster measures attitude and feeling related to the courage while loss of self symptom cluster measures the attitude change after the traumatic event. There is no cut-off score in this

inventory, as the researcher does not intend to make a diagnosis from this inventory at this time. *Baksbat* has shown excellent internal consistency (Cronbach's α=0.94) when tested with the group of 390 participants.

- **PTSD Checklist Civilian version (PCL-C)**

The PCL Checklist was developed by Wealthers et al., (1993), a simplified version questionnaire which consists of a 17-item self-report rating scale designed to measure PTSD symptoms. The item addresses different types of traumatic events known to have occurred under the Khmer Rouge. Respondents were asked (yes-no) whether or not they encountered each of these types of traumatic event at the time of the Khmer Rouge regime. A total trauma exposure score was calculated based on summing the number of items endorsed. Respondents rate the extent to which they experience each of the symptom items during the prior 30 days on a 5-point scale (1= not at all, 5=extremely). The PCL can be used to assess the severity of trauma symptoms on a continuum and to provide score cut-off criteria for making a PTSD diagnosis. The overall internal consistency of the translated Khmer version based on all 17 items was excellent (α =0.93). The PCL subscale has excellent internal consistency across subscale (1) Re-experiencing subscale (α=0.86), (2) Avoidance subscale (α=0.77) and (2) Arousal subscale (α=0.79) (Wealthers, 1993).

- **Hopkins Symptoms Checklist-25 (HSCL-25)**

The HSCL-25 is a widely used measure that was developed by for Indochinese refugees resettled in the USA (Mollica et al., 1987). The Khmer version of HSCL-25 consists of 25 items, 10 of which are for the assessment of anxiety and 15 others are for the assessment of depression. HSCL-25 has a very good internal consistency both overall (α=0.94) and the subscale Anxiety (α=0.91), depression subscale (α=0.91) and this measure has also been widely used in Cambodia and has been referenced as a culturally appropriate tool (Mollica,

Wyshak, de-Marneffe, Khuon & Lavel, 1987). However, as further rationale for the development of the inventory for *baksbat* syndrome, the HSCL-25 and PCL were normed on those who migrated out of Cambodia.

3.6. Statistical analysis

3.6.1. Inventory development phase

During the inventory development phase of *baksbat*, both open coding and selective coding techniques (Saldana, 2011) were used to analyse the qualitative data from the ethnographic interviews and FGDs. Open coding is the process of breaking down into small parts, closely examining, comparing for similarities and differences, conceptualizing and categorizing data (Strauss, 1998, p.102), whereas selective coding is the process of selecting the core category, systematically relating it to other categories, validating those relationships, and filling in categories that need further refinement and development. The responses from the experts are broken down and compared for similarities and differences between each response, conceptualizing the responses and categorizing them to develop an initial inventory for *baksbat* syndrome.

3.6.2. Inventory validation phase

Factor analyses were performed the first as exploratory factor analysis (EFA) and secondly as confirmatory factor analysis (CFA). EFA was used to explore the loading pattern of items while developing the inventory while CFA was used to test whether factors are consistent with a researcher's understanding of the nature of that factor (or construct) (Strauss, 1990, p.62).

The newly developed inventory for *baksbat* was administered_with 390 participants. The principal axis factoring was used to extract the factors followed by oblique rotation, while the number of factors was identified by the visual examination of the Scree plot test. Reliability

was evaluated by calculating Cronbach's alpha coefficient, a measure of internal consistency of the response to the group of items. Correlation between inventories: inventory for *baksbat*, PCL-C and HSCL-25 and inter-subscale correlations were evaluated by calculating Pearson's correlation.

Then the CFA was performed with another group of 159 participants in order to validate and confirm the final inventory for *baksbat* syndrome. CFA was performed to investigate goodness-of-fit of *baksbat* inventory, and several fit indices that was selected to test which CFA model best represents the present data set: root-mean-square error of approximation (RMSEA), comparative fit index (CFI), goodness-of-fit (GFI), adjusted goodness=of-fit (AGFI), chi-square (x^2) and the ratio of x2 and degree of freedom (x^2/df)

Multiple regression analysis was performed to explore the relationship between PCL-C, HSCL-25 as dependent variables and the 3 symptom clusters of inventory for *baksbat* as predictors. This analysis can tell us how well a set of variables is able to predict a particular outcome (Byrne, 2004). All statistical procedures were performed using the SPSS 16.0.

Chapter 4: Findings and description of the trauma-based syndrome

4.1. Socio-demographic information:

The socio-demographic information for participants in the ethnographic interview is summarized below.

As far as the geographical location is concern, 47.17% (n=25) live in the provinces and 52.83% (n=28) live in Phnom Penh. The analysis indicated that the age of participants ranged from 25 years to 75 years, the mean age was 56 (SD=12.87). The age group is classified the following: 13.2% aged between 20-35, 26% aged between 36-45, 34% aged between 46-55 and 26.4%

aged between 56-75. In regard to gender, 35.8% (n=19) are female and 64.2% (n=34) are males.

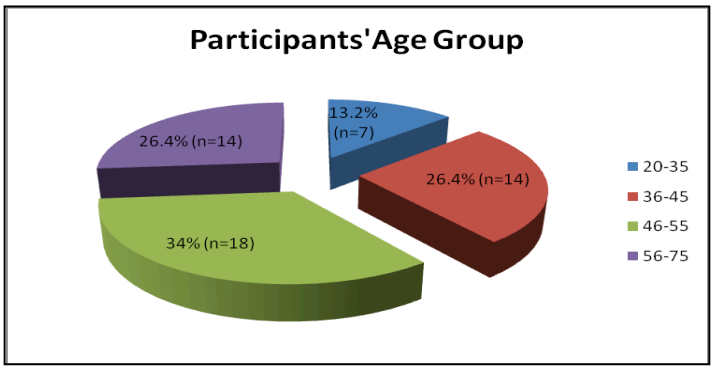


Figure 2: Graph of Participants' Age Group

As far as the roles are concerned, 35.8 % (n=19) are victims of torture. These men and women are the civil party members of the Khmer Rouge Tribunal, 15.1 % (n=8) are psychologists, 11.3 % (n=6) are psychiatrists, 11.3 % (n=6) are religious leaders/traditional healers/mediums altogether, 9.4 % (n=5) are academics, 5.7 % (n=3) are historians/linguists and the rest 11.3 % (n=6) are community leaders/elderly people and NGO leaders.

In regard to their education, 28.3 % (n=15) completed postgraduate degree, 22.6 % (n=12) completed university degree, 13.2 % (n=7) completed high school, 9.4 % (n=5) completed secondary school and 26.4 % (n=14) completed primary school.

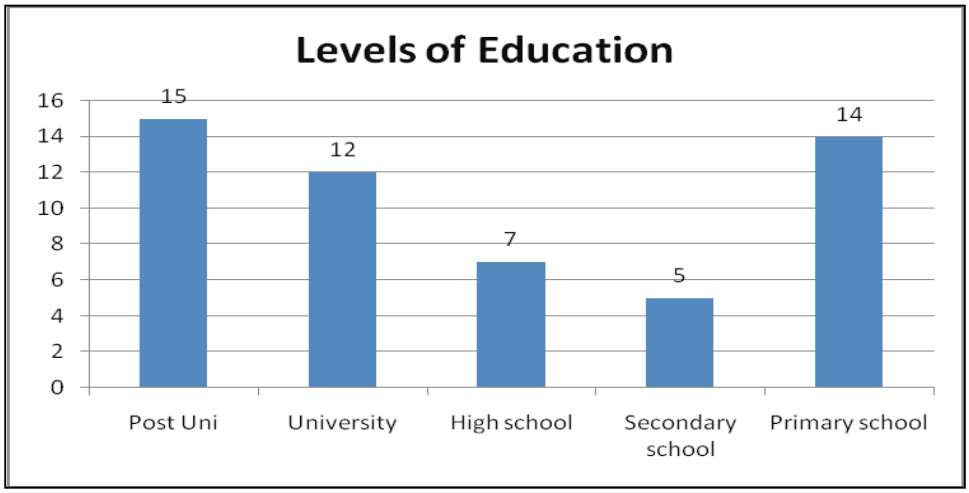


Figure 3: Graph of Levels of Education

Of 53 participants, 28.3% (n=15) said that they have not experienced any major traumatic events, 4 out of this number lived abroad during the Khmer Rouge period while the other 71.7 % (n=38) experienced a variety of traumatic events. Of these 38 respondents, 55.26% (n=21) experienced mal treatment under the Khmer Rouge, followed by 23.68% (n=9) of respondents who experienced torture and imprisonment and 7.89% (n=3) who witnessed relatives being killed by the Khmer Rouge.

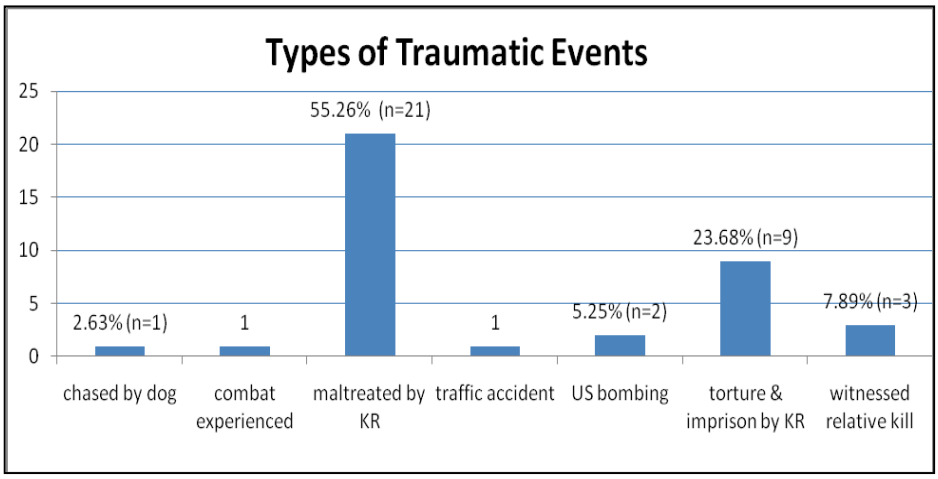


Figure 4: Graph of Types of Traumatic Events

4.2. Ethnographic findings of baksbat:

4.2.1. Explore ethno-cultural range of response to distressing events:

This section of the chapter presents the range of ethno-cultural responses expressed by the participants in this study related to questions: what have you consider being the most 5 challenging events in your life? And what of your senses are impacted the most?

The responses that have not been included in the published articles are summarized below:

1. **Challenging events:**

The worst and most challenging event experienced by about half of participants (51 %, n= 27) was related to the difficult life under the Khmer Rouge when everyone was forced to work hard during the day and night without sufficient food, shelters and medical care. In addition, they were living in constant fear as the Khmer Rouge guards constantly monitored them closely as they have to be careful with every step they took. The Khmer Rouge said that "*Angkar* has as many eyes as a pineapple[1], so *Angkar* knows whatever you do and whatever you say". One respondent spoke of his suffering as follows:

> "I was sent to work at *kang chalat* (a mobile labour camp) where everyone participated in digging the water canals, every day we work so hard, but the Khmer Rogue didn't let us rest or have sufficient meals. One day I fell down from the steep dyke because I was so exhausted and hungry, the *mé kang* (team leader) kicked me on my back and hit me so hard with the stick. I've got injuries from the felt as well as from his punishment. I felt even more pain, but I dare not cry so I had to get up and went to work again. Nevertheless, I cried inside every time I think of this, I still remember this pain; I can't understand why they did this to me and to other Cambodians? " (Mr P.P).

The second most challenging event reported among respondents was the experience of torture and imprisonment under the Khmer Rouge. Approximately 19 % (n=10) of participants in the study said they had experienced severe torture and imprisonment during the Khmer Rouge time. Three of them were imprisoned in Tuol Sleng prison in Phnom Penh (currently a Genocide Museum), one was imprisoned in Siem Reap prison which is another notorious prison in Siem Reap province. The rest were imprisoned elsewhere in Cambodia. They reported

[1] Cambodians called the scale of the as eyes, so pineapple has many eyes. Angkar is the Khmer Rouge abstract administration body, it exists everywhere, and it has many eyes like pineapples. So they can see whatever people do.

that life in the Khmer Rouge prison was much more difficult than death. They were imprisoned because they were accused of betraying *Angkar*, they were cuffed and shackled day and night in their cells. They were interrogated almost every day, about one hour each time. During this interrogation, they were sometimes blind folded and then asked to answer questions of the crime that they have not committed. One respondent reported that:

> "Once every 3 to 4 days, they took me to the interrogation room, they said my crime was that I was the enemy of *Angkar*, because I have been implicated so by other people. They hit me with electric wire, electrocuted me and pulled my fingers nails when I did not give the response as what they wanted. It was so painful, I cried, I shouted, but the more I shout, the stronger I was hit. They hit me until I was unconscious, I didn't know what happened next, I woke up in my prison cells with bruises and blood covering my body. You can see my fingers, my fingers have no nails because they were extracted. Every time after the interrogation, I cannot eat food (even if there is no food) for a few days, my tongue didn't recognise the taste any food, every thing is bitter. The pain in the body lasted several weeks before they took me to the interrogation room again. My life in prison were so terrible, living in the Khmer Rouge prison is worse than death, I wanted to die but the Khmer Rouge guard won't let me die because they needed my confession. I stayed in this prison for more than a month, I constantly fear about being taken to the interrogation room again, I can't bear such torture anymore". I survived because they needed someone who could fix the sewing machine, I said that I could do it, so they released me from the prison cells but I continued to work in the prison until the Vietnamese soldiers came (Mr. MC).

Another participant who was tortured and raped by many Khmer Rouge guards said that she vividly heard the voice of her husband who called her name while he was being executed, she was so scared about this and afraid that later would be was her turn. She described her story as follows:

> "After my husband was killed, *Angkar* summoned me and other 4 women to discuss the work plan. I was so afraid because I had that experience and I knew that they would kill me. On the way to meet *Angkar*, I was beaten from behind, I felt down on the ground and then 4 guards raped me. I tried to defend myself but I was beaten even more. I got unconscious from this, when I woke up I was lying naked on the ground; I then tried to put on cloth and returned home. When the Khmer Rouge regime was over, the villagers discriminated against me; they said that I am a bad person, which bring bad luck to the other villagers. Whenever the children in the village got sick, they attributed this to my presence in the village. So, they asked my mother to pray and ask for an apology from God because of me living in the village. This even hurt me more whenever this happen, I cannot live in this village anymore, so I have to move out of the village to live far away from other" Mrs LK.

The third hardest challenge faced by participants was the witnessing the death of close relatives, friends killed by the Khmer Rouge or in traffic accidents or in the course of a robbery. More than 13 % (n=7) of participants witnessed brother, sisters and parents killed by the Khmer Rouge and others witnessed other people was dragged by the Khmer Rouge to the killing fields.

> "Mrs HSV said that my problem was that I cannot forget what happened to my family and myself. I witnessed my 3 siblings; and my parents killed by the

> Khmer Rouge guards. I could not do anything to help them. I witnessed my elder brother who was stabbed to death because he stole sweet potatoes to eat with other family members. Some time later, I saw my two elders siblings who were beaten and stabbed to death with the bayonet of the gun because they refused to get married arranged by *Angkar*. Later on, my father was executed with my mother because they both failed to accomplish the task that *Angkar* assigned to them. I was trying to help my parents but the Khmer Rouge guards took me away and raped me until I became unconscious. The last guard who raped me, told me to leave this village, otherwise I could die; he said that he would find me there. A few weeks later, he went to se me in new village and gave me a bag of jewellery and told me that I should keep it for doing business later and asked me to take care his child. I've got pregnant and got one son from this rape. I never forget about this, what am I doing wrong? "

The fourth challenge faced by more than 5 % (n=3) of participants was the experience of the US bombing in Cambodia during the period before the Khmer Rouge victory in 1975. There was massive bombing by the US in order to get rid of the Khmer Rouge communists, many villagers were killed and/or wounded, and many houses and buildings were destroyed. One participant said that she couldn't hear the sound of the airplane anymore because she thought that it was another bombing about to happen. Mrs CTD said, "One day I heard the sound of the plane, I jumped to a hiding place because I thought of the bombing. Then I realised that it was my crazy state of mind, there was no bombing anymore, it was just a civilian plane".

The last challenge identified amongst our respondents especially those who were living overseas was the lack of information from their family members in Cambodia from the time when the Khmer Rouge took power in 1975.

"I was feeling extremely anxious when I heard the news about the Khmer Rouge taking over the country, I did not hear anything from my family back home, I kept crying and I couldn't study. My professor appeased me, he told me that everything is not going to be the same, just like the weather in Melbourne, one day is rain and the next day is warm. So one day your family will get out of this, his statement only calmed me for a while", Mr TT.

2. Senses impacting experience:

There were varied responses to the question, What senses have been impacted the most for you?. For those who were severely tortured, they spoke of hearing sounds or vivid voices of their deceased relatives calling them. Mr BM said, "The sense that disturbs me is the auditory sensation as I sometimes hear my wife, who was killed by Khmer Rouge guards, crying and calling to me for help". Many other respondents have a mixture of visual and olfactory sensations, or a vivid visual image of the killing and smell of the blood from the graves at the killing site. No other senses such as visual, gustatory and tactile were reported by respondents.

4.2.2. Explore the meaning of 'trauma' in Cambodian context:

In order to explore the meaning of trauma in Khmer context, the researcher asked, "What Khmer words or expressions do you or others use to describe suffering?" There were many Khmer words to express pain and suffering described by our respondents, or non-verbal expressions.

Verbal expressions of pain and suffering:

ជីវិតឈឺចាប់ (*chivit chheuchab* – literally translated as life is full of pain with throbbing sensation). This is expressed as physical and mental pain. **ជីវិតឈឺផ្សា** (*chivit chheu phsar* – life

is full of pain in burning character). **ជីវិតខ្លោចផ្សា** *(chivit khloach phsar* – a pain character of burned and burning sensation). **ជីវិតឈឺចាប់ខ្លោចផ្សា** (*chivit chheuchab khloach phsar* – life is full of combined pain of a throbbing or pulsatile character plus over burning/over cooked charactering). **ទុក្ខវេទនា** (*tukha vedhanear* – life is full of painful, miserable feelings of pain). **រាងចាល** (*reang chal* – dare not do something again, to stop or quit doing something due to a previous unhappy experience; to resolve to stop doing something). **បវិសជៀសឆ្ងាយ** (*bor veas cheas chhgnay* – wishing all the bad things to go away). **ជីវិតល្វីងជូរចត់** (*chivit lvinh chou chot* – life full of bitter and sour taste/experiences). **ទុក្ខធ្ងន់ ធ្ងរហួសនិស្ស័យ** *(tukha thgnon thgnor hours-ni-say* – refers to the present suffering being heavier than karma that he/she is supposed to have, beyond karma). **ឆ្អែតចិត្តណាស់** (*chha aeth chet nas* – literally translated as saturated mind which refers to having enough with something and no longer wanting to see, to hear that again.

Some respondents said that in some cases, the expression of pain and suffering is expressed in emotional hopelessness, reflecting the acceptance of karma for what they have done in this life or a past life, or relates to their destiny in life. Those include: **នេះគឺកម្មផលខ្ញុំទេ** (*kam pha knhom te* – this is my karma), **វេទនាណាស់អញអើយ** (*vedhanea-nas-anh-euy!* - how miserable am I), **ខ្ញុំ កម្មអើយ** (*Oh! kam anh euy* - how karma/sinful am I), **វាសនាអញបានត្រឹមប៉ុណ្ណឹង** (*veasna anh ban trem pon noeung* - this is all my destiny. This expression reflects the influence of Buddhism), **ព្រហ្មលិខិត និស្ស័យអញបានត្រឹមប៉ុណ្ណឹង** (*brum li khet anh, ni say anh – ban trem pon noeung* - this is all my destiny, this expression is used according to the influence of Hinduism). In other cases, people express their life as meaningless **ជីវិតឥតន័យ** (*chivit ort nei* – life is meaningless), life is dry. **ជីវិតសោះកក្រោះ** (*chivit soh kokroh* – life has no essence). Some people express the word

និយាយ មិនចេញ (*ni yay min chenh* – unspeakable pain), or other would say **ហួសពីការស្មាន** (*hours pi kar smann* – beyond expectation).

Respondents also reported that in some cases the pain and suffering is mixed with anger and revenge, so people would express their suffering as **ជីវិតឈឺចាប់ពុះកញ្ជ្រោល** (*chivit chheu chab pu kanh chroeul*. The fuller meaning of this phrase is that life is full of pain, which is like water boiling over.

4.3.2. Explore phenomenon of baksbat:

In order to explain the phenomenon of *baksbat*, the author asked respondents to discuss the following: meaning of *baksbat*, descriptions of someone who has *baksbat*, whether the respondents experienced *baksbat* themselves, the causes of *baksbat*, what makes it better and what makes it worse, the evolution of *baksbat (how it rises and falls)*, the best treatment for *baksbat,* and whether or not *baksbat* is transmitted to the next generation.

1. **The meaning of *baksbat*:**

The majority of respondents stated that the very first reaction to *baksbat* is *phey khlach* (fear-fright), and that this relates directly to the shocking events they had experienced, directly. *Phey* means fear but it is expressed as an attitude, while *khlach* is more related to a reaction or behavioural response to fear; therefore the concept of *phey khlach* combined both attitude and behaviour emerging from fear in response to distressing events. This *phey khlach* reaction leads the person who experienced horrible events to become *reang charl* (to resolve to cease doing anything), *khlach ro-arh* (being fearful or feeling dread, and wishing not to experience the event again, ever again), *khlob khlach*[2] (fear, respect, bow, giving in), *chos chanh* (defeat), *leng chang chourb* (never want to see that event again), *cha-aet cha-al* (this expression refers

[2] This expression refers to a kind of plant in rural Cambodia that bows when people touch or step on it. Cambodian people refer people with *baksbat* as having the behaviour like this plant when someone touches it.

to the act of eating more food until extremely full, and then causing sickness in the stomach, unable to move, become nauseated and gas bloated. Following, they never want to eat again; *bor veas cheas chgnay* means wishing the traumatic event or the bad thing would go away.

In this case, our respondents give examples in different contexts. Soldiers who lost a battle were often described as having *baksbat*, and they feared the battlefield and didn't dare to go back to fight in the battle again. These soldiers had lost courage and were unable to confront the enemy. Some respondents give an example of *baksbat* by comparing a dog that encounters a tiger, the dog becomes withdrawn, and dares not to attack the tiger. The dog hides its tail and lowers it body down as a signal of fear, withdrawn and defeated. Similarly, the respondents give examples of buffalo or ox fighting wherein the loser never wants to get close to the victor again. The loser runs away when they see or just smells the victor. (The Cambodian sensitivity to smell and taste is important here as people often describe feelings as a taste adjective, such as bitter or sour.) Similarly, the Cambodian people who have more than enough experienced through war and Khmer Rouge genocide have a feeling of *khlach ro-arh* of the former regime and wish to *bor veas cheas chgnay* from it. Some interviewees said that "I am *reang chal* and *khlob khlach* with the Pol Pot regime now; I wish to *bor veas cheas chgnay* this regime" Mrs CN.

The respondents reported that most people with *baksbat* are afraid of disclosing their identity or of telling their stories to others. The respondents use the concept of *dam doeum kor* [3] or planting the kapok tree or mute tree in order to explain how *baksbat* people have difficulty in disclosing their identity. They said that in difficult time under the Khmer Rouge, the only way to survive was not to disclose their identities, or to pretend to be deaf or stupid or uneducated,

[3] In the Khmer Rouge time, many people hid their identity in order to survive. They told each other to *dam doeum kor* (plant the kapok tree or *Ceiba pentandra*), which means to pretend to be mute and deaf. In Khmer the word *kor* has different part of speech. *Kor* as a noun means kapok tree (*Ceiba pentandra*) but *kor* as an adjective means "mute and deaf". Only those who pretend to be mute, dumb and deaf are survived.

not knowing, not hearing or not seeing anything, or to act like a *kor* tree. They were also not able to speak or express their ideas (or *kob yobal* – the idea is buried).

Picture: The statue of 3 monkeys: hear nothing, see nothing, say nothing, which resembles to the concept of *dam doeum kor,* which is a component of *baksbat* (Courtesy of Wikiality.com)

The respondents described that in *baksbat* there are many types of expressions of fear, for example: **ភ័យញ័រ** (*phey nhor* –fear with trembling), **ភ័យភ្នែកនៅកញ្ឹងករ** (*phey phnek nov kachoeung kor* – fear that makes the eyes move to the neck), **ភ័យភ្នែកដូចត្រីស្ងោ** (*phey phnek doch trey sgnor* – fear that make the eyes like the eyes of fish in the soup), **ភ័យរត់បាតជើងសព្រាត** (*phey bat choeung sar preat* – fear until the sole of the foot become white), **ភ័យផ្អែមមាត់** (*phey pha em maot* – fear until having sweet taste in the mouth), **ភ័យសាបមាត់** (*phey sab maot* – fear a certain taste in the mouth) **ភ័យលេចអាចម៏លេចនោម** (*phey lech arch lech norm* – fear until one defecates and urinates), **ភ័យឡើងព្រលឹងធំចេញសីអាចម៏បាត់** (*phey loeng praling thom chenh si-arch* – fear

until the big soul goes out of the body to eat stool), ភ័យឡើងស្រាលខ្លួនដូចសំឡី (*phey loeng khlourn sral doch samlei* – fear until the body becomes light like the cotton), ភ័យលោះព្រលឹង (*phey lours praling* – fear until some of the souls go out of the body), ភ័យព្រលឹងចុងសក់ (*phey praling chong sak* – fear until the souls go to the extremity of the hair), ភ័យបះសក់ (*phey preu roam* – fear until the hair becomes straight).

The respondents reported that the most extreme type of fear is the fear associated with losing souls (*lours praling*) or the souls go to the extremity of the hairs (*praling chong sak*). In fear associated with *lours praling*, the majority of souls are lost. There are 19 small souls and one large soul in the body. If small souls are lost, people go into a trance that looks much like a dissociative state, depersonalization, or derealisation. If the big soul is lost, the individual may become psychotic or die.

2. Describe someone with *baksbat*:

The person with *baksbat* becomes frightened more easily than usual, and is hyper-alert and easily trembles or shakes. (A respondent gave an example of a man who says he is over sensitive to sound; he suddenly jumps to escape the crowd after hearing thunder, because it reminds him of the USA bombardment from the 1970s). During the period of fear, people avoid places that remind them of traumatic events. One becomes '*slot'* or '*sralaing kaing'* which is similar to a 'frozen' or catatonic state. The person's eyes become white, like *phnek doch trey sgnor* (fish eyes in the soup), *phey pha em maot* (fear until having sweet taste in the mouth), *phey phnek nov kachoeung kor* (fear that makes the eyes move to the neck).

In the extreme fear, people with *baksbat* have *phay lous praling;* this is when the soul goes out of the body. When this happens, the individual gets sick until hair drops out.

People with *baksbat* do not make eye contact with others; they reduce participation in any discussion, they continue to have a sense of permanent fear; they dare not make decisions and have often been easily exploited.

They express feelings of exhaustion; they do not want to stand up, having a sense of having had enough, and usually they generalise that everyone (in this world) is the same, which refers to their lack of trust of others. They are sensitive to any trigger that might cause *baksbat*. For example, due to *baksbat* many people believe that a kind of night bird predator called *oav-lar* comes and takes their soul, which can result in deaths of people in the village. Many respondents who have *baksbat* from the Khmer Rouge time described that they heard the cry of *oav-lar* bird every night, and people died every night too because they believed that when this bird comes, it took the soul of the people with them. Therefore, whenever they hear the sound of this bird, they become extremely fearful; they are known to scold this bird with dirty words, making noise to show that they are not asleep in order to chase the bird away.

People with *baksbat* have a problem trusting others and they easily give in or submit to defeat (*chos nhorm* – submissive or submitted to defeat), or feel or act in a cowardly way (*kam saak*) and cannot stand up for themselves and confront others. *Baksbat* makes people lose the sense of togetherness, and they become afraid of helping others. Unfortunately they are misunderstood often and appear to others to be selfish in the way that isolates them more from their communities (when in fact the selfishness is isolation and detachment akin to dissociation).

People with *baksbat* often have physical symptoms such as headaches, poor sleep, and poor attention, with reports of thinking too much (rumination), feeling emotionally and physically weak and having digestive problems. They often have repeated bad dreams about past events.

They become withdrawn and socially isolated; they rarely go outside their home, and fear something (phenomenal) has caused their problems. They often feel anxious, shaky, lose control, or appear to have pale colour and cold extremities.

3. *Baksbat* as an illness:

Twenty out of 23 respondents (86.96 %, n=20) during the ethnographic interviews believed that *baksbat* is an illness because it has clearly defined causes, an evolution of symptoms, with therapeutic ways of dealing with the symptoms. By contrast, 13.04 % (n=3) believed that *baksbat* is not an illness because it is just a response to a severe distressing event.

4. Respondents who experienced *baksbat* personally:

Fifteen percent (n=8) of respondents in the ethnographic interview reported that they have *baksbat* themselves. Most of them said they have *baksbat* from the Khmer Rouge time, some said they have *baksbat* from witnessing a severe traffic accident, or from being chased by a dog. One respondent said that having been tortured by the Khmer Rouge, he is having *baksbat* himself throughout his life. He said that he is *bak* (broken) physically and mentally, and he cannot be himself ever again. Another respondent said that he couldn't trust other people since after the Khmer Rouge time; therefore he cannot be open as before. One respondent said that his life is meaningless; he is living now just to keep company with other people in the village before he dies naturally.

5. What makes *baksbat* increase and what make *baksbat* decrease?

The majority of respondents agreed that cohesiveness in community and family are the factors that could make their *baksbat* condition improve. Strengthening cultural identity, promoting the respect of religious beliefs, upholding social morals are also factors that could help people overcome *baksbat*. The other respondents said that the promotion of democratic space and human rights could help people whose *baksbat* is caused by torture and human rights violations. At the same time, increased access to justice or allowing victims to get involved in

the process of justice helps them to strengthen their ability to cope with *baksbat*. Some respondents who have been tortured by the Khmer Rouge found that they could overcome *baksbat* through their gradual participation in the civil party group who testify against the former Khmer Rouge leaders in the Extraordinary Chambers in the Courts of Cambodia. Those residing in the city seemed to reference justice more; this could be due to media influences and requires further study.

Many respondents think that the severity and repeated nature of distressing events make *baksbat* get worse because it make the people to be totally broken which will never be repaired. The lack of family, community and social support is another factor that makes *baksbat* worse.

6. *Baksbat* and generational transmission

Opinions among respondents varied on the question of generational transmission of *baksbat*. Many people have said that *baksbat* can be transmitted across generations and believe the history of Cambodia has proven this. Others people say said that it is the problem of individuals and only those who experienced the event will suffer from it.

4.3. Quantitative findings:

4.3.1. Correlation between TPO Baksbat Inventory (TPO BI), PCL-C and HSCL-25

Correlational analysis between each inventory was established during the validation phase of the *baksbat* inventory. The correlations between *baksbat*, its sub-cluster (broken courage, psychological distress and erosion of self), PTSD (PCL-C), anxiety and depression (HSCL-25) were investigated using Pearson's correlation coefficient. Preliminary analyses were performed to ensure no violation of the assumptions of normality, linearity and homoscedasticity.

Pearson's correlation analysis in table 2 reveals that the inventory for *baksbat* has a higher correlation with depression subscale of HSCL-25 ($r = 0.71$, $p < 0.01$). It also has a high

correlation with both anxiety subscale of HSCL-25 ($r = 0.67$, $p < 0.01$) and with PCL-C ($r = 0.66$, $p < 0.01$) but this correlation is a bit lower compare with that of depression subscales.

The 'broken courage' symptom cluster of the TPO-BI has medium correlation with PCL-C ($r = 0.51$, $p < 0.01$), anxiety ($r = 0.52$, $p < 0.01$) and depression ($r = 0.55$, $p < 0.01$). The 'erosion of self' symptom cluster of the TPO-BI has lower correlation with PCL-C ($r = 0.43$, $p < 0.01$), anxiety ($r = 0.42$, $p < 0.01$) and depression ($r = 0.50$, $p < 0.01$) subscales in comparison with the 'broken courage' cluster.

The 'psychological distress' cluster of TPO-BI, however, has a stronger correlation with PCL-C ($r = 0.70$, $p < 0.01$), anxiety ($r = 0.73$, $p < 0.01$) and depression ($r = 0.75$, $p < 0.01$) subscales in comparison with the other 2 clusters of TPO *baksbat* inventory.

In relation to HSCL-25, broken courage symptom cluster of TPO-BI is slightly correlated with total score of HSCL-25 ($r = 0.38$, $p < 0.01$) and its subscale, anxiety ($r = 0.23$, $p < 0.01$), and depression ($r = 0.44$, $p < 0.01$). Similarly, erosion of self symptom cluster of TPO-BI is also slightly correlated with total score of HSCL-25 ($r = 0.38$, $p < 0.01$) and its subscale anxiety ($r = 0.25$, $p < 0.01$), and depression ($r = 0.43$, $p < 0.01$).

Table 2: Pearson's Correlations (sig. 2 tailed)

	1	2	3	4	5	6	7
1. Broken courage	1						
2. Psychological distress	**0.68****	1					
3. Erosion of self	**0.60****	0.65**	1				
4. TPO-BI (*baksbat*)	**0.88****	0.93**	0.78**	1			
5. HSCL 25 – anxiety	0.52**	**0.72****	0.42**	0.67**	1		

6. HSCL 25 – depression	0.55**	**0.75****	0.50**	0.71**	0.80**	1	
7. PCL (PTSD)	0.51**	**0.70****	0.43**	0.66**	0.68**	0.74**	1

**. Correlation is significant at the 0.01 level (2-tailed). N=159

4.3.2. Multiple regression analysis:

Relationship between TPO-BI, PCL-C and HSCL-25:

Multiple regression analysis was performed to explore the true relationship between the 3 inventories. The relationship between PCL-C as dependent variable and symptom clusters of *baksbat* as predictors. Table 3 and 4 show that only the "psychological distress sub-cluster" of TPO-BI (*baksbat*) has a unique relationship which explains 24% (R^2= 0.49) of variance in PTSD ($\beta = 0.68$, $p < 0.001$). Similarly, multiple regression analysis was also performed to see the true relationship between anxiety and depression as dependent variables and symptom sub-clusters of TPO-BI as predictors. Again, the 'psychological distress' symptom sub-cluster has a unique relationship PLC-C which explain 26% ($R^2 = 0.52$) of variance in anxiety ($\beta = 0.73$, $p < 0.001$) (table 5, 6) and also explain 28% ($R^2 = 0.56$) of variance in depression ($\beta = 0.69$, $p<.001$) (table 7, 8). There is no relationship between PCL-C, anxiety and depression and 2 symptom sub-clusters of TPO-BI (broken courage and erosion of self).

Table 3: Model Summary[b]

Model	R	R Square	Adjusted R Square	Std. Error of the Estimate
1	0.70[a]	0.49	0.48	0.67

a. Predictors: (Constant), erosion_self, broken_courage, psychological_distress

b. Dependent Variable: MeanPTSD

Table 4: Regression analysis summary for *baksbat* symptom clusters variables predicting symptoms of PTSD

		Unstandardized Coefficients		Standardized Coefficients	t	Sig.
Model		B	Std. Error	Beta		
1	(Constant)	1.21	0.12		9.90	0.00
	broken_courage	0.08	0.07	0.08	0.10	0.28
	psycho_distress	0.60	0.07	**0.68**	7.71	**0.00**
	erosion_self	-0.07	0.10	-0.06	-0.76	0.44

Dependent Variable: MeanPTSD

Table 5: Model Summary[b]

Model	R	R Square	Adjusted R Square	Std. Error of the Estimate
1	0.72[a]	0.52	0.51	0.56

a. Predictors: (Constant), loss_self, broken_courage, psychological_distress

b. Dependent Variable: MeanANX

Table 6: Regression analysis summary for *baksbat* symptom clusters variables predicting symptoms of anxiety

		Unstandardized Coefficients		Standardized Coefficients	t	Sig.
Model		B	Std. Error	Beta		
1	(Constant)	0.98	1		9.83	0.00
	broken_courage	0.06	0.06	0.08	1.05	0.29
	psycho-distress	0.56	0.06	**0.73**	8.79	**0.00**
	erosion_ of self	-0.11	0.83	-0.10	-1.38	0.16

Dependent Variable: MeanANX

Table 7: Model Summary[b]

Model	R	R Square	Adjusted R Square	Std. Error of the Estimate
1	0.75[a]	0.56	0.55	0.50

a. Predictors: (Constant), erosion_self, broken_courage, psychological_distress

b. Dependent Variable: MeanDEP

Table 8: Regression analysis summary for *baksbat* symptom clusters variables predicting symptoms of depression

		Unstandardized Coefficients		Standardized Coefficients	t	Sig.
Model		B	Std. Error	Beta		
1	(Constant)	0.92	0.08		10.45	0.00
	broken_courage	0.05	0.05	0.07	0.97	0.33
	psycho-distress	0.49	0.05	**0.69**	8.72	**0.00**
	erosion_of self	0.00	0.07	0.02	0.02	0.97

Dependent Variable: MeanDEP

SECTION II

Chapter 5: Published articles

Outline of the published articles

Following background information, a review of literature, justification for the use of local concepts of trauma responses, an outline of the progressive methodologies, and data collection and analyses, the results of this study have been presented in the three published articles. As follows:

Article 1: *Baksbat (broken courage): A trauma based cultural syndrome in Cambodia*. The article introduces the Cambodian concept of trauma, which was expressed by many Cambodian survivors of the Khmer Rouge, after experiencing cumulative, traumatic events. The author used multiple sources of explanation across etymological, ethno-medical, and social and historical origins of *baksbat* in order to explain what *baksbat* means to Cambodians.

The author presents the impact of *baksbat* on Cambodian society illustrating how Cambodian people today have been affected by *baksbat,* especially as experienced during the Khmer Rouge period. The ethnographic method was used in order to understand *baksbat* from perspective of the experts who have knowledge or experiences of *baksbat* themselves. Data related to symptom features, the perceived causes and the proposed treatment of *baksbat* derived from the ethnographic interviews were presented in this article. The case studies of *baksbat* were shown and its symptoms were discussed in comparison with the symptoms of PTSD described in the DSM-IV. The symptoms of *baksbat* were also discussed by comparing with idioms of distress previously studied. The author concludes that *baksbat* is a valid cultural syndrome of distress in Cambodia. The author did not intend to use *baksbat* to replace PTSD, but rather to complement PTSD and advance sensitivity to the dimensionality of trauma in the clinical and research setting, particularly in regard to Cambodia.

Article 2: *Baksbat (Broken Courage): The Development and Validation of the Inventory to Measure Baksbat: Cambodian Trauma-based Cultural Syndrome of Distress*. The article shows the development of an inventory to measure symptoms of *baksbat* and validate it against the Western standardized instrument called PTSD (checklist civilian version: PCL-C). The author selected 56 items that describe symptoms of *baksbat* by the experts during the ethnographic interview and focus group discussion to develop a 56-item initial inventory for *baksbat*. A further consultation with the experts via individual interviews and FGD took place and reduced the number of items to 32. This 32-item inventory for *baksbat* was then administered to 390 patients, and then the exploratory factor analysis was performed, and 3 symptom clusters were extracted with the total number of items further reduced to 24. The first symptom cluster is called 'broken courage' which consists of 9 items, the second symptom cluster is called 'psychological distress' which consists of 11 symptoms and the last symptom cluster is called 'erosion of self' which consists of 4 items.

This 24-item inventory for *baksbat* syndrome was administered to another 159 respondents and the confirmatory factor analysis was performed in order to test the goodness-of-fit of items in this inventory. The author discusses significant findings and why *baksbat* is not the same as PTSD. This article highlights the extent to which the symptoms of *baksbat* overlap with PTSD and how *baksbat* may also be clearly differentiated from PTSD. In addition, the author has also focused on the importance of *baksbat*, what the implications are for both mental health professional and patients, and how an understanding of *baksbat* contributes to the field of mental health, ethno-psychiatry and trauma in Cambodia.

Article 3: *A place for baksbat (broken courage) in forensic psychiatry at the Extraordinary Chambers in the Courts of Cambodia (ECCC)*. The article shows how the Cambodian cultural syndrome known as *baksbat* could apply in reality and this article is the application of *baksbat* syndrome in forensic psychiatry at the international court that are currently prosecuting the

former Khmer Rouge leaders who are accused of committing crimes against humanity. The aim of this article is to present a culturally valid forensic evidence of psychological trauma experienced by Cambodian survivors of the Khmer Rouge genocide. Since cultural variation in symptomatology exists among Khmer Rouge survivors, the use of PTSD diagnosis by many foreign forensic experts, lawyers, and prosecutors as forensic evidence in this court may not be sufficient and that undermines the survivors' suffering from trauma under the Khmer Rouge time.

5.1. Article 1

Baksbat (Broken Courage): A Trauma-Based Cultural Syndrome in Cambodia

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Baksbat (Broken Courage): A Trauma-Based Cultural Syndrome in Cambodia

Sotheara Chhim

Transcultural Psychosocial Organization, Phnom Penh, Cambodia, and Monash Asia Institute, Monash University, Caulfield East, Melbourne, Australia

Whether posttraumatic stress disorder (PTSD) sufficiently explains and encompasses the symptoms experienced by people from non-Western cultures is debatable. The etymological, social, and historical contexts of idioms of distress experienced by Khmer, known as *baksbat*, were studied through interviews with 53 Cambodian experts. *Phey-khlach* (double fear), *bor-veas-cheas-chgnay* (wishing that the trauma would go away), *dam-doeum-kor* (planting a kapok tree—remaining mute), *chos-nhorm* (submissive, easily giving in), *kob yobal* (ideas are buried), and loss of togetherness, were all identified as specific symptoms of baksbat. Similarities and differences between symptoms of baksbat, PTSD, anxiety, and depression indicate that baksbat is a Cambodian idiom of distress with sufficient characteristics to be recognized as a formal cultural trauma syndrome distinct from PTSD. Increased awareness of its criteria and phenomenology may help clinicians provide appropriate support for traumatized Cambodians.

Keywords *Cambodia, cultural syndrome, idiom of distress, PTSD, trauma response*

The phrase 'idioms of distress' describes specific expressions of psychological disorder that occur and are recognized by members of particular cultures. These have been described extensively by scholars of anthropology, psychiatry, and psychology, especially in the context of research on culturally informed assessment and treatment of various conditions. According to Mark Nichter (2010), primary idioms of distress, referenced often as somatic-based disorders in Asia, have been common for 30 years and have clearly taken on a life of their own. The term is used in the *Diagnostic and Statistical Manual IV* (DSM-IV), and will likely be used again in the forthcoming DSM-V. Idioms of distress have refined global understanding of psychological, social, and somatic expressions of distress and mental illness, while providing a blueprint for researchers and clinicians across countries to account for the phenomenology of distress in specific cultural settings.

Sotheara Chhim, MD, is a psychiatrist, Executive Director of the Transcultural Psychosocial Organization, Cambodia (TPO Cambodia), and a lecturer of psychiatry, Royal University of Phnom Penh, Cambodia. His areas of interest are community mental health, trauma, transcultural mental health, and transitional justice. He received a Human Rights Award for 2012 from the Leitner Center for International Law and Justice, Fordham Law School, New York City, in recognition of his work promoting the rights of people with mental health problems in Cambodia.

Address correspondence to Sotheara Chhim, TPO Cambodia, No. 2 & 4, Oknha Vaing Road, Sang Kat Phnom Penh Thmey, Khan Sen Sok, PO Box 1124, Phnom Penh, Cambodia. E-mail: [redacted]

Scholars define idioms of distress in different ways but stress similar themes. Hollan (2004:63), for example, regarded idioms of distress as "culturally shared symbols, behaviors and language that express, explain and/or transform peoples' experience of distress and suffering." In some cases, such idioms are interpersonally effective ways of expressing and coping with distress; in other cases, they indicate psychopathological states that undermine individual and collective states of well-being (Nichter 2010). Hinton and Lewis-Fernandez (2010) have classified idioms of distress and related prototypes to include psychological or somatic complaints, eating abnormalities, cultural illness syndromes, zealous-religious involvement, and acting-out behaviors. Several idioms of distress have been described within the Cambodian refugee context such as 'weak heart' (Hinton et al. 2002), '*khyâl* attack' and '*khyâl goeu*' (wind overload; Hinton, Khin, and Ba 2001), and 'the ghost pushes you down' (sleep paralysis; Hinton et al. 2005).

My own research brought to light a perhaps peculiarly Cambodian idiom of distress called *baksbat*. This literally means 'broken courage' and describes psychological responses to the severely traumatic events experienced by Cambodian people in the past decades. While this term has been described by Kong (2003) and Huot and LeVine (2000), there has been no systematic phenomenological study. Previous studies, such as those by Devon Hinton and colleagues (2010) on idioms of distress and local cultural syndromes among Cambodians in the United States, Maurice Eisenbruch (2000) on traditional healings and rituals in Cambodia, Peg LeVine (2010) on spirit-based anxiety among survivors of the Khmer Rouge, and Joop De Jong and colleagues (2003) on psychosocial and mental health problems in postconflict Cambodia, have not included baksbat.

Baksbat appears to be an idiom of distress with some degree of overlap with post-traumatic stress disorder (PTSD), anxiety, depression, and/or dissociative features, but further research is required to flesh this out. Baksbat appears to be unique to the Cambodian population because of the complexity of traumatic and phenomenological experiences that people have endured. It is particularly evident when studying those who survived the Khmer Rouge regime (1975–1979). My study on baksbat, on which this article is based, is unique, too, because of my own position as a Cambodian national, who experienced trauma under the Khmer Rouge and has treated survivors of the Khmer Rouge regime for more than a decade. Accordingly, I brought to the study insight both as a clinician and a participant observer, with the ability to reflect on what had happened during and after the Khmer Rouge regime. Given my personal history, a peer debriefing process was employed to mitigate against any risks to the validity of the study.

In this article, I draw on multiple sources of explanation across etymological, social, and historical contexts to explain what baksbat means to Cambodians. In addition, I draw on ethnographic interviews to describe its presentation. I conclude by discussing the phenomenon of baksbat within the debate of idioms of distress, cultural syndromes, and the presumed universality of PTSD, anxiety, and/or depression.

UNDERSTANDING BAKSBAT

Etymology

The concept of baksbat expresses most fully the fear that follows a distressing or life-threatening situation. Chourn Nath (1967), the late Supreme Head of Monks and an author of the first Khmer Dictionary, wrote that baksbat comes from the word *bak* (noun), which means break/broken,

and the word *sbat* (noun), meaning body or form. Baksbat literally means broken body or form. In the Khmer language, people often use compound nouns or use alliteration to strengthen meaning and allow for flow in their expression. The word sbat can also be used as *sbat-sbov;* in this instance, *sbat* (adjective) means thick or dense while *sbov* (noun) means thatch or the type of grass that rural Khmer use for roofing. Combined, the expression means thick thatch. Chourn Nath (1967) gave an illustration that once an elephant steps on this sbat-sbov (thick thatch), the original form of the thatch is broken forever. So, baksbat is literally translated as the permanent breaking of the body or spirit. The former Supreme Head of Monks referred to this as ''the psychological break down of courage'' or ''broken courage.'' This etymological explanation is couched in lay terms, such as sbov (thatch) and elephant; by drawing on images common in the daily life of Cambodian villagers, the idea is easier to understand.

Huffman and Im (1977:68) translated baksbat into English as ''terror-stricken,'' whereas Sos, Kheang, and Erham (1975:192) have translated baksbat into English as ''being afraid forever,'' which suggests that people who suffer from this condition will never regain their previous level of calm, functioning, or courage. In common terms, baksbat means fear related to bad experiences. People with baksbat feel *reang-charl*; they sense that they will not or dare not do something ever again. In this context, baksbat or broken courage is a condition that has a broader meaning than baksbat as used in everyday spoken Khmer.

Baksbat is also used collectively. For instance, a group of villagers who experience the same terrible event may not dare to do something or take a particular action ever again. The terrible events significant to this study include the sudden loss of a loved one, combat shock, a landmine accident, being frightened by spirits or ghosts, or being chased by wild animals. The research study, which I describe next, was designed to sort out the difference between casual analogy and actual distressing experiences of baksbat with informants.

Ethnomedical Origins

Some traditional healers in Cambodia refer to baksbat when describing an illness in which symptoms relate to intense *phey-khlach or khlach* (fear); this fear is attached to the ways one's soul can get lost, or to fears that lead one to scream out in the night when having a bad dream. 'Soul loss' is categorized as (1) *lours-praling* (some of the souls jump out of the body): or (2) *paling-chong-sak* (souls run to the extremity of the hairs on the body; Ly 2006). According to Ly and Thompson (2005), and from the personal accounts of elderly Cambodians, there are 19 small souls and one large soul (or crystal soul) in our body. *Lours-praling* refers to the condition when the majority of these 19 souls are lost, or the large soul is lost, when a people's consciousness is partly or completely lost as well. On a clinical note, this lost-soul/lost-consciousness phenomenon resembles the DSM definition of dissociation. The lost soul can be regained through a method that is called *hav-praling* (calling back the soul; Ly 2006; Thompson 2005). The loss of the large soul may lead to individuals becoming mad, with symptoms that appear psychotic, or they may give an appearance of dying. These kinds of symptoms occur more often after a person experiences an extremely frightening situation or is shocked suddenly. The clinical condition of baksbat is more serious than baksbat as used in everyday language. A person may tell a friend that he or she is baksbat, whereas clinicians would see baksbat as a condition akin to PTSD.

In the Khmer language, when emphasis is placed on something more severe or more enduring, people usually add the prefix *chumgneu* (illness or disease) and attach another word in order to strengthen the meaning. Examples are *chumgneu kcheul* (lazy illness), *chumgneu puk-roloury* (rotten illness or corruption illness), and *chumgneu sangkum* (social illness). People use the term *chumgneu baksbat* (baksbat illness) to emphasize that baksbat has resulted in a severe, debilitating form of illness after experiencing fright.

According to a Cambodian scholar, Meas Nee (personal communication, December 22, 2008), baksbat takes two forms: normal reactions, and pathological, exaggerated reactions. In normal baksbat reactions, symptoms relate directly to the situation or event. With pathological baksbat, the symptoms become more enduring and behavior becomes increasingly maladaptive. Symptoms continue long after the event has been resolved. Some Cambodian psychiatrists and psychologists equate the concept of baksbat to that of PTSD because of the overlaps in features related to psycho-emotional distress. Nevertheless, they acknowledge that there are underlying differences, such that Khmer with baksbat give in easily, are submissive, mistrust people, or are mute. Again, to date there has been no research on this idiom of distress or its relationship to PTSD, anxiety, and/or depression.

Social and Historical Origins

The concept of baksbat dates from the collapse of Angkor and the Khmer Empire in 1413, following the invasion of Siamese from the West (Corfield 2009:11). These ancient events may have induced baksbat in Cambodians, and this baksbat may have been transmitted to the next generation of Cambodians. Some Cambodian historians describe Indigenous Khmer as the 'ethnics with baksbat' because Cambodia has suffered for centuries from war with its neighbors, as well as horrific living conditions under oppressive regimes and forced colonialization. Many respondents interviewed in this study believe that baksbat has been transmitted intergenerationally, undermining and demoralizing people, leading them to be more passive and reluctant to stand up for their rights. In some ways, this is akin to the descriptions of generational trauma that have been identified among displaced people and indigenous people globally, such as First Nation People in North America and Aboriginal Australians. Rohr (2004) argued that the pain that is not transformed is transferred, reflecting transmission of trauma across generations. Many neurobiological studies on the offspring of Holocaust survivors also support this view (Brand et al. 2006; Broekman, Olff, and Boer 2007; Davidson and Meller 2001; Yehuda et al. 1998, 2000).

In his epic poem, Kong Bunchoeun, a renowned national author and poet, categorized 41 types of Khmer illnesses; baksbat was one:

> Those people who witnessed Pol Pot's militia tying up and killing people, those who witnessed Pol Pot militia marching people to the Killing Fields, those who witnessed people killed by bombardment, these people still have baksbat today.
>
> Those people, ordinary people of all levels, who, when meeting people with greater power, stand bent, their hearts beating faster and their bodies trembling with fear, they never dare to make comments due to their fear of blame and retribution.
>
> Those people who want to complain but dare not do so, who prefer to stay shy, their faces downturned, when they see powerful people make mistakes, they dare not blame them, because they fear hatred.

> When powerful people fart, ordinary people say it has a good smell: they bear the smell and say it smells like perfume, because baksbat illness follows them everywhere. People fear that, if powerful people hate them, they will disappear. (Kong 2003:26)

Because of baksbat, Cambodians often feel exhausted, and are passive and reluctant to fight back. This explains why, over a three-day period on April 17–19, 1975, there was so little resistance in Phnom Penh and other major cities to the Khmer Rouge troops who came to the city and forced the evacuation of millions of people. No one dared to stand up and resist the Khmer Rouge security guards, some as young as their children, who tied up people, marched them like animals to the Killing Fields, and then executed them one by one. The killing under the Khmer Rouge, the subsequent civil war against the Khmer Rouge guerillas, and random postregime violence, leaves people continually vulnerable to baksbat.

I have worked for 16 years as a psychiatrist in community mental health, and lived through four regimes in Cambodia—including the genocidal Pol Pot regime. My observations validate the existence of baksbat, alongside the nonsolicited use of this term by my patients who describe their condition as baksbat. It is plausible that baksbat, together with the history of patronage in Cambodia, has created an environment in which it is impossible to imagine the future or to identify and defend human rights. As a result, people are much more likely to become victims of exploitation and abuse by authorities. Because passivity is at its core, baksbat may be a major stumbling block to social development and prosperity. When people dare not support what is just and fair, they are at risk of being exploited across generations.[1]

On the basis of the previous descriptions, baksbat resembles an idiom of distress that is more defined than an everyday metaphor. In particular, baksbat fits well with the definition of idiom of distress by Hollan (2004) and De Jong and Reis (2010), that is, a culturally shared set of symbols/metaphors (broken body or form), behaviors (being submissive, easily giving in), language, or meaning (the psychological state of 'broken courage') that are used and understood by Cambodian people to express distress or psychosocial suffering. In this regard, baksbat may be used to express trauma responses as well as the cultural syndrome itself.

METHODOLOGY

The study on which this article is based was conducted in Cambodia using ethnographic methods, as described by Hubbard (2007), to understand the concept of baksbat from the perspective of experts or key informants with knowledge of this concept. Verbal informed consent was sought from the experts in advance of each interview. These experts included traditional healers, mediums, religious people, elderly people, mental health professionals, historians, linguists, and other academics. Some of the experts were interviewed on multiple occasions, using information from previous interviews to elicit further information, clarify, and gain deeper responses upon re-interview. I conducted all interviews and focus group discussions.

Sampling was purposive and convenient (Teddlie and Yu 2007) in order to assist the understanding of the concept of baksbat and trauma-related issues from experts' points of view. Snowball sampling was used to find additional experts with knowledge of baksbat and establish regional and different points of view. Fifty-three experts were selected and interviewed individually or in focus group discussions. There were two groups of expert participants: first a group of victims of trauma/torture who had direct experiences of trauma and were likely to have

experienced baksbat themselves; and a second group of people who had observed and had knowledge of baksbat. The latter group included health and mental health workers, psychiatrists, psychologists, teachers, linguists, historians, university professors, and villagers with status in their villages as traditional healers, mediums, *prit-theacha* (elderly people), and *achar* (priests). Although participants were divided into two groups, all had experienced trauma and hardship during the period of the Khmer Rouge; all participants in the first group had experienced baksbat to some extent.

The main questions for individual interviews and focus groups included: What is baksbat? Please tell me about symptoms of baksbat of persons you know (you don't need to tell me the name) (e.g., their behavior, attitude, relationship, function)? Subsidiary questions included: What are the causes of baksbat? Is baksbat transmitted to the next generation? What can be done to prevent baksbat? Open and selective coding techniques were used to analyze the data (Strauss and Corbin 1998:102).

RESULTS—ETHNOGRAPHIC FINDINGS ON BAKSBAT

Although I divided the respondents into two groups, there appeared to be no differences in terms of responses to or understandings of the concept of baksbat, because all participants had, to some extent, experienced hardship and torture under the Khmer Rouge and many had experienced baksbat as victims of trauma. Brief information from the ethnography is summarized next.

Symptom Features

The majority of respondents stated that the very first sign of baksbat is *phey-khlach* (fear-fear), related directly to the shocking events that they experienced. This phey-khlach reaction leads the person who experienced the events to become *reang-charl* (to resolve to cease doing anything; Sath and Chhit 2001), *khlach ro-arh* (being fearful or feeling dread, and wishing never to experience the event ever again), and *bor-veas-chea-chgnay* (wishing the traumatic event would go away). Many reported a loss of courage and an inability to confront others. Most were afraid to disclose their identity to anyone or talk to others about what they had experienced (*dam-doeum-kor*, planting the kapok tree or mute tree; Ebihara, Mortland, and Ledgerwood 1994:82), and some pretended to be dumb or deaf: "Say nothing, hear nothing and understand nothing" (Yathai 1987:63). They also felt unable to speak about their fears (*kob yobal*—idea is buried), and experienced this as a kind of fear about fear (or double fear). People with baksbat would avoid anything that reminded them of the event. They sometimes experienced extreme fear associated with losing their soul (*lours praling*) or believed that their soul would go out to the ends of the hairs on their body (*praling-chong-sak*). In lours-praling, with the loss of the majority of souls, people often went into a trance, as if they were in a dissociative state, and so reacted as if in a state of depersonalization and derealization.

People with baksbat have a problem trusting others, and they easily give in or accept defeat (*chos-nhorm*—submissive), feel or act in a cowardly manner (*kam-saak*), and cannot stand up for themselves and confront others. Baksbat has an impact on one's sense of integrity. One often becomes afraid of helping others, and finally appears to others as selfish, leading others to criticize them and how they live their lives in their communities.

People with baksbat often have physical symptoms such as headaches, poor sleep, poor attention, and they report 'thinking too much' (ruminating), feeling emotionally and physically weak, and experiencing digestive problems. They often have repeated bad dreams about past events. They become withdrawn and isolated, do not go outside, and fear that something might cause them problems. They often feel anxious, shaky, lose control, and may appear to be pale and have cold extremities. In addition, respondents reported that people with baksbat experience loss of self-confidence, feelings of loneliness, irritability, and anger, have reduced contact with former relations, and avoid meeting others or avoid socializing.

Perceived Causes

Respondents reported that experiencing traumatic events at an individual, community, or societal level can cause baksbat. These events make individuals frightened or *bak smaradey* (broken consciousness or alertness). These events include genocide, war, bombardment, torture, domestic violence, breakdowns in marital or family relationships, and being attacked by animals. Specific to (and normalized in) the Southeast Asian region are events that include supernatural forces, for example, being haunted by ghosts or frightened by evil spirits. Many believed that the breakdown in culture and family structure of Cambodian society, witnessed after the Khmer Rouge regime, had made people even more vulnerable to baksbat. Some referenced Buddhism and believed that the lack of knowledge or understanding about Dharma, excessive desires, the inability to accept the reality of impermanence, and going against the reality of the natural life cycle (birth, old age, illness, and death), may also lead to baksbat and other mental illnesses (personal communication, December 23, 2008, Venerable Yos Hut Khemacharo).

Some respondents explained that according to Khmer traditional beliefs, *reasey*[2] (bad luck, fortune, or supernatural luck), can cause such problems (Hinton et al. 2009). Once a person has *reasey dak* (one's fortune is low), he or she may have met or will be likely to meet *kruah* (bad experiences/dangers), which will lead to baksbat. There are two types of bad experiences or bad luck: *kruah dach sangreng* (people without clear reason become more irritable with others in the house) and *kruah kambot kâ* (the bad luck cuts off the head); in this latter case people may be predicted to meet with danger that will lead to death. A few respondents suggested that baksbat could run in the family, as they described that the children of parents with baksbat may have baksbat too, but it is not clear whether they felt that there was a genetic or a common personality trait among people who were therefore especially vulnerable to baksbat. Opinions vary, however, on whether baksbat can be transmitted generationally. Many people believed that the history of Cambodia had proven that this was possible, but others saw it as an individual problem, and only those who experienced a specific traumatic event would suffer from baksbat.

Treatment and Protection

Most respondents agreed that the following treatments were successful for baksbat. The first was education about baksbat, helping people to understand the context underlying their problems and encouraging them to feel supported and to feel stronger. With reassurance, people may become more self-aware and better able to cope with baksbat.

The second was the use of traditional methods. For example, monks or traditional healers can help correct *kruah* (bad luck or danger) through water blessings. *Rumdâh kruah* ceremonies (to divert danger; Hinton et al. 2009) help individuals not only recover from baksbat but also avoid potential danger in the future. Of the many forms of rumdâh kruah ceremonies, one used by healers is to make a small statue or model symbolizing the person with baksbat. The healer tells the spirit that there are two bodies, the real one (the person with baksbat) and his statue. The healer asks the spirit to pick up the statue and take it away, so enabling the person with baksbat to remain at home, safely, with his or her family.[3]

The third is *hav-praling* (calling the souls back). Ceremonies, which vary in detail across regions, are held to call back souls that have become lost, because fearful situations have forced them to leave the body of the individual. The ceremonies help people recover their lost soul or souls, so ensuring a speedy recovery and healing baksbat. With children, a simple way of calling the soul is to embrace the child who is frightened and say, ''*EH*! Let the complete 19 souls *EUY* come back into the body.'' After calling the souls back, the caller blows air onto the head of the child, so calming the child. In the event of a major loss of souls, especially for adults, the caller performs a ceremony and sings to call the soul back. The content of the song reminds the soul that ''the individual (who has baksbat) is the real body; do not let the evil spirit cheat you; here is your real house; do not get lost; here is your own banana tree in your house.'' The medium or the person who calls the soul describes all types of trees or materials that belong to the house of the individual with baksbat (Hinton et al. 2009; Ly 2006; Thompson 1996, 2005). By doing so, the soul will hear, remember, gain insight, and return. Afterwards, the person recovers from baksbat.

The fourth approach, one favored by mental health professionals, is to treat attitudes and behavioral changes associated with baksbat. Such cognitive reframing can be difficult and time consuming, although it may be helpful if the person has a supportive environment from family and community. Mental health professionals can also be helpful by offering support additional to the traditional approaches mentioned previously.

A fifth approach is *korl-kar samaki* (to encourage solidarity). A sense of feeling part of a solid community and a sense of social togetherness among Cambodians in turn decreases baksbat. Solidarity relates to the cohesiveness and capacity of people to live together well as good neighbors and friends. In the words of one respondent, ''If Khmers have solidarity amongst themselves, Khmer will survive, if not, Khmer will die'' (Ouk Chorn, August 20, 2009, pers. comm.).

The final approach is by resort to medical interventions. Medication that treats anxiety can help reduce those psychological symptoms of baksbat similar to anxiety, depression, or PTSD. Such medication is not accessible to the majority of Cambodians living in rural Cambodia.

CASE STUDIES

The two case studies next, presented pseudonymously for confidentiality, were chosen to illustrate two dimensions of baksbat. Each case describes typical symptoms of baksbat, although these may not cover all symptom clusters of baksbat.

Mr. Sam is 56 years old and a former military commander who was stationed in the 1980s in Stung Treng province in northeastern Cambodia. One day, five of his soldiers went to the forest in order to hunt animals for food. In the forest, they suddenly encountered a troop of roughly 20 wild elephants.

The elephant herd chased them and they feared being stampeded to death. Everyone ran away separately in order to divert the elephants and escape this near death situation. They were not trampled by elephants, but all of them were lost in the forest for four to five days before they returned to their base. They were ill upon the return: They seemed to have lost self-control; they could not speak coherently; were not able to eat or sleep; had hair loss; and eventually they all died. Mr. Sam said that the soldiers suffered from baksbat in which extreme fear caused their souls to go out of their bodies or lours-praling. The souls did not return and so they died. Mr. Sam said that a Kru Khmer (traditional healer) tried to perform a ''calling the soul'' ceremony, but he was not able find the souls of the soldiers as they had been out of their bodies for too long.

Mr. Sourn is 56 years old and a married veteran with seven children, who lives in Pursat Province, central Cambodia. During the time of the Khmer Rouge, his family was allowed to live in his village instead of being moved elsewhere. The family was accused of being ethnic *Khmer Krom* (a term identifying Cambodians who live in the lower Mekong delta, now in the southern part of Vietnam) and thus automatically they were regarded as enemies of *Angkar* (the Khmer Rouge administration). Consequently, Mr. Sourn's parents and other family members were killed and he was imprisoned. In prison, he was beaten and electroshocked severely, but was rescued after the arrival of Vietnamese troops in 1979. Mr. Sourn now describes himself as *bak* (broken), a short form of baksbat; he feels he exists in only half of his body. The other half has been broken (loss of self), making him feel very insecure. Thus he is overly cautious and does not easily trust people. He expresses this state of 'bak' by saying that he has become reang-charl; he dares not speak or express his feelings to others. During the Khmer Rouge times, Mr. Sourn remembers talking with an old man who told him not to complain about anything, otherwise he might die. Now Mr. Sourn thinks that his survival was due directly to keeping his mouth closed and being submissive. This, in turn, has led to him being fearful that the Khmer Rouge regime might return, and he would not know how to deal with this.

DISCUSSION

The descriptions of symptoms and case studies suggest that baksbat could be considered as an idiom of distress, a culturally specific trauma response experienced by Cambodians residing inside or outside Cambodia. Most often survivors consult a doctor with culturally specific symptoms more frequently than with PTSD. This idiom of distress baksbat may help clinicians to understand trauma responses expressed by sufferers (Hinton and Lewis-Fernandez 2010). Since this study was designed and implemented from the perspective of Cambodian experts, it provides a culturally sensitive perspective from which to make comparisons between PTSD and baksbat. The case studies illustrate two key features of baksbat. The first case, Mr. Sam, shows the relation between baksbat and loss of soul (lours-praling). This type of baksbat is more acute, caused by more sudden and extreme fear leading to loss of soul, which is difficult to handle and may lead to death. This type of baksbat may be similar to an illness from fright or soul loss called *kesambet*, a North Balinese syndrome, described by Wikan (1989), or susto and soul loss among Mexicans and Mexican Americans (Glazer et al. 2004).

The symptoms revealed in the case of Mr. Sourn are more common than soul loss. They are usually caused by prolonged trauma and are relatively common among survivors of the Khmer Rouge genocide. The trauma does not cause the soul to jump out of the body, and so this type of baksbat does not result in sudden death. This type of baksbat, in contrast, is chronic, persistent, and may be difficult to deal with, as evidenced by the many survivors of the Khmer Rouge

regime who continue to live with baksbat. The features of baksbat in Mr. Sourn's case, such as reang-chal ('plant the kapok tree'; that is, see nothing, hear nothing, and speak nothing), submissiveness and acceptance of defeat, are common among Cambodian survivors today.

Baksbat resembles the anxiety-based components of PTSD, yet there are differences. Bor-veas-cheas-chgnay or 'wishing the trauma event would go far away' in baksbat is similar to avoidance as included in criterion C of PTSD. Although people with baksbat do not have specific features of avoidance such as avoiding thoughts, feelings (criterion C1), activities, places, or people (criterion C2), they will avoid anything that serves as a reminder, as occurs in PTSD too. Another baksbat feature, 'fear of helping others,' captures people's reluctance to help others because this could be detrimental to their own safety; therefore they choose to remain passive and silent. Consequently, they lose a sense of identity and connectedness, as occurs with feeling 'detached or estranged from others' in criterion C5 of PTSD. Symptoms of baksbat like 'withdrawal,' 'isolation,' 'do not go outside due to the fear that something may cause them problems' would be similar to the symptoms of 'markedly diminished interest' or 'participation in significant activities' in criterion C4 of PTSD. In addition, baksbat symptom features such as 'repeated bad dreams about the past,' 'feeling anxious, shaky,' and 'losing control' or 'appearing to have pale color and sweating,' are similar to criterion D of increased arousal symptoms of PTSD.

Individuals with baksbat who present with lours-praling (the majority of souls are lost) may present in a trance-like state in which they act or behave as if in a dissociative state similar to depersonalization and derealization. This would be similar to criterion B3 of PTSD. While the perceived causes of PTSD were not mentioned in DSM-IV, criterion A of PTSD could be similar to the perceived causes of baksbat, as respondents stated that a variety of traumatic events could lead people to have baksbat.

However, several features of baksbat, such as being overly submissive and mute ('planting the kapok tree,' literally refraining from speaking), do not exist in PTSD. And while a high-level mistrust of others is very common in baksbat symptoms among respondents, this mistrust is less specific in those with PTSD and mistrust of the spirit domain is part of this feature among Cambodians. Cultural norms, such as the Cambodian culture of hierarchy and the value placed on obedience to parents and elders, may cause submissiveness. However, these cultural aspects appear to have become abnormally exaggerated under and after the regime of the Khmer Rouge, when no one would dare to stand up to resist the guards who could torture or kill any person they wished. The 'planting the kapok tree' feature of muteness also became extreme during this period, as people mistrusted and would not speak even to family members (see also Ebihara et al. 1994:85). Many other authors have identified symptoms other than PTSD symptoms that are common among traumatized groups. Reports of idioms of distress by trauma survivors may indicate not only PTSD but also the presence of other comorbidities, especially symptoms that are culture-bound like *khyâl* attack (Hinton et al. 2010), *kiyang-yang* (De Jong and Reis 2010), 'evil and bad thought,' or 'a burning head,' or having 'cried the eyes out' (Elsass 2001).

Baksbat includes neuro-vegetative symptoms, and therefore overlaps with anxiety. The first symptom of baksbat, *phay-khlach* (fear-fear), relates to the fear symptom of anxiety. The fear in baksbat is a kind of fear that is embedded in a survivors' mind; it is a mixture of a sense of remembrance (leading people to mark a stone or pierce their ears as a reminder) and wishing all bad things to go away (*bor-veas cheas-chhgnay*). In addition, baksbat has many physical

symptoms in common with anxiety, such as palpitations, trembling or shaking, difficulty breathing, sweating, and pallor. Baksbat is also similar to depression as it relates to mood features: people with baksbat lose confidence and may be lonely, irritable and labile, and withdraw from social relationships.

Although similar to PTSD, baksbat also has some similarity to the 'weak heart' syndrome (Hinton et al. 2002) and khyâl attack (Hinton et al. 2010). But again, there are differences. Weak heart is thought to be caused by fearful events and marked by extreme fear reactivity symptoms only, while baksbat has persistent feelings and behavior of reang-chal and bor-veas-cheas-chgnay, and symptoms of fear reactivity may or may not be present yet. Once exposed to the trauma again, they may experience fear reactivity as they would with weak heart. In some instances, one could say that baksbat could trigger 'weak heart' syndrome.

While Western-based diagnostic criteria and treatment provide foundational knowledge to address mental disorder, cultural and phenomenological-based experiences most often take a back seat. By placing indigenous criteria such as baksbat alongside the DSM criteria, there is less danger that mental health clinicians will ignore the underlying causes that may manifest in the metaphysical realm of souls and spirits. In countries like Cambodia where both financial and professional services are limited, this puts an unnecessary burden on available resources. By including cultural-specific concepts such as baksbat in assessment protocols, treatment methods can be provided sequentially to assist and improve the rate of true recovery and problem resolution. Without the inclusion of baksbat, individuals with this particular condition may fail to receive targeted treatment, which may inhibit their healing from trauma. Teasing out this concept is an important element to heal a complexly traumatized society. For mental health professionals working with Cambodian clients, it is important to understand the concept of baksbat and how it differs from the Western diagnosis of PTSD. Cambodian people may self-identify as having baksbat, and while their symptoms may not fully meet PTSD criteria, this does not mean that they are not suffering from trauma-related problems and do not need assistance. An understanding of the meaning of this idiom of distress and its interpretation in a Cambodian cultural context will help professionals deal more effectively with Cambodian clients.

CONCLUSION

Khmer expressions of emotional problems are rich in meaning and metaphor, and it is difficult to translate visceral and perceptual experiences into meaningful words: cultural meanings may be lost in translation. Even so, the descriptive and phenomenological investigation into baksbat reveals a significant idiom of distress, manifesting as a Cambodian cultural syndrome of complex trauma. The aim of developing this cultural syndrome is not to undermine PTSD but rather to complement it in the Cambodian context. In this way, mental health professionals and paraprofessionals will be able to pay clinical attention to the cultural aspects of trauma responses in Cambodia. This idiom of distress baksbat may also help foreign researchers in fostering a reliable link between cultural and mental health responses in Cambodia, making their research more meaningful and relevant. This study will also open an avenue for younger Cambodian researchers, and those in neighboring countries, for more studies on mental health and culture within their own cultural and historical framework.

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NOTES

1. The Venerable Yos Hut Khemacharo at Wat Lanka Pagoda in Phnom Penh, on December 23, 2008, told me that due to baksbat, many of his fellow monks would not express their opinions and were very submissive toward their superiors.

2. Traditional healers predict or diagnose their clients through looking at reasey. If someone's reasey is low, they are prone to illness; once their reasey is up, they can succeed in their life and resist illnesses, curses, and spells. Hinton and colleagues (2009) found that having low reasey (*riesey*) increases patients' vulnerability to illness.

3. See different descriptions of rumdâh kruah (Hinton et al. 2009).

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5.2. Article 2

Baksbat (Broken Courage): The Development and Validation of the Inventory to Measure Baksbat, a Cambodian Trauma-based Cultural Syndrome of Distress

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ORIGINAL PAPER

Baksbat (Broken Courage): The Development and Validation of the Inventory to Measure Baksbat, a Cambodian Trauma-based Cultural Syndrome of Distress

Sotheara Chhim

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Abstract This article outlines the development and validation of an inventory measuring a Cambodian cultural syndrome of distress called '*baksbat*' (broken courage). The inventory development phase involved ethnographic interviews with a preliminary group of 53 experts having knowledge or experience of baksbat. The initial ethnographically derived inventory with 32 items was developed and administered to a second group of 390 consecutive patients to assess factor loadings. The validation phase used confirmatory factor analysis (CFA) to test goodness-of-fit of four hypothesized factor models of the newly developed inventory in a third group of 159 participants. CFA confirms three-factor models that have the best goodness-of-fit, thus a 24-item baksbat inventory clustering of three-symptom categories was developed. Multiple regression, which assesses the relationship between the dependent variable (PTSD) and a subcluster of baksbat inventory (predictors), shows baksbat inventory accounts for 47 % of the total variance of symptoms in PTSD ($R^2 = .47$). Of the three-symptom clusters, 'psychological distress' shows significant contribution to the total variance of symptoms in PTSD ($\beta = .63$, $p < .001$). Of significance, some symptoms of baksbat were independent from symptoms of PTSD with isolated symptoms that are culturally specific. These preliminary findings suggest that baksbat could be a potential Cambodian trauma-based syndrome with its own culturally validated inventory.

Keywords Development and validation · Inventory · Cambodian cultural syndrome of distress · PTSD

S. Chhim
Transcultural Psychosocial Organization (TPO Cambodia), TPO Building, No 2&4, Oknha Vaing Road, Sangkat Phnom Penh Thmey, Khan Sen Sok, Phnom Penh, Cambodia

S. Chhim (✉)
Monash Asia Institute, Monash University, 900 Dandenong Road, Caulfield East, VIC 3145, Australia
e-mail: [redacted]

Background

Thirty years ago, Cambodians experienced dreadful atrocities committed by the Khmer Rouge (KR) communist regime. April 17, 1975 and January 7, 1979 mark the official beginning and the end of the 'Democratic Kampuchea' (DK) regime. Cambodians who lived through the KR era can remember clearly the number of days the regime lasted; they call it 'the regime of 3 years, 8 months and 20 days.' Under the control of DK, an estimated 1.7 million people died as a result of mass killings, starvation, forced labour and disease (Chandler 2007)—approximately 25 % of the total Cambodia population at that time. Indeed, every single moment of that period has been permanently embedded into the body-mind memories of its survivors.

Literature Review

Given these devastating experiences, it may come as no surprise that many Cambodians suffer from a high rate of post-traumatic stress (PTS) symptoms and other mental health disorders. The study of Mollica, McInness, Poole and Tor (1998) with Cambodian refugees along the Cambodia-Thailand border shows that there are dose–effect relationships between the severity of traumatic events the people experienced and the symptoms of depression and PTSD among Cambodian survivors of mass violence. From this finding, one can logically assume that psychological and mental health problems among Cambodian people would be high given the severity and the prolongation of trauma in Cambodia over the past decades. The quantitative study of Cheung (1994) on PTSD among 233 Cambodian refugee adults aged over 18 seeking psychiatric services in New Zealand showed that approximately 21 % met criteria for PTSD. Similarly, the study by Kinzie et al. (1990) on PTSD among Southeast Asians seeking psychiatric help found that the rate of PTSD among Cambodian patients were among the highest (92 %, $N = 84$).

The study on the prevalence of PTSD among Cambodians residing inside Cambodia by De Jong, Komproe and van Ommeren (2003), in collaboration with the Transcultural Psychosocial Organization (TPO), compared the prevalence of common mental disorders in post-conflict settings on a sample of people who experienced armed conflict and non-armed conflict in Algeria, Cambodia, Ethiopia and Palestine. The rank-order results showed that within the Cambodian sample, 28.4 % ($N = 610$) met criteria of PTSD in the Diagnostic and Statistical Manual-IV (DSM-IV), while the Algerian, Ethiopian and Palestinian samples had 34.7 % ($N = 653$), 15.8 % ($N = 1{,}200$) and 17.8 % ($N = 585$), respectively, for PTSD. Meanwhile, the household survey of psychiatric morbidity in Kampong Cham province of Cambodia by Dubois, Tonglet, Hoyois, Ka, Roussaux and Hauff (2004) found that 7 % of the sample of 769 adults over 20 years of age met criteria for PTSD (DSM-IV). The most recent quantitative survey by Sonis, Gibson, de Jong, Field, Hean and Komproe (2009) on the mental health status of 1,017 Cambodians before the start of Khmer Rouge Tribunal found that 14.2 % of those aged above 35 (a cohort that directly experienced the Khmer Rouge) and 7.9 % of those aged

between 18 and 35 (too young to have experienced the Khmer Rouge time directly) have probable PTSD.

Yet, despite the above findings, there seems to be a large contrast in the prevalence of PTSD in research findings and the prevalence of PTSD in clinical settings in Cambodia. The prevalence of PTSD ascertained by checklist criteria across outpatient clinics in Cambodia is consistently low with the figure of 2–3 % of the total number of patients admitted to the mental health clinics (Bernsen 2005). The prevalence of PTSD in most mental health clinics in Cambodia in subsequent years has not shown an increase (TPO 2011). Given the inconsistent findings, PTSD as a diagnostic category may not be a culturally valid indicator of the complexity of trauma suffered by Cambodians after the past atrocities. This author's study was designed initially to ascertain whether the cultural factors underlying the diagnostic category of PTSD have created such differences. Many other researchers have also questioned whether the notion of trauma and particularly PTSD is a universal response (Braken and Petty 1998; Marsella, Friedman, Gerrity and Schondfield 1996; and Summerfield 1999).

This author contends that there are several reasons for a discrepancy in trauma outcomes between research and clinical practice. A primary reason is that a conspiracy of silence and a conspiracy of avoidance exist between Cambodian therapists and their patients. When therapists and patients both have experienced the KR genocide and all the hardship in the aftermath which followed, they tend to avoid talking or discussing KR issues together as doing so could bring up too much painful past. To avoid such discussion is to avoid allowing painful memories to resurface. De Jong et al. (2003) found that Cambodian sample has the highest avoidance symptoms compared to samples from other countries. In this case, avoidance could be a part of the cultural responses among Cambodians. In addition, many traumatized people tend to isolate themselves socially. They tend to withdraw from participating in any social and community activity, which in the Cambodian village context is a protective factor. They find their own home and/or environment more comfortable and safe; therefore, it is possible that they may not seek treatment from a public health clinic, but may be more likely to seek treatment from traditional means in their villages. Also, many survivors do not like to talk about their traumatic memories or about their suffering. They may think that it is not worth talking about it; as the retired King Norodom Sihanouk of Cambodia often said, 'Let bygones, be bygones'. Finally, many researchers use scales which were developed in Western contexts or on refugees who are hosted and resocialized in Western cultures. This practice generates transcultural discrepancies as most of the scaled items are not familiar to local Cambodian people and are not easily understood by both the respondents and administrators (Kohrt and Hruschka 2010). In particular, there is no appropriate Khmer language which can describe trauma in Western terminology and some of the meaning may have been lost in translation. In addition, some of the measures have not been properly validated in Cambodia and the PTSD criteria itself may not capture the entire trauma symptoms expressed by Cambodian patients.

Other aspects of the difference in the prevalence of PTSD among Cambodians may relate to culture and spiritual belief, which could influence on the difference of

prevalence of PTSD previously studied. Eisenbruch (1992) stated that cultural features are a major factor with Cambodians and are sometimes misinterpreted by clinicians. He suggested that the high rate of PTSD that appears in many research studies in Cambodia was probably a direct consequence of misinterpreted Khmer idioms of distress (Eisenbruch 1991).

Spiritual beliefs held by Cambodians are a part of the culture needing to be taken into account. LeVine (2010) found that more Cambodians had access to spirit protective rituals, the more their anxiety was contained; there was less panic over the potential harm by roaming ancestors. Since Cambodia can be considered a spirit-based country, it is important not to overlook perceptions about spirits, and related honouring and protective practices among people whose lives are interdependent with the spirit realm. According to Cambodian beliefs, spirits live in many places such as in houses, buildings, trees, hills and in the water, and consequently disturbing or upsetting those spirits may result in sickness or problems (Thompson 2005).

To minimize such differences, some researchers have developed tools to measure trauma symptoms for specific populations. Mollica 1991 developed the Harvard Trauma Questionnaire (HTQ) to measure trauma symptoms for an Indochinese population. Later on, Marwa, Weinstein and Mollica (2007) developed a new version of HTQ for Iraqi refugees who resettled the US. The Indochinese version (Cambodia, Laos and Vietnam) does not include idioms of distress shown on the Iraqi version. Therefore, the Cambodian version of HTQ may not be culturally sensitive enough for a Cambodian population because it may not capture many idioms of distress that Cambodian population express (Hinton, Pich, Marques, Nickerson and Pollack 2010; Rechtman 2000).

Cambodian Cultural Syndrome of Distress Known as *Baksbat* (Broken Courage)

Over the past 17 years, this author has worked directly with trauma survivors of the Khmer Rouge genocide. He observed that many survivors expressed more symptom characteristics than those described in the diagnostic criteria of PTSD in the DSM-IV and International Classification of Disease—version 10 (ICD-10). In addition to describing physical and psychological symptoms, survivors express their inability to trust others, while becoming more submissive, feeling more cowardly, becoming '*bak'* (broken) or baksbat (broken courage), and being mute and deaf (*dam doeum kor or planting mute tree*).[1] These symptoms parallel to trauma symptoms expressed by survivors of the Khmer Rouge genocide in Cambodia.

This Cambodian cultural syndrome of distress derived from a concept called 'baksbat' literally means 'broken courage' (Chhim 2012). Cambodians use this concept to express conditions following distressing or life-threatening situations they have experienced. Venerable Chourn Nath, the late Supreme Patriarch of

[1] In the Khmer Rouge time, people hid their identity to survive. They told each other to *dam doeum kor* (plant the kapok tree or *Ceiba pentandra* tree), which means to pretend to be mute and deaf. In Khmer language the word *kor* has different function. *Kor* as a noun means kapok tree (*Ceiba pentandra*) but *kor* as an adjective means 'mute and deaf.' So, people survive because they plant the mute tree or pretend to be mute, dumb and deaf.

Monks and an author of the first Khmer Dictionary wrote that 'baksbat' comes from the word *bak* which means break/broken and the word *sbat* (noun) which means the body or form (Chourn 1967). Therefore, baksbat means, 'broken body or form'. In daily communication, Cambodians use related or combined words to emphasize strong meaning. The words *sbat* can also take the form *sbat-sbov*; in this sense *sbat* is an adjective and means 'thick or dense'; *sbov* is a noun and means the thatch or the type of grass that people in the countryside use to make the roof of the house. So, the *sbat-sbove* means a 'thick thatch', which is supposed to be strong and protective in a storm. Once a heavy weight occurs, such as elephants stepping on the *sbats-bove* field or 'thick thatch', its form/body has been broken and will never be returned. So, baksbat is literally translated as a permanent break of body or form. Baksbat is a concept that is often used by soldiers who have been defeated in the battle. It means that they do not want to fight back again, they dare not show their forms (*sbat*) again or they dare not confront in any battle again. They become discouraged, and feel cowardly both physically and psychologically. The late Supreme Head of Monks has also referred to this as the 'psychological break down of courage'. This author calls it 'broken courage' and thinks broken body and loss of courage better describes and challenges the 'psychological-only models of disorder'. Traditional healers in Cambodia diagnose someone as having baksbat if they present with fear-related symptoms following dreadful situations. Beside ethno-medical, baksbat also has been used in historical and social contexts as well, but they are not the focus of this study.

Methodology

This author has studied the phenomenon baksbat, and identified its criteria to develop an inventory to measure this baksbat cultural syndrome of distress in Cambodia. The study combines qualitative and quantitative methods, beginning from qualitative ethnographic methods to understand the phenomenon of baksbat from the perspectives of experts. From this, the criteria to measure baksbat were generated and the baksbat inventory developed. The baksbat inventory was then validated in a quantitative survey by comparing its correlation with the internationally standardized scale, PTSD Checklist Civilian version (PCL-C).

This study was conducted in two phases: the inventory development phase and the inventory validation phase.

Inventory Development Phase

Sampling involved purposive and convenient methods (Teddlie 2007) to assist this qualitative study as a means of understanding the concept of baksbat and trauma-related issues from experts' points of view rather than to generate representatives among populations or groups. Snowball sampling was also used in the qualitative part of this study to find experts who have the knowledge of baksbat and to have differing points of view. Participants were formed from two groups, recruited for the inventory development phase.

Participants

There were two groups of participants recruited for the inventory development phase. The first group consisted of 53 experts who were selected for ethnographic interviews and focus group discussions (FGD) to come to consensus on their understanding of baksbat concept from their perspectives and to develop an initial baksbat inventory. All experts had been exposed to the Khmer Rouge era and some of them experienced severe torture inflicted by the Khmer Rouge militia during this period. The experts included people who have knowledge, understanding and experiences about the concept of baksbat. They include health and mental health professionals, psychiatrists, psychologists, counsellors, traditional healers, mediums, elderly people, priests, victims of the trauma/torture, teachers, linguists, historians and academics. The participants' mean age is 56 (SD = 12.87), 35.8 % (N = 19) are female and 64.2 % (N = 34) are male. As far as the roles are concerned, 35.8 % (N = 19) are victims of torture who are eligible civil party members testified at the Khmer Rouge Tribunal, 15.1 % (N = 8) are psychologists, 11.3 % (N = 6) are psychiatrists, 11.3 % (N = 6) are religious leaders/traditional healers/mediums altogether, 9.4 % (N = 5) are university professors, 5.7 % (N = 3) are historians/linguists and the remaining 11.3 % (N = 6) are community leaders/elderly and NGO leaders.

The second group consisted of 390 consecutive patients who received mental health services from the TPO Cambodia in Phnom Penh and other provinces.[2] This second group was recruited to develop the final baksbat inventory. They were selected from a broad range of socio-demographic variables across geographical location, gender (268 females, and 122 males), age (M = 53.40, SD = 12.96), marital status [64.4 % married (N = 251), 27.7 % widowed (N = 108), 3.3 % divorced/separated (N = 13), and 4.6 % never married (N = 18)], level of education [39 % never attended school (N = 152) and 36.9 % attended primary school (N = 144), 23.3 % attended high school (N = 91) and 0.8 % attended university (N = 3)], and type of work involvement [92.8 % unskilled workers (Farmer/worker/housewife/seller, N = 362), 7.2 % skilled worker (teacher/civil servant/other professional, N = 28)]. Exclusion criteria included people with psychosis, dementia and alcohol intoxication during the interview session.

Procedures

The author interviewed the first group participants by the brief ethnographic methods developed by Hubbard (2007) in which participants were asked to answer one main question: What is baksbat? Please tell me about the symptoms of baksbat in persons you know (you don't need to tell me the name) (e.g. please tell me about their behaviour, attitude, relationship, function). The interview lasted about one hour and was audio recorded and then transcribed. The responses that explained the meaning of baksbat from this ethnographic interview were coded and grouped.

[2] Pursat, Battambang, Banteay Meanchey, Siem Reap, Preah Vihear, Kampong Thom, Kampot and Takeo provinces.

Fifty-six initial items were selected for developing an inventory. The author conducted second round of FGDs with about 20 experts from the first group of participants to discuss the relevance of each item and seek their opinion on which items should be kept, and which items should be removed. After the second round of FGDs, 32 items of initial baksbat inventory were developed, by means of a 5-point Likert (0-4). The reason for using Likert scale is that this scale is an ordered, one-dimensional scale from which respondents choose one option that best aligns with their view (Kumar, 2008). As for this study, it is consistent with PTSD checklist civilian version (PCL-C), which also uses Likert scale, so it is easy to compare. The second group participants (N = 390) was administered with the initial baksbat inventory to explore factor loading and to develop the final baksbat inventory.

Inventory Validation Phase

Participants

The third group participants consisted of 159 victims of the stampede on the bridge incident during the Water Festival in Phnom Penh on November 2010. The interview was conducted in November 2011, one year after the event, to eliminate the acute stress reaction symptoms that are generally alleviated over time.

Procedure

Participants were interviewed by the final year (fourth year) students from the Psychology Department of the Royal University of Phnom Penh who was closely supervised a Research Assistant. The author trained the interviewers in the use of questionnaires, including case examples and role-play to ensure that everyone understood the items the same way to increase consistency and inter-rater reliability. Interviews lasted approximately 1 h, and were conducted in the Khmer language. No incentives were provided to participants of this study. The interviewers were also trained in mental health first aid and how to identify signs and symptoms of distress among people they interviewed so that they could assess for referral if needed. The interview participants were also provided with a list of mental health services available including the hotline telephone number of TPO Counselling Center where they could seek help in cases of distress caused by the interviews.

Instruments

The third group participants (N = 159) for the validation purposes was administered with the following instruments:

Baksbat Invent ory A 24-item of self-report inventory consists of three experiential clusters: (1) broken courage, (2) psychological distress and (3) erosion of self. Respondents were rated on the extent to which they experienced each problem as itemized on a 5-point Likert scale (0 = not at all, 4 = extremely). There is no

cutoff score in this baksbat inventory, as its use is intended to show evidence of a syndrome rather than a disorder. A syndrome in psychiatry is regarded as a collection of behaviours, attitudes and perceptions of self that co-exist. In the case of baksbat, this trauma-related syndrome was founded on the clustering of Khmer experiences of trauma.

PTSD Checklist Civilian Version (PCL-C) The PCL-C is a widely used 17-item self-report rating scale designed to measure PTSD symptoms. Respondents rate the extent to which they experience each of the symptom items during the previous 30 days on a 5-point Likert scale (0 = not at all, 4 = extremely). The PCL-C has already been translated and back translated into Khmer and has been widely used in Cambodia in many researches. The PCL-C can be used to assess the severity of trauma symptoms on a continuum and to provide score cutoff criteria for making a PTSD diagnosis. The overall internal consistency of the translated Khmer version based on all 17 items was excellent ($\alpha = 0.93$). The PCL-C subscale has excellent internal consistency across subscale (1) Re-experiencing subscale ($\alpha = 0.86$), (2) Avoidance subscale ($\alpha = 0.77$) and (2) Arousal subscale ($\alpha = 0.79$) (Field and Chhim 2007).

Statistical Analysis

During the inventory development phase of the baksbat inventory, the open coding and selective coding techniques (Strauss and Corbin 1998) were used to analyse the qualitative data from the ethnographic interviews and FGDs. Second consultation with selected experts from the first group was conducted in 2 FGDs to remove items which were not relevant and merge together items that were similar to develop initial baksbat inventory of 32 items. The newly developed initial baksbat inventory was administered with the second group participants ($N = 390$). The EFA was performed to explore factors loading for baksbat inventory. Principal axis factoring was used to extract the factors followed by oblique rotation, while the number of factors was identified by the Scree plot test and parallel analysis by means of a computer software called Monte Carlo developed by Marley Watkins, (2000).

The confirmatory factor analysis (CFA) was performed to investigate goodness-of-fit of baksbat inventory in a third group of 159 participants by means of AMOS 18. Byrne (2004, 2010) and Myers et al. (2006) recommended the model as good if it is tested on a separate data, while Firat et al. (2009) suggested that the result from separate data are more generalizable. Several fit indices were selected to test which CFA model best represents the present data set: root-mean-squared error of approximation (RMSEA), comparative fit index (CFI), goodness-of-fit (GFI), adjusted goodness-of-fit (AGFI), Chi-squared (χ^2) and the ratio of χ^2 and degree of freedom (χ^2/df). RMSEA is a measure of the average of the residual variance and the covariance; good models have RMSEA values between 0.05 and 0.08 (Vieira, 2011). CFI quantifies the amount of variation and covariation accounted for by the proposed model by comparing its fit to the fits of a null model of uncorrelated variables. Its values of $>.90$ are good (Hu and Bentler 1999). GFI measures the

relative amount of covariance and variance by comparing the theoretical model to the observed model (Meyers et al. 2006). The recommended value of GFI and AGFI is $>.90$ (Meyers et al. 2006). GFI also takes into account the degree of freedom. However, GFI and AGFI are less sensitive to sample size than the χ^2. When comparing models, a lower χ^2 value indicates a better fit, given an equal number of degrees of freedom (Atkinson et al. 2011). The best value of χ^2/df should be between 2-1 or 3-1 (Vieira 2011).

Reliability was evaluated by calculating Cronbach's alpha coefficient, a measure of internal consistency of the response to the group of items. Correlation between baksbat inventory, its symptom clusters and PCL-C were evaluated by calculating Pearson's correlation. Multiple regression analysis was performed to explore the relationship between symptoms of PTSD in PCL-C as dependent variables and the three symptom clusters of baksbat as predictors. This analysis can tell us how well the three symptom clusters of baksbat are able to predict variance in symptoms of PTSD (Pallant 2011). All statistical procedures were performed by means of the SPSS 16.0.

Results

Inventory Development

A list of initial 56 items that described characteristic feature of baksbat by the experts was selected. The second FGDs with selected experts from the first group participants were conducted to reduce the number of items from 56 to 32 because some of the items are not relevant to reflect baksbat condition and others are similar. The initial baksbat inventory of 32 items was developed, and 5-point Likert scale was used to rate the severity of the problems experienced by respondents. The data from the interview using initial inventory was subjected to a factor analysis.

Exploratory Factor Analysis

The newly developed 32 items inventory was administered to 390 consecutive patients to develop the final baksbat inventory. Principle axis factoring with oblimin rotation was performed after the data was assessed for its suitability for factor analysis. The overall Cronbach's α is .93 (32 items), while the individual symptom clusters are .87, .90 and .86 for broken courage, psychological distress and erosion of self, respectively. The Kaiser–Meyer–Oklin value was .91 and the Bartlett's test of sphericity was statistical significance ($p < .001$), which indicates factorability of the data. The principal axis factoring revealed the presence of 5 factors with eigenvalues exceeding one, explaining 33.25, 9.16, 7.31, 5.41 and 3.64 % of variance. The inspection of the Scree plot revealed a break point after the three factors. This was supported by the result of parallel analysis, which showed three factors with eigenvalues exceeding the corresponding criterion values for a randomly generated data matrix of the same size (32 variables $\times$ 390

respondents). The actual eigenvalues from principal axis factoring that is higher than the criterion value from parallel analysis is accepted (Pallant Pallant and Julie 2011). In order to decide which item to retain, Pallant and Julie (2011) suggest that the item which has communality value smaller than three will be removed because it does not fit in the factor. Therefore, four items with communalities value smaller than three will be removed leaving only 28 items in the baksbat inventory (please see Table 1).

Inventory Validation

Confirmatory Factor Analysis

The newly developed baksbat inventory was administered to a third group of 159 victims of the stampede on the bridge in Phnom Penh, Cambodia in November 2010 to investigate the construct validity of baksbat inventory. According to Table 2, model 2 was significant improvement over model 1. Model 2 has lower RMSEA (.06), lower χ^2/df (1.73), higher in GFI (.84), AGFI (.80) and CFI (.92) compared to model 1. Model 3 was statistically superior to model 2 in term of lower RMSEA (.05), lower χ^2/df (1.45) and higher GFI (.86), AGFI (.83), CFI (.95). In contrast, model 4 has higher RMSEA (.06), higher χ^2/df (1.45) and lower GFI (.83), AGFI (.78) and CFI (.91) compared to model 3. From these results, model 3 was selected as the best fit for the data with model 2 treated as a suitable alternative representation in this sample. Standardized factor loading for model 3 is displayed in Table 3 and the graph of model 3 is presented in Fig. 1.

Reliability

The total score of each inventory shows a good internal consistency with a Cronbach α coefficient reported baksbat inventory of $\alpha = .93$, and PCL-C of $\alpha = .90$. The internal consistency of total PCL-C, baksbat inventory and its clusters are summarized in Table 4.

Correlations Between Inventories and Between Clusters

Pearson correlation analysis reveals that baksbat inventory has a high correlation with PTSD symptoms in PCL-C ($r = 0.65$, $p < .001$). The 'psychological distress cluster' of baksbat inventory has highest correlation with PTSD symptoms of PCL-C ($r = 0.70$, $p < .001$) compared to the other two clusters. The 'broken courage cluster' and 'erosion of self cluster' has medium ($r = .50$, $p < .001$) and low ($r = .33$, $p < .001$) correlation with symptoms of PTSD in PCL-C.

Multiple Regression Analysis

Multiple regression analysis was performed to explore the relationship between symptoms of PTSD in PCL-C as dependent variable and symptom clusters of

Table 1 Summary of factor loading for principal axis factoring with direct oblimin of three factor solution of baksbat inventory

	Broken courage	Psychological distress	Erosion of self	Communalities
Marks the stone or pierce one's ears as reminder (*Kap-thmorchamnam*, *chostra-cheakchamnam*)	0.7	–	–	0.44
Plants kapok tree (*Dam Doeumkor*), remains mute	0.68	–	–	0.52
Loss of solidarity (*Bat Samakipheap*)	0.67	–	–	0.38
Feeling and acting cowardly compared to before or loss of courage	0.63	–	–	0.53
Cannot rely on oneself	0.62	–	–	0.51
Cannot be open as before	0.57	–	–	0.40
Dares not confront	0.56	–	–	0.40
Dares not make decisions or cannot make decisions	0.55	–	–	0.45
Submits to others or admits defeat to others	0.48	–	–	0.42
Dares not want to take initiative	0.48	–	–	0.43
Recalls all stories in life related to horrible things that happened to them	0.30	–	–	0.22
Tightness in the chest, palpitations, difficulty breathing	–	−0.78	–	0.57
Sleeping problems	–	−0.72	–	0.46
Trembling, shaking of extremities, cold extremities	–	−0.67	–	0.47
Trouble thinking (difficulty concentrating)	–	−0.66	–	0.48
Nightmares	–	−0.64	–	0.42
Feeling flat or low emotionally and physically	–	−0.64	–	0.50
Feeling restless or trapped	–	−0.62	–	0.51
Extreme fear, Fright	–	−0.57	–	0.51
Irritable mood, easily getting angry	–	−0.55	–	0.35
Poor appetite (loss of appetite)	–	−0.53	–	0.29
Easily fearful (fear bad consequence may happen)	0.38	−0.46	–	0.48

Table 1 continued

	Broken courage	Psychological distress	Erosion of self	Communalities
Feeling lonely	–	−0.46	–	0.43
Loss of self-confidence	0.34	−0.44	–	0.46
More cruel to others (due to inability to control themselves)	–	−0.39	–	0.25
Loss of honesty	–	–	0.75	0.52
Feeling no one can help one any more (feeling beyond help)	–	–	0.75	0.61
Selfishness	–	–	0.73	0.52
Reduced contact with former relationships, loss of relationships with others	–	–	0.66	0.50
Avoids meeting others, reduced socialization	–	–	0.58	0.49
Wishing all bad things would goes away (*Bor-veas-cheas-chhgnay*)	–	–	0.52	0.42
Cannot trust others or loss of confidence in others	–	–	0.47	0.29
Factor correlations matrix				
Broken courage	1	.40	.39	
Psychological distress	.40	1	.38	
Erosion of self	.39	.38	1	

Extraction method: principal axis factoring; rotation method: Oblimin with Kaiser normalization

Table 2 Goodness-of-fit indices of the four models (N = 159)

Model	χ^2	*df*	χ^2/df	GFI	AGFI	CFI	RMSEA	*p* value
Factor 1	999.04	351	2.84	.64	.59	.71	.10	<.001
Factor 2	354.21	204	1.73	.84	.80	.92	.06	<.001
Factor 3	291.45	201	1.45	.86	.83	.95	.05	<.001
Factor 4	393.01	223	1.45	.83	.78	.91	.06	<.001

χ^2 Chi-squared, *df* degree of freedom, *GFI* goodness-of-fit, *AGFI* adjusted goodness-of-fit, *CFI* comparative fit index, *RMSEA* root-mean-squared error of approximation

Table 3 Standardized solutions by confirmatory factor analysis for the three factor model

	Factor		
	Psychological distress	Broken courage	Erosion of self
Bak13	.81		
Bak15	.77		
Bak14	.76		
Bak12	.74		
Bak22	.72		
Bak17	.65		
Bak19	.65		
Bak20	.62		
Bak18	.50		
Bak24	.37		
Bak8		.83	
Bak7		.80	
Bak10		.73	
Bak2		.62	
Bak9		.61	
Bak4		.61	
Bak1		.59	
Bak6		.56	
Bak5		.51	
Bak28			.45
Bak29			.44
Bak26			.36

baksbat inventory as predictors. Tables 5 and 6 indicate that broken courage, psychological distress and erosion of self explain 47 % of the total variance in symptoms of PTSD in PCL-C. Of these three variables, psychological distress makes the largest unique contribution ($\beta = .63$, $p < .001$), while the other two variables broken courage ($\beta = .14$, $p = .07$) and erosion of self ($\beta = -.07$, $p = .29$) were no significant contribution to the variance of symptoms of PTSD.

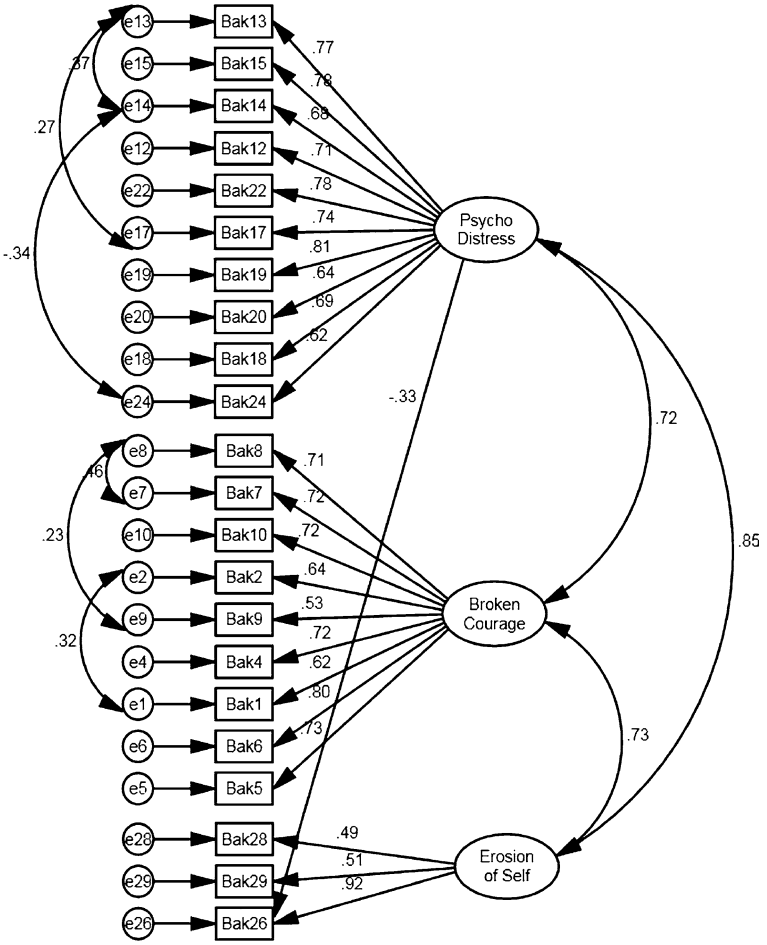

Fig. 1 Final model of factorial structure for the baksbat inventory

Table 4 Reliability estimate of measure

Variables	Cronbach's α
Total baksbat inventory	0.93
Broken courage (baksbat)	0.87
Erosion of self (baksbat)	0.83
Psychological distress (baksbat)	0.90
Total PCL-C (PTSD)	0.90

All scales and subscales demonstrate acceptable levels of reliability

Table 5 Means, standard deviations and inter-correlations for mean score of PTSD symptoms and mean score of baksbat symptoms clusters

Variables	*M*	SD	1	2	3
PTSD	2.24	.95	.50**	.68**	.33**
Predictor variable					
Broken_courage	1.47	1.10	1	.63**	.50**
Psychological_distress	1.85	1.13		1	.54**
Erosion_self	.75	.86			1

** Correlation is significant at the 0.01 level (two-tailed)

Table 6 Regression analysis summary for baksbat cluster variables predicting symptoms of PTSD

Variable	*B*	SE B	β	*t*	*p*
Broken courage	.12	.06	.14	1.76	.07
Psychological distress	.52	.06	.63	7.72	.001
Erosion of self	−.08	.08	−.07	−1.04	.29

Note: $R^2 = 0.47$ ($N = 159$, $p < .001$)

Developing the Final Inventory of Baksbat Syndrome

From the confirmatory factor analysis, the baksbat inventory can now be developed. The inventory baksbat syndrome has three clusters with 28 symptoms. The inventory is designed on a 5-point Likert scale (from 0 to 4) and participants were asked to rate the severity of their problems based on their subjective experiences from 0 (not at all) to 4 (very frequent), (please see Appendix).

Discussion

The author highlights the differences between PTSD and baksbat based on statistic and contents. From statistical point of view, there is high correlation between both conditions ($r = .65$, $p < .001$), which indicates the similarity between the two conditions. However, multiple regression analysis shows that only the psychological distress symptom cluster ($\beta = .63$) of baksbat significantly contributes to the total variance in symptoms of PTSD in PCL-C. The other two symptom clusters, broken courage and erosion of self, do not contribute to the variance in symptoms of PTSD in PCL-C. In this sense, baksbat and PTSD are not exactly the same conditions; PTSD criteria cannot capture symptom clusters of broken courage and erosion of self in baksbat. Therefore, if clinicians or researchers use PTSD criteria alone to identify symptoms of trauma responses in Cambodian population, they may not be able to sufficiently capture symptoms experienced by many traumatized Cambodian.

From the content point of view, many authors found that symptoms such as anxiety, depression and somatoform disorder are common among traumatized groups. While reflecting on these symptom factors, this study compared baksbat with PTSD, rather than with anxiety and/or depression. In other cultural settings, when trauma survivors report their symptoms, this may indicate not only PTSD but also other co-morbidity to present especially symptoms which are culturally bound like '*khyal attack'* (Hinton et al. 2010), '*khyal goeu'* (wind overload) (Hinton, Un and Ba 2001), 'ghost pushes you down' (sleep paralysis) (Hinton, Pich, Chhean and Pollack 2005) and Kiyang-yang (De Jong and Reis 2010). Elsass (2001) who examined the collective traumatic memories and post-traumatic stress symptoms in Peru and Colombia found that survivors present with some trauma symptoms showing consistency with the diagnostic of PTSD, but most often post traumatic stress symptoms, are more than those described in PTSD diagnostic criteria especially the symptoms that relate to cultural context, e.g. 'evil and bad thought', 'a burning head', having 'cried the eyes out', etc. He also found that despite the differences in symptoms, clinicians often insert them into DSM diagnostic criteria. This finding is also supported by Herman (1992a), (b) that PTSD diagnostic criteria cannot capture symptoms expressed by survivors of prolonged and repeated trauma like in the case of the genocide and prolonged civil war in Cambodia.

While 'psychological distress' overlapped with some PTSD symptoms, broken courage and erosion of self sat outside PTSD criteria. The symptoms of the broken courage cluster, such as planting the kapok tree (*dam doeum kor* or pretending to be mute), pretending to be ignorant or saying nothing, are central responses that many Cambodians who lived under the Khmer Rouge time present. DOwing to the fear of being persecuted by the Khmer Rouge guards, many people hid their identities across 4 years and longer to survive. Submissiveness or submission to defeat (*chos-nhorm ke-eng*) is another problem which does not exist in PTSD; again, to survive, people did not dare to stand up for their rights or they easily gave into others's demands; some are seen as being selfish when they are actually withdrawn (erosion of self subscale); such foci result in loss of solidarity (*samakipheap*) or sense of being together among people.

This discussion could probably explain that the rate of PTSD in mental health clinic settings in Cambodia is low (Bernsen and Markus 2005) because the clinicians use PTSD diagnostic criteria of DSM and ICD that may not fully capture the local-cultural aspects of problems in Cambodia as shown in baksbat. When traumatized, clients complaint of symptom such as 'planting the kapok tree', 'submitted to defeat', 'loss of courage', khyal attack', 'khyal goeu', etc.… therapists may not pay much attention to those symptoms as it was not described in PTSD criteria. Littlewood and Cheng (2001) and De Jong and van Ommeren (2001) stated that international standardized scales cannot fully capture the specific cultural responses to trauma in non-Western culture.

Many Khmer Rouge survivors expressed fear, mistrust, an inability to speak out, an impulse to hide their identity or a tendency to remain submissive rather than clear-cut symptoms of PTSD. This has been confirmed through personal communication with many experts in the study (personal communication with venerable Yous Hut Khemacharo, Wat Lanka Pagoda, December 23rd, 2008).

Conclusion

The study shows that baksbat is a cultural syndrome of distress that does not fully overlap with PTSD in particular symptoms that are culturally bound such as those of broken courage and erosion of self symptom clusters. This study led to the development of the baksbat inventory, which is the first of its kind to investigate a trauma-based cultural syndrome of distress on a broad Cambodian sample inside Cambodia, as well as the first inventory to begin with an ethnographic base. The study was designed to capture an original meaning of construct, Indigenous Khmer emotional expression, as well as long and sustaining attitudes and behaviours from the perspective of the experts in this study.

The baksbat inventory provides reliable and valid information for baksbat syndrome that better demonstrates and represents the pain and suffering of Cambodian survivors who are affected by the Khmer Rouge Genocide and its aftermath. This cultural syndrome of distress, baksbat, can help Cambodian clinicians to identify neglected symptoms of trauma responses that are yet to be captured by PTSD criteria. While it is necessary to address baksbat as a Cambodian cultural syndrome of trauma baksbat is not designed as a diagnostic tool to replace PTSD. Rather, the inclusion of baksbat as a trauma syndrome can assist clinicians and researchers in filling the gaps left open by international classification systems and other international standardized tools, in the hope of representing better the complexity of suffering that ripples for years into survivors' lives. The baksbat inventory and this mixed methodology has potential for their use in clinical and research settings where symptoms fall outside the range of PTSD criteria.

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Appendix

TPO Baksbat Inventory (TPO BI): An inventory measuring symptoms of trauma responses in Cambodia.

An individual who has baksbat should fulfil the following conditions: An individual must have experienced or witnessed traumatic events such as torture, physical or sexual abuse, been defeated in the war, been physically and psychologically oppressed, been held hostage, experienced a natural disaster, been frightened by ghosts, been chased by wild animals or other similarly frightening situations. When the traumatic event is over, the individual should experience problems in the following three areas: broken courage, erosion of self and psychological distress. Please indicate your problems' severity according to the following inventory.

Broken courage	0	1	2	3	4
TPO BI-1	Dares not make decisions or cannot make decisions				
TPO BI-2	Dares not confront				
TPO BI-3	Dares not want to take initiative				
TPO BI-4	Submits to others or admitted defeat to others				
TPO BI-5	Plants kapok tree (*Dam doeum kor*), remains mute				
TPO BI-6	Feeling and acting cowardly compared to before or loss of courage				
TPO BI-7	Marks the stone or pierce one's ears as reminder (*Kap-thmor-chamnam*, *chos-tracheak-chamnam*)				
TPO BI-8	Cannot be open as before				
TPO BI-9	Cannot rely on oneself				

Psychological distress	1	2	3	4	5
TPO BI-10	Sleeping problems				
TPO BI-11	Trembling, shaking of extremities, cold extremities				
TPO BI-12	Trouble thinking (difficulty concentrating)				
TPO BI-13	Tightness in the chest, palpitations, difficulty breathing				
TPO BI-14	Easily fearful (fears bad consequence may happen)				
TPO BI-15	Feeling flat or low emotionally and physically				
TPO BI-16	Extreme fear, fright				
TPO BI-17	Irritable mood, easily getting angry				
TPO BI-18	Feeling restless or trapped				
TPO BI-19	Loss of self-confidence				
TPO BI-20	Feeling lonely				

Erosion of self	1	2	3	4	5
TPO BI-21	Avoids meeting others, reduced socialization				
TPO BI-22	Loss of honesty				
TPO BI-23	Selfishness				
TPO BI-24	Reduced contact with former relationship, loss of relationship with others				

0: Not at all, 1: A little, 2: Sometime, 3: Frequent, 4: Very frequent

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5.3. Article 3

A Place for *Baksbat* (Broken Courage) in Forensic Psychiatry at the Extraordinary Chambers in the Courts of Cambodia (ECCC)

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A Place for *Baksbat* (Broken Courage) in Forensic Psychiatry at the Extraordinary Chambers in the Courts of Cambodia (ECCC)

Sotheara Chhim[a,b]

[a]*Transcultural Psychosocial Organization, Phnom Penh, Cambodia;* [b]*PhD Candidate, School of Political and Social Inquiries (PSI), Monash University, Melbourne, Australia*

There are growing debates on the importance of culture in forensic psychiatry. Post-traumatic stress disorder (PTSD) has often been used as forensic evidence of trauma for survivors, regardless of their cultural background. This study justifies and advocates the use *baksbat* (broken courage), a culture-based syndrome, as forensic evidence among Khmer Rouge (KR) genocide survivors. Seventy-seven participants were interviewed; statistical tests were performed to study the correlation between KR trauma, post-KR trauma, *baksbat* and PTSD. The results show that KR trauma predicts *baksbat* ($\beta = .34$, $p < .01$), while post-KR trauma predicts PTSD ($\beta = .25$, $p = .04$). The zero-order correlation shows that controlling for PTSD has little influence on the relationship between KR trauma and *baksbat*. This indicates that *baksbat* can capture more trauma symptoms among KR survivors and consideration of culture in identifying trauma symptoms can provide unique information beyond that described by PTSD. The author recommends adding *baksbat* as additional evidence for KR survivors who testify in the Extraordinary Chambers in the Courts of Cambodia.

Key words: *baksbat*; broken courage; PTSD; Cambodian cultural syndrome; forensic evidence; Khmer Rouge trauma.

Introduction

Cambodia has experienced tragic events since the early 1970s when it became entangled in civil war and internal conflict, which later led to genocide, committed by the Khmer Rouge regime of Democratic Kampuchea (DK) between 17 April 1975 and 7 January 1979. Cambodian people of all social classes were subjected to hard work, starvation, malnutrition, illness and systematic execution. It is estimated that almost two million people, approximately 25% of the population at that time (Chandler, 2000), perished during this period of 3 years, 8 months and 20 days. Even though this genocidal regime ended in January 1979, the Khmer Rouge group remained a strong guerrilla force, which prolonged the civil war in Cambodia for another two decades. That war finally ended in 1998, when the Khmer Rouge political and military structures were dismantled.

The legacy of genocide and civil war affects Cambodian society from the individual to community and society levels. The psychological wounds of survivors have not been healed, in part because justice has never been done in ways that are culturally primed in the Cambodian context, which includes resting the spirits of deceased relatives. Thirty years after the genocide, the Royal Government of

Correspondence: Sotheara Chhim, TPO Building, No 2-4, Oknha Vaing Road, Sangkat Phnom Penh Thmey, Khan Sen Sok, Phnom Penh, Cambodia. Tel.: [redacted]

Cambodia and the United Nations (UN) established a hybrid tribunal to prosecute the senior leaders of the Khmer Rouge in an effort to find justice for those who died and to heal the psychological wounds. This court is a joint effort involving Cambodian and International Courts, and is called the Extraordinary Chambers in the Courts of Cambodia (ECCC). Its role is to prosecute five top senior Khmer Rouge leaders for their crimes committed during the DK era.

It is hard to find evidence of the crimes committed during the past 30 years—and in particular, evidence of psychological trauma because of the length of time involved. The tribunal invited several national and international forensic experts in the field of trauma and mental health to testify to the impact of the DK regime on the psychological wellbeing of the survivors today. The international experts face some challenges because the perception of trauma in Cambodia is different from that of Western countries. There is no Khmer concept that is equivalent to trauma and post-traumatic stress disorder (PTSD). Thus they need to take into account the cultural context of Cambodia and to seek second opinions from local experts in order to justify their conclusions.

Many international forensic experts use the diagnosis of PTSD, a disorder developed in the Western context, as a form of evidence of the psychological scars from torture or trauma inflicted by perpetrators. A forensic team from the Rehabilitation Council for Torture Victims (IRCT) based in Copenhagen, Denmark was also requested to conduct forensic psychological assessments on the civil party members who had filed complaints at the ECCC. These experts use PTSD diagnosis in combination with physical scars as evidence of torture and maltreatment that civil parties experienced during the Khmer Rouge time (Hansen, 2012). However, given the nature of the sociocultural context in Cambodia and the complexity of trauma inflicted by the Khmer Rouge, some of the problems experienced by the survivors may not be sufficiently captured by the diagnostic criteria of PTSD.

In order to fill this gap, the author suggests introducing a Cambodian cultural-based syndrome of distress called *baksbat*—a phrase literally translated as 'broken courage' as potential evidence of a trauma syndrome at the ECCC. *Baksbat* is a Cambodian concept, and was originally used to describe a profound loss of courage and extreme anxiety after experiencing a dreadful life event. The author has undertaken an ethnographic study of this concept which later led him to develop and validate an inventory to measure this cultural syndrome *baksbat* (Chhim, 2012, 2013). *Baksbat* covers many aspects of the trauma responses experienced by the survivors of DK, so its use as evidence in the court could add a cultural dimension of understanding for lawyers, prosecutors and judges when negotiating fair justice outcomes for the defendants and the plaintiffs at the ECCC. A growing body of literature argues for the importance of including culture in forensic psychiatry and in tribunals (Boehnlein, Schaefer, & Bloom, 2005; Kirmayer, Rousseau, & Lashley, 2007); and the culturally based syndrome of distress, *baksbat,* could be an important form of evidence because it could give a better picture of the suffering experienced by civil party members, witnesses and survivors of the KR regime.

In this article, the author extends his previous work on *baksbat* by focusing on the following: (1) distinguishing items of the *Baksbat* Inventory from PTSD symptoms, (2) exploring how the effect of Khmer Rouge trauma and post-Khmer Rouge trauma influence the occurrence of broken courage and PTSD, and (3) proposing *baksbat* as additional evidence for the psychological effects of trauma stemming from the Khmer Rouge at the ECCC.

Literature Review

Cultural Factors in Forensic Psychiatry

Experts in the field of psychiatry and psychology have often been invited to testify as expert witnesses in tribunals and asked to

provide psychiatric assessments. Some are asked to provide social and cultural factors that can explain or contextualize the behaviour of individuals accused of crimes. The accounts of psychological problems that pay attention to social and cultural factors relating to the accused or plaintiffs help legal practitioners to understand cases better and make sensible decisions about each case. Most often, the experts provide psychiatric assessment based on the disorders that fit with the "norm" of the international classification of mental disorders such as ICD-10 or DSM-IV, which were developed in Western countries.

There have been many debates on the place of culture in the legal system. Kirmayer et al. (2007) argue that attending to culture allows legal practitioners to have a better understanding of the origins of behaviour, psychological mind-set, beliefs and the level of a person's intention (Kirmayer et al., 2007). At a wider level, acknowledging cultural differences in law can contribute to building a multicultural society that can accommodate some differences in values that are important to cultural communities (Kymlicka, 1995). Drummond (1997) and Ross (1996), for example, said in efforts to develop customary law and sentencing, that traditional values of harmony and connectedness among indigenous people must be respected.

PTSD in Litigation

PTSD has become a common basis for civil lawsuits and a frequent diagnosis for soldiers returning from war and seeking to receive social benefits from governments. By 1989, the diagnosis of PTSD was referred to as the "diagnosis of choice" in civil litigation. It is also increasingly used in criminal cases, typically in arguments of justification or mitigation in sentencing (Hall & Hall, 2006). A diagnosis of PTSD can provide advantages in litigation. It is obvious that PTSD might be the result of a clear traumatic event and that it is subject to a legal and moral obligation, whereby someone else is responsible for such an overwhelming traumatic event and that anyone could have developed this psychological problem as a result (Gold, 2005).

However, because of the interaction between culture and mental health, use of the diagnosis of PTSD in criminal courts in a non-Western culture (e.g., in the ECCC in Cambodia), should be applied carefully. In the case of Cambodia, the complexity of traumatic experience, the culture, idioms of distress and other ethnocultural responses may create a specific set of trauma response symptoms that present culturally when accounting for symptoms of PTSD. In addition, important features of PTSD symptoms among survivors of the Khmer Rouge genocide may have subsided since the traumatic events and torture they experienced took place more than 30 years previously. Therefore, the full criteria of PTSD may not be met, as supported by the fact that the prevalence of PTSD in mental health clinics in Cambodia is constantly low, with reports of between 1 and 3% of PTSD cases admitted to the Transcultural Psychosocial Organization Counselling Center in Phnom Penh (TPO, 2011), but no cases of PTSD treated in the government mental health clinics across the country in 2011.[1]

The Place of Baksbat *(Broken Courage) in Forensic Psychiatry*

The concept of *baksbat* expresses most fully the fear that Cambodians describe as accompanying and following a distressing or life-threatening situation. Choun (1967), the late Supreme Head of Monks and an author of the first Khmer Dictionary, wrote that "*baksbat*" comes from the word *bak* (verb), which means break/broken, and the word *sbat* (noun), meaning body or form *baksbat* literally means broken body or form. *Baksbat* is literally translated as the permanent breaking of the body or spirit. Choun Nath referred to this as "the psychological break down of courage" or "broken courage."

Baksbat is a term used frequently by Cambodian survivors after any traumatic

event. Many survivors of the Khmer Rouge have said that they have *baksbat* stemming from events of the Khmer Rouge time or other events. This author has developed an inventory that measures features of *baksbat* gathered from experts' opinions[2] using an emic perspective (Chhim, 2013).

Ethnographic interviews with the experts enabled the author to identify items that describe the meaning of *baksbat*, and to develop an inventory to measure *baksbat* and then use statistical methods to validate the inventory (Chhim, 2013). The *Baksbat* Inventory has shown good internal consistency ($\alpha = .93$) and good construct validity compared with an inventory of PTSD symptoms. The *Baksbat* Inventory consisted of three subclusters: "broken courage", "psychological distress" and "erosion of self". The psychological distress subcluster has strong correlation with PTSD ($r = 0.70$, $p < .01$). It consists of arousal symptoms, which make the largest unique contribution to symptoms of PTSD ($R^2 = .47$, $\beta = .63$, $p < .01$). However, broken courage ($\beta = .14$, $p = .07$) and erosion of self ($\beta = -.07$, $p = .29$) make no significant contribution to the variance of symptoms of PTSD (Chhim, 2012).

The two subclusters are very distinct from the symptom features of PTSD. It is clear that PTSD criteria focus more on symptoms, particularly arousal symptoms, whereas *baksbat* has behavioural and attitude components in addition to the arousal symptoms of PTSD. In this case, it is possible that *baksbat* might capture more symptoms of trauma responses in Cambodia, especially symptoms that are culturally bound. Other authors have identified similar culturally based syndromes of trauma in difference cultures. Basically, the repertoire of trauma responses is wider ranging than those comprising PTSD and is shown to be common among traumatized groups in Cambodia. Reports of idioms of distress by trauma survivors may indicate not only PTSD, but also the presence of comorbidities, especially symptoms which are culture-bound like *khyâl* attack among Cambodian survivors in the United States (Hinton & Lewis-Fernández, 2010), *kiyang-yang* in East African culture (De Jong & Reis, 2010), "evil and bad thought", or "a burning head" or having "cried the eyes out" in Latin America (Elsass, 2001). Elsass found that survivors of torture in Chile and Columbia have more symptoms of trauma than exist in our PTSD criteria, but many psychiatrists simply include them as part of their diagnosis of PTSD. For reasons such as this, it is probable that PTSD fails to capture important symptoms of trauma that are experienced among Cambodian survivors. Thus, it is important to include *baksbat* alongside PTSD, as a way of maximizing an inclusive cultural process in Cambodia when presenting evidence at the ECCC.

Methods

Participants

This study is part of a prolonged study of grief among those who lost their children during a stampede on a bridge in Phnom Penh, Cambodia on 22 November 2010, during which 350 people died. The participants in this study ($n = 77$) were among a control group in the above mentioned study who did not have any relatives or children die during this incident. The participants lived through the Khmer Rouge era (mean age, $M = 52.3$, $SD = 9.3$) and so experienced Khmer Rouge trauma and possibly other traumatic events after the Khmer Rouge as well.

Procedure

Participants were interviewed by fourth-year students from the Psychology Department of the Royal University of Phnom Penh under the supervision of the author and a research assistant. The author and research assistant trained the interviewers on how to use questionnaires, which included the use of case examples and role-play to ensure that everyone understood the items in the same way in

order to ensure consistency and inter-rater reliability. Interviews lasted approximately 1 hour, and were conducted in the Khmer language. No incentives were provided to participants of this study. The interviewers were trained in mental health first aid and knew how to identify signs and symptoms of distress among people they interviewed so that they could assess for referral if needed. Interview participants were provided with a list of mental health services available including the hotline telephone number of the TPO Counselling Centre where they could seek help in cases of any distress caused by the interviews.

Instruments

The TPO *Baksbat* Inventory (TPO BI) is a self-report rating inventory, which consists of three subclusters: a broken courage subcluster, a psychological distress subcluster and an erosion of self subcluster, with the total of 24 items. This inventory and its subclusters have good internal consistency: *baksbat* ($\alpha = .93$), broken courage subcluster ($\alpha = .87$), psychological distress subcluster ($\alpha = .90$) and erosion of self subcluster ($\alpha = .83$) (Chhim, 2012). Each item was rated on a 5-point Likert scale (0 = not at all, 4 = extremely). There is no cut-off score in this TPO BI, as its use is intended to show evidence of how frequent *baksbat* symptoms are endorsed, rather to identify *baksbat* as disorder (please see TPO BI in the Appendix).

The PTSD Checklist Civilian Version (PCL-C) is a widely used 17-item self-report rating scale designed to measure PTSD symptoms. Respondents rate the extent to which they experienced each of the symptom items over the previous 30 days on a 5-point Likert scale. The PCL-C has already been translated into Khmer and has been widely used in Cambodia in much research. It can be used to assess the severity of trauma symptoms on a continuum and to provide score cut-off criteria for making a PTSD diagnosis. The overall internal consistency of the translated Khmer version based on all 17 items was excellent ($\alpha = .93$). The PCL-C subscale has excellent internal consistency across three subscales: (1) re-experiencing subscale ($\alpha = .86$), (2) avoidance subscale ($\alpha = .77$) and (3) arousal subscale ($\alpha = .79$) (Field & Chhim, 2007).

The Harvard Trauma Questionnaire (HTQ; Mollica et al., 1982), trauma events include Khmer Rouge trauma (KR trauma) and post-Khmer Rouge trauma (post-KR trauma) events. A list of 19 trauma events from the HTQ was used. These range from experiences of a lack of food and shelter to experiences of murder or torture. Ten types of traumatic events extracted from the KR trauma lists of the HTQ were used for post-KR trauma. Participants were asked to endorse any trauma events they had experienced under the Khmer Rouge and traumatic events experienced later. Mollica et al. (1992) classify KR trauma into two subcategories: loss/separation under the KR (KR loss/sep) and murder/torture under the KR (KR murder/torture). KR loss/sep has five items: forced to live in isolation, forced separation, witnessed close relatives dying or being close to death, witnessed close relatives being killed, and witnessed someone else being murdered. KR murder/torture also has five items: forced to live in isolation, witnessed close relatives being killed, experienced tortured, witnessed close relative being tortured, and witnessed someone else being murdered.

Statistical Analysis

In order to compare *baksbat* and PTSD and also to show how *baksbat* captures more symptoms of the KR trauma than PTSD, the following statistical tests were used.

Multiple regression is used to determine whether a new psychometric assessment will increase the predictive ability of an existing method of assessment (Sackett & Lievens, 2008). In this case, this analysis might determine whether the *Baksbat* Inventory will increase the predictive ability of PTSD or seeks to answer if the *Baksbat* Inventory adds

Table 1. Regression analysis summary for KR trauma and post-KR trauma variables predicting *baksbat* and PTSD

	Baksbat[a]					PTSD[b]				
Predictors	*B*	SE *B*	*β*	*t*	*p*	*B*	SE *B*	*β*	*t*	*p*
KR trauma	1.33	.44	.34	3.04	.01	.63	.47	.17	1.42	.16
Post-KR trauma	.04	.06	.06	.57	.57	.14	.07	.25	2.12	.04

[a] Dependent variable: *baksbat*, $R^2 = .13, p$ .01, $n = 77$. [b] Dependent variable: PTSD, $R^2 = .11, p$ .01, $n = 77$.

more information on PTSD symptoms than exists in the PCL-C scale. It also explores how well each type of traumatic event is able to predict symptoms of *baksbat* and/or PTSD. In this case, *baksbat* and/or PTSD are dependent variables, whereas KR trauma, KR loss/sep, KR murder/torture and post-KR trauma are predictors (independent variables). This analysis can tell us how much unique variance in the independent variable (nature of traumatic events) can predict symptoms of *baksbat* and/or PTSD (Pallant, 2011).

Partial correlation analysis will tell us whether or not correlation between *baksbat* and traumatic events is influenced by PTSD or the correlation between PTSD and traumatic events is influenced by *baksbat*. The author explores partial correlation between *baksbat* and traumatic events while controlling for PTSD and at the same time exploring the correlation between PTSD and traumatic events while controlling for *baksbat*. All statistical procedures were performed using SPSS 16.0.

Results

Multiple Regression

Predictors of baksbat

To assess what contributes to traumatic experiences and symptoms related to *baksbat*, the author used KR trauma ($M = .31$, $SD = .17$) and post-KR trauma ($M = 1.71$, $SD = 1.23$), as predictor variables and *baksbat* ($M = 1.20$, $SD = .68$) as dependent variables. The analysis revealed a significant model, accounting for 13% of the variance in *baksbat* ($R^2 = .13$). According to the standardized multiple regression coefficients analysis, KR trauma ($\beta = .34$, $p < .01$) is the best predictor of *baksbat*, whereas post-KR trauma does not predict *baksbat* ($\beta = .06$, $p < .57$) (Table 1)

Predictors of PTSD

Similarly, to assess what contributes to traumatic experiences and symptoms related to PTSD, the author also used KR trauma ($M = .31$, $SD = .17$) and post-KR trauma ($M = 1.71$, $SD = 1.23$) as predictor variables and PTSD ($M = 1.74$, $SD = .70$) as the dependent variable. Analysis reveals a significant model, accounting for 11% of the variance in PTSD ($R^2 = .11$). According to standardized multiple regression coefficients analysis, among the two predictors, post-KR trauma ($\beta = .25$, $p = .04$) was the best predictor of PTSD, while KR trauma does not predict PTSD ($\beta = .17, p = .16$) (Table 1).

Predictors of baksbat

To assess what traumatic events lead to *baksbat*, the author used KR loss/sep ($M = .39$, $SD = .30$) and KR murder/torture ($M = .18$, $SD = .23$) as predictor variables and *baksbat* ($M = 1.20$, $SD = .68$) as the dependent variable. Analysis revealed a significant model, accounting for 22% of the variance in *baksbat* ($R^2 = .22$). According to the standardized multiple regression coefficients analysis, KR loss/sep ($\beta = .54$, $p < .01$) is the best predictor of *baksbat*, while KR murder/torture did not predict *baksbat* ($\beta = -.18, p = .15$) (Table 2).

Table 2. Regression analysis summary for KR loss/sep and KR murder/torture variables predicting *baksbat* and PTSD

	Baksbat[a]					PTSD[b]				
Predictors	*B*	SE *B*	*β*	*t*	*p*	*B*	SE *B*	*β*	*t*	*p*
KR loss/sep	1.23	.20	.54	4.38	.01	−.28	.30	−.12	−.95	.35
KR murder/torture	−.52	.35	−.18	−1.44	.15	1.58	.39	.53	4.06	.01

[a] Dependent variable: *baksbat*, $R^2 = .23, p$ .01, $n = 77$. [b] Dependent variable: PTSD, $R^2 = .22, p$ .01, $n = 77$.

Predictors of PTSD

Similarly, to assess what generates PTSD, the author also used variables loss / separation under the KR (KR loss/sep) ($M = .39$, $SD = .30$) and variable murder / torture under the KR (KR murder/torture) ($M = .18$, $SD = .23$) as predictor variables and PTSD ($M = 1.75$, $SD = .70$) as dependent variables. According to the standardized multiple regression coefficients analysis, among the 2 predictors, KR murder/torture ($\beta = .53$, $p<.01$) was the best predictor of PTSD while KR loss/sep variable did not predict PTSD ($\beta = -.12$, $p = .35$) (Table 2).

Partial Correlation

Partial correlation was used to explore the relationship between *baksbat*, KR loss/separation, KR murder/torture and post-KR trauma, while controlling for scores on PTSD. Preliminary analyses were performed to ensure no violation of the assumptions of the normality, linearity and homoscedasticity. *Baksbat* has significant partial correlation with KR trauma ($r = .35$, $n = 77$, $p < .01$) and KR loss/sep ($r = .44$, $n = 77$, $p < .01$). But there was no correlation with KR murder/torture ($r = .12$, $n = 77$, $p = .30$) and post-KR trauma ($r = .13$, $n = 77$, $p = .26$) while controlling for PTSD. An inspection of the zero order correlation for KR trauma ($r = .30$) and KR loss/sep ($r = .41$) suggested that controlling for score on PTSD had very little effect on the strength of the relationship between *baksbat* and KR trauma and KR loss/separation.

Similarly, while exploring the partial correlation between PTSD and related traumatic events when controlling for score on *baksbat*, PTSD has a partial correlation with KR murder ($r = .46$, $n = 77$, $p < .01$) and post KR trauma ($r = .30$, $n = 70$, $p = .01$) but no correlation with KR trauma ($r = .21$, $n = 77$, $p = .07$) and KR loss/sep ($r = .17$, $n = 77$, $p = .16$). An inspection of the zero order correlation for KR murder/torture ($r = .45$) and post-KR trauma ($r = .25$) suggested that controlling for score on *baksbat* had very little effect on the strength of the relationship between PTSD and post-KR trauma and KR murder/torture.

Discussion

First, the author discusses the distinction between *baksbat* and PTSD from the statistical standpoint. He goes on to propose the use of *baksbat* condition as potential evidence in the ECCC.

The statistics above also show that *baksbat* and PTSD were predicted by different types of traumatic events. Multiple regression shows that KR trauma predicts symptoms of *baksbat*, whereas the post-KR trauma predicts symptoms of PTSD. This might mean that the KR trauma is likely to cause *baksbat*, whereas post-KR trauma is likely to cause PTSD. Thus, if forensic experts use PTSD criteria as the only means of measuring trauma response, they find a low incidence of PTSD among KR survivors as the trauma symptoms may be overlooked because KR trauma was found to cause *baksbat* rather than PTSD. This might explain why there is

such a low rate of PTSD in mental health clinics in Cambodia (Bernsen, 2005; TPO, 2011), and the finding of high rates of PTSD in Cambodia by Western scholars (De Jong et al., 2001; Dubois et al., 2004; Sonis et al., 2009) might be the result of a misinterpretation of Cambodian idioms of distress (Eisenbruch, 1991, 1992). This finding might explain how the consideration of culture-specific symptoms can provide unique information beyond that supplied by PTSD in revealing the effects of the KR trauma. The culturally based syndrome *baksbat* has more cultural features that could capture trauma symptoms among Cambodian survivors than PTSD criteria.

In addition, there is another interesting finding between the nature of traumatic experiences and related trauma responses. Partial correlation analysis shows that loss and separation under the KR has a partial correlation with *baksbat*, whereas murder and torture under the KR has a partial correlation with PTSD. Furthermore, the finding in Table 2 suggests that loss and separation in the DK era predicts the symptoms of *baksbat*, whereas murder and torture under the KR predicts symptoms of PTSD. This might explain why the PTSD checklist captures symptoms related to fear, anxiety threat, defensiveness, arousal, etc., while the *baksbat* inventory captures items that are more related to hopelessness, withdrawal, sadness, depression, avoidance, retreat (the courage is broken), etc. This finding is supported by the study of De Jong, Komproe, and van Ommeren (2003) who found that Cambodian survivors have higher symptoms of avoidance and are more withdrawn than survivors from other post-conflict countries. This might reflect the fact that Cambodian survivors of the Khmer Rouge had endured the prolonged and repetitive nature of trauma that promoted such emotional withdrawal responses as seen in *baksbat* rather than in PTSD. In addition, the type of traumatic event that leads to symptoms of PTSD is usually caused by a one-off trauma, which is not the same as repetitive traumatic events experienced by Cambodian survivors under the Khmer Rouge period. Herman (1992) found that PTSD criteria cannot capture symptoms of trauma response among those who have been in long-term incarceration and she found that they met criteria for disorder of extreme stress, not otherwise specified (DESNOS) than PTSD.

In addition, Cambodian culture and the personality traits of the people in this country who are described as being gentle, humble and introverted (Chandler, 1991; Ebihara, Mortland, & Ledgerwood, 1994; Kong, 2003) might well contribute to this type of trauma response. Dith Pran, a survivor whose story was featured in the film *Killing Fields*, said that Cambodian expressions of anger, pain and suffering do not show on their faces, but were in their hearts (Schanberg, 1985)—survivors tend to appear calm and will not express their anger and pain; they keep their feelings inside and endure pain silently.

Overall the *Baksbat* Inventory has the ability to capture more trauma symptoms experienced by Cambodian people than PTSD. Therefore, when forensic psychiatrists or psychologists use PTSD criteria solely to conduct psychological or psychiatric assessments on witnesses or civil party members who testify at the ECCC, their results might not fully describe the suffering of survivors. Consequently, the survivors' status as witnesses or civil party members may be removed by the trial chambers of the ECCC due to insufficient evidence that could prove their trauma was caused in the Khmer Rouge era. Once their status as civil parties has not been granted, or taken away, the healing of the psychological wounds would not occur because the pain and suffering of these survivors has not been officially acknowledged or addressed. Therefore, for the sake of promoting justice and healing for survivors of the Khmer Rouge genocide, it is very important that cultural aspects of trauma should be taken seriously into consideration. As stated

by Kirmayer et al. (2007), acknowledging cultural differences in law could contribute to building a multicultural society that can accommodate some differences in value that are important to a cultural community. For this reason, the author strongly recommends that the cultural-based syndrome of *baksbat*, which has more cultural value in the Cambodian context, be used as expert evidence in the ECCC.

Conclusion

The findings of this study reveal a very important message showing that there is space for the culturally specific syndrome of *baksbat* in forensic psychiatry/psychology in the Cambodian context. Using PTSD, a syndrome developed initially within the Western cohort, as expert evidence, might miss dimensions of suffering that are currently experienced and/or suffered by Cambodian survivors. By adding *baksbat* as potential expert evidence in the ECCC, forensic psychiatrists and psychologists from foreign countries/cultures might extend their data before drawing conclusions. Overall, the author strongly recommends the inclusion of *baksbat* or broken courage as expert "evidence" in order to maximize cultural reliability in the courts as this syndrome has potential to complement PTSD in the Cambodian context. This study can also be replicated in other cultures that have experienced similar extreme traumatic experiences. Despite the study's limitations related to its sample composition, further study on *baksbat* within Asia is warranted, especially among those who have experienced prolonged trauma irrespective of their geo-cultural background.

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Notes

1. 2011 Statistics from Bureau of Mental Health of the Ministry of Health, Cambodia
2. These experts included traditional healers, mediums, religious people, elderly people, mental health professionals, historians, linguists and survivors of torture who have different perspectives of *baksbat*. The experts provided full descriptions of *baksbat* that enabled the author to further develop a working definition and criteria to identify *baksbat*. Some of the experts were interviewed on multiple occasions, using information from previous interviews to elicit further information, and to clarify and gain deeper responses upon reinterview.

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Appendix

TPO Baksbat Inventory: An Inventory Measuring Symptoms of Trauma Responses in Cambodia

An individual who has *baksbat* should fulfil the following conditions: they must have experienced or witnessed traumatic events such as torture, physical or sexual abuse, been defeated in war, been physically and psychologically oppressed, been held hostage, experienced a natural disaster, been frightened by ghosts, been chased by wild animals or other similarly frightening situations. When the traumatic event is over, the individual should experience problems in the following three areas: broken courage, erosion of self and psychological distress. Please indicate the severity of your problems according to the following inventory.

Broken courage		**0**	**1**	**2**	**3**	**4**
TPO BI-1	Dare not make decisions or cannot make decisions					
TPO BI-2	Dare not confront					
TPO BI-3	Dare not want to take initiative					
TPO BI-4	Submit to others or admitted defeat to others					
TPO BI-5	Plant kapok tree (*Dam doeum kor*), remain mute					
TPO BI-6	Feeling and acting cowardly compared to before or loss of courage					
TPO BI-7	Mark the stone or pierce one's ears as a reminder (*Kap-thmor-chamnam, chos-tracheak-chamnam*)					
TPO BI-8	Cannot be open as before					
TPO BI-9	Cannot rely on oneself					
Psychological distress		**0**	**1**	**2**	**3**	**4**
TPO BI-10	Sleeping problems					
TPO BI-11	Trembling, shaking of extremities, cold extremities					
TPO BI-12	Trouble thinking (difficulty concentrating)					
TPO BI-13	Tightness in the chest, palpitations, difficulty breathing					
TPO BI-14	Easily fearful (fear bad consequence may happen)					
TPO BI-15	Feeling flat or low emotionally and physically					
TPO BI-16	Extreme fear, fright					
TPO BI-17	Irritable mood, easily getting angry					
TPO BI-18	Feeling restless or trapped					
TPO BI-19	Loss of self-confidence					
TPO BI-20	Feeling lonely					
Erosion of self		**0**	**1**	**2**	**3**	**4**
TPO BI-21	Avoid meeting others, reduced socialization					
TPO BI-22	Loss of honesty					
TPO BI-23	Selfishness					
TPO BI-24	Reduced contact with former relationship, loss of relationship with others					

0, Not at all; 1, A little; 2, Sometimes; 3, Frequent; 4, Very frequent.

SECTION III: CONCLUSION

Chapter 6: Conclusion and closing note

This thesis focused on ethno-cultural responses to trauma in the Cambodian context by exploring the Cambodian trauma-based cultural syndrome called *baksbat,* or broken courage. The author used multi-modal methods with semi-structured interviews, and developed and validated an inventory to measure this cultural syndrome that ids sensitive to the Cambodian social, geographic, cultural, historic and psychological context. There were three broad aims of this study:

1. To explore the meaning of trauma, and ethno-cultural range of responses to distress in Cambodia as a way of developing a culture-based syndrome of trauma, called *baksbat* (broken courage). In this way Cambodian people's collective and individual experiences of trauma may be better represented, and compared to trauma syndromes classified in the International Classification of Mental Disorders of DSM-IV or ICD-10.

2. To develop an inventory to measure *baksbat* and validate this newly developed inventory against internationally standardized instruments such as PTSD Checklist (PCL-C) and Hopkins Symptoms Checklist-25 (HSCL-25)

3. To increase the cultural competency for foreign and local mental health workers who are practicing and researching in Cambodia. In this sense, the author hopes this newly developed ethno-cultural syndrome of trauma responses, *baksbat* could increase cultural reliability in assessment, and act as forensic evidence of psychological impact from the Khmer Rouge genocide among civil parties and witnesses who testify at the Extra-Ordinary Chambers in the Courts of Cambodia (ECCC).

The three published articles presented in this thesis correspond to the three broad aims of this study. This study was largely exploratory and confirmatory, as there have been no prior systematic and in depth study conducted on this topic among the Khmer population in Cambodia.

I discuss the major findings in this chapter.

In relation to the research, this study found that there are many symptoms related to ethno-cultural responses to trauma expressed by the participants in this study. This study explored the five most challenging events faced by participants, they are 'life circumstances under the Khmer Rouge time', the 'experiences of being tortured and imprisoned' by the Khmer Rouge, 'witnessing the death of close relatives', 'experiencing the US bombings' in Cambodia before 1975, and 'the lack of information from relatives who lived through the Khmer Rouge time'. The challenges faced by participants in this study are consistent with those of the Khmer Rouge survivors living in Cambodia or overseas who endured all the hardships of the Khmer Rouge regime. The previous studies on the nature of traumatic events experienced by survivors of the Khmer Rouge found similar types of traumatic events and challenges expressed by participants in the study (Pallant, 2011).

Moreover, many of the stories testified by civil party members against the former Khmer Rouge leaders in cases 001 and 002[4] at the ECCC also revealed that their life challenges are not different from the participants in this study. For example, the testimony of the following civil party members on June 4th 2013: Mrs Bay Sophany, 67 year old, Cambodian-American living in San Jose, California; Mr Soeun Sovandy, 57 year old, currently lives in Battambang

[4] Case 001 refers to the trial of Kaing Kiek Eav alia Duch who was the former chief of Toul Sleng Prision of the Khmer Rouge, which was a torture center that killed nearly 17,000 people. Case 002 refers to the trial of 4 top former Khmer Rouge leaders namely Noun Chea, Khiev Samphan, Ieng Sary and Ieng Thearith.

province in Sangkhae district) and Mrs Seng Sivutha, 47 currently lives in Takeo province.[5] All of them described the details of their hardships under the Khmer Rouge, which include forced labour, lack of food, absence of safe medical treatment, being subjected to multiple tortures, and being constantly put under surveillance. Mrs Sophany described her experience. "*We were treated as the new people*[6]*, the 17 April people, who had a different social status or class compared to the base people. While we were working, we were watched by armed people, even during the night time when we were sleeping, people would be walking around and monitoring us*".

As far as the Khmer words used to express trauma, participants of this study explained that the Khmer words and metaphors that are used to express emotional problems are rich in meaning. Some of those emotional expressions required an understanding of the geographic and cultural context of Cambodia in order to understand the pain and suffering of participants. This level of pain increases according to the metaphor used in addition to the word pain itself. The metaphor "burn or burning or over cooked" have been used to express different degrees of pain, for example, **ជីវិតឈឺផ្សា** (*chivit chheu phsar*) – life is full of pain in burning character, is less painful than **ជីវិតខ្លោចផ្សា** *(chivit khloach phsar*) – a pain character of over burned and over burning sensation. However, **ជីវិតឈឺចាប់ខ្លោចផ្សា** (*chivit chheuchab khloach phsar*) – life is full of combined throbbing pain and with over burned / over cooked character, which expresses the most hurtful event, or the most degree of suffering that one can possibly endured. Similarly, the word of taste has also been use to express the suffering, too. **ជីវិតល្វីងជូរចត់** (*chivit lvinh chou chot*) – life is filled with bitter, sour and bitter tastes/experiences; this expresses the indigestible

[5] Retrieved from Cambodia Tribunal Monitor blog http://www.cambodiatribunal.org/2013/06/04/if-you-tell-them-you-will-be-killed-civil-parties-stories-heard/

[6] The Khmer Rouge divided Cambodian people into 2 groups: new people or 17 April people and the base people. The new people are people who lived under the government-controlled areas prior to the Khmer Rouge victory on 17 April 1975. The base people are the people who live under the Khmer Rouge controlled areas. The base people have all the power over the new people, they live better lives and controlled the new people every step.

nature of the suffering; this can be compared to eating something that has mixed taste of bitter quinine (plant used for anti-malaria purposes), or the tongue-curling taste of the green mango or banana. This expression of life suffering indicates the difficult life circumstances that can be compared to something that is difficult to swallow. Huot and LeVine (2000) found that many Cambodian people in Melbourne expressed their life under the Khmer Rouge as bitter-sour-bitter (*chivit lvinh chou chot*) (Boehnlein, 2001; Mollica et al., 1998; Mollica et al., 1987; Pham et al., 2009, Sonis et al., 2009 & Stammel, 2010). Similar studies on cross-cultural issues in health in other countries have also found that the words or metaphor have also been used widely to express pain and suffering.

In addition to the Khmer words, there are many symptoms of trauma expressed by Cambodian survivors of the Khmer Rouge regime; some of them have similarity to the international classification of mental disorders, DSM-IV and ICD-10 whilst others do not exist in that classification system. Some physical symptoms of *baksbat* such as headache, poor sleep, thinking too much, easily fearful, trembling/shaking of the extremities, cold extremities, tightness in the chest, palpitation, difficulty breathing, feeling restless, feeling flat etc… are typical symptoms of PTSD, depression, anxiety and somatoform disorder classified in DSM-IV or ICD-10.

However, there are many other symptoms of *baksbat* that are not the same as those symptoms classified in the international classification. Dare not confront, submitted to defeat to others, admitted defeat, plant kapok tree (*dam doeum kor*) or remain mute, feeling or acting cowardly compared to before the event (or loss of courage), unspeakable fear (*kob yobal*) etc… are specifically identified among Cambodian survivors who have *baksbat*. Some of these symptoms has also been described in by Yathai Pin in his book "Stay Alive My Son" which describes how Cambodian people during the Khmer Rouge time pretended to be dumb and deaf (say nothing, hear nothing, and understand nothing – *dam doeum kor*) in order to survivor

the regime (Huot, 2000). Similarly, Ebihara, Mortland and Ledgerwood (1994, page 85) described that due to the experience of torture and threat, many Cambodian people showed features of the kapok tree (*dam doeum kor*); they become mistrustful of each other and they did not speak to their family members (Yathai, 1987, p. 63).

Similar to *baksbat*, there are also other types of trauma-based culture syndromes studied in other countries. In Japan, for example, a condition similar to *baksbat* is "*kyodatsu*" was found to be prevalent around the period after World War II. Before World War II, this concept was originally used by Japanese doctors to describe physical or emotional prostration in individual patients who felt exhaustion and suffered from neurasthenia. But only after the emperor's announcement of the surrender in World War II, was this concept widely used as a way of characterizing the "distracted" and "dejected" condition of Japanese people as a whole. *Kyodatsu* was a condition of collective exhaustion and despair that overwhelmed many Japanese after their defeat. It was a state of psychic collapse so deeply widespread that many Japanese believed that it was not the military occupation that would destroy Japan, but it was the *kyodatsu* condition itself that destroyed and impeded post war reconstruction in Japan. It was widely believed that this misery posed the greatest of all possible dangers to the country – that it had become "the great enemy that could destroy Japan" (Dower, 1999). Comparing *kyodatsu* to *baksbat*, many Cambodian believe that most Cambodian people have *baksbat*, if this condition is not addressed, as it can continue to affect the development of the entire society and future generations because people dare not confront and dare not stand up for their rights. They are too weak, and let the authority and the government continue to abuse them. Personal communication with the venerable You Hut Khemacaro of Wat Langka on 23 December 2008 revealed that due to *baksbat*, many of his fellow monks would not express their opinions and were very submissive toward their superiors.

Cultural syndromes resembling *baksbat* in other countries include *Hwa-Byung*, which is a Korean folk illness ordinarily understood by patients and families to be a physical affliction despite the fact that its manifestations include both physiological and psychological symptoms. In addition, the patient often recognizes interpersonal conflicts and anger as precipitating factors (Min, 2010). *Shinkeishitsu* (constitutional neurasthenia, and in those with sensitive somatic natures) is a culture bound syndrome found in Japan and some East Asian countries (Suzuki, 1989). In fact, Shoma Morita, who was a contemporary of Freud at the turn of the last century, developed a rest and ecological therapy for people with this type of neurasthenia, which assisted them to rest in a safe environment so they could recover their neurological balance. Morita would relate a trauma syndrome to the loss of life spirit.[7] This term is heavily utilized both in diagnostic category and used by laypersons to describe somatic illness experiences. A subcategory of *Shinkeishitsu* is *Taijinkyofusho* usually glossed as 'social phobia' or 'anthropophobia' but they are not the same as social phobia in the Western diagnostic classification, though perhaps it can be more accurately translated as "fear of interpersonal relationships" or "fear of interpersonal situation" (Geen, 1998; Kitanishi, 2002; Russell, 1989; Suzuki, 1989). Like *baksbat*, both *Hwa-Byung* and *Shinkeishitsu* are types of mental health problems that are culture specific and are not found in the western classification of mental health disorders, therefore Western instruments cannot fully capture these culturally specific problems (Choi, 2011; Min, 2010). Hence it is very important for Korean, Japanese and foreign mental health professionals from non-Western countries to understand cultural syndromes as it can help them in their work with patients from those cultures.

Other culture bound syndromes exist in other parts of the world include *Attacque de Neverviose* that is shared among Latin Americans and people with Hispanic backgrounds (Guarnaccia, DeLaCancela, et al., 1989; Guarnaccia, Rubio-Stipec, et al., 1989; Leibowitz, 1994). *Susto or* soul loss when fear leads to the soul leaving the body which is found in Latin

[7] See Morita, S (1928/1998). *The True Nature of Anxiety-based Disorders: Shinkeitshitsu*. Kondo (ed.) LeVine, P, (editor). State University of New York Press, New York.

America (Glazer, 2004; A. Rubel, O'Nell, C.W, and Collado-Ardon, R., 1984), and North Balinese syndrome of fright and soul loss called *Kesambet* (Wilkan, 1989) etc. these cultural syndrome are more specific and are not described in the international classification of DSM-IV or ICD-10.

In relation to the trans-generational effects of *baksbat,* some experts of this study think that *baksbat* can be transmitted across generations while others disagree with this statement. In the Western countries, many studies among second generation of survivors of the World War II found that their children have symptoms features of trauma and PTSD even though they didn't have direct experiences of traumatic event.

The study of the effect of parental Holocaust trauma on their children's Holocaust-related ideation found that children of survivors showed significantly more Holocaust ideation than did those of American Jews who were not exposed to the Holocaust. These findings offer empirical support for the notion that Holocaust trauma has a psychological impact on the children of survivors (Sorscher, 1997). Similarly, the study on trans-generational effects of the Holocaust on the offspring of Holocaust survivors found that the trans-generational effects of the Holocaust might be stronger among middle-aged offspring of Holocaust survivors. This study concluded that the offspring of Holocaust survivors, and especially those with two survivor parents, reported a higher sense of well-being but more physical health problems than the comparison group (Sorscher, 1997). Beside the study on the children of the Holocaust, other studies have been undertaken on the trans-generational effects of trauma among children of war veterans with PTSD. The studies found higher rates of anxiety and aggression among children of war veterans with PTSD along with many other factors such as low socio-economic status in this group which signifies the importance of mental health screening programs and appropriate interventions among veterans as well as their children (Arie Nadler, 1987; Arie Nadler, Kav-Venaki, & Gleitman, 1985; Shrira, 2011).

In relation to the study on trauma in the second generation in Cambodia, Field (2011) studied the impact of parental styles on second-generation effects of trauma among adolescent offspring of survivors of the Khmer Rouge (KR) genocide in Cambodia. This author involved two hundred high school students in completing questionnaires addressing their parents' trauma stemming from the Khmer Rouge regime in particular focussing on parental styles (role reversing, overprotectiveness), depression and anxiety. This study found that parents' role reversing parental style and mothers' overprotective parenting were shown to mediate the impact of their trauma symptoms on the child's depression and anxiety (Ahmadzadeh, 2004; Heyrend, 2009)

The above studies on children of Holocaust survivors, children of war veterans with PTSD and second generation children of the survivors of the Khmer Rouge genocide in Cambodia suggest that there are connections between parent survivors with psychological problems and children with higher rates of anxiety, depression, and other trauma related problems. However, there was no previous study on *baksbat* and its effects on the second generation Cambodians. History suggests that the concept of *baksbat* may have originated from the collapse of Angkor and the Khmer Empire in 1413 following the invasion of Siamese (Thailand) from the West (Corfield, 2009). There were so many Khmer people taken hostage and tortured severely; it took the Khmer Empire nearly two centuries to be able to defeat the Siamese and to reclaim land from the Siamese Kingdom. This could suggest that the Khmer could have suffered from *baksbat* since then as one Khmer historian said Khmer is an ethnic *baksbat* (Saing, 1973). Mr. Kong Bunchoeun, the author of the book on 'Khmer Illness', said the fear that ordinary people have toward powerful people is an aspect of *baksbat* that has been carried over with them for a long time and this *baksbat* condition makes it difficult for Cambodian people to stand up for their rights and hence they remain submissive to the authorities all the time (Kong, 2003, p. 26).

On a personal note, the author, who was a child during the Khmer Rouge time, had experienced and witnessed the mass evacuation of the population of Phnom Penh by the Khmer Rouge troops on 17 April 1975. The whole population of Phnom Penh of more than half a million at that time unconditionally agreed to leave their homes in Phnom Penh on foot without any protest or resistance. The whole city was completely emptied in a very short period. On top of that they were forced to live without dignity; millions were forced to work hard like slaves; many were tortured severely and treated like animals by the Khmer Rouge militia. There was no resistance from the people; many waited to be killed by the Khmer Rouge militia – adults and children. This could well be because of *baksbat* (submitted to defeat, feeling or acting cowardly etc.) that have been transmitted from generation to generation. The killing and the hardship under the Khmer Rouge itself made Cambodian people suffer even more *baksbat* and the effects could have passed to many Cambodians today.

Some Cambodians offer an alternative explanation that younger generation Cambodians may not be affected by *baksbat* from their parents because they had not experienced the same traumatic event as their parents and their parents had never told them about their story. In recent political campaigns toward the upcoming election in Cambodia of 28 July 2013, and the political protests against the election results thereafter, it is observed that most of participants (more than 70%) who joined hands with the opposition party, the Cambodian National Rescue Party (CNRP) were youths whose parents were survivors of the Khmer Rouge regime, some of whom may have *baksbat*. Even if their parents try to stop them from participating in protests because of their own *baksbat*, the Cambodian youths didn't seem to take it seriously. They have not been through the Khmer Rouge time, they have never been taught the history of the Khmer Rouge and had never been told by their parents, and therefore they seem not to be affected by the perceived fear like their parents. This may indicate that the youth may not have suffered from *baksbat* of their parents and that could be a good prospect for Cambodian society

as the future of Cambodia depends on them to change what their parents failed to do due to the parents' *baksbat*.

There is contemporary relevance for understanding *baksbat*. The demonstrations organized by the opposition party continue to grow. More and more people continue to take part in them because so far they feel safe in participating. However, until the second week of January 2014, the government started to crack down on demonstrators and dismantled their camps. The security force killed 4 demonstrators and injured more than 20. After the killings, no one dared to show up to protest against the government. The killing of four people, instead of fuelling more anger and aggression among the public, made people became afraid. They started to shut up and hide themselves. This attitude reveals the quick trigger feature of *baksbat*, where people's courage was silenced or overridden by fear. Perhaps like *baksbat* their courage is broken, submitted to defeat and they dare not stand up to confront the situation. In this case, the author hypothesizes that *baksbat* remains deeply rooted in Cambodian society, with potential transfer to the next generation of Cambodians. As Rohr (2004) said the trauma that is not transformed, is transferred.

As far as the treatment and the prevention of *baksbat* is concerned, unlike PTSD, the treatment of *baksbat* requires a more traditional approach involving herbal medicine, a religious approach which involves monks or *achar* (religious elders) to help correct bad luck or *kruah* (danger), traditional healers / mediums who perform a ceremony called *rumdâh kruah* to divert the source of danger and to increase *reasey* (fortune or luck) (Hinton, et al., 2009), a cosmological approach which consists of *hav-praling* (calling back the loss souls) that involves ceremony that is held to call back the loss soul that went out of the body during the frightening event (Hinton & Good, 2009), a medical approach through the prescription of psychotropic medications by mental health professionals, and last but not least through the 'reconstitution of courage' as most report that their courage has been broken.

The reconstitution of courage could be done through a multi-disciplinary team. This would involve the provision of education about the problem of *baksbat* itself to those who have *backbat* and the public, teaching about conflict resolution, which also includes teaching a new generation about non-violent behaviour, and healthy problem solving skills. It is also very good to set up empowerment programs, create democratic space, and create *korl-kar samaki* (encourage the principle of solidarity to enable people with *baksbat* able to overcome their problems (personal communication with Ouk Chorn, Aug 20, 2009). It is very importance that people with *baksbat* are aware of *baksbat* within themselves first, so that they could do something to overcome it. If they do not aware of this problem, they won't be able to deal with it. Just like *kyodatsu* in Japan where Japanese people become aware of this problem, do something "together" (*isshoni*) to over come it.

In relation to the research aim 2, this study focussed on the development and validation of an inventory to measure *baksbat* through a mixed-research method that combined qualitative and quantitative sequences (Teddlie, 2007). The study began with ethnographic interviews with the experts who understand, have knowledge and experiences of *baksbat* themselves in order to generate items that could represent the syndrome from different perspectives and use these items as a basis to develop inventory which is relevant to the Cambodian context. After developing it, the author validated the *baksbat* inventory in a quantitative survey. Statistical methods were used to analyse the data. These statistical techniques were comprised of exploratory factor analysis (EFA), performed in order to explore the numbers of factors and how items within the inventory load together. Then, confirmatory factor analysis (CFA) was performed in order to test goodness of fit of this inventory; then logistic regression was also performed in order to see the relationship between symptoms of inventories used in this study and also to see how well the three symptom clusters of *baksbat* are able to predict variance in symptoms of PTSD.

The use of combined methods of qualitative and quantitative research in order to develop an ethnographically derived inventory was highly recommended by previous authors as the most appropriate research method in a cross-cultural setting (Tashakkori, 1998; Teddlie, 2007). More importantly, this research uses an *emic* approach, which enabled the author to understand the problems within Cambodian culture. Stewart et al., (2008) confirmed the importance of using a mixed approach in research, he stated that qualitative methods fostered in-depth understanding of experiences and also generated detailed information on support needs, support resources, and intervention preferences from the perspective of vulnerable populations among the population of his study. At the same time, the quantitative methods documented the effectiveness and outcomes of intervention strategies and enhanced the reliability and validity of assessments and interventions, and generalizability of findings (De Jong et al., 2001; Phan et al., 2004).

Other studies that aim to develop and validate an inventory to measure culture-bound syndromes in non-Western cultures, rarely use these mixed research methods to develop their inventories as this author has done, Robert, Han and Weed, for example, adapted Western instruments to measure a Korean culture-bound syndrome called *Hwa-Byung*. They developed a standardized assessment scale to measure symptoms of *Hwa-Byung* based on a Western instrument, the Minnesota Multi-phasic Personality Inventory (MMPI-2) (Roberts, Han, & Weed, 2006). These authors translated the MMPI-2 into Korean and then administered it to Korean inpatients, followed by confirmatory factor analysis of the data in order to confirm the fitness of the inventory for Korean patients. The author thinks that translating and modifying the western instrument in order to measure Korean problems may not be culturally relevant since the MMPI-2 was the instrument that was developed in the US and based on an American, white population. Therefore, this measure may fail to capture some of the idiom of distress expressed by Korean patients. Thus there may be some transcultural gaps with this *Hwa-Byung*

checklist when applied to Korean patients. These authors should have undertaken qualitative data from *emic* approach in order to understand what *Hwa-Byung* means from the Korean perspective first.

When the study compares *baksbat* to other mental disorders, results show that *baksbat* has a higher correlation to depression (r=.71, p<.01), anxiety (r=.67, p<.01) and PTSD (r=.66, p<.01) (please see table 2). This may well be related to culture, attitude and behaviour of Cambodian people. Cambodian people have often been described as the stereotype of "gentle, …politeness and smiles which are the expected norm" Hinton, (2005, p. 253), so the expression toward trauma tends to take a gentle and calm way. They tend to keep the pain and suffering inside themselves and continue to suffer. As Dith Pran, whose story featured in the film *The Killing Fields* has said Cambodian people keep anger in their hearts; they do not show anger in their face. Despite getting angry, most Cambodians remain calm outside, but their insides are "boiling like water" (Schanberg H., 1985). This could indicate that responses to trauma in Cambodia could be seen in different forms, the survivors of the Khmer Rouge not fully presenting symptoms of PTSD, but presenting symptoms of *baksbat*, depression and anxiety. Therefore, this could be a reason that Cambodian survivors of the Khmer Rouge genocide do not assume a PTSD profile, but appear more like depressive features. Thus this could also partly explain the fact that the rate of PTSD in Cambodia is low. Yet if therapists consider culture and mental health, they may see trauma responses such as *baksbat* underneath of depressive symptoms.

Forensic Impact of acknowledging the validity of *baksbat*

In relation to the research aim 3, this study aims to increase cultural competency on ethno-cultural responses to trauma especially about *baksbat* for foreign and local mental health workers who are practicing and conducting research in Cambodia. In this sense the third article on 'a place for *baksbat* in forensic psychiatry at the ECCC' fits very well to research aim 3.

The author himself used this cultural syndrome of *baksbat* as forensic evidence in the ECCC during his 2-day testimony as an expert witness on the psychological trauma on June 5-6, 2013[8]. Many forensic psychiatrists and psychologists use PTSD as a forensic evidence of crime. Due to the fact that the prevalence of PTSD in Cambodia is low, as we have seen in an earlier chapter, the defence lawyers argued that Cambodian survivors do not suffer very much from the psychological wounds of the genocide. They used the figures of Sonis et al., (2009) who found 14% of Cambodian people aged above 18 have probable PTSD. To the defence lawyer this figure is small because he thinks the other 86% of Cambodian survivors do not have any psychological problems. The defence lawyer posed the question to the author that *'Is it correct to say that the other 86% of Cambodian survivors do not have PTSD?'* The author responded that if the defence lawyer refers to PTSD as 'the only type of trauma response', then the defence lawyer might be correct and in this case it maybe true to say that 86% of Cambodian do not have PTSD. But the psychological and psychiatric responses to trauma are not the only form of trauma; many survivors who experienced trauma could suffer from many types of mental health and psychological problems such as depression, anxiety, psychosis, *baksbat*, and alcohol and drug abuse and dependency resulting in their committing violent acts. Therefore, many Cambodian survivors who do not fall within the range of PTSD criteria (they are not among the 14% in Sonis study), fall within the radar of 86%. It is probable that they may have suffered from other problems such as *baksbat*, depression, psychosis, alcohol abuse or are victims of domestic violence. There are still high rates of domestic violence and alcohol abuse in Cambodia even today (Fulu, 2013).

In this case, it is wiser for foreign forensic psychiatrists or psychologists not to use PTSD diagnosis alone as forensic evidence of psychological symptoms of trauma for survivors of the Khmer Rouge genocide. They should also consult local expert who have better understanding of Cambodian cultural context especially the understanding of *baksbat*.

[8] Cambodia Tribunal Monitor's daily blog (www.cambodiatribunalmonitor.og). Official court transcripts for the ECCC's hearings may be accessed at http://www.eccc.gov.kh/en/case/topic/2.

In an opinion column entitled 'trauma models used at the ECCC flawed' published in the Phnom Penh Post daily on June 11, 2013, Dr Peg LeVine wrote that "If only the defence team could have refrained from challenging research markers on the percentage of the Cambodian population traumatised today, they could have gathered evidence on the spread of trauma found in *baksbat*"(LeVine, 2013).

This trauma based cultural syndrome *baksbat* will also assist national and international lawyers, prosecutors and judges when assessing and judging cases related to crimes against the former Khmer Rouge leaders. However, the use of *baksbat* as forensic evidence is not intended to replace PTSD, but rather to compliment it and other internationally recognized diagnostic criteria in the legal systems especially in the ECCC, and in clinical settings and in research.

Baksbat can also be applied in clinical, training and research settings in Cambodia. The diagnostic criteria can be used to educate Cambodian psychiatrists, psychologists, and other mental health workers about *baksbat*. In this way, culturally sensitivity will increase and as well as cultural competence that enables Cambodian mental heath professionals to observe and assess and treat their patients using Cambodian cultural lenses (Aleshire, 2007).

6.1. Conclusion

Baksbat was validated as a cultural syndrome of trauma in Cambodia through the development of a valid, reliable inventory. Care was taken to make sure the inventory was culturally appropriate in measuring symptoms of trauma among Cambodian survivors. *Baksbat* has some features of PTSD, depression, anxiety, and dissociative features in cases that involve the 'loss of soul' and other phenomenal features that are culturally specific to Cambodia. This study demonstrates the need for clinicians and researchers studying trauma in Cambodia to include *baksbat* and other idioms of distress that may be otherwise overlooked. Without taking those issues into consideration, the true picture of trauma cannot be seen clearly and respectfully,

given the tremendous traumatic experiences that Cambodia and the Cambodian people have endured.

The study has shown that *baksbat* symptoms extend beyond the conventional medical models of mental distress. Without identifying this trauma syndrome *baksbat*, the suffering of Cambodian survivors will not be assessed fully by mental health professionals or by policy makers, stakeholders, or by the judges, prosecutors and defence lawyers at the ECCC. To understand the full cultural scope of traumatic aftermath for Cambodian people is to assist the capacity building mechanisms of justice, healing and reconciliation in Cambodian society. Trauma runs across generations and consideration of *baksbat* may decrease long-term risks by generating programs that rekindle collective courage by including traditional methods of care.

As stated earlier, *baksbat* cannot be used to replace PTSD; rather, *baksbat* can be considered alongside PTSD in order to understand in more cultural depth, the full range of traumatic expression in Cambodian people.

6.2. Implications of the findings

The findings of the present study have several implications: 1) to increase attention and understanding among clinicians, researchers, students and academics in the field of ethno-cultural responses to trauma, 2) to provide a model of a methodology for studying ethno-cultural response to trauma across South East Asia, 3) to create an opportunity for further dialogue on the social and political implications of *baksbat* on Cambodian society and on the post Khmer Rouge generation of Cambodians, and 4) to devise strategies to heal *baksbat* in Cambodian society, while increasing reconciliation in Cambodia.

1) The findings in first article assist clinicians, researchers, students and academics to increase their understanding of *baksbat* and pay more attention to this type of ethno-cultural

response to trauma. The findings describe *baksbat* from historical, legal, medical models of health, and traditional models of health, linguistic perspectives with reference to those who have experienced the syndrome personally. From this understanding, clinicians who see clients with *baksbat* would be able to spend more time to explore the local idioms of distress, which would lead them to understand their clients' problems in context and in more depth. By considering formally the criteria of *baksbat*, clinicians will be less likely to impose a PTSD diagnosis without taking into consideration of full cultural influences on the presenting problems.

Through the understanding of the features of *baksbat*, researchers are encouraged to design their research methodology more carefully by looking into an appropriate set of questions and instruments that enable them to capture ethno-cultural response and make appropriate results and recommendations. Increased understanding of *baksbat* would help Cambodian medical, social work and psychology students, and university lecturers to be aware of trauma experiences and expressions in Cambodia and to differentiate between local and normed descriptions. Cambodia's ethno-cultural response to trauma deserves to be more formally endorsed, and indigenous methods of care preserved, while generating responsive care for *baksbat*.

2) The mixed research method of qualitative and quantitative used in the second article has been highly recommended as an appropriate method that would increase more understanding of transcultural psychology. Brewer (1989), De Jong et al., (2001), Phan et al., (2004), Tashakkori (1998) and Hunter (2003) stated that combined quantitative and qualitative data inclusion in a study enables researchers to gain a deeper understanding of the phenomenon of interest and generalise the result from sample to population. Therefore, ethnographic interviews enabled the author to develop the *baksbat* inventory entirely from indigenous idioms of distress, alongside expressions and understandings of mental

disorder. It deserves to be stated again that mental and physical dis-order in Cambodia occurs when the cosmological realm is out of order.

Furthermore, the adoption of a mixed research approach has enabled the development of a cultural syndrome of trauma, which differs in nature and in content from the international classification of mental disorder in the ICD and DSM systems. The author hopes that both contents of the findings and the methodology used in this study will help clinicians to take into consideration the natural Cambodian nature of trauma responses and find better ways to help their clients who have trauma related syndromes like *baksbat*. This research will also pave the way for other researchers to further develop, refine and validate the TPO Baksbat Inventory in specific groups (for example children, trafficked women and children, ethnic minorities) in Cambodia and the region.

3) The issue of transmission of *baksbat* across generations, identified in this study is an interesting topic for Cambodia today. Similar to *kyodatsu* in Japan, if Cambodian survivors of the Khmer Rouge genocide are currently suffering from *baksbat*, if this *baksbat* is transmitted to the next generation, and if this *baksbat* condition is not properly addressed, then it may affect the concerted effort to rebuild Cambodia. Therefore, mental health professionals, the relevant authorities and the government should take it into consideration and work together to find a proper way to address this *baksbat* in Cambodia society.

4) The treatment options for those suffering with *baksbat* need further research with attention to holistic and cosmological influences; inside Cambodia attention is given to participation by local sources – from spirit mediums to monks to local physicians. Focusing on the "reconstitution of courage" could be a key to helping survivors recover from *baksbat* so that it may promote healing and reconciliation in Cambodia after the genocide. The reconstitution of courage includes political and social activities that could empower people

to be claim their human rights, promote safety and security for people and their communities, enhance their livelihood, teaching people about positive conflict resolution within the human and ancestral realm. Another challenge that Cambodians have witnessed is the creation of an international court to prosecute those who designed and implemented the Cambodian genocide, which induced *baksbat* in a nation of people. In this context, the meaning of justice and pathways to healing and reconciliation is on-going for Cambodians. Prager (2011) considers the ways social trauma serves as a prelude to development of policies of recovery and reconciliation; this can be the case for *baksbat*.

If *baksbat* is transmitted to the next generation and the *baksbat* condition is not addressed strategically, Cambodian society is at risk for not healing fully from *baksbat*. Result of this study could be used as a warning for Cambodian health policy makers to prepare and take possible measures to deal with *baksbat* across generations.

6.3. Limitation of the research:

Although the current study makes a significant contribution to the knowledge base in the ethno-cultural psychiatry and mental health in Cambodia, it is the first study into the aetiology of *baksba*t.

In the current study, the qualitative and quantitative phases used non-random samples and applied convenience and snowball sampling methods in order to identify expert participants. While an *emic* approach to this study assisted the identification, knowledge base, and life experiences of *baksbat*, the data for the quantitative phase employed non-random sampling inside Cambodia as well. In this regard, care needs to be taken to avoid generalising the results of this validation study to the wider population outside Cambodia. Nevertheless, the findings provide invaluable insight into the nature of a Cambodian cultural response to trauma, which

can be used to complement the current international standardised instruments. It also contributes to the growing knowledge in traumatic studies by highlighting the transcultural nature of people's lived experiences of trauma.

While building reliability of data analyses into the study, the ethnographic interviews could have been compromised by the author's background; he shares the same cultural and national backgrounds of his respondents and is a survivor of the Khmer Rouge. Even though the author applied peer debriefing, triangulation techniques to ensure trustworthiness of the data, such measures to minimize bias, including supervision to enhance cultural validity could have had loop holes that went unnoticed.

In keeping with method research, Prager (2011) recommends that mixed research methods are better implemented in teams since team members can be involved in multiple stages of data collection when analysis extends over long periods of time. Working in teams allowed this researcher to make use of others' expertise in quantitative methods and analyses, qualitative methods and analyses, and research design. The author of this study did not have a large team with members that played specialist roles; however, he called on scholars and local sources to discuss and share knowledge and expertise with each other.

6.4. Recommendations for future study

- Although the data shows that the *TPO Baksbat Inventory (TPO-BI)* has high validity and reliability, it is necessary to review this inventory over a period of time in order to reassess its reliability and consistency of reliability across time and place, while widening the tangle of demographics of respondents. Thus it is necessary to study how this particular Baksbat Inventory validates across different sub-groups of the population, such as to children, youth, survivors of domestic violence or trafficking, victims of rape, ethnic minority group

marginalisation, such as Cham people (Khmer Islam), and minority groups in the highland areas of Cambodia.

- While there is a trend, it is not fully determined when and where and with whom *baksbat* is transmitted across generations, although many respondents believed this to be true. Since PTSD has been found to have transgenerational effects on the offspring of the European Holocaust survivors; it is necessary to consider whether *baksbat* has any similar trends to PTSD.

- Since this study led to the validation of this inventory among Cambodian survivors living inside Cambodia, it is necessary to validate this inventory with Cambodian people who live overseas. Recently the Khmer Health Advocate Inc. (KHA), a Cambodian NGO in Connecticut, USA has requested the author's permission to use it with the Cambodian population there; KHA researchers will test the validation of this *baksbat* inventory among their clients. So hopefully in the next few years, there will be information available on how valid and reliable this inventory is among some of the Cambodian diaspora in the United States and elsewhere.

- Researchers need to keep improving the content of the *baksbat* inventory through an iterative process (Hanson, 2005). Thus, research needs to be implemented with a project management cycle that starts from developing the research questions, then conducting interviews with observations, collecting and analysing data analysis, and further developing the theory which feeds back to the improvement of the inventory. Through the continuation of refining the data and theory, the theory building of *baksbat* that stems from this study can lead eventually to a formal theory of ethno-cultural trauma as experienced and expressed by people in the Cambodian spirit landscape.

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Appendices

Appendix 1: Human Ethic

MONASH University

Standing Committee on Ethics in Research Involving Humans (SCERH)
Research Office

Human Ethics Certificate of Approval

Date:	**26 September 2008**
Project Number:	**CF08/2010 - 2008000982**
Project Title:	**Ethno-cultural aspects of mental health in Cambodia**
Chief Investigator:	**Assoc Prof Peg LeVine**
Approved:	**From: 26 September 2008 To: 26 September 2013**

Terms of approval

1. The Chief investigator is responsible for ensuring that permission letters are obtained and a copy forwarded to SCERH before any data collection can occur at the specified organisation. **Failure to provide permission letters to SCERH before data collection commences is in breach of the National Statement on Ethical Conduct in Human Research and the Australian Code for the Responsible Conduct of Research**.
2. Approval is only valid whilst you hold a position at Monash University.
3. It is the responsibility of the Chief Investigator to ensure that all investigators are aware of the terms of approval and to ensure the project is conducted as approved by SCERH.
4. You should notify SCERH immediately of any serious or unexpected adverse effects on participants or unforeseen events affecting the ethical acceptability of the project.
5. The Explanatory Statement must be on Monash University letterhead and the Monash University complaints clause must contain your project number.
6. **Amendments to the approved project (including changes in personnel):** Requires the submission of a Request for Amendment form to SCERH and must not begin without written approval from SCERH. Substantial variations may require a new application.
7. **Future correspondence:** Please quote the project number and project title above in any further correspondence.
8. **Annual reports:** Continued approval of this project is dependent on the submission of an Annual Report. This is determined by the date of your letter of approval.
9. **Final report:** A Final Report should be provided at the conclusion of the project. SCERH should be notified if the project is discontinued before the expected date of completion.
10. **Monitoring:** Projects may be subject to an audit or any other form of monitoring by SCERH at any time.
11. **Retention and storage of data:** The Chief Investigator is responsible for the storage and retention of original data pertaining to a project for a minimum period of five years.

[redacted]

Professor Ben Canny
Chair, SCERH

Cc: Dr Sotheara Chhim

Postal – Monash University, Vic 3800, Australia
Building 3E, Room 111, Clayton Campus, Wellington Road, Clayton
Telephone [redacted] Facsimile +61 3 9905 1420
Email [redacted] www.monash.edu/research/ethics/human/index/html
ABN 12 377 614 012 CRICOS Provider #00008C

Appendix 2a: Explanatory Statement G1

MONASH University

14 July 2008

Explanatory Statement: Group 1
Title: Ethno cultural aspects of mental health in Cambodia

IMPORTANT NOTE: Distress, due to recent life events may occur (unawares to the researcher) and if so, please discontinue reading about the following research.

My name is Sotheara Chhim and I am conducting a research project with Prof. Peg LeVine from Monash Asian Institute towards a PhD in transcultural mental health at Monash University. This means that I will be writing a thesis which is the equivalent of a 300 page book.

The aims of this study are (1) to explore cultural aspects of mental health/psychological responses to long-term distress and/or life threatening events among Cambodians, and (2) to map the ways people cope with these events, and (3) to compare the differences between distressing/trauma responses classified in the international classification of mental health disorders used by the World Health Organization (WHO).

The study will be conducted jointly with the Transcultural Psychosocial Organization, Cambodia (TPO Cambodia), Social Services of Cambodia (SSC) and Center for Child and Adolescent Mental Health (CCAMH) because the staff of these organization has knowledge and skills for assisting Cambodians who suffer from mental health problems as consequences of Khmer Rouge atrocities and wars in Cambodia through a community based prevention and intervention projects. The above NGOs welcome my request to conduct research among its collaborators which include traditional healers, fortune tellers, monks, elderly people, nurse, general practitioners and academic people. Your participation in this study is very important because you are the local experts who have knowledge and experiences in both culture and mental health aspects of the people in your community.

The study will enable mental health workers in Cambodia and from other regions in South East Asia to distinguish cultural specific responses to trauma in different cultural contexts. This study will enable both Cambodian and foreign mental health workers to understand more about this cross-cultural aspect of mental health and that will enable them the capacity to take care our clients/patients effectively. Therefore, you as participants and/or society will be directly or indirectly benefit from this study.

This research involves individual face-to-face interviews. The interview will be guided by open-ended questions. The interviews will be audio-taped. It will take approximately 2 hours of your time, and possible one hour for follow-up.

You will be offered a small incentive as to compensate your time lost during the interview. The gift will be given in form of soap, scarf, sarong or snack in the amount of 20,000 Riels, which is equal to approximately A$5.00 (five Australian dollars).

Your name and details will be coded. During the data entry, your name will be omitted and leave only the code in the questionnaire in order to ensure confidentiality. Only myself and my supervisor can access to this information which will be stored in a private and secured place for 5 years as required by Monash University regulations.

Monash Asia Institute
Faculty of Arts
Menzies Building, Level 8 South, Room S833
Monash University, VIC 3800
[redacted], Facsimile +61 3 9905 5370 [redacted]
ABN 12 377 614 012 CRICOS provider number 00008C

A report of the study may be submitted for publication, but individual participants will not be identifiable in such a report. Where participants information is required, pseudonyms will be used. However, please keep in mind that it is sometimes impossible to make an absolute guarantee of confidentiality /anonymity but I will do my utmost to ensure this.

As this research involves discussions on psychological experiences if you find any of the discussion to be stressful, you will be referred to a team of professionals for consultation, with a private and public option.

- Private Psychiatric OPD, Dr Muny Sothara, No.79, Tep Phan Road, Psa Depot, Toul Kork, Phnom Penh. Tel: 012 380 609.
- Psychiatric OPD, Khmer Soviet Hospital, Phnom Penh
- TPO Phnom Penh: No 20, Street 334, Boeung Keng Kang 1, Phnom Penh, Cambodia Tel: 023 218 478
- TPO Pursat: No 513, Street 27 (TV Channel 10 street), Peal Nhek Commune, Sampov Meas district, Pursat province. Tel: 052 951 555.
- Dr Teng Hokly, Psychiatric OPD, Pursat Referral Hospital, Pursat province.
- TPO Battambang: No 652, Street 57, Toul Ta Ek commune, Battambang Province. Tel: 053 952 343
- Dr Um Nhil, Psychiatric OPD, Battambang Referral Hospital, Battambang provine.
- TPO Banteay Meanchey: Street 3, Samphy village, Kampong Svay commune, Sereysophorn district, Banteay Meanchey province. Tel: 054 958 910
- TPO Kampong Thom: No 36, Pracheathipatay road, Kampong Thom commune, Stung Sen district, Kampong Thom province. Tel: 062 961 375
- Dr Ort Bunky, Psychiatric OPD, Kampong Thom Referral Hospital, Kampong Thom province.

Please be aware that participation in this research is voluntary, you may withdraw from participating in this research at anytime. This means that you can pass on questions you do not wish to answer, you can stop the interview at any time.

Please feel free to contact me, **Sotheara Chhim, MD** at any time after the interview is completed for any information related to this research. My office phone number is 023 218 478.

If you would like to contact the **researchers** about any aspect of this study, please contact the Chief Investigator:	If you have a **complaint** concerning the manner in which this research is being conducted, please contact
Prof. Peg LeVine Monash Asia Institute Menzies Building, Level 8 South, Monash University, VIC 3800 [redacted]	**Mr Sam Mara** Operation Manager, TPO Cambodia No 20, Street 334, Boeung Keng Kang 1, Chamcarmon, PO Box 1124, Phnom Penh, Cambodia. [redacted] Fax: 023 219 182 [redacted]

Thank you.

Sotheara Chhim

MONASH University

ថ្ងៃទី ១៤ ខែ កក្កដា ឆ្នាំ ២០០៨

សេចក្តីថ្លែងពន្យល់: ក្រុមទី ១

ចំណងជើង: **ការសិក្សាស្តីពីទិដ្ឋភាពវប្បធម៌នៃសុខភាពផ្លូវចិត្តនៅកម្ពុជា**

សម្គាល់សំខាន់: ទុក្ខព្រួយ ដោយសារព្រឹត្តិការណ៍ជីវិតថ្មីៗដែលអាចនឹងកើតឡើង (ដោយអ្នកស្រាវជ្រាវមិនទាន់បានដឹង) ហើយប្រសិនបើយ៉ាងនេះ សូមឈប់អានអំពីការស្រាវជ្រាវខាងក្រោមនេះតទៅទៀត។

ខ្ញុំបាទឈ្មោះ ឈឹម សុធារ៉ា ហើយខ្ញុំកំពុងធ្វើគម្រោងស្រាវជ្រាវមួយ ជាមួយលោកសាស្ត្រាចារ្យ តែហ្គ ឡឺវ៉ាញ (Prof. Peg LeVine) មកពីវិទ្យាស្ថានសិក្សាអាស៊ីម៉ូណាស្ស (Monash Asian Institute) ដើម្បីទទួលបានសញ្ញាប្រ័តថ្នាក់បណ្ឌិត ផ្នែកសុខភាពផ្លូវចិត្តអន្តរវប្បធម៌ នៅសកលវិទ្យាល័យម៉ូណាស្ស (Monash University)។ នេះមានន័យថា ខ្ញុំបាទនឹងត្រូវសរសេរនិក្ខេបបទមួយ ជាសៀវភៅដែលមានចំនួន ៣០០ ទំព័រ។ គោលបំណងនៃការសិក្សានេះគឺ:

១-ដើម្បីស្វែងយល់អំពីទិដ្ឋភាពវប្បធម៌នៃប្រតិកម្មឆ្លើយតបផ្សេងៗផ្នែកសុខភាពផ្លូវចិត្ត/បញ្ហាចិត្តសាស្ត្រ ទៅនឹងព្រឹត្តិការណ៍ដែលគំរាមកំហែងដល់អាយុជីវិត និង/ឬទុក្ខព្រួយ ក្នុងរយៈពេលយូររបស់ប្រជាជនកម្ពុជា, ហើយនិង
២-ដើម្បីកត់ត្រាអំពី របៀបដោះស្រាយរបស់ប្រជាពលរដ្ឋទៅនឹងព្រឹត្តិការណ៍ទាំងនោះ, និង
៣-ដើម្បីប្រៀបធៀបពីភាពខុសគ្នារវាងប្រតិកម្មឆ្លើយតប ទៅនឹងទុក្ខព្រួយ/ការប៉ះទង្គិចផ្លូវចិត្តតាមវិធីសាស្ត្រខ្មែរ ទៅនឹងប្រតិកម្មឆ្លើយតបដែលមានបែងចែកក្នុងចំណាត់ថ្នាក់អន្តរជាតិស្តីពីជំងឺសុខភាពផ្លូវចិត្ត ដែលបានប្រើប្រាស់ដោយអង្គការសុខភាពពិភពលោក (WHO)។

ការសិក្សានេះនឹងរួមគ្នាធ្វើឡើងដោយមានការសហការជាមួយអង្គការចិត្តសង្គមអន្តរវប្បធម៌កម្ពុជា (TPO), អង្គការសេវាសង្គមកិច្ចកម្ពុជា (SSC) និងមណ្ឌលសុខភាពផ្លូវចិត្តកុមារ និងយុវជន (CCAMH) ពីព្រោះបុគ្គលិករបស់អង្គការទាំងនេះមានចំណេះដឹង និងជំនាញការច្រើនក្នុងការជួយដល់ប្រជាជនកម្ពុជា ដែលមានផលវិបាកបង្កឡើង ដោយសារសង្គ្រាមជាច្រើន និងអំពើសាហាវព្រៃផ្សៃនៃរបបប្រល័យពូជសាសន៍ខ្មែរក្រហមក្នុងប្រទេសកម្ពុជា តាមរយៈគម្រោងការងារការពារ និងទប់ស្កាត់ជាច្រើនដែលមានមូលដ្ឋាននៅតាមសហគមន៍។ អង្គការ **ធីភីអូកម្ពុជា** ស្វាគមន៍ចំពោះសំណើរបស់ ខ្ញុំបាទដើម្បីធ្វើការស្រាវជ្រាវនៅក្នុងចំណោមជៃគូការងារជាច្រើន ដោយរាប់បញ្ចូលទាំង គ្រូបុរាណ គ្រូទាយ ព្រះសង្ឃ មនុស្សចាស់ទំ គិលានុបដ្ឋាក គ្រូពេទ្យព្យាបាលជំងឺទូទៅ និងបញ្ញវន្ត។ ការចូលរួមរបស់លោកអ្នកក្នុងការសិក្សានេះមាន សារៈសំខាន់ណាស់ពីព្រោះលោក

Monash Asia Institute
Faculty of Arts
Menzies Building, Level 8 South, Room S833
Monash University, VIC 3800
[redacted]
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អ្នកជាអ្នកមានជំនាញការក្នុងស្រុកដែលមានចំណេះដឹង និងបទពិសោធន៍ទាំងផ្នែកវប្បធម៌ និង សុខភាពផ្លូវចិត្តរបស់ប្រជាជនដែលរស់នៅក្នុងសហគមន៍របស់លោកអ្នក។

ការសិក្សានេះនឹងធ្វើអោយបុគ្គលិកសុខភាពផ្លូវចិត្តនៅប្រទេសកម្ពុជា និងមកពីតំបន់ផ្សេងៗទៀតនៅអាស៊ីអាគ្នេយ៍អាចបែងចែកច្បាស់លាស់អំពីការឆ្លើយតបជាក់លាក់ បែបវប្បធម៌ចំពោះការប៉ះទង្គិចផ្លូវចិត្តក្នុងបរិបទវប្បធម៌ផ្សេងៗគ្នា។ ការសិក្សានេះនឹងធ្វើអោយបុគ្គលិកសុខភាពផ្លូវចិត្តកម្ពុជា និងបរទេសកាន់តែយល់បន្ថែមទៀតអំពីទិដ្ឋភាពវប្បធម៌ផ្សេងគ្នាៗនៃសុខភាពផ្លូវចិត្ត ហើយវានឹងធ្វើអោយពួកគេមានសមត្ថភាពក្នុងការថែទាំអតិថិជន/អ្នកជំងឺរបស់ពួកគេប្រកបដោយប្រសិទ្ធភាព។ ហេតុដូច្នេះហើយលោកអ្នកដែលជាអ្នកចូលរួម និង/ឬ សង្គមយើងនឹងទទួលបានអត្ថប្រយោជន៍ដោយផ្ទាល់ ឬដោយប្រយោលពីការសិក្សានេះ។

ការស្រាវជ្រាវនេះទាក់ទងនឹងការសម្ភាសន៍បុគ្គលដោយផ្ទាល់។ ការសម្ភាសន៍នេះត្រូវបានណែនាំដោយប្រើសំណួរបើកចំហទូលាយជាច្រើន។ ការសម្ភាសន៍នេះនឹងត្រូវគេថតសំឡេងទុក។ លោកអ្នកនឹងត្រូវចំណាយពេលប្រហែល ២ ម៉ោងសំរាប់ការសម្ភាសន៍នេះ ហើយក្នុងករណី ខ្លះលោកអ្នកប្រហែលជាត្រូវចំណាយពេល ១ ម៉ោងថែមទៀតសម្រាប់ការតាមដានការងារ។ លោកអ្នកនឹងទទួលបាន អំណោយលើកទឹកចិត្តបន្តិចបន្តួច ដើម្បីតបស្នងចំពោះការបាត់បង់ពេលវេលារបស់លោកអ្នកក្នុងពេលសម្ភាសន៍។ អំណោយដែលនឹងផ្តល់ជូន មានទម្រង់ជា សាប៊ូ ក្រមា សារ៉ុង ឬ អាហារសម្រន់ ដែលមានតម្លៃ ២ ម៉ឺនរៀលដែលប្រហាក់ប្រហែលនឹងចំនួន ៥ ដុល្លារអូស្ត្រាលី។

ឈ្មោះ និងព័ត៌មានលំអិតរបស់លោកអ្នកនឹងត្រូវបានគេដាក់លេខកូដជំនួសវិញ។ នៅក្នុងអំឡុងពេលនៃការបញ្ចូលទិន្នន័យឈ្មោះរបស់លោកអ្នកនឹងត្រូវគេលប់ចេញ និងទុកតែលេខកូដក្នុងបញ្ជីសំណួរប៉ុណ្ណោះ ដើម្បីធានានូវការសម្ងាត់នៃព័ត៌មានផ្ទាល់ខ្លួនរបស់លោកអ្នក។ មានតែខ្លួនខ្ញុំបាទផ្ទាល់ និងអ្នកមើលខុសត្រូវការសិក្សាស្រាវជ្រាវរបស់ខ្ញុំប៉ុណ្ណោះ ដែលអាចមើលព័ត៌មាននេះបាន ហើយព័ត៌មានទាំងនេះ នឹងត្រូវគេរក្សាទុកក្នុងកន្លែងឯកជន និងមានសន្តិសុខតឹងរ៉ឹងក្នុងរយៈពេល ៥ ឆ្នាំដូចដែលមានចែងនៅក្នុងបទបញ្ជាផ្ទៃក្នុង របស់សកលវិទ្យាល័យម៉ូណាស្ហ (Monash University) ។

របាយការណ៍នៃការសិក្សានេះអាចនឹងត្រូវគេបោះពុម្ពផ្សាយ ប៉ុន្តែគេនឹងមិនបង្ហាញពីអត្តសញ្ញាណនៃអ្នកចូលរួមណាម្នាក់នៅក្នុងរបាយការណ៍នេះទេ។ ប្រសិនបើមានការដកស្រង់សំដីរបស់អ្នកចូលរួមនៅក្នុងអត្ថបទសំរាប់បោះពុម្ពផ្សាយនោះ យើងនឹងដាក់ជារហស្សនាមផ្សេងជំនួសវិញដើម្បីរក្សាការសម្ងាត់។ ទោះបីជាយ៉ាងណាក្តី សូមចងចាំថា មានពេលខ្លះ វាមានការលំបាកក្នុងការរក្សាការសម្ងាត់/ភាពអនាមិកអោយបានទាំងស្រុង ប៉ុន្តែខ្ញុំនឹងខំប្រឹងប្រែងឱ្យអស់ពីសមត្ថភាពក្នុងការរក្សាការសម្ងាត់នេះ។

Monash Asia Institute
Faculty of Arts
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ដោយសារការស្រាវជ្រាវនេះពាក់ព័ន្ធនឹងការពិភាក្សាអំពីបទពិសោធន៍ផ្លូវចិត្ត ប្រសិនបើលោកអ្នកមានអារម្មណ៍ថាការពិភាក្សានេះវានាំអោយមានការតានតឹងក្នុងចិត្តនោះ លោកអ្នកនឹងត្រូវគេបញ្ជូនអោយទៅពិគ្រោះយោបល់ជាមួយក្រុមជំនាញសុខភាពផ្លូវចិត្តរបស់រដ្ឋ ឬឯកជន តាមអាសយដ្ឋានដូចខាងក្រោម:

- មន្ទីរពិគ្រោះជំងឺផ្លូវចិត្តឯកជន: **វេជ្ជ. មុន្នី សុថារ៉ា** ផ្ទះលេខ ៧៩ ផ្លូវទោងធន សង្កាត់ផ្សារដេប៉ូ ខ័ណ្ឌទួលគោក ភ្នំពេញ។ ទូរស័ព្ទលេខ ០១២ ៣៨០ ៦០៩ ។
- ផ្នែកពិគ្រោះជំងឺផ្លូវចិត្ត មន្ទីរពេទ្យមិត្តភាព ខ្មែរ-សូវៀត ភ្នំពេញ ។
- អង្គការធីភីអូ ភ្នំពេញ: ផ្ទះលេខ ២០ ផ្លូវ ៣៣៤ សង្កាត់ បឹងកេងកង ១ រាជធានីភ្នំពេញ ប្រទេសកម្ពុជា ទូរស័ព្ទលេខ ០២៣ ២១៨ ៤៧៨ ។
- អង្គការធីភីអូ ពោធិសាត់: ផ្ទះលេខ ៥១៣ ផ្លូវ ២៧ (ទូរទស្សន៍ប៉ុស្តិ៍លេខ ១០) ឃុំពាលព្លែក ស្រុកសំពៅមាស ខេត្តពោធិសាត់ ទូរស័ព្ទលេខ ០៥២ ៩៥១ ៥៥៥ ។
- ផ្នែកពិគ្រោះជំងឺផ្លូវចិត្ត មន្ទីរពេទ្យបង្អែកខេត្តពោធិសាត់: **វេជ្ជ. កេង ហុកលី**
- អង្គការធីភីអូ បាត់ដំបង: ផ្ទះលេខ ៦៥២ ផ្លូវ ៥៧ ឃុំទួលតាឯក ខេត្តបាត់ដំបង ទូរស័ព្ទលេខ ០៥៣ ៩៥២ ៣៨៣ ។
- ផ្នែកពិគ្រោះជំងឺផ្លូវចិត្ត មន្ទីរពេទ្យបង្អែកខេត្តបាតដំបង: **វេជ្ជ. អ៊ឹ ញ៉ិល**
- អង្គការធីភីអូ បន្ទាយមានជ័យ: ផ្លូវលេខ ៣ ភូមិសំភី ឃុំកំពង់ស្វាយ ស្រុកសិរីសោភ័ណ ខេត្តបន្ទាយមានជ័យ ទូរស័ព្ទលេខ ០៥៤ ៩៥៨ ៩១០ ។
- អង្គការធីភីអូ កំពង់ធំ: ផ្លូវលេខ ៣៦ ផ្លូវ ប្រជាធិបតេយ្យ ឃុំកំពង់ធំ ស្រុកស្ទឹងសែន ខេត្តកំពង់ធំ ទូរស័ព្ទលេខ ០៦២ ៩៦១ ៣៧៥ ។
- ផ្នែកពិគ្រោះជំងឺផ្លូវចិត្ត មន្ទីរពេទ្យបង្អែកខេត្តកំពង់ធំ: **វេជ្ជ. អ៊ិក ប៊ុនគី**

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សូមជ្រាបថា ការចូលរួមក្នុងការស្រាវជ្រាវនេះគឺជាការស្ម័គ្រចិត្តទេ លោកអ្នកអាចដកខ្លួនពីការស្រាវជ្រាវនេះបានគ្រប់ពេលវេលា។ នេះមានន័យថា លោកអ្នកអាចរំលងសំណួរដែលលោកអ្នកមិនចង់ឆ្លើយ ឬលោកអ្នកអាចបញ្ឈប់ការសម្ភាសន៍បានគ្រប់ពេលវេលា។

សូមទាក់ទង ខ្ញុំបាទ **វេជ្ជ. ឈឹម សុធារ៉ា** គ្រប់ពេលពេលវេលាក្រោយការសម្ភាសន៍ចប់ ប្រសិនបើលោកអ្នកត្រូវការព័ត៌មានទាក់ទងនឹងការស្រាវជ្រាវនេះ។ ទូរស័ព្ទការិល័យរបស់ខ្ញុំបាទលេខ ០២៣ ២១៨ ៤៧៨ ។

ប្រសិនបើលោកអ្នកចង់ទាក់ទង **បណ្តាអ្នកស្រាវជ្រាវ** អំពីផ្នែកណាមួយនៃការសិក្សានេះ សូមទាក់ទង ប្រធានស៊ើបអង្កេត:	ប្រសិនបើលោកអ្នកមាន **ការភាំ** ទាក់ទងនឹងរបៀបនៃការស្រាវជ្រាវនេះ សូមទាក់ទង:
សាស្ត្រាចារ្យ តែហ្គ ឡឺវីញ វិទ្យាស្ថានសិក្សាអាស៊ីម៉ូណាស្ត អាគារមិនហ្សឺ ជាន់ទី ៨ ផ្នែកខាងក្បូង សាកលវិទ្យាល័យម៉ូណាស រដ្ឋវិចថូរៀ ៣៨០០ លេខទូរស័ព្ទ: +៦១ ៣ ៩៩០៥ ០៥០១ លេខទូរសារ: +៦១ ៣ ៩៩០៥ ៥៣៧០ អ៊ីមែល: Peg.LeVine@adm.monash.edu.au	**លោក សម ម៉ារ៉ា** អ្នកគ្រប់គ្រងផ្នែកប្រត្តិបត្តិអង្គការ ធីភីអូ កម្ពុជា ផ្ទះលេខ ២០ ផ្លូវ ៣៣៤ សង្កាត់ បឹងកេងកង ១ ខ័ណ្ឌ ចំការមន ប្រអប់សំបុត្រ ១១២៤ រាជធានីភ្នំពេញ កម្ពុជា លេខទូរស័ព្ទ: ០២៣ ២១៨ ៤៧៨ លេខទូរសារ: ០២៣ ២១៩ ១៨២ អ៊ីមែល: admin@tpocambodia.org

សូមអរគុណ

ឈឹម សុធារ៉ា

Translation Checker's Note:

I, Alex Khun, a NAATI Professional Translator (NAATI No.: 47904), certify that the above translated document is a true and correct translation from English language to Khmer language, which was done to the best of my skill and ability.

Translator: …… 07/07/2008, Melbourne, Victoria

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Appendix 2b: Explanatory Statement G2

MONASH University

14 July 2008

Explanatory Statement: Group 2
Title: Ethno cultural aspects of mental health in Cambodia

IMPORTANT NOTE: Distress, due to recent life events may occur (unaware to the researcher) and if so, please discontinue reading about the following research.

My name is Sotheara Chhim and I am conducting a research project with Prof. Peg LeVine from Monash Asian Institute towards a PhD in transcultural mental health at Monash University. This means that I will be writing a thesis which is the equivalent of a 300 page book.

The aims of this study are (1) to explore cultural aspects of mental health/psychological responses to long-term distress and/or life threatening events among Cambodians, and (2) to map the ways people cope with these events, and (3) to compare the differences between distressing/trauma responses classified in the international classification of mental health disorders used by the World Health Organization (WHO).

The study will be conducted jointly with Transcultural Psychosocial Organization, Cambodia (TPO Cambodia), Social Services of Cambodia (SSC) and Center for Child and Adolescent Meant Health (CCAMH) because the staff of these organization the have a lot of experiences in assisting Cambodians who suffer from mental health problems as consequences of Khmer Rouge atrocities and wars in Cambodia through a community based prevention and intervention project. The above NGOs welcome my request to conduct research among its beneficiaries. Therefore, your participation in this study is very importance for us to understand more of the problems related to your past experienced. Participants must be able to communicate, must not have a psychotic or suicidal condition, from dementia, must not be under the influence of any intoxicated substances and must not have a life threatening physical health condition.

The study will enable mental health workers in Cambodia and from other regions in South East Asia to distinguish cultural specific responses to trauma in different cultural contexts. This study will enable both Cambodian and foreign mental health workers to understand more about this cross-cultural aspect of mental health and that will enable them the capacity to take care our clients/patients effectively. Therefore, you as participants and/or society will be directly or indirectly benefit from this study.

This research involves interview individual face to face using questionnaire and it will take approximately 1 hour of your time. You will be offered a small incentive as to compensate your time lost during the interview. The gift will be given in form of soap, scarf, sarong or snack in the amount of 20,000 Riels which is equal to approximately A$5.00 (five Australian dollars).

Your name and identification details will be coded or changed. During the data entry, your name will be omitted and left only to code in the questionnaire in order to ensure that no one sees it (confidentiality). Only myself and my supervisor can access to this information which will be stored in a private and secured place for 5 years as required by Monash University regulations.

A report of the study may be submitted for publication, but you will not be identified in such a report. Where information is quoted, made up names will be used. However, please keep in mind that it is sometimes impossible to make an absolute guarantee of confidentiality /anonymity but I will do my utmost to ensure this.

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As this research involves discussion on past experiences, you may become distressed. It is very important for you to know about this reaction so that it will help you prepare to deal with it in advance. Some discomfort may include:

- You may become more fearful or sad without reason or you may feel as if the past event may come back to you again.
- You may experience that the image of some past event comes back to you during the day and that it may disturb your daily routine such as work as well as diet and leisure etc.
- You may have trouble falling asleep or have a bad dream about the past or feel unsettled about something that reminds you of the past event.
- You may lose concentration and may become more irritable than usual after the interview and this may disturb you in relating to friends or other family members.

However, it is also importance to note that these reactions are normal and will subside within the next few days. If any of these persist, you will be referred to a team of professionals for consultation, with a private and public option.

- Private Psychiatric OPD, Dr Muny Sothara, No.79, Tep Phan Road, Psa Depot, Toul Kork, Phnom Penh. Tel: 012 380 609.
- Psychiatric OPD, Khmer Soviet Hospital, Phnom Penh
- TPO Phnom Penh: No 20, Street 334, Boeung Keng Kang 1, Phnom Penh, Cambodia. Tel: 023 218 478
- TPO Pursat: No 513, Street 27 (TV Channel 10 street), Peal Nhek Commune, Sampov Meas district, Pursat province. Tel: 052 951 555.
- Dr Teng Hokly, Psychiatric OPD, Pursat Referral Hospital, Pursat province.
- TPO Battambang: No 652, Street 57, Toul Ta Ek commune, Battambang Province. Tel: 053 952 343
- Dr Um Nhil, Psychiatric OPD, Battambang Referral Hospital, Battambang provine.
- TPO Banteay Meanchey: Street 3, Samphy village, Kampong Svay commune, Sereysophorn district, Banteay Meanchey province. Tel: 054 958 910
- TPO Kampong Thom: No 36, Pracheathipatay road, Kampong Thom commune, Stung Sen district, Kampong Thom province. Tel: 062 961 375
- Dr Ort Bunky, Psychiatric OPD, Kampong Thom Referral Hospital, Kampong Thom province.

Please be aware that participation in this research is voluntary, you may withdraw from participation in this research at anytime. This means that you can pass on questions you do not wish to answer, you can stop the interview at any time.

Please feel free to contact me, **Sotheara Chhim, MD** at any time after the interview is completed for any information related to this research. My office phone number is 023 218 478.

If you would like to contact the **researchers** about any aspect of this study, please contact the Chief Investigator:	If you have a **complaint** concerning the manner in which this research is being conducted, please contact
Prof. Peg LeVine Monash Asia Institute Menzies Building, Level 8 South, Monash University, VIC 3800 [redacted]	**Mr Sam Mara** Operation Manager, TPO Cambodia No 20, Street 334, Boeung Keng Kang 1, Chamcarmon, PO Box 1124, Phnom Penh, Cambodia. [redacted]

Thank you.

Sotheara Chhim

MONASH University

ថ្ងៃទី ១៤ ខែ កក្កដា ឆ្នាំ ២០០៨

សេចក្តីថ្លែងពន្យល់: ក្រុមទី ២

ចំណងជើង: **ការសិក្សាស្តីពីឥទ្ធិពលវប្បធម៌នៃសារធាតុនៃសុខភាពផ្លូវចិត្តនៅកម្ពុជា**

សម្គាល់សំខាន់: ទុក្ខព្រួយ ដោយសារព្រឹត្តិការណ៍ជីវិតថ្មីៗដែលអាចនឹងកើតឡើង (ដោយអ្នកស្រាវជ្រាវមិនទាន់បានដឹង) ហើយប្រសិនបើយ៉ាងនេះ សូមឈប់អានអំពីការស្រាវជ្រាវខាងក្រោមនេះតទៅទៀត។

ខ្ញុំបាទឈ្មោះ ឈឹម សុធារ៉ា ហើយខ្ញុំកំពុងធ្វើគម្រោងស្រាវជ្រាវមួយ ជាមួយលោកសាស្ត្រាចារ្យ តែហ្គ ឡឺវ៉ាញ (Prof. Peg LeVine) មកពីវិទ្យាស្ថានសិក្សាអាស៊ីម៉ូណាស្ហ (Monash Asian Institute) ដើម្បីទទួលបានសញ្ញាប្រត្តិថ្នាក់បណ្ឌិត ផ្នែកសុខភាពផ្លូវចិត្តអន្តរវប្បធម៌ នៅសែកលវិទ្យាល័យម៉ូណាស្ហ (Monash University)។ នេះមានន័យថា ខ្ញុំបាទនឹងត្រូវសរសេរនិក្ខេបបទមួយ ជាសៀវភៅដែលមានចំនួន ៣០០ ទំព័រ។ គោលបំណងនៃការសិក្សានេះគឺ:

១-ដើម្បីស្វែងយល់អំពីទិដ្ឋភាពវប្បធម៌នៃប្រតិកម្មឆ្លើយតបផ្សេងៗផ្នែកសុខភាពផ្លូវចិត្ត/បញ្ហាចិត្តសាស្ត្រ ទៅនឹងព្រឹត្តិការណ៍ដែលគំរាមកំហែងដល់អាយុជីវិត និង/ឬទុក្ខព្រួយ ក្នុងរយៈពេលយូររបស់ប្រជាជនកម្ពុជា, ហើយនិង
២-ដើម្បីកត់ត្រាអំពី របៀបដោះស្រាយរបស់ប្រជាពលរដ្ឋទៅនឹងព្រឹត្តិការណ៍ទាំងនោះ, និង
៣-ដើម្បីប្រៀបធៀបពីភាពខុសគ្នារវាងប្រតិកម្មឆ្លើយតប ទៅនឹងទុក្ខព្រួយ/ការប៉ះទង្គិចផ្លូវចិត្តតាមវិធីសាស្ត្រខ្មែរ ទៅនឹងប្រតិកម្មឆ្លើយតបដែលមានបែងចែកក្នុងចំណាត់ថ្នាក់អន្តរជាតិស្តីពីជំងឺសុខភាពផ្លូវចិត្ត ដែលបានប្រើប្រាស់ដោយអង្គការសុខភាពពិភពលោក (WHO)។

ការសិក្សានេះនឹងរួមគ្នាធ្វើឡើងដោយមានការសហការជាមួយអង្គការចិត្តសង្គមអន្តរវប្បធម៌កម្ពុជា (TPO), អង្គការសេវាសង្គមកិច្ចកម្ពុជា (SSC) និងមណ្ឌលសុខភាពផ្លូវចិត្តកុមារ និងយុវវ័យ (CCAMH) ពីព្រោះបុគ្គលិករបស់អង្គការទាំងនេះមានចំណេះដឹង និងជំនាញការច្រើនក្នុងការជួយដល់ប្រជាជនកម្ពុជា ដែលមានផលវិបាកបង្កឡើង ដោយសារសង្គ្រាមជាច្រើន និងអំពើសាហាវព្រៃផ្សៃនៃរបបប្រល័យពូជសាសន៍ខ្មែរក្រហមក្នុងប្រទេសកម្ពុជា តាមរយៈគម្រោង ការងារការពារ និងទប់ស្កាត់ជាច្រើនដែលមានមូលដ្ឋាននៅតាមសហគមន៍។ អង្គការ **ធីកីអ្នកម្ពុជា** ស្វាគមន៍ចំពោះ សំណើ របស់ខ្ញុំបាទ ដើម្បីធ្វើការស្រាវជ្រាវក្នុងចំណោមអ្នកទទួលផលប្រយោជន៍ពីអង្គការនេះ។ ជូរច្នេះការចូលរួមរបស់លោកអ្នកក្នុង ការសិក្សានេះមានសារៈសំខាន់ណាស់សំរាប់យើងខ្ញុំក្នុងការស្វែងយល់ឱ្យកាន់តែច្រើនអំពីបញ្ហាផ្លូវចិត្តរបស់លោកអ្នកពាក់ព័ន្ធនឹងបទពិសោធន៍

Monash Asia Institute
Faculty of Arts
Menzies Building, Level 8 South, Room S833
Monash University, VIC 3800
[redacted]

របស់លោកអ្នកពីអតីតកាលកន្លងមក។ អ្នកចូលរួមត្រូវតែអាចប្រាស្រ័យទាក់ទងបាន មិនមានរោគចិត្តវិកល ឬការសំលាប់ខ្លួន មិនមានបញ្ហាវង្វេង មិនស្ថិតនៅក្រោមឥទ្ធិពលសុរា ឬគ្រឿងញៀន និង មិនមានជំងឺរាងកាយ។

ការសិក្សានេះនឹងធ្វើអោយបុគ្គលិកសុខភាពផ្លូវចិត្តនៅប្រទេសកម្ពុជា និងមកពីតំបន់ផ្សេងៗទៀតនៅអាស៊ីអាគ្នេយ៍អាចបែងចែកច្បាស់លាស់អំពីការឆ្លើយតបជាក់លាក់ បែបវប្បធម៌ចំពោះការប៉ះទង្គិចផ្លូវចិត្តក្នុងបរិបទវប្បធម៌ផ្សេងៗគ្នា។ ការសិក្សានេះនឹងធ្វើអោយបុគ្គលិកសុខភាពផ្លូវចិត្តកម្ពុជានិងបរទេសកាន់តែយល់បន្ថែមទៀតអំពីទិដ្ឋភាពវប្បធម៌ផ្សេងគ្នាៗនៃសុខភាពផ្លូវចិត្ត ហើយវានឹងធ្វើអោយពួកគេមានសមត្ថភាពក្នុងការថែទាំអតិថិជន/អ្នកជំងឺរបស់ពួកគេប្រកបដោយប្រសិទ្ធភាព។ ហេតុដូច្នេះហើយ លោកអ្នកដែលជាអ្នកចូលរួម និង/ឬសង្គមយើងនឹងទទួលបានអត្ថប្រយោជន៍ដោយផ្ទាល់ ឬដោយប្រយោលពីការសិក្សានេះ។

ការស្រាវជ្រាវនេះទាក់ទងនឹងការសម្ភាសន៍ជាមួយបុគ្គលផ្ទាល់ដោយប្រើបញ្ជីសំណួរ លោកអ្នកនឹងត្រូវចំណាយពេលប្រហែល ១ ម៉ោង សំរាប់ការសម្ភាសន៍នេះ។ លោកអ្នកនឹងទទួលបានអំណោយលើកទឹកចិត្តបន្តិចបន្តួច ដើម្បីតបស្នងចំពោះការបាត់បង់ពេលវេលារបស់លោកអ្នកក្នុងពេលសម្ភាសន៍នេះ។ អំណោយដែលនឹងផ្តល់ជូន មានទម្រង់ជា សាប៊ូ ក្រមា សារ៉ុង ឬ អាហារសម្រន់ដែលមានតម្លៃ ២ ម៉ឺនរៀល ដែលប្រហាក់ប្រហែលនឹងចំនួន ៥ ដុល្លារអូស្ត្រាលី។

ឈ្មោះ និងព័ត៌មានលំអិតរបស់លោកអ្នកនឹងត្រូវបានគេដាក់លេខកូដជំនួសវិញ ឬត្រូវគេប្តូរ។ នៅក្នុងអំឡុងពេលនៃការបញ្ចូលទិន្នន័យ ឈ្មោះរបស់លោកអ្នកនឹងត្រូវគេលប់ចេញ និងទុកតែលេខកូដក្នុងបញ្ជីសំណួរប៉ុណ្ណោះ ដើម្បីធានានូវការសម្ងាត់នៃព័ត៌មានផ្ទាល់ខ្លួនរបស់លោកអ្នក។ មានតែខ្លួនខ្ញុំបាទផ្ទាល់ និងអ្នកមើលខុសត្រូវការសិក្សាស្រាវជ្រាវរបស់ខ្ញុំប៉ុណ្ណោះដែលអាចមើលព័ត៌មាននេះបាន ហើយព័ត៌មានទាំងនេះ នឹងត្រូវគេរក្សាទុកក្នុងកន្លែងឯកជន និងមានសន្តិសុខតឹងរ៉ឹងក្នុងរយៈពេល ៥ ឆ្នាំដូចដែលមានចែងនៅក្នុងបទបញ្ជាផ្ទៃក្នុង របស់សកលវិទ្យាល័យម៉ូណាស្ស (Monash University) ។
របាយការណ៍នៃការសិក្សានេះអាចនឹងត្រូវគេបោះពុម្ពផ្សាយ ប៉ុន្តែគេនឹងមិនបង្ហាញពីអត្តសញ្ញាណរបស់លោកអ្នកនៅក្នុងរបាយការណ៍នេះទេ។ ប្រសិនបើមានការដកស្រង់សំដីរបស់អ្នកចូលរួមនៅក្នុងអត្ថបទសំរាប់បោះពុម្ពផ្សាយនោះ យើងនឹងដាក់ឈ្មោះក្លែងក្លាយជំនួសវិញដើម្បីរក្សាការសម្ងាត់។ ទោះបីជាយ៉ាងណាក្តី សូមចងចាំថា មានពេលខ្លះ វាមានការលំបាកក្នុងការរក្សាការសម្ងាត់/ភាពអនាមិកអោយបានទាំងស្រុង ប៉ុន្តែខ្ញុំនឹងខំប្រឹងប្រែងឱ្យអស់ពីសមត្ថភាពក្នុងការរក្សាការសម្ងាត់នេះ។

ដោយការស្រាវជ្រាវនេះពាក់ព័ន្ធនឹងការពិភាក្សាអំពីបទពិសោធន៍ផ្លូវចិត្ត ដូច្នេះវាអាចធ្វើឱ្យលោកអ្នកអាចនឹងមានការតានតឹងផ្លូវអារម្មណ៍ដោយសារការសម្ភាសន៍នេះ។ វាសំខាន់ណាស់ដែលលោកអ្នកត្រូវយល់ដឹងអំពីប្រតិកម្មនេះ ព្រោះវាជួយលោកអ្នកក្នុងការត្រៀមខ្លួនដោះស្រាយទុកជាមុន។ ភាពមិនសុខស្រួលទាំងនោះអាចរួមមាន:

- លោកអ្នកអាចមានការភ័យខ្លាចដោយគ្មានហេតុផល ឬអាចមានអារម្មណ៍ក្រៀមក្រំ ឬមានអារម្មណ៍ថាព្រឹត្តិការណ៍អតីតកាលអាចវិលត្រឡប់មកវិញម្តងទៀត។
- លោកអ្នកអាចនឹងស្រមៃយនឹកឃើញព្រឹត្តិការណ៍អតីតខ្លះរបស់លោកអ្នកនៅពេលថ្ងៃ ហើយវាអាចរំខានកិច្ចការជាទម្លាប់ប្រចាំថ្ងៃរបស់លោកអ្នកដូចជា ការងារ ការហូបចុក និងការលំហែជាដើម។ល។
- លោកអ្នកក៏អាចមានការលំបាកក្នុងការទទួលទានដំណេក ឬមានសុបិន្តអាក្រក់អំពីព្រឹត្តិការណ៍អតីតកាល ឬមានអារម្មណ៍ច្របូកច្របល់អំពីអ្វីមួយ ដែលធ្វើអោយលោកអ្នកនឹកឃើញនូវព្រឹត្តិការណ៍ពីអតីតកាលនោះ។
- លោកអ្នកអាចបាត់បង់ការផ្តោងអារម្មណ៍ និងអាចទៅជាមួរម៉ៅច្រើនជាងប្រក្រតីបន្ទាប់ពីការសម្លាសន៍ ហើយវាអាចរំខានដល់ទំនាក់ទំនងរបស់លោកអ្នកជាមួយមិត្តភក្តិ ឬសមាជិកក្នុងគ្រួសារ។

ទោះបីជាយ៉ាងនេះក្តី វាក៏ជាការសំខាន់ដែរដែលត្រូវចំណាំថា ប្រតិកម្មនេះជាប្រតិកម្មធម្មតា ហើយវានឹងធូរស្រាលទៅវិញក្នុងរយៈពេលពីរបីថ្ងៃបន្ទាប់។ ប្រសិនបើប្រតិកម្មនេះនៅតែបន្តមិនបាត់ លោកអ្នកនឹងត្រូវគេបញ្ជូនឱ្យទៅពិគ្រោះយោបល់ជាមួយក្រុមជំនាញសុខភាពផ្លូវចិត្តរបស់រដ្ឋ ឬឯកជន តាមអាសយដ្ឋានដូចខាងក្រោម:

- ❖ មន្ទីរពិគ្រោះជំងឺផ្លូវចិត្តឯកជន: **វេជ្ជ. មុន្នី សុថារ៉ា** ផ្ទះលេខ ៧៩ ផ្លូវទេពធន សង្កាត់ផ្សារដេប៉ូ ខ័ណ្ឌទួលគោក ភ្នំពេញ។ ទូរសព្ទ័លេខ ០១២ ៣៨០ ៦០៩ ។
- ❖ ផ្នែកពិគ្រោះជំងឺផ្លូវចិត្ត មន្ទីរពេទ្យមិត្តភាព ខ្មែរ-សូវៀត ភ្នំពេញ ។
- ❖ អង្គការធីភីអូ ភ្នំពេញ: ផ្ទះលេខ ២០ ផ្លូវ ៣៣៤ សង្កាត់ បឹងកេងកង ១ រាជធានីភ្នំពេញ ប្រទេសកម្ពុជា ទូរស័ព្ទលេខ ០២៣ ២១៨ ៤៧៨ ។
- ❖ អង្គការធីភីអូ ពោធិសាត់: ផ្ទះលេខ ៥១៣ ផ្លូវ ២៧ (ទូរទស្សន៍ប៉ុស្តិ៍លេខ ១០) ឃុំពាលញ្ជែក ស្រុកសំពៅមាស ខេត្តពោធិសាត់ ទូរស័ព្ទលេខ ០៥២ ៩៥១ ៥៥៥ ។
- ❖ ផ្នែកពិគ្រោះជំងឺផ្លូវចិត្ត មន្ទីរពេទ្យបង្អែកខេត្តពោធិសាត់: **វេជ្ជ. កេង ហុកលី**
- ❖ អង្គការធីភីអូ បាត់ដំបង: ផ្ទះលេខ ៦៥២ ផ្លូវ ៥៧ ឃុំទួលតាឯក ខេត្តបាត់ដំបង ទូរស័ព្ទលេខ ០៥៣ ៩៥២ ៣៨៣ ។
- ❖ ផ្នែកពិគ្រោះជំងឺផ្លូវចិត្ត មន្ទីរពេទ្យបង្អែកខេត្តបាតដំបង: **វេជ្ជ. អ៊ុំ ញ៉ិល**
- ❖ អង្គការធីភីអូ បន្ទាយមានជ័យ: ផ្លូវលេខ ៣ ភូមិសំភី ឃុំកំពង់ស្វាយ ស្រុកសិរីសោភ័ណ ខេត្តបន្ទាយមានជ័យ ទូរស័ព្ទលេខ ០៥៤ ៩៥៨ ៩១០ ។
- ❖ អង្គការធីភីអូ កំពង់ធំ: ផ្លូវលេខ ៣៦ ផ្លូវ ប្រជាធិបតេយ្យ ឃុំកំពង់ធំ ស្រុកស្ទឹងសែន ខេត្តកំពង់ធំ ទូរស័ព្ទលេខ ០៦២ ៩៦១ ៣៧៥ ។
- ❖ ផ្នែកពិគ្រោះជំងឺផ្លូវចិត្ត មន្ទីរពេទ្យបង្អែកខេត្តកំពង់ធំ: **វេជ្ជ. អ៊ឹក ប៊ុនគី**

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សូមជ្រាបថា ការចូលរួមក្នុងការស្រាវជ្រាវនេះគឺជាការស្ម័គ្រចិត្តទេ លោកអ្នកអាចដកខ្លួនពីការស្រាវជ្រាវនេះបានគ្រប់ពេលវេលា។ នេះមានន័យថា លោកអ្នកអាចរំលងសំណួរដែលលោកអ្នកមិនចង់ឆ្លើយឬលោកអ្នកអាចបញ្ឈប់ការសម្ភាសន៍បានគ្រប់ពេលវេលា។

សូមទាក់ទង ខ្ញុំបាទ **វេជ្ជ. ឈឹម សុធារ៉ា** គ្រប់ពេលពេលវេលាក្រោយការសម្ភាសន៍ចប់ ប្រសិនបើលោកអ្នកត្រូវការព័ត៌មានទាក់ទងនឹងការស្រាវជ្រាវនេះ។ ទូរស័ព្ទការិយ័យរបស់ខ្ញុំបាទលេខ ០២៣ ២១៨ ៤៧៨ ។

ប្រសិនបើលោកអ្នកចង់ទាក់ទង **បណ្តាអ្នកស្រាវជ្រាវ** អំពីផ្នែកណាមួយនៃការសិក្សានេះ សូមទាក់ទង ប្រធានស៊ើបអង្កេត:	ប្រសិនបើលោកអ្នកមាន **ការភាព** ទាក់ទងនឹងរបៀបនៃការស្រាវជ្រាវនេះ សូមទាក់ទង:
សាស្ត្រាចារ្យ កែល្អ ឡឺវីញ វិទ្យាស្ថានសិក្សាអាស៊ីម៉ូណាស្ស អាគារមិនបង្ហី ជាន់ទី ៨ ផ្នែកខាងក្បូង សាកលវិទ្យាល័យម៉ូណាស រដ្ឋវិចថូរៀ ៣៨០០ លេខទូរស័ព្ទ:+៦១ ៣ ៩៩០៥ ០៥០១ លេខទូរសារ:+៦១ ៣ ៩៩០៥ ៥៣៧០ អ៊ីមែល: Peg.LeVine@adm.monash.edu.au	**លោក សម ម៉ារ៉ា** អ្នកគ្រប់គ្រងផ្នែកប្រត្តិបតិអង្គការ ធីភីអូ កម្ពុជា ផ្ទះលេខ ២០ ផ្លូវ ៣៣៤ សង្កាត់ បឹងកេងកង ១ ខ័ណ្ឌ ចំការមន ប្រអប់សំបុត្រ ១១២៤ រាជធានីភ្នំពេញ កម្ពុជា លេខទូរស័ព្ទ: ០២៣ ២១៨ ៤៧៨ លេខទូរសារ: ០២៣ ២១៩ ១៨២ អ៊ីមែល: admin@tpocambodia.org

សូមអរគុណ

ឈឹម សុធារ៉ា

Translation Checker's Note:

I, Alex Khun, a NAATI Professional Translator (NAATI No.: 47904), certify that the above translated document is a true and correct translation from English language to Khmer language, which was done to the best of my skill and ability.

Translator: ..... 07/07/2008, Melbourne, Victoria

Monash Asia Institute
Faculty of Arts
Menzies Building, Level 8 South, Room S833
Monash University, VIC 3800

Appendix 3: Qualitative Questionnaires

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QUALITATIVE INTERVIEW QUESTIONS
"Ethno-cultural Aspects of Mental Health in Cambodia"

Note: This is an interview guide and not a survey. Therefore, the questions may not be asked exactly the way in which they are phrased below. This interview guide provides an indication of the types of questions to be asked.

Cambodians have exposed to many distressing, if not horrific events, such as colonization, wars, genocide associated with the Pol Pot regime, and various natural disasters. Some people have serious repercussions from these events, (social poverty, anxiety and so on). The purpose of this question is to better understand individual and community challenges to these life events, and how people find support and protection along the way.

Exploring ethno-cultural range of responses to distressing events

1. What have you considered to be the 5 most challenging
2. What senses are impacted the most for you (what you see, hear, smell, touch)?

Explore the meaning of 'trauma' in Cambodian context

3. What Khmer words or expressions (metaphors) do you used to describe suffering or trauma?

Explore phenomenon of *Baksbat*

4. Please describe the meaning of the word ***'Baksbat'***.
5. Describe someone with ***Baksbat***? *(What have you seen? What have you heard? What have you smelled?)*
6. Have you ever experienced ***Baksbat*** in yourself? If so, what did it feel like?
7. What made it better?
8. What made it worse?
9. What do you think causes ***Baksbat***?
10. How long can it last?
11. What do you think can happen if someone with ***Baksbat*** does not get help?
12. Can someone get infected with ***Baksbat*** by associating too much with someone who has it?
13. Can it be transmitted from one generation to another?
14. Who can best help someone with ***Baksbat***? (Have you helped anyone; if so what did you do?)
15. How can someone be helped most?

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សំណួរសម្រាប់ការសម្ភាសន៍បែបគុណភាព
ការសិក្សាស្តីពីនិដ្ឋភាពនៃបញ្ហាធម៌នរសាស្ត្រនៃសុខភាពផ្លូវចិត្តនៅប្រទេសកម្ពុជា

ការកត់សំគាល់: នេះគឺជាសេចក្តីណែនាំសម្រាប់ការសម្ភាសន៍ ហើយវាមិនមែនជាការស្ទង់មតិឡើយ។ អាស្រ័យហេតុនេះ គេប្រហែលជាមិនសួរសំណួរទាំងឡាយនេះត្រង់ៗដូចដែលមាននៅក្នុងឃ្លាខាងក្រោមនេះឡើយ។ សេចក្តីណែនាំសម្រាប់ការធ្វើបទសម្ភាសន៍នេះ ផ្តល់នូវការចង្អុលបង្ហាញមួយរំពីប្រភេទសំណួរមួយចំនួនដែលគេអាចសួរនៅក្នុងការសម្ភាសន៍។

ប្រជាជនកម្ពុជាបានជួបប្រទះនូវព្រឹត្តិការណ៍ជំទុក្ខព្រួយជាច្រើន ទោះបីជាពួកគេមិនបានជួបប្រទះនឹងព្រឹត្តិការណ៍រន្ធត់ក៏ដោយ ដូចជារបបអាណានិគម. សង្គ្រាមជាច្រើន. របបប្រល័យពូជសាសន៍ប៉ុលពត និងគ្រោះធម្មជាតិផ្សេងៗទៀត។ អ្នកខ្លះមាន ផលវិបាកធ្ងន់ធ្ងរដោយសារតែព្រឹត្តិការណ៍ខាងលើនេះ (ដូចជា ភាពក្រីក្រក្នុងសង្គម. ភាពចាប់អារម្មណ៍ជាដើម។ល។)។ គោលបំណងនៃការសួរសំណួរនេះ គឺដើម្បីស្វែងយល់ពីការលំបាករបស់បុគ្គល និងសហគមន៍ដែលទាក់ទងទៅនឹងព្រឹត្តិការណ៍ទាំងនេះ ហើយនិងដើម្បីស្វែងយល់នូវរបៀបដែលពលរដ្ឋទាំងនេះស្វែងរកការគាំទ្រ និងការការពារក្នុងជំណើរជីវិត។

ស្វែងយល់ពីបញ្ហាវប្បធម៌នរសាស្ត្រស្តីអំពីប្រតិកម្មខ្លើយតបផ្សេងៗទៅនឹងព្រឹត្តិការណ៍ទុក្ខព្រួយ
១. តើអ្វីទៅដែលអ្នកគិតថា ជាបញ្ហាលំបាកខ្លាំងបំផុតចំនួន ៥ សំរាប់អ្នកនោះ?
២. តើវិញ្ញាណណាខ្លះដែលរងការប៉ះពាល់ខ្លាំងបំផុតសំរាប់អ្នក *(ចក្ខុវិញ្ញាណ? សោតវិញ្ញាណ? ឃាណវិញ្ញាណ? កាយវិញ្ញាណ?)*
ស្វែងយល់ពីអត្ថន័យរបស់ពាក្យ "ការប៉ះទង្គិចផ្លូវចិត្ត" (Trauma) នៅក្នុងបរិបទប្រទេសកម្ពុជា
៣. តើមាន**ពាក្យខ្មែរអ្វី** ឬ **ពាក្យប្រៀបធៀបអ្វី** ដែលអ្នកប្រើសំរាប់រៀបរាប់អំពី **ការរងទុក្ខ** ឬ **ការប៉ះទង្គិចផ្លូវចិត្ត**?
ស្វែងយល់ពីពាក្យកូត "ចាក់ស្បាត"
៤. សូមរៀបរាប់ពីអត្ថន័យរបស់ពាក្យ "**ចាក់ស្បាត**"?
៥. សូមរៀបរាប់ពីជនណាម្នាក់ដែលមានការ **ចាក់ស្បាត**? (តើអ្នកបានឃើញអ្វីខ្លះ? បានឮអ្វីខ្លះ? និងមានធំក្លិនអ្វីខ្លះ?
៦. តើអ្នកធ្លាប់មានបញ្ហា **ចាក់ស្បាត** ខ្លួនឯងដែរឬទេ? ប្រសិនបើមាន តើវាមានអារម្មណ៍ដូចម្តេចដែរ?
៧. តើអ្វីដែលធ្វើអោយវាបានប្រសើរឡើង?
៨. តើអ្វីដែលធ្វើអោយវាកាន់តែធ្ងន់ធ្ងរឡើង?
៩. តើអ្វីដែលអ្នកគិតថា ជាមូលហេតុដែលនាំអោយមានការ **ចាក់ស្បាត**?
១០. តើវាអាចមានរយៈពេលយូរប៉ុណ្ណា?
១១. តើអ្នកគិតថានឹងមានអ្វីកើតឡើងប្រសិនបើអ្នកដែលមានបញ្ហា **ចាក់ស្បាត** មិនបានទទួលការជួយទេនោះ?
១២. តើគេអាចឆ្លងការ **ចាក់ស្បាត** ដោយគ្រាន់តែមានភាពជិតស្និទ្ធខ្លាំងហួសជាមួយអ្នកមានការ **ចាក់ស្បាត** ឬទេ?
១៣. តើការ **ចាក់ស្បាត** អាចបន្តទៅអោយកូនចៅជំនាន់ក្រោយដែរឬទេ?

១៤. តើអ្នកណាដែលជាអ្នកអាចជួយអ្នកមានការបាក់ស្បាតប្រសើរជាងគេ?
(តើអ្នកធ្លាប់ដែលជួយជនណាម្នាក់ទេ? ប្រសិនបើធ្លាប់ តើអ្នកជួយគេយ៉ាងដូចម្តេច?)
១៥. តើយើងអាចជួយអ្នកមានការ **បាក់ស្បាត** បានច្រើនប៉ុណ្ណា?

Translation Checker's Note:

I, Alex Khun, a NAATI Professional Translator (NAATI No.: 47904), certify that the above translated document is a true and correct translation from English language to Khmer language, which was done to the best of my skill and ability.

Translator: …… 07/07/2008, Melbourne, Victoria

Appendix 4: Quantitative Questionnaires

ការសិក្សាលើបញ្ហា ជាក់ស្តែង

ចំនួបរលើកទី មួយ - ពីរ

1 ឈ្មោះអ្នកធ្វើសំភាសន៏ .....

2 ឈ្មោះអ្នកឆ្លើយ .....

3 ភូមិ/សហគមន៏.....ឃុំ.....ស្រុក.....

4 ថ្ងៃ, ខែ, ឆ្នាំ ធ្វើសំភាសន៏.....

លេខទូរសព្ទ័:.....

ប្រជាសាស្ត្រ DEMOGRAPHICS

DEMO1 កត់ត្រានូវភេទដែលបានសង្កេត ប្រុស ☐ ស្រី ☐

DEMO2 អ្នកអាយុប៉ុន្មាន ? .....

DEMO3 ស្ថានភាពអាពាហ៏ពិពាហ៏

1.រៀបការ 2. មេម៉ាយ/ពោះម៉ាយ 3.លែងលះគ្នា 4.មិនដែលរៀបការ 5.ផ្សេងៗ

ប្រសិនបើក្រឡាលើលេខ ១ ឬ ២ សូមបន្តទៅសំនួរទី ៦

DEMO5 តើអ្នកមានកូនប៉ុន្មាននាក់ ? .....

DEMO6 តើអ្នកចេះអានទេ ? បាទ ☐ ទេ ☐

DEMO6-1 តើអ្នកចេះសរសេរទេ ? បាទ ☐ ទេ ☐

DEMO6-2 តើអ្នកបានទៅរៀនទេ ? បាទ ☐ ទេ ☐

ប្រសិនបើចំលើយ ១៥ សូមបន្តទៅសំនួរទី DEMO8

DEMO7 តើអ្នករៀនបានកំរិតណា ?

ឧត្តមសិក្សា, សាកលវិទ្យាល័យ ☐ វិទ្យាល័យ ☐

សាលា មធ្យមសិក្សា ☐ សាលា សាសនា ☐

សាលា បឋមសិក្សា ☐

DEMO8 តើអ្នកសព្វថ្ងៃមានមុខរបរអ្វី?.....

ដើម្បីបញ្ជាក់ថាបុគ្គលម្នាក់មានជំងឺបាក់ស្បាត គេត្រូវមានលក្ខណៈដូចខាងក្រោម: បុគ្គល ឬក្រុមត្រូវបានជួបប្រទះ ដោយផ្ទាល់នូវហេតុ ការណ៍ភ័យរន្ធត់ ឬឃើញផ្ទាល់ភ្នែក នូវព្រឹត្តិការណ៍ទាំងនោះដូចជា ការរងនូវអំពើទារុណកម្ម ការរំលោភ បំពានលើរាងកាយ ឬ ផ្លូវភេទ ការចុះចាញ់ក្នុងសង្គ្រាម ការគាបសង្កត់លើផ្លូវកាយ និងផ្លូវចិត្ត ការចាប់ជំរិត គ្រោះធម្មជាតិ ខ្មោចលង ជួបប្រទះនឹងសត្វសាហាវ ភ័យខ្លាចដោយរងនូវការបន្ទាចណាមួយ... នៅពេលដែលព្រឹត្តិការណ៍ ទាំងនោះ បានកន្លងផុតទៅ បុគ្គល ឬ ក្រុមមាននូវបញ្ហាធំៗ ៣ ខាងក្រោម

0: គ្មានសោះ (Not at all), 1: មានតិចតួច (A little), 2: មានម្តងម្កាល (Sometime), 3: មានបង្ខូរ (Frequent) 4: មានញឹកញាប់ក្រៃលែង (Very frequent)

Confident – broken courage		0	1	2	3	4
1	មិនហ៊ានប្រឈមមុខ/បាត់បង់ស្មារតី(មិនអាចធ្វើអ្វីៗដើម្បីតតាំងនឹងសភាពការណ៍បាន) Dare not to confront - Lost of memory, remembrance or consciousness					
2	មិនហ៊ានផ្តួចផ្តើមគំនិត Dare not want to take initiative					
3	ចុះចាញ់ ចុះញ៊ែមគេ សុខចិត្តធ្វើអ្វីៗតាមគេ ត្រូនៗ សំងំសុខ/ មិនហ៊ានបញ្ចេញយោបល់គេ To submit to, to admit defeat, submissive to others - Dare not oppose others, hide quietly to have peace for himself - Dare not want to share idea					
4	មិនអាចធ្វើការសំរេចចិត្ត/ មិនហ៊ានធ្វើការសំរេចចិត្ត Cannot make decision - dare not make decision					
5	ដាំដើមគរ: មិនហ៊ានបង្ហាញពីអត្តសញ្ញាណខ្លួនឯង Planting *kapok tree – dare not want to show own identify*					
6	មិនអាចពឹងពាក់លើខ្លួនឯង Cannot rely on oneself					
7	កំសាកលែងហ៊ានចេញមុខ/បាត់បង់សេចក្តីក្លាហាន/ មានលក្ខណៈកំសាកជាងមុន Cowardly - lost of courage - Cowardly compare to before					
8	កាប់ថ្មចំណាំ - ចោះត្រចៀកចំណាំ Mark the stone or pierce ones' ears – *to remember not to do this again*					
9	មានអារម្មណ៍ថាគ្មាននរណាអាចជួយខ្លួនបានទៀត feeling no one can help him anymore.					
Attitude						
10	បាត់បង់នូវគំនិតសាមគ្គីភាព Lost of solidarity					
11	មិនមានចិត្តទូលាយដូចមុន Cannot be open as before					
12	មិនមានភាពស្មោះត្រង់ទៀត Lost of honesty					
13	ផ្តាសំប្តូរជំនឿចំពោះអ្នកដទៃ Cannot trust others					
14	ក្តាយខ្លួនជាមនុស្សកាចជាងមុនដោយសារគាត់ មិនអាចគ្រប់គ្រង ខ្លួនឯងបាន More cruel to other due to inability to control themselves					
15	រាងចាល ខ្លាចរអា បាក់បបខ្លបខ្លាច/ បរវិាសជ្បៀសវ្លាយ:មិនចង់ជួបនូវស្ថានការណ៍ដូចមុន ទៀត Cease doing something, very timid, sheepish - Wishing all bad thing goes away,					

	do not want to meet anyone					
16	គេចចេញពីគេឯង និង សង្គម Avoid meeting other and socialization					
17	មានការថយចុះក្នុងទំនាក់ទំនង/ មានការបាត់បង់នូវទំនាក់ទំនងជាមួយអ្នកដទៃ Reduce in relationship - lost of relationship with others					
18	មានលក្ខណៈអាត្មានិយម Self-fishiness					
Psychological Distress						
19	មានអាការៈញាក់ញ័រដៃជើង / ត្រជាក់ចុងដៃជើង/ ស្លេកស្លាំងលើផ្ទៃមុខ Trembling/shaking extremities, pale on the face, cold extremities					
20	ញ័ររដើមទ្រូង/ ពិបាកដកដង្ហើម/ ណែនទ្រូង តឹងទ្រូង/ បែកញើស Palpitation, heart pounding - sweating - difficulty breathing - tightness in the chest					
21	មានអារម្មណ៍នៅមិនសុខ ទៅមុខមិនរួចថយក្រោយមិនរួច Feeling restlessness, being trapped					
22	ឆាប់ភ័យ និង ភ័យខ្លាចចំពោះផលវិបាកអ្វីមួយដែលនឹងអាចកើតឡើង Easily fearful - fear of bad consequence may happen (apprehension)					
23	នៅចងចាំនូវរឿងរ៉ាវឈឺចាប់ដែលបានកើតឡើង ចំពោះ គេជាប់ជានិច្ច Remember all stories in life related to the bad thing happened to them					
24	ទទួលទានដំណេកមិនបាន Sleeping problem					
25	យល់សប្តិអាក្រក់ Nightmare					
26	មានការស្មុគស្មាញក្នុងការគិត / មានការពិបាកក្នុងការផ្តោតអារម្មណ៍ Trouble thinking - difficulty in concentrating					
27	ឆាប់ខឹង ឆាប់មួរម៉ៅ Irritable mood, easily getting angry					
28	មានសភាពខ្សោយខាងផ្លូវកាយ និង អារម្មណ៍/ មានអារម្មណ៍ធ្ងៀយណាយ - ឆ្អែតឆ្អន់/ មានអារម្មណ៍ធ្លាក់ទឹកចិត្ត Feeling down emotionally and physically - feeling of being saturated, annoyance - feeling depressed					
29	ភ័យខ្លាច (*ភ័យតក់ស្លុត, ភ័យលោះព្រលឹង , ភ័យព្រលឹងចុងសក់, ភ័យញ័រ, ភ័យភ្នែកនៅកញ្ឆឹងករ, ភ័យភ្នែកដូចត្រីស្ងោរ, ភ័យរត់បាតជើងសព្រាត, ភ័យបះសក់, ភ័យផ្អែមមាត់, ភ័យជ្រុះសក់, ភ័យព្រលឹងធំចេញស៊ីអាចម៍បាត់*) Fear, fright					
30	មានអារម្មណ៍ឯកកោ Feeling loneliness					
31	ទទួលទានអាហារមិនបាន Poor appetite					
32	បាត់បង់ជំនឿ និងទំនុកចិត្តលើខ្លួនឯង Lost of self-confidence					

PTSD CHECKLIST

សេចក្តីណែនាំ

ជាដំបូង ខ្ញុំចង់សួរអ្នកថាព្រឹត្តិការណ៍ណាមួយដែលអាក្រក់ជាងគេ - ធ្វើអោយអ្នកមិនសប្បាយចិត្ត ដោយសារតែព្រឹត្តិការណ៍នោះ (សូមសរសេរនូវព្រឹត្តិការណ៍នោះ) ។

INTERVIEWER: PROBE FOR WORST EVENT AND DESCRIBE BELOW:

អ្នកសំភាសន៏: សូមញ្ជាក់ពីព្រឹត្តិការណ៍ដែលអាក្រក់ ហើយ រៀបរាប់ខាងក្រោម:

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ឈានទៅដល់ខាងស្តាំបង្កើនំនួរដើម្បីបញ្ជាក់ពីកំរិតនៃការរំខាន ដោយសារបញ្ហានោះ កាលពី៤សប្តាហ៍ ចុងក្រោយនេះ ។

Last Month	គ្មានសោះ	មានតិចតួច	ល្មម	ខ្លាំង	ខ្លាំងណាស់
P1តើអ្នកនៅតែចងចាំនូវរូបភាពនៅតែគិតចំពោះព្រឹត្តិការណ៍ដែលកើតមានកន្លង មកដែរឬទេ?	1	2	3	4	5
P2 តើអ្នកមានយល់សប្តិឃើញព្រឹត្តការណ៍តានតឹងផ្លូវចិត្តដែលកើតមានចំពោះអ្នក កន្លងមកដែរឬទេ?	1	2	3	4	5
P3 ភ្លាមនោះហាក់ប៊ីដូចជាមានព្រឹត្តិការណ៍ភ័យរន្ធត់ដែលអ្នកបានជួប ប្រទះពីអតីតកាល បានកើតឡើងម្តងទៀតនៅចំពោះមុខអ្នក? *(ហាក់ដូចជា អ្នកកំពុង បានរួមរស់ជាតំព្រឹត្តិការណ៍នេះម្តង ទៀត)* ។	1	2	3	4	5
P4 មានអារម្មណ៍ក្រៀមក្រំយ៉ាងខ្លាំងនៅពេលដែលមានអ្វីមួយធ្វើអោយ អ្នកនឹកឃើញ ពីព្រឹត្តិការណ៍ភ័យរន្ធត់ ដែលអ្នកបានជួបប្រទះពីអតីតកាល?	1	2	3	4	5
P5 កើតមានប្រតិកម្មរាងកាយ (ឧទា. ដូចជាបេះដូងញាប់ ពិបាកដកដង្ហើម បែកញើស) នៅពេលដែលមានអ្វីមួយធ្វើឱ្យអ្នក*នឹកឃើញ*ដល់ព្រឹត្តិការណ៍ភ័យរន្ធត់ដែលបានជួបប្រទះពីអតីតកាល?	1	2	3	4	5
P6 ជៀសវាងនូវ *ការគិត វិនិយាយ* អំពី ព្រឹត្តិការណ៍ភ័យរន្ធត់ដែលបានជួបប្រទះ ពីអតីតកាល ឬជៀសវាងនូវ *ការមានអារម្មណ៍* ផ្សេងៗដែល ទាក់ទងទៅនឹង រឿងពីអតីតកាលនោះ?	1	2	3	4	5
P7 គេចចេញពី *ស្ថានភាព វិសកម្មភាព* នានា ពីព្រោះទាំងអស់នោះ បានធ្វើឱ្យអ្នកនឹកឃើញដល់ព្រឹត្តិការណ៍ ភ័យរន្ធត់ពីអតីតកាលទាំងនោះ?	1	2	3	4	5
P8 ពិបាកនឹងចងចាំនូវផ្នែកសំខាន់ៗ ពីបទពិសោធន៏នៃភាពតានតឹងពី អតីតកាល? (ចងចាំមិនបានល្អ រឿង កាលពីអតីតកាល)	1	2	3	4	5
P9 *បាត់បង់នូវចំណាប់ចិត្ត* ក្នុងសកម្មភាពផ្សេងៗ ដែលអ្នកធ្លាប់បាន រីករាយពី មុនមក?	1	2	3	4	5
P10 មានអារម្មណ៍ថាខ្លួននៅឆ្ងាយ រឺកាត់ផ្តាច់ពីអ្នកដទៃ?	1	2	3	4	5
P11 មានអារម្មណ៍ស្ពឹកស្រពន់ក្នុងចិត្ត រឺគ្មានអារម្មណ៍ស្រឡាញ់អ្នកដែលនៅជិត ស្និទ្ធ នឹងអ្នក?	1	2	3	4	5
P12 មានអារម្មណ៍ហាក់ដូចជា *អនាគត* របស់អ្នកនឹងត្រូវកាត់ផ្តាច់ក្នុងពេលដ៏ខ្លីខាងមុខនេះ?	1	2	3	4	5
P13 មានបញ្ហាដំណេក	1	2	3	4	5
P14 មានអារម្មណ៍ឆាប់ខឹង រឺងាយផ្ទុះកំហឹង?	1	2	3	4	5
P15 មានការពិបាកក្នុងការផ្តោងអារម្មណ៍?	1	2	3	4	5
P16 មាន *"ការប្រុងប្រយ័ត្នជាខ្លាំង"* រឺប្រយ័ត្នប្រយែងជានិច្ច ?	1	2	3	4	5
P17 មានអារម្មណ៍ផ្អើលៗ	1	2	3	4	5

HOPKINS-25 ASSESSING ANXIETY AND DEPRESSION

HSCL-25

ឥម្ប៉ូវនេះខ្ញុំនឹងអានឱ្យអ្នកស្តាប់នូវរោគសញ្ញា ឬបញ្ហាខ្លះៗ ដែលមនុស្សទូទៅតែងជួបប្រទះ ។ ខ្ញុំចង់ឱ្យអ្នកសំរេចចិត្ត ចំពោះរាល់រោគសញ្ញានិមួយៗ ថាតើវាបានរំខាន ឬធ្វើអោយអ្នកបារម្ភដូចម្តេច ក្នុង**មួយសប្តាហ៍មកនេះ** រួមទាំងថ្ងៃនេះផង ។

I will read some symptoms or problems to you that people sometimes have. Please listen carefully to each one and tell me how much the symptoms bothered or distress you in the **last week**, including today.

ផ្នែកទី ១: រោគសញ្ញានៃការថប់បារម្ភ **Part 1: ANXIETY SYMPTOMS**	**គ្មាន** **Not at all**	**បន្តិចបន្តួច** **A little**	**ខ្លាំងបន្តិច** **Quite a bit**	**ខ្លាំងក្រៃលែង** **Extremely**
	(1)	(2)	(3)	(4)
1. ភ័យខ្លាចមួយរំពេចដោយឥតហេតុផល Suddenly scared for no reason	❒	❒	❒	❒
2. មានអារម្មណ៍ភ័យខ្លាច Feeling fearful	❒	❒	❒	❒
3. ងងឹតមុខចង់ដួល វិលមុខ ឬខ្សោយកំលាំង Faintness, dizzy, or weakness	❒	❒	❒	❒
4. ការជ្រួលច្រាល ឬញ័រខ្លួនដោយភ័យខ្លាច Nervousness or shakiness inside	❒	❒	❒	❒
5. បេះដូងលោតខ្លាំង ឬដើរញាប់ ឬបុកជើមថ្លើម Heart pounding or racing	❒	❒	❒	❒
6. ញាប់ញ័រខ្លួនប្រាណ Trembling	❒	❒	❒	❒
7. អារម្មណ៍តឹងតែង ឬរំជើបរំជួល Feeling tense or keyed up	❒	❒	❒	❒
8. ឈឺក្បាល Headaches	❒	❒	❒	❒
9. មានការភ័យខ្លាំង ឬស្ទុះស្ទារ Spells of terror or panic	❒	❒	❒	❒
10. អារម្មណ៍រសាប់រសល់ អង្គុយមិនសុខ Feeling restless, can't sit still	❒	❒	❒	❒

ផ្នែកទី ២: រោគសញ្ញានៃការធ្លាក់ទឹកចិត្ត Part II: DEPRESSION SYMPTOMS	ក្នុង Not at all	បន្តិចបន្តួច A little	ខ្លាំងបន្តិច Quite a bit	ខ្លាំងក្រៃលែង Extremely
11. មានអារម្មណ៍ខ្សោយកំលាំង ស្ងួត Feeling low in energy, slowed down	❒	❒	❒	❒
12. ស្តីបន្ទោសខ្លួនឯងអំពីរឿងអ្វីៗដែលកើតមានឡើង Blaming yourself for things	❒	❒	❒	❒
13. យំស្រែកដោយងាយៗ Crying easily	❒	❒	❒	❒
14. អស់ការសប្បាយក្នុងការរួមដំណេកឬអស់ជំរុញ Loss of sexual interest or pleasure	❒	❒	❒	❒
15. មិនសូវឃ្លាន ញុំមិនសូវបាន Poor appetite	❒	❒	❒	❒
16. ពិបាកគេងលក់ ឬគេងលក់ពុំបានយូរ Difficult falling asleep, staying asleep	❒	❒	❒	❒
17. មានអារម្មណ៍អស់សង្ឃឹមអំពីអនាគត Feeling hopeless about the future	❒	❒	❒	❒
18. មានអារម្មណ៍ស្រងូតស្រងាត់ Feeling blue	❒	❒	❒	❒
19. មានអារម្មណ៍ឯកោ ម្នាក់ឯង Feeling lonely	❒	❒	❒	❒
20. មានគំនិតចង់សំលាប់ខ្លួនឯង Thoughts of ending your life	❒	❒	❒	❒
21. មានអារម្មណ៍ដូចជាជាប់អន្ទាក់ Feeling of being trapped or caught	❒	❒	❒	❒
22. ព្រួយបារម្ភច្រើនពេក ពីបញ្ហារឿងៗ Worrying too much about things	❒	❒	❒	❒
23. អត់មានអារម្មណ៍លើអ្វីៗទាំងអស់ Feeling no interest in things	❒	❒	❒	❒
24. មានអារម្មណ៍ថាអ្វីៗក៏ពិបាកទាំងអស់ Feeling everything is an effort	❒	❒	❒	❒
25. មានអារម្មណ៍ថាខ្លួនឯងឥតមានតំលៃ Feeling of worthlessness	❒	❒	❒	❒