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Loss, Reconnection and Reconstruction: A Former Child Soldier's Return to Cambodia

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Clinical History

Introduction

This chapter will describe the narrative of a young Cambodian man, Mony, who sought therapy when he probably was 30–31 years old (he had no papers regarding his real birth date). He was at that time working as a technical expert in Phnom Penh. The patient sought therapy because he suffered from pathological gambling. During a course of brief therapy he unfolded a life history characterized by periods of danger and tragedy, separations and losses – but also of new opportunities, fulfillment and satisfaction. He may be described as a traumatized war child, a refugee, an adoptee, an immigrant and as a returned expert to his native country.

As a child he had been incarcerated in a Khmer Rouge labor camp for children where he was recruited as a child soldier. Subsequently he was exposed to war incidents during the Vietnamese invasion in Cambodia in 1979, and then managed to flee across the border to Thailand where he stayed for 2 years in an orphanage. Then he was received as a refugee in the US and was adopted by an American family. After having completed his college education he returned temporarily to his native country to contribute to its reconstruction. Thus Mony had experienced a complex set of life events related both to extreme trauma, uprooting, forced migration and resettlement – and in this respect his story may be helpful in illustrating several of the challenges forced migrants are faced with, and which are expressed in therapies with these patients. He could have sought therapy in the US, or in Europe for that matter. But would his story and the way he told it be the same? How were his narrative and the clinical encounter, in which it was told, characterized by the context, by the fact that he was back in his native country in a completely different position than when he left it?

I will try to retell parts of his story, and I do this with a certain measure of humility, not the least because my contact with the patient was of a short duration. It can be difficult enough to giving proper justice when retelling the stories of patients with whom we have had long term therapies – even if we feel we share

most of the socio-cultural context with them. In our case we were intertwined in a discourse of a marked degree of cultural complexity.

History of Present Illness

Mony, an athletic and healthy looking young man, was probably 31 years old at the time of our initial contact, although he thought he might be 1–2 years younger, and he had no official information about his birth date. He was working as a technical expert in his native country Cambodia, having returned temporarily from the United States. He was accompanied to the therapist by a friend, a North-American lawyer, who had insisted that Mony needed treatment when the patient had confided in him about his gambling practices and debt. I was at the time practicing as a Senior Psychiatrist for the Cambodian Mental Health Training Program in Phnom Penh (Hauff, 1996; Hauff, 1999) and the examination took place there.

The patient agreed that he was ill and that this heavy gambling which had lasted for about a year, had to stop. He had been introduced to gambling two years ago, but initially no large sums were involved. Now he had lost all his savings, however, about USD 25 000, and had run debts. He was also worried about potential threats from loan sharks in the future. He described how his hands started to shake of excitement when he entered the gambling halls. “I feel I want the power (of winning). It is like sex, like the feeling that I just got to have that girl”. He was preoccupied with gambling, needed to gamble with increasing amounts of money to achieve the desired excitement, became restless and irritable when he tried to cut down on the gambling, was “chasing his losses” (returned another day to get even), lied to conceal the extent of his gambling, jeopardized significant relationships, because of the gambling, and relied on others to provide money to relieve the desperate financial situations he got into. However, he did not report that gambling was a way to escape from particular problems or to relieve dysphoric mood. He also denied to have committed illegal acts to obtain money for gambling. During the initial interview his mood did not appear markedly lowered, but he stated that he felt depressed at times. However, he reported considerable insomnia, poor appetite, he felt low in energy and felt everything was an effort, worried a lot, felt trapped and blamed himself for his present problems.

He denied any substance use, however, and stated that he was particularly careful not to drink because his father had been drinking too much at times. He also denied using any illegal substances and he did use tobacco. He suffered quite a bit from headaches, but had only mild symptoms of anxiety, feeling a little shaky and nervous at times.

Psychiatric History and Previous Illness

Mony first felt depressed for a period during his high-school years in the United States, but did not consider it serious. In college, however, he started feeling very depressed. He had a Vietnamese girlfriend for 2 years, but eventually her parents

demanded that she should marry a Roman-Catholic man and she wanted to terminate the relationship with the patient. He was arguing a lot with his girlfriend about this, and one day he lost control, went to the library where she was studying and started slashing her books with a knife. Subsequently he was admitted to a private psychiatric institution for two weeks. He remembered little from this admission, but apparently he did not receive any course of anti-depressant medication. He did not have any further psychiatric treatment after this.

Social and Developmental History

The patient was born in Phnom Penh and also spent part of his childhood in Pailin, a provincial town close to the Thai border. He felt very close to his father, who gradually became a wealthy businessman, also having businesses in Thailand. He has one brother, approximately 4 years younger. He had fond memories of his mother, who died from tuberculosis in 1973. His father married again after that, and had two sons with his new wife. When he described his early childhood, he compared himself to the "rich kids" in Phnom Penh at the time of the therapy. "I did not know how the real world was out there, how poor people lived and how poor they could get, until the communists took over in 1975". Then the Khmer Rouge regime forced the family to leave the city, like the rest of the population there, and he was separated from his parents. He was placed in a group with 300–400 children. He managed fairly well at first. "For the first year, I don't think I was sick a single day". He was proud when in 1976 he was picked out to be a "volunteer" as a leader in the group and was subsequently offered to join the army, which he accepted. He felt powerful being treated as a leader. "They made you want to see that you are part of them. They wanted to give you ambitions to become like one of them". He liked his black uniform and was given a gun. "The gun was taller than me!", he disclosed. Then he was sent to become a guard in the mountains at the border between Thailand and Cambodia. Fortunately, he did not have to kill anybody since his unit did not capture any people who tried to get across to Thailand. But in other places he heard that they caught them every day, and when they caught them they killed them instantly. He was exposed to sleep deprivation with only two hours of sleep each night, and after two years in the mountains he became seriously ill. He could not urinate and became very skinny. "They only need you when you are healthy, and I could hardly walk. When I was very sick, I always asked for my mum and dad. And then that was not acceptable. The commander instead threatened to burn down the area where his parents lived. When his leader finally took him home, he first expected to be killed. "At that age it did not matter to me any more, because I'had seen so much. I mean, not so much, but I knew what it was like. So he took me with him. He had these knives, long knives – they were very sharp, and he could cut my head off with them because that's how they used to kill people. They did not want to use their bullets". However, the leader did not kill him, but brought him back to his parents.

He thought everybody expected him to die, and that he had tuberculosis at that time. He was hospitalized, but there was no medication. Mony then confirmed

that life did not mean anything at that time for most people, and he did not really care if he would live or die. Surprisingly he regained his health and energy, and he was sent back to the youth group. They put him in a group that had to work especially hard, and they had to attend political meetings at 4 in the morning. "The young adults, 18–20 years old, they barely survived. They looked like the Jewish people with very skinny and old faces".

After a year he was permitted to visit his parents. When he approached their house he heard somebody say that the guards took some people away the same afternoon. They mentioned names familiar to him, and he suddenly knew that his fathers name was on that list. "They took my father away and I never saw him again". As the eldest child, he expected to be killed as well.

He then escaped with his best friend Socheata, a girl of the same age, whose father had been taken away at the same time. They were pretending to be brother and sister from another area whose parents had died from starvation. This was a highly dangerous journey. He was extremely scared and suspicious at the time. However, the people they met in the other area bought their story, and they survived. Eventually they met an old farmer who took them into his house pretending they were his grandchildren. This man apparently had a little freer relationship with the Khmer Rouge who barter traded with him. Mony got attached to his daughter, whom he started to call "mom". The old man was tougher, however, and demanded that he carried out a lot of missions for him into the jungle. "Sometimes this old man hit me, but they hit Anne Frank as well. My story is just like hers". He did not explain where and when he had heard of Anne Frank, but it is unlikely that he had heard of her in his early childhood in Cambodia. I expect that his comparison with her was part of his attempts to understand and come to terms with his own suffering in retrospect, during his adolescent years in the United States.

He remembered how he felt in command when he was riding the ox in the forest, looking for food. Then the Vietnamese army eventually invaded the area in 1979 and he saw a lot of corpses on his way. This scared him, especially when he once slept close to a corpse, since he was afraid of spirits and ghosts. These ghosts were dangerous and they could kill him or possess him. The presence of spirits and ghosts is part of the world view of many or most Cambodians today, as it was at that time. During my time in Cambodia I have heard numerous stories about how ghosts can interfere in the lives of the living, and I can easily understand that he was extremely frightened.

When he returned home one day, he saw that the house where Socheata was staying was hit by artillery fire, and she had died instantly. This was a terrible shock to him. "This was the saddest day of my life. I felt they took my soul from me". He felt that every time he got close to someone, they disappeared.

After the invasion of the Vietnamese army, he was brought to the Thai border by a family who visited the old man. That family looked after him for a while, until he subsequently was taken under the care of leaders in the border camp who later became senior politicians in Cambodia. He also connected with peers, who he now called foster brothers, and with whom he had resumed contact. He stayed in an orphanage in the border camps for approximately two years, before he was

resettled in the US. He had high expectations of how life would be there, and dreamt about getting rich parents. However, he ran away from the first foster home, and was placed in another family instead. At the time of our encounter he asked himself what kind of power and influence he might have had if he had returned to Cambodia instead of going to the US. Obviously he felt that the "American dream" did not come through.

Mony seemed in a way to continue his fight for survival in the United States, but this time more in the sense of dealing with the feelings and memories of the past, as he at the same time struggled to "make it" and be successful academically. He struggled with the English language, only knowing Khmer, his mother tongue. He could not speak any English when he started school in the 7th grade, but still his results gradually improved. He had mostly Southeast-Asian friends in school. He found college especially difficult, and several times he almost gave up completing his education, but he graduated with a degree in a technical field.

He had several girlfriends in the US, stating that he felt it safer to have two girlfriends at the time, so he would not feel so bad when one of them left him, since he expected them to do that. He felt that the important persons in his life had always left him– by death or otherwise. He fathered a son with a Cambodian girlfriend in the US, with whom he had had several conflicts, and he did not cohabitate with her at the time when he left the US for Cambodia. The son was almost 5 years at the time the patient was in therapy. He loved him deeply and he also visited the patient in Cambodia on one occasion.

When he returned to Cambodia for the first time to work there he met his younger brother by chance, and since then they kept in touch. He assisted both him and his family financially, as well as one of the half-brothers. He knew that his step-mother was alive and living in the country. He postponed to contact her, however, because he was afraid that her expectations of him were too high, and that he would not be able to support her completely. He did not clearly state if this was primarily financially, or also emotionally, but my understanding was that his worries were related to both of these types of support. He expressed a deep anger towards the regime that killed his father, but he did not explore his fantasies about his father's death during this brief therapy. He seemed to be more inclined to hold on to a somewhat idealized image of his father, instead of exploring the image of his father as a victim. Mony was ambivalent towards working in Cambodia. On the one side he wanted to serve his people. On the other side, however, he stated that "sometimes I do not know what I am doing here, because I hate this country! But I have to try to forgive – otherwise I could not live here".

Course and Outcome

The patient underwent a short term therapy which totally consisted of 18 sessions (including the assessment sessions), mostly once in a week. The therapist attempted to explore the connections between Mony's presenting complaint, his problems in the past and his current interpersonal relationships. During the first part of the therapy we worked with simple behavior modification interventions, combined with

a focus on emotional aspects of his coping attempts. Subsequently, he opened up to tell his childhood history, and then we also explored the possible relationship between this and his gambling behavior, as well as with his interpersonal difficulties and depressive symptoms. He soon stated that he did not feel the urge to gamble anymore. He spent more time at work, and reported some increased work satisfaction. His interpersonal relationships improved in quality, and he felt more stable emotionally and socially. Gradually he also slept well and had a good appetite. He still felt depressed, but was able to cope with it. This may seem to be a fast recovery. Although I had no reason to doubt that his level of functioning was improved, I also felt that the improvement to some extent was related to a wish to show me that he could deliver and achieve the objectives of the therapy. I felt he was eager to keep an image of me as a good helper, probably related to his idealization of his father. We both realized that he had not completely processed the painful memories related to the dramatic events in his life. He still felt bored without the gambling, but he partially coped with this by working harder in his job. Towards the end of the therapy he reported that he had been back to the casino once, losing USD 5000. He felt sad about it, and at the same time his sleep became more disturbed and he lost his appetite again. He also reported that he had problems with his girlfriend in Phnom Penh at that time, with whom he had had a relationship over the last two and a half years. Just after the last regular session, his girlfriend broke up with him, and initially he felt that history was repeating itself and that his life was falling apart. But after two additional crisis sessions he realized that he could cope with the loss. Aware of his vulnerability to losses and broken attachments, he was surprised about the emotional strength he experienced. He did not receive any antidepressant medication during this therapy.

Sixteen months later we had a follow-up session by telephone, when I was back in my native country. He had gambled again and had run a debt of USD 50 000. But during the last 5 months he had not been gambling, and reported that he did not feel any urge to go back now. He sounded otherwise content and had continued the relationship with his girlfriend in the US (the mother of his son). His son would soon be 6 years old and was going to school and doing well. My impression was that his return to his girlfriend to a large extent was related to provide a better family life for his son.

Social Psychological Dimensions

The Context of the Trauma

In his early childhood the patient was living in a more traditional Khmer context, characterized by Theravada Buddhism, a predominantly agrarian society, a strict social hierarchy, collective rituals and respect for the elders (Chandler, 1999). But soon the Vietnam War and the civil war in Cambodia led to an increasing fragmentation, corruption and uprooting (Bit, 1991). During the war the American planes dropped several hundred thousand tons of bombs over the

country, contributing to the disaster, suffering of the population and disruption of the country's social and cultural fabric.

The major subsequent disaster set in immediately after the Vietnam war ended in 1975 when the Khmer Rouge took power over the whole country. The forced uprooting of the urban population, to which the patient was exposed, was implemented almost immediately.

An estimated 1.7–2 million people died during this regime, due to executions, hunger, exhaustion and treatable illnesses. The uprooted population was forced into camps with a strict regime of hard labor and very limited access to food. There were separate camps for children who were kept away from their parents. An outline of the modern Cambodian history including the period before and -during the Khmer Rouge reign can for example be found in Chandler's book on the tragedy of the Cambodian people (Chandler, 1991).

Although the Khmer Rouge regime imposed an extreme harshness and terror, the country did not have a uniform policy and there was a variation in the type and level of terror, depending upon the attitudes and practices of the local leaders in the different areas (Chanda, 1986). The peasants living in the more remote provinces were regarded as the Old People and were less exposed to the systematic terror. Population groups that were especially persecuted were the Cham (Muslim) population, Buddhist monks and the Vietnamese minority population. Eventually the Vietnamese army invaded the country and Khmer Rouge had to withdraw from most of the territory. This war created a rather chaotic situation in the border areas to Thailand where the patient was situated. There was a mass refugee exodus to the Thai refugee camps on the other side of the border. A large number of the refugees wanted to be resettled in a third country, but only a smaller number achieved this. Thus the patient was achieving a perceived benefit that was not available to everyone. The remaining refugees in these camps were later repatriated, like the surviving members of his family. During the years when Cambodia was dominated by the Vietnamese army and government, the country was quite isolated internationally, except in relation to the Soviet Union and other communist regimes. When the Vietnamese troops had been withdrawn and the Cambodian government appealed for assistance in the reconstruction from the international community, the United Nations played a major role through the UNTAC operation. This was the first time that the patient had the chance to return to his native country and reconnect with his brother. But the war was not over. There continued to be civil war incidents for a number of years in some of the Western provinces of the country, where the Khmer Rouge still had troops. There was a new democratic constitution, but the political climate continued to be full of conflicts and intrigues, and at one time led to battles between the two major political parties (1997). Thus at the time of the therapy the political future of the country was full of uncertainties. Although the opening towards the international community and the introduction of new market oriented economical policies took place, the country continued to be one of the poorest in the world.

When the patient contemplated his fate in case that he had returned to Cambodia instead of going to the US, he probably could have become a poor

farmer just as well as a budding affluent businessman and politician in the new ruling class in Phnom Penh.

Societal Dimension

What were the patient's native and host cultures? Or perhaps better, which cultural spaces and contexts has he familiarized himself with, and moved in and out of? This question reminds us about the complexity of comparisons of cultural backgrounds. The patient's original cultural context was rooted in a Buddhist society with hierarchical social structures and with a strong adherence to tradition. Loyalty to and respect for parents, teachers and other authority figures were strongly emphasized, as well as strict adherence to social norms in public, with avoidance of public expression of aggression. The extended family unit was the main collective base, and inter-dependence in the family system, where the eldest son had comprehensive responsibilities, was emphasized. The belief in Karma was widespread in this Buddhist society.

From this traditional cultural space the patient and his family were thrown into a context of upheaval and tragedy, where the rulers intentionally tried to break down the traditional cultural patterns and create a New Man from the year Zero. The experiment failed, but not before the Cambodian population was reduced by two million people and the survivors were more or less emotionally and bodily scarred. The patient described his encounters with the Khmer Rouge predominantly as a space of power abuse and suspiciousness. As a child, Mony seems even to have been seduced by this power play, when they appealed to his strength and leadership qualities, and made him join the army, without knowing the implications.

In the border camps he encountered the context of a refugee camp, consisting of a mélange of Khmer survivors, international aid workers and Thai officials. This was a space where hopes for the future started to grow eventually, and where the patient nurtured his dreams of America.

In the US he appears to have encountered the traditions of the Mid-West including Baptist Christianity. But at the same time he appears to have had access to milieus consisting of a mixture of other young South-East Asians, probably partially creating their own original cultural spaces.

Finally he found himself in a socio-cultural context of his native country, but where the cultural fabrics were only partially repaired and modified and new patterns appeared. For example, processes of modernization were emerging with emphasis on internationalization, efficiency and industrial productivity. New media channels were formed and the internet was introduced. A new urban middle and upper class emerged, and in this new urban context gender roles started to change in a slightly more egalitarian direction. The international aid community with its human rights rhetoric was also clearly visible. At the same time there were intertwined processes of such rapid culture change but also of socio-cultural disintegration, such as increased corruption and crime, broken homes, and weak leadership (Leighton, 1998; Bit, 1991).

Mony experienced all these patterns and was part of these processes. Such a context-changing journey could easily have been confusing and leading to a sense of anomie. However, my impression of the patient was that he showed his survivor skills by handling these changes fairly well. It appeared more difficult and painful to come to terms with and mourn all the losses in his life, while also trying to make sense of his experiences during the Khmer Rouge regime.

Cultural Identity of the Patient

Regarding his basic outlook in life, he described himself as a Buddhist and a Christian, and underlined that his foster-father had been a Baptist Minister, but he did not give the impression that religion played any important role in his life. However, in psychotherapeutic encounters, references to religion may be downplayed if the patient expects that the therapist does not have any particular interest in religion. This may have been the case in our encounter, in spite of my general interest in the psychological aspects of religion. But the fact that he described himself both as a Christian and as a Buddhist may indicate that he neither saw himself as a doctrinaire Christian nor as a traditional Buddhist.

He explicitly tried to combine and integrate some of the values that he met through his odyssey. When he worked in Phnom Penh he stated that he tried to work hard and systematic as an American, while at the same time he tried to honor some of the values of his childhood, like generosity and loyalty to the family. In this respect I think it must have been a painful dilemma for him not having visited his step-mother yet. He spoke English and Khmer fluently, but his verbal English had components of young American slang language.

Mony was to some extent preoccupied with his self-image and self-esteem, related to his many attempts to re-establish himself in different environments during and after the extreme traumatic incidents that he had experienced. He also had several compensatory fantasies of becoming a film star or obtaining other powerful positions. Thus he seemed to be struggling with issues of self-esteem regulation. This is a phenomenon I often meet as a clinician in my work with refugees and other immigrants.

Throughout his migration process he was several times faced with the challenge to adjust his self-image and cope with potential blows to his self-esteem. His relationship with women may have been another source of self-esteem as he seemed to find new girl-friends easily. However, this was not a very stable source considering he expected that they would leave him, in accordance with his previous experiences. There seems to have been a related streak of sensation-seeking throughout his life, starting as a child when he was enjoying the freedom and excitement while roaming the forest to find food. He was easily bored, and the tendency to sensation-seeking behavior may have been a decisive vulnerability factor regarding his pathological gambling. According to my observations, however, he was not likely to be in any major conflict with ethnic norms to the extent that he could be perceived as a "womanizer" and an adventurous gambling young man.

During the time of the therapy he appeared well established in his role as a technical expert in Cambodia. He mostly enjoyed his job, and this was a source of self-esteem for him. To some extent he participated in the expatriate milieu in Phnom Penh and had foreign friends like the lawyer who brought him to the therapist. As a Khmer-American he seemed to experience more social independence than his peers who had stayed in Cambodia. It might have been more complicated for many of them to spend a lot of time in a high-class casino. He actually reported that he became closer to his foster-brothers (from the camp) when he stopped going to the casino. He also kept an identity as a Khmer young man and related socially to his brothers and his Khmer friends. He probably identified more with the emerging middle and upper classes, which he originally belonged to, than with the poorer segments of the population, although this is not clear from the material. However, his ethnic identification as Khmer appears to be complicated in line with his ambivalent feelings towards the Cambodian society as described above. He gave an impression of striving towards social and cultural integration in Cambodia as well as in the United States, but that he oscillated between feeling as an insider and as an outsider in both contexts.

Cultural Formulation of Diagnosis

Cultural Explanations of the Illness

There is a wide variety of traditionally based emic concepts for suffering and health problems in Khmer and Khmer-American culture (Daley, 2005), and there are also a variety of traditional healers (Kru Khmer) and monks addressing emotional suffering, and a wide variety of culturally based healing practices. One example of a well known cultural idiom with its related healing practices is "wind overload", which Hinton and Hinton (2002) associate with panic attacks. Such explanatory models are also found among the most educated segments in the society (Hauff, 2001). However, the patient never referred to such traditional concepts, and to my knowledge did not consult traditional healers of monks neither for his gambling problem nor for his depressive symptoms.

Gambling is a prevalent activity globally, and it is described in different ethnic groups as well as among immigrants and refugees (Petry, Armentano, Kuoch, Norinth, & Smith, 2003; Raylu & Oei, 2004). Anecdotal evidence indicates that it also may be prevalent in Southeast Asian countries. Considering the problems presented by the patients in psychiatric outpatient clinics in Cambodia, pathological gambling is a cause of great distress for a large number of families in the country. Usually the problem is presented by the spouse and not by the gambler. Pathological gambling appears to be seen more as a moral problem than as an illness. The problem might also be perceived as a result of "bad Karma", a consequence of wrongdoings in a former life. There is a need, however, for more research on the explanatory models and related help seeking behavior for gambling in different cultural contexts.

Currently, depression may be perceived as a physiological disturbance, a spiritual problem or a psychological disturbance. The author had ample opportunity to observe the variations in symptom presentation and explanatory models during his work at a psychiatric out-patient department in Phnom Penh (Hauff, 1996; Hauff, 1999).

Cultural Factors Related to Psychosocial Environment and Levels of Functioning

Social Stressors

The difficult relationship with his present girlfriend and the subsequent break up was a pronounced stressful element during the last phase of the therapy. His economical problem, as a consequence of the gambling, was another stressful element in his life. The unresolved relationship to his stepmother was an issue that he did not elaborate on as a stressor, but it appeared to me that he might experience this as more problematic the longer he postponed contacting her.

Social Supports

Mony received sustained support from his closest friends in his attempts to end the pathological gambling behavior. He seemed to perceive himself mostly as supportive for his brother and half-brothers, at least financially, but it is likely that the social and emotional support was mutual to some extent. He had also bonded again with his foster brothers from the refugee camp and they seemed to represent his connection with the past, as well as s supportive network in his present life situation in Cambodia. The love for his son in the United States probably represented his deepest inter-personal commitment and thus also a strong support for his attempts to avoid bankruptcy and self-destruction.

Levels of Functioning and Disability

Mony was able to fulfill his work obligations throughout the therapy period, in spite of the gambling, the pain and the sadness he encountered when he told me his life story and upon the break of relationship with his girlfriend. He had at one stage an aggressive outburst at work, but otherwise he reported enjoying what he was doing and seemed to find it gratifying.

Cultural Elements of the Clinician-Patient Relationship

The clinical encounter can be seen as a polyphony of narratives, where the patient's and the therapist's multiple verbalized and non-verbalized stories are activated and often entangled into each other. During the therapy I sometimes felt overwhelmed by the drama and losses that Mony shared with me. I sometimes felt I could not quite follow the sequence of events and felt confused. A few times I also noticed that I started to doubt if the events really could have taken place in the manner

Mony described them. This mostly happened when I was overwhelmed by the material and felt that the patient was not emotionally involved in his story. When we listen to stories of extreme abuse, violence and loss we sometimes need to protect ourselves by creating a distance to the story and the story-teller, and I probably defended myself in this way at such times–even if I was already well informed about the atrocities of the Khmer Rouge regime. But there are no particular reasons to believe that Mony exaggerated his story. When I presented it to a Cambodian colleague, who also had survived the killing fields, his comment was that many survivors had experienced even more dramatic childhoods. In spite of the taped sessions I probably also have misunderstood part of his story, and I apologize to the patient and the readers for this. But most of the time I felt I was able to hold on to an empathic and listening position.

During the time the patient was in treatment, I was teaching and supervising Cambodia's first batch of psychiatric residents (Hauff, 1996). I was slightly frustrated not having my own patients in treatment, and was pleased when the opportunity arose to offer Mony a therapy which could be conducted in English. I think my willingness and motivation might have contributed to the patient's decision to embark on this venture. In spite of having been in psychiatric treatment briefly before during his brief admission to a psychiatric ward at the time of his crisis in college when his girlfriend left him, he did not seemed familiar with this type of self-revelation. In my eyes he was more Khmer than American in this respect. Thus the patient was ambivalent towards exploring his past and in the beginning often gave rather sketchy or vague accounts of events during his childhood and adolescence. However, gradually the material became more detailed, accompanied by a more emotional narration. It seemed that he allowed himself doing this by establishing an apparently altruistic reasoning. He wanted to tell his story so that he could give a voice to children like himself who had suffered in the killing fields of Cambodia. In a similar vein, other young Cambodians have made the painful effort to tell their childhood stories from the killing fields, too (DePaul, 1997).

As a therapist I was more familiar with the socio-cultural context of Mony's present life in Cambodia than with the context of his life in the US. I had visited Cambodia many times during the preceding four years, and had lived there for almost a year when we started the therapy. I was working closely with my Khmer students every day, and I also had Khmer friends who had returned from abroad to serve their country in a similar way as the patient did. Furthermore, I had visited the casino where he gambled away his money and was to some extent familiar with the urban young adult milieu that the patient was a part of. There were obviously cultural elements present continuously in our discourse, but these were not explicitly focused upon in the therapy to any great extent. Thus most of the time during the therapy I did not feel a great cultural distance between me and the patient. We had both sufficient cross-cultural experiences that we were able to maintain a feeling – or may be an illusion – of understanding each other sufficiently most of the time, for a meaningful dialogue to take place. However, in spite of having a considerable clinical experience treating traumatized refugees

in Norway, as well as having lived and worked in several countries, I sometimes felt a vast experiential distance, as described above.

Overall Cultural Assessment

The patient sought therapy for a specified problem, i.e. his gambling behavior. The main diagnosis according to DSM-IV R was pathological gambling behavior (APA, 2000). Mony received a positive score on 8 out of 10 DSM IV criteria for this diagnosis. I did not find that he satisfied the criteria for any personality disorder (DSM-IV axis II). Physically he was very healthy (axis III). Summing up his psychosocial problems, he had childhood exposure to war and genocide, subsequently being a refugee, presently returned to the country where he was traumatized (axis IV).

Mony also had some depressive symptoms, and a screening for anxiety and depression respectively with Hopkins' Symptom Check List-25 (Mouantounoua & Brown, 1995) indicated that he might have a depressive disorder, but it did not indicate that he had any anxiety disorder. Clinically assessed, the condition was most in line with the criteria for Adjustment Disorder with Depressed Mood. He showed an improvement in his psychological, social and occupational functioning during the time of the therapy from moderate to mild symptoms and problems of functioning (DSM-IV axis V). Mony did not fulfill the full criteria set for posttraumatic stress disorder, although this disorder is highly prevalent in Cambodia (de Jong et al., 2001; Dubois et al., 2004). He did not complain about the classical symptoms of re-experiencing the trauma, nightmares etc. Neither did he show the main features of personality change after catastrophic experiences, including social and emotional withdrawal. His condition reminds us of the many faces of reaction to extreme trauma. Pathological gambling has to my knowledge not been described as a consequence of childhood traumatization. Obviously it is not clear that he would not have developed this condition if he had not been exposed to multiple traumatic events and situations in his childhood. He might e.g. have developed this condition anyway based on a genetic disposition towards sensation seeking. On the other hand, certain dynamic elements emerged, indicating that the condition could be, at least partially, a consequence of the trauma. Mony appeared to use gambling, to some extent, as an active defense against depression. There also seemed to be elements of re-enactment of his childhood drama in the casino. He compared the feeling of freedom and excitement he felt on the back of the buffalo roaming the forest for food and other commodities with the feeling he had in the gambling hall when he taught he was going to win, and when he won. He then felt a strong sense of mastery. However, in this way he might also have re-enacted his traumatic losses. The multiple traumatic losses in his life appeared to be the most painful memories he dealt with in the therapy. Death was a constant companion during a decisive period of his life. In accordance with his upbringing and cultural traditions, he also feared the spirits of the persons who had met a violent death and that he has met on his way.

Final Comments

When I read thorough the transcripts of the tape again, I was struck with a feeling of meeting a rather fragmented story. I remembered how I was struggling to get a sense of continuity and my attempts to help the patient to connect the fragments together. I wonder to which extent I understood how much the patient probably was struggling with this himself.

In the first sessions of this short term therapy the patient felt that it was a mystery to him why he gambled. Gradually he came to the conclusion that it was related to the sadness and losses he experienced as a child. However, it seemed that he regarded this more like a hypothesis rather than that it represented an insight on a deeper level. When he summed up his experiences in the therapy, he could see how he initially tried to avoid talking about the past to avoid the pain. But he eventually felt that the sessions also had helped him to mature a bit, as well as to process his feelings, especially in connection with the loss of his father and with his war experiences.

The patient had at least one relapse of gambling after the therapy ended. He was obviously not cured for his pathological gambling disorder. To achieve this, he might have needed a more systematic follow-up with a focus on further behavior modification. To process his childhood trauma and tragic losses on a deeper level he might have benefited from a longer term systematic psychotherapy. If the situation had been different and I could have offered him this, I probably would have done so, and I do not see this treatment as the optimal one for the patient. Was it harmful? I have not found indication that is was. Something happened in the therapy. There was a therapeutic connection and a sincere attempt of reconstructing a life history. The patient experienced this as meaningful, and he also discovered his emotional strength and coping capacity at the end of the therapy. At time of the termination of the treatment process, he was confronted with a new loss of a girlfriend, but this time he dealt with it in a different and less painful way than he used to deal with losses earlier in life.

I would like to express my gratitude to “Mony” for allowing his life history to be used in this chapter.

References

American Psychiatric Association (APA). (2000). *Diagnostic and statistical manual of mental disorders* (4th ed., text revision). Washington DC: American Psychiatric Association.

Bit, S (1991). *The Warrior Heritage. A psychological perspective of Cambodian Trauma*. El Cerrito, California: Seanglim Bit

Chanda, N. (1986). *Brother Enemy. The war after the war. A history of Indochina since the fall of Saigon*. New York: Collier Books.

Chandler, D. P. (1999). *A history of Cambodia*. Boulder, Colorado: Westview Press

Chandler, D. P. (1991). *The tragedy of Cambodian history. Politics, war, and revolution since 1945*. New Haven: Yale University Press.

Daley, T. C. (2005). Beliefs about treatment of mental health problems among Cambodian American children and parents. *Social Science and Medicine, 61*, 2384–2395.

De Jong, J. T. V. M., Komproe I. H., Van Ommeren, M., El Masri, M., Araya, M., Khaled, N., et al. (2001). Lifetime Events and Posttraumatic Stress Disorder In 4 postconflict settings. *JAMA, 286*, 555–562.

DePaul, K (Ed.). (1997). *Children of Cambodia's killing fields. Memoirs by survivors*. New Haven: Yale University Press

Dubois, V., Tonglet, R., Hoyois, P., Sunbaunat, K., Roussaux, J. P., & Hauff, E. (2004). Household survey of psychiatric morbidity in Cambodia. *International Journal of Social Psychiatry, 50*, 174–185.

Hauff, E. (1996). The Cambodian mental health training programme. *Australasian Psychiatry, 4*, 187–188.

Hauff, E (1999). Transcultural Perspectives of the Management of Mental Health Care: Challenges in Europe and in Low-income Countries. In J. Guimon & N. Sartorius (Eds.), *Manage or Perish* (pp. 95–100). New York: Kluwer Academic/Plenum Publishers.

Hauff, E. (2001). Kyol goeu in Cambodia. *Transcultural Psychiatry, 38*, 468–473.

Hinton, D., & Hinton, S. (2002). Panic disorder, somatization, and the new cross-cultural psychiatry: The seven bodies of a medical anthropology of panic. *Culture, Medicine and Psychiatry, 26*, 155–178.

Leighton, A. H. (1998). Recollections of culture and personality. In S. Okpaku (Ed.), *Clinical methods in transcultural psychiatry* (pp. 18–41). Washington DC: American Psychiatric Press.

Mouantounoua, V. L., & Brown, L. G. (1995). Hopkins Symptom Checklist-25, Hmong version: a screening instrument for psychological distress. *Journal of Personality Assessment, 64*, 376–383.

Petry, N. M., Armentano, C., Kuoch, T., Norinth, T., & Smith, L. (2003). Gambling participation and problems among South East Asian refugees to the United States. *Psychiatric Services, 54*, 1142–1148.

Raylu, N., & Oei, T. P. (2004). Role of culture in gambling and problem gambling. *Clinical Psychology Review, 23*, 1087–1114.