WORKING WITH CAMBODIAN REFUGEES:
OBSERVATIONS ON THE FAMILY
PRACTICE WARD AT KHAO I DANG

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This report is a narrative commentary; based on my experiences and professional observations of work in the Family Practice Ward at Khao I Dang camp on the Thai-Cambodian border, during the winter of 1979-80. It is necessarily a personal report, and, although it draws on many shared perspectives and discussions, it is not intended to represent the sum of the experiences and views of all of my colleagues and friends who served at Khao I Dang.

In the fall of 1979, extreme famine conditions, compounded by internal military conflicts resulted in a massive movement of refugees from Cambodia to the border, into Thailand. Hundreds of thousands of men, women, and children collected in camps hurriedly constructed on nearly barren plains only a few miles from active war zones. The refugees arrived in advanced stages of malnutrition and exhaustion. Many were ill or wounded, psychologically traumatized or otherwise suffering from the disastrous effects of war and social upheaval.

The great and immediate need for food, shelter, and medical treatment caused various national and international organizations to bring in supplies and personnel to aid the refugees. Many temporary hospitals were constructed and medical treatment was begun by teams of physicians and nurses from many countries.

In November, 1979, television reports of the great difficulties of the refugees led two psychologists, Virginia Veach and Dominie Cappadonna, to organize a team of volunteers to serve in the camps. This quickly assembled group! was inter-

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ested in serving not only as a medical team, but also as a psycho-social, holistically oriented treatment team. Within a few weeks, Virginia Veach found a sponsor, The Catholic Office for Emergency Relief to Refugees/International Catholic Migration Commission (COERR/ICMC). By mid-December, 1979, our team had passed through Bangkok, Thailand, and arrived at the Khao I Dang Holding Center for Cambodians, near the border.

I will always remember the first time we walked through the camp as a beautiful experience. We were surrounded by curious children, men and women. If we looked at them in the eyes and held our gaze just a second longer than normal, their expressionless faces would transform into a smile. It was a time for them to look us over and when we mutually passed whatever barrier was there, they were open to us.

By the time we arrived at the camp, sprawled out on barren red clay earth, had been open three weeks; the weakened had died and it was now a matter of survival for the 70,000 inhabitants (eventually the camp totaled 115,000). The United Nations provided food: a small head of cabbage, sometimes two, each week for six people, along with rice and several cans of dried fish. That represented an improvement in their nutrition, but it was still not enough. They also were given bamboo and blue plastic to make their own small thatched huts. They were safe in these camps-at least safer than on the border or inside Cambodia. But they did not want to go back to their own war-torn country and they could not get out of Thailand because the host government would not recognize them as refugees. They were trapped.

When we arrived at Khao I Dang the team was separated because, except for the bamboo shell, our hospital was not built. Temporarily the doctor and nurses went to out-patient departments and the rest of the team concentrated on finding supplies, contacting other professionals, helping wherever possible, and generally preparing for the opening of the hospital ward. When the hospital opened, the team came back together and the project blossomed.

Our tour of duty lasted six weeks. During that period my perception experienced a subtle change. The first photos I took

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of the camp were distant pictures of vistas and activities. They represent an initial perspective of getting to know the surroundings, learning the workings of the camp, and meeting some of the 300 foreigners who were serving there. Halfway through my tour, and at the end of it, my photos were close-ups of the people. I was more involved, and my experience became more intimate. Also, we were working with interpreters, and as the interpreters learned more English they became closer with us because the language barriers were breaking down.

In the hospital we spent a great deal of time interviewing the Khmer people, letting them tell their stories about what happened to them, what their expectations were of us, what we could do to help them, and how they wanted to heal themselves. We also conferred with the Khmer public health doctor in the camp about the living conditions in the villages, and did other research to learn what it was like for these people in the years before all the oppression and tragedies began.

Many of the people were without immediate relatives. Their family members had died or been killed over the past four years. Our main concern was to recognize that each one of these individuals was a whole person, with a mind, body and spirit. Our ward was an active one, and we intentionally involved patients in their own healing processes. In other camp hospital wards patients would be lying with intravenous tubes, waiting for something, waiting for a miracle, waiting to be healed. Although this may have been appropriate in many medical cases, our ward’s approach included a more participatory option. We had our patients involved in sewing, artwork, dancing, singing, and physical rehabilitation using bamboo crutches or walkers. Many activities were designed to encourage the Khmers to take responsibility for their own health. This also provided an opportunity for developing social relations. Though many patients had no living family members, here they could create another quasi-family unit. Recently “half-way” houses have been built for these people who have been part of the ward so they can function as a little collective in the midst of the camp community.

We had one Khmer doctor (90 percent had been killed in Cambodia) who was with us on the ward, and he told us about previous psychiatric treatment services before the Pol Pot regime took over. He said there was only one psychiatrist in Cambodia and one hospital many kilometers away from the capitol of Phnom Penh. The prevailing treatment was shock therapy, and medication. With such limited services the people tended to incorporate what we would term psychiatric cases into their family and community, to be treated by their tra-
acknowledging and incorporating cultural differences

donational healers. Our approach recognized this history and also reached into the camp community for support instead of trying to rely on a Western drug treatment model. In part, this became necessary due to the unavailability of many pharmaceuticals.

Our ward's approach also involved letting-go of the attitude of being the expert who "cured." We did not abandon Western medical and psychological knowledge so much as we tried to disconnect ourselves from the overly-directive attitude so easily connected with such knowledge and skills. Our holistic philosophy of treatment and care assumed that these people would help themselves if they had the opportunity, the support, and some materials. As it turned out, this was also an appropriate approach for working with the Khmers because it permitted us to acknowledge their culture. One of their beliefs is that everything is ruled by a spirit—their body has a spirit, so too their house, all of nature, nearly everything has a spirit.

Our decision to incorporate these beliefs and some of the related practices into our treatment work meant we were encouraging the evocation of their own "healing spirits." To this end when the hospital opened we purchased a spirit house affixed on a pedestal at shoulder height and placed it outside the hospital door. The people's faces lit up with joy when they saw it. Their religious practices had been severely repressed during the previous four years and for many this represented a reconnection to their religious identity. The recognition of the Khmers' beliefs and religious practices also permitted us to work with a surviving shaman.

A good example was provided by our difficulties with an 11-year-old patient, Kasaul, who was visibly disturbed. He giggled and laughed inappropriately and, if unattended for even a moment, would remove his clothes, run outside the ward, or literally try to climb the walls. He slept no more than one hour each night and his mother was exhausted attempting to care for him and a smaller brother. When asked what Kasaul needed for healing, she requested a shaman. At our request a shaman came in and worked with Kasaul. The method had the appearance of the shaman beating on the boy's body with his hands. According to the shaman, Kasaul was possessed by his grandfather's powerful spirit. Our staff was told to wait three days for results. The symptoms grew more pronounced and Kasaul was nearly uncontrollable. However, on the third day he came up to me with serene eyes, and asked for incense. Kasaul burned the incense by some flowers placed in front of his father's picture (he had been a Buddhist priest). That day he started interacting appropriately with the other
children and his behavior returned to normal. He was a transformed child, and I remember being simultaneously thrilled and shocked. It was not possible to determine how the shaman had worked, or even if his procedure was responsible for the favorable outcome. Nevertheless, this experience increased our confidence in working with him.

Some of the Western doctors did not appreciate the use of such methods. Their displeasure was voiced openly. But the shaman, along with some other Khmer traditional medicine approaches, was given latitude on our ward because of the social recognition and acceptance of these methods by those we were trying to help. Because we kept seeing healing results under difficult conditions, along with an expanding trust in us, we went ahead with this approach despite the lack of support from other medical personnel. In some cases the shaman and our ward physician conferred to arrive at an appropriate treatment, and this worked out satisfactorily.

We could have applied a traditional Western medical model and the Khmer would have accepted it because they were grateful for the foreigners' help. Certainly standard medical intervention cured many diseases and saved many lives in the camp. Sometimes the flood of refugees, as many as 20,000 wounded in two days, left no time for anything but medical and emergency care. At these times the ward met these demands as they arose.

Every week we went to a meeting of all the volunteer agencies. About two weeks after we had the ward underway, Magnus Grabe, a German doctor and the medical director of the entire camp, opened one of these meetings by announcing that the medical crisis was over and the hospitals needed to speak to the psychosocial and spiritual needs of the people. This was a real turning point for the camp and a confirmation of our ward. Later, other foreign medical personnel began to ask us to consult with them about services other than acute medicine. About this time our ward's orientation also received support from a Swiss psychiatrist and assistant medical director of the International Red Cross, Jean-Pierre Heigel, M.D. He had vast experience in working with refugees and totally supported our philosophy of treating the whole person as well as evoking the people's own traditional methods of

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2Another Khmer practice was "coining," a procedure in which the edge of an oiled coin is rubbed on the skin along the meridian lines (as depicted in acupuncturist charts). It results in a bruise-like mark of blood trapped under the skin. The Khmers associated this treatment with alleviation of minor illnesses.
healing. He was adamant in his concern of not having the Khmer become psychologically-or drug dependent on Western medicine.

Along with medical care these people needed self-esteem, dignity, and identity. Everything had been taken away from them. Most had no sense of being a person. For the previous four years they were part of an impersonal mass laboring in the rice fields under great fear. From its first days, one of the purposes of our ward was to encourage the return of their dignity, their humanness. An opportunity to do this was provided when we learned that the surviving classical dancers (most of the Royal Cambodian Ballet had been killed) chose to use our temporarily uncompleted ward space to teach their children cultural dancing. The floors of our hospital were made of sharp rocks, but team members found more blue plastic and mats to protect the dancers' feet. Soon a former court dancer began instructing the children in the lost and forgotten dance steps that depicted their heritage (Mydans, 1980). Eventually the dancers staged a wonderful tragi-comedy.

They portrayed in mime their story about being taken over by the Pol Pot government, having to leave their homeland, hoping for something better, walking to the border, running into land mines, or Vietnamese soldiers or Khmer Rouge soldiers, getting on buses much larger than they had ever seen before, and generally being terrified with the unknown. They acted out meeting strange people with huge cameras, thinking they were going to be shot. They did not know that those cameras were not guns. They described being transported to the camps but being told in the hospital that they might now die because of some disease, such as parasites. The play depicted the collective fear and pent-up tension of the people and it was expressed with great melodrama. The Khmer audiences were laughing uproariously and crying at the same time. It was the most cathartic and beautiful thing we had ever seen. We asked the actors if they would stage their performance for the rest of the foreigners along with the cultural dances. They did this and a Christmas performance in a place in the camp where there was an open area the size of a football field. The day of the dance the field was shoulder-to-shoulder people with joyful, reminiscing faces. It was the first time in four years the Khmers could see their own dancing and hear their own music. It was a true coming-alive.

In our work with individuals on the ward, the psychological effects of years of severe repression had to be handled on a
case-by-case basis. Most of the men in our hospital wanted to forget about what had happened and for the most part did not want to talk about it. However, acting-out behavior was seen in numerous cases of severe wife beating. The children expressed an awareness of great suffering through their drawings in which people were fighting or their houses were under attack from large tanks. Some children were mute and expressionless, but others expressed a sense of hope in their drawings of colorful butterflies, flowers, scenes of homes surrounded with plentiful coconut trees and chickens. For the women there was more of an hysterical explosion of their feelings, not in laughing or crying, but in a rigid comatose state. When these states occurred, we carefully held them down so they would not hurt themselves. Other women were mourning and grieving. We encouraged them to go through it and generally provided emotional support. Often, just by sincerely listening to their story, we allowed for the possibility of release and change.

There were times when an individual benefited from a more confrontive approach. In one case, a woman I called "Big Mama" (she was taller than me which was unusual for Cambodian women) complained of an ulcer or bad stomach, and her left leg was too weak to bear weight. Evidently I had promised her a sarong and forgot to bring it in the next day. According to an interpreter, instead of directly getting angry at me, she became hysterical and thrashed about on a wooden bed in a spasmodic, fitlike fashion. Her eight-year-old son, Che, was quite upset when he saw her do this. I did not give her any attention until the end of the day when I went up to her and through my interpreter said, "I'm upset with you for two reasons: one, because of the way you acted when I did not give you a sarong. You did not need to become hysterical. I am sorry I forgot your sarong and I will bring it to you tomorrow. But I'm also upset for what you are doing to Che when you go into hysterics. That is not fair to him." In our talk she realized what she was doing to her son, and she admitted she was frightened of me and the hospital. I accepted that and said, "Do you want to help yourself?" In a surprised tone she said yes and I said, "One thing you have to do is start sitting up (she was laying down all day but promptly started to sit up). You have to start walking (we had made her a bamboo crutch). Another thing is that you can control your seizures or fits if you want to." I asked her if she was Buddhist, and she said she was and that she wanted to be a Buddhist priest. I told her she could "bring Buddha in" whenever she wanted, including times when she felt pre-symptoms of hysteria (i.e., parts of her body getting cold, tingling up her spine, headaches, and sometimes noises in her head). Here I was applying a variation...
The next morning, I asked a colleague familiar with Buddhism to go talk with her about appropriate practices and how she could "bring Buddha in" and learn some voluntary control of physical and psychological reactions. Almost immediately thereafter the woman's hysterics decreased and soon stopped. She became involved in the ward's activities and, with her beautiful voice, led the singing while her son danced.

Another case, which also led to the therapeutic use of indigenous practices, involved a woman who had nightmares. I asked her to draw out her dreams. She first drew a picture of herself sleeping and her three friends visiting her. She had apparently become separated from them in the war and longed for them (I learned months later that they came into the camp and it was a warm and joyous reunion). In reference to the nightmare, she drew a picture of her dead mother calling her to come join her-drawn as the waving hand, which means "to come" in Khmer. Knowing that her family was dead, I asked, "Do you want to go with your mother?" She answered, "No." I asked, "Do you want to let her spirit go on?" and she said, "Yes." Again, "What do you need to do to let her go?" She needed rice, a banana, a flower, some incense, and wine or water. I got her all of these and left her to complete the relationship through a ritual which was meaningful to her. In Western therapeutic terminology, we might say that she had used the ritual to break the tie to her dead mother. A subsequent conversation indicated that the nightmares had ceased.

Incorporating some of the indigenous cultural practices into our work with the Khmer did not necessarily imply our acceptance of their beliefs or an attempt to become part of their culture. While respecting their social, cultural and spiritual practices, we maintained our own independent judgment of the therapeutic value of activities in the ward.

In terms of therapy, these cases illustrate the advantage of combining indigenous treatment methods and cultural support, with Western psychotherapeutic and medical practice. (A useful and recently published discussion of the holistic approach to indigenous and biomedical therapeutics, including references and an annotated bibliography, may be found in Kleinman [1980].) It is also important to recognize that we were meeting only the survivors. They had lived through the four years, and had somehow made it across the border. There were
hundreds of thousands, perhaps millions that did not. What part of the population these survivors represent is difficult to determine. I have privately speculated that they may have been motivated by a belief in, or identification with, something other, however conceived. Of course this may also be mostly my own perception and an expression of my own orientation.

It is interesting and perhaps helpful to describe what happened in the midst of such a demanding living and working environment as exists in the camp. When I first arrived, I (and others in the team) kept up a regular morning meditation. But soon the long work schedule (4:30AM to 8:00PM) made meditation a luxury. My own meditation practice went by the wayside as the work became our practice. It was like being swept up by an energy and focusing in on whatever was presented to us to do. Everything was synchronistically working as we put in 14-16 hours daily. It was as if we were connected to a greater plan during the entire time, and all we had to do was be absolutely present to every moment and the plan would unfold. There were no rest periods on the ward except walking to meet someone. We were under much physical stress and nearly all of us became ill the moment we left the camp—either colds, bronchitis, or respiratory diseases. Like other team members, I had two days off for rest and relaxation and I started to become sick and achey during that period. However, when I returned to camp I felt fine. This may represent an imbalance of energies that one can experience, being drawn or almost seduced by a higher energy and the innumerable needs of the people. This also suggested to me that being physically ill sometimes may be a matter of choice.

The camp experience clarified some issues I had considered regarding service and serving. For many years I was attached to service and serving: I had to do it. But in recent years I learned that I do not have to be attached to service, and I do not need to serve in order to follow my purpose. Paradoxically this realization permitted me to serve even more (I would have been suspicious if I had had a burning need to go to the border camp—the excitement for me was that I had never served in such a large and crucial project). An interesting example of how a driving need to serve can create problems is provided by several physicians. They had been in the camp three weeks through the worst initial crises, and were so caught and so trapped into needing to serve that their health was deteriorating. There were several fresh physicians available to replace them, but they could not bring themselves to let these new doctors come in and work with them. Another ex-
ample is that of a nurse who had diarrhea for seven days and was still working fifteen hours daily, even though others were available to help.

I would guess that people who go to work in refugee camps or similar situations may want to consider why they are there. It is possible to be caught by a driving need to serve. It is possible to become attached to the joys and depression, to be rendered almost ineffectual by the overwhelming drama of great human need. On the other hand it is also possible to step back somewhat, to disidentify from one's "hidden agenda" of the drivenness of needing to serve. In my own case, I learned from the Khmer how to let go of the moment and to be present to the moment. And I believe this made a difference in my work. In not being driven by my own need to serve, I felt able to serve with greater openness to others' needs, and this openness led to greater depths of feeling, understanding and giving than I had thought possible.

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