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CROSSING THE SEA

**narratives of exile and illness
among Cambodian refugees in New Zealand**

A thesis presented in fulfilment
of the requirements for the degree of
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ABSTRACT

Cambodian refugees have settled in many countries of the West, including New Zealand. Cambodian refugees are consistently described as the most traumatised of Southeast Asian refugees; hence they are expected upon resettlement to be in special need of health care, which host countries must provide. Most Cambodians from rural areas have had little prior experience with Western-type health care, having employed mainly local (rural Cambodian) healing techniques, supplemented with a range of available Western and Asian medicines, in an environment of medical pluralism.

Using the ethnographic method, this three year study set out to determine illness experiences of resettled Cambodian refugees, and to interpret experiences in the contexts of the events that led to their fleeing Cambodia, the trauma of the flight itself, and the process of resettlement in an unfamiliar nation, geographically and culturally far distant from home. Theories that Cambodians hold regarding the origins, progress, and preferred treatments of illness are described. Experiences of seeking health care from New Zealand's biomedically based health services are presented, and complementary health-care practices such as Cambodian self-care and alternative medicines are identified.

Adult Cambodian who have survived severe deprivation, atrocities and profound loss often suffer serious ill health. Ill health is both cause and consequence of inability to acquire new skills and education, low facility in English, unemployment and poverty. For adults caught in the cycle of illness and poverty, social interaction is primarily with other Cambodians. A Cambodian sub-society on the margins of mainstream society has emerged, in which, among other things, healing practices are carried out.

Cambodian refugees show no reluctance to use Western medicine, and little desire to employ Cambodian medicine, which in any case is now largely unavailable. While some Cambodians suffer from diseases that appear amenable to Western medical diagnoses and treatments, others have been found to suffer intractable, often painful illnesses for which no biomedical explanation could be found. In such cases, the sufferers themselves offered explanations for their illnesses, drawing from Cambodian theories of illness, and personal life experiences, in doing so. However, some serious illnesses experienced by Cambodian refugees fit neither Cambodian nor Western biomedical disease categories. A result of exile is that familiar Cambodian systems of healing are no longer relevant, and at the same time, conditions of exile and transition cast doubt on former theories of illness, leading to a search both for understanding and for healing. Employing Cambodian self-care techniques together with Western and Asian medicines, resettled Cambodians are actively creating a transitional system of healing appropriate to their transitional status. Hard, solitary intellectual labour ("thinking too much") is a central process by means of which exiled Cambodians struggle to regain control of their shattered lives.

The development of a new system of healing is part of the global process of hybridization of cultures, accelerated by massive transnational migration. To depict both the danger and the generativity of the transformations of which Cambodian refugees are both agents and subjects, the study concludes by borrowing a Cambodian metaphor for giving birth: "crossing the river." Cambodians consider women post-childbirth to be weakened and vulnerable to illness, cold and wind; while the child is newly born into humanity, the mother too is reborn into a new social status. Refugees who have literally crossed the sea to settle in a new country are undergoing a similar rebirth.

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GLOSSARY

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Naat, Dj. (1967) Dictionnaire Cambodgien (Tome 1). Paris: Institut de l'Aise du Sud-Est.

Naat, Dj. (1968) Dictionnaire Cambodgien (Tome 2). Paris: Institut de l'Aise du Sud-Est.

Huffman, F.E. and Proum, I. (1978) English-Khmer Dictionary. Mass: Yale University Press.

Chapter 1

khmer: the descriptor for the dominant ethnic group of Cambodia; the name for the language of the *khmer* people, which is also the official language of Cambodia.

Chapter 4

dtoas: "allergy"; a category of illnesses that afflict postpartum women who do not observe precautions, or are shocked.

gkru khmer: traditional Cambodian healer (literally, Cambodian teacher, or wise person).

chmorb: Cambodian birth attendant, traditional midwife.

Chapter 5

Cham: name of a minority ethnic group of Cambodia, who are followers of the Muslim religion.

Angkar Leo: the regime of the Khmer Rouge; the State.

cj'laat: mobile teams of children and youths, during Khmer Rouge regime.

suel'bpaak: art, cultural dancing and music. The term was applied to dances practised under the Khmer Rouge to recruit, and to "educate" the population.

Khmer Krohom: *khmer* term for Khmer Rouge.

wat: Buddhist centre; residence of monks; place for community meetings for prayer, festivals, and non-religious reasons.
Variously translated as "temple" and "pagoda".

chheu kuo kbal: "brain hurts", as when one is excessively worried and thinking.

phol: merit for doing good.

Chapter 6

baaraing: people of European descent. In Southeast Asia used to denote foreigners, while in New Zealand used in reference to white New Zealanders.

dton'dtine [tontine]: a game to acquire large sums of money by pooling the contributions of all players.

som'peah lea: respectful greeting when departing, made by placing hands together at about chin level, bowing the head and bidding farewell.

som'peah bh'ru: respectful greeting at arrival, made by placing hands together at chin level, bowing the head, and informing elders of arrival.

cjoal chn'um: Cambodian New Year, which falls on April 13.

p'jum buend: Ancestor ceremony, which falls sometime in August-September.

Chapter 7

gkuet cj'roum: "thinking too much"; literally "to think excessively".

bpi! baak cjuet: worry; "thinking a lot" about the difficulties of life; literally "a difficult, or hard, state of mind".

prouy cjuet: worry, or anxiety in the face of danger.

a'rom: memory, or state of mind, accompanied by feelings.

nuek keuhn: to remember vividly.

sok sub'bai: Healthy, well. *Sok* means safe; *sub'bai* is happy. Together, this means "I am well, safe, healthy".

ot sub'bai dte: not happy; not in a state of well-being. This is not necessarily accompanied by having a disease.

prouy cj'roum: worry too much, sometimes used interchangeably with "think too much".

gkuet klarng: thinking very hard.

smok-smarnh: state of mind that is complex, complicated, difficult, clouded.

lob: confused.

gkam: fate (*karma*).

sraucj dtuek: a "shower", a sprinkling of holy water to bless and bring good luck.

bon ceremony: merit-making ceremony.

too: relieved, eased, made soft.

Chapter 8

sue: fatigued.

k'jol: a state of general unwellness, with symptoms of dizziness, headache, nausea, fatigue, abdominal pain, and diarrhoea, relieved by "coining" and other similar techniques. Can be the precursor of more serious illness, and "coining" is believed to help avert full-blown sickness. *K'jol* is also described as resulting from poor circulation.

pey: a general term meaning afraid, fright. When more severe and causing shock, the term *dtok sl'oht* is used.

grun nji-ac: a fever when the sufferer feels excruciatingly cold.

grun pouh-vien: lit. "fever of the intestines"; probably typhoid.

grun chanj: malaria.

heum: swelling of face, body, legs and arms as a result of starvation. The term also refers to a condition resulting from a lack of sugar.

tnam k'dav: "hot" medicine.

sor'sai: nerves.

cjea: recover, get better.

on'dtung cjuek: eel bite.

k'njaak: a sensation of chill in the body; a shiver down the spine.

Chapter 9

cjaak: stab, inject. *Cjaak tnam* refers to giving medicine by injection.

gkru bpat: "Western" style doctor, a concept which incorporates paramedics and nurses.

tnam acj dtun-sai: lit. "rabbit droppings", a derogatory term for traditional Cambodian medicine used *only* during the Pol Pot regime.

dtor'nueb: offering to *gkru khmer* at time of requesting assistance.

lauk gkru: generally means teacher. *Lauk sonk* is used to address a monk, or can be used as a respectful form of address.

dta: lit. "grandfather"; also used as a term of respect when addressing old men.

Pali: ancient language of South Asia, in which scriptures were written. *Pali* words are used for their supernatural power, and therefore *Pali* words are spoken or "sprayed" by a *gkru khmer* or by a monk to exert spiritual force for good.

s'raucj dtuek: a ritual shower of holy water, to bless or protect against bad luck or danger.

kbuon: rules.

preah dti-nairng: foretelling according to the rules, by reading the palm, and according to the date of birth.

tnam: medicine. Types of medicine distinguished with qualifiers, for example: *tnam khmer*: Cambodian medicine; *tnam acj dtun-sai*: lit. "rabbit droppings", a derogatory term for traditional Cambodian medicine; *tnam k'dav*: "hot", or warming, medicine; *tnam tro'cjeak*: "cold", or cooling, medicine; *tnam d'os*: scraping medicine; *tnam bpat*: "Western" medicine; *tnam cjaak*, injected medicine.

saab: tasteless.

dus: to warm, or wake up, medicine by blowing a *pali* incantation.

bpues: poison.

aab preay: spirits, ghosts.

oucj: moxibustion, a form of treatment by burning on areas corresponding to "nerves". On small patches of material, termed *bpoy*, prepared from a coconut or similar palm, is placed a plug of "wool" scraped from bamboo or a particular kind of soft wood. These are then lit, and smoulder until burnt away.

cjub'cjour: treatment by holding or controlling the pulses, applying pressure.

dol so: depending on the context, this general term can mean "thorough", or "excessive".

sro'bhun: numbness; pins and needles.

sro'gkear: skin, or teeth, or ears sore to touch.

cjock cjaab: a sharp stabbing pain.

s'riev s'ranh: sensation of cold shivers, as with a chill.

Chapter 10

*gon'seng yoin*d: the inscribing of words or design on paper or cloth, which are worn as a scarf to offer protection through magical power to the wearer.

k'se gk'taa: amulets, usually made by rolling soft metal on which *Pali* words have been inscribed, which are then worn on a piece of string for protection.

toir-aa: "spirit words" spoken to create a protective cordon.

pro'dtiel: medicinal plants.

aab: witch

koas k'jol: "coining". *Koas* literally means "scraping", usually carried out using the edge of a coin lubricated in Vicks ointment or in Tiger Balm, although the edge of a spoon or other blunt-edged object is sometimes used.

cjoub k'jol: "cupping"; *cjoub* literally means "cup".

cjaab k'jol: "pinching". Literally, massage for *k'jol*.

cjaab sor'sai: massage of "nerves".

Chapter 11

chlong dtunlei: lit. crossing the river; euphemism for giving birth.

gkourt gkoan: to give birth [direct speech].

pro'soat gkoan: a synonym used to refer to the high-born giving birth.

tnam s'doh: medicine to ease labour, into which an incantation has been sprayed.

a'gkum kie-ta: the practice of magic.

p'njak: startle.

sor'sai kjey: unripe, or young nerves, believed to be the state of the "nerves" of the woman after childbirth.

dtoas sor'sai: disorder of "nerves" following childbirth, for example after a fright, or shock.

kor: sweet and salty braised chicken, pork, or beef.

aing pleurng: "grilling", or "roasting" of the new mother. A practice of burning a fire beneath her bed so as to heat her, based on the belief that after childbirth the woman is "cool" inside, and needs to be warmed.

knong-kei: the post-natal period, literally "indoors for a month".

c'jeinh bpi pleurng: the completion of the post-natal period, literally "to come out from the fire".

ch'pung: steaming; an alternative to "grilling".

gkom'laing: energy.

rog: sickness, disease.

Chapter 1

INTRODUCTION

Throughout the 1960s and 1970s the Vietnam War dominated world news, and spilled over the borders into neighbouring Cambodia and Laos. In its wake millions of refugees drifted on the high seas and fled through the jungles, seeking asylum initially in refugee camps hastily established in nearby "second" countries, and eventually being accepted by "third" countries for resettlement. Thus New Zealand has become host to some 10,000 refugees of Southeast Asian origin since the late 1970s, an unprecedented influx of peoples of Asian origin into its existing population mix of European, Maori and Pacific Island peoples (Department of Statistics, 1990).

This study documents the experiences of Cambodian families who settled in Palmerston North, New Zealand. The events leading up to and including their flight to refugee camps in Thailand are described as told by them, along with their experiences as they endeavoured to adjust to New Zealand conditions. The focus of this study is illness. The consequences for people's health of migration in general, and the refugee experience in particular are well-documented in international literature (for example see Hull, 1979; Cohon, 1981). So also are patterns of using health care, including both formal health care systems, and alternatives such as self-care, complementary and non-Western practices (for example Kinloch, 1985). These two areas of study regarding resettled Cambodians are developed in the thesis.

Refugees who resettle in other countries lose country and home, family and friends, lifestyle and livelihood. In addition they often leave behind their familiar ways of explaining and dealing with illness, which characteristically make sense in the context of the place from which they fled, and find they need to adjust to both a different belief system regarding illness and to its related system of health care delivery. This ethnographic study describes what it is like for these Cambodian settlers to be ill in New Zealand, and to seek health care in a context and cultural milieu vastly different from that with which they are familiar.

Further to reporting on these experiences and phenomena and refugees' perceptions of these, this study demonstrates that to migrate to and settle in another country demands far more than adjustment to and even conformity with alien values and ways of seeing and doing. It became apparent from discussions with participants and by interacting with other members of the Cambodian community over a period of three years that they do not exist in a single place (Palmerston North, New Zealand), nor time (the 1990s). Rather their consciousness is occupied intensely and simultaneously with multiple places and times. These geographical and temporal reference points reflect where their kith and kin now reside, or had resided until they were lost to them, and where they themselves experienced life events and crises of a severity that is scarcely credible. This, too, is characteristic of the refugee experience, which both affects health status and is mirrored in health-seeking behaviour. The global scattering of Cambodians, like other Southeast Asian peoples, is described by some scholars as diaspora (Haines, 1993). The dimensions of the Cambodian diaspora and the personal demands made on scattered Cambodians are, however, as yet poorly understood.

The intended focus of this study was illness-related phenomena. Therefore a principal criterion for the selection of the adult participants was that they had experienced multiple or prolonged episodes of illness since being in New Zealand, necessitating contact with health services. Accordingly, the study population is not typical of all Cambodian families in respect of health status, but is representative in other respects. While the size and composition of the Cambodian community is not static, at the time of embarking on the study the participating households represented about a quarter of the total community, that is sixteen out of some sixty households. The individuals and families who were involved most intimately in the study, as well as the Palmerston North Cambodian community overall, will be introduced and described at appropriate points in the body of the thesis.

Those taking part in this study have been driven far from their homeland by global political forces generated beyond the borders of their land, forces of which they had little understanding and over which they had little, if any, control. In a recent

analysis of historical events that precipitated the Cambodian refugee crisis, the question was raised whether such studies are necessary at all. Isn't the Cambodian genocide simply an aberration? (Burgler, 1990, p.5). Burgler goes on to argue that complex global forces continue to generate uncounted millions of displaced peoples and refugees worldwide, particularly in the Third World. Such forces include economic and ecological factors, inter-ethnic conflict, and super-power hegemony. That the Cambodian experience of genocide is not an isolated instance is seen in the more recent examples of the former Yugoslavia and Rwanda.

According to Stein (1981), the literature on refugees has tended to occupy a marginal position in relation to major disciplines. While certain aspects of the refugee phenomenon are studied from the perspective of such disciplines, the totality of the refugee experience is seldom studied in an integrated manner. For example, scholarship on the global systems that continue to generate refugees is likely to be located within or near the provinces of political science and history. Research on the consequences for the refugees themselves, in contrast, tends to be picked up by interested social scientists, including psychologists and sociologists.

Until recently, anthropologists have tended to neglect refugee studies, since these deviate from the long anthropological tradition of studying local communities in their natural settings. They are also put off by the apparently chaotic environment which characterises refugees' lives (Donnelly and Hopkins, 1993, p.2). The establishment in 1988 by the American Anthropological Association of the Committee on Refugee Issues, and the regular publication of papers by this Committee, are evidence that previous neglect is being addressed (Hopkins and Donnelly, 1993, p.i). Indeed, the in-depth nature of anthropological research which interprets phenomena in their social contexts, equips anthropology to explain hitherto poorly understood aspects of the refugee experience and its aftermath. As such, studies such as this have an importance far beyond the time and region in which they were conducted.

A Personal Introduction

My own interest in health and migration, and in the interaction of different illness-related beliefs and practices, developed two decades ago while I was working as a nurse in an Australian inner-city hospital used by a high number of so-called "new Australians" of southern European origin. As I observed differences in culturally-prescribed behaviour, expressions of pain for example, I became aware that the distress of patients could actually be exacerbated rather than eased when treated by practitioners who did not understand or allow for such variation. Such was the personal impact of this experience that I went on to develop a model for cross-cultural nursing, published as a short monograph (North, 1979).

However, it was while I was working for a decade in Nepal in the area of community health development that I came to appreciate just how deeply-embedded in the respective cultures are divergent systems of healing. This, in my experience, has significant implications for health care delivery, and in particular for developing Western health infrastructure in non-Western societies. I also became cognisant of the strategies developed by people as they chose among a variety of available practitioners and remedies according to the ailment and their social and economic circumstances.

Given that these observations in Nepal were with respect to the introduction of Western medicine into non-Western systems of healing, including the Ayurvedic "great tradition" and folk medicine, I was curious to explore the extent to which non-Western healing persisted among members of an Asian migrant community who had settled in a Western society. The presence in Palmerston North of a sizable Cambodian community facilitated this study: most of these refugee Cambodians had arrived in New Zealand within the past decade, and many were from rural backgrounds with little prior experience of Western medicine.

As well as my involvement in international health and health system interaction, I have had a particular interest in the matter of migrant health, that of refugees in

particular. My work in Tibetan refugee camps highlighted to me the high risk to health of the refugee experience, including changes in climate, food, and living conditions which characterise their exile. My own extended period as an expatriate, mixing with a great many other similarly-placed people, brought home to me the stresses related to uprooting, homesickness, cultural adjustment, and adapting to foreign climes that are from time to time likely to be reflected in illness. When medical treatment is sought, the very unfamiliarity with the way services are delivered may add to anxiety. When finally I returned to a much more cosmopolitan New Zealand than the one I had left, the wider consequences of global population movements presented themselves as significant yet poorly understood phenomena.

The implications of large-scale movements across geopolitical and cultural borders are far-reaching both for the well-being of the migrating people, and for the host nation's social systems including the health system. Accordingly, I chose to explore these implications in relation to a refugee community, on the assumption that as the refugee experience itself involves trauma and often deprivation, issues would be more likely to manifest themselves. I selected the Cambodian community as it was numerically significant and recently established. Further, my recent experience of living among Nepalese villagers, whose subsistence-level peasant lifestyle bore similarities to that of rural Cambodian refugees, helped me to appreciate the social and cultural backgrounds of participants.

In the process of carrying out the study, given my background, I frequently found myself empathising with those who shared their stories and experiences with me. With them I longed for the hot, humid climate of southern Asia, the range of tropical fruits and cheap, spicy food, the pattern of living outside rather than behind closed doors, and the easy sociability of village life. We grieved about the loss not only of places, things and ways of life left behind, but also for the people of that place from whom we were permanently separated. Like them, I have experienced some of the fears and frustrations of being uprooted and transplanted into a different place, and known that awful sense of realising that the new place is not as rosy as anticipated, but that the decision to settle there is not easily reversed.

In my case, though, uprooting and exile were voluntary; I was in a position to choose to go, and to choose to return. The Cambodians did not have these choices. Although in our discussions we found we had many experiences and preferences in common, in the writing of this thesis I have chosen to restrain myself, and to severely limit the intrusion of my experiences of migration into their narratives. Not to do so would risk negating the qualitatively different kind of experience that, as forced migrants, is theirs. When it comes to discussing non-Western healing and health care, however, the interconnectedness of our experiences makes it appropriate for me to enter the dialogue as a participant.

Definition of Terms

Cambodian: I am using the term "Cambodian" throughout this thesis to refer to the people of the country that became known as Cambodia during the period of French colonisation. Alternatively they are sometimes referred to in English as "Kampuchean", derived from an anglicization of the name of the country in the *khmer* language. It is a name preferred by the Khmer Rouge and now associated with that regime by the international community. "Khmers" is also used by English-speakers, but the correct usage is "*khmer* people", as they call themselves. However, "*Khmer*" specifically denotes the dominant ethnic group of Cambodia, whereas the country's population is ethnically mixed. "Cambodian" thus includes *Khmer*, Chinese, and other ethnicities that make up the population of Cambodia. Curtis (1990), Ablin and Hood (1987), and Ebihara, Mortland and Ledgerwood (1994) are among scholars who also prefer the term "Cambodian" on similar grounds. In this thesis, I reserve the term *khmer* to refer adjectivally to the language, medicine, and other aspects of the culture of Cambodians.

Refugee: The United Nations High Commission for Refugees defines a refugee as:

a person who, owing to a well founded fear of persecution for reasons of race, religion, nationality, membership of a particular social group or political opinion, is outside the country of his

nationality and unable or, owing to such fear, unwilling to avail himself of the protection of that country. (Quoted by Abbott, 1989, p.1.)

This definition does not take into account those uncounted millions who are displaced within the boundaries of their own country, nor those who abandon their country for well-founded reasons other than persecution. The twentieth century has been described as "the century of the refugee" (St Cartmail, 1983, p.3), in view of the scale of armed conflicts, human rights violations, and expanding populations, environmental deterioration, and poverty in much of the world.

Western: Western is used adjectivally to refer to the highly developed, industrialised world traditionally associated with capitalist economies. Although New Zealand's geographical location is not in the West, its economic and sociocultural characteristics place it firmly among Western nations.

Health Care System: The term "Western health care system" is used in this study to denote the biomedical system dominant in Europe and in the colonised countries of the Americas, southern Africa, Australia and New Zealand. This Western system is variously termed "modern" and "scientific", terms I reject due to their implied superiority to non-Western systems, and the implication that others are neither modern nor scientific. The term "cosmopolitan system" is also employed to indicate the supposedly universal character of Western biomedicine (eg in Leslie, 1976). For Cambodian refugees, Western medicine as practised in Cambodia, and Western medicine in New Zealand, are very different and clearly do not comprise a unitary cosmopolitan system. In the context of this thesis, as "cosmopolitan" blurs these differences, the term is not used.

Medical Pluralism: is a term used in more than one sense. In this study I am using it to refer to plurality of systems of healing in a given society, eg when Western biomedicine, Chinese medicine, and Cambodian healing are all available and used. "Medical pluralism" is also used to describe a national health care system which is characterised by a combination of state, private, and voluntary (charitable) service

providers, in contrast to a system with a monopoly provider, usually the State (eg Ellenweig, 1992, p.96f).

Clinician: the term is used to denote Western health professionals, including medical doctors, nurses and other professionals. Cambodians used the term "doctor" in a similar way to refer to Western-type health professionals in Cambodia, not differentiating among medical practitioners, nurses and auxiliaries. In New Zealand they do differentiate between doctors and nurses, but as cross-cultural issues raised in the study apply equally to all interactions between Cambodian patients and health professionals, I use the term "clinician".

Kiwi: used colloquially as an adjective, this term refers to matters of or pertaining to New Zealand. Used colloquially as a noun, it refers to the people of New Zealand and their embodiment of a lifestyle and culture (Delbridge and Orsman, 1986, p.341). It is a term favoured by the participants of this study, when referring to New Zealanders of European origin.

Significance of the Study

This study is significant for the Cambodians themselves; for professionals and organisations offering health care services to resettled Cambodian refugees; for its contribution to a better understanding of refugee health from an anthropological perspective; for its contribution to understanding rapid transition of resettled people from non-Western to Western systems of healing; and finally, because of its location within the recently emerging body of anthropological literature on refugee issues.

In their publication on Cambodian culture since 1975, editors May Ebihara, Carol Mortland and Judy Ledgerwood (1994, p.1) describe the pervasive sense among the Cambodian diaspora, as well as among Westerners, that Cambodian culture has been lost and indeed, is still being lost. The task of documenting and salvaging this rich but threatened culture takes on a measure of urgency, therefore, not only to reduce

further loss, but to address the very anxiety that Cambodian culture will cease to exist. This thesis focuses on one important element of threatened Cambodian culture, its system of healing in an era of forced and extraordinarily rapid change.

Intimately related to culture is a sense of identity, which for resettled Cambodian refugees is fragile and fluid. As this study progressed, it became clear that the emergent culture of the first generation of Cambodians settling in Palmerston North is itself threatened. The culture of refugee Cambodians is continually and incrementally being modified as they accommodate successively to the dominant cultures of international refugee camps, New Zealand society, and the global encroachment of Western culture. Due to a range of factors the transmission of Cambodian refugee culture to their children, who are growing up in and being shaped by the dominant New Zealand culture, is uneven and weak. A major contribution to knowledge about Cambodian culture is made by this study, therefore, in that it documents and analyses features of this transient culture, its very transience a mirror of the lives of these first-generation Cambodian New Zealanders.

At a more pragmatic level, the study describes and interprets illness-related beliefs and practices of Cambodians settling in New Zealand, who are unavoidably making a rapid transition from a Cambodian system of healing to the dominant biomedical system of New Zealand. International literature is agreed that, as a class, refugees are likely to experience high levels of illness (for example see Muecke, 1992). It follows, therefore, that the demand for health care of those Cambodian New Zealanders whose health is adversely affected by their refugee experience is likely to be high, a premise that was indeed borne out in the study. For this reason alone, a better understanding of the perceptions and experiences of Cambodians, now a significant ethnic minority in New Zealand, is important. The significance of such a study is, however, not limited to New Zealand, but applicable to other Western countries where Cambodians have settled.

By describing illness experiences of this important ethnic group, the study addresses the paucity of knowledge about the health of non-Maori, non-Anglo-Celtic New

Zealanders. The ethnic composition of New Zealand's population is becoming increasingly diverse, and with it the need is growing to deliver health services in such a way as to acknowledge this diversity. The Maori of New Zealand have eloquently argued that their poorer health status in comparison with non-Maori is attributable to widespread disregard of cultural issues and colonial experiences by those providing health care, rendering institutionalised health care "unsafe". This same argument is applicable to other ethnic groups making up New Zealand society on the eve of the twenty-first century. Not only is an appreciation of culturally embedded beliefs and values important for the safe delivery of health care, but the pervasive anxiety that Cambodian culture is being lost, due in part to "colonisation" by the dominant culture, can be expected to negatively affect health status.

This study is one of very few anywhere in the world to approach illness phenomena from the perspective of the Cambodians themselves, taking as its starting point the totality of refugee and resettlement experiences of participants. A basic premise of the study is that illness phenomena of Cambodian refugees can be understood and explained in the totality of such factors as cultural systems of healing, exposure to different systems of healing, experiences of deprivation, trauma and torture, bereavement, exile, and rapid social change. Furthermore, interpretations made draw heavily on the perspectives of the Cambodian narrators themselves. As such, this study departs from the bulk of studies on Cambodian refugee health, and indeed refugee health, which take a Western medical diagnosis or set of symptoms as their starting point, or alternatively explore pre-migration health beliefs and practices in isolation from the totality of the refugee experience. The majority of studies are located in one or other of the principal paradigms of Southeast Asian refugee health, reviewed in Chapter 2.

This study provides one of the few comprehensive descriptions of the continuing immediacy in the daily lives of people, of the total refugee experience, as well as the continuing effects on well-being and illness of the extended and fragmented period covered by refugee flight, asylum, and resettlement. At the same time, I endeavour to throw light on the obverse phenomenon, that these people are survivors who have

demonstrated an extraordinary capacity to endure assaults on person, society, culture and identity, and yet continue to function socially. Alongside the question, "why are they sick?" I am also asking throughout the study, "why are they not sicker?" These are questions that have also been asked in relation to European holocaust survivors (Antonovsky, 1980, pp 6ff).

Relating mental and other health problems to aspects of the refugee experience is not new. Acknowledgement of the effects of adjustment stress, bereavement, concentration camp and survivor "syndromes" and the like have been prominent in refugee studies since the Second World War. Indeed, these theories have been picked up by many providing health care to Southeast Asian refugees, and have significantly informed related research. What is new, as Stein (1981, p.330) points out, is the shift from "traditional" and culturally similar refugees, mainly from Europe, to culturally and socially dissimilar "new" refugee populations now arriving in the West for resettlement. Southeast Asian refugees in general, and Cambodians in particular, well illustrate this phenomenon. As I will show in the following chapter, although there is now a wealth of research on the health of these refugees, notably on their mental health, it is not marked by its contribution to understanding illness from the multiple cultural perspectives represented in refugee populations. Medical anthropology is thus at the forefront of research into refugee health in addressing this relatively neglected dimension. It is principally here that the present study is located, and therein lies its chief significance.

The study is also significant in offering one of the few accounts of a community of Cambodians who have been resettled in a small, quiet city characterised by a low-density, suburban pattern of residency in predominantly European neighbourhoods. This contrasts with the majority of studies, conducted in the main in the United States, where Cambodian refugees tend to accumulate into sizeable ethnic communities in large, culturally-diverse metropolitan cities, living in high-density apartment buildings (see Mortland and Ledgerwood, 1987). This thesis includes a description of a community of people who have settled in a very different kind of environment, where they make up a little community that is scarcely viable. As such,

it follows the tradition of ethnography that is carried out in respect to small "knowable communities", as Marcus and Fischer (1986, p.91) put it.

A consequence of the Cambodian tragedy is that its people, those who survived those years of genocide, are scattered throughout the world as the "Cambodian diaspora". In the 1990s, therefore, the true study of the Cambodian people and their culture is international in scope. To carry out a global study is, however, too ambitious an undertaking for a lone researcher. Even so, the findings of the study contribute to knowledge of a globally-dispersed Cambodian society in two ways. It includes a dimension on the effects on individuals of such a scattering and the resultant separation from loved ones. More important, the study contributes a further New Zealand dimension to a body of literature dominated by research conducted in North America.

Finally, the study's importance lies in its contribution to literature on medical pluralism in developed, industrialised countries such as New Zealand. Much of the research on medical pluralism carried out within the sub-discipline of medical anthropology has been located in developing countries where Western health care is a relatively recent introduction into the dominant local systems of healing (eg see Janzen, 1978; Kleinman, 1980). Less attention has been paid to the impact on and of alternative traditions used by ethnic minorities, where the Western biomedical system is established and dominant. The focus of the study is, however, not "tradition" but "transition", looking not only at continuities but modification and change of those traditions of belief and practices.

In their introduction to the second volume of *Papers on Refugee Issues* published by the American Anthropological Association, Donnelly and Hopkins (1993, p1 f) discuss the unprecedented opportunities afforded to study rapid social change. The aspect of change that I have focused on in this study is that concerning health and illness, and the resultant reconstruction of the cultural system of healing. May Ebihara et al (1994, pp 1ff) argue along similar lines, pointing out that the process of change and adaptation is extraordinarily accelerated and compressed. In

comparison with the single "snapshot in time" provided by an ethnographic study carried out in a slow-moving historical setting, the findings of this study, therefore, offer the equivalent of a "video film", with all its movement, action and change compressed into a brief period.

Structure of the Thesis

The background for the study is set out in the first four chapters. The context for acceptance and resettlement of refugees is described in Chapter 2, outlining the development and application of New Zealand policy on refugees. In particular, the roles of sponsorship and of English learning programmes are described, both of which are aimed at easing the integration of refugees into society. Principal paradigms and theories arising from and informing research on refugee health are introduced in Chapter 3, along with published research specifically about health and illness of Southeast Asian refugees resettled in the West. I go on to establish the gaps and contradictions in this body of knowledge which I set out to answer in the present ethnographic study. The approach I used in conducting the study is described in Chapter 4, along with a discussion on procedural, ethical, and political issues related to conducting cross-cultural research among members of a vulnerable ethnic minority.

The next three chapters address the dominant paradigm of refugee mental health, which is popularly related to pre-migration trauma, on the one hand, and post-migration stress, on the other. Accordingly, Chapter 5 describes the lives of the participants leading up to their becoming refugees, their experiences of forced labour, flight and asylum. Chapter 6 documents the process of adjusting to living in a small New Zealand city experiencing some pressure to rapidly integrate into mainstream society, and the evolution of a Cambodian society on its margins. As later chapters will demonstrate, the experiences described in Chapters 5 and 6, singly and cumulatively, shed light on long-term or subsequent illnesses. In the context of collecting narratives of refugee lives, the concept of "thinking too much" (the literal

translation of the *khmer* term) emerged. It soon became clear that this phenomenon embedded in Cambodian culture accompanies both the process of refugees' adjustment to the adopted country and resolving past traumatic experiences and grief. The meaning of this phenomenon is unfolded in Chapter 7.

"Thinking too much" occupies the borderlands between health and illness, leading naturally into interpretations of illness experiences, and explanations of illness given by Cambodians, set out in the following three chapters. Such explanations conform neither to traditionally-held Cambodian explanatory models, nor to those dominant in the Western health care system. Rather, Cambodian refugees engage in a process of drawing on both sets of explanatory models, and on past experiences of starvation, excessive labour, grief and a move to a foreign geophysical environment, in their search to explain illness.

Chapter 8 focuses on the complexities and uncertainties entailed in endeavouring to understand and make sense of illness experiences, in an uncertain context characterised by rapid change. Chapter 9 describes the process and experiences of learning to navigate the health care system of New Zealand, expectations of which are shaped by pre-migration experiences of both Cambodian and Western-type health care, along with the medical pluralism characterising Southeast Asia. Although outcomes of Western medicine are frequently disappointing, in Chapter 10 I show that Cambodian healing is seldom regarded as a suitable alternative. A local system of healing has developed based on Cambodian self-care techniques, and which draws on Western and available alternative therapies.

The themes that emerge in the phenomenon of illness and healing experiences are illustrated most clearly in the context of childbirth, referred to in *khmer* as "crossing the river". Chapter 11 is devoted to a discussion of childbirth experiences, both in Cambodia and in New Zealand, including the transition willingly made to the hospital style of delivery. By borrowing the *khmer* metaphor for the risks and uncertainties surrounding childbirth, "crossing the river" or "crossing the sea", and applying it in a novel way to the Cambodian diaspora who have literally "crossed the sea" to

resettle on the far side, the thesis concludes in Chapter 12 by returning to its central theme, the relationship between exile as the essence of the refugee experience, and illness. "Crossing the sea" offers a potent metaphor for the events which have overtaken this community of Cambodian refugees, and offers an alternative perspective for understanding refugee health.

Conclusion

The actual process of involvement in the study appeared to have been therapeutic for several participants. Poignant comments were made to me in the course of this research, for example: "Thank you for listening to our stories. We want you to know, and we want you to tell others what our lives are." Others expressed their gratitude to me for my interest. Such comments support the experience of others who also have commented on the "overwhelming compulsion to remember and to recount, to tell the story of their experiences" (Ebihara et al. 1994, p.21). To be entrusted with the stories of Cambodian refugees was both telling and very humbling.

However, apart from their sponsors and a small group of people teaching them English or working closely with them in some other capacity, it seems that few New Zealanders have shown much interest in the backgrounds and current experiences of these Cambodians. In cases where *kiwi* New Zealanders have expressed interest, some Cambodians intimated that they prefer not to tell their stories to people not well-known to them, and who they suspect of being merely curious. I am sensitive to this mix of sentiment among Cambodians in making this thesis available. I suspect, though, that the "merely curious" will not do more than leaf through it, while the genuinely interested will take time to read and personally respond.

I have presented the narratives as closely as possible to the form in which they were told, editing mainly to ensure readability in English, the language into which they were translated from the original spoken *khmer*. I have adopted a style of writing which integrates narratives with scholarship into a unified piece of work, rendering

the thesis accessible to Cambodian readers and other interested people, as well as the research community. While the information so willingly given me belongs to those who told it, and has been collected and presented truly, the analysis, interpretation and comment is mine, made from the perspective of an outsider.

Out of this study comes an important document for the New Zealand Cambodian community. The old people will in time pass on, and their stories are far removed from those of their children and grandchildren who grew up in refugee camps and in New Zealand. I sincerely hope that the conglomerate personal histories documented here will provide a record for their descendants. Moreover, as Cambodian culture has not at any time been a popular subject for ethnographic research, contemporary Cambodians scattered through the world have little written on their culture to draw from, informing their "sense of themselves" (Marcus and Fischer, 1986, p.36). My desire therefore is that this thesis will add to the small literature on the experiences of Cambodians during and after the Khmer Rouge regime of terror, and so contribute to the resources of the Cambodian people, now scattered throughout the globe, in giving them a greater knowledge of the nature of their cultural transition.

Chapter 2
SETTING THE CONTEXT:
Refugee Resettlement Policy

New Zealand has been described as a "nation of migrants" (Department of Statistics, 1988/9, p.193), beginning with the arrival of the Maori people in the Great Fleet some thousand years ago. This early group of migrants went on to establish themselves as the *tangata whenua* (people of the land). The size and racial mix of the population was boosted by colonisation, involving immigration mainly from Great Britain, from the early 1800s. New Zealand's tradition of accepting refugees fleeing political violence and persecution goes back to the turn of the century with the arrival of Lebanese refugees (Department of Statistics, 1990, p.190). Up until the 1970s it was mainly refugees of European origin who were accepted for resettlement, reflecting the prevailing preference for traditional sources of migrants. Since then both voluntary and forced migrants have increasingly come from the Pacific basin, and its Asian rim.

This chapter outlines the policy context underpinning refugee resettlement in New Zealand, beginning by describing the bicultural social policy based on the Treaty of Waitangi. I go on to discuss the changing racial mix of the population of New Zealand, reflecting recent shifts in patterns of immigration, including that relating to refugees. There are important implications of this increasingly multicultural population for social systems, including health, that are based on the official policy of biculturalism. The implications for the health care system of a changing population are of central interest to this study.

Refugee policy is then described in detail, along with an outline of procedures and infrastructure development to ease their resettlement. Refugee entry into New Zealand society is affected by policy on acceptance, orientation, and the centrality of sponsorship for refugee resettlement. After summarising policy and infrastructure development, and its impact on refugees according to findings of selected studies, I will go on to summarise the implicit expectations. These are then discussed in the

light of theory on acculturation and the relationship to health status. To conclude the chapter, an overview of the establishment in New Zealand of communities of Cambodian refugees is described, commenting briefly on related research and scholarship.

New Zealand's Bicultural Social Policy

The Treaty of Waitangi, signed in 1840 by representatives of Great Britain's Queen Victoria, and participating Maori *iwi* (tribes), provides the basis for partnership between Maori people and the Crown in the affairs and resources of Aotearoa New Zealand. Although the Treaty is not included in New Zealand's constitutional law, its principles are being incorporated into certain social legislation. The Royal Commission on Social Policy (1988, p.14f) recommended that *all* social and economic policy be based on the Treaty.

Maori people have all along accorded the Treaty a special status, above the level of legal agreements. It provides the basis for achieving partnership, protection, and participation in the affairs of the country. As the *tangata whenua*, Maori regard themselves as host to all other peoples in New Zealand, thus occupying a unique position in society, a position accepted in the spirit of the Treaty. Although the Treaty historically reflects partnership between Maori people and New Zealanders of British descent as the two major groups making up New Zealand's population, it provides the basis for the presence of all settlers irrespective of origin (Royal Commission on Social Policy, 1988, p.14ff).

Within the framework of the bicultural policy derived from the Treaty of Waitangi, a foundation principle of New Zealand society is that of equality of the races. Yet the Royal Commission on Social Policy (1988) was emphatic that this principle is far from being a reality, with intolerance and discrimination evident in immigration policies, practices of treating and supporting immigrants and refugees, and in employment and social structures. For equality to be a reality, existing personal and

institutional racism need to be eradicated. Racial equality also involves a fair sharing of national resources, and maintenance of the cultural identities of ethnic minorities. In view of a recent revision of immigration policies that go some way in reducing the traditional bias favouring immigrants of European origin, improvement in racial tolerance and equality in society is the more urgent (Royal Commission on Social Policy, 1988, p.53).

The Cambodian refugees who are the subject of the present study are settling into a bicultural New Zealand which officially espouses a principle of racial equality. The extent to which this is true for them, particularly as it affects their perceived freedom to maintain and transmit their Cambodian identity, along with their experiences of personal racism, and institutional racism in the domain of health care, are issues that emerge in this study.

Migration Trends, and a Multicultural Population

Newcomers to New Zealand are accepted under a variety of provisions governing immigration, broadly classified as occupational, family reunification, humanitarian and other (Trlin, 1992, p.4-8). Refugees are accepted primarily on humanitarian grounds, and also under family reunification provisions. Thus over little more than a decade some 10,000 Southeast Asian refugees were granted entry, adding to New Zealand's population of a little over three millions.

A special article on immigration policy in the New Zealand Official Yearbook (1988-89) described the way migration has provided the base for both the population and economy of New Zealand. A major review of policy that had become chaotic and unwieldy was carried out in 1986 and resulted in the passing of the Immigration Act 1987. This provides for the selection of immigrants primarily on the basis of personal merit rather than ethnicity or nationality, a significant departure from the previously biased policy favouring immigration from traditional European sources. Included here is the principle of "business immigration" aimed at revitalising the country's flagging

economy, which has paved the way for an inflow of Asian entrepreneurs. Policies of "social" immigration, allowing for family reunification, and "humanitarian" immigration by which the quota of refugees are accepted for resettlement, were maintained. In view of the fact that some half million New Zealanders were born overseas, the family reunification policy has the potential to further alter the ethnic balance of New Zealand's population.

The net result for the character of the nation's population has been a fall in the proportion of citizens of European ethnic origin, and marked growth of those of Pacific Island and Asian origin, the latter largely within the space of a few years (Department of Statistics 1990, p.181-182, 1986 census data). In his analysis of immigration policy prior to the 1986 review, Trlin (1986) points out that discrimination against immigrants of Asian and Southern and Eastern European origin persisted despite the disappearance of explicit assimilation policies that until the 1970s restricted their entry. The major new objective to emerge in revision of immigration policy is, in Trlin's view, "enrichment of the nation's multicultural fabric", a shift that has far-reaching implications for the cultural identity of New Zealand as well as for its ethnic groupings (Trlin, 1992, p.23). Trlin points out that immigration policy cannot be separated from economic policy, a premise supported by the interest taken in ongoing reviews of immigration policy by, for example, the "Top Tier Group" of associations of producers and employers (Immigration Symposium, 1989) and policy analysts Poot, Nana, and Philpott (1988).

New Zealand's former immigration policy that favoured immigrants racially similar to New Zealand citizens, went hand in hand with pressure to assimilate, a pressure that remains strongly entrenched in public opinion, even though officially discarded (Trlin, 1992, p.19). Thus strangers are welcome so long as they "fit in, don't criticise, are grateful, undemanding, and become like us as soon as possible" (Abbott, 1989, p.4f). Leaving aside the fundamental question of why refugees and other migrants should abandon their customary beliefs and practices and embrace those institutionalised in New Zealand, it remains a huge challenge and strain to "fit in" and learn the new ways, the more so when familiar ways of seeing and interpreting

the world are so different from those of the majority of New Zealanders.

This movement toward a multicultural society, at least in terms of population composition, raises questions about social services and institutions that have their roots in those of Britain, and which are being modified in response to challenges posed by biculturalism. Are these designed and delivered in such ways as to also meet the diversity of needs and preferences represented in a multicultural population? There is little evidence that this is the case, this study showing that even fundamental requirements such as language interpretation are largely reliant on voluntary assistance from family and community members. To effectively reorient institutions requires policies grounded in a knowledge base developed through empirical research, such as the present study.

The Development of Refugee Resettlement Policy

Although one-off arrangements had allowed for the acceptance of small groups of refugees since the turn of the century, New Zealand's formal participation with the international community in the resettlement of refugees began with the arrival in 1944 of a ship load of 733 Polish children together with 105 adults. Since then, New Zealand has accepted thousands of "displaced persons", at first principally from Europe, working in co-operation with the International Refugee Organisation, and then with its successor, the United Nations High Commission for Refugees.

Over a span of fifty years, New Zealand has accepted about 20,000 refugees from various trouble spots of the world, representing a variety of languages, cultural backgrounds, faiths, and levels of education and skill. Peaks of refugee arrivals and places of origin have coincided with political disruptions and violence, such as the acceptance of about 1000 Hungarians in 1956. There have been quotas of several hundred each of Ugandan Asians, Chileans, Russian Jews, Poles, other East Europeans, Assyrian Christians, Iranian Baha'i, and smaller numbers of Chinese from Asia. In addition, some 210 families have been accepted from Europe under the

special programme for the disabled, to provide for the entry of families when the handicap of a member put them outside the acceptance criteria of other countries (New Zealand Immigration Service, 1992, pp.1ff).

By far the most impressive wave of refugee resettlement, however, followed the war in Vietnam, in the wake of which between 1977 and 1992 New Zealand accepted over 10,000 Southeast Asian refugees, (described by the Immigration Service as Indo-Chinese refugees). A total of 7,546 were resettled between 1977 and 1987 under a series of agreements, with priority given to those with close family already settled. The rate of acceptance peaked in 1980, when 1,801 arrived. Even after the introduction of the global quota practice, explained below, Indo-Chinese refugees continued to contribute the largest numbers from 1987-1991 (New Zealand Immigration Service, 1992, p.6f). Of the Southeast Asian refugees almost 4,000 arrived over the three year period 1979-1982, putting an enormous strain on the country's capacity to resettle them. The largest group were Cambodian (5,071), then Vietnamese (4,221) and Laotian (1,113) (information supplied by Refugee and Migrant Service). With the closure of Thai border camps and the repatriation of remaining refugees, since 1992 refugees from new conflicts such as those in Somalia and the former Yugoslavia have taken their place (Auckland Refugee Council Inc., 1994, p.2).

Prior to 1987 New Zealand's policy was a piecemeal acceptance of individual quotas, such as the Assyrian Christians, or the Ugandan Asians, and indeed the majority of Southeast Asian refugees were admitted under a series of specific quota agreements. Currently, in order to enhance flexibility, a global quota policy applies, with an annual intake of up to 800 refugees accepted. By this programme the United Nations High Commission for Refugees normally approaches the New Zealand government for consideration, and the families are selected by officials of this country, taking account of prior links with New Zealand and expected ability to adapt to New Zealand living and working conditions. This intake includes "handicapped" refugees, with some 200 "handicapped" Southeast Asian refugees having been accepted between 1987-1991 (New Zealand Immigration Service, 1992, pp.5,9). Acceptance

of refugees under family reunification policy may be included in this annual quota.

New Zealand is normally categorised as a "third country" for purposes of resettlement. This constitutes one of the three durable solutions of the "refugee problem", namely voluntary repatriation to country of origin, permanent settlement and integration into the country of first asylum to which the refugee fled, and thirdly, resettlement in a third country (Stein, 1986, p.268; Adelman, 1988, p.7). Increasingly, New Zealand is also a country of first asylum, with the hope of acceptance for permanent settlement by some applicants. These "on-shore applicants for refugee status", or asylum seekers, may arrive with valid documentation and subsequently apply for asylum, such as Indians fleeing the *coup* in Fiji, or request refugee status on arrival in New Zealand as in the case of ship-jumpers (Cotton, 1993, p.8 ff). Statistics released by the New Zealand Immigration Service, presented in the Refugee and Migrant Service Annual Report 1991, demonstrate a dramatic rise in such applications, from about 350 in 1989 to almost 1200 in 1991. Asylum seekers accepted for permanent settlement are included in the quota, thereby potentially displacing long-term refugees awaiting resettlement.

As Adelman (1988, p.9) argues, asylum seeking in distant countries represents a self-selection for refugee status, in contrast with the bureaucratic selection characteristic of the refugee quota system. As such it is regarded as unfair that asylum-seekers should disadvantage the relatively powerless refugee camp populations, made up predominantly of women, children and the infirm. Perhaps it is for this reason that such self-selected refugees seeking recognition and resettlement are subjected to the most stringent processing, to ensure *bona fide* status as well as to discourage hopeful migrants without good cause for claiming refugee status. Asylum-related interviews and hearings can be fraught with cultural and language misunderstandings, fuelling concern about human rights and justice (Kalin, 1986).

Although policy concerning refugee acceptance has been simplified and streamlined, there nevertheless remain some anomalies and a resultant unevenness in assistance provided for resettlement. For example, people may seek to immigrate because of

well-founded fear of persecution if they remain within their country. However, if such people are not outside their country of origin at the time of acceptance as immigrants, technically they are not classed as "refugees". Such migrants do not automatically receive the same degree of support and assistance as those accepted under the refugee quota. On the other hand, Cambodians were accepted in New Zealand under the quota system although, as Cotton (1993, p.4 f) points out, they were technically never regarded as refugees by the Thai government nor the United Nations High Commission for Refugees, but rather as "displaced persons" or "illegal immigrants". Nevertheless, their acceptance into New Zealand under the refugee quota entitled them to full support for resettlement. In addition, Southeast Asians have been accepted under the General Migration Programme through the provisions of Family Reunion or the Humanitarian sections of the policy. They, too, are not automatic recipients of special support, even though their requirements for support and resettlement assistance are no less than those accepted under the refugee quota.

As Galliène (1991, p.8) notes, although New Zealand's acceptance of refugees in terms of numerical quotas is meagre, the level of acceptance per capita has been among the highest in the world. It currently ranks ninth, according to the Immigration and Refugee Services of America, (1994, p.44) although ranked higher at the peak of acceptance of Southeast Asian refugees. Furthermore, the level of response to the so-called "hard core" refugees not accepted by other nations (that is, those whose refugee situation has remained unresolved for unduly long periods), and levels of acceptance of disabled refugees and at-risk women, have been remarkable. Even so, it has not been altogether altruistic, and, until recently, reflected the earlier policy of assimilation. While the refugee resettlement quota reflects New Zealand's humanitarian obligations, the acceptance of particular ethnicities and numbers continues to be guided by such principles as affinity with New Zealand's predominantly Anglo-Celtic and Polynesian racial mix and social fabric, along with the availability of resources to facilitate resettlement (Trlin, 1992, p.2 f).

New Zealand's policy of accepting refugees needs to be seen in the light of the extent of displacement worldwide. At the beginning of the decade, there were an

estimated 17 million refugees living temporarily in countries of first asylum, double the figure of five years earlier (Muecke, 1992, p.515), and an additional estimated 40 million displaced within their own countries (Refugee and Migrant Service, 1991, p.3). That the brunt of refugee flight is consistently borne by low-income countries, with some 90 per cent of the world's refugees arriving *en masse* in neighbouring developing countries, is unsettling (Stein, 1986). As of December 1993, there were 16.25m refugees and asylum seekers needing protection and assistance, the majority in Africa and the Middle East (Immigration and Refugee Services of America, 1994, pp 40f). This takes into account neither the millions of internally displaced persons nor the permanently resettled. Further, owing to the variable use of the terms "refugee", "asylum seeker", "displaced person" and "illegal immigrant" it is at best a partial picture.

At the same time, the sheer magnitude of the "refugee problem", both in terms of the continued generation of displaced persons, as well as the work of resettlement in "third countries", is paradoxically having the effect of discouraging compassionate and generous responses on the part of the more stable and wealthy nations. Stein (1986, p.278) comments that the hardening of attitudes toward accepting asylum-seekers and refugees for resettlement is euphemistically referred to as "compassion fatigue". It is also evident in discourse on asylum-seeking, which impinges strongly on redefining what in fact constitutes refugee status. No doubt this also reflects the immediacy of the "problem" of the asylum-seeker which contrasts to the distant "problem" of displaced persons encamped in far-off developing countries.

During the first four years after the annual quota was set at 800, annual acceptance ranged from 775-993, acceptance which was conditional on sponsorship being available (New Zealand Immigration Service, 1992, p.8). Sponsorship, which is explained fully in the following section, entails charitable organisations or individuals, who comprehensively prepare for a refugee family and provide support during their adjustment to New Zealand society. The Auckland Refugee Council Inc. notes in its 1994 Annual Report (p.1) that the quota was filled in 1994 for the first time in three years. Refugees joining family already resident in New Zealand are,

however, included in this quota, as are asylum seekers who successfully claim refugee status (Auckland Refugee Council Inc., 1994, p.2). A combination of factors thus accounts for failure to fill the quota, including availability of sponsorship, the ability of refugees to finance their fares, and legal or bureaucratic determination of refugee status and relationship of applicants to previously-settled family. In view of the global increase in refugees, New Zealand's failure to fill even a modest quota is shameful, and certainly incomprehensible to the refugees resettled here who are aware of the thousands of families identified as requiring resettlement.

Roles of Government and Voluntary Sectors in Resettling Refugees

Refugee resettlement has implications for New Zealand society as well as for the refugees themselves. With the flow of even small numbers of refugees into New Zealand likely to continue, it is imperative that the processes of resettlement be better understood and problems addressed, so that potentially negative effects on both refugees and New Zealand society can be minimised. While possible negative effects, such as the strain on infrastructure, are quickly cited by opponents of a more generous policy, New Zealand society has also benefitted. For a nation geographically distant from the rest of the world, with a slow growing population that has only recently topped the three and one half million mark, the refugee resettlement programme has provided a steady source of socio-cultural enrichment, adding to that supplied from voluntary migration. The acceptance of more than four and a half thousand Displaced Persons from Europe in the wake of the Second World War enhanced the pockets of cultural variety introduced by earlier groups of refugees and immigrants. Such enrichment is valued, with resettlement patterns favouring dispersal nationwide to maximise the benefit of diversity.

Procedures New Zealand has in place for assisting refugees have been cited by the United Nations High Commission on Refugees as among the world's most humanitarian (Minister of Immigration, to Immigration Symposium, 1989). Both government and voluntary sectors play critical roles in the resettlement of refugees.

In his major review of refugee resettlement in New Zealand, Cotton (1993, p.18) identifies four elements for successful settlement. These are: commitment and support from the Government; acceptance and support from the public; adaptation on the part of the refugee; and (beyond New Zealand's control) global-level geo-political and socio-economic change. The New Zealand Immigration Service (1992, p.10) regards the element of community support and assistance as vital to successful settlement, a policy which largely accounts for notably humane resettlement experiences, but is at the same time criticised because of the shifting of responsibility and cost onto the voluntary sector.

The importance of the interplay between government and voluntary sectors is evident in New Zealand's response to a request by the United Nations High Commission for Refugees to accept a special quota of 1,000 long-term Indo-Chinese refugees, as an outcome of an International Conference on Indo-Chinese Refugees held in 1989. This was agreed to, subject to sponsorship being found and that it was not over and above the annual quota of 800 refugees. In the event this special quota was not filled, as in the meantime the Minister for Immigration discontinued the "special assistance" provided to Indo-Chinese refugees by way of paying their airfares to New Zealand, (a provision not made to any other refugee group). As of July 1991 all refugees accepted under the quota system are required to meet the cost of getting to New Zealand, a pay-as-you-go policy which eliminates those not able to do so.

Involvement of both sectors is seen, too, in health service provision. Refugees as New Zealand residents are entitled to the full range of health services and benefits from the time of their arrival in New Zealand, fortunate indeed for those few who need specialist and hospital care soon after arrival. Initial medical clearance carried out at the Immigration Reception Centre (see below) is a Government service. However, the Government has shown little willingness to establish a national refugee health service providing for needs for long term, specialised trauma and mental health care (Solomon, 1993). Voluntary organisations have established services, all Auckland-based, to meet specific obvious needs. Principally, these are Frederick House, set up by the Refugee and Migrant Service for the reception of asylum-

seekers, and Auckland Refugee Health Centre at which health professionals work on a largely voluntary basis. Finally in 1995 a specialist health service for refugees was established in Auckland, namely the RAS (Refugees as Survivors) Centre. Primarily a mental health service, it is administered by the Mental Health Foundation, housed by the Red Cross and funded by the Regional Health Authority (Auckland Refugee Council Inc., 1994, p6, and Newsletter May 1995).

Successful resettlement has entailed considerable investment from the government and public of New Zealand, with facilities and programmes having been set up to ease refugee adjustment. The backbone of the process, however, has been voluntary sponsorship, a scheme whereby arriving refugees are provided with the basic necessities and personally introduced to the New Zealand way of life. The Refugee and Migrant Service (formerly the Inter-Church Commission on Immigration and Refugee Resettlement) plays a crucial role in the resettlement process, particularly in arranging sponsorship. Since its inception in 1976 this service has, as New Zealand's national refugee resettlement agency, assisted with the resettlement of about 95 per cent of arrivals. Sponsors come chiefly but not exclusively from churches, although membership of the Refugee and Migrant Commission itself is broad-based. The organisation represents the major Christian denominations, Jewish, Buddhist and Baha'i associations, a range of ethnic associations, and humanitarian organisations such as Red Cross and Amnesty International (Refugee and Migrant Service Annual Report 1991, p.20).

Refugees are normally settled in the locations where sponsorship can be found, and where these sponsors live. At the same time, however, refugees are free to settle wherever they wish in New Zealand. Some decline to take up the sponsorship that has been arranged for them, preferring instead to settle in the place of first arrival, usually Auckland. During the years 1989-1991 the vast majority of refugees settled in the Auckland area, between some 400-600 per year, provoking the comment that "oversaturation in the Auckland area has stretched available sponsors and resources to breaking point" (Cotton, 1992, p.15). The remainder were dispersed in Wellington (approximately 170-450 per year), Christchurch (about 60-150 per year), Hamilton

(about 50-100 per year), Dunedin (some 40-60 per year), Palmerston North (some 40-50 per year), and "other" locations (40-60 per year) (Refugee and Migrant Service Annual Report 1991, p.6).

The Role of Sponsorship

So prominent is sponsorship for acceptance and successful settlement of refugees that it warrants detailed consideration. As noted above, acceptance of refugees is conditional on availability of sponsors. Its importance is reflected by Hafeez (1988), who devoted a major part of his thesis on Southeast Asian refugee resettlement to the experiences and perspectives of sponsors. Hawley (1986, p.64) describes sponsorship as a "grass-roots people-to people interaction" and as such, an important tool in achieving integration into society (as well as a tool to enable Government to avoid its long-term responsibilities).

Although entirely voluntary, sponsorship is a major commitment. It involves setting up a furnished and equipped home in readiness for the arrival of the refugee family, finding employment, enrolling children in schools and families with doctors, assisting with obtaining social welfare benefits and English language tuition, and above all being available as friend and support for as long as is necessary (New Zealand Immigration Service, 1992, p.10; Galliene, 1991, p.187). An updated "*Manual for Refugee Sponsorship*" produced by the Refugee and Migrant Service (Crosland, 1991, p.5) offers very specific guidelines for the "work of the refugee sponsor", involving three essential responsibilities. These are firstly, enabling settlement and the establishment of economic self-responsibility; secondly, providing friendship; and thirdly, being an advocate, ensuring just and decent treatment. From my own observations, sponsorship as "work", albeit unpaid, is an accurate reflection of what is entailed. Not only is considerable work entailed in preparing for the arrival of the sponsored refugee family, but sponsors remain at call to advise and assist with all manner of needs including finding their way through bureaucracies and institutions, often for two or more years.

One couple known to me who have sponsored several families are still called on to advise or assist in new developments long after the family has apparently established itself, such as job-hunting for a young person who has, several years down the track, completed school, or to advise on the most recent changes in Social Welfare that affects their benefits. Sponsorship therefore represents a very significant investment of time, people, and finance, as well as of personal life. It cannot be confined to a set time on a daily or weekly basis, but involves sponsors being both available and accessible as and when required. At first, the sponsor may be the only *kiwi* friend the refugee family has, and as such the relationship can be a highly dependent and intimate one. Many sponsorship relationships blossom into genuine and lasting friendships. Some friendships may even end in marriage.

To have a good and caring sponsor can even be a source of status within the refugee community, as well as being instrumentally useful. For example, it became apparent that sponsors who are diligent and effective are highly sought after by Cambodian families to take on new families. These are usually new arrivals but may include established families whose sponsorship relationship has not been positive, or who wish to augment the support already provided. In my own experience while conducting the study, even though I personally had not sponsored refugees, two families whose designated sponsors had little contact with them began to regard me as a potential surrogate sponsor, looking to me for advice, advocacy and friendship, while others regarded me as a useful adjunct with expertise in health.

While sponsorship provides a bridge easing the entry of refugees into New Zealand society in a very human, warm manner, with mutually-enriching relationships being established, success is by no means assured. A major source for potential disappointments, it seems, is the conflict between what the refugee family can expect from the sponsors, and what sponsors can expect of "their" family. Refugee families may expect far more of their sponsors in terms of material goods than sponsors are prepared for, or may go on expecting a high level of support beyond the period in which a family may reasonably be expected to become independent.

After the first wave of Cambodian refugees had been settled and these families assumed the role of primary sponsor, misconceptions as to the role of back-up sponsors, usually *kiwis*, were even more likely. While the back-up sponsors may view their role as mainly enabling, with primary sponsors being responsible for friendship and an introduction to New Zealand life, the refugee family and their primary sponsors may nonetheless expect full material and affective support, and be saddened and rejected when they don't experience it. The *Manual for Refugee Sponsorship* (Crosland, 1991) is silent on the role of back-up sponsorship, reflecting the rapidity of change in patterns of sponsorship, an omission to be remedied with the next revision (personal information, Refugee and Migrant Service). Added to this, with refugees now having to pay their own way, their kin who have previously settled and assumed the role of primary sponsor, have often gone into debt to finance airfares. This situation and pressure to repay the debt can give rise to tensions between the sponsoring family and the newly arrived refugee family, with the result that the affective support the back-up sponsor assumed would be offered by the primary sponsor may in fact be undermined.

On the other hand, *kiwi* sponsors have made substantial and at times sacrificial investments in sponsoring families, with some groups even setting up loan schemes to assist refugee families to establish themselves. Understandably they have expectations, not necessarily expressed or even acknowledged, that the refugee families will demonstrate their appreciation, such as by being grateful, or by settling in smoothly and becoming good citizens of New Zealand. Perhaps the closest sponsors come to articulating their implicit expectations is disappointment when refugee families leave the area and migrate to a preferred location elsewhere in New Zealand or even Australia, "after all that we have done", as one sponsor expressed it. While such reactions are understandable, the departures can also be interpreted as success; for example, evidence that the family is sufficiently secure in their adopted country to leave the care of their sponsors.

Infrastructure to Facilitate Resettlement

Arriving refugees spend their first six weeks in the Immigration Reception Centre at Mangere, undergoing a structured orientation programme. Full accommodation is provided in this former barracks in a suburb of Auckland, which includes a nursery, recreational facilities, a clothing store to supply an initial set of warm clothing, classrooms for English lessons, and a clinic for medical examinations (New Zealand Immigration Service, 1992, p.10 f). They are introduced to aspects of life such as shopping, money, using public transport, using electricity and gas, dealing with government offices and completing forms, using health services and all the multitude of matters that affect life in New Zealand but which may be quite unfamiliar to those just arrived.

The involvement of several government departments in this limited orientation period has over the years generated tensions. For example, the Department of Education has found the short time left to them after the week-long medical examination process insufficient (Galliene, 1991, p.185 f). This gave rise to moves to extend the orientation period. In addition, the premature departure of some refugees without being cleared medically has prompted the Department of Health to seek compulsory detention of refugees. Pressures to compulsorily detain refugees and extend the period of time were rejected, out of a concern not to repeat or extend the refugee camp experience which they had just escaped. Nonetheless, the importance of protecting the public health remains.

The Immigration Reception Centre has had its critics, not least from among the refugees themselves. St. Cartmail (1983, p.266) describes the first part of the resettlement process of medical clearance as being put "in quarantine". As far as refugees participating in this study are concerned, however, the practice in New Zealand of medically screening refugees after arrival compares favourably with countries practising screening prior to their departing the country of asylum.

Gubbay and Cogill (1988, p.39 ff) are particularly critical of the lack of

appropriateness and integration of this six week period of preparation, and its failure to focus on clear outcomes. Further, the timing of English and orientation instruction doesn't necessarily fit with the newly arrived refugee's priorities, which often include arriving at their final destination as soon as possible and in particular, being reunited with their relatives. While many of the orientation talks and visits are helpful to people who will settle in Mangere, or even Auckland, they need to be repeated for those whose destination is elsewhere. For these and other reasons, Cotton (1993, p.14) argues that centralised orientation should be replaced with a regional orientation practice.

A criticism raised by many refugees in the present study concerned food; they didn't like it, and claimed it made them feel sick. Yet for reasons of health and administration, the refugees are not permitted to cook their own food. According to Gallienne (1991, p.191) attempts to address the issue of unsuitability of New Zealand fare for Southeast Asian refugees have gone back to the early 1980s, when its unpalatability and indigestibility were acknowledged. It is therefore disturbing to find that years after the problem was recognised and supposedly addressed, the first impressions of newly arriving refugees are marked by unpalatable food. Furthermore, for some herein lies the seeds of negative attitudes toward the *tangata whenua*. As Polynesian people staffed the canteen, collectively defined as Maori by my informants, they regard the fatty starchy food served there as "Maori food".

The Centre has also attracted considerable criticism for its failure to give a good grounding in English. This is hardly the fault of the Centre, but a fair comment on the infrastructure available nationwide for teaching Asian refugees English as a Second Language (ESL). Unlike previous groups of refugees, many of this new wave were from rural villages who had not been exposed to English in school or marketplace. For some, particularly men and younger people, their first opportunity to learn English was in the refugee camps (see Gallienne, 1991, p.161). For most it was the "survival course" in English offered at the Immigration Reception Centre that provided the first real exposure to English learning. On arrival at their resettlement destinations this was generally followed up with language and orientation classes at

the local polytechnic together with home tutoring. As Henderson (1987, p.185) points out, successful English language learning is related to and often dependent on such factors as prior educational attainment, age, pre-migration occupation and employment, factors not always taken into account in developing ESL programmes.

Gubbay and Cogill (1988, p.27 ff) comment that most government funding for the educational aspect of immigrant and refugee resettlement is channelled through polytechnics, but that frequently these ESL sections are peripheral to the main purpose of the polytechnics and accountability is weak. The result is that courses can be unfocused, not adequately matched to the needs of different minority groups nor different levels of fluency of English, and may be detached from the overall picture of resettlement needs. Gubbay and Cogill (1988) go on to reinforce the accepted assumption that language acquisition is the single greatest need for refugees, and moreover the key to knowledge about the institutions and social mores of the host country. However, reflected throughout their report is the need for language learning to be integrated with other resettlement issues and orientated toward outcomes related to adjustments to the host country, rather than being an end in itself.

Henderson (1988, p.249) focuses her criticisms on the lack of a clear language policy, which she describes as "a plethora of *ad hoc*, stop gap language provisions", with success reflecting local and voluntary enthusiasm rather than government design. Gubbay and Cogill (1988) are, however, critical of the largely voluntary home tutor service, particularly the unskilled aspect of the scheme. As with sponsorship, so also in the area of language acquisition, explicit government policy and an associated shoe string level of funding has shifted much of the responsibility and cost onto the voluntary sector. The validity of the above criticisms is supported by the findings of the few studies that have investigated English acquisition by Southeast Asian refugees. In his Dunedin study, Andrew (1985, p.31 f) found that between 80 and 87 per cent of Southeast Asian refugees had minimal or no comprehension in English, similar to Henderson's (1989, p.214) figure of 76 per cent with minimal or no English. Not surprisingly, language difficulty was found to be a leading cause of distress among refugees in the survey by Hafeez (1988, p.183).

These disappointing findings are attributable not only to the ESL programmes themselves, but also to the prior inexperience of a significant number of refugees with both the English language and formal learning processes. Crosland (1991, p.7) further points out that domestic and child care responsibilities, together with the formality of classes, make the polytechnic courses inaccessible and inappropriate for many women. Added to these obstacles that affect women in particular, the straightforward issue of travelling to the venue for ESL classes, especially in large cities, can deter men and women alike, especially if public transport is infrequent or indirect. Recognising the nature of the situation affecting many women, a small community-based class was initiated in Wellington by the home tutor scheme. Led by a Cambodian woman using a less-threatening bilingual approach, the scheme overcame some structural problems of polytechnic learning delivery, and subsequently became a model for Cambodian communities elsewhere in New Zealand (Crosland, 1991, p.7).

The social ramifications of little or no English acquisition are both negative and far-reaching. Crosland (1991, p.10) found evidence of loneliness and isolation among Cambodian women whose inability to speak English barred them from developing friendships outside the Cambodian community and becoming involved in the wider community. In these situations, the family's sponsor may be their sole contact with New Zealand society. Lack of confidence in using English and lack of opportunity to build confidence is thus mutually interactive and reinforcing. A common result, especially in households where the children have acquired English rapidly, is that parents become dependent on their children to translate (Henderson, 1987, p.203). While this has the advantage of maintaining a facility in the mother-tongue among the children, the temptation for adults to avoid using English is an obvious drawback. A more profound outcome is the undermining of traditional intergenerational relationships characterised by children's dependence on and respect toward parents.

English acquisition in New Zealand is widely viewed instrumentally, as a means to get jobs and benefits. An alternative view put forward by Gubbay and Cogill (1988, p.13 f) is that the importance of English lies in it being a community language, the

mother tongue for a majority of New Zealanders, and it is the common language by which all members of linguistic communities can converse with one another. Furthermore, it is both the official language of the nation and an international language. Taken together, these points are powerful reasons to learn the language. Such is the pressure, both intrinsic and external, to learn English that difficulties in doing so can become a focus on which their adjustment difficulties in general are projected. As Boman and Edwards (1984, p.45) put it, some believe that all their problems will be over once English is mastered.

The reality for many is that motivated though they are, they can't retain the words. Difficulties that refugees experience in concentrating and in absorbing material have been attributed to the after-effects of the severe and sustained trauma they have experienced (Crosland, 1991). Crosland reports that these difficulties have been documented both at refugee camps and in New Zealand, and were also described by participants in the present study (see Chapter 6). My informants identified current worries, stress and illness, not past trauma, as interfering with concentration and retention. Difficulties with concentration compounding the inappropriate and often poorly delivered ESL service result in low levels of English acquisition, which in turn exacerbate social isolation and distress.

Particular difficulties are experienced by older people in learning something new, and Cotton (1993, p.21) suggests that the chances of older adults making the linguistic and cultural shifts necessary for participation in mainstream society are remote indeed. The Refugee and Migrant Service advances the concept of older refugees being "human bridges" for the next generation, members of which often go on to become assets to New Zealand society as highly talented multilingual New Zealand citizens. This view does suggest that a shift in attitude is required, from one of putting pressure on all refugees to become good English-speaking New Zealanders, with inability to acquire English regarded as a blameworthy "failure", to one of facilitating the settlement and comfort of linguistic (and ethnic) minorities within mainstream society.

Policy on Employment and Welfare

The Government's desire is that refugees become self-supporting through employment or business, and not a burden on state welfare provisions. At the same time, those accepted under the refugee quota are granted immediate residency, and as such have full and immediate entitlement to welfare benefits when needed, as well as social services. To this end, one of the principal responsibilities of sponsors is to assist employable refugees in finding jobs. The *Manual for Refugee Sponsorship* (Crosland, 1991, p.5), addressing this responsibility, itemises the duties as job counselling, placement in jobs, advising on availability and application procedures for training programmes and, of course, assisting with enrolment in ESL programmes or other language learning approaches, insofar as ability to speak English improves employability.

There are, though, a number of reasons why some refugees are unable to find suitable employment. Henderson (1987, p.225) notes that in the case of Cambodians, skills acquired in Cambodia and Thailand, such as rice farming, vending and lay social work, have limited marketability in New Zealand. This is a different problem to that of downward mobility, reported especially among educated, urban Vietnamese (Boman and Edwards, 1984, p.47). In spite of the disadvantages identified, in his Dunedin study, Andrew (1986, p.34) found that, overall, Cambodians, particularly ethnic Chinese, were successful in finding jobs.

Added to this, the inflow of Southeast Asian refugees throughout the 1980s coincided with a major economic downturn. Concern that refugees might displace New Zealanders in the labour force became pervasive, the more so when refugees were recognised and sought after as good reliable workers (Gallienne, 1991, p.190). Hawley (1986, p.67) points out that in 1984 the unemployment rate of refugees was half the national average. The government's desire that refugees be self-sufficient, and the refugees' determination to establish themselves, over-rode worries about taking *Kiwis'* jobs. Refugees' success in retaining jobs, establishing their independence and advancing socio-economically has been held up to welfare-

dependent New Zealanders as an example to emulate (Gallienne, 1991, p.190). The very fact that refugees were subject to the mixed messages to both be self-reliant and not encroach into the labour market, and at the same time achieved high rates of employment, is testimony to their determination and resilience.

When refugees are unable to secure work, whether through nonavailability, or because of a lack of skills or ill-health, subsistence on social welfare benefits is their main option. Families become well-versed as to their welfare entitlements, and demonstrate a determination and astuteness in securing these. This is not surprising given the responsibility of sponsors to inform and assist refugee families to register for benefits to which they are entitled, and to act as advocates to ensure social justice (Crosland, 1991, p.6). It can also be viewed as a progression of skills learned over long years of dependence; "working the system" is, in this respect, simply a continuation of the survival skills that brought them to the camps in the first place, and then on to New Zealand. Sadly, these skills can also work against them by alienating sponsors and others in the community.

Expectations of Refugees and Acculturation

Although New Zealand has officially discarded the assimilationist policy for immigrant resettlement, prevailing requirements for community sponsorship of refugees tend to militate against the current multicultural policy. Not only are refugees thus scattered according to availability of sponsors, but the *kiwis* among whom they live are likely to affirm refugees who progress toward adopting the new culture, with its English language, patterns of behaviour and values. Programmes designed to ease their entry into New Zealand society, including the initial orientation, ESL courses and sponsorship arguably reinforce an assimilationist position that is inconsistent with both immigration policy explicitly favouring pluralism, and New Zealand's bicultural social policy.

In the view of Cotton (1993, p.21), the measure of successful resettlement is the

adaptation of refugees to New Zealand, while at the same time maintaining "positive elements" (which are not defined) of their own culture. In a nation with an official policy of Maori and non-Maori biculturalism, it is perhaps ironic that it is principally the English language and European-derived economic systems and institutions to which refugees are expected to adapt. While Cotton recommends that the initial orientation of refugees includes information on biculturalism and the Treaty of Waitangi that underpins it, there is little if any evidence in the documents reviewed that refugee orientation is so underpinned.

Implicit in policy and practice surrounding refugee resettlement are certain expectations. In summary, refugees are expected to become law-abiding citizens fluent in English, to be economically self-sufficient as soon as possible and not be a burden on society, with talented offspring going on to become assets to the nation. Even if refugees have difficulty in acquiring English and employment, there must be a determination to try. At the same time, refugees are expected to retain elements of the culture of origin that are valued as "positive" by the host culture, and so fulfil the expected function of enriching the social fabric. Refugees are expected to co-operate with arrangements made for their resettlement, and in particular to refrain from subsequent migration to already over-burdened areas such as Auckland. In short, refugees are expected to simultaneously become good New Zealanders and in retaining their cultural distinctiveness, to enrich the socio-cultural fabric of New Zealand, expectations that may not be in conflict but which certainly add to the demands of adjustment.

Adjusting to a strange culture is termed *acculturation*, with several strategies having been distinguished (Berry, Poortinga, Segall and Dasen, 1992, p.278). An individual who embraces the new culture while not wishing to maintain the old is said to be pursuing a strategy of *assimilation*, a strategy encouraged in New Zealand's immigration policy until recently. In contrast, a path of *separation* is described when a person retains the old culture while avoiding contact with the new. A strategy of *integration* values and maintains the old culture while at the same time daily interaction with the new is sought. In cases where such interaction is minimal, such

as because of discrimination or lack of opportunity, *marginalisation* follows. According to Garza-Guerrero (1974, p.417), successful acculturation depends not only on acquiring the language, values and resources of the host culture, but also on mourning the abandoned culture. He goes on to argue that this process is complicated for refugees for at least two reasons: they did not depart in a planned and orderly manner; and the culture was already lost to them, which was a compelling reason to abandon their country. It is likely that migrants and refugees pursue none of these strategies, but move among available strategies according to the contingency of the situation. The importance of these theories lies not in explaining acculturation, but in informing both social policy and research (for example see Cheung, 1994 [b]).

An alternative to the above is to revive the lost and abandoned culture in the adopted country, which entails the development of vigorous ethnic communities. In his review of research on the adaptation of refugees, Cohon (1981, p.266) points out that rates of mental illness are lower when ethnic groups are preserved and cultural pluralism encouraged. Westermeyer (1987, p.943) cites positive examples of maintaining the group integrity, for example by the Hmong in the United States. Westermeyer goes on to recommend that practices which scatter and isolate refugees, reflecting assimilationist policy, should be replaced with more informed and considered approaches.

The Refugee and Migrant Service suggests that a community of between 300-400 people is the minimum viable ethnic community for successful resettlement, and advises against isolating refugee families from their ethnic community (Cotton, 1993, p.22). However, promoting the establishment of ethnic communities, which require sufficiently large numbers of people living in the same location if face-to-face interaction is to be possible, is frequently discouraged by current resettlement practices in New Zealand. It can be argued that the requirement for community support, which results in resettling refugees where sponsors are found, is basically assimilationist. While the positive aspects of sponsorship are not to be ignored, including the personal link that facilitates integration, the positive aspects may well be outweighed by the risk of isolating refugees from the support found in ethnic

communities. In common with other aspects of refugee resettlement in New Zealand, this matter has received scant research attention.

The Cambodian Community: a Significant Ethnic Group

As of 1987, Cambodians were the largest single group of refugees to be accepted by New Zealand since the second World War (Abbott, 1987, p.5). It was principally during the 1980s that over 5,000 Cambodians were accepted for resettlement, people whose lives had been totally disrupted, and who were dislocated and uprooted. For most, New Zealand was not their first choice of destination for resettlement, as was indicated to me both by people who participated in the study and by personnel of the Refugee and Migrant Service. The United States of America commonly ranked first, followed by Canada, Australia, France and other European countries. In addition to this, if they had a second language other than *khmer*, it was likely to be French, which would be useful in France or Canada, but not in New Zealand. There is a view held by some that New Zealand offered a stepping stone, a place from which they hoped to migrate to a preferred country. Most of them had never before heard of New Zealand, and had no idea where in the world it was. Locating New Zealand on a world map, seeing how far from the rest of the world it is and surrounded only by blue ocean, was not reassuring. Acceptance by New Zealand was nonetheless an attractive alternative to languishing in the camps, or worse, being repatriated to Cambodia.

So it was that little communities of Cambodians were established in various New Zealand urban and town centres, the most significant being in Auckland and Wellington, followed by Hamilton, Christchurch, Dunedin and Palmerston North, with scatterings in smaller centres. With the support of their sponsors and a rapidly developed resettlement infrastructure, Cambodians have set about making New Zealand their new home. When asked directly, they invariably claim to like it here, remarking universally on the availability of food, opportunities for their children, and the freedom from fighting. Nevertheless, I found in the course of carrying out this

study that those years of deprivation and terror both in Cambodia and the border camps in Thailand have taken their toll. As I will show, this can seriously impede the process of resettlement, and as well the added burden of adjustment expectations can aggravate illness. Abbott (1989, p.4) points out that:

A recipe for physical illness and psychological disorder in any individual is severe, prolonged stress combined with weak or absent social support. On both counts most refugees score highly.

Such concerns for the long-term well-being of refugees have been slow to be translated into the setting up of specialised and integrated health services for refugees. This is in spite of considerable energy having gone into the preparation of a series of documents, setting out the case for such services. It has been argued that the provision of specialised services is incumbent on New Zealand as a signatory to the 1951 Geneva Convention and 1967 Protocol, under which refugees are accepted for resettlement. Basing the case on the knowledge that some refugees arrive bearing communicable diseases from which the New Zealand population needs protecting, and the estimate that up to 30 per cent of refugees have suffered torture or trauma, all of these reports conclude that better screening and assessment services, together with specialised mental health and trauma care, are urgently needed. (See Deloitte Ross Tomatsu (consultancy), 1991; Solomon, 1993; Hygeia (consultancy), 1993; Population Health Services, 1993.)

These reports acknowledge that there is no data or only very limited local data on which to base the development of refugee health services. Taking Cambodian refugees alone, who comprise the largest single ethnically distinct group of resettled refugees, research activity generally reflects neither their significance as an ethnic minority in New Zealand nor, moreover, one known to be highly traumatised and expected to demonstrate higher than normal demand for health and other social services. Hence the recommendations made are based on overseas data and experiences. However, recognising that resettlement itself affects mental health, and that the experience of resettlement in New Zealand is uniquely influenced by both

the local environment and policy, overseas data do not necessarily hold true.

In their exhaustive immigration bibliography of articles and theses published in New Zealand in the period 1980-85, Trlin and Spoonley (1986) cited twelve on "Kampuchians, Khmer", all of which related to experiences such as teaching English, and telling the life stories of refugees. Of a total of 52 articles grouped under the headings "Indochinese" and "Refugees (Indochinese)" only two included Cambodian (or its alternatives) in the title. This paucity of research published by 1984 is not surprising, considering that Cambodian arrivals were at the time relatively few and recent. However, in their second Digest and Bibliography covering the period 1985-89, Trlin and Spoonley (1992, pp.105-149) uncovered a mere seven with Cambodian, Kampuchean or *khmer* in the title, five of which were again to do with language and education, and only one specifically concerned with health. There were many more that included Cambodian refugees along with others from Southeast Asia, but even these figures are inflated as several articles appeared to be generated from a single project or study.

For the period since 1990, no escalation of research activity is evident. Aside from the present study, only four others have been completed, two of which are on health (Cheung, 1993; Crosland, 1991; Galliène, 1991; Patchett and Brunton, 1993). These studies that deal with the adjustment and health of Cambodian refugees in New Zealand will be reviewed in the following chapter, along with a review and categorisation of international literature on Southeast Asian refugee health.

Chapter 3

PERSPECTIVES ON SOUTHEAST ASIAN REFUGEE HEALTH

Cambodians resident in New Zealand are an important ethnic group on account of their numerical strength, and because it is expected that they have high levels of need for health and other social services (see Solomon, 1993). While a large volume of research has been generated in countries where the Cambodian diaspora resettled during the 1980s, particularly the United States and Canada, this has not been as evident in New Zealand. Nor had specialised refugee health services been established in New Zealand until as late as 1995, unlike other English-speaking Western countries which exhibit similarly high levels of accepting refugees for resettlement. In those countries, including Australia, the United States, Canada and Britain, such refugee health services have long been established, based conceptually on widely-accepted theories of refugee health.

These theories and dominant paradigms will be introduced to open this chapter, the term "paradigm" used in the sense of establishing questions to be answered by research (Marcus and Fischer, 1986, p.179). I argue that recent research carried out internationally on the health of resettled Southeast Asian refugees, in particular Cambodians, has been informed by theories of refugee health developed among ethnically and historically different refugee populations. An exhaustive review of English language literature on Cambodian refugee health follows, including selected literature pertaining to Southeast Asian refugees. By categorising this literature according to location and method, it is seen that the vast majority of studies are conducted on clinical samples or employ instruments derived from a biomedical perspective. There is a paucity of research employing qualitative methodologies, and particularly scarce are ethnographic studies, and those which focus on changing healing practices. The present ethnographic study thus addresses an under-researched aspect of Southeast Asian refugee health.

Antecedents to Dominant Theories of Refugee Health

A voluminous international literature reflects the growing global population of refugees and the recognition of long-term implications for adjustment and health that accompany refugees wherever they go. According to Muecke (1992, p.515) the world's population of refugees has almost doubled in the space of a mere half decade, presently standing at about 17 millions. Most are from Third World countries, and most have temporary asylum in other Third World countries. The majority either return to their country of origin or settle permanently in the country of asylum. With a decline in assistance from wealthy countries, more refugees are suffering from malnutrition, communicable diseases, mental distress, and violence while in camps, with consequences for health wherever the refugees eventually end up. Most research attention has been on those accepted for resettlement by third countries. These refugees often arrive with entrenched health problems.

Refugee studies in general are commonly located in discrete stages of the refugee experience. Stein (1981, p.320) lists these stages: "perception of threat; decision to flee; period of extreme danger and flight; reaching safety; camp behaviour; repatriation, settlement or resettlement; the early and late stages of resettlement; adjustment and acculturation; and residual states and changes in behaviour caused by the refugee experience." Of these, the significant stages reflected in studies of refugee health are: health problems presenting in refugee camps along with medical care delivery in camps; and health status in relation to all stages following resettlement. According to this categorisation, much of the research carried out on resettled refugees focuses primarily on the relationship between health and the demands of adjustment and acculturation, or alternatively on health problems as an outcome of the assaults and trauma incurred prior to resettlement. The importance of acknowledging the unique problems for health long-term generated by each stage is reiterated by a number of researchers (for example, Felsman, Leong, Johnson and Felsman, 1990).

Antecedents to the dominant theories of refugee health can be traced to other bodies

of literature. Principally, these are literature on migration (usually voluntary) and health, and studies on survivors of concentration camps and catastrophes. In her review of literature on the relationships of migration, adaptation, and illness, Hull (1979, p.32) points out that it is "widely observed that migrants have more infectious illness than non-migrants". Explanations offered for this phenomenon include genetic vulnerability, immune status, nutrition and general health, and disequilibrium of the host brought about by migration which lowers resistance. The development of specialised mental health services for Southeast Asian and other refugees also owes its inspiration to theories and experiences of mental disorder suffered by earlier refugee populations. For example, Lin, Tazuma and Masuda (1979, p. 955) list prevalent psychiatric disorders reported among refugees since the Second World War, which influenced their study of Southeast Asian refugees. These are paranoid reactions, depression, anxiety, reactive psychosis, conversion reaction, and somatic complaints.

Literature on migration and health points to the stresses of migration, with mental and physical health being adversely affected when stress is excessive (Hull, 1979). International migration and crossing cultural borders add to adaptive stress believed to be related to migration even within one's own country. Early theorists seeking to explain greater than normal levels of psychological disorder detected in certain migrant populations, attributed it to intrinsic factors that prompted migration in the first place, and to an assumed constitutional weakness predisposing migrants to mental disorder, deterministic theories now largely abandoned (Nguyen, 1985). In the case of refugees, whose migration is not voluntary, such explanations are the more irrelevant.

A perspective on migrant health that has long attracted research interest is the relationship between adjustment and health. In his review of refugee mental health, Cohon (1981) cautions against confusing stages of the adaptation process with psychopathology. Certain symptoms similar to those of mental disorder may equally be regarded as expected responses to transient stressful adjustment, characterised by a high-demand, low-control situation (Rumbaut (1985, p.435). Furthermore,

psychopathological nomenclature itself tends to change over time, as for example the pathological condition of "nostalgia", popular up until the nineteenth century since when it has largely disappeared. Great cultural and linguistic distances between refugees and members of the host society are likely to aggravate stress as the refugee struggles to adjust.

Refugees commonly share a history of trauma. A dominant set of theories of refugee mental health, namely those concerned with the consequences of trauma and torture, have their antecedents in the Second World War. Survivors of the holocaust of Nazi Germany were described as suffering from a "concentration camp syndrome" (Eitinger, 1961). Similar sets of symptoms were, years later, described among Vietnam veterans and other survivors of conflict and calamity including refugees (August and Gianola, 1987). So it was that the diagnostic category of Posttraumatic Stress Disorder, formalised in the third edition of the Diagnostic and Statistical Manual of Mental Disorders (DSM-111) (American Psychiatric Association 1980), found its place in clinical practice (see Horowitz, 1986).

The theories described above which developed in the aftermath of the Second World War have significantly influenced views of Southeast Asian refugee health. Within a few years of their arrival in the West, there appeared a spate of articles on the health of refugees from Southeast Asia. By 1981, according to van Deusen (1982), some hundred articles had appeared, yet very few of these were research-based. The bulk reflected personal experiences of treating refugee patients, in the forms of paper presentations at professional meetings and conferences, and consultative reports. Four general domains were apparent: Southeast Asian medical systems; adjustment while interned in refugee camps; adjustment after resettlement in third countries; and utilisation and effectiveness of Western health services.

Whereas "traditional" refugees coming from Europe, or of European descent, were culturally similar to the host populations, the so-called "new" refugees are predominantly from the poor and war-torn regions of Africa, Asia and Latin America (Stein, 1981). Not only are the cultural and linguistic distances much greater, but

frequently the level of development of the country of origin differs markedly from that of the host country. While theories on migrant and refugee health outlined above are as likely to hold true for "new" refugees as for "traditional", there is the added and urgent need to orient refugee assistance, including health services, to diverse cultures. In spite of this, there is as yet little evidence that anthropological knowledge is becoming as influential on discourses of refugee health as the established theories derived from migration and biomedical knowledge (see Young et al 1987.) There are some notable attempts at gathering information about traditional cultural healing practices of certain refugee groups, but as I argue throughout this study, "tradition" is very much a misnomer in a people suffering from culture destruction and undergoing precipitous culture change, as are Cambodian settlers.

For this reason van Deusen (1982, p.231f) argues that anthropological involvement in refugee research is both necessary and urgent, not only for its immediate application in cross-cultural work. There is the need to document cultural systems at high risk of being lost through abandonment or by being merged with elements of mainstream culture. Little is known about the complex interaction of acculturation, ongoing culture loss, and health. Still less is known about the impact of resettlement of significant communities of refugees on host communities. In the light of such dramatic changes in the characteristics of the world's refugees, early theories of refugee health are only partially useful, and in need of revitalisation.

A Review of Literature on Southeast Asian Refugee Health

The above theories have dominated literature on the health of Southeast Asian refugees. The literature reviewed is principally about Cambodian refugees, although selected seminal literature on Southeast Asian refugees generally is included. Articles that report on research form the bulk of this literature, with some commentary articles included. The vast majority of this literature relates to the resettlement phase of the refugee experience, with a small selection of articles on the refugee camp phase seeking to shed light on subsequent health status in the light of camp

experiences.

Communicable Diseases

There was an initial interest in communicable and "exotic" diseases seldom seen in the West. An early article reported a prevalence among 149 Indochinese refugees of intestinal parasitosis, infectious disease such as tuberculosis, leprosy, malaria and hepatitis, and haematological abnormalities (Erickson and Hoang, 1980). In view of the high prevalence of intestinal parasitosis, fears for the American public health were raised, fears that were subsequently shown to be unfounded except in the case of giardiasis (Weisenthal, Nickels, Hashimoto, Endo and Edwards, 1980). Catanzaro and Moser (1982) made the point that the Indochinese should not be considered a homogeneous group, as in their sample of 709 Indochinese, the Cambodians in particular demonstrated poorer health. Two recent studies of intestinal fauna of Cambodians suggests first that infestation can persist for years after resettlement (Gyorkos, McLean, Viens, Chheang and Kohoskin-Nelson, 1992), and secondly, that screening tests lack reliability (Lurio, Verson and Karp, 1991).

Some responsibility for shaping expectations that refugees would pose a public health risk can be attributed to the spate of articles reporting the experiences of doctors working in refugee camps (for example, Dahlberg, 1980; Levy, 1981; Soffer, 1986). These highlighted the malnourished condition of refugees, the infectious diseases with which they were beset, and the extremely limited facilities and medical services for dealing with them, issues which continued as the focus for health services in the camps (WHO, 1986). Kulig (1990, p.51f) makes the point that by the time such articles on communicable diseases appeared, many conclusions no longer applied. After the "first wave" of refugees who came directly from chaotic situations to the United States, refugees had generally spent some time in refugee camps with improved nutrition and health services, and by the time they reached third countries the bulk of minor communicable diseases had been successfully treated.

Chronic communicable disease presents a more serious problem. A New Zealand study involving auditing the medical screening of 631 Southeast Asian refugees arriving between 1982-92 revealed high rates of tuberculosis (over 6 per cent), hepatitis B (9 per cent) as well as intestinal parasitosis (60 per cent) (Patchett and Brown, 1993, p.23). With New Zealand experiencing a resurgence of tuberculosis, the importance of detection and follow-up of infected Southeast Asian refugees was emphasised (Brett, Harrison, Breed, and Brett, 1986; Karalus, 1988). Southeast Asians, mainly refugees, comprised 20 per cent of new cases seen at Greenlane Hospital, and more seriously, 57 per cent of Cambodian and 31 per cent of Vietnamese patients were resistant to first-line drugs. (Brett et al, 1986).

Adjustment and Acculturation

Attention soon shifted to the measurement of psychological disorder, anticipated to be prevalent in Southeast Asian refugee populations. As in the case of communicable diseases, all refugees originating from Southeast Asia were often lumped together as "Indochinese", thus obscuring the dramatic differences in pre- and post-migration experiences as well as their being ethnically diverse. This group of studies also suffered from the wide range of instruments used to measure health status, including non-standardised questionnaires not validated cross-culturally. A study of psychological distress among young Vietnamese refugees in camps highlighted this problem (Felsman et al. 1990). Using three different instruments believed to be both comparable and valid for this population, there was significant variance among some measures, raising concerns about construct validity.

The little research conducted in New Zealand has suffered from these tendencies. For example, that by Hafeez (1988) provides a broad portrayal of refugee resettlement in all its dimensions, with some discrete findings being broken down according to country of origin. It is, however, methodologically weak in its use of self-rating questionnaires about health status using both English language and concepts. Its conclusions about prevalence of mental illness need to be taken with caution. A

methodologically rigorous study by Pernice (1988), using a culturally validated, standardised questionnaire, compared anxiety and depression levels among the three migrant populations of Indochinese refugees (mixed origins), Pacific Islanders and British, finding that rates of mental distress overall, and depression in particular, were highest in the refugee population. (See also Pernice and Brook, 1994.) While the study advances understanding of differences among New Zealand's migrant populations, it does not discriminate within the refugee group, thus reinforcing the view that refugees can be seen and treated as a class by virtue of their refugee status.

A seminal study relating adjustment to mental health status of the new wave of refugees is that of Lin, Tazuma and Masuda (1979). They found high and persisting levels of physical and/or mental dysfunction among two successive annual samples of Vietnamese, with somatic complaints being prominent. Surprising findings that were contrary to literature were low depression scores, and little evidence of reticence in expressing psychological symptoms. Notwithstanding, their conclusions that Southeast Asian refugees suffer high levels of depression, expressed somatically because of the shame attached to mental disorders, has been frequently cited in literature. In view of the total absence of data reflecting normal levels in a normal population, before experiencing war, escape, and confinement in camps, the significance of findings is uncertain (Lin, Tazuma and Masuda, 1979; Felsam et al, 1990).

Rumbaut (1985), reporting preliminary findings of a longitudinal study on resettlement of Indochinese refugees (sample of 599), notes that as a group they do demonstrate significantly higher levels of mental distress than the general population, and that the Cambodians are at highest risk. However, he goes on to point out that affective "depression" and unhappiness are surely to be expected given the extent of misfortune they have suffered, which a "pathogenic" view tends to overlook.

The importance of the "pathogenic" position in interpreting distress is well-illustrated in a number of articles by mental health professionals. For example, noting that mental health facilities were used less than expected by Southeast Asian refugees,

Nguyen (1985, p. 272 ff) carried out a community-based study into the extent of emotional distress. He concluded that while generally refugees have resettled successfully, significant numbers experience distress. While respondents did not perceive this distress as mental health problems, the author, a psychiatrist, clearly did. The divergence in perception of sad emotions between professionals and refugees emerges repeatedly in such studies. Nguyen (1985) goes on to explain differences in interpretation in terms of culturally-embedded beliefs and attitudes of refugees, a point echoed by Westermeyer (1985, pp 72, 79) who decries the underdiagnosis by health professionals of the true extent of mental disorder among Indochinese refugees.

The relationships among acculturation and sociodemographic variables and psychiatric morbidity has been described in a New Zealand Cambodian community (Cheung, 1994 [b]). He found that those who were older, widowed, of lower educational level, lower socioeconomic status, and had been in New Zealand for shorter durations, were less acculturated as determined by an acculturation scale developed for the purposes of the study. Those who were least acculturated demonstrated the highest levels of psychiatric morbidity. At the same time, it was not clear whether socioeconomic disadvantage could account for such morbidity. This cross-sectional study also reports a preference on the part of Cambodians for an integrated mode of acculturation, retaining aspects of their own culture while acquiring elements of the host culture (see Berry et al, 1992, p.278), a desire that he suggests is potentially in conflict with the assimilationist view still prevalent in New Zealand society. Psychiatric morbidity was found to be associated with employment, financial status, accommodation, culture, loneliness and boredom, on which social support and coping styles had little effect (Cheung and Spears, 1994 [c]).

Westermeyer's contribution to Southeast Asian refugee health is chiefly in the area of its relationship with acculturation. He conducted a longitudinal study of Hmong refugees over a ten year period. Subjects demonstrated considerable improvement of symptoms, particularly depression, during the first two years of settlement, with high depression scores associated with low English proficiency and unemployment

(Westermeyer, Neider and Vang, 1984). This same sample of 100 Hmong were tested three times over the decade, during which time mental-emotional problems decreased dramatically, from 62 to 25 per cent, while general health problems remained at about the same level (Westermeyer, Neider and Callies, 1989). At the same time, English fluency improved and illiteracy declined, and assets were built up. A process complementary to acculturation is that of maintaining ties with one's ethnic group. Hmong who did not relocate away from their first place of resettlement but maintained strong links to their ethnic community, showed lower levels of mental disorder, a finding on which suggested preventive mental health strategies were based (Westermeyer, 1987).

Acculturation is bound up with time. Depression was the dependent variable measured in a sample of 1348 mixed Southeast Asian refugees, not including Cambodians or Hmong. Beiser (1987, p.451) reports that a nostalgic time orientation, in which the past dominates the present and future, was associated with depression. He acknowledges differences in time orientation from a cultural standpoint and for different age groups, but concludes that a preoccupation with, and intrusion of, the past interferes with present adaptation. Two years later 87 per cent of the original sample were reinterviewed. In general, depression scores peaked at 10-12 months after arrival, and thereafter declined with the period of time spent in Canada (Beiser, 1988, p.48).

One of the few prospective studies tracking refugees from the time of their arrival, was that of Krupinski and colleagues (1986). Their ethnically mixed sample included 339 children, 279 adolescents and 374 young adults, who were first interviewed within two weeks of arrival, and then followed up at six, twelve and 24 months. The initially high prevalence of psychiatric disorder halved at six months, and went on to decline steadily, with rates of disorder being consistently higher for adults and females (Krupinski et al, 1986, p.123 ff). They concluded that morbidity was usually transient, and contested the levels of pre-migration stress and trauma commonly reported in literature except in the case of Cambodians.

Chung and Kagawa-Singer (1993) report that even five years after arrival, pre-migration trauma events and refugee camp experiences significantly predicted psychological distress and inter-group differences, with Cambodians showing the greatest levels of distress. At the same time, post-migration factors of low income, low proficiency in English and unemployment were also associated with distress five years or more after arrival. From these results, Chung and Kagawa-Singer (1993, p. 638) argue that refugee distress arising from pre-migration factors may not in fact resolve itself with time during the early years of resettlement, as suggested in the above studies.

A very small number of studies have focused on the consequences of confinement in refugee camps for subsequent adjustment and health. The probability of profound cultural and personal loss which has preceded the flight of refugees from their countries is compounded by the transit period, particularly when violence persists and cultural values are not revived (Mollica et al, 1993). Camps are characterised by a moral and social vacuum in which refugees are transformed into a type likely to be considered favourably for resettlement (Chan and Loveridge, 1987; Mortland, 1987). The result is anomie, a confused identity, loss of a sense of self and its social context, one's culture, as inmates conform with international expectations of refugees in their desire to be selected for resettlement.

The debate emerges repeatedly as to whether pre-migration trauma or present adjustment stress accounts for mental distress, and indeed whether such distress is pathological or an expected human response to profound suffering. One departure from viewing psychological morbidity as a dependent variable of adjustment is that reported by Uba and Chung (1991). They showed that pre-migration trauma among a mixed sample of 2180 Southeast Asian refugees predicted income, current employment status and health, with multiple trauma events being associated with both lower income and worse psychological health. Such triads among poor health, low adjustment and unemployment have been commented on by others (for example Mollica et al, 1990), but as Westermeyer et al (1984, p.91) point out, causality in any direction cannot easily be established.

Sequelae of Trauma and Torture

This group of theories of refugee health has arisen directly out of the treatment of clinical populations of Southeast Asian refugees in specialist psychiatric centres. The earliest published report of Posttraumatic Stress Disorder (PTSD) occurring in Cambodian patients was at Oregon, where patients with persistent severe depression were reassessed (Kinzie et al, 1984). After a year of treatment for PTSD, they remained as severely impaired as before treatment, raising questions as to whether improvement would be sustained (Boehnlein, Kinzie, Ben and Fleck, 1985). Subsequently, the same team surveyed all 322 patients currently attending their clinic to determine the prevalence of PTSD. The highest rate of 95 per cent was found among the Mien, closely followed by the Cambodians at 92 per cent. Laotian and Vietnamese demonstrated lowest levels (Kinzie, Boehnlein, Leung, Moore, Riley and Smith, 1990).

By way of explanation of such high levels of previously-undiagnosed PTSD in a clinical population under treatment, the authors point out that a trauma history was only reluctantly and partially disclosed, and then only when specifically inquired into. This impression is at variance with experiences of ethnographers, who have rather remarked on the compulsion among traumatised refugees to recount their stories (Ebihara et al, 1994, p.21; Krulfield and others, personal communication). It is likely that the clinical nature and intrusiveness of the psychiatric interview account for these differences (Mollica, 1988, p.297).

A second university clinic to conclude that PTSD and major depression were prevalent and co-existent in traumatised Indochinese refugees was at Boston, led by Mollica and colleagues. What they term the "trauma story" has become the basis for diagnostic and treatment procedures (Mollica, 1988; Mollica, Wyshak and Lavelle, 1987). Cambodian patients had experienced more trauma and torture events than other Southeast Asian refugee groups, and patients diagnosed with PTSD had experienced twice as many such events as those with other diagnoses (Mollica et al, 1987). However, the trauma diagnostic model developed in this clinic is distinct

from PTSD, and Mollica (1988) is emphatic that the popular medical perspectives on Southeast Asian refugee patients of somatisation and PTSD must be "bracketed" off in the medical management of the trauma patient. The resultant therapeutic approach produced significant improvement of some symptoms over a six month period (Mollica, Wyshak, Lavelle, Truong, Tor and Yang, 1990). Much of their ongoing research on refugee health is oriented toward developing adequate diagnostic and treatment approaches for the sequelae of torture and trauma. In this, the "trauma story" is central, and somatic complaints may yet prove to have physical bases (see Mollica, 1988; Mollica and Lavelle, 1988; Mollica and Caspi-Yavin, 1992.)

The very high prevalence of PTSD found in clinical populations raises questions about rates in non-clinical samples, in view of the likelihood that levels of trauma experiences are similar within ethnic groups. A small survey compared a sample of Cambodian mental health patients with a matched sample of non-patients attending a community centre, concluding that most of both groups reported symptoms indicative of PTSD. While the patient group had sought treatment because of somatic and psychological symptoms, non-patients did not seek treatment both because they didn't believe they had a problem, and because they didn't believe medicine could help (Young, 1988).

The first community-based study to determine PTSD prevalence to be published was that of Carlson and Rosser-Hogan (1991). In a small sample of 50 randomly-selected Cambodian adults who had been resident in the United States for some five years, an astonishing 86 per cent qualified for a PTSD diagnosis, while 80 per cent also had clinical depression, and 96 per cent demonstrated high dissociation scores. In contrast, Cheung's (1994) New Zealand study found a PTSD prevalence rate of only 12.1 per cent, although nearly 60 per cent reported five or more trauma events. Carlson et al (1991) suggested that their high prevalence may be explained by the comparatively long duration of stress endured by their sample prior to resettlement, while Cheung (1994, p.21) rather attributes variation to the methods used in eliciting symptoms together with cut-off criteria for determining presence.

That PTSD can also occur in the young was confirmed in the Khmer Adolescent Project, which also compared the rates found in the adolescents and their parents. While just under 20 per cent of adolescents qualified for a current diagnosis of PTSD, this rose to 58 per cent of their mothers and 33 per cent of fathers. As with clinical samples, there was high co-morbidity with major depression among all groups. The prevalence in adolescents was positively related with age, with older adolescents who had experienced more trauma demonstrating higher levels of PTSD. These findings reinforce conclusions that the effects of war trauma persist over time, and that these effects must be distinguished from psychiatric morbidity arising from adjustment stress and from bereavement (Sack, McSharry, Clarke, Kinney, Seeley and Lewinsohn, 1994).

The only reported community-based study of refugees other than Cambodians was a prospective study conducted among 145 Vietnamese in Norway, measuring morbidity periodically from the time of arrival. Ten per cent demonstrated PTSD, a figure much lower than that reported in comparable studies of Cambodians. While this prevalence is greater than that found in general populations, it is similar to that of other traumatised populations such as veteran soldiers (Hauff and Vaglum, 1994).

A community study of Cambodian refugees still confined in the Site 2 border camp where they were subject to frequent shelling and violence, provides a useful reference point. Major depression was evident in 55 per cent, while nearly 15 per cent qualified for a diagnosis of PTSD (Mollica et al, 1993). Notwithstanding, for the vast majority the diagnosis did not interfere with social functioning, a finding which raises questions about whether refugees diagnosed with PTSD but who are not socially impaired ought, in fact, to be deemed to be mentally disordered.

A growing interest in PTSD to explain entrenched ill-health and mental distress among refugees is obvious. What is less clear, however, is whether the application of this recent diagnostic category is any more helpful than earlier ones in relieving their distress and getting them better. Muecke (1992, p.520) points out that while PTSD focuses on past experiences of trauma and persecution, it fails to take into

account current and ongoing experiences of being a stigmatised and sometimes despised minority, out of step with one's own culture yet not fully part of the culture of the host country. Added to this, variation in the experience of trauma itself, and indeed the experience of new and ongoing trauma, is not reflected in the criteria for PTSD, factors now being taken into account in successive revisions of the DSM manual.

The enormous variation in reported prevalence rates in both clinical and community populations, that is unlikely to be related to equivalent variations in trauma experienced, is worrying. So too is the suggestion that significant numbers of refugees are not recognising they are psychiatrically impaired. The concern expressed for large populations of supposed undiagnosed and untreated refugee patients living in the community is somewhat baffling in the light of the equivocal success of available treatment programmes. Both Boehnlein et al (1985) and Mollica (1988) stress the importance of simple commitment to long-term support, not the prerogative of psychiatric services.

On the other hand, the recent interest in trauma and torture represents an important advance in acknowledging the ongoing consequences for health of pre-migration experiences of refugees, and as such balances the earlier pre-occupation with post-migration stressors. Therapeutically, it is surely a relief for distressed, traumatised refugees to have clinicians agree with them that there is good reason for them to feel as poorly as they do, and to support them in their impaired and distressed state.

Bereavement

In spite of the ubiquitous experiences by refugees of high levels of death and dying in unnatural circumstances, and of ongoing culture loss, bereavement has not been prominent in discourse on refugee health. Yet as Harrell-Bond and Wilson (1990) point out, this high level of contact with death and dying is compounded by difficulties in carrying out proper burials and associated rites. On the basis of

circumstantial evidence, such experiences are believed to be associated with psychological distress. I located only one article which speculated on the relationship of profound grief over deaths of loved ones with possible long-term health consequences, an article describing observations of sadness and weeping over the dead by a nurse working in Cambodian border camps (van der Westhuizen, 1980).

Generally, personal bereavement is included as a type of trauma, and cultural loss as a factor in adjustment. It is likely that symptoms of profound grief have been diagnosed as PTSD. Supporting this conjecture, Horowitz (1986, p.243) points out the similarity of symptoms of PTSD with the condition Freud termed "pathological mourning". Based on clinical work with Cambodian refugees, James Boehnlein (1987, pp.765 ff) describes the striking similarities between symptoms of PTSD and of chronic grief. Witnessing violent deaths, being unable to grieve and carry out proper funerary rites, combine to produce profound grief. In Boehnlein's view, recognition and therapeutic resolution of unresolved grief is a necessary part of treatment. When mourning is complicated by guilt at not having saved the deceased from their fate or accorded them a proper burial, the concept of "survivor guilt" has become popular, characterised by continued self-recrimination (Harrel-Bond and Wilson, 1990).

Garza-Guerrero (1974) puts forward the notion that culture shock and grief for the lost culture are also associated with mental distress. Developing the notion of cultural bereavement, psychiatrist Maurice Eisenbruch takes issue with the increasing popularity of PTSD (1991, 1992). In his view, the popularity of PTSD is "based on an ethnocentric view of how refugees should express their distress, how their disorders should be classified, and how the distress should be ameliorated" (Eisenbruch, 1992, p.8). In contrast Eisenbruch puts refugee distress into the contexts of uprooting, homesickness, and bereavement for the lost culture, arguing that personal and cultural bereavement are complementary (Eisenbruch, 1988, 1991). He goes on to argue that distress is not necessarily a disorder but a normal, even constructive, response to such vicissitudes (Eisenbruch, 1991, pp 673f). Eisenbruch's alternative diagnostic category of "cultural bereavement", which includes the

appropriate rituals for mourning one's dead, is replete with standardised diagnostic tools and suggested courses of treatment particularly for Cambodian refugees. In spite of Eisenbruch's claim to be free of Western biomedical nosology, his biomedical leanings are nevertheless evident in the prescriptive use of selected ritual for therapeutic purposes in his proposed model.

Somatisation

In contrast, somatisation is widely employed to explain Southeast Asian health problems. As a paradigm for explaining refugee health problems, somatisation has been reported since the Second World War (Westermeyer, Bouafuely, Neider and Callies, 1989). Somatisation is defined as: "the expression of personal and social distress in an idiom of bodily complaints and medical help-seeking" (Lin, Carter, and Kleinman, 1985, p.1080). The complaints of somatising patients pertain to numerous bodily locations and systems. As symptoms have no detectable organic pathology and patients may amplify physiological changes, somatisers are expected to be high users of health services, representing a "major burden" for the health care system (Lin et al, 1985; Westermeyer et al, 1989). Somatisation has been described as prevalent among migrants, the poor, those of less education, and of particular races, notably (but not only) Asians.

Kleinman's interest in somatisation emerged in the context of his clinical work among Chinese patients in Taiwan and in the United States. In common with Chinese and other Western-style doctors, Kleinman (1977) found extremely high rates of depressed patients presenting only with somatic complaints, and many who experienced complete relief with anti-depressant medication never admitted to depressed mood. Further clinical research of patients of indigenous healers indicated that some 50 per cent suffered from somatisation, making this the commonest presenting condition (Kleinman, 1977 p.5f). This pattern he attributes to mental illness being highly stigmatised among Chinese in particular, and Asians in general. Somatisation thus becomes a legitimate metaphor for dis-ease and the accompanying

sick role. Although mental disorders are common to all societies, the presenting features are not constant cross-culturally, somatisation being described as one such presenting feature (Kleinman, 1977).

A study was undertaken to establish the prevalence of somatisation among immigrants from Asia, including refugees (Lin et al, 1985). Data was collected by retrospectively analysing the medical records of 526 patients of a Seattle clinic, who made a total of 901 clinic visits over a two month period. Reasons for clinic visits were overwhelmingly related to physical symptoms, and diagnoses categorised according to the International Classification of Diseases. Illnesses were then classified as "physical disorders", where there was detectable physical pathology (for example diabetes), "mental disorders", where a clear psychiatric diagnosis was made (such as depression), and "vague symptoms and signs" in the absence of detectable pathology (like dizziness and abdominal pain). It was this third group which was categorised as demonstrating somatisation, a prevalence rate arrived at through a process of elimination. In this study, widely cited in literature on Southeast Asian refugee health, "somatisation" accounted for 35 per cent of clinic visits, which rose to 42.7 per cent in the refugee population.

The use by Southeast Asian refugees of the somatic idiom to express psychological distress is described frequently (for example, see Baughan, White-Baughan, Pickwell, Bartlome and Wong, 1990, p.566; Cheung, 1993; Hondius and van Willegen, 1989, p.730 f; Kinzie et al, 1990, p. 916; Moore and Boehnheim 1991, p.1030; Nguyen, 1985, p.270; Westermeyer, 1984, p.87; Westermeyer et al, 1989). However, while the range of somatic complaints reflected those characteristic of somatisation, the pictures diverge from the description provided above.

In many cases the patients readily admitted to dysphoria and other symptoms of psychological distress, which is contrary to one of the main criteria for somatisation, a socially acceptable idiom onto which is projected mental distress. This is well-illustrated in Nguyen's (1985, p.269f) clinical sample, where somatisation was the commonest reason for referral to the psychiatric clinic. Nguyen goes on to argue that

the distress of these symptoms as experienced by patients is quite genuine, and they often feel that if the physical problem could be eliminated, so too their difficulties would subside. At the same time, they also reported symptoms of psychological distress and dysphoria, even though they did not view these as mental health problems. Baughan et al (1990) and others also describe the co-existence of depressive symptoms and somatisation. It is concluded, therefore, that somatisation and complaints of psychological distress need not be mutually exclusive (Westermeyer et al, 1989, p.41). It can be argued that somatisation reflects failure of clinical diagnostic techniques to find organic causes for symptoms, thus providing a convenient explanation for undiagnosed bodily symptoms.

A parallel but different construct to explain otherwise mysterious functional phenomena is that of conversion hysteria, reported for example by Nguyen (1985, p.266). This has been employed most prominently to functional visual loss among Southeast Asian refugees, with Cambodian women accounting for the majority of cases seen (Drinnan and Marmor, 1991; Wilkinson, 1994). More than half of cases described reported facial trauma from an explosive device during the war, along with the severe food shortages. After ocular function was assessed, and visual loss could not be organically accounted for, the possibility of hysterical conversion was posited. Drinnan et al (1991) suggest that such a presentation could reflect the cultural background of their patients, but anthropological literature sheds no light on whether this is a culturally embedded way of seeking help. Nor, as Wilkinson (1994) argues, does the refugee conform to the personality type prone to Freudian conversion hysteria.

There is disagreement as to whether undiagnosed bodily symptoms do, in fact, constitute somatisation (Mollica, 1988, p.298; Mollica and Lavelle, 1988). Goldfield, Mollica, Pesavento, and Faraone (1988) describe how research into the sequelae of torture is supporting the view that there may in fact be occult underlying organic pathology, especially head injuries and injury to the skeletal and soft tissue system. Drawing from qualitative data from respondents, Rumbaut (1985, p.476) asserts that their eloquent expression of their distress "belies the often uncritically accepted (and

just as uncritically disseminated) notion of somatisation". Using a different argument, Muecke (1992, p.520) is strongly critical of using such reductionist categories as somatisation and PTSD to objectify refugee suffering while empowering clinicians, and by so doing, sanctioning continued neglect of the social causes of their suffering.

Chronic Disease

An association between migration and chronic disease has been observed (Hull, 1979). Yet chronic disease has been neglected as a topic of research among Southeast Asian refugees. Hull (1979, p.32f) refers to such conditions as cancers, heart and lung disease and diabetes as being linked with migration. Most commonly reported among Southeast Asian refugees are joint and bone pain, backache, dermatological complaints, headaches and dizziness, gastrointestinal complaints, and anaemia (Baughan et al, 1990; Lin et al, 1985). Probably a large proportion of these complaints are regarded as somatisation. Others not regarded as clinically unusual are dealt with and statistically subsumed in normal clinical populations (Hondius et al, 1989, p.730). The relationship, if any, between chronic disease and Southeast Asian refugees is therefore unlikely to be established unless deliberately searched out.

There are two notable exceptions, the first being a large study of the health status of 709 refugees settling in California which reported on both communicable and haematological diseases (Catanzaro and Moser, 1982). While some cases of anaemia (present in 37 per cent of those tested) was associated with hookworm infestation, there was strong evidence for the presence of a hereditary anaemia in others. Unusually high rates of serological reactivity indicate the presence of yaws or syphilis, both diseases with chronic sequelae, and hereditary disorders of the blood indicate the need for revised management protocols (Catanzaro and Moser, 1982, p.1307). The only other study I located in this genre investigated blood pressure and changes in nutritional intake as outcome measures of social support and acculturative stress (Burke, 1986). Hypertension was surprisingly uncommon in view of the levels of known migration stress-related risk factors present in this population, but Burke

suggests that the healthy Cambodian diet and low body mass of subjects, along with good social support, protected the subjects from hypertension, a disease frequently associated with migration and changes in diet.

The possible long-term effects of exposure to chemicals used during the conflict in Southeast Asia does not appear in literature on their health. St Cartmail (1983, pp.13f) describes the use by Americans in 1975 of the defoliant, Agent Orange, in the catchment area of the Mekong River, which may have affected Cambodians who were living near the target area, or who consumed contaminated water and foods. Soviet-supplied chemicals are alleged to have been used by occupying Vietnamese troops against Cambodian civilians and the Khmer Rouge in 1980. The use of the nerve gas "yellow rain", or trichothecene toxin, was reportedly used in Laos and Cambodia in 1981 by Vietnamese forces. The only reference I located to speculate whether such agents could be responsible for sudden death was that by Adler (1994, p.54) in relation to Laotian exposure to "yellow rain", a hypothesis apparently rejected by the medical establishment. However, claims are made that vague, chronic illness follows exposure to chemical agents, as for example after the Gulf War. Therefore, the possibility cannot be ruled out that certain symptoms experienced by Southeast Asian refugees are the result of damage caused by chemical agents.

Cross-Cultural Service Delivery

The final discourse to be considered in this review, and one that does not echo traditional positions on refugee health, reflects the challenge confronting Western health professionals from their Southeast Asian refugee patients. This is well-illustrated in articles reporting unfamiliar practices, for example the practice of coin rubbing, while endeavouring to reassure clinicians that the practice is harmless. These articles report that the resultant lesions, themselves transient, have been erroneously interpreted as child battering, and can also confuse clinicians, who risk misdiagnosing the condition (Goldman and Duster, 1977; Yeatman and Dang, 1980). There is a diverse collection of articles reflecting wide cultural differences between the worlds

of clinicians and those of their patients. Subjects include culture-bound syndromes, cross-cultural validation and orientation of biomedical diagnostic and therapeutic approaches, and inquiry into non-Western healing systems.

Medical conditions that present as unusual diagnostic challenges, unlike so-called somatisation and chronic disorders, tend to attract considerable scientific curiosity. The single *culture-bound syndrome* reported in literature about Southeast Asian refugees is known as Sudden Unexplained Nocturnal Deaths (SUNDS), a syndrome that usually affects young adult Hmong males. These previously healthy refugees died unexpectedly at night, with no cause being found at autopsy. Such was the interest generated by the unexplained deaths of at least 51 young men over a five year period that a special surveillance mechanism was put in place. Although no organic or physiological cause could be established, similarities with previously-described patterns among the Filipino (*Bangugut*) and Japanese (*Pokkuri* disease) were noted (Baron, Thacker, Gorelkin, Vernon, Taylor, and Choi, 1983; Furst, 1982). Since then, the number of deaths has risen in excess of one hundred, a death rate of 92 per 100,000 of the affected Hmong population, peaking in 1981 (Adler, 1994).

In order to establish whether there was a relationship with refugee resettlement in the United States, a study was conducted in a Hmong refugee camp in Northeast Thailand. Here, too, a pattern of sudden death during sleep was documented, indicating that a higher risk was associated with membership of sub-clans, family history of nocturnal death, and previous non-fatal sleep disturbances (Munger, 1987). Clinical studies continue in the search for genetic, physical, and environmental causes for what is apparently a culture-bound syndrome found in several Asian societies, so far without success. SUNDS has also attracted the interest of anthropologists. Adler (1994) has described the role played by traditional explanations in the cause of this fatal illness, in particular the role of the nightmare. An analysis of ethnic identity, adaptation of traditional culture to life in the new cultural context of America, and anxiety related to having abandoned their own land are all drawn on to explain sudden cardiac deaths in a Laos community already unnerved by the phenomenon of SUNDS (Muecke, 1987). Despite the interest the syndrome has generated, Western

medicine offers little to prevent or relieve it.

The majority of literature on cross-cultural health care is oriented to what Western medicine can in fact offer. An example is the small collection of articles devoted to *establishing valid and reliable questionnaires* for screening refugees which are cross-culturally valid for Southeast Asian populations. Included here are: Vietnamese Depression Scale (Kinzie, Manson, Vinh, Tolan, Anh and Pho, 1982); Indochinese versions of the Hopkins Symptom Checklist-25 (Mollica, Wyshak, de Marneffe, Khuon and Lavelle, 1987); Cambodian version of the General Health Questionnaire-28 (Cheung and Spears, 1994); and trauma and torture measurement (Mollica and Caspi-Yavin, 1991; Mollica, Caspi-Yavin, Bollini, Truong, Tor and Lavelle, 1992). In spite of such work, the cross-cultural reliability and comparability of results remain in doubt (Felsman et al, 1990). Moving further toward alternative models of health care are the questionnaires developed by Eisenbruch (1990) to assess cultural bereavement in refugees, and to classify mental distress on the basis of explanations, both natural and supernatural, of causation (Eisenbruch, 1990).

The influx of Southeast Asian refugees to the West was responded to by *seeking to understand the "Indochinese refugee"*. Vietnamese doctors concerned to improve understanding by Western clinicians of their refugee patients included Tran Tung (1980) and On Lien (1993). The former has been extensively cited, thus contributing to the formation of stereotypes, based on Vietnamese, about the supposedly similar class of Southeast Asian refugee patients, as for example by Boman and Edwards (1984). Muecke (1983, 1983[b]) also draws from these depictions as well as from her own work in Northeast Thailand, going on to suggest appropriate styles of delivery of Western health care, and the place of traditional practitioners in treating refugees with intractable health problems.

Particular health projects and specialised clinics have been described, which operated on bicultural principles, building teams of workers comprising members of both Western medical and refugee cultures, and *incorporating culturally acceptable approaches into treatment*, for example, Fox, (1985). The majority relate to

psychiatric care (Kinzie, Tran, Breckenridge and Bloom, 1980; Kinzie, 1989; Boehnlein, 1987; Moore and Boehnlein, 1991; Mollica, 1988; Mollica and Son, 1989; Westermeyer, 1985). Kinzie and colleagues in particular take into account the culturally embedded beliefs of their patients (Moore and Boehnlein, 1991), as well as expectations held by Southeast Asian patients for the doctor to be active while they themselves are passive. Somatic complaints were treated seriously, and patients' preferred pattern of avoiding being reminded of traumatic events respected (Kinzie, 1989, pp.79 ff). Eisenbruch (1983, 1990) oriented clinical treatment around the patient's interpretations of both the cause and course of illness. The chief limitation of the above approaches is that they cannot be generalised beyond the individual patient or clinically and culturally alike groups of patients.

Another group of articles take published articles and research findings, their own or those of others, from which *recommendations for "culturally sensitive" health care practice* are made, for example for nursing practice (Frye, 1990; Frye and McGill, 1993; Kemp, 1985) and care of the dying (Schriever, 1990). Cultural sensitivity is not the only concern, however. Utilisation of available health services by Southeast Asian refugees, believed to be in high need of such care, is a recurrent concern, addressed by developing "culturally sensitive" services.

A sub-group of studies focus on maternity services, reflecting high fertility rates of Southeast Asian refugees (Rumbaut and Weeks, 1986; Gordon, 1989). Maternal and infant risks were assumed to be high, because of low levels of uptake of prenatal services and low infant birth weights (Hopkins and Clarke, 1983). That assumption was subsequently proved wrong, when infant mortality rates of Southeast Asian refugees were found to be lower than those of the American white population, and substantially below that of Blacks (Weeks and Rumbaut, 1991).

One of the few studies into utilisation of Western health services by refugees as an indicator of adaptation, is that of Strand and Jones (1985). Several studies of *health care utilisation patterns* describe self care, health-seeking practices and change. For example, patterns of use among the Tai Dam, from Laos, in Iowa (Bell

and Whiteford, 1987); Lao settled in Ohio (Brainard and Zaharlick, 1989); Cambodians in New Zealand (Cheung and Spears, 1994[b]); and a comparison of different Southeast Asian groups in California (Chung and Lin, 1994) and in Washington (Buchwald, Panwala and Hooton, 1992). Frye (1991) and Tudsri (1987) provide fuller descriptions of beliefs to explain health decision-making by Cambodians. These studies highlight the extent of divergence of beliefs and practices within the Southeast Asian refugee population, the dual medical system in use, and that clinicians need to be aware of non-Western healing practices to minimise risks of misdiagnosis or negative interaction of these with Western treatments.

Still on the theme of health care practices, a final group of studies focus principally on *culturally embedded explanations of illness*, and the influence on health practices. These articles are distinct from the clinically-oriented articles referred to above, in seeking to understand different world views as important in its own right, and not primarily as a means to delivering clinical care. All the articles reviewed in this category describe Cambodian explanations of illness, covering cause and preferred ways of dealing with mental distress, described by Smith (1987), and the perception of stress and how it is dealt with (D'Avanzo, Frye and Froman, 1994). Fertility and childbearing again emerge, with studies into Cambodian knowledge and practices relating to conception (Kulig, 1988), maternity care (Sargent, Marcucci and Elliston, 1983), and childbearing (Lenart, St.Clair and Bell, 1991). A notable exception to the largely descriptive studies reviewed above is the analysis by Marcucci (1994) of pain, in which he discusses expression of pain, on the one hand, and social constructs of pain inflicted in self-care techniques.

Shifts in Understanding Refugee Health

Muecke (1992) drew attention to the marked shifts in paradigm for understanding health problems of those refugees who resettle in the West. Under the first paradigm refugees were objectified as a medical phenomenon, perceived and treated as a class. As a class, refugees were regarded as posing an infection risk to host populations,

and as potentially having clinically-interesting diseases seldom encountered in the West. A shift occurred as it became apparent that many refugees had intractable health problems not diagnosed and remedied by Western medicine, explained as somatisation. The currently dominant paradigm which is derived from recognising the occurrence and consequences of trauma and torture became popularised in the mid 1980s by a few university-based psychiatric clinic/research centres. Muecke (1992) is critical of the use of clinical diagnostic labels such as somatisation and PTSD, which undoubtedly assist clinicians but which appear inadequate to alleviate the suffering of the refugee.

Muecke (1992) concludes her analysis by noting that literature on refugee health in the West is invariably pessimistic, an observation borne out by the themes of many conferences and workshops on refugee health (for example Abbott, 1989). This pessimism she attributes to the predication of medicine on pathology and problems, and to a focus on the patient while underplaying the environment in which the person lives. A similar concern was expressed by van Deusen (1982, p.241), who suggested that the high level of clinically oriented studies was reinforcing the popular view of refugees as both traumatised and dependent. Supporting these contentions, an analysis of studies on Southeast Asian refugee health follows.

Categorising Research According to Location and Method

Knowledge of Southeast Asian refugee health has been shaped not only by existing theories on refugee health generally, but also by preferred method and location of studies. Using a grid adapted from that used by Beasley (1993, p.9, see Figure 1), I have located each article in one of four quadrants created by two intersecting continua, the one describing location of study, whether clinic or community, and the other the nature of the research, whether qualitative or quantitative. Using this approach, literature is categorised not only on the basis of substantive areas, as employed in the review above, but according to where (clinical or community settings) and how (by quantitative or qualitative approaches) these studies were

conducted. For the purpose of this analysis, only articles reporting research are selected, including all articles located on Cambodian refugee health, and studies on Southeast Asian refugee health that report on Cambodians.

QUANTITATIVE					
Populations and communities as subjects Mainly survey methodology					
Adjustment/Mental Health	12	(3)	Communicable Disease	6	(3)
PTSD/Trauma	5	(5)	PTSD	3	(2)
Somatisation	1	(1)	Somatisation	2	(1)
Chronic Disease	1	(1)	Traditional Beliefs/Utilisation	2	(1)
Traditional Beliefs/Utilisation	4	(4)	SUNDS	2	
Fertility	4	(1)			
Total Studies	27	(14)	Total Studies	15	(7)
COMMUNITY			CLINIC		
LOCATED			LOCATED		
Traditional Beliefs and Utilisation	7	(5)	PTSD	3	(3)
re Mental Health - 1(1)			Trauma/torture	3	(3)
re Women's Health - 6(4)			Somatisation	2	(2)
			Traditional beliefs/utilisation	4	(3)
Total Studies	7	(5)	Total Studies	12	(11)
(Ethnographic interview) Mainly interview methodology. (Clinical interview) Individuals and families as subjects					
QUALITATIVE					

FIGURE 1: Studies of Southeast Asian Refugee Health, According to Method and Location. Total Studies Categorized - 61

As Figure 1 shows, categorising literature along the lines described demonstrates that, as the vast majority of studies are biomedically-oriented, the prevailing view of the health of Cambodian and other Southeast Asian refugees is defined by the dominant biomedical perspective of health. In the biomedical tradition, disease is defined by the presence of abnormal pathology as agreed through the scientific process underpinning medical science, and the absence of disease regarded as a state of

health. Such a perspective gives little space for alternative views of health and ill-health (for example see Gordon, 1988, p.25; Kleinman, 1980, p.32). Furthermore, the main disciplines of medicine, such as internal medicine and psychiatry, reflect an implicit dichotomy of the person into soma, or body, and psyche, or mind. Arising from this dichotomy, a distinction is made in clinical practice between physical and mental disorders, and the signs and symptoms relating to these, a distinction that does not resonate with refugees of Southeast Asian origin (Frye, 1990).

The analysis shows that the predication on clinic populations and employment of biomedically-derived instruments evident in the majority of studies confirm existing perspectives of refugee health. Of the 61 studies categorised, less than half (27) report on clinic populations, and an additional 22 community-located studies have employed biomedically derived instruments. A focus on mental health is reflected in that over half (32) of the 61 studies analyzed describe psychological morbidity, including 13 discussing PTSD and trauma, in contrast with just 7 reporting on communicable or chronic disease. The emergent discourse on cross-cultural health care is evident, with 17 studies reporting on traditional beliefs, and/or utilisation patterns and/or change of health-related practices. All the qualitative, community-located studies reflect this interest. The shaping of beliefs about the health of refugees by the research carried out on them is even more obvious when Cambodian-related studies alone are analyzed, shown in Figure 2.

QUANTITATIVE

Populations and communities as subjects
Mainly survey methodology

<p>Burke (1980) Carlson et al (1991) Cheung (1994) Cheung (1994 [b]) Cheung et al (1993) Cheung et al (1994) Cheung et al (1994 [b]) Cheung et al (1994 [c]) D'Avanzo et al (1994) Lenart et al (1991) Rumbaut (1985) Sack et al (1994) Uba et al (1991) Weeks et al (1991)</p> <p>Total - 14</p> <p>COMMUNITY</p> <hr/> <p>LOCATED</p> <p>Frye (1991) Kulig (1988) Sargent et al (1983) Smith (1987) Tudsri (1987)</p> <p>Total - 5</p>	<p>Baughan et al (1990) Buchwald et al (1992) Catanzaro et al (1982) Gyorkos et al (1992) Kinzie et al (1990) Lurio et al (1991) Yeung (1988)</p> <p>Total - 7</p> <p style="text-align: right;">CLINIC</p> <hr/> <p style="text-align: right;">LOCATED</p> <p>Boenhlein (1987) Boenhlein et al (1985) Cheung (1993) Drinnan et al (1991) Eisenbruch (1983) Eisenbruch (1990) Eisenbruch (1991) Kinzie et al (1984) Mollica (1988) Mollica et al (1987) Mollica et al (1990)</p> <p>Total - 11</p>
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(Ethnographic interview) Mainly interview methodology (Clinical interview).
Individuals and families as subjects

QUALITATIVE

FIGURE 2: Studies of Health of Cambodian Refugees, According to Method and Location
Total Studies Categorized - 37

It is seen that almost half (18) of the 37 published studies on Cambodian refugee health is clinic-located. Biomedically derived instruments are preferred in community-located quantitative studies. In all, over half (22) of these studies, including all except one of the clinic-located qualitative studies and all except five of the community-located quantitative studies, concern themselves with psychological disorder. Among the Cambodian population, widely acknowledged as the most traumatised of the Southeast Asian refugees, interest in PTSD and trauma/torture

sequelae dominates research on mental health, particularly in the clinic-located qualitative articles. Community-located studies, which for Southeast Asians generally have shown a preference for relating mental health to acculturation, in the case of Cambodians demonstrate a shift to PTSD.

Studies that are clinic-located and qualitative in kind represent an influential body of literature derived from experiences in treating a relatively small number of cases in specialised clinics. These articles reflect Kleinman's (1992) view that thorough and careful clinical interviewing that also explores the personal context of illness is comparable to the ethnographic interview. However, the clinical interview must be seen as being distinct from the ethnographic interview, in that being diagnostically and therapeutically biased it selectively draws out the material that the clinician considers relevant for clinical purposes.

The lapse of time between first encountering severely depressed refugees and hearing their stories of trauma is described vividly by Mollica (1988, p.296). As for others working closely with Cambodians, acknowledgement of the role of trauma and torture in intractable ill-health opened up new and more effective ways of assessing and treating their patients (for example Boehnlein, 1987). These new models of refugee health, derived from clinical work with individual cases and including case material to support contentions being made, is a well-established method of developing clinical theory in medical science. Published clinical experiences with Cambodian refugees postulating theories and therapeutic models include: refugees as victims of trauma/torture (Mollica, 1988; Mollica et al, 1987; Mollica et al, 1990); refugees as suffering from PTSD (Kinzie et al, 1984; Boehnlein et al, 1985); refugees as bereaved of loved ones (Boehnlein, 1987) and of culture (Eisenbruch, 1991). Although refugees presenting at psychiatric clinics are presumably more severely incapacitated than those who do not, the perspectives derived from clinical work go on to shape beliefs about refugees as a class.

The other articles in this category do not propose an integrated model for the diagnosis and treatment of refugees, but using case material, sometimes a sample of

one only, endeavour to shed light on diagnostic and therapeutic challenges encountered. Examples here are Cambodian refugees demonstrating somatisation (Cheung, 1993); conversion hysteria (Drinnan and Marmor, 1991); and the inclusion of traditional beliefs and rites in treatment (Eisenbruch, 1983, Eisenbruch and Handelman, 1990). Such articles reinforce the view that refugees from other cultures may not present their complaints as "normal" patients do, and similarly may not respond to treatment in a predictable way, thus rendering clinicians somewhat helpless unless they acquire the necessary knowledge that explains such behaviour in their patients.

A second category of literature which is also clinic-based, describes findings of populations of patients rather than discrete cases, presenting these findings quantitatively. Clinical records rather than clinical interviews provide the principal source of data. It is this category which reflects the early concern with communicable diseases carried by refugees, (Catanzaro and Moser, 1982; Lurio et al, 1991; Gyorkos et al, 1992; Patchett and Brunton, 1993). Trauma was the theme of other studies on Cambodians (Yeung, 1988; Baughan et al, 1990; Kinzie et al, 1990). Reflecting the perplexity regarding health behaviour of Cambodian patients is the study of Buchwald, Panwal and Hooton, 1992) which surveyed patients about traditional health practices. This family of studies do little to advance understanding of Cambodian health. The data is descriptive, reliant on clinical records which may be neither complete nor accurate, and being generalised from a population of patients, lacks the richness of clinical case material. The picture that Cambodians suffer poor physical and mental health is reinforced, and findings regarding a clinical population are presumed to hold true for the Cambodian refugee population as a whole. To establish whether or not this is so is the stimulus for the next category.

The largest single collection of studies on Cambodian health are community-located, using quantitative methods. The topics reflect those that have captured interest in clinical settings, with the majority of community-located surveys estimating levels of psychological morbidity by applying instruments developed within biomedicine. While studies agree that Cambodians are the most distressed among Southeast Asian

refugees, comparability is limited because of the different instruments used. For example, Rumbaut (1985), using the Psychological Well-Being Scale, and Chung and Kagawa-Singer (1993), using the Health Opinion Survey, both expressed findings as a mean score, while Cheung (1994[b]) and Cheung and Spears (1994[c]), using the 28-Item General Health Questionnaire, presented prevalence rates. With adjustment and psychosocial factors often being evaluated differently, comparability is further limited. Relating scores from psychological instruments to psychosocial and acculturation factors describes co-presence, but does little to explain why and how such relationships occur.

A number of studies have sought to measure prevalence of PTSD in communities of Cambodians. Rates vary from 86 per cent (Carlson and Rosser-Hogan, 1991), through 18-58 per cent (Sack et al, 1994), both American studies, to a low of 12.1 per cent in New Zealand (Cheung, 1994). Differing prevalence may reflect variation in the cut-off point for determining presence, as Cheung (1994, p.22) suggests, or may equally reflect major differences in the environments in which Cambodians have resettled. For example, the continued presence of symptoms of PTSD may reflect fresh trauma from living in a hostile, even violent, neighbourhood. Studies linking trauma with adjustment (Uba and Chung, 1991) and distress (Chung and Kagawa-Singer, 1993) are deterministic in their conclusions, showing the continued ill-effects of trauma while not shedding light on those Cambodians who have also suffered trauma, but whose physical and financial well-being is more positive. A drawback in such quantitative studies is that questions raised by findings of surveys remain unanswered. Furthermore, the studies throw little light on whether those Cambodians assessed as suffering from PTSD are in fact continuing to function normally.

While the above studies reinforce the popular belief that Cambodian refugees carry a heavy burden of mental morbidity, the findings of the only two studies concerned with physical health do not conform to the pessimistic view of refugee health.

Burke (1986) found less evidence of raised blood pressure than expected. Like other Southeast Asian refugee groups Cambodian infants were found to have a lower mortality rate than white American infants with a lower risk profile, contrary to

prevailing views that Cambodian infants were at high-risk (Weeks and Rumbaut, 1991). Finally, four surveys of Cambodian healing practices showed that while these were still followed, with resettlement in the West there is a pronounced shift to using Western services, and little evidence of conflict between Cambodian and Western medicine (Cheung and Spears, 1994[b]; Chung and Lin, 1994; D'Avanzo, Frye and Froman, 1994; Lenart, St. Clair and Bell, 1991).

Community-located studies have advanced knowledge about Cambodian refugee health, in that data on levels of psychological distress in the non-clinic population is provided to complement experiences of clinic-located studies. At the same time, the level of confidence in these findings is compromised because of methodological concerns, and different instruments used limit comparability. A major drawback is that findings are seldom related to the social contexts in which morbidity and behaviour occur, thus not advancing an understanding of why Cambodian refugees both remain healthy and fall ill.

Studies both community-located and qualitative in kind represent an advance in this respect. All five such studies analyzed are concerned with culturally-embedded explanations of health and illness, and the interaction with those of the West where Cambodian refugees have settled. Smith (1987) focuses on mental illness, while studies by Tudsri (1987) in New Zealand, and Frye (1991) in the United States discuss Cambodian healing generally. A further two studies describe childbirth and fertility (Kulig, 1988; Sargent, Marcucci and Elliston, 1983), portraying Cambodian women as moving between Cambodian and Western systems of healing. The women readily use Western health care and at the same time use available Cambodian practices. Health decision-making is, in qualitative community-located studies, portrayed as a dynamic and complex process, a complexity which the somewhat static descriptions of surveys fail to convey. Such findings offer an alternative perspective to that dominated by morbidity. However, with the exception of Smith's (1987) descriptive study on mental illness, the studies reviewed do little to promote an understanding of the experiences of and meanings ascribed to illness, pain and suffering.

Conclusions from Reviewing and Categorising Literature

The analysis highlights the fact that the choice of research method has a bearing on the kind of knowledge generated, irrespective of whether the research is carried out on clinic-based populations or in communities. Characterised by a medical orientation and the methods derived from it, the body of research on health of Cambodian refugees depicts their physical and mental health status as generally poor. High levels of psychiatric morbidity demonstrated in both clinical and non-clinical populations are attributed to both adjustment stress and trauma. Clinical diagnosis and management can be complicated by unusual presentations of complaints and expectations of treatment. Although it is suggested that there are high levels of unmet need for psychiatric care and a tendency to somatise mental distress, there is no evidence of a reluctance to use Western health services.

Derived from the dominant biomedical paradigm of refugee health, most studies set out to answer questions raised by existing theories, but seldom challenge these. Research on Southeast Asian refugees frequently takes such stereotypes as a starting point, evident in introductory reviews of previous literature on refugee health generally, as well as that of Southeast Asian refugees, which effectively reinforce a particular view. An example of such stereotyping is illustrated in a review article by Boman and Edwards (1984). Drawing from a variety of sources on Vietnamese, this article depicts "the Indochinese refugee" as demonstrating high rates of psychiatric dysfunction yet reluctant to express feelings, ashamed of mental illness, distrustful of Western medicine, prone to psychosomatic complaints, strongly attached to family, whose women are accorded a low social status, and so forth. While useful and critical information appears in the article, it is such oft-repeated generalisations that go on to shape beliefs held by health professionals about their refugee patients. This article is but one example of the dangers for refugee populations inherent in the very process of academic writing, when views expressed are frequently cited by subsequent researchers and generalised to other ethnic groups even though the descriptions may not in fact apply nor be supported by research.

In fact, the Southeast Asian refugee population is marked by multiple ethnicities and language groups, as well as by social and educational differences, a point often obscured in literature referring to them collectively as Indochinese or Southeast Asian refugees. Kulig (1990) also takes issue with the tendency of some literature to stereotype along gender lines. She notes the common depiction of Southeast Asian refugee women as "frightened and shy (who) refuse pelvic examinations", and is especially critical of the merging of women with the reproductive function (Kulig, 1990, pp. 51, 54). Not all studies support the position that refugee health status is generally low. For example, a comparative study of recent European, Middle East and Southeast Asian refugees found that their health was generally good, and similar to that of the American population of equivalent ages (Young, Bukoff, Waller and Blount, 1987). But such findings seem drowned out by those supporting the popular view derived largely from clinical populations and methodology.

In spite of the substantial literature on Southeast Asian refugee mental health, as a body it suffers from a number of weaknesses, most of which have been pointed out by authors cited in the above review. Most important, there are no baseline measurements available of psychological health in these refugee populations, prior to their experiences of war, flight, confinement in refugee camps and of adjustment in the West. Findings among refugee Asian populations are frequently compared with levels of morbidity among populations that are neither refugee nor Asian, a practice which is questionable but nevertheless widespread, and reinforces the belief that refugees suffer high levels of ill-health. Added to this, the cross-cultural validity and reliability is questionable of instruments that have been developed in and for Caucasian populations, and comparison of findings using different instruments limited. Most studies are cross-sectional, although there are important exceptions to this. The earlier practice of presenting Indochinese refugees as a homogeneous group has blurred the differences among them. So too, generalising from a clinic population to the general population is a practice of questionable validity, yet it seems to be commonly practised.

Research to date on Cambodian refugees thus generally reinforces the stereotype of

refugees being traumatised and in poor health. The focus is on those demonstrating morbidity, with little research attention on the healthy. An alternative perspective, that refugees demonstrate resilience in the face of adversity, and are creators of culture out of the remnants of the old in the context of the new, has received little attention. Concluding their respective reviews of literature on the health of Southeast Asian refugees, van Deusen (1982), Muecke (1992) and Kulig (1990) reflect this alternative view, all expressing dismay at the propensity of literature for isolating health and illness-related issues from the total processes of settlement and habilitation of refugee populations in the broadest sense.

A perspective based on positive features of refugee adjustment would offer a way out of the medicalisation of refugee suffering (Muecke, 1992). The view that we have much to learn from refugees, who somehow manage to maintain a sense of order and dignity in the midst of chaos and lack of control, is shared by Donnelly and Hopkins (1993, p.2), and Rumbaut (1985, p479), but as theories of refugee health these have yet to find acceptance. More subtle still is a view of refugees as creators of cultural systems, including the system of healing, an elusive subject because of the very rapidity of change which refugees commonly undergo. Such a perspective could incorporate meanings they ascribe to their pain and suffering, meanings which are currently marginalised by the dominant theories.

Location of the Study on Cambodian Health

The present study is community-located and qualitative in nature, building on the knowledge of Cambodian systems of healing generated by other qualitative studies, but going further by explaining the lived experience of illness in the personal, historical, and social contexts of change in which it occurs. The focus of the study is illness and healing as a cultural system, a system embedded in the total culture of resettled Cambodian refugees. These cultural systems are sharply discontinuous with pre-war and pre-migration Cambodian culture for many reasons. Firstly, the culture of the people of Cambodia was decimated through the deliberate policies of the Pol

Pot regime which attempted to establish an ahistorical materialistic society from "Year Zero", described in Chapter 5. Secondly, as a people transplanted first to refugee camps, and then to New Zealand, Cambodian refugees have been undergoing rapid culture change. On top of this culturally derived knowledge, values, and ways of seeing and interpreting the world are continually being challenged in the process of the ongoing, intimate interaction with the Western culture which is the daily experience of resettled Cambodians, portrayed in Chapter 6.

This process of redefinition of the cultural system of healing is further impelled by the fact that the health status and specific health problems of Cambodian refugees are different from those Cambodians knew prior to becoming refugees. The experience in total for Cambodian refugees, of surviving war and genocide, flight and confinement, and now resettlement and acculturation pressures, would be expected to dramatically affect all aspects of well-being. Hence, the prevalence and dimensions of morbidity attributable to war and migration-related trauma are, as we have seen, the most-researched aspects of Cambodian refugee health. A neglected aspect is the effect of the total refugee experience on the way Cambodians experience, interpret and ascribe meaning to these illnesses. To dip back into pre-refugee beliefs and norms alone, as other studies have attempted, is insufficient to understand these issues; after all, the refugee experience is quite outside traditional norms.

This study explores with participants their interpretations, opinions and questions about the causes of their illnesses, along with their uncertainties and sometimes fears about the course illnesses may take. Whereas at one time such knowledge (as distinct from the outcome of illness) would have been more certain, such is the social and cultural disruption accompanying geographical relocation that this no longer is the case. The responses of Cambodian refugees to the experience of illness are inquired into, revealing a rich pattern of using Western, Cambodian and other techniques and medicines, employing both self-care and professional treatment, in their search for healing. As a longitudinal ethnographic study, interpreting illness and healing in the contexts of both past life experiences and current culture change, the research occupies an area which has received little attention.

Chapter 4

RESEARCH METHOD AND PROCESS

During a period spanning almost three years, from late 1991 until mid 1994, I gathered and verified the data that has provided the basis for this interpretive study. The methodology employed and the process followed are explained fully in this chapter, but briefly, comprised the "focused conversation" (or in-depth interview), carried out with the assistance of a Cambodian interpreter. Most of these conversations were tape-recorded, and translated and transcribed by independent Cambodian research assistants.

The location of the study was Palmerston North, near where I live and work, which enabled me to attain the level of interaction required by ethnographic research, especially given the constraints of maintaining a full-time job. Palmerston North is a small city and regional service centre located in the lower half of New Zealand's North Island. Among its increasingly ethnically mixed population of some 70,000, between 350 and 400 Cambodians reside. According to a refugee staff worker, the Palmerston North community is particularly interesting in being sufficiently large to allow a sense of community, yet not so large as to weaken the element of all members being known to one another. Most of the resident Cambodians have arrived in the city within a ten year period, and apart from some new settlers coming under family reunification policy, there are unlikely to be further increases in this community. On the contrary, this community is experiencing some losses due to onward migration, particularly to the north. Thus, in the course of this study, some interaction went on outside Palmerston North, in Hamilton (where several families who were participating in the study now live), in Wellington and Auckland, and even in Sydney (Australia), to talk with key informants identified by my research assistants.

The research questions that guided the study are set out in the opening of this chapter. I go on to describe the process of conducting ethnographic research, and the particular challenges posed by doing so among an ethnic minority population. The

principal way in which I addressed some of the difficulties encountered in this was to work with an interpreter and transcribers, an experience I describe in some detail. The participants of the study are introduced, and after this a description is given of the actual process followed in collecting and analysing data. I address the range of ethical issues posed by researching a community that is vulnerable on account of its linguistic and ethnic minority status, and moreover is known because of its refugee status to be a traumatised population. Going on from ethical concerns that arose, I conclude the chapter by considering the politics of conducting research among an ethnic minority.

Research Questions and Rationale

I set out to make what was previously not well known or understood about the health of resettled Cambodian refugees, as delineated in Chapter 3, both known and meaningful. Specifically, I was interested in these issues as they related to the Palmerston North community in New Zealand, in view of the probable influences on health and illness experiences and interpretations of such contexts as New Zealand's health system, the more general social and physical environments, and the small city location. The following interrelated questions guided the conversations and dialogues:

- What are the illness experiences of these Cambodians, and how do they understand and explain them ?
- What self-care strategies do they employ, both Cambodian and Western?
- What are their patterns of interaction with the New Zealand health care system, their expectations and experiences of it?
- How do the above compare with, and to what extent are they influenced by, their premigration experiences of illness and health care ?
- What are the effects on well-being of loss of access both to Cambodian healers, and to treatment strategies which are not readily available in New Zealand?

- What are the processes of cultural transformation that have occurred over the period of asylum and resettlement regarding illness and health care?

The conversations ranged over many more topics than these, particularly in relation to the broader contexts of Pol Pot's Cambodia, fleeing, life in the camps, and settling into life in New Zealand. However these were the questions which provided the basis from which discussions on broader issues emerged.

The rationale for the focus and selection of the above research questions arose from my reading of the relevant literature. The discussion in the previous chapter on dominant models of health of resettled Southeast Asian refugees demonstrates that perspectives are shaped by a clinical orientation, comparability among studies is severely limited, and the level of confidence in conclusions is limited by methodology or scope. In particular, the bulk of research on refugee health answers those questions that are raised by the dominant medical paradigm, while neglecting other equally serious questions. As a result, beliefs are shaped by resultant descriptions of morbidity, but even here there is an imbalance. While a great deal of research describes mental health problems, there is a paucity of knowledge about general health and chronic disease. Illness experiences, and interpretations of symptoms and illness phenomena are largely neglected. Descriptions of traditional beliefs and practices are static and stereotypical, and there is very little information on the relationship of the phenomenology of illness with patterns of utilisation of health care services, and pluralistic practices.

I have located no studies that examine the health of Southeast Asian refugees in the conceptual context of their transitional status. While their social and cultural transitions are acknowledged, together with the relationship of adjustment and acculturation to mental health, the effect of transition on their health-related beliefs and practices has not been systematically researched. It is principally this transitional process as reflected in illness phenomena and caring for health that is central to this study.

An Ethnographic Study

To generate answers for questions such as those posed above, ethnography was selected as the most appropriate method. Ethnography is described by Marcus and Fischer (1986, p.18) as a research process where the researcher closely observes, records and engages in the daily lives of those of the culture being studied. Using the ethnographic method of inquiry, I set about the task of constructing and interpreting the phenomenon under study, namely that of illness and health care experiences of the Cambodian community, in the contexts of their domestic settings, and of New Zealand society with its dominant biomedical health care system. This is a community with little prior experience of Western medicine, a factor expected to be significant for the rapid transition they were undergoing.

The study involved me in interacting with the Cambodian community over an extended period of almost three years, principally through dialogue with participants, but also to a lesser extent as participant-observer, a process by which I overtly observed the effects of illness on family and community life. Tonkin (1984, p.217) describes participant-observation, a process by which the researcher is involved in the daily lives and social interchanges of the life of the community being studied, as defining anthropological practice. At the same time, this very process is paradoxical, as greater levels of true participation arguably interfere with impartial observation and interpretation. As is common in anthropological research, my participation was as an outsider, by specific invitation or with tacit agreement. My actual presence was not appropriate or desired at all social settings, which meant that I could not rely on participant-observation as the sole method of gathering data. My outside position was an advantage in maintaining a critically reflexive stance, and at the same time rendered me reliant on the continued goodwill and co-operation of the community throughout the study.

In the context of participating in the community in relation to matters of illness, the principal method of collecting data was in-depth interviewing, unstructured interviews which are best described as "focused conversations". While dialogue is a key element

of participant-observation, in this study interviewing were distinctive in being specifically arranged and initiated by me, and focused on a specific phenomenon, in contrast to occurring spontaneously in the course of interacting in ordinary daily life.

All such conversations took place in the homes of participants, and ranged over a variety of topics. The usual form these took was that after the preliminaries were over, I would focus the discussion by asking a question or introducing a topic (see Appendix 1 for topics that provided the basis for initiating the conversations). Normally I would start the discussion off by raising a question or an issue that was central to the study. Thereafter the conversation frequently took on a life of its own triggered, but not necessarily narrowly focused on, the topic I had initially raised. As I explain below, my reliance on face-to-face interpretation meant that I had less control over the directions these conversations took than would normally be the case, which had the serendipitous effect of facilitating the identification of issues that might otherwise have remained unnoticed. The majority of these conversations were tape-recorded, and subsequently translated and transcribed by two independent Cambodian research assistants.

These conversations I recorded in note form, and in addition tape-recorded in the second phase, as explained below. Data generated by dialogues was supplemented by my observations of the physical and social settings in which these took place. I recorded these at times by photographing the scene, but mainly in the form of descriptive notes, such as the example below:

Old man squatting smoking by fire (fire smoking and not too warm). Grandmother trying to put one baby to sleep. Daughter with another child. Daughter-in-law perched on arm of chair suckling the infant born last week and entertaining her older one (there really are a lot of people in this room for the available seating). This young mother looks very pale, sallow even. Garlic outside drying in sun, on step. Eight adults and 4 kids live here, 4 b.r. house, their own. Into the midst of our conversation came another elderly couple who turned the place into a market - set out their produce on a cloth on the floor and began to sell veg! This often happens, Sok says. They brought news of the sick infant, very serious apparently, in ICU.

Conversational and observational data were supplemented with involvement in events as a participant. On the request of participants, I sometimes accompanied them on visits to their doctors, invitations extended mainly so that I, too, could hear what their doctors told them, so as to be able to answer questions raised for them by the explanations that frequently were poorly understood. This was with the knowledge of the doctor, to whom I explained my involvement with "their patient" and certainly these visits provided elucidating information to supplement the stories told me. Along with members of the Cambodian community and their *kiwi* friends, I visited them in hospital when their conditions necessitated admission.

I also took part in community gatherings such as those celebrating major annual festivals, or concerned with the affairs of the Cambodian Association, and some life-cycle occasions such as birthdays, merit-making ceremonies, and funerals. Increasingly, I participated in ordinary domestic life as a friend who called to visit, sometimes staying for a meal. These occasions enabled me to glean additional information when interacting in domestic tasks. For instance, on one occasion when I was assisting to prepare a meal by cleaning spring onions, one of the women commented that when a baby has a very tight belly, rubbing a spring onion over it sometimes helps. On occasions I looked at photographs and videos of far-off family and friends or a much-copied video movie in Thai or Khmer, and even engaged in the exchange and sale of culinary products and artifacts. Most poignantly, when during the course of carrying out the study I myself became quite disabled with illness for several months, I was regularly the recipient of Cambodian self-care techniques believed to ease pain and dysfunction, offered, from their supplies of medicine, Thai, Chinese and even Western medications to try, and even offered hospitality until I had recovered.

Hammersley and Atkinson (1983, p.24) argue that a major advantage of ethnographic research is its flexibility, allowing a potentially fruitful but perhaps previously unsuspected line of inquiry to be followed. Indeed this was the case in this study, in which certain Cambodian explanations of illness and suffering, such as those they translated as "fright" and "nerve" disturbance, promised to shed more light on illness

phenomena than the Western medical categories of, for example, Posttraumatic Stress Disorder. Further, traditional mechanisms for resolving anxiety seemed to outweigh the pessimistic outlook derived from theories on trauma, exile, and minority status. While this is not to deny that problems and long-term effects of trauma do occur, this study suggests that other dynamics are also at work.

An ethnographic approach to health-related research, argues Kleinman (1988, p.128), represents a radical departure from the way clinicians see and construct the world of medicine with its convergence on its objects the patients. Ethnographies of illness take instead a divergent approach from the subjective position of the patient as key player. The accounts and explanations that are thus generated are, however, different from and greater than a subjective study; they make up a series of "local worlds" which although apparently fragmentary, demonstrate a coherence in the intersubjective flow of actions and relations uncovered in the course of ethnographic research. At the same time, Kleinman and Kleinman (1991, p.276) caution that the temptation for the anthropologist to "professionally transform" the suffering of the subjects is no less than that for the clinician. In other words, the dilemma facing both clinicians and anthropologists, who are faced with the anguish of refugees in the course of their work, is that distress must be transformed by being medicalised or anthropologised, respectively. This is accomplished by the process of categorising, labelling, and developing explanatory models of distress, a process which may comfort the professional, but not necessarily the sufferer.

Given that the ultimate aim of research is to make what was previously unknown, both known and meaningful, it has been persuasively argued by Hinds, Chaves, and Cypess (1992, p.62) that to attach meanings to phenomena and accounts of these depends on a knowledge of the multiple contexts in which these phenomena occur. These authors caution against a painstaking description of a specific, and perhaps most obvious, context, while overlooking the multiple layers which they describe as immediate, specific, general, and meta contexts. While the obvious contexts for the ethnographies of illness and health care of Cambodians were those of their homes and health service facilities, other contexts emerged as highly significant. These

included the general physical and social contexts of Palmerston North; the personal historical contexts of Cambodia and the refugee camps; and the meta contexts of Buddhism, Cambodian culture, the Cambodian diaspora and global politics.

Issues in Cross-Cultural Research

The problems of conducting studies of ethnic and linguistic minorities, and specifically Southeast Asian refugees, have received some attention. There is the sheer complexity of issues, including flight, asylum, transition, changes (usually downward) of occupational and social status, adjustment, and acculturation, that must be addressed if a meaningful interpretation is to emerge. Liu and Cheung (1985, p.506) point out that few studies view the refugee community as a social group, but rather focus on specific matters that affect refugees without consideration of the context of this social group. Problems that particularly plague survey methodologies include those of sampling, non-response and response errors, conceptual and linguistic non-equivalence between researcher and subjects, and problems in recruiting and training interviewers (eg Liu, 1982, p.2f; Pernice, 1994, pp.209ff; Won and Kwang, 1979, p.63ff; Yu, 1985).

These problems are not altogether overcome by avoiding questionnaire surveys. Responses even to open-ended questions may lack validity because of the way a question is framed, and because social and cultural factors militate against answering fully or truthfully. While my choice of an ethnographic approach sidestepped some of these difficulties, there remained the subtle cultural and situational differences that influence disclosure. As Liu (1982, p.4) suggests:

A Chinese proverb says, "before a stranger it is better to express only one third of your opinion". For immigrant populations, perhaps the proverb should be changed to one fourth.... For refugee populations, one's whole opinion should probably be entirely withheld.

In the light of this discussion of ethnic minority research, my inability to converse

directly with participants, a limitation that forced me to work with an interpreter, proved serendipitous. As we struggled together to find the meanings attached to phenomena, our very difficulties in finding linguistic and conceptual equivalence forced a deeper exploration of the issue. I frequently needed to rephrase a question to ensure that my interpreter grasped the point of it. Similarly, as I reread transcripts of tapes there are recorded many times her attempts to ensure I understood:

"Have you got it?" she would demand. "Have you got that about the *dtoas* ?"

And then would follow more discussion among all of us taking part, as I was often slow in grasping such concepts.

Selection and Roles of Interpreter and Transcribers

My knowledge of *khmer* is limited to a smattering of words, and many adult Cambodians among those interviewed had as yet a limited facility in English. It was therefore necessary to work with an interpreter when engaged in the focused conversations. Tape-recorded interviews were translated and transcribed by two persons not involved in interviewing.[1]

The choice of interpreter was most important for the process of generating data. Obviously I required someone fluent in both *khmer* and English, able to translate both language and concepts. This narrowed the field to only a few, mostly young, Cambodians. Moreover, this person needed to be available at times which suited the participants, which as it turned out was during the day in weekdays, and not evenings and weekends as I had expected. I wanted someone who was fully part of the Cambodian community and their history, sharing a common background and therefore able to empathise with participants, which excluded young bilingual Cambodians who had grown up mainly in camps and New Zealand. I did not want a trained health care professional such as a nurse, as such a person was likely to

affect respondent disclosure of traditional beliefs and interpretations, and I would have risked an overlay of respondent accounts with the interpreter's "educated" view.

In the first instance I approached the leader of the local Cambodian Association for assistance in selecting an interpreter. He suggested three possibilities, and of these, Sok both met my criteria, and was available and willing. This choice did not go unchallenged by the transcriber/translators of tapes, for reasons that will be made clear in the following discussion. Their concerns included the following aspects: that there were other Cambodians whose English was better, she didn't know some English names for human anatomy and diseases; she did not confine herself to a literal translation of questions and responses; and that a more educated interpreter would have obviated the need to tape interviews.

It subsequently transpired that other social and ethnic issues underlay these objections, such as the mutual antagonism that at times emerges between Chinese Cambodians and ethnic *khmer*. Reflected here are the political factions that are a feature of the Cambodian Association, conflicts between Cambodians of urban and rural origin, as well as conflicts between the educated and less educated. My experiences in this respect heightened my awareness that the Cambodian community is not a homogeneous group, but one characterised by ethnic, political, and (increasingly) intergenerational differences.

The choice of the translator/transcribers was equally important to the success of the study. Again, I first requested assistance from the leader of the Cambodian Association, pointing out that this person needed to be highly literate in both English and *khmer*. Young people who grew up in Southeast Asia, but had been educated in New Zealand, I thought would be suitable. One such person was identified, who was willing but uncertain that she had the skills. She then suggested SomNaang, a student completing his degree at university, who agreed to assist. Having completed most of the tapes, SomNaang left the country before the final four were translated. His suggested replacement, a young professionally educated woman, was as competent

as SomNaang, and having been furnished by him with detailed guidelines as to how to carry out the task, the standard of her work was comparable. The guidelines prepared by SomNaang are included in Appendix 2. These two young persons were ideal in several respects, not least because with their keyboard skills they were able to provide me with typed transcripts.

The interpreter, Sok, and the translator/transcribers of tapes, particularly SomNaang, themselves became key informants. In her research among Cambodian women in Wellington, Crosland (1991 [b], p.40ff) likewise reported that her interpreter was her key informant. In my experience, this was particularly the case with Sok, who was intimately involved in selecting participants as well as in every interview, and inevitably influenced the data through her two-way interpreting. Furthermore, as we drove away from participants' homes she would frequently add her interpretation to what we had been discussing, or contribute stories of other experiences, her own or others she was familiar with, all of which was most useful in establishing the linkages among individual stories and contexts. She was also my principal sponsor for participating in Cambodian festivals and meetings, and took it upon herself to instruct me in social mores, conventions, and the expectations participants had of me.

The role of SomNaang (and later, his successor) differed. Unlike Sok, he had a university education, was from the urban Westernised section of Cambodian society, and did not hold with many of the beliefs and explanations of illness that the participants, including the interpreter, had. He voluntarily informed me of alternative interpretations and views (reflecting those of urban educated Cambodians), verified these with his sister (who had studied medicine in Phnom Penh for five years prior to the Khmer Rouge regime), and introduced me to his mother to add her accounts to those of my participants. When it came to translating words and concepts for which there were no corresponding English terms, these two translator-transcribers furnished me with detailed explanations, supported by dictionary references, drawing from the leading *khmer* and *khmer-English* dictionaries. SomNaang's accurate and thorough documentation and explanations are displayed in Appendix 3.

An example follows of the interplay between myself as interviewer, the participant, Sok as interpreter, and SomNaang's clarifications and comments. SomNaang used a system of brackets, with round brackets denoting spoken and translated *khmer*, and square brackets distinguishing his own additions or comments for clarification. I had asked a participant, BoPa, about a recent medical investigation for headache and other symptoms:

BoPa: (They said nothing was wrong, just that [my] blood was not circulating properly. Nothing was wrong.)

Sok: She said her brain, that's okay. Her blood and her nerve for the blood running, [is] not normal.

BoPa: ([they] said nothing was wrong. All were normal. But just told [me] not to *gkuet cj'rourn* [think too much], because that one [is] like you said.)

BoPa was then advised at some length by Sok, together with another woman present, as to how she should stop herself "thinking too much". At the end of this SomNaang offered one of his personal opinions, an example of his interaction with material throughout the transcriptions:

[I think it can be quite dangerous for some (untrained) self-appointed counsellors to deal with or offer advice to people like "BoPa" in cases like hers. From my own experience (with this *gkuet cj'rourn* problem) there would be nothing wrong with "thinking", if it was forward-looking, if the thinking was complemented with action....]

A reading of both the translated conversation, and the commentary offered by the translators, brought home to me the extent of divergence in views and beliefs about illness and health care among Cambodian refugees. This divergence reflects regional and socioeconomic differences in the Cambodian origins of refugees, as well as intergenerational differences and the influence of a Western education. Having personally moved from a largely biomedical perspective on health and illness to a much more eclectic one, I now needed to face the reverse process evident in Cambodians settling in the West.

A Study in Two Phases

As I embarked on this ethnography, I was conscious of the vulnerability of the Cambodian community, reflecting their marginality and newness in New Zealand society, and arising from the trauma of experiences surrounding their refugee status. For these reasons I undertook a preliminary study during 1992, having first worked on building relationships and seeking assistance from recognised leaders of the community over the previous several months. Thus I was able to "test the waters" as far as acceptability of such a study by the Cambodians was concerned, and to establish a basis for further focusing of the research.

This preliminary study involved in-depth interviewing in their homes of those who agreed to participate, with the assistance of Sok. Criteria for eligibility were that they were adult, and had experienced illness since arriving in New Zealand which necessitated interaction with the health care services and its clinicians. I was heavily dependent on contacts within the Cambodian community, in particular my interpreter, to identify and initially contact eligible persons, using a networking technique to do so. None who were approached refused to participate, although it became clear that some were much more forthcoming than others. On the recommendation of the interpreter, and others who either knew the Cambodian community well or were themselves Cambodian, interviews at this stage were not tape-recorded. The reasoning was that tape-recording could be threatening to them. None, however, objected to my making written notes of the interviews, notes which provided my major record of data at this stage. In the first phase, the data I collected mainly described details of episodes of illness and interactions with health professionals and facilities.

This cautious approach paid off. When it came to extending the study into the second phase, which was carried out during 1993-94, trust had been established and none objected to my tape-recording of conversations. The recording apparatus was neither distracting nor intrusive. Although the study could have been carried out without the

introduction of audiotaping technology, its use contributed to the generation of a rich base of data. This was particularly important in the second stage of the study which focused less on the details of the illnesses themselves, and more on the contexts of illness and the explanatory models held.

In the chapters that follow, the findings of both phases of the study are reported as an integrated whole. It makes sense to do so, as there was a great deal of overlap and interflow between the two phases. Together, they constitute a single coherent study. In combination, the data allow me to make the thick descriptions characteristic of ethnographic research, and to present these narratives of illness in the wider context of the total experiences of these Cambodian refugees.

Study Participants

The key participants included twenty-one adults, invited because they were reported to have experienced episodes of illness since settling in New Zealand necessitating their interaction with the health care system. No distinction was made regarding the kinds of illness, whether physical or mental, acute or chronic, life-threatening or relatively minor and of brief duration. As it happened, all of these kinds of illness experiences were represented, which enabled the experience of illness, as distinct from the diagnosis of disease, to be thoroughly explored. The single most important factor which these experiences had in common was that assistance outside the household was sought for treatment of the illness, which enabled me to pursue the related issue, that of experiences of health care. In addition, traditional Cambodian health practitioners became significant participants, including two *gkru khmer* (Cambodian healers), two *chmorb* (traditional birth attendants), women skilled and active in Cambodian therapeutic massage, a lay injector, and vendors of medicines. Some of the twenty-one people who had suffered illness were themselves traditional health practitioners, or their spouse contributed from this perspective. Sok and her household are included in this group of people, who together represented sixteen households (a term I am using to refer collectively to the residents, normally related,

of separate dwellings). This includes about a quarter of all Cambodian households in Palmerston North.

The involvement of these key participants was invited because I believed that they had much to contribute to an understanding of experiences of illness and health care of Cambodian refugees, and not simply because they were representative of the Cambodian community. I was told that their backgrounds are typical of Palmerston North Cambodians. All had arrived in New Zealand since 1984, the most recent in 1992. Almost all had fled Cambodia in 1979, with the exception of a couple of families who had left in the early 1980s after they concluded that the prevailing political and economic instability was likely to continue. One participating family, having fled in 1979, had returned to Cambodia for several years, before fleeing a second time out of fear of the Vietnamese occupying forces. Overall, the participants had spent between five and thirteen years in refugee camps, with sojourns of six and ten years being the most frequent, a pattern that reflects experiences common to Cambodian refugees.

In terms of the social and demographic characteristics of the twenty-one who had suffered illness, fourteen were female and seven male, with ages ranging between 27 and 80 years, the average being 48 years. Thirteen participants were less than 40 years, five in the 40-69 year range, and three over 70 years old. Seventeen were married, three widowed, and one had never married. None of the participants lived alone, with widowed and unmarried adults living with relatives or friends. Only five of the households comprised nuclear families (that is, parents and their children), while the majority demonstrated some form of extended or stem family. The numbers of people residing in these households varied from two (an elderly married couple) to eleven (two related nuclear families of three and four children each), with five or six being most common (comprising parents and their children, and often a grandparent). I was told that in some households in the Palmerston North community there were up to three families living together.

All of these households, including that of the interpreter, were from rural village

backgrounds, except for one military family of the pre-Pol Pot period. Represented in several of these families were supplementary occupations such as mining, school teaching, vendoring and soldiering (including in the Khmer Rouge), and as described above, traditional community services such as the carrying out of life-cycle ritual services, healing and attending births. In contrast, the translator/transcribers' families were from urban, educated backgrounds. While their role in the study differs from that of the key participants, their remarks and clarifications about issues raised in the interviews added a valuable perspective.

I have explained above that the study was carried out in two phases. Those who agreed to participate in the preliminary study included seventeen adults, a group which formed the core for the ongoing ethnography with the exception of three who either moved away, or had less to contribute and seemed to run dry in the initial phase. This number was added to as the study progressed. As I and my study became better known, there tended to be an increase in the number of people who turned up when I had arranged to interview a key participant. A characteristic of ethnographic research conducted in natural settings is that others add their accounts and interpretations to those already offered, thus helping establish linkages and increasing confidence in individual accounts as shared experiences. The actual number of people involved in the "focused conversations" therefore far exceeded the core of twenty-one together with traditional health practitioners.

In addition, I interviewed key people of New Zealand's Cambodian refugee population in general, namely the Cambodian Buddhist monk in Wellington, and a Cambodian staff worker at the Mangere Immigration Reception Centre in Auckland. Discussions were also conducted with New Zealanders working with refugees, and with Australian and Cambodian staff of two facilities in Sydney, Australia, set up to provide language and cultural adjustment resources, and post-trauma counselling services, respectively.

Certain information offered by principal participants referred to such matters as beliefs, preferred behaviour and protective ritual within the Buddhist frame of

reference, as well as their understanding of migration requirements, matters about which I sought clarification from those with recognised expertise in their respective areas.

Participants are introduced by pseudonym and described at the beginning of Chapter 5. Table 1 sets out their relationship to one another and the constitution of their households, and in Table 2 an overview of their illness experiences is provided.

Effects of the Research Process on Phenomenon under Study

This ethnography is a critically interpretive and reflexive study. As researcher, I needed to continually recognise and make allowance for my own presuppositions, biases and indeed my very presence and questioning, which themselves affected the social phenomena I was seeking to interpret. Watson-Franke and Watson (1975), discuss in their article the distinction between commonsense and science, and between a subjective story presented in a journalistic manner, and that story interpreted in the light of other stories and contexts. In anthropology, the central themes in interpretation, or hermeneutics, are the relationships between a phenomenon and its component parts, how these are integrated, and the dialectical process of arriving at understanding.

There were times in the course of carrying out this research when the sheer scale of human tragedy, and at the same time human endurance and courage, threatened to interfere with such an interpretive perspective. As I interacted with the narratives of migration, exile and illness of the Cambodian participants I risked merging my own such experiences with theirs, on the one hand, and of being alienated from them by the very differences in degree, on the other. Some of the stories told so overwhelmed me by their pathos that the interpretations and connections I set out to establish were likewise subsumed. On such occasions, I wept for them as they mourned, struggled to rebuild their lives, and confronted frustration and disappointment as they sought relief from their pain and illness.

When I was able to refocus on the phenomenon I was studying, these individual stories became part of a shared experience, common to many Cambodians resettled in this part of the world. Descriptions in accounts of interpretive research did not prepare me for the experience of alternately identifying with the study population to the extent of experiencing a sense of alienation and anger on their behalf, and being painfully conscious of the distance between us, irrespective of my empathy with them. It came as a relief, therefore, to read of other researchers who likewise were deeply affected by the histories of their participants, yet accomplished the critical, participatory research they set out to do (Thompson, 1991, p.33).

Hammersley and Atkinson (1983, p.14ff) point out that philosophical difficulties related to the researcher's being part of the phenomenon under study are resolved by acceptance of the reflexive nature of research. They go further, however, in arguing for this reflexivity to be turned to advantage with the ethnographer exploiting her/his role and person. My involvement with families suffering illness, my known expertise in health and first-hand experience of illness and health care in Asia, unavoidably affected the phenomenon under study, as for example when interviews entailed not only my gathering information from them, but their soliciting information from me.

When requested I accompanied them to their doctor to help them secure the explanations and interventions they desired. In one instance I proved to be the impetus for a man with intractable ill-health to try an alternative form of treatment, in this case acupuncture, which did effectively relieve him of some of his distress for a time. I have indicated above how this area of expertise in particular was to my advantage in developing my role as participant-observer. My previous careers as nurse and midwife were obvious personal attributes and credentials which proved useful in securing their interest and co-operation, particularly when they themselves stood to benefit from my knowledge of the health system and of Western medicine. I was also seen as a potential surrogate sponsor by some, to supplement their sponsor or fill a void where a sponsor was no longer involved. (See also Rashbridge, 1993, who describes the benefits accruing to participants from their contact with the researcher.)

This particular study was complicated by my need of both interpreter and translator/transcriber, thereby introducing another major dimension into my task of interpretation. Sok's involvement in this study and the effect she had on the social world that was its focus was considerable. The potential for her to overlay my questions and participants' responses with her understanding and experiences was very high, yet at the same time her centrality to the study process facilitated the interlinking of stories. I was reliant on her to identify suitable participants and make the initial contacts, and it is likely that her personal circle of friends was well-represented. I do not see this possibility as a problem, however, in that it did not appear to result in any misrepresentation of the phenomena under study.

My reliance on an interpreter meant that I had less control on the direction these conversations took than would have been the case in a monolingual interview. There were times when the conversation drifted off the topic, and we did not return to the point of interest, but in most instances this could be remedied at our next meeting after I had reviewed notes made during the interview. Occasionally my low level of control proved to be an advantage, as the conversation ranged over subjects that I hadn't anticipated but which were highly relevant. An example was when I was trying to uncover the concept they translated as "allergy", which triggered a discourse on "fright", a concept I hadn't previously been acquainted with. There were occasions, as illustrated above, when the subject of the conversation prompted Sok to offer advice, or even a reprimand, to the person being interviewed, arising out of her own experiences and knowledge. While I had not intended this to happen, and was initially disturbed about the extent to which the research team appeared to be affecting the phenomenon, in retrospect I was naive to assume she would maintain her non-involvement (as briefed), the more so as she was a very active person in the community.

As it happened, her active involvement proved to be an added advantage, as I was thereby able to document the actual issues that I was asking about, such as whether they talked among themselves about past trauma and loss, and whether and how they advised another who was worrying excessively. Rather than compromising the stories

as told by participants, therefore, the interpreter enhanced the range and quality of information. The same can be said for the translator/transcribers. They contributed extensively to the data, offering their own perspectives on raw data and adding their own experiences and those of their families. Not only was the range of views thereby enhanced, but there were times when their comments provided me with the insight I needed to make sense of the narratives.

During the period in which I further analysed data, interpreted material and drafted the report, my continued proximity to and interaction with the Cambodian community was clearly an advantage. I was easily able to raise matters about which I was uncertain, to seek clarification, elaboration and verification of my understanding. This process of verification continued with the translator/transcriber agreeing to read a draft, comment on, and if necessary correct, my descriptions of historical events and definitions of *khmer* words and concepts. On occasion his reading provoked a personal reaction as for example his comment that "it is hard for me to read this as I, too, have experienced this". As I was personally affected in the course of conducting the study, so too were those who assisted me, and those who were involved as participants. The process of the research, therefore, affected the phenomenon that was being studied, and all who participated in it for the extended period of interviewing, analysing and verifying material.

Process of Data Analysis

As characteristic of the method of research, analysis of data was carried out concurrently with its collection. At the conclusion of each interview and its debriefing I reviewed my notes, including reflexive comments I made in the margins. These formed the basis for the next interview with that person, when I would follow through with issues that I wished to clarify or elaborate on. As some themes began to emerge as potentially significant, I would raise these with a number of participants until they had been thoroughly discussed by several people with different experiences and perspectives. An example of one theme is what they described as "thinking too much". The frequency with which this was mentioned raised the possibilities of either

interpreter influence or overlay (a concern which I had noted in the margin of my field notes), or that it was indeed a significant concept emerging in the study. I had hoped also to have the transcriptions of tapes available for this preliminary analysis, but the inability of the transcriber to keep pace with interviewing made this impracticable.

At the same time, throughout the period of interviewing, I often engaged in conversations about "my research" with people from a variety of disciplines, including geography, psychiatry, and psychology, as well as people from non-academic walks of life, for instance those who had sponsored refugees. Aside from the very pertinent suggestions they often offered, these triggered my own thinking in fresh directions. After one such exchange, I refocused my interviewing on the significance of "place" for health and health practices, themes I was initially interested in but had let slip as I pursued ethnomedicine and other issues.

Miles and Huberman (1984) regard this preliminary analysis of data, including reflexive notations, as essential to good qualitative research, the means by which the inquiry takes shape in response to the data itself. For me personally this deliberate critical hold on the data as it emerged was simultaneously invigorating and yet generated uncomfortable levels of anxiety, as I moved between the relative safety of predecided topics, and the more chaotic inquiry that shifted direction before emergent themes.

A second stage of analysis followed the winding up of interviewing. This occurred both on mechanical and conceptual levels. It involved categorising excerpts that were raised in these interviews according to subject, and then grouping the subjects. Using the example of "thinking too much", excerpts from transcripts on the concept were put together. These were then sorted into more specific groups, such as what causes this excessive thinking, and what is done about it, both in New Zealand and in Cambodia, and whether this adversely affects health. The next stage was to link these groupings of excerpts with other categories, such as adjustment, health, and distressing memories. Finally, "expert" comments were added, such as those of

Cambodians working with refugees, and the Cambodian monk.

While this is similar to procedures described by both Miles and Huberman (1984) and McCracken (1988), the actual process of doing so is less clear-cut and straightforward than such sources indicate. I found that I needed to review, sometimes several times, my initial categorising and sorting to address such problems as over-narrow categories that fragmented the whole, on the one hand, or became too general and thus obscured important differences, on the other.

Writing the thesis is itself to engage in analysis, taking the levels described above on to a third and higher level. While some refinement of categorising, grouping and finding linkages still goes on, at this point the findings are linked into the wider body of knowledge generated by research and scholarship internationally. As I intend to show, the illness-related experiences of this Cambodian refugee community can be understood in the light of some of this literature. As well, the findings of this study advance understanding of the health and illness of refugees and ethnic minorities, and of medical pluralism as fields of importance internationally.

Ethical Considerations

Research among ethnic minorities, especially of refugee origin, entails particular ethical considerations. Ethical issues in this study fell into three areas. The first and most general relates to research involving human subjects, the fundamental underlying principle being to "do your subjects no harm".

This consideration is complicated by the second consideration, that the Cambodian community is a vulnerable population. Cambodian refugees are vulnerable in their newness to the country: they may not be fully conversant with their right to decline from participating in part or whole at any time; and/or because of their desire to please members of the host country, including stranger researchers. They are also vulnerable in being ill and classed as "refugees", which in combination is likely to give rise to a perceived and real dependence on those about them as they endeavour

to find their way in an unfamiliar health care system, compromising their own sense of control and self-determination. This vulnerability and dependence may not only affect their capacity to freely continue their participation, but may also be a factor in their consenting in the first place.

The third ethical concern in this study is in respect to the likelihood that the participants may have been victims of torture, and certainly of trauma and loss. Although these experiences were not the focus of the study, not surprisingly participants did themselves raise them. Being mindful of Muecke's (1992) observation that revisiting a very traumatic past can worsen rather than alleviate distress, and that Palmerston North lacked professionals and facilities with expertise in working with distressed Cambodian refugees, I was anxious lest I thereby harmed my participants, even though I did not specifically probe into their trauma. After one disclosure of truly gruelling experiences, in this instance of flight to Thailand, I asked the narrators whether recounting that episode was painful or difficult for them. They assured me it wasn't, that they daily remembered these events, frequently talking about them among themselves. They went on to say:

From the stomach thank her for wanting to know such. The misery is such, the *khmer's* misery, our plight when we escaped. We don't mind, we want her to know. It is all true, true from the heart, and [we] want everyone to know about that too....

Rashbridge (1993, p.56) describes similar experiences in collecting narratives from Cambodian refugees as the cathartic effect for them in being able to relate their private hells to a sympathetic outsider. Moreover, there seems to be a legitimacy arising from the academic context of these narratives being told and published that contrasts with therapeutic contexts, a point made by others, shadow writers and co-writers, who refer to the blurring between the processes of healing and writing.

A major provision to protect participants in their vulnerability was my briefing of my interpreter, reminding her to allow participants not to respond to certain queries. On one occasion my questions about people in a photograph were rebuffed by the

interpreter. Much later, when I read the interview transcript, the way she was protecting participants became clear in her explanation of the interchange to them:

She seems very intrigued, but just now she seemed too curious.
And I said, "Why do you want to ask? It is not the sickness."

Similarly, the advantages of working with a member of the group being studied also lay in the more sensitive issues that the nature of this study occasionally uncovered. For instance, once when I was asking an older chronically ill woman what she thought caused her illness, she and Sok chatted away for a long time. Eventually I butted in, and the response to my query concerning the subject of their lengthy conversation was, much to my annoyance, that they were talking about their own affairs. As we drove away, Sok explained that the woman had been disclosing a matter of deep shame to her, a matter to which she attributed the exacerbation of her illness. Sok did not want to add to her embarrassment by translating then and there.

The matter of requiring written informed consent is questioned by Yu (1985, p.529ff) and Yu and Liu (1986) in respect to research on Southeast Asian refugees. Existing cultural difficulties in ensuring that consent is truly informed and free are complicated by their vulnerability, as discussed above, and further compounded by the deep fear and suspicion that many refugees have with respect to signing papers. The procedure of using a consent form, ostensibly to protect potential participants, can in fact be injurious, generating high anxiety.

As I embarked on the preliminary phase of this study, my intent was to comply with Massey University's human research ethics requirements by obtaining written consent. However, I was strongly discouraged by Cambodian leaders, for the very reasons that Yu and Liu (1986) outlined. I therefore proceeded (with the somewhat reluctant agreement of the Massey University Ethics Committee) on the basis of informed verbal consent. The experience of this ethnographic study has demonstrated that the spirit behind the normal requirement of obtaining written consent need not be violated by instead obtaining verbal consent, provided this is informed, free, and ongoing. In certain populations, the procedure described here is not only more

appropriate but safer.

I regard consent as a process, initiated at the outset of the study, when participants were given a written description, in both English and *khmer*, (see Appendix 4) of what I intended to do, together with a personal introduction and contact numbers. I also sought consent quite specifically for tape-recording interviews, and for taking photographs. Process consent has been suggested (Raudonis, 1992) as preferable to written informed consent when studying vulnerable populations. Particularly is this so with a flexible research approach that is responsive to emergent data, when the study involves interviews and participant-observation over an extended period of time. Its strength is that it provides for renegotiation between participants and researcher as the study unfolds. In the case of ethnographic research, when the borders between participant-as-researcher and participant-as-friend tend to become blurred, process consent is particularly appropriate.

Throughout the study I was watchful for signs of unwillingness to continue participation, such as avoidance, not keeping arranged times, or unwillingness to converse, with a view of letting them withdraw if they so wished. In fact, only one participant in the preliminary study showed her reluctance in these ways, and her involvement did not continue beyond the first phase. In another instance one woman thought, because of a question I asked about her health problem (commonly experienced by Cambodians), that I had been talking to her doctor, a concern relayed to me indirectly. While assuring her I hadn't met her doctor, I explained how I came by the general information that prompted my question. I also explicitly gave her an opportunity to withdraw, both personally and indirectly, an option she didn't take up.

Ensuring satisfaction of ethical requirements with respect to the confidentiality and storage of data was less problematic. Throughout the study, all data were boxed and kept safely in a private facility. At its conclusion, this data will be destroyed. I replaced names with a code (eg F3a) to label tapes and notes, and have used pseudonyms rather than proper names throughout this thesis. Individual identifying information is avoided unless it is important for the study overall, and the

aggregation of data where possible also helps to protect confidentiality. While due care has been taken to protect participants, people who know the Cambodian community well, including Cambodians themselves, may be able to recognise some families, although not correctly named, by the descriptive information. The matter of literate members of the refugee community having access to documents and interpretations about their group, setting anthropological research among refugees apart from similar studies carried out in distant lands, has also been raised by Krulfield (1993, p.36). Not only does it comprise an ethical dilemma, but raises questions of power between researcher and researched.

I required the interpreter and transcriber to abide by confidentiality agreements, and to indicate this by signing a letter to that effect, one copy of which they retained. Moreover, all of us avoided discussing details provided by one individual or family with those of another. Even so, as the study progressed, I was very conscious of cultural differences between the Cambodians and middle class New Zealanders regarding the nature and observance of confidentiality. It is fair to say that, to a far greater extent than is general in New Zealand society, one person's business is known by many among the Cambodian community. Although in this study my co-researchers willingly complied with requirements to respect confidentiality, it did constitute a cultural imposition. No such imposition could be enforced on others involved in interviews, however, who from time to time compared their experience with that of an acquaintance who was also participating in the study, or used examples about others to illustrate or strengthen the point being made.

In his critical discussion on the issue of cross-cultural ethics, Chritakis (1992) proposes four models, none of which, he argues, resolve the underlying difficulties. He concludes by arguing for "local" ethical solutions. While it can be argued that it is reasonable to apply uniform local ethical requirements to all research conducted in New Zealand, regardless of the ethnic group being researched or conducting the study, there is equally a case for negotiation and resolution of the issues between the parties concerned in respect to ethnic minorities. The Cambodian community successfully achieved such negotiation in this particular case by persuading me not

to insist on signed consent.

The Politics of Studying an Ethnic Minority

In concluding this description of the ethnographic study, I would like to address the issue of a person from the dominant culture of the society conducting research among an ethnic minority. Questions are being raised and objections voiced, with justification, about researchers who advance their academic careers on the backs of minorities, while those minorities stand to gain little or nothing (Stokes, 1985, p.3). The politics of research referred to in this statement concern power, the relative powers of researcher and researched which allow the study to proceed in the first place. It is this imbalance which traditionally enables the researcher to gather data, do things with that data (usually without further reference to those providing it), and finally earn academic and/or financial merit on the basis of the study, which is not enjoyed by the researched. Furthermore, the outcome of that research may be used to inform policy and services that affect the ethnic minority, which will deepen their sense of disempowerment if their view of themselves and their needs does not coincide with those of the researcher. While this holds true for research among human subjects in general, it is magnified in the case of a group whose minority status renders it socially disadvantaged.

The obvious way around this dilemma is for people from the ethnic minority to conduct research among members of their own community. In the case of this study, there are equally obvious reasons why this would be unlikely to happen. First, only now are young educated Cambodians graduating from tertiary educational institutes, and the few known to me favour courses in business and technical fields over those of social inquiry. This may change, but in the interim the opportunity to describe the processes both of transforming the culturally-embedded system of healing, and of adjusting to a very different health care system, will be lost. Added to this is the apparent, and understandable, priority of Cambodians to adjust to the New Zealand way of life and to be financially and socially secure, objectives which are likely to

militate against their conducting a study comparable with the one I have been engaged in. An added drawback of people studying their own culture relates to factions and power differentials that often exist within a given ethnic group. The more powerful may well impose their points of view on the less powerful, and use their social position to gain access to information, raising ethical and methodological questions.

To examine the issue from a philosophical rather than pragmatic position, the tradition of anthropological scholarship is based on the rationale that cross-cultural research by its very nature makes known those aspects of another culture that are implicit and therefore to some extent unknown to members of that culture. Members of the ethnic group under study lack the advantage of applying the critical perspective of the outsider, a role described by Malinowski as "interpreter of the native" (Watson-Franke and Watson, 1975). As Geertz (1983, p.57) points out, the posthumous publication of Malinowski's diaries well demonstrated that one doesn't have "to be a native" to know one. What anthropology offers, however, is more than and different from taking the "native's" point of view. Tedlock (1983, p.323) views the anthropological dialogue as creating "a world, or an understanding of the *differences between* two worlds, that exists between persons who were indeterminately far apart, in all sorts of different ways when they started out on their conversation." It is this *between-ness* of the two worlds of the anthropologist and the community being studied that characterises anthropological research, whether researcher and researched are of the same or different cultural groups.

These are convincing arguments that criticism of an ethnic minority being studied by an outsider is not an academic dilemma. The criticism therefore falls into the realm of the politics of research, a concern that the very process and possible outcome of the research potentially further disempowers the ethnic minority. In the case of refugee research, such concerns are particularly acute, as it was struggles of power that forced their relocation as refugees in the first place (Krulfield, 1993, p.30). Krulfield goes on to suggest that a shift in paradigm of research method is evident in response to these experiences. Participant involvement in the formulation of the

research, in the interpretive process, and their inclusion as co-writers of the reports of research blur the traditional boundaries between anthropologist and researched, and in so doing, reduce the differences in power (Krulfield, 1993, pp 36f; Thompson, 1991, p.31).

In the case of the present study, the very fact of carrying out the research in association with members of the Cambodian community went some way in addressing the concerns outlined above. I needed their co-operation and assistance in carrying out the research, and this was willingly provided as I have described throughout this chapter. I sought and took into account their advice on a variety of issues, to do with acceptability of the study, its process, and questions to be included. My involvement as an outsider provided that critical interpretive perspective as we painstakingly inquired into the multiple worlds of the Cambodian transitional generation. In this endeavour, I worked with members and leaders of the Cambodian community, principally with Sok and with the invaluable intermediary role of the translator/transcribers. These research assistants have had further input into my final interpretation by commenting on my analysis of data while in draft stage.

However, the paradigm of the study has not shifted as far as constituting truly participatory research; the final interpretation and the writing of the study remain my own. Like the phenomenon being researched, the study itself occupies a transitional territory. It falls in the middle ground between traditional anthropological research, where an outsider (myself) does research *on* Cambodians, and "new paradigm" research into which Cambodians are fully participating, involved in doing research on their own people. It was I who initiated the study, took the lead in seeing it through to completion, and the responsibility for the interpretation and report is mine. It is mainly the process of the research which has been characterised by participation, albeit informal, between myself and Cambodian assistants, in which a continuous give-and-take dialogue on progress, perspectives and interpretations was a feature.

While I have certainly benefited both academically and personally from the

Cambodian community and their willingness for me to carry out this study, I do not believe the benefit has been one-sided. Over the years of my involvement, mutually positive friendships have been formed, and certainly some Cambodians have benefited from my occasional role as informant about medicine, advocate, and facilitator (explained by Rashbridge, 1993, p.57 as patronage). In response to general criticisms that all too often the ethnic minority being studied gains little from their participation, it is not my intent to let this study languish in the archives of academe. These findings will potentially influence policy in New Zealand concerning refugees and ethnic minorities, and the officially bicultural health services. Finally, my hope is that the insights yielded by this study will be useful to health professionals caring for Cambodian and other ethnic minorities making up a growing proportion of increasingly multicultural and transglobal population structures. It is these findings and my interpretations of them that occupy the remainder of the thesis, beginning in the next chapter with insight into what it means to have narrowly escaped death by slow starvation or instruments of war, experiences which resulted in their becoming refugees in the first place.

Note:

- [1] I hold the view that to be able to speak the language of research participants is highly desirable. Depending on the level of fluency in the new language and the complexity and subtlety of the phenomena being explored, an interpreter may still be required to facilitate communication. Even so, the effort of learning the language of the other is an act of respect and commitment to the community participating in the ethnographic research. In this section I point out the unanticipated benefits of working with interpreters, but in no way do I intend to imply that to do so is superior to speaking the language of participants.

Chapter 5

SURVIVORS OF FORCED LABOUR, FLIGHT AND INTERNMENT

The process of inquiring into illness experiences of Cambodian refugees led to disclosure about life under the Khmer Rouge and in refugee camps. I have described in the previous chapter my caution in probing into the traumatic events that had precipitated their flight from Cambodia, and eventual resettlement in New Zealand. Significantly, Cambodians themselves frequently raised these issues in the context of discussing their ill-health, indicating that their experiences of that period continued to exert a powerful presence in their New Zealand lives. Being unable to forget lends support to the preferred theories of refugee mental health which, as we saw in Chapter 2, seek to explain illness in terms of pre-migration traumatic experiences of refugees. The willingness and manner with which participants related their stories, coupled with their desire that such events not be forgotten, point to alternative explanations which are raised in the course of this chapter.¹

The purpose of this chapter is to summarise the events that led up to the participants abandoning their own country and enduring confinement in refugee camps. As such, the broadest possible context of illness is painted, incorporating the refugees' personal histories into the national and international events that swept them into the destruction of rural life in Cambodia as they had known it. Important though that context is, the significance of the material is far greater than a description of background. Offered here are the perspectives of the refugees themselves on these events, and the effects they believe these experiences exert on their health. Narratives of their suffering, which are the focus of this chapter, enable an appreciation of the circumstances that they believe account in part for subsequent illnesses. While the theme reflects those of medical perspectives on refugee health, we will see in subsequent chapters that the implicit determinism can be challenged.

I will begin by introducing the principal participants and their households, going on to summarise the health problems afflicting them. From this personal introduction, I will proceed by locating these families in historical accounts of Cambodia. In doing

so, I seek to show that the bitterness of Cambodia's history, far from being impersonal, constitutes an intimately personal bitterness that persists as an element of the survivors' very existence. Personal histories of participants are interwoven with this collective history of the Cambodian people, making up a single fabric of bitterness that is both general and individual.

A second theme that occupies a prominent place in refugees' conversations and memories is the deprivation and suffering they experienced during the periods of internal relocation, forced labour and flight. Throughout, their very survival was at risk, and the danger increased if they showed fear and grief. Escape to refugee camps in many cases did not mean safety and plenty, and for many extending for a decade or more, was a period dominated by ongoing uncertainty regarding their destiny. In this chapter I show that although these experiences took place as far back as one and two decades, they retain a prominent and immediate position in the memories of refugees today.

I go on to discuss the meaning of being a survivor in terms of "mission", and also the relationship of survivorhood to a longing for a lost way of life, with its associated people and places. The chapter concludes with the premise that far from occupying a single place and time, that is New Zealand in the 1990s, these Cambodian settlers inhabit multiple places and times, reflecting the intensity of the events they survived.

Participants and their Illnesses

Driving through Palmerston North's suburbia one may pass a house that appears on the outside like every other house in the street, save for the collection of footwear at the entrance. In a casual meeting with the Cambodian occupants, one will see little to suggest the kind and degree of suffering they have lived through. Yet in his treatise on the Indo-Chinese exodus, St. Cartmail (1983, p.35) states that "Kampuchea has become a synonym for suffering". These Cambodian settlers are survivors of a genocide, which has become known as the "killing fields". Survivors of those "killing

fields" who participated in this study are now introduced, their relationships with one another outlined, and the illnesses with which they are afflicted identified, illnesses which many hold to be linked to the suffering and deprivation described in this chapter.

Those who agreed to participate in the preliminary study included twenty-one adults spread over fifteen households, and in addition, four Cambodian healers and midwives. The Cambodian healers were members of those fifteen households, except for one man and his wife, who contributed a sixteenth household to the study. A descriptive profile of the study population is provided in Chapter 4. Apart from Cambodian healers, individuals were invited to participate primarily because they had experienced illness in New Zealand necessitating their seeking help from the health care system. In terms of health status, they were not necessarily "typical" of the Cambodian community. With regard to pre-migration social characteristics, they were representative of Cambodians who had settled in the city. In the course of interviewing, others present contributed their own comments, which appear in the narrative of the thesis. Thus about one quarter of Palmerston North Cambodian households were included, which alone suggests that the relationship of refugee status, illness and resettlement warrants careful attention. Indeed, a number of participants, whose illnesses were incapacitating, expressed their frustration that illness experiences interfered with their ability to settle and enjoy life.

Participants are introduced by pseudonym on Table 1, which sets out individuals' relationships to households and to each other, and identifies their roles in the study. The number of persons per household indicates the number resident at the time of the study, not the total number of persons in the family.

Table 1: Principal Participants and their Relationships and Roles

Key

- * Other offspring have established their own households in Palmerston North
- # No related families in Palmerston North
- @ No related families in New Zealand
- = These households are all interrelated one with another
- o Since moved away from Palmerston North

Household Number	Pseudonyms	Total Persons in Household
1.	# Sok (key informant, interpreter, medicine vendor) SuBai (Sok's husband) Mrs Kev (Sok's widowed mother) + 3 children	6
2.	*o Mr Meas Mrs Meas + 1 daughter	3
3.	* Mrs Nhim Mr Nhim (injector) + 3 children, and spouse of one	6
4.	*o PolGkun (<i>gkru khmer</i>) Seorn (PolGkun's wife; birth attendant, massager)	2
5.	#@o BoPa Som But (BoPa's husband) + 3 children, including ViBaal + an older unrelated couple and their daughter	8
6.	=*o Mrs Cjea Mr Cjea (<i>gkru khmer</i>) + 2 offspring and spouses, 1 grandchild	7
7.	=*o Mr Chhum Mrs Chhum SomDey (Mrs Chhum's son) + 3 adult children, + grandchild	7
8.	= RoTaa and husband (Mr Chhums's son) + 3 children	5

Household Number	Pseudonyms	Total Persons in Household
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Key

- * Other offspring have established their own households in Palmerston North
- # No related families in Palmerston North
- @ No related families in New Zealand
- = These households are all interrelated one with another
- o Since moved away from Palmerston North

9.	= *	VuTaa and husband + 2 offspring and spouses + 3 grandchildren	9
10.	# o	RottaNaak SaRom + 4 children + RottaNaak's sister, her husband, and 3 children	11
11.	o	VuTy NeaRy (VuTy's wife) + 6 children + VuTy's widowed mother + 1 boarder (unrelated)	10
12.	o	VeasNa (VuTy's sister) BoNa (VeasNa's husband) + 2 children + BoNa's widowed mother	5
13.	* o	TiDaa (widowed) + son and spouse + 3 children	6
14.	*	Mrs Gket (widowed) + daughter and spouse + 1 child + 1 boarder (unrelated)	5
15.	# o	SomNieng and husband + 3 children	5
16.	@ o # @ o	ReakSmey and husband + 3 children	5

Table 2 indicates the kinds of illnesses from which the twenty-one participants were

suffering. Presented here are not formal diagnoses made by medical practitioners, but the sufferers' understandings of what is wrong with them. These illnesses range from relatively minor and temporary, to chronically and seriously incapacitating, even fatal.

Table 2: Principal Participants, According to Description of Illness

Household Number	Name	Illness
1.	Sok (medicine vendor) Su Bai Mrs Kev	Joint pain, tubal pregnancy Glandular fever High blood pressure, stroke, joint pain, chronic diarrhoea
2.	Mr Meas (Mrs Meas, birth attendant)	Asthma, heart attack, diabetes
3.	MrsNhim (Mr Nhim, injector)	Numbness, acute collapse
4.	(PolGkun, <i>gru khmer</i>) (Soem, birth attendant and massager)	
5.	BoPa SomBut ViBaal	Paralysed after childbirth Progressive muscular weakness Died in infancy
6.	Mrs Cjea (Mr Cjea, <i>gru khmer</i>)	Frequent colds and 'flu
7.	Mr Chhum SomDey	Cancer (died) Died in young adulthood
8.	RoTaa	Paralysed after childbirth
9.	VuTaa	Lost her mind
10.	SaRom RottaNaak	Abdominal pain, joint pain Allergic rash after childbirth

Table 2: Principal Participants, According to Description of Illness

Household Number	Name	Illness
11.	VuTy NeaRy	Chronic pain, dizziness, headache Tingling of hands when pregnant
12.	VeasNa	Headache, joint pain, dizziness
13.	TiDaa	Dental clearance, removal of goitre, lost her mind
14.	Mrs Gket	Dental clearance
15.	SomNieng	Toxaemia of pregnancy, removal of goitre, gout
16.	ReakSmey	Tuberculosis

The participants had all arrived in New Zealand within the previous decade, the most recent being two years previously. Apart from two families, all had fled Cambodia at the time of the Vietnamese invasion in 1979, and all had spent between six and ten years in refugee camps. The study population had backgrounds of a rural village way of life, where rice was the principal crop. One family had previously been in the military, and another had a Khmer Rouge background. Urban New Zealand society, its values and its institutions, including the health care system, were foreign to all, presenting ongoing challenges to make the required transitions. The degree of difference between the two societies becomes obvious when one explores the social, historical and political features of the land of their birth.

Traditional Cambodian Society

Cambodian village society was not extensively studied prior to the Khmer Rouge regime. There is a paucity of information, much of which is comprised of descriptive

material and generalisations. Chandler (1983, p.3) describes the widely depicted cast of mind of this rural society as conservative and unchanging, a changelessness he regarded as a myth but nevertheless a pervasive one. Regardless of political and social disruption, the village farmers had to get the crops harvested and raise families, in just the way they had always done. A society characterised by tradition is described in the Area Handbook for the Khmer Republic (Whitaker et al, 1973), updated just prior to the destruction of this way of life wrought by the Khmer Rouge.

The critical elements of rural society were the village and the family (Ebihara, 1974, 1987). Village society, termed a "critical cornerstone" by Ebihara (1987, p.23), was depicted as strikingly homogeneous, strongly bound by kinship and locality networks, and the sharing of a common economy and religion. Within village society, the family unit was described as the "basic and only well-defined enduring social unit" (Whitaker et al, 1973, p.57). The family is ideally a nuclear unit, sometimes including grandparents, with villages often consisting of a number of interrelated nuclear family households (Whitaker et al, 1973, p.57).

As recently as 1970 Cambodia was still primarily a country of rural farming communities, the rhythm of life set by the wet and dry seasons which determine the sowing and harvesting of crops, interspersed with festivals and holidays. While pre-war Cambodian society was made up of three sectors, the government bureaucracy, the Buddhist clergy and the peasantry (Steinberg, 1959, p.96), only the description of peasant life will be summarised. In village communities that were characterised by an absence of landlord-tenant distinctions, each family owned its own rice fields and vegetable gardens, occupying individual houses often constructed on stilts above mangrove swamps. Privacy was described as being at a premium in these bamboo and palm-leaf structures, and crowding common, giving rise to a situation of everybody knowing about everybody else (Steinberg, 1959, p.78).

Crosland (1991 [b], p.70) portrays the pre-Pol Pot village life described by Cambodian women settled in Wellington as one of enjoyment of a subsistence way

of life, with plentiful rice, abundant fruit, surrounded by family and friends and characterised by happiness. This somewhat idyllic portrayal of traditional village and family life is not fully supported by Ebihara (1974, p.306). She described the village she was in as representative of Cambodia's ethnic *khmer* peasantry. There, rice was grown only for subsistence on small holdings, with many villagers needing to turn to other cash-generating endeavours to make ends meet.

The traditional village society portrayed in early publications seems to have largely vanished well before the Khmer Rouge regime. Already by the late 1950s when Ebihara (1974) was observing village life, the only escape for children of poor families with little land was to seek domestic or other menial work in towns. People complained of poverty and hardship, a complaint echoed by Cambodians in Palmerston North when describing life before Pol Pot. Getting enough to eat was a constant worry. Nevertheless, that this struggle to subsist took place in an environment of pleasant thatched dwellings, verdant growth, and an abundance of fruit (Ebihara, 1974), was also alluded to by participants in this study. Unlike Crosland's (1991[b]) informants, in the case of my informants memories of hardship and insufficiency overshadow those of an idealised village life. Some of the older women describing to me how hard they had to work in the village, said that they have worried all their lives about the basic necessities, factors to which they attribute in part their current ill-health.

According to Ebihara (1974, p.321), although men enjoyed higher status in law and Buddhist doctrine, in the reality of village life the positions of men and women were virtually equal. Women not only had equality with men, but in fact may have been more central as custodians of social and moral values, keepers of the purse and marketers of surplus produce, as well as being equal or dominant in decision-making. There was no particular preference for the birth of male or female children. Parents were responsible for preparing sons for the period of late adolescence spent in the Buddhist temple, these being located in both village and town areas, and for arranging good marriages for their children.

Steinberg (1959, p.84 f) described the arrangement of marriages as cautious, both the young people and their parents having the opportunity to influence proceedings and ensure compatibility, with the result that divorce was reportedly uncommon. In Ebihara's (1974, p.315) experience, however, the influence of parents was often subtle and powerful, incompatibility wasn't uncommon, and did lead on to divorce. Neolocal residence for newly-weds was preferred, but in practice, until the couple could afford to establish their own residence, they commonly lived in the house of either set of parents. Both nuclear and extended households were, therefore, common.

Cambodians are adherents of the Buddhist religion, and its influence on everyday life and values, as well as on ritual activities and authority structures, cannot be underestimated (Steinberg, 1959, p.87 f). Until the mid-1950s, the King was the head of the clerical hierarchy and protector of the religion, which accounts in part for the persistence in authority and reverence accorded the King by rural Cambodians in particular. The monks and the Buddhist temple, the *wat*, occupied a central place in the lives of people, such as in the monks' begging for food giving daily opportunity for doing meritorious deeds, and the *wat* providing the focal point for regular and special prayers.

The orgy of killing that characterised the Pol Pot regime is incompatible with the Buddhist moral code, as a few participants in this study pointed out. Under Pol Pot's regime, all forms of religious worship, including Buddhist, Moslem and Christian, were ruthlessly suppressed, monks and priests executed, and temples, mosques and churches desecrated (Burchett, 1981). In spite of this, Buddhist beliefs and values have survived. On more than one occasion I was told of the avoidance in New Zealand by the more devout of digging in the garden on certain high days, lest they inadvertently kill a creature.

Ethnic conflict was purportedly not a feature of pre-Khmer Rouge Cambodian society, with the predominantly *khmer* population described as living peaceably with the few minority groups within its borders (Whitaker et al, 1973, p.71). Of these

minorities two were present from ancient times. The tribal *khmer* leou traditionally were jungle dwellers, but a farming way of life adopted more recently was similar to that of the majority of Cambodians. The Muslim *Cham* inhabited present-day southern Vietnam (previously Cambodian territory), and have been displaced westwards by the southward migration of Sino-Vietnamese people. Living along the Mekong river, the *Cham* pursued livelihoods in farming and fishing, and according to participants, led their own separate way of life, retaining both their language and religion. The *Cham* were feared for their spiritual powers, which *Khmer* people say cause misfortune and illness.

Two other significant minorities are the Chinese and Vietnamese, both of whom arrived between the late nineteenth and mid-twentieth centuries. Unlike the *Cham*, the Chinese frequently intermarried with the *khmer*, and spoke fluent *khmer* as well as their own languages. The Chinese in particular, but also many ethnic Vietnamese, tended to concentrate in urban centres where they were engaged in commerce (Whitaker et al, 1973, p.71 f). As one participant put it, having this ethnic mix was very useful for the Buddhist Cambodians for whom the killing of animals is proscribed; they would buy beef and fish from the *Cham* while the Chinese would supply pork and chicken.[1]

Apart from the work of Ebihara, much scholarship regarding Cambodia focuses on ancient history and on recent political events (Marston, 1987, p.10). A similar pattern is apparent from the narratives of resettled Cambodians. Although from time to time I enquired into life before Pol Pot, the people involved in my study had little to say. None harked back to an idyllic life characterised by sufficiency and safety. While they missed familiar features such as a tropical climate and fruits, the hardship and poverty were also recalled. Yet even these memories, it seems, have been eclipsed by the events of recent history that overran the village way of life. These events will be described in some detail in an effort to understand the reasons for rural poverty and civil war, culminating in the massive exodus from Cambodia and large-scale resettlement in the West.

Cambodia's Long and Bitter History

The tragedy of Cambodia's history, especially of the centuries since the collapse of the Angkorian kingdom, is a theme that runs through historical and political treatises. Chandler's (1983) history of Cambodia highlights the extent to which political and social affairs have been affected by the country's location between two powerful and hostile neighbours, Thailand and Vietnam. Over the past two centuries in particular, Cambodian rulers have been forced into deferring alternately to the rulers of neighbouring countries in an attempt to neutralise them, and have forfeited tracts of land to both sides in the process.

The origins of the Cambodians are uncertain, with early inhabitants thought to have come from India, China, or Southeast Asia's islands, or possibly all three. However, it is generally agreed that the area has been inhabited since 4,000 B.C. at least (Ablin, 1987, p.xvii), probably much longer (Chandler, 1983, p.9). Present day *khmer* language is very closely linked to the *mon-khmer* languages found scattered throughout Southeast Asia. The Buddhist Thais are culturally much closer to Cambodians than are the Vietnamese, who coming from a Sino-Confucian tradition migrated southward from present-day China, reaching the Mekong River delta as late as the seventeenth century (Chandler, 1983, p.115).

During Cambodia's "golden age" - the Angkorian era between the ninth and fifteenth centuries - the kingdom included parts of what are now Thailand, Laos, and Vietnam. Present-day Saigon, for example, was once part of Cambodia (Chandler, 1983, p.94), and Cambodia's influence is evident in Thai temple architecture. Cambodia was successively influenced by the brahmanism of Shaivistic Hinduism, Mahayana Buddhism (or Greater Vehicle), and Theravada Buddhism (Lesser Vehicle) (Chandler, 1983, p.3f). Chandler describes Cambodia's location as lying on the "cultural fault line", forming the extreme eastern edge of Theravada Buddhism and the frontier of expanding Sinicized Vietnam, herein lying an explanation for domination by both.

According to Chandler (1983, p.114 f) in the eighteenth and nineteenth centuries

Thailand and Vietnam were more or less equally balanced in power and prestige, in contrast to Cambodia which they regarded as "barbaric". In addition, Cambodia's relatively small population and low population density has rendered it vulnerable to being threatened by its more populous neighbours (Ablin, 1987, p.xvi). Diplomatic correspondence between Cambodia's more powerful neighbours indicates this in saying, "it is fitting for large countries to take care of smaller ones", and by referring to Cambodia as "an unruly child" (Chandler, 1983, p.114). The language of this correspondence further declared dependency in applying the terms "father" and "mother" to Thailand and Vietnam, respectively. At the same time, it reflected "the continuing struggle between increasingly incompatible parents for the custody of a weak but disobedient child" (Chandler, 1983, p.115).

In the early nineteenth century, the previously balanced power of Thailand and Vietnam, and their shared patronage of Cambodia, changed. Cambodia became a buffer state, and to survive engaged in a strategy of playing one "parent" off against the other in a quest for patronage and protection, losing independence and land in the process. Repeatedly invaded and occupied by one or the other of its neighbours, interspersed with civil wars, this period of Cambodia's history culminated in turning to the French for the purpose of securing protection against Thailand's domination (Chandler, 1983, p.4f; pp.115 ff).

From 1863 Cambodia was a French protectorate, a period characterised by Cambodia paying dearly for the costs of being administered by France out of its natural resources (Chandler, 1983, p.99). There was little investment by its colonial occupant in education and infrastructure. Traditionally Cambodia was a society of small independent land-owning farmers, but French taxation and control resulted in consolidation of land by the elite. By 1930, 20 per cent of the population owned more than 50 per cent of the land, and increasingly peasant farmer holdings were sufficient only for subsistence-level production. Even after independence the process continued, so that by 1970, 20 per cent of farmers were indebted tenants (Strand and Jones, 1985, p.22). Favourable conditions were thus established for receptiveness by the rural poor to the message of land redistribution being preached by the communist

insurgents.

It was the ousting of the French, a process that began immediately after the Second World War and was successfully concluded in 1953, that launched Cambodia into a period of continual instability and a series of bloody civil wars, culminating in the "killing fields". In the period leading up to the establishment of Pol Pot's revolutionary government of Democratic Kampuchea, the key political factions were those of Prince Sihanouk, who dominated Cambodian politics throughout the 1950s and 1960s, the right-wing republicans led by General Lon Nol, and the communist insurgents. Even today, and even in New Zealand, many Cambodians continue to ally themselves with one of these three political factions.

Sihanouk, who had succeeded to the throne at age nineteen in 1941, abdicated in 1955 in order to assume a more central political role than that of monarch (St. Cartmail, 1983, p.41). His monopolistic style of government generated increasing opposition from both right-wing factions and communist insurgents. In spite of his intense nationalism that successfully won Cambodia its independence, Sihanouk gave access to North Vietnam's troops to South Vietnam by way of the infamous Ho Chi Minh Trail, thereby reviving fears among Cambodians of renewed Vietnamese influence. Ironically, Sihanouk's apparent sympathy with communists lost him the support of the United States and its allies as well as Cambodian republicans, while at the same time his apparent sympathy with the Vietnamese provoked the ire of the communists. A communist insurgency against Sihanouk that began in 1967 culminated in a successful *coup* by General Lon Nol's Republicans in 1970 (Chandler, 1983, p.190 f).

Cambodia's crisis deepened as the authority of Lon Nol's inept and corrupt government extended to no more than a fifth of the country, including the capital, Phnom Penh, and a few other towns. The rest was in chaos as communist insurgents progressively extended their influence, eventually to cover 90 per cent of all territory. The Republican government enjoyed the support of the United States, a fact exploited by Pol Pot in winning popular support against the Republican government. The aerial

attacks by United States bombers, initiated by the United States in 1970 against Cambodian civilians, further encouraged the Khmer Rouge.

According to St. Cartmail (1983, p.43), more American bombs were dropped on Cambodia, a country against which war had not been declared, than against all of Europe in the Second World War. Cambodia's economic base was destroyed, including in 1969 the defoliation of nearly 40,000 acres of rubber trees. Land under cultivation dropped from six million acres to a little over one million acres, with rice production declining drastically. Between 1970 and 1975 some half million tons of bombs were dropped in heavily-populated areas, displacing at least half a million people. The internal refugees thus generated doubled the population of Phnom Penh. They lived under conditions of severe deprivation, lacking the most basic of needs (Strand and Jones, 1985, p.21; Tollefson, 1989, p.27).

One study participant, an ex-Khmer Rouge soldier who had joined as a youth, described how Pol Pot's forces were recruited largely from among poor peasant farmers of the hilly borderlands of Cambodia. Along with many recruits, he was attracted by promises of land redistribution, and because of fear of Vietnam and America. Successes for the Khmer Rouge came in the wake of increasing political instability along with American bombing of Cambodia. The issues of its ascendancy were to purge Cambodia of its feudal tradition, to rid it of its "exploitative" urban sector, and to defend the country against its outside enemies (Chandler, 1983).

So it was that well before the communist victory in 1975, traditional Cambodian life had in fact come to an end. However, it was the fall of Phnom Penh to the Khmer Rouge on 17 April 1975, that formally terminated the traditional society including its economy, culture and religion. That year became "Year Zero", marking the beginning of a new socialist Kampuchea without historical precedent. Seeing cities as sources of "bourgeoisie decadence", a first move of the new government was to empty cities of their populations by circulating rumours of imminent American bombardment. The next move was to relocate these two and a half million people and involve them in the nation-wide collectivization of farming. As St. Cartmail

(1983, p.46) put it, Cambodia was thus transformed into a vast concentration camp characterised by forced labour, starvation, torture and killing. During the 1970s the economy and human services of Cambodia were decimated, with schools, books and hospitals destroyed, and teachers and health workers executed or fleeing (Curtis, 1990, pp. 80 ff, 132 ff).

The misery, hunger and displacement of the people of Cambodia did not cease with the invasion by Vietnamese forces in December, 1979 to "liberate" them from the Khmer Rouge. According to St. Cartmail (1983, p.13), several divisions of Vietnamese troops are reported to have used toxic chemicals against civilians and the Khmer Rouge in Kampuchea in 1980, with further attacks in 1981 using "yellow rain", or trichothecene. The combined effect of genocide, war, starvation and massive flight from the country was a massive decline in Cambodia's population from about eight million in 1970 to 5.7 million in 1981 (St. Cartmail, 1983, p.39)[2]

Cambodia's historical hatred of the Vietnamese, and the treatment civilians received from Vietnamese insurgents during the 1960s and 1970s, precluded their perceiving the invading army as "liberators" from their own internal enemy, the Khmer Rouge. For example, one woman described to me how her mother was one of a party of women and girls working in a forest who were abducted by Vietnamese in the early 1970s. They were held captive for several months, completely at the mercy of their captors. Likewise, though Cambodians fled in their thousands to find refuge in Thailand, here too their deep distrust of the Thai made them ambivalent about seeking their protection. Participants told me of Thai soldiers returning the first groups of refugees, prior to the establishment of United Nations refugee camps, to the heavily mined borderlands, and forcing them at gun point to return to Cambodia. Those who weren't killed by mines were shot for refusing to return, and many of those who did manage to escape subsequently died of starvation and thirst.

The deep-seated bitterness and distrust of Cambodians toward their historical enemies persists. Tirades against the Vietnamese, and to a lesser extent against the Thai, are commonplace, occurring to a greater extent than against the French, and even the

genocidal Khmer Rouge. Emotions run strong regarding land on both borders which Cambodians say belonged to Cambodia, including the "Ho Chi Minh Trail" which has not been restored to Cambodia since the reunification of Vietnam. A particular grievance is against the Vietnamese who are alleged to have settled in Cambodia only since the 1979 invasion. In the course of the study a young man stated passionately that Thailand is currently taking Cambodian land by surreptitiously felling "marker trees", thereby pushing the border eastward, and at the same time capturing rare jungle animals. Whether or not these accounts are factual is almost impossible to ascertain, but they do illustrate the animosity Cambodians nurture toward their neighbours [3].

Resettled Cambodian refugees are vulnerable due to their marginality as refugees and as an ethnic minority in the countries where they have settled. This brief historical overview suggests that the vulnerability of Cambodians goes back much further than the Pol Pot regime, being rooted in several centuries of domination and patronage by more powerful neighbours hostile to each other and to Cambodia, as well as by their colonisation experience. From their comments on recent developments in Cambodia, Cambodian New Zealanders still perceive their native country as vulnerable to further losses of land and self-determination. Moreover, for these resettled Cambodians, the history of Cambodia is at the same time their own personal history. Consciousness and personalisation of history is reflected in the account of one young man.

Puk's Story

This is the story written in English by a Cambodian father ("Puk" being *khmer* for "dad") about his own and his family's experiences for his daughter's scrapbook. The writer SomNaang, who translated and transcribed taped interviews, made his story available to me to use. His own parenthetical explanations are indicated (thus), while my own inserts to replace proper names and summarise sections I have shown [thus].

Cambodia has had a very bitter and shameful history, more bad than good. It started well before Christ's birth... Through a series of fighting because of jealousy, invasions and so on the majority parts of Cambodia were lost to neighbouring countries namely Laos, Thailand and Vietnam. During last century... Cambodia was colonised by the French after ousting the Vietnamese and then the Thai... During these era Cambodia lost yet again a number of provinces to both countries, about four fifths to each. Too good to be true? Indeed it was true!...April 18 1975 marked the beginning of a nightmare for most Cambodians, including Puk. We were forced to leave our home and property behind to get out of the city...for a few days so that the Khmer Rouge could "clean up" the city [4]. It was around 8am on 18 April 1975 when 2 or 3 youths in black uniform and red scarves around their necks came and knocked at our door and ordered us to leave. QUICK! One of them pointed a pistol at Pa-Oum [child's grandfather] and said we would all be shot if we had not left by the time he got back... Because there were a lot of people on the main roads as well as us, we could not move very far, about 2 km from where we lived. We spent the first night of our exodus in the "open", alongside of the main road...Sewage, bodies and carcasses that had died during the fighting gave very unpleasant smells, and I could hardly sleep that night...because I am the sort of person who does not like sleeping in strange beds [places]...Several days later because your [cousins] were not feeling well...we decided to rest...Food was scarce, hygiene was a thing of the past, disease and death were very common. Days became weeks which in turn drifted into months. Your late Pa-Oum, a colonel, realised the situation was going downhill, so we decided to head south...Our stock of food ran low. We were persuaded to stay and help the locals (called the base-people) cultivate rice [5]...All of Pa-Oum's ex-bodyguards and their families were taken away to be "educated" because they told the Khmer Rouge what their occupations were (soldiers). Puk saw them being marched away... And that was the last time all of us saw them [6]... Before the harvest season arrived we were relocated...(north)...and then relocated again on the grounds that the base-people in another region needed our help. Before April 1975 about 30-40 per cent of Cambodia's population were producing rice and rice was abundant. But after [April 1975] more than 90 per cent were producing rice, yet the "new people" only had rice soup, in which the grains of rice could be counted, to eat [7]...If we were sick, they would accuse us of [being] either lazy or psychologically ill. Some people, including Puk, were sometimes really crook [slang for "sick"] and sometimes were just pretending to be sick (or psychologically ill). Our morale was just lower than zero, but who can blame us? For [we were] working 12 hours a day and had only two lousy meals...we could have chosen to die, [there were] many ways to die or get "educated"! But the will to survive, hoping that things would change for the better one day, outstood other negative temptations... Months had matured into years, things were getting quite bad. Your Pa-Oum got sick (his stomach got swollen) for a few days and passed

away (no medicine, just ancient remedy). A few months later, we got another [item of] shocking news, one of your [uncles] passed away. [That] family was separated from our main family, the reason was too bitter for me to describe, but one day I will have enough courage to write it down...It was followed by the [son's] death. I felt very - it is hard to describe because I was about 13 - I knew the difference between life and death and I love my family but at that time my life was threatened by a lot of other things too. Some months later [this family] was relocated... passed through our village... [we] begged the leader [to let us] reunite. It was useless. [This was] the last time I saw [them] and the dry innocent and helpless look in his face [of the 18 month old boy]. [He was] very skeletal, you know what I mean. We all stood, helplessly, watching the group making the journey into the receding trees along the road. **THAT WAS THE VERY LAST TIME WE SAW [THEM]**. Sometime later (I lost count of time) M. died of malnutrition (and disease). And then N's mum died, leaving this poor and helpless being behind...My brother got sick...he was very skinny (he was in his mid twenties but looked as if he was in his fifties)...

And so the narrative continued through to the invasion by Vietnam in 1979 when the family could return to Phnom Penh, their extreme poverty in the aftermath of the war, their flight to Thailand, and eventual coming to New Zealand. I was told there was just one survivor of that related family, who came to New Zealand along with Puk's family. I have reproduced the account as it was written without comment, to let the full impact be made of a young boy's experience, written factually by the man for his daughter. It is an account that is told with occasional cynicism, but seems surprisingly lacking in outrage or grief that must surely be stirred up by such tragedy and waste. Was it really only the strange "bed" and not the stench of death that gave him a bad sleep that first night? At the same time, there are limits to how much outrage and detail of the atrocities witnessed can be articulated in a written account, using a language acquired in adulthood, and addressed to a baby daughter born in another country.

SomNaang's narrative is consistent with accounts of experiences related by many. Like SomNaang, they often told of their experiences factually, sometimes jokingly, but not with overt anger or distress. Indeed, to joke about threats to their survival seemed to be a mechanism enabling them to talk about their suffering to me, a

person who hadn't lived through them. For example, on one occasion Sok laughed about being seriously threatened with execution after making a frivolous comment to a guard. While there was no sign of attempts to deny or repress events of this period of their lives, some versions did seem to be sanitised, cleansed of depth of emotion and detail concerning atrocities, or transformed by humour. A New Zealand sponsor has suggested that this may reflect attempts to protect outsiders from the true horror of their tragedy, and to protect themselves from being in the position of defending their experiences against possible disbelief or undue curiosity.

That their personal recollections are for them neither emotionally sanitised nor a joke became clear on those occasions when they seemed to forget the presence of myself and the tape recorder. Self-absorbed, engaged in remembering among themselves, their pain and sadness emerged. At other times, they will complain that they are still suffering from the effects of those years of starvation, of excessively hard labour, and of fear. Chronic diarrhoea and joint pain are among the symptoms that continue to distress significant numbers of these survivors which they attribute to deprivation.

Puk's story clearly conveys his sense of being personally a part of Cambodia's collective shame and bitterness. He hints at a grave collective sin committed at some earlier stage of their history, for which today's generation are suffering. Some participants went further, remarking that in their past Cambodians as a people must have been exceedingly evil to have deserved such suffering. According to this view, paradoxically, the *khmer* people are collectively deserving of their suffering, yet also exonerated of immediate responsibility.

The relationship between the personal and collective in terms of history is reflected also in the presentation of accounts of suffering. Whenever anyone referred to their suffering and losses under Pol Pot, I was repeatedly told that "everyone is like this", that any Cambodian I cared to talk to would have a similar story, differing only in detail. This generalisation is disputed by some, especially by "New People", who argue that they suffered much more as targets of the Khmer Rouge relocations and purges, in addition to being unaccustomed to manual labour. According to surviving

"New People", the lives of some of the "Ancients" went on virtually unchanged, depending on the area where they lived. Be that as it may, all ethnic *khmer* who participated in this study lived through grossly disrupted lives, marked by starvation and threats on their lives, and separation from their loved ones. The frequency with which they connected their individual suffering with the shared suffering of the Cambodian people suggests to me that the very fact that it was collective also provided them with a way of dealing with it.

SomNaang's allusion to what he perceives as his personal responsibility for the fate of the related family is suggestive of "survivor guilt", a concept coined by psychiatrist Robert Lifton to explain the passion of Hiroshima survivors to tell of that horror and the fates of those who died (Des Pres, 1976, p.39). Des Pres disputes the validity of the phenomenon of "survivor guilt" as a pathological condition, arguing instead for such emotions as guilt to be viewed in the context of the enormity of the experiences they have survived. In such circumstances survivors feel sad when others succumb, wonder whether they could have done more to prevent the death and even take personal responsibility for death, but then go on to accomplish the task of the survivor, of keeping alive the memory of the dead.

In his analysis of death camps, Des Pres (1976, p.13) is emphatic that what sets survivors apart from the rest is that survivors "choose life". Survivors of the concentration camps of Nazi Germany and the Soviet *gulags* described a critical first period of internment during which the vast majority of deaths occurred. It is principally in this period that survivors make their choice to stay alive, although internees are faced again with that choice repeatedly during their camp life. SomNaang makes this point explicitly in his statement that "we could have chosen to die". To choose death was easy, both volitionally and mechanically, a fact borne out by the death rate under the regime of Pol Pot. As Des Pres (1976, p.13) argues, to choose life in circumstances of hostility to choice, human dignity, and life itself is indeed a powerful action. This action was made by SomNaang along with millions of his compatriots. All subsequent challenges faced by Cambodians in order to secure a better future, experienced throughout the periods of living in refugee camps and

after arriving in the West, must be viewed in the light of a choosing to stay alive.

At the same time, my informants indicated that lives continued to be dominated by past suffering, for some to a distressing degree. From the personal histories that follow, a number of issues which continue to affect happiness and health are drawn out. These include sleep disturbances, preoccupation with past events, and living with bereavement.

Life Under the Rule of the Khmer Rouge

Prior to the advent of the Pol Pot government in 1975, the lives of the participants of this study were shaped by the slow pace of village life, with its enduring social structures and values. At the same time, they were increasingly being affected by political instability and the war in Vietnam. Yet in conversations with them, they seldom talked spontaneously about village life, aside from occasional mentions of such mundane matters as the way they carried loads, the reptiles they contended with in the fields, and the kind of transport to take them to the city. This period of their lives seems to have been largely eclipsed by the events that effectively destroyed the traditional life of the village.

Under the Khmer Rouge, personal rights over self, family and property were removed and given over to *Angkar Leo* (the regime, or as SomNaang put it, "Big Brother"). All suffered from shortages of food, medicine and other basic necessities. Currency was abolished, and the hiding of gold and gems with which to barter for favours, food and medicine became a key to survival. All experienced weakness, sickness, and were close to death and dying, along with the constant fear and even terror that was the hallmark of the regime. All lost loved ones during these years. Burchett (1981, p.4), a journalist present at the "Trial for Genocide of the Pol Pot-Ieng Sary Clique" conducted in Phnom Penh in August 1979, compared the regime with Hitler's Germany in these stark terms:[8]

Hitler tried to exterminate..."non-Aryan" groups. Pol Pot set about exterminating not only Vietnamese, Chinese, Islamic Chams, and other ethnic groups but also those of his own *khmer* race. Hitler brought in slave labor from...other countries and worked them to death in labour camps. The Khmer Rouge transformed their entire country into one great concentration camp...Hitler burned books by anti-fascist writers. Pol Pot and his gang destroyed all books and libraries, trampling on every vestige of Cambodian culture and tradition...the Khmer Rouge separated wives from their husbands and parents from their children and totally suppressed family life.

One such family that survived the regime now lives in a rented brick house in an unremarkable street in Palmerston North, reached by driving through an ordinary suburb. The ordinariness of the place conceals one of the most poignant and sorrowful of stories. This account was told to me by the attractive, smiling young woman occupying that house with her family, whom I shall call BoPa (see Table 1).

This family have no near kin in New Zealand, and indeed have largely lost contact with their families altogether. BoPa and her husband SomBut met and married in a refugee camp, without parents to assist with negotiations. They lived in refugee camps for ten years awaiting an opportunity for resettlement, and it was there that their two children were born and spent their formative years. In New Zealand they are acutely and painfully conscious of the aloneness of their small nuclear unit of "only four heads", lacking a wider network of kin. The following conversation between BoPa and Sok about her life under Pol Pot illustrates the nature of family disruption under the Khmer Rouge.

Sok: You said that they took you from your parents to go to the *cj'laat* [9] [mobile teams of children and youth]?

BoPa: Yes, [taken] from my parents for *suel'bpaak*. [This word refers to "art" but in the Pol Pot regime was synonymous with dance and music in the Chinese communism style designed to provoke hatred and anger.]

Sok: They got you to dance the *suel'bpaak*!

BoPa: Yes, [I] danced...and then when Phnom Penh was broken [taken over] [I] went to work in a factory.

Sok: How old were you then, do you remember?

BoPa: At that time, 16.

Sok: Only 16? So they taught you this dance? Everyone had to [watch] that. Even on the farm even in the field, the place where we work, we have that song coming up [all the] time.

Sok then explained her view of this to me saying:

They take her from her parents and [put her in] the traditional dance group. But [it is] not Cambodia dance, its a Khmer Rouge dance, like the one shown in the *Killing Fields*. Khmer Rouge [dance] is just Kill! Kill! Work! Work! that is all. When they come on stage they got the gun, yes, like that [demonstrated by BoPa]. I hate that. I hate that. When they got the [performance] everyone have to go and sit down and look at it. I hate to go to that, but we must go. Lots of people hate that because when we go to see the show, to see the art or something...[it is to] be nice, to make us happy, but that one [is] to kill! kill! and shoot! shoot!

I wondered whether BoPa's activity in the hated propaganda machine of the Khmer Rouge could be a barrier to her acceptance by the people subjected to it, but I was assured this wasn't at all the case. People knew that she and others like her did so involuntarily. Furthermore, as this excerpt indicates, not everyone in the Cambodian community is acquainted with the details of others' involvements during the Pol Pot years. Even ex-Khmer Rouge living in the community seemed to attract no undue dislike, especially if their rank was low, and indeed were often fully involved in community activities.

BoPa went on to describe the various areas of work that members of her group were involved in, including salt production and factory work. She mentioned that although salt evaporation ponds were formerly cemented, these were broken up so that extra work in rebuilding and maintaining them would be required, provoking this outburst among the people present:

Neighbour: They get rid of the concrete? That's stupid. Stupid Khmer Rouge. And they get rid of all the house. They knock the house [down] and make us build another one.

BoPa: And the bosses [the former owner of the plant] they still produced too. If they hadn't, what would we have to eat? And us learning. [At this point, I was told of the practice of executing these previous private owners and also "experts" of the overthrown government, once they had trained one of the "Ancients" to do the job.] The boss got, like, ten or twenty tons, and *Khmer* Krohom [Khmer Rouge] only three or four tons, because we didn't know how to do like them, and [didn't know] their technology.

Friend: Yes. So [nothing] belongs to us any more. We [are] just the group...So you just come to work just for food, not for your business. Just for your tummy.

BoPa: Everyone [is] the same, exactly the same. Whatever the teacher ate, the students ate like that.

While now it is safe to call the practices of the Khmer Rouge stupid, at the time to express criticism and opposition to the regime were punishable by execution, as indicated in Puk's story. Nevertheless, people described themselves as having been acutely aware of the irrationality of much of what was going on, and suspicious of its ideology. At the same time, the regime effectively controlled the population, partly by techniques of hard labour and starvation. The sheer hard work over excessive periods of time on starvation rations was a common complaint, and one they sometimes laugh ruefully about, joking over the watery "food" of indescribable colour and flavour, unfit even for pigs. NearRy, a young mother of six children, was, like BoPa, separated from her family as a teenaged girl and has not traced them since. She recounted with laughter how her work group was having to walk a considerable distance to their site of labour, setting off in the middle of the night to do so. In her exhaustion, she fell asleep during the march, yet maintained step with the others. Others, however, see little to joke about as they recount the sheer punishment of that hard, unconstructive labour in appalling conditions. Several attribute their chronic pain to prolonged and excessive labour, a premise further developed in Chapter 7.

The most potent weapon of control of the Cambodian population was the determined breaking down of cohesive social units, the village and family units, and the

undermining of trust. Villages were reorganised into communes and work teams, thereby replacing the household as the unit of production and consumption. Families were undermined and divided, with children beyond babyhood segregated into their own units under the supervision of a "mother", who was in turn controlled by a superior. Buddhism was suppressed as exploitative. Together, these strategies effectively brought about a dissolution of the village, the family and the *wat* that traditionally competed for loyalty (Ebihara, 1987). BoPa described her life in a youth group:

[In my group there were] ten, five boys and five girls... young children...During the day [we] worked together, but at night [we] had to sleep separately. The girls had to sleep in one group [supervised by a "mother", usually a young, single female] the boys had to go to sleep in the group of boys. They were not allowed to go out and meet each other. If [a girl] tried going out and meet another boy in the corner... they killed...If [the "mother"] does not take care they killed her...

Sok: In Khmer Rouge we give the name "pineapple eyes". You know pineapple? because they got too many eyes. In Khmer Rouge we called it like that because they are like pineapple eyes. Nowhere was safe [from the eyes of the *Angkor Leo*].

It was explained to me that these eyes could be anyone's eyes, with sometimes even one's relatives becoming the *Angkor Leo*'s appointed eyes reporting other people's "misdeeds" to the authority (see also Burgler, 1990). These "pineapple eyes" were themselves in a dilemma, when if they didn't report a "crime", they risked being accused of conspiracy, and being punished in the same way as the "wrongdoer". Sometimes these "misdeeds" were more to do with survival than criminal intent. As an example, one young man told me of the time he had voluntarily assisted with preparing a meal in the communal kitchen, and was caught eating the raw, almost inedible bark-like peel of the sweet potatoes he had been preparing. He was threatened with execution if he did so again.

Even those in authority, members of the Khmer Rouge, were under the same pressure to enforce tenets of the regime. One such Khmer Rouge supervisor (who described himself as "little", that is of low rank) talked of the fear each layer of

the hierarchy was under, which ensured they exacted compliance from those beneath them. He related how he had granted one day's leave to a man in the group he was responsible for, to visit his sick wife. The man was absent three days, thus putting this overseer at high risk of being punished, perhaps even executed.

Nevertheless, people continued to marry and have children. One woman explained that she was somewhat hastily married to a man she scarcely knew in order to avoid being taken by a member of the Khmer Rouge, who she said had prior claim over unmarried girls. Under the Khmer Rouge, though, family life, traditionally one of the most important and highly valued units of Cambodian society, the unit in which children learned skills for good living and were nurtured in the values of society, was targeted for destruction. BoPa described how she was removed from her parents in 1975 at the age of 16 years, and has not since seen nor been able to trace her parents or siblings.

I was with my parents until 1975. [The province she grew up in was in fact "liberated" by the Khmer Rouge well before the sacking of Phnom Penh.] When AA Pot [a derogatory term] came I was on tour performing the *suel'bpaa* [in villages] At that time I could come home sometimes, and my mum could visit me too. [Then] I got separated from them. Since 1975 [I have] never known [seen] my parents and brothers. At that time the Pol Pot took control, didn't they send us everywhere! I don't know what they look like, and don't know how old they are. I have almost forgotten all about them. And my brothers, I don't know what they look like now they have grown up.

Sok [relaying my question as to whether she and others cried much as young girls removed from home.] She said if it had been her she would cry every day. And I said we cried, but it was beyond crying already, wasn't it.

BoPa: It was way past crying. And when crying too much and thinking too much... the family doctor said not to worry. That is what he said. But how can I not worry if it just keeps surfacing?

Sok: She said she's thinking too much [about her lost family]. And when she was in the Khmer Rouge she cry too much until she have no tears coming. Yes, everyone like that, not just for her.

BoPa referred several times to her distress in being unable to picture her family, of not knowing whether or not they were still alive and of being unable to trace them. Someone she met in the refugee camp had once told her that they saw her father die, but she isn't sure if this is true. The only chance would be for her to go to Cambodia to try to find them, but as she and her ailing husband SomBut cannot work, they are unable to get the necessary money together. She can see no hope, and is preoccupied with thinking about these things. Even her surrogate family in Cambodia, the teenagers grouped together, met with tragedy when fleeing with their Khmer Rouge overseers from the invading Vietnamese. The train they were on was bombed and the severed half, carrying many of her friends, rolled back down the track to its destruction.

BoPa is one of several participants who frequently described her present situation as being dominated by her "thinking too much" about events in the past, whether some time back or more recently (to be discussed in depth in Chapter 6). Yet as so many experienced truly horrifying and tragic events over extended periods of time, it would be surprising if these events did not keep resurfacing. Sometimes people are "very upset", as they describe it, when they think back to those times. The kinds of experiences they related to me have been well-documented. For example, a journalist and documentary filmmaker collected testimonies of survivors in the years immediately following the collapse of the Pol Pot regime. Summing up his experiences, Burchett (1981, p.81) states:

Ask any Kampuchean child to draw a sketch of life as he or she remembered it under the Khmer Rouge. More likely than not, the sketch will be dominated by a black-clad young man whipping someone at a work site or clubbing someone to death on the edge of a mass grave. Such were the most frequent images portrayed by the many people I interviewed in the refugee camps...and during my five visits to Kampuchea between May 1979 and March 1981.

The film drama-documentary on Cambodia entitled *The Killing Fields* was screened on television at the time I was interviewing. Several participants declared they

wouldn't watch it, as they didn't want to go back to that time, but wanted to forget. Yet they cannot forget. One such is an elderly widow, VuTaa, who had recently been hospitalised for "losing her mind". She told of having had seven children, only three of whom had survived. One was killed by a mine, another in an accident in the forest, and the rest when young, before the war. Because of insufficient food, her husband swelled up and died after the invasion by Vietnam. Of her surviving children, one now lives in North America, and the two who live locally quarrel constantly. She is, she said, unhappy, and thinks all the time of those terrible years, as well as about her dead family members. She is always sad, describing her countenance as often misleading as to her inner mental state:

It looks like I'm not thinking, but I am thinking. Or looks like I am thinking but I'm not thinking. I'm thinking that I only have three children left, and [they are] always fighting.

She is not alone among elderly resettled Cambodians in her mourning. Sok's mother, Mrs Kev, also had a large family. Of her twelve children, she knows of four who are still alive, two of whom are in New Zealand. She worries about her children constantly, including those who are "lost", putting up with her daughter's reasoning that wherever they are, they are now adult and able to look after themselves. Like many Cambodians, she liked to remit some money to those still in camps (until their closure) and Cambodia.

In another house, a conversation centred around a display of snapshots on the wall of the home of an elderly couple. Mr and Mrs Meas are a particularly warm and welcoming couple, yet they, too, continue to grieve for their fragmented family. Of their nine children, four have accompanied them to New Zealand, one they knew had died, and the remaining three were scattered in Thailand and Cambodia. One of these whom they feared had died was "found" only in 1993, and one is still "lost". They are not sure where she is, but remarked that "maybe she is married with Thai, and she live in Thai, or she [has] died, we don't know." Their daughter described (in English) how the family members got separated one from another, and reunited.

In the war, during the communist time with Pol Pot, they separate the

children away from the parent, even when just five year old. Only the baby they [keep]...So when the war finish, the Khmer Rouge fight Vietnam, and everyone separates. That's why we [got] lost...Because when my dad moved to Thailand the children [were] separate, not staying together, because of Pol Pot. My dad...hadn't seen me for five or six years, [and] I [had] not heard anything from mum or dad. Someone said "Pol Pot killed your dad" but I didn't believe that. No news. I can't send letter to dad because it's just hard work... But when I moved to Thailand I found my mum and dad. Happy! Happy, and sad too. Makes me cry because I [thought] my dad and mum got killed by the Pol Pot...and my mum think me [dead] too...[she thinks] maybe my children died or sick. Because when we stayed in Cambodia we didn't know.

This young woman's account alludes to her powerlessness to maintain contact, her sustained mental anguish at not knowing the fate or whereabouts of loved ones, and her refusal to believe news of death while at the same time fearing that loved ones had in fact died. Concerning one daughter, the anguish of this family is not yet over. During the telling of this family's story, Mrs Meas interrupted, to reassure me that she was not complaining:

Please tell her that I am very happy to have come to your country, but I really miss my relatives back home. I often cry at night, sorry for them...nothing [for them] to eat. I have *chheu kuo kbal* [translated as "my brain hurts", commonly used to describe what it is like when one thinks or worries too much.]

Sok: She is here now, she is happy to be here, but her mind is still in Cambodia. And her brain was burnt. Everyone is like that, still miss their family in the back.

Mrs Meas: Here we eat free, good food, good sleep, and remember the people who died in the back...at night time, near dawn, when we were miserable. We think about it every day, never forget. I think I shouldn't [have] survived.

Mrs Meas' experience, which according to Sok is common to many, is of being grateful to New Zealand for being able to settle here, and yet constantly thinking of her loved ones left behind in Cambodia. Life in New Zealand thus incorporates both past and present time, traversing the countries in which they were born, found

asylum, and have now settled. She seemed anxious lest I interpret her admission of missing her family and weeping for them each night as a sign of ingratitude, and perhaps that as a member of the host society I may be offended. Mrs Meas is simultaneously living with and enjoying the remnant of her family in New Zealand, and yet constantly her thoughts are with those still in Cambodia and Thailand. It is not surprising that with such extended and constant sorrow, she is suffering from a "burnt" and "hurting" brain.

Yet whenever I visited this home, as was the case with many, I was invariably greeted with smiles and laughter that concealed the family's self-confessed continuing sadness, grief, and anxiety. Members of the family had been close to death, particular Mr Meas, yet at the time when I met Mr and Mrs Meas they had the appearance of a relaxed and healthy couple of retirement age. Likewise, the ordinariness of their suburban houses gives no sign that those who dwell within have survived such extraordinary loss and trauma. My occasional interchanges with New Zealanders reinforce popular impressions of Cambodians as people who are "happy, always smiling". Kiwis describe Cambodian refugees as "survivors", suggesting that this positive attribute which has brought them this far will see them through, and perhaps at the same time absolve the host society of responsibility for assisting refugees.

A similar observation of Cambodians was made by an anthropologist researching camp life, who pointed out that the serious psychological and social toll of long-term trauma and deprivation may not be apparent to a visitor, nor even to agency workers (Reynall, 1989, p.153):

The Khmer say "we smile during the day but we cry at night" - as a way of maintaining their dignity and pride. It is therefore essential to bear in mind that such problems will not necessarily be outwardly expressed or easily observable.

Common to all these narratives is that memories of Cambodia are dominated by those few catastrophic years of communist rule, which for refugees constitute the most recent experience of Cambodia. The focus of that period is the fate of loved

ones. Without exception, participants convey a persistent grieving for those known to have died, together with a sorrowing for those who are known to be living in hardship in Cambodia, and anguish concerning those whose fate is unknown. "Thinking" about this part of their lives occupies a significant position in the New Zealand lives of Cambodian refugees. Yet the countenance presented by the Cambodian participants towards outsiders was one of smiling cheerfulness, even when they admitted that they cried each night, and that their brain was hurting with their "thinking".

The narratives shed some light as to why Cambodian survivors convey happiness to outsiders. They do not wish to risk offending their hosts by showing unhappiness, and are anxious lest admitting to sadness is misconstrued as ingratitude. On a more mundane level, for many it is not possible to do more than communicate non-verbally, through smiles, as their facility in English is inadequate to do more (and so very few of the host population have learned *khmer*). More important, it is difficult to talk about such experiences with people who have not lived through those times, partly because explanation of background issues is often required. I suspect this underlay Sok's tendency to generalise, insisting that "it was the same for everyone", a technique that protected her and others from detailing their experiences. The result of living among people who have no first-hand experience of deprivation and genocide, and the limitations in being able to discuss such experiences with kiwis, combine to isolate Cambodians from mainstream society.

Flight and Asylum

Although living in the Pol Pot regime was indeed terrible, for some it was the experience of fleeing to Thailand that remains the single most traumatic memory. This comes through clearly in Yathay's (1987) account. He and his wife deserted their ill and starving child to flee for their own survival along with a band of other adults; some of the party, including his wife, never reached Thailand alive. As a survivor he carried with him the "not knowing" as to whether or not his abandoned

son had survived, and whether or not his wife would have lived had they not fled.

According to those with whom I discussed this period, some fled on their own initiative, while others were driven to Thailand at gun point by Khmer Rouge soldiers, themselves fleeing from the invading Vietnamese. As they fled, the soldiers alarmed the population with stories of Vietnamese atrocities, even blaming their own atrocities on the Vietnamese. Mr Meas and his wife related the kind of rumours and fear tactics that were terrifying the population, precipitating a terrified flight:

[We] heard someone say that the Vietnamese cut your head off, and they pin through [the Achilles tendon], putting string through... we never saw that but they just scared us so that we kept running...Another problem was the shelling, [Khmer Rouge] shot the cannon so make [us] believe it's true [that] the Vietnamese were bad...they shot the cannon right through the cave [where the people had taken refuge, thus setting them to flight again].

There were several possible routes, some across normal border crossings but made extremely dangerous by mines, bombing and strafing. Here, people like Sok would travel by night and hide during the day. It would take a couple of days of rushed walking, carrying babies, the ill and the maimed through a "no-man's land" littered with the bodies of victims, to reach the safety of the Thai side of the border. No-one weighed themselves down with luggage, and so they arrived in Thailand exhausted, starving, and often ill, an exodus of a magnitude that "exceeded the world's capacity to cope with" (St. Cartmail, 1983, p.35).

For others their escape route took them through the jungle-clad mountains. This was the experience of the remnants of the Meas family. Two adult daughters and their husbands joined their parents in relating this episode, at times interrupting each other, finishing one another's sentences, and for emphasis echoing one another as they went on.

When my dad move to Thailand, he [was] very sick, he couldn't walk...[He] sold the gold to buy medicine...

swollen...[because of] no food...and yellow skin [a sign of imminent death due to starvation].

...cold..

...cold in the jungle, so cold. No sun coming through...very cold..

...rain. I think summer time, raining...When we were escaping was it tenth or eleventh month?

The fourth month. We were escaping since [New Year].

Very cold. That month is hot over there, [but it was] very cold. And deadly insect bites...

From Battambang to Thai, and they [Khmer Rouge] herded us from Thai back to jungle...

[We were] so very miserable...

They push [us] to go to Thai ..no place to stay, they push [us] back to the border, to the jungle.

Water! Water was the problem.

The water was not that good.

The water buffalo urinated in the water, but we just had to drink...some died...

...we had to drink the water in the little ponds as we were so thirsty...

...and corpses lay rotten in the water...

[Sok, to me]: We're just talking about the background story.

At the time, this wasn't translated except in the most general of terms, as they had strayed off the subject of the interview, which was Mr Meas' asthma. This is one of many such examples of participants' forgetting my presence and that of the tape-recorder, and recalling their past experiences when memories were triggered. On this occasion, it was at Cambodian New Year when this conversation took place, prompted by recalling those who didn't survive at approximately the fourteenth

anniversary of their dying. In response to my enquiry as to how long they spent in such conditions, I was told that it was many, many months. They were terrified, starving and sick, cold, being subjected to forced marching, and the added assaults on their debilitated bodies by insects and contaminants in the water. According to the Meas, thousands of those who survived the genocide of the Pol Pot regime died while escaping. Experiences of flight added to those of excessive labour and hunger under the Khmer Rouge, which in combination have had ongoing consequences for health. In addition, several women in the study who had given birth shortly before or during their flight, attribute current illnesses to their inability to observe culturally prescribed practices. Participants' views on the aetiology of certain health problems lying in those experiences are developed in Chapters 8 and 11.

Thousands upon thousands fled in this way; in the Meas' group alone there were some three hundred. The Meas told of corpses lying on the trail, some lacking limbs that they assumed had been eaten by tigers. Others stepped on mines and died, while still others died from gunfire. When it came to swimming across rivers, many, all women and children, were swept away. These months were marked not only by constant, intense fear and the appalling deprivation which threatened survival, but by the stronger abandoning the more vulnerable in the struggle to reach safety and survive. On the other hand, there were instances of people who disregarded the risks to themselves, and helped one another out. Mrs Meas is a Cambodian midwife, and she and her husband went on to relate her experiences when her skills were called on during those times:

Mrs Meas: Some either died due to birth complication or gave birth to a dead baby...Some people left the baby behind, babies about this size, left on leaves... some were eaten by tigers. Maybe too tired to carry the baby. And some, not [with] her family, when the baby was born they left, had to go. Everyone had to go, the mother had to go and left the baby behind, because she cannot stay alone by herself...just went with the group, because it's hard to stay alone in the jungle. But some had the husband to carry [the baby].

Mr Meas: She is a midwife. We just wanted to help other people...[One woman with three children and no husband went into labour.] She had nothing to wear. The sarong, everything was filthy. And an old man cut

the umbilical cord with an axe. And he got some big branches and made a fire for her [to protect her from wild animals] and he left. And people had some bread and they gave her half a loaf, whatever they had. And she just stayed with the children with the fire going...and some [who] went that way gave a sarong. She stayed there for three day, couldn't go anywhere, until she gained a bit of strength to walk. [Other people passing] saw her, the men put more wood on the fire to obtain *phol* [merit for doing good]...and the newborn baby survived. How tired she must have been! She walked and crossed the mud, one child on her back, [going into labour], and she by herself in the middle of the jungle.

Steeped in values that proscribe the taking of life, the Meas and other survivors carry within them the memory of weaker ones being deserted, and of their powerlessness, in many instances, to stay and tend them. They fled to the imagined safety of Thailand. But even there, safety from protracted war, theft, and threats on their persons and lives didn't cease. The Meas continue their narrative:

Mrs Meas: After we had crossed the stream...we [reached] Thailand. The Thai maltreated us. At night they would come and rape the young [virgin] girl...come looking for the young and looking for the gold, looking for property to steal. Yes, it's another [difficulty].

Mr Meas: We got the small plastic sheet to make the bed, slept on ground in the open...some on leaves...We got sick from sleeping on the ground and the ground absorbed our energy. [We had] no medicine. [Transcriber's note: "Cambodians believe that when they sleep right on the ground it drains their physical strength."]

Mrs Meas: The Thai treated us badly. They inspected, and confiscated gold, silver...some who had something, they took it off...They don't kill, the Thai never kill...first it was alright, but later on they started to treat us badly. They came and searched for women...we could hardly sleep...some were raped...

Mr Meas: Some died...filled the eyes [I saw it with my own eyes]...the neighbours, they were put into groups...they put the young girls in the middle and the adults sleep around, just to keep an eye...at night time they never have enough time to sleep...keep awake every night.

Once the camps were reached, refugees were comparatively safe, unless they ventured outside to forage for green food or engaged in bartering clothes or gold for

food. The Khmer Rouge continued to deceive them prior to the establishment of the camp culture, extorting valuables and rice by threatening that the Thai would shoot them if such were found on their person. By then, although the Khmer Rouge lived with them in the camps, they were disarmed and relatively powerless. However, the Khmer Rouge continued to use the historical enmities with the Thai and Vietnamese to frighten and manipulate the refugees, even when experience did not support some rumours being circulated. The refugees were thereby placed in a situation of having trust constantly eroded, toward their Vietnamese "liberators" as well as toward the Thai who "never kill" and provided asylum and food. The pattern of distrust extended toward factions of the refugee community itself. Participants complained of power cliques within camps by which one group of residents was able to occupy interpreting positions. Interpreters used their privilege to extort bribes for assisting with official matters, and to control resources for the benefit of themselves.

The remnants of the Meas family were separated into two camps after arriving in Thailand. Mr Meas, too ill to walk to a camp, was told to wait until a truck came. No truck arrived, and already close to death, by superhuman effort he headed for a camp. Once there, though, he had difficulties in satisfying his basic needs, as his daughter explained (in English):

Daughter: He go to get medicine. He go in first, the [Chinese] go in last. Too many people and none left [for my dad]. Like that very often, the Chinese people are interpreter over there, you know? Look after Chinese first.

Friend: [There were] hundreds of Chinese in Cambodia, they speak Chinese but they live in Cambodia, half/half. They like to keep the group like that, they looked after each other. Its always like that, they speak *Khmer* very well, and at home speak Chinese.

Mr Meas: [I was] very hungry, very sick. They weren't, so they took all [the food] [the fitter had the strength to obtain more]...When [the swelling] was gone [I was] so very hungry. They distributed food, but not enough.

The stories participants related of their escape to Thailand speak eloquently of the

vividness of their memories, as though the events had happened only yesterday. For the majority of participants, this was their last experience of Cambodia and the beginning of exile.

Long-Term Sojourn in Refugee Camps

Thailand provided asylum for Cambodian refugees from October 1979, although as the account of the Meas family indicated, thousands had by then been on the run and suffering appalling deprivation for many months. Roesel (1988) describes this refugee population as not only sick and starved but also as disorganised, having lost community leadership during the Pol Pot years. The structured organisation of refugee camps did make necessary arrangements for them, but even so, for thousands the life-threatening and fearful conditions that characterised life under Pol Pot extended into their refugee camp life. Even for those fortunate enough to find refuge in Khao I Dang Camp, days were marked by waiting, hoping for acceptance for resettlement, and in fear of being returned to border camps or perhaps Cambodia itself.

After some months, Mr Meas was strong enough to start searching for his wife. They went on to explain their difficulties in achieving co-operation, in locating each other and being reunited. Mr Meas queued day after day to see the "boss", but without the means to bribe the interpreters was unable to get access. Such bribery and abuse of official positions occupied by Cambodian refugees was documented at the time in published studies and articles. Chim Chan Sastra (1990, p.131) described conditions in Site 2 Camp, a United Nations Border Relief Organisation (UNBRO) camp, as being "one-half freedom, one-half dictatorship", perpetrated by Cambodian officials mainly concerned with their position and political power. At the same time, distribution of resources to meet basic needs continued to be uneven and often inadequate.

By 1983, the situation had largely stabilised, with logistical support being well-

established. Although basic necessities were provided, as Reynell (1989, p.17) points out, the camps were defined as "temporary" with rations of food and medical supplies set at emergency levels. The setting of rations took into account the expectation that internees would cultivate vegetables, an expectation not possible in many camps due to poor soil and a lack of both water and safety. Rations were therefore supplemented by black marketeering, a "crime" punished with severe beatings by Thai authorities.

Conditions and safety within camps varied. Reynell (1989) explains that the eight UNBRO camps were located along the Thai-Cambodian border, right in the war zone between the Vietnamese troops and three Cambodian groups of resistance fighters, namely the Khmer Rouge, the Kampuchean People's National Liberation Front, and Prince Sihanouk's forces. Site 2 was established in 1985 inside Thai territory for the protection of civilian refugees, but was still not safe from shelling (Chim, 1990). Internees were also subject to atrocities committed by bandits who over the years 1985-1988 conducted raids almost nightly, pillaging, raping, and severely assaulting residents. Nor were refugees safe from either Cambodian soldiers or the Thai forces responsible for guarding them (Chim, 1990; Reynell, 1989).

The continuation of conditions of war and violence, with little real safety or certainty for the future, raises questions as to why refugees stayed there, rather than returning to their homes. Reynell (1989, p.31) suggests that one reason lies in the fact that homes, families and livelihoods had been destroyed to such an extent that there was little to draw refugees back. Relative to experiences of slave labour in the collective farms of the Pol Pot regime, the camps were infinitely preferable (Reynell, 1989, p.18). Such was certainly the impression conveyed by the participants in this study, who did not regard life in the camps as a terrible experience but as a very tedious one, with their only hope lying in being accepted for resettlement by a country in the West.

An acceptance of camp life may also be because my informants were in Khao I Dang Camp, situated well within Thai territory and run by the United Nations High

Commission for Refugees. Levels of safety were much higher there, and the hope of resettlement more real. Although the camp was officially closed to newcomers in 1980, and even though after 1982 residents were not eligible to apply for resettlement (Reynell, 1989, p.137), Cambodians able to do so continued to bribe their way in from the border camps. Their hope was that family who had gone before them would be able to sponsor their acceptance by a third country. A family who gained entry to Khao I Dang by bribery, after it was closed to new registrants, told of living in a hollowed out space beneath the floor of someone's home. They hid there for much of each day, emerging only when it was safe to do so. Fear of their baby's crying alerting a soldier to their presence was a constant anxiety. Along with thousands of other "illegal" families, they lived in this way for months until they could register under an amnesty for "illegals".

As months drifted into years, these "temporary" refugee camps became places of permanent residence, often for six to ten years and even up to thirteen years for the people in this study. One young woman, who spent many of her impressionable years growing up in such a camp, described them as "concentration camps". In her view the years spent in refugee camp conditions explain why many of the Cambodians she is acquainted with have lost their traditional values, and are no longer caring and helpful toward one another (a perception also expressed by Ebihara, Mortland and Ledgerwood, 1994, p.2).

Refugee camp life has variously been described as being in "no-man's land", in "midway-to-nowhere", and as the in-between step from being a temporary refugee to being an exile (Chan and Loveridge, 1985, p.745 f). Reynell (1989, p.155 ff) described the anxiety related to long-term confinement, and a lack of personal control over the most fundamental aspects of internees' lives. Cambodian refugees likened their situation to being in gaol, like being "chickens in a cage", or even "animals in a zoo" being stared at and fed fruit by curious Thais and foreigners. Therefore, even though basic needs of food, medicine, and in some camps safety, were provided, reports cited by Reynall (1989, p.152) indicated that psychologically conditions were worsening:

Sometimes I feel a sadness here. A sadness that lies deep below the surface....behind the quick *Khmer* smile. It lies much, much deeper at a level that no medical programme, no feeding programme, can touch. It is an elusive sadness. It defies words. It is only felt, sensed, or touched upon and then only for a few moments.

Internees complained that their minds were being affected, that they could no longer concentrate, that people were going crazy. Women were particularly affected, being vulnerable to rape and desertion, constantly anxious about their husbands engaged in black marketeering or guerilla fighting, and powerless to provide their children with a satisfactory diet. The use of alcohol to deaden pain and despair became rampant, its purchase becoming a priority. Some participants in this study, including an elderly woman very ill with alcohol-induced liver cirrhosis, began their alcohol consumption in the camps. Dalliances became common, along with domestic violence. According to the traditional values and practices of Cambodian village society (Steinberg, 1959, p.80), children were reared gently by modelling desirable behaviour, while avoiding scolding or beating. Now, child-beating was common, and children would be violently chastised if, for example, they failed to acquire extra rations.

Refugee camp life was at the same time characterised by sheer boredom, passivity, waiting, helplessness, uncertainty, even despair, and it was this aspect that participants in this study emphasised in their descriptions. Refugees have to put up with things, comply, and wait. Chan and Loveridge (1987, p.746) found interned refugees to be: distrustful and suspicious of those in authority; in some cases, deeply depressed and withdrawn; exhibiting passivity and learned helplessness; and seeing people in instrumental rather than affective terms.

The phenomenon of refugees languishing for extended periods in camps has, according to a number of authors, been used by the international community as an opportunity to "transform" refugees into potential citizens of the West. Being subjected to such programmes when acceptance for resettlement is not yet assured further highlights internees' liminality and powerlessness, and undermines the vestiges of national identity. Pointing out that sojourns in refugee camps are likened to the liminal phase or *rites de passage* (see van Gennep, 1960), Mortland (1987,

p.378 ff) argues that there are fundamental differences. Refugees have no hope of returning to the previous life, a life that has largely been destroyed, with the transit camp lying between a disrupted past and an uncertain, unknown future. Society's elders have no part in the transformation, their place being taken by outsiders. Thus the transit experience itself compounds the refugees' sense of displacement, adding layers to the profound trauma of experiences that have gone before.

Cambodians who have settled in New Zealand, as elsewhere in the West, endured prolonged sojourns in camps resembling prisons. Life was characterised by powerlessness, with internees reliant on external sources for their survival, thereby setting up a pattern of dependency. Conditions characterised by a lack of security, safety and certainty served to further break down traditional Buddhist and family values. In this crowded environment family violence, deception, violation of the weak, and alcohol abuse became widespread. The assault begun by the Khmer Rouge on the values and structure of Cambodian society was thus aggravated by the very conditions in which they now subsisted. Above all, those years were dominated by the long-term tedium of having little in the way of constructive occupation while waiting, powerlessness in resolving uncertainty, and always by anxiety about missing family members along with grief for the dead.

Surviving Memories of the Past

As I got to know Cambodian settlers better, their apparently positive outlook on life and quick smile seemed at variance with their frequently remembering loss, deprivation and terror. Participants said they talk constantly about their past experiences among themselves, particularly the older people. One group, referring to the bitter experience of an old woman in their midst, added:

Poor thing, that's why she got the bad memory. She relived that [all the time] when she was in the camp. Now, her feelings, her thoughts, even here [still the same]...she said she still thinking about that, [it is] just the same [as the initial experience].

As one man put it, his face smiled and as one looking on, I thought he was happy, but his mind was always troubled. According to the Meas, they were cheerfully composed by day, but at night, in the dawn hours, they remembered and cried. Intrusive distressing memories of trauma is a cardinal criterion of PTSD (Peterson, Prout and Schwarz, 1991, p.13). Alternatively, crying at night, crying within, while maintaining composure to the outside world, I suggest is evidence of inner strength and courage, and a sign of dignity in refraining from burdening strangers with suffering. Personal suffering and closeness to death is a topic for reminiscing, and the content of nightmares. But weeping is for the dead, and for missing and far-flung surviving family members. An inability to recall what they looked like, and not knowing their fates, gives rise to particular anguish. The breaking apart of family units by the Khmer Rouge caused a great deal of suffering at the time as Puk's story indicates. The narratives of almost all survivors demonstrate that suffering persists when reunification of families has not been achieved.

In addition to the practices of talking and thinking about past experiences, the Buddhist faith offers a means of resolving suffering. Buddhism makes moral sense of great suffering by attributing it to bad *karma* (see Tambiah, 1970, p.53). Even though the assumed misdeeds were not carried out by the sufferers in their present lives, nor even in recorded history, yet present suffering is not random. Nor is it without purpose, as through suffering past sin is expunged and one may be reincarnated into a more favourable existence. There is also the possibility of favourably influencing one's *karma* through ritual and adherence to precepts. For example, older Cambodian refugees find comfort in regularly meeting together to pray, thereby making merit. Two aged women said that their main desire now is to conduct a big ceremony for their dead and to make merit for themselves.

During interviewing, the fact that traumatic experiences, bereavements and the like happened to everyone became a refrain. Suffering is therefore both personal and collective. The shared experience of suffering may help explain why many participants were doing better than knowledge of their horrific past would lead one to predict. Within the Cambodian community those who survived the experiences described in this chapter know what each other has been through. There is no need to explain to a curious listener unable to identify with experiences, or to face the possibility of disbelief and disinterest. Thus an

immediate rapport and understanding by friends within the Cambodian community can be expected when a person is overwhelmed by the past. Furthermore, by virtue of all having experienced and survived such trauma, it is possible to talk naturally about the past and so minimise the risk of having to bottle it up through lack of suitable listeners. On the other hand, the fact that everybody had suffered sometimes resulted in dismissal of complaints of individual suffering. When someone referred to a past loss or trauma, the complaint might be silenced with the rebuke "it wasn't only you to go through that". A shared experience of suffering, therefore, can be helpful, but may be unhelpful when individual suffering is negated.

Much of the literature on survivors of violence, trauma and forced migration, beginning with studies of internees of Nazi concentration camps which coined the term "Concentration Camp Syndrome" (Eitinger, 1961), focuses on the pathological ill-effects. A central tenet is that survivors pathologically suffer from their vivid recall of events. An alternative perspective developed by Des Pres (1976) looks at the mission of survivors. He links the survivor's choosing of life in an environment which is hostile to life as related to the mission of testifying to the experience. According to this view, the survivor must not only remember but tell. The survivor's passion to let the world know what went on is, in Des Pres' view, a moral task to the memory of those who died, and for the survivor provides a use to which their memories can be put. Such passion is vividly illustrated in such accounts as those of Yathay (1987), Mam (Criddle and Mam, 1987) and Kanai (1991).

Among the participants of this study the apparent reluctance to burden their hosts with their story seems not to support Des Pres' (1976) premise. On closer analysis, however, the passion to remember and transmit those experiences is indeed evident. In the case of Palmerston North Cambodians, they are limited in fulfilling this task among the host society by language and cultural barriers. For me, working with an interpreter, those barriers were reduced. Expressions of gratitude for listening, and of a desire that I should pass on the information to others, suggests that these survivors, too, want their story to be known. In addition, some survivors were insistent on telling their stories to the young generation growing up in New Zealand, so that they will not forget.

There is no question that Cambodian refugees settled in New Zealand, as elsewhere, have suffered indescribable anguish, loss and danger over a prolonged period. Cambodia continues to be poor, unsafe, and uncertain as to its future. It is not surprising that there is little evidence of longing for forsaken Cambodian life. While some Cambodians miss living in a lush, tropical environment, none are homesick for the hard, hand-to-mouth existence of peasant farming nor conflict. Even when Cambodian settlers are disappointed and encounter difficulties in New Zealand, their active reviewing of the circumstances leading to their coming affirms the wisdom of their choice to leave Cambodia.

Beiser (1987) points out that nostalgia, a condition in which the past dominates the present and future to the point of interfering with adjustment, differs from memory. Participants cannot, will not, forget. By frequently discussing past experiences among themselves, they keep alive both their past and the memory of those who didn't make it. In so doing, younger members of families who were born and raised outside Cambodia become acquainted with their history and culture, as well as aware of their elders' suffering and survival.

Conclusions

By the time Cambodian refugees had reached the camps along the Thai border they had lived through year upon year of turmoil, war, terror, grave danger to their persons, starvation, forced labour, and decimation of home, family and social life. They had risked their lives to flee their country taking nothing with them, not even their displaced loved ones, facing more death as they ran. Far from finding refuge and safety in the camps, violations of human dignity and continued suffering followed them there. Throughout, refugees did not know who or what was true or reliable, were frequently unable to protect either themselves or their families, and often unable to bury and mourn their dead.

This chapter has shown that the bitterness of Cambodia's history is not a recent phenomenon, but goes back for several centuries. The sufferings of survivors of the Khmer Rouge genocide are shared, with almost all having endured deprivation, trauma and

bereavement. Yet at the same time, each has his or her own particular story like no other, which keeps surfacing, as these survivors put it, in their "thinking too much". These specific, personal stories also demand a hearing. Whether such "thinking" behaviour is harmful or not to their health is the focus of Chapter 7. Those participating in this study are also afflicted with poor health. Can their low health status be understood at least in part in the light of the pre-migration experiences described in this chapter? The belief that there is a link is widely held, and will be explored in greater detail in Chapter 8. At the same time, not all Cambodian refugees whose experiences were similar suffer from ill-health, a fact which challenges the determinism implicit in theories of refugee health that are based on pre-migration trauma and its effects.

The participants of this study were among the survivors who have been given the chance of leaving their suffering and uncertainty behind them, to start a new life for themselves and a better future for their children. The reality of ongoing uncertainty and poverty, had they returned to Cambodia, is borne out by the continued activity of Khmer Rouge insurgents. And so the next stage of their journeying was settling in New Zealand, leaving behind "lost" relatives, their dead, and all that was familiar. They brought with them 20 kilograms of belongings and decades of war, trauma, and bereavement etched into their memories.

While memories of past experiences are vividly alive, the majority are concerned more with the present and future than with living in the past. I am finding clear evidence of tenacity as they face rebuilding their lives. Smiles conceal the inner pain of overwhelming loss, just as the ordinariness of the houses and streets they live in conceals the extraordinary life-histories of those who reside within. The following chapter enters these houses and the lives of the families occupying them, as they endeavour to adjust to a very different society, while at the same time maintaining their values and identity.

NOTES:

- [1] For a more comprehensive description of village life prior to the Khmer Rouge regime, the reader is referred to May Ebihara (1968) *Svay, A Khmer Village in Cambodia*. University Microfilms, Ann Arbor, Mich., 1968.
- [2] The factual accuracy of the alleged use of chemical weapons has not been proven. Two of my informants claimed such chemicals were used. A possible link between exposure to chemical agents and long-term health problems has been suggested (see Chapter 3).
- [3] Vietnam was censured by the international community for its invasion and occupation of Cambodia between 1979 and 1989, by being deprived of assistance and isolated (Klintworth, 1989). Klintworth argues, however, that on the grounds of international law criteria justifying invasion were met, including the continued violation of human rights and that the people consented to the intervention.
- [4] Based on information provided by refugees, St. Cartmail (1983:48f) described the tactic of deceit used by the Khmer Rouge to empty the cities. Soldiers urged residents to leave immediately, as the Americans were about to bomb Phnom Penh. They were enjoined to go for only a few days, about 10 kilometres distance, thus obviating the need to take much luggage, and that the soldiers would care for their properties until their return.
- [5] The Khmer Rouge termed rural peasant Cambodian farmers as "Ancients", or "Base People" and the educated and the businessmen of the towns and cities as "New People". These "New People" were sent to the country-side for reeducation, required to assist with cultivation, tasks many had never done before, but were also forced to move from region to region, thus often being denied the fruit of their labours (Burgler, 1990, p.75). This process and its tragic consequences for the people and economy of Cambodia are described by survivors Yathay (1987) and Kanal (1991).
- [6] This is an example of the tactics of the Khmer Rouge to purge the nation of "New People", by duping military officers of the previous regime into volunteering to train soldiers. The officers were instead executed. Likewise, educated people who had voiced criticism of the Khmer Rouge for failing to provide food and medicine, were purged after identifying themselves in response to a call for "specialists" to assist the *Angkar Leo* (translated "the regime") to govern better (St. Cartmail, 1983).
- [7] Commenting on the lack of food in spite of the entire population being mobilised to produce it, Kanal (1991) remarks on some of the absurdities, such as adjacent fields of rice at all stages of growth, from seedlings to harvest, irrespective of season.

- [8] Burchett's (1981) work is based on journalistic research, and does not set out to provide an historical analysis of life under the Khmer Rouge. For an analysis of that era, see Vickery, Michael (1984) *Cambodia 1975-1982*. Hemel Hempstead, North Sydney: Allen and Unwin/South End.
- [9] The *Khmer* script is quite different from the Roman script of English. Anglicised *Khmer* words are reproduced here as the translator/transcribers wrote them. They informed me that there is no right or wrong in this, but style is individual. Their explanations and translations are also reproduced [in brackets] *verbatim*. The translators were unaware that in fact there are standardised systems for transliteration of *khmer* words. Those most widely used were devised by Savaros Lewitz (published in 1969 in the *Bulletin de l'Ecole Francaise d'Extreme Orient, Vol. 55*); and Franklin Huffman's *Franco-Khmer Transcription System*, 1983. (Information supplied by Dr. Judy Ledgerwood.)

Chapter 6
ADJUSTING TO NEW ZEALAND
AND DEVELOPING A PARALLEL SOCIETY

The Cambodian refugees who arrived for resettlement in New Zealand came directly out of the background described, a background of immense suffering, trauma and powerlessness over a protracted period. The years spent languishing in refugee camps were years characterised by waiting and hoping. Far from providing an opportunity to resolve grief and losses related to the abandoned country, these in-between years of "mid-way to nowhere" strengthened the resolve of refugees to seek resettlement in the West, to which end they underwent an internationally-sanctioned process of transformation (Mortland, 1987). Living in camps provided the most recent point of reference for the initial encounter with the new country. They arrived overwhelmed with relief at their good fortune and full of hope for a better future for their children.

During the 1980s over 5,000 Cambodians arrived in New Zealand, exchanging their refugee status for that of permanent exile. Those accepted for resettlement often arrived in New Zealand in groups of about 100, and, as a group, experienced their first taste of New Zealand through a four to six week stay in the Immigration Reception Centre at Mangere, Auckland (Hawley, 1986, p.60), as explained in Chapter 2. Once processed by the Department of Immigration and cleared medically, they left for the centres where their sponsors had made preparations for their resettlement. So it was that a significant number of families came to Palmerston North.

This chapter describes the continuing journey undertaken by resettled refugees, this time not a geographical but a social and cultural journey, characterised by adaptation, cultural loss and change as they have endeavoured to rebuild their lives. In spite of the desire and efforts of refugee Cambodians to participate fully in New Zealand society, for reasons that will be made clear, many remain on the margins of society. After describing the Cambodian community, language acquisition and employment are discussed. Ill-health, low facility in English and unemployment are mutually

reinforcing, and in turn compound marginalisation. Lacking confidence and opportunity to interact with members of mainstream New Zealand society, the Cambodian community becomes the principal context for social interaction.

The remainder of the chapter discusses the distinctive features of this resultant sub-culture of "little Cambodia". While serving a protective function for its members, at the same time "little Cambodia" further marginalises older Cambodians within mainstream society, and alienates them from their children who are undergoing rapid acculturation. Among the most significant characteristics are the development of an internal economy that runs parallel to and supplements the economic system of mainstream society. The negotiation of a Cambodian identity in New Zealand society is discussed. In this regard, fissures are appearing in the Cambodian community between generations, along lines of racial and political affiliation, and reflecting different levels of integration into New Zealand society. These fissures are magnified in the context of community festivals, one of which (Cambodian New Year) is described.

Paradoxically, marginalised Palmerston North Cambodians, whose principal social networks are within their community, are in fact global in their orientation. Much of their "thinking" energy is directed to their kin and friends in Cambodia, and indeed to those scattered throughout New Zealand and the West. Resources are expended in sending gifts to those in Cambodia, in travelling and in telecommunications. It appears that the pattern of secondary migration, a pattern which has significantly depleted the Palmerston North community, is associated with the global perspective. In conclusion, I portray the study group as characterised both by poverty, impaired health, unemployment and poor English, and by qualities of tenacity and courage.

As explained in Chapter 3, a significant body of literature on refugee health is concerned with the relationship between health and adjustment stress, health being regarded as dependent on successful adjustment. Low acculturation, and the resultant marginalisation from the host society is generally portrayed as negative, while the matter of marginalisation from one's own culture is seldom addressed. The

significance of this chapter lies in showing that arrival in the country of resettlement does not spell the end of refugees' difficulties. (See also Criddle, 1992, and Ebihara, Mortland and Ledgerwood, 1994, p.18.). The data presented in this chapter shows that indeed the work of adjustment is stressful and often disappointing. However, I argue from the findings that the relationship of discrete factors with impaired health is seldom a simple lineal effect, but rather an element in a complex, vicious cycle of multiple interacting factors, which include the pre-migration experiences described in the previous chapter. My findings show that the development of a society on the margins is in fact the most significant factor in the development of a transitional system of healing. The community of "Little Cambodia" described in this chapter describes the context for the experience of illness in New Zealand, and the practice of healing, which are the subject of the remaining chapters.

The Cambodian Community in Palmerston North

As a medium-sized city of some 70,000 population, Palmerston North has been generous in its response to resettle Southeast Asian refugees. At its peak, there were some 65 Cambodian households there, totalling between 500-600 people. It is not possible to be more precise than this, because there were continual comings and goings, with even the Cambodian Association being unsure of exact numbers at any one time. O'Neill (1990, p.40) was given the figure of an estimated 500 by the local Red Cross office, a figure with which the Cambodian Association agreed. During 1992-1994 this dropped sharply to 42 households, or about 300-400 people, but it remains a viable community in terms of size. Other North Island cities with far larger populations of Cambodians are Wellington, a two hour journey to the south, and Hamilton and Auckland to the north. Many Palmerston North Cambodians have relatives and friends in one or more of these North Island cities, with resultant regular road travel between them.

As a general comment, Palmerston North is not the most popular place to live for Cambodians, partly because of its disagreeably cool, wet and windy climate, but

more importantly because of the much larger concentrations of Cambodians in the other centres. Larger communities foster stronger growth of cultural and religious identities and institutions, and are sufficiently large to allow the emergence of several sub-groups within the community. The extent to which the Palmerston North Cambodian community is marginalised, in spite of a desire by Cambodians themselves to be integrated, is conveyed eloquently by O'Neill (1990) in his portrayal of life on the "borderlands".

By and large, the Cambodian community in Palmerston North is not highly visible. The families live in their homes, frequently visiting one another, and go about their work and lives much the same as other residents of New Zealand. As good citizens of the region, Cambodians actively participate in such events as the annual 'International Festival', treating those who attend to a display of graceful traditional dancing by young Cambodians. Their children attend local schools from kindergarten upwards, and the parents and grandparents are variably involved in their children's education. For people whose skills and education were for the most part circumscribed by a peasant village economy and by war and refugee camp life, acquiring English and finding employment have proved problematic; lacking marketable skills, they often cannot find jobs. Even so, in general Cambodian New Zealanders are responsible citizens, when possible earning their own living and paying their taxes. Commonly they seek citizenship status when eligible, a status with symbolic as well as instrumental importance.

Low visibility has also been documented from the perspective of Displaced Persons who arrived after the Second World War. Both Beaglehole (1990) and Sawicka-Brockie (1987) allude to the invisibility of the Jewish and Polish communities respectively, both of which were established in New Zealand by refugees. Like the Cambodian refugees, European Jews and Poles had suffered a history of persecution and suffering. Unlike Cambodians, they were generally urbanised, with a high proportion of professional and business people represented. Nevertheless, European refugees, too, were acutely aware that they were different, with their own values contrasting and even conflicting with those of New Zealand, resulting in a sense of

dislocation demanding continual accommodation. Beaglehole (1990, p.1) describes dual lives characterised by moving between the "New Zealand world of school and neighbourhood" and the European domestic world; living outwardly as New Zealanders, their parallel European way of life continually reminded them that they were different.

The participants of this study were accepted principally under the refugee quota system, with some being accepted later under family reunification (see Chapter 2). Several families settled in the early 1980s provided the core for acceptance of other related families, with back-up sponsorship from church and other groups. This pattern reflects official policy that gave priority to refugees with immediate family in New Zealand together with a preference for new arrivals to settle in the same town as those relatives (New Zealand Immigration Service, 1992, p.6).

The role and expectations of sponsors have been explained in Chapter 2. Sponsors are expected to ease the adjustment of refugees into society by such means as ensuring housing is ready for them on arrival, assisting in the enrolment of the family at a doctor and the children at school, advising on English language tuition, social welfare benefits, and assisting in securing employment. More than this, the sponsor is expected to offer friendship and support for an extended period of time. Sponsorship is therefore a major and long-term commitment, with affective as well as instrumental value for the refugees. (See Mortland and Ledgerwood, 1987, for a discussion of sponsorship in the United States.) Enterprising refugees develop skills in utilising the expertise of sponsors (and others who enter their orbit), a process described by Rashbridge (1993, p.55) as patronage.

When sponsorship works well, genuine friendships develop. Experiences of sponsorship among the participants were on the whole positive, some exceptionally so. However, sponsors may fail to fully discharge their responsibilities, fall short of meeting the refugee family's expectations, or maintain too high or prolonged a level of involvement. There are instances when refugees hold unrealistic expectations of sponsors in terms of what sponsors do and for how long, with a risk of remaining

dependent. On the other hand, there are instances of sponsors dominating "their" refugee families, maintaining a high level of involvement long after such is needed or even wanted. Fear of offending their sponsor would make it unlikely that refugees would discuss the issue openly, and perhaps the closest families come to articulating the matter is when they leave the area of first settlement to migrate to a preferred location.

Sponsors may withdraw from or even abandon their refugee family when it doesn't conform to their expectation of a "good refugee family". I became involved to a greater extent than usual with a family with severe health problems who neither appeared to be finding their way through the health system, nor managing the treatment regimens. When contacted, the sponsors unloaded details of their trying and unrewarding experiences in sponsoring this family. They told of domestic violence, lying, and gambling, and of the sponsors paying back-rent to enable the family to remain in their accommodation. In spite of having persevered over three years, the sponsors eventually gave up. In the view of the sponsors, the general behaviour of the family was unacceptable to the Cambodian community also, and the family were thus isolated by both Cambodian and New Zealand society. From the example described and others I observed, paradoxically it is those families who experienced the most incapacitating illnesses, and whose needs were greatest, whose sponsorship arrangements fell down. Perhaps the dependence and demands of such families were such that sponsors were themselves overwhelmed.

Although Cambodian refugees are grateful to New Zealand for enabling them to escape the strife of Cambodia and the tedium of camps, the country and the city were well down their list of preferences, a factor which must surely affect their adjustment. The majority who were settled in Palmerston North came from village peasant backgrounds. The city of Palmerston North, in contrast, offers a culture of quiet, orderly, urban living in what is being promoted as the "knowledge centre" of New Zealand. While such an image may appeal to the large proportion of people involved in education and research industries, it can marginalise those who are minimally educated through no fault of their own.

Alongside anglophile New Zealand society, there has developed a parallel Cambodian society that offers what mainstream society is unable to provide, which I call "little Cambodia". Here there is social intercourse free of struggling with a foreign language, and a starting-point of a common background of experience which New Zealanders don't share. A market of information develops, with exchanges on the availability of certain foodstuffs and goods, cheap prices, concerns with children's schooling, special benefits available, and discussion of one another's troubles and ailments along with possible remedies. Cambodians engage in conversation about lost and distant relatives, continued or renewed conflict in Cambodia, and Cambodian politics and elections. *Khmer* language videos are circulated, and purchases from out-of-town specialist stores are ordered. These and other matters frequently occupied at least a part of my interviews.

Unlike the stereotypical ethnic enclaves or "ghettos" that developed around large communities of refugees settling in an American metropolis (see Strand and Jones, 1985, p.131), or even in Sydney, there are no suburbs occupied predominantly by Cambodians, nor are there Cambodian shops, newspapers, and institutions. However, the majority of households are concentrated in two areas, which coincide with the availability of low-cost housing and state housing, reflecting a similar pattern to that found in Dunedin (Andrew, 1985, p.36) and Wellington (Crosland, 1991 [b], p.8). Even so, households may still be several blocks from each other, and thus too far to visit easily without transport.

From the exterior their houses are like any other in the street apart from the usual collection of footwear in the porch, a custom carried over from their life in Cambodia (practised, in common with other Asian societies, to maintain cleanliness and in some societies, ritual purity of the interiors of houses). In the gardens of most Cambodian houses a little "glasshouse" had been erected of heavy-duty polythene, chiefly for the cultivation of lemongrass, chilies and other herbs and spices. The more energetic also grow a variety of off-season vegetables and flowers in quite large structures. The garden of one house I visited was full of tobacco, but more commonly vegetables were grown in abundance, with surpluses distributed among

the community.

Houses occupied by Cambodian refugee families have tended to accommodate more people than is the accepted norm in New Zealand. Although many households comprise a nuclear family and perhaps a grandparent or other unattached adult, some consist of two or more nuclear families. This is especially likely when an established family sponsors related families to join them under the family reunification programme. In such instances, to sleep each family in a single room was not uncommon. Although I was informed that this was in the "Cambodian style", I was also told that the practice in Cambodian villages before Pol Pot was normally for each nuclear family to have its separate structure, as described by Ebihara (1974) and Steinberg (1959).

The practice of several nuclear families co-habiting therefore suggests that it was out of need and a desire to save money, rather than preference and a persistence of customary practices. It also reflects a Cambodian saying that goes, "better a packed house than to be narrow-hearted". That is, it is better to live in a small house where everybody is happy than in a large house with a lot of tension and conflict. Apparent here is a pattern not only of being hospitable and generous, but a value on face-to-face interaction, with privacy subordinated to relationships. This value contrasts with New Zealanders who live behind closed doors, valuing space, privacy, and the separation of society into nuclear family units.

The distinctive internal furnishings are also likely to make an impression. Initially furnished by sponsors in readiness for the arrival of refugee families, much of the assorted second-hand furniture is retained and subsequently added to, to accommodate the large number of people resident or visiting. The houses of some families were crowded with furniture, with up to two lounge suites and other assorted chairs, and an array of television, video and stereo equipment. In contrast was a family who separated themselves from their relative's household. With no household equipment provided for their arrival, at first their small flat was pitifully bare, lacking even a kitchen table and seating in the lounge.

Common to all Cambodian homes was the adorning of walls with photographs or brass-rubbings of Cambodia's most famous monument, Angkor Wat, and in a majority of houses, brightly-coloured pictures of Buddha, and often of the Hindu god Krishna. Alongside these were the photographs of family members: living and dead; far away and in Palmerston North; old, damaged or faded photographs, as well as recent snaps and children's school photos. In one house a picture of Buddha and a large but damaged photograph of a dead parent were the focus of a little shrine that had been arranged, a place for the regular burning of incense. The television set often served as a convenient surface for the arrangement of such shrines. I was told that in homes of the more devout an entire room could be set aside for use as a shrine. Distinctive decorations usually manufactured in Thailand, such as plastic baskets of flowers, objects to bring good luck, and fans became familiar to me, as did the practice of spreading a large plastic woven mat (after the traditional style of rice straw mats) on top of the wool carpet.

Cambodians thereby put their mark on their houses, keeping before them constant reminders of their origins, their homeland and family. When they visit one another they remain to that extent in familiar territory. These social interactions are by no means limited to talking and sharing information. Older people who habitually chew betel often transport the necessary material and spittoon whenever they visit, their socialising over betel offering relief to their constant thoughts about "those in the back". Preferred food is cooked and shared, filling the air with a distinctive spicy aroma. Frequently people will at the same time engage in playing cards. In this regard, the comment was made by several people that the excitement and enjoyment of playing helps them forget their sadness and current worries. At these visits, too, Thai, Cambodian, and sometimes Hindi videos are watched and circulated. The nature of these activities adds to the distinctive flavour of these homes, contributing to the pervasive odours of betel and cooking food, and the sound of the *khmer* language spoken and Cambodian music being played.

As I went in and out of homes for the purposes of interviewing, I became aware that frequently the same group of people would be visiting one another. Thus I could turn

up to interview a family one day, as arranged, only to find another family or two already there, or others could arrive at some stage during the interview. These same families may then have visited when I was later interviewing a different household. The impression I gained, an impression subsequently confirmed, was that certain groups of people were frequently in one another's houses, particularly when not in paid employment. Many (but not all) of these groups were interrelated, such as grown siblings and their families visiting one another. The apparently intense social interaction among Cambodians, who have little else to occupy their time, must reduce the social isolation and loneliness that afflicted over half of Hafeez's (1988, p.184) sample, and that of Crosland's (1991 [b], p.10) female sample described as "tied to their domestic worlds".

When interaction is largely confined within the Cambodian community opportunities for using English are few, and the chances of developing patterns of positive participation with the wider mainstream society are restricted. The extent of reliance on "little Cambodia" for social and other needs varies, from an almost exclusive reliance on the part of non-English speaking, unemployed people, to intermittent contact by those who successfully move between New Zealand and Cambodian "worlds". For the latter, involvement may be largely a resource drawn on by the less-acculturated Cambodians on the occasions when they need to interact in the New Zealand world. The pattern of "dual worlds" (Beaglehole, 1990, p.1) was also apparent, characterised by a moving with apparent ease between the domestic Cambodian world and the New Zealand world of work, school, and leisure. A greater effort is required by apparently well-integrated people, including those who have achieved educationally and are positive about New Zealand and the opportunities offered. This is evident in the song written by Dararith Kim, composed for Refugee Day, 1983, and used here with his permission.

GIVE US A CHANCE

Some have it hard, some have it easy
Some live in hell, some live in luxury
Some have it all, but some have nothin'
And some are full, yet some are starvin'

(Give them a chance, give them a chance)
Give us a chance, give us a chance
A chance for life, to live again
We've got the will, and we've got the instinct
TO SURVIVE!

Life's so precious, above all else
We only live once, so give us a chance.

I discussed with the Nhims the issue of interaction with members of New Zealand society. An elderly couple who had come to New Zealand with their large family in 1983, the Nhims were one of the earlier arrivals in Palmerston North. They now own their own home and cultivate a large garden. Neither speak English beyond survival level, and the life they have established for themselves revolves largely around their family, friends and Buddhist activities. From the beginning, Mrs Nhim has found life lonely and very quiet, lacking both the large circle of acquaintances she had enjoyed in Cambodia and a network of *kiwi* friends. I questioned them about the extent to which they mixed with *kiwis*.

Mr Nhim: We live in their country. We have to see them a lot.

Mrs Nhim: We do see them a lot, but on the street. Not like meeting, talking like this.

Mr Nhim: Yes, it is *khmer* people who talk to each other.

Mrs Nhim: And the *baaraing* [Europeans], we just see them on the street....and say 'hello' at the end.

[Transcriber's interjection: THAT'S CORRECT!]

Sok: *Kiwi* people don't usually interact with us...[to me] Because the Nhims don't have any *kiwi* friend, only sponsor, that's why. And she doesn't speak their language.

Mrs Nhim: When I first got here, I only cried.

Sok: Is that right. Too quiet?

Mrs Nhim: [The first house we lived in] was far from here. Nobody went to visit, it was too quiet. [My husband and children] all went to work and school, and I was just by myself. When living in Cambodia I went everywhere, knew everyone. In our country

who would shut the door CHEUNG! like that!

The shutting of the door with a bang that was so jarring and rejecting to Mrs Nhim may be explained by the need to keep the interior of the house warm. The practice may also reflect values carried over by the colonists and migrants from Britain, summed up in the adage "an Englishman's house is his castle". Here, then is a clear instance of conflict in culturally derived values. Explaining such ubiquitous habits and values is typically neglected in orienting newly arrived refugees to society. The result of such oversight is that refugees, already experiencing some culture shock, may interpret normal New Zealand behaviour as rude and unwelcoming. In the case of Mrs Nhim, it was only as she grew to understand that such behaviour was normal, and moved house to be nearer her own and other Cambodian families, that she ceased crying and her loneliness became less acute.

Although life in New Zealand is comparatively easy, and refugees no longer fear hunger as "the government feeds us", there are aspects of the adopted country that Cambodians do not like. The cold weather is especially disliked, along with some customs such as the performance of all domestic tasks within one's house. This practice contrasts sharply with life in Cambodia, where domestic tasks are frequently carried on outside of the house, and thus become contexts for social interaction with neighbours and passers-by. Considering the cultural differences between the host society and Cambodian refugees, the net result is to confine those who are not "like us" on the borderlands, a social location made the more acute if refugees lack fluency in English, do not eat the same food and do not do the same things as mainstream New Zealanders (O'Neill, 1990, p.43).

Outright complaints of antagonism or racism were never made in my hearing. Rather, most were quick to emphasise their gratitude to be here. Perceptions that their presence wasn't welcome slipped in accidentally, such as an anecdote from a family who lost their way when visiting friends in Auckland. It was already dark when they knocked on a door to ask directions, only to have the door slammed in their faces "when they saw our black hair, you know, Chinese or something like that..."

Antagonism from neighbours also occurs. One family who left Palmerston North were emphatic that they got on well with their *kiwi* neighbours. However, although at least two families known to me were in urgent need of low-rental housing, the vacated house in good condition with a well-planted garden was declined because of the unfriendly neighbour. This is by no means an isolated example, with hostility going as far, on rare occasions, as Cambodian families being victims of verbal abuse and stone-throwing.

Particularly significant factors that seemed to deepen this marginalisation, to be discussed in greater detail below, were a lack of progress in establishing friendships outside the Cambodian community, difficulties in acquiring English, and disappointments in getting and retaining jobs, with resultant problems in providing for their families' requirements. A large study of Southeast Asian refugees in Chicago similarly found relationships between low adjustment and lower proficiency in English, lower socio-economic status, having few American friends, and a self-perception as very different from Americans (Nicassio, 1983). The reverse also holds true, that better adapted Vietnamese were proficient in English and of higher occupational and financial levels (Starr and Roberts, 1981, p. 606). These elements are interactive, with language acquisition being both a cause and a consequence of an inability to find work and a failure to establish social relationships. In this respect, the active and positive sponsorship of families has assisted in integrating Cambodians into New Zealand society, and mitigated the experience of isolation.

English as Means of Entry into the Host Society

While this study did not focus on English language acquisition, the extremely limited ability of the core group of participants to converse in English is a measure of the success of the services described in Chapter 2. A major factor in second language acquisition is the fit between method and contexts of learning, and prior educational experiences. Although data on pre-migration educational level was not collected in this study, Andrew (1985, p.30 f) did so among the similarly sized community in

Dunedin. Only thirteen per cent of the population of 350 had been to secondary school, two thirds of whom were of Chinese origin. A majority, 46 per cent, had received no formal education whatsoever.

Of the sixteen households that contributed core participants, there was only one, other than the interpreter's home, where I could interview without the assistance of an interpreter. This man, BoNa, had learned English prior to arrival in New Zealand and continued to work hard at improving it. There were another two households where grown children could have interpreted, but out of respect for the participants I chose not to use offspring to interpret. A number of households included children who chattered freely in English, with distinctively *kiwi* accents. In half of the households both the elderly and younger adults spoke practically no English at all. Members of the remaining households were able to exchange a few words in English with me, but not to the level of being able to engage in conversation.

The relationship between language learning services and English acquisition is not one of simple cause and effect. A result of the disruption and anti-intelligentsia stance of the Pol Pot regime is that many Cambodian adults have had little or no experience of school, and thus found the adjustment to the formal class structure of polytechnics especially difficult (Henderson, 1989, p.220). This was particularly the case for women, who arrived in New Zealand with a lower rate than men and children of having attended English classes offered in refugee camps . This pattern reflects both the fact that they were not free of child care and domestic chores, and the prevailing attitude that education was for males, limitations that persist after arrival in New Zealand (Henderson 1987, p.215; Crosland [b], 1991, p.7).

Recognising the situation affecting many women, a small community-based class was initiated in Wellington by the home tutor scheme. Led by a Cambodian woman using the less-threatening bilingual approach, it overcame some structural problems of polytechnic learning delivery (Crosland [b], 1991, p.7). A very similar initiative in Palmerston North by a young professional Cambodian woman saw two classes each week attended by mainly older women and young mothers for whom polytechnic was

neither possible nor attractive. Paradoxically, these classes seemed to be valued as a context for social interaction and sharing of information, in the style of "little Cambodia", as much as for improving English. The divergence in expectations between the teacher and participants eventually led to classes being discontinued.

As I interacted with Cambodian families over an extended period, I became aware that little or no facility in English was reflected in little or no social interaction with members of New Zealand society, except instrumentally. Lack of confidence in using English and lack of opportunity to build confidence are thus mutually interactive and reinforcing. An important factor here is that of shyness. In view of their culturally marginal positions, this is not surprising, and can be compounded when halting English is not understood and mistakes are laughed at. Mostly it was males and younger people who were prepared to keep using English, while several women tended to avoid using what little English they knew. This became apparent in the course of interviewing, when at first people gave every indication that they were totally reliant on the interpreter. For example, Sok pointed out to me that one man often commenced his reply (in *khmer*) before she had had a chance to translate, indicating that he understood what I was saying, although lacked the confidence to reply in English.

The experiences of three young adults in this study, all of whom were troubled with intractable health problems, demonstrated that such difficulties were compounded by impaired health. For example both VeasNa and VuTy explained that formerly, prior to coming to New Zealand, they were able to understand and speak some English, but with the stress related to problems of adjusting to New Zealand together with on-going debilitating illness, they had lost much of their ability. BoPa was desperately keen to be able to speak English, explaining that she wasn't one of the "old" ones who couldn't learn because of age, but was still young. She was moreover attending the community class, but making little progress:

Every day I go, never miss, but when I go, everything I say is wrong. When I study, when P. teaches, I listen and Bong! I can see [understand] everything! But suddenly it seems like there is

something coming into my mind, and it makes me "think [that is, uninvited, painful memories and thoughts suddenly flood her mind]. Before this "thing" [memory] arrived, I knew everything, but when this "thing" arrives, I forget about the letters, all is dark.

Her inability to learn or remember English was genuinely distressing for BoPa. She was suffering from distressing memories following the death of her baby son, which compounded her sorrow in being separated from her natal family. Her distress was exacerbated by her "ignorance", as she expressed it, in being unable to acquire English. As with other Cambodians, her prior exposure to formal educational settings was minimal and had been disrupted. Somatic and mental distress interfered with attempts to learn English. The resultant frustration and social isolation hindered participation in social and occupational settings of society, thus exacerbating distress. In contrast, employed Cambodians grew in confidence and facility in English as they regularly conversed and mixed with *kiwis*. For various reasons, though, few participants in this study were employed.

The young children (who rapidly acquire English) increasingly identify themselves primarily as New Zealanders, and resist learning and practising *khmer* language and traditions. One result is the undermining of relationships between generations, when children with contrasting attitudes and values are used as the mediators between the Cambodian world of the parents and New Zealand society. In the experience of the Refugee and Migrant Service, the chances of the adults successfully becoming integrated into society are remote, and they thus become "human bridges" for the younger generation to move from the culture of origin to that of the host country. (Cotton, 1993, p.21).

Work and Welfare

The work skills of Cambodian refugees often have limited marketability in New Zealand. For example, in Cambodia my informants had been rice farmers, with adjunct skills in mining, midwifery and healing, sewing, wood-carving, and even

watch-repairing (the old-fashioned, clockwork kind). Not many of these skills find immediate demand. The limited availability in Palmerston North of unskilled factory and agricultural work which Cambodians can readily fill is a frequently cited reason for secondary migration. Racism was also blamed for failure to find employment. Not finding employment, many Cambodian refugees are therefore reliant on social welfare benefits and state housing. Thus they became obvious targets for criticism as a "drain on society". Such criticisms, in combination with Cambodians' liking for their own foods, social activities and so forth, combined to militate against their acceptance into mainstream society. Such experiences and perceptions can set the scene for heightened sensitivity to perceived antagonism.

If self-sufficient, on the other hand, refugees are sometimes criticised for displacing New Zealanders from jobs. Given the degree of economic downturn and the depth of social pain that characterised the 1980s in New Zealand (see Randerson, 1992), the Southeast Asian refugees who arrived in large numbers over the space of just a few years provided a ready scapegoat for society's woes. Refugees were in a double bind, as *Kiwis* were antagonistic with regard to refugees both working too hard and thus driving up productivity expectations, and to their displacing New Zealanders from jobs. Gallienne (1991, p.190) notes that such criticisms were levelled in spite of evidence to the contrary. Earlier studies found that Southeast Asian refugees had little difficulty in finding jobs, even when unemployment was rising (Hawley, 1987, p. 67; Andrew, 1986, p.34).

This was not the experience of the participants of this study, however, not one of whom was continually employed during the course of the study. Eight of these people were over 40 years and three over 70, which puts them outside the easily employable age groups. Of the 13 females, some were working at home caring for small children and/or aged parents. At the household level when the study commenced, members of only five of the 16 households were in regular employment, which included three households headed by older couples whose adult offspring living there were employed. The low rate of employment is partly explained because these individuals were included in the study because health was impaired, which can

be expected to interfere with their ability to work.

Before data collection was completed, two of the five in work had their employment either reduced or cut because of illness. One was dismissed because he had been off sick (with glandular fever) for six months, leaving no wage earners in his six person household. Having worked for the company since arriving in New Zealand, a period of eight years, and having taken little sick leave, the family was stunned by the perceived lack of loyalty. Another reduced his hours to half-time and eliminated heavy physical tasks, because of continuing health problems thought to be related to major abdominal surgery received several years earlier. Although DeVoe (1992, p.112) cites complaints from American employers of absenteeism and abrupt quitting by refugees, factors which may indicate health problems, the relationships among trauma, ill-health and employment have not been researched.

Illness of a dependent member of a household can also affect the employment of healthy members. For example, two people had had to give up work in order to care for sick family members. One of these had resigned his factory job on the advice of the family doctor, to care for his wife who had complications of pregnancy. Once she and the infant were well again, as jobs were scarce he was unsuccessful in securing a new job. The other, a young woman, claimed that when her mother was seriously ill, she was often called at short notice by hospital staff to interpret, whether she was at home or at work. Her resultant unreliable attendance was given as the reason for her eventual dismissal.

In half of the participating households, none of the current adult members had ever held a job since arriving in New Zealand. Four of these consisted of older parents with their teen-aged children, while four were younger, working-age adults with small children. In the case of all the four younger couples, they claimed that their own ill-health or that of a close family member was a major factor in their being unable to get work. Two men, who claimed they wanted to work, were unable to job-hunt because of domestic and caring responsibilities, the need to frequently taxi the sick person to the doctor or hospital, and once there, to interpret. Interpreting is a

full-time job in itself, claimed one man whose relatives seemed to carry a particularly heavy burden of ill-health, and whose services were widely called on by other Cambodian families, a job which he considered should be adequately remunerated. In the case of elderly relatives who were mentally or physically disabled, available facilities for rehabilitation or for respite care were of limited usefulness, because of communication difficulties and the negative effects of the fear and isolation commonly experienced by the old person separated from the family. Caring for elderly parents thus became a full-time occupation for some.

The study population, which represents over a quarter of Palmerston North Cambodian households, demonstrated an overall low rate of employment, a rate which cannot be generalised to all Cambodian households in view of the selective nature of the sample. Indeed, several of the wider Cambodian community are known to have established their own businesses such as owner-driver taxis and restaurants, and others are employed in a range of service and manufacturing industries. There is, however, a clear relationship between impaired health and employment, both directly and indirectly. Ill-health in one member can affect the entire household, resulting in families in which no potential wage earners are employed. This is a significant issue, and one which has flow-on effects on household finances, English language acquisition and adjustment to New Zealand society generally.

Without work, families must subsist on social welfare. Hugo's (1990, p.199) study of Indochinese refugees in Australia likewise found that difficulties in entering the labour market was reflected in that 43 per cent were welfare dependent. Many of the refugee families participating in the study suffered from the sharp reduction in benefits in 1990. While the decreased benefit was intended to encourage the unemployed to find work, many Cambodians were, as has been argued, unskilled, ill or otherwise unfit to work. A paradoxical effect of this strategy was to encourage those who saw themselves as unemployable to find their way round the system. For example, in his attempt to secure a Sickness Benefit (more generous than the Unemployment Benefit), one person developed new symptoms that simulated those of another person known to him who was a Sickness Beneficiary. Another gave an

account of his "tough" stance with Social Welfare, demanding (successfully) to see the Manager in his effort to raise the level of a relative's benefit. Such determination, astuteness and initiative in maximising resources is not surprising given the priority for sponsors to inform and assist refugee families in registering for benefits to which they are entitled, and to act as advocates to ensure social justice (Crosland, 1991, p.6).

It can also be viewed as an adaptation of skills learned over long years of dependence in refugee camp settings, when survival depended on knowing how to exact and increase one's entitlements. Refugees' skill in "working the system" is, in this respect, simply a continuation of the survival skills that brought them alive to the camps in the first place, and then on to New Zealand. Describing parallel but different welfare provision in the United States, Rashbridge and Marcucci (1992, pp.81 ff) describe the apparent passiveness and conformity of the Cambodian refugee, but go on to demonstrate how the recipients use the benefits in different ways from those intended, in the process even exploiting the prevailing views of them as helpless and dependent. Capitalising on sympathy for their current plight and past suffering is used in both official and charitable contexts to secure goods and services, as explained by both experienced New Zealanders and Cambodians. The description above of a family selling sponsor-donated goods and demanding replacements can be interpreted as successful adjustment to their refugee status, exploiting that status and the benefits attached, while at the same time asserting autonomy in their actions.

However, exploiting refugee status and the related characteristics of dependency, powerlessness and poverty, can also alienate otherwise, or previously, sympathetic members of the host society. For example, the Cambodian who organised English classes gave it up partly because she perceived that people came mainly for the "hints" they could pick up, such as in relation to special benefits, and access to food parcels and free clothing. As she saw it, they were not taking responsibility for themselves. Indeed, some of the strongest criticism was levelled from Cambodians who through hard work and dedication are successfully establishing themselves,

toward fellow- refugees who are making little progress either with English acquisition or securing employment,

While I appreciate these views, I can also sympathise with refugee families experiencing difficulties in "taking responsibility". They have endured years of war, collective living and "concentration camp" life. Trust of authorities and the word of governments and officials is discouraged in such circumstances, and it is hardly surprising that distrust and disbelief persist. The qualities needed to survive these contexts, in which chaos was constant, included acceptance, compliance, resourcefulness and tenacity. Although New Zealand's social and political environments contrast sharply with all that has gone before, the survival skills developed during those disrupted and uncertain years characterised by powerlessness are still evident in refugees' efforts to secure a better future. At the same time, an orientation programme that emphasises conformity with mainstream society, including its language and social structures, implicitly reinforces the qualities of dependency and compliance, and is unlikely to assist refugees in identifying and discarding redundant survival skills, while maximising useful ones.

An Alternative Economy

Occupying low-paid jobs or dependent on welfare, the socio-economic status of many Cambodian refugees is low. Notwithstanding, I was told repeatedly that house ownership was the highest priority for these uprooted, exiled people, rendering refugees less vulnerable to policy and market fluctuations and the capriciousness of the landlords. Transport is needed to maintain the high level of social interaction described above, and cars are often the first major purchase. Television, video, and stereo equipment are also needed to be able to enjoy preferred videos and music, as well as for tuning in to English-language programmes which, they explain, facilitates language acquisition. Most owned these costly electronic items, and knowing that few were employed, I was interested in how they managed to finance them. The answer is found in the parallel economy, described below, operating within "little

Cambodia".

For Cambodians settling in New Zealand, the acquisition of particular goods offers security, especially in the case of a house. Chattels can readily be converted into cash. The ownership of goods such as fine clothing and good furnishings demonstrates, among other things, the *kiwi* sponsor's love and care; that family members have work and a good boss; and good luck in winning money. In addition, the ability to purchase and display goods is a powerful sign that their fortunes have turned around, that their extreme losses of previous years has passed, and that they are now in a period of prosperity. It was also pointed out to me that prior to the communist experiment of the Khmer Rouge, many Cambodian people were circumspect in their spending. Having been deprived of the opportunity to enjoy the fruits of thrift, a common reaction is to spend one's income and enjoy the present.

In view of the fact that many resettled refugees had previously owned little in the way of house furnishings and electronic equipment, the apparent priority placed on acquiring such items has attracted comment both from informants and in the literature. According to a *kiwi* informant, the purchase of the "flash" items is of so high a priority that children may be neglected and underfed to pay for them. For this reason, he maintained, some parents discourage their children from continuing their education, preferring that they go to work to augment the household income. Whether such allegations are sustainable is questionable, but I observed no evidence of either neglect or malnutrition, and children's education was highly valued by even the poorest families. In the opinion of successful Cambodians (who set themselves apart from less fortunate refugees), the peasant and rural backgrounds of the majority of Cambodian families in the area accounted for the priority placed on accumulating "status symbols". It was the opinion of a young Cambodian from an urban background that as his family had been wealthy and had had all these things, they now didn't care whether they had them or not. The fact that they had survived and had the opportunity to rebuild their lives was of far greater importance. In contrast, as he saw it, the poor, rural families had never had access to such goods but always hankered for them.

It has been suggested that the value ascribed to possessions is derived from both refugees' impoverishment as peasant farmers and subsequent dispossession under the Khmer Rouge. Mortland (1987, p.368) points out that as refugees they owned nothing, and were totally dependent on those in power for provision of even the most fundamental of things needed to live. The lack of possessions in a consumer society reinforces the status of poverty, refugee status, and marginality. In this perspective, possessions are particularly potent in the lives of these refugees, representing a turnabout in their status. An alternative explanation is offered from Sen's (1987, p.188) study of accommodation among refugee Lao settling in the American Midwest. In common with all migrants facing novel situations requiring multiple choices, the Lao are guided by both pre-migration values and current contingencies, with the result that some choices may be incomprehensible to others looking in from the outside. For example, whereas in Laos wealth was based on ownership of land, now in Sen's view it was determined primarily by access to a range of goods.

For the purchase of such costly items, it is unlikely that sufficient savings could be made from fixed and low incomes. Some of the strategies used by Cambodian families to augment incomes and/or make ends meet are no different from those of many other low-income New Zealanders. For example, they frequent the "flea market" and similar outlets for the purchase of cheaper fresh foods, clothing and household articles. They are adept in getting to know and use such resources as "opportunity shops", Red Cross, and networks of *kiwi* friends for access to cheap clothing, and foodbanks when needed. Delicacies available only in Thai emporia and from a few other importers vary considerably in price, giving rise to quite complicated arrangements among friends for the purchase of such products from cheaper sources. Again like many families on low incomes, most Cambodians cultivate their gardens intensively, growing a range of vegetables and herbs, selling or exchanging surpluses. A couple of old women did a thriving trade in producing bean sprouts, offered at far lower prices than in supermarkets. Along similar lines are a range of services offered by community members at very low rates, including hair cutting, car mechanics, and sewing.

Many Cambodian refugees owe their survival to some extent to gold and gems. The possession or use of gold was considered a crime in the Pol Pot regime, which had scrapped cash as a means of exchange. Even so, many families managed to conceal gold and jewellery, which were exchanged for food, medicines or services. In the camps, the currency of gold retained its importance for black market purchases, and to bribe officials for favours. There are still those who distrust cash and banks, preferring to store their capital in the form of jewellery. The use of gold and gems persists in Palmerston North. It so happened that my interpreter acted as an intermediary for many transactions, so I was well-placed to observe the continuing role of the currency of gold and gems. Frequently, before or during interviews, Sok drew a purse of articles out of her handbag, or slipped them off her person (the safest place to keep them), before passing the items around. She was selling on behalf of people who wished to sell for cash. Women from even quite poor families were often bedecked in jewellery worth several hundred dollars, jewellery that was both decorative, and readily convertible into cash to pay a bill or purchase a desired electronic article.

For a majority of Palmerston North Cambodians, cash has in the past been an uncertain medium of exchange, what with escalating inflation in pre-war years and the scrapping of cash along with loss of savings in the Pol Pot regime. Most village Cambodians moreover, would have had little or no prior experience of dealing with banks; to be confronted with banks can be daunting indeed. In such conditions, gold and gems as the medium of exchange are more enduring, along with the simple bartering of goods, both of which persist in Palmerston North.

A widespread practice is that of gambling. While I observed only small stakes of a few coins, I was told that gambling can result in both gains and losses on a grand scale. For example, wins enabled the purchase of new furniture and electronic equipment on display in one house I visited. On the other hand, there are accounts, such as that related above of the "bad" refugee family, when gambling debts result in the loss of possessions. Gambling is not a recent development for Cambodians, being an enjoyable pastime in village life, and a common way of whiling away the

tedium of refugee camp life.

The diverse practices described at best allow small savings to be made, and make available a ready source of quick cash. However, the most significant and widespread practice that enables Cambodians to make the costly purchases they desire is the "game" of *dton'dtine*, a scheme involving about thirty persons for any one syndicate, and similar to the way a building society operates. I was informed that the game was originated by a Parisian banker in the seventeenth century, and has become widespread in parts of Asia. I had come across this myself in Nepal, where it was played to generate large sums in a short time. Similarly, Cambodians were familiar with *dton'dtine* in Southeast Asia.

According to my informant, one person who acts as underwriter organises the game, and each month each player puts into the pool the agreed share, commonly \$300. Each month all eligible players bid interest for the pool for that month, with the highest bidder receiving the money. The successful bidder then pays each player the interest, except those who have previously taken out money and are therefore no longer eligible. Even though players who have taken out money are not able to rebid, they must continue with the scheme until it terminates, putting their share in each month. It follows that the last player to receive money pays no interest. Also, the underwriter receives the money in the first week of playing, again without interest, to compensate for the risk that he/she carries.

The risk is indeed high, because in the rare event of a player absconding directly after receiving the pool, it is the underwriter who must recompense all other players. I knew of an instance where this did happen, resulting in the underwriter having to pay back \$300 per month over a period of three years, along with having to cope with considerable hostility from players. Despite the high risk, *dton'dtine* remains very popular because of its high yield and quick returns. As one person put it, "only \$300 a month, and that's why all the *khmer* people can buy the car". After a car, the next major purchase was a house. To quote my principal informant on the game: "Within five years of settling down in New Zealand over 50 per cent of these people

own houses and a few have managed to repay all the mortgages!" If a scheme involves, say, 35 players putting in \$300 shares each month, the underwriter will receive \$10,500.00 in the first round. Thereafter, the sum drawn from the pool is reduced by the amount of interest deducted according to what is bid, but the pool remains substantial at between \$9,000 and \$10,000, and clearly sufficient to make a sizeable reduction in a mortgage, or to purchase a car. Certainly, as was pointed out to me, *dton'dtine* guarantees a win, which a regular purchase of a Lotto ticket (in which many indulge) does not!

This alternative economy provides an important means of facilitating successful settlement in New Zealand, allowing Cambodians to acquire the commodities they seek. It is at the same time an important strand in the culture of "little Cambodia" in which pre-migration customs and practices persist. Exchanging goods and services among members of the community serves to encourage social interaction and to strengthen social relationships. The social contexts of gambling and playing *dton'dtine* are both entertaining and exciting, important factors for the unemployed in their otherwise tedious existence. The alternative economy supports both identity and a sense of autonomy. Autonomy is both individual, because they are not dependent on banks for loans, and communal, as money stays in the community.

In his research into the factors that influenced the psychological well-being of Vietnamese refugees, Tran (1987) found that the four factors that had the strongest effect on well-being were: participation in ethnic social organisations; availability of ethnic confidantes; self-esteem; and income. Of these, the former two were characteristic of "little Cambodia". Other variables identified by Tran, such as educational level and length of residence in the host country, tended to be related to income. Aside from wins in gambling and *dton'dtine*, participants in this study didn't enjoy a high income, a factor that seemed to cause stress as their ability to purchase wanted goods and their hopes for their children's future diminished. But even here, it was "little Cambodia" that offered the chance of these wins, and with them, the satisfaction of being able to acquire desired possessions. Psychological well-being for those who are unable to participate positively in mainstream society, then, appeared

to be associated with participation in the parallel informal Cambodian community.

A Cambodian Identity

The identity of Cambodian New Zealanders is inextricably bound up with their identity as refugees. To be classed as refugees is to be stigmatised. The practice has particularly negative overtones for Cambodians who are often lumped together with their historical enemies the Vietnamese, and to a lesser extent the Laos, as "Indo-Chinese" or "Southeast Asian" refugees. *Kiwi* informants pointed out that the refugee identity can be an advantage, for example attracting the assistance of the "white middle-class liberals who were out to help refugees". The practice of categorising refugees together is widespread. For example, in Canada government workers who were unaware of either the differences between Southeast Asian refugee groups or the historical hostilities among them, unwittingly appointed Vietnamese in middleman roles and as translators (Indra, 1987, p.160). With a growing number of immigrants coming to New Zealand from a range of Asian countries, a Cambodian identity is tending to be merged into a general Asian identity, potentially making them targets for xenophobic verbal or physical attacks.

While the Cambodian identity from the perspective of New Zealanders is vague and confused with refugees and/or Asians in general, Cambodian refugees' own sense of identity is much more precise. It is inextricably bound up with their survival and escape from the Pol Pot regime. In New Zealand, their identity becomes interwoven with that of the Cambodian community. However, the Cambodian community is by no means homogeneous nor entirely harmonious. For example, families will tend to keep themselves aloof from those whose behaviour they believe brings disrepute upon the Cambodian community. In the wake of fighting, such as over gambling and debts, the respective parties may subsequently avoid one another, taking their supporters with them.

Pre-war socioeconomic level as a source of discord was significant. Members of

urban, educated families were inclined to look down on those with limited education of rural backgrounds. Urbanisation and wealth in Cambodia had often coincided with ethnicity, those of Chinese origins dominating commerce and bureaucracies. For this reason they were principal targets of Pol Pot's extermination and re-education tactics, and as such bear a particular hatred toward the perpetrators of the *khmer* revivalism that was an element of the regime. *Khmer* culture, such as healing practices, may be regarded by Chinese Cambodians as inferior, and the people who adhere to it as "ignorant" and "superstitious". Chinese Cambodians are inclined to distance themselves from a Cambodian community that is predominantly comprised of *khmer* people. In fact many are racially mixed, as extensive intermarrying has traditionally gone on. Nonetheless, in Cambodia and in New Zealand, Chinese Cambodians have maintained a degree of separateness within the wider Cambodian community, and while Chinese participate in Cambodian ceremonies, this is not reciprocated by customary attendance of *khmer* people at Chinese affairs.

Fissures are also developing along generational lines. These tensions are especially noticeable when the adults are marginalised while their offspring are being assimilated into the host society. Cambodians who were adult by the time they arrived in New Zealand seemed comfortable with their Cambodian identity. Younger people who finished their growing up in New Zealand portrayed a lack of ease with both societies. Young people find themselves under pressure from their peers to join their social activities, yet are subject to their parent's authority and standards, standards which reflect those appropriate to Cambodian society. Children are expected to be respectful toward their elders, yet this is compromised by the parent's dependence on children to assist in transactions and communications, and by their becoming privy to their parent's affairs in their role as interpreters (an issue described also by Henderson, 1987). On the other hand, as the children and young people become socialised into mainstream society, older adults become increasingly isolated, even within their own households. (See also Chung and Kagawa-Singer, 1993, p.638). School children, students and workers who move between two worlds, that of mainstream New Zealand and of the Cambodian community, need to negotiate separate identities appropriate to each context.

In her study of renegotiation of identities among Laotian and Cambodian women who settled in Chicago, Burki (1987, p.348) postulated that survivors' identities coincided with "ideal types", categorised as traditional, transitional, and modern. Of these the modern type, who grew up in an urban, Westernised environment, adapted best to camp life and was well-placed to participate positively in American life. Their prior experience of classroom learning was an added advantage. In contrast, the traditional and transitional types were unlikely to benefit from English and orientation classes after resettlement irrespective of age, having had no prior experience in learning except by imitation. According to Burki (1987), the traditional and transitional types identify themselves with Cambodian society but not with that of the host country, and consequently become agents for the preservation of traditional ways and values. While generational and racial differences can explain intracommunity tensions appearing in the Palmerston North community, Burki's ideal type construct suggests that modern and traditional types will be mutually suspicious and at times critical of one another. Burki's construct is problematic, however, in its implicit determinism. Among my informants were traditional and transitional types who identify themselves with New Zealand society, place a high priority on education, and vary in the extent to which they preserve Cambodian customs.

Differences are compounded further by the fact that ideologically the Cambodian community is not united. The political factions that led to ongoing civil wars culminating in genocide are reflected in communities in New Zealand. There are those loyal to the monarchy, who are more likely to be devout Buddhists; the communists, some of whom reportedly still adhere to the philosophies of Pol Pot; and the republicans who followed Lon Nol. There are also those who want nothing to do with ideology but simply wish to get on with their lives. While these differences are not always evident, disagreements and conflicts emerge from time to time. Participants were very reluctant to discuss the existence of politically-related differences, and while I refrained from probing, comments were occasionally dropped about someone who "still acts like Khmer Rouge". In his analysis of this same Palmerston North community, O'Neill (1990, p.45) referred to these oppressive power relations, and the Dunedin Cambodian community was reportedly shaken when

their former persecutors were resettled in their midst (Andrew, 1985, p.52).

The institutional identity of the Cambodian settlers as a community is derived from the Cambodian Association, one of the few institutions not carried over from pre-migration life, but which is a unique response to refugee resettlement. The association provides the principal constitutional body of Cambodians in Palmerston North, as in most cities where there is a sizeable community. It was the body that I approached for advice and assistance when I embarked on the study (see Chapter 4). The Association is responsible for organising such events as the major community festivals, occasional meetings such as when a dignitary from Cambodia visits, and from time to time has successfully applied for funding for interpreter and other services. Nevertheless, the Association does not represent all Cambodians resident in the city, with some preferring to remain aloof for a variety of reasons. An apparent result is that, contrary to American studies that assert the importance of ethnic associations for the well-being of refugee communities (Khoa and Bui, 1985; Tran, 1987), the Cambodian Association in Palmerston North, as elsewhere in New Zealand, seems to have a less important role.

Organised Buddhist religious practice provides a source of corporate Cambodian identity. As with the Cambodian Association, by no means all Cambodians identify themselves with Buddhism. Unlike larger centres such as Wellington and Auckland, where monks reside and temples are being constructed, in Palmerston North the practice of Buddhism is a domestic and informal affair. It is nonetheless a significant force for the protection and persistence of Cambodian Buddhist culture, a powerful influence shaping the lives of all refugees irrespective of whether or not they continue to adhere to its tenets [1].

The Nhim family are devout Buddhists on whom has fallen the role of providing leadership in observances. As leader, Mr Nhim would determine by the lunar calendar the correct day for prayer, arrange at whose house the meeting would be held, drive people there in his car, and lead the prayers. In village Cambodia this is usually the responsibility of religious functionaries, the monks, but in Palmerston

North the monk officiates only at the two principal ceremonies, *cjoal chn'um*, New Year, and *p'jum buend*, the Ancestor Ceremony. Mainly older people attend prayers, not unlike in Cambodia itself (Ebihara, 1974, p.385; and Tambiah, 1970, p.145). Children and young people show little interest in participating voluntarily in prayers and rituals, and other Cambodian customs. The Nhims had this to say about their grandchildren:

Mr Nhim: I want them to keep the custom too, but I don't know what they will turn out to be. The ones who live with us see us doing things [the proper way]. Before they go to school they *som'peah lea* [with hands together at about chin level, bow the head and bid farewell] and when they return they *som'peah bh'rub* [respectfully inform their elders of their return].

Mrs Nhim: But what about those ones behind our back?" [ie out of sight]...once every week or two when we see them, how can we teach?

They could not do more than encourage their sons to teach the grandchildren the customs, acknowledging a physical and social distance which contrasts with Cambodian village life, where generations normally lived close enough for grandparents to be involved in the socialisation of their grandchildren. Several times my questions about Cambodian culture and aspirations for transmitting it were answered with the comment "we live here now", suggesting both a powerlessness and ambivalence regarding the extent to which elders could insist that the children followed the customs.

A comparable pattern of simultaneously desiring to preserve the "old", while letting the young choose whether or not they would follow Cambodian practices, was observed with respect to the *khmer* language. All adults whom I asked wanted their children and grandchildren to speak *khmer*, and in all houses I frequented, *khmer* was the language used among adults. Their children thus grow up exposed to both languages, but in spite of this, several parents were concerned about their children's declining ability to speak *khmer*. Although many claimed to encourage their children to answer in *khmer*, the youngsters refused to do so. Objections to learning the

language and traditions of one's forbears is not peculiar to Cambodians. Sawicka-Brockie (1987, p.2) describes the rancour of children of Polish descent whose parents insisted they did so. In some families, however, children were actively encouraged to learn *khmer* language and culture. Sok's children were growing up in a domestic environment where such learning was insisted on and obeyed. Hand-printed notices in two languages declared that "in our home we use *khmer*", and I observed their bilingual New Zealand-born son respectfully greet his elders on returning from school.

Inculcating a sense of identity and cultural values takes place not only through language and formal organisations, however. In families where traditional values are observed in daily life, children witness, for example, that by the procurement and preparation of delicacies, their elders are honoured. The following excerpt illustrates how intra-family devotion and status is symbolically communicated, at the same time reinforcing traditional values of respect to elders:

You, Jeay [Grandmother], wait and listen! People coming back from Cambodia, I got them to bring dried fish (a delicacy), not just one but three kinds! And dried shrimps, selecting the largest, \$10 a packet...Chinese sausages, there is everything. The fridge is full, so long as it is delicious [meaning to whet the appetite], all for my mum...Nobody can buy these things in Wellington, everyone tried to get it for her...I'm not bragging, there is more food than for the royal, [she is] better served than royalty!

The communication and transmission of such values is subtle, inculcated by day to day exposure, and seldom by verbal instruction. It follows that the transmission of Cambodian values and mores, which contribute to a sense of identity, is likely to be weak when the socialisation of the parents themselves was disrupted and distorted by the Khmer Rouge regime and its aftermath, as described in Chapter 5. Cambodians who were children during the Khmer Rouge regime will have been strongly socialised into unquestioning compliance with authority. Thus a perceived pressure to assimilate into New Zealand society will threaten an already weak Cambodian identity, a process compounded by society's institutions and laws which further undermine and thwart Cambodian values (Hopkins, 1994, pp.145f).

The issue of maintaining and renegotiating identities has attracted considerable research interest, with some unexpected results. For example, contrary to expectations that Cambodian refugees would demonstrate Americanising or traditional preferences, Hopkins (1992, p.77) found that employed Cambodians who were apparently Americanised maintained traditions, having mobilised the financial resources to do so. The marginalised, on the other hand, lacked the means to maintain their traditions, and had difficulties in managing either culture. Similarly, Dorais (1991) shows that economically successful individuals are instrumental in the establishment of ethnic communities, which then become vehicles for maintaining cultural values. Taking a different approach, Krulfield (1992, pp.4 ff) argues that the re-creation of traditional rituals and modification of adopted host culture rituals by Lao refugees is a feature of the innovativeness of refugee communities as they renegotiate their identity in a novel context. In the case of the Cambodian community in Palmerston North, however, the two major calendrical rituals seemed rather to indicate a weakening cultural identity.

Cambodian New Year

There are two major festivals each year which bring people together, and at which the attendance of all Cambodians, young and old, is expected. One of these is Cambodian New Year, a festival which highlights how traditional practices are being modified, and the declining importance of such community ritual occasions. My analysis therefore focuses not on uncovering the religious meanings, but the way such festivals reinforce the changes going on at every level within this resettled Cambodian community.

It was Easter, that moveable Christian feast taken as a national holiday by all New Zealand, which falls sometime from late March to mid-late April. The Cambodian community in Palmerston North usually celebrate Cambodian New Year on Easter Saturday, although the proper date is April 13 or 14. I was invited to participate, and accordingly went to my sponsor's home at the stated time. It was late by the time we

set out, as the many dishes of delicious, special food that had been prepared had to be served into separate containers of beaten silver for the monk, as the medium for honouring and feeding ancestors, while the remainder was packed into everyday dishes for the community "pot luck".

We didn't have far to go, only to the school hall about four blocks away. The parking area was packed with the modern, tidy cars most families own. Children dressed in their best clothes were running about at play, while small groups of adults chatted and ferried food inside. This is one of the few occasions on which adults bring out their traditional finery to wear, but even at these festivals this practice is on the decline, with younger people in particular preferring fashionable Western apparel. The colourful movement of distinctively-dressed people contrasted with the primary school hall, making for a somewhat incongruous setting for the playing out of the day's ceremonies.

The Cambodian monk, dressed in cotton robes over his woollen socks and sweater, had been driven up from Wellington for the occasion, and by the time our party entered was inside seated cross-legged on a mat on a platform, the ceremonies already well underway. Late-arriving families set down their food offerings and made their respects, bowing three times in the ritually prescribed manner to the monk, before settling themselves on rugs on the floor amid much chatter. Throughout the monk continued praying, his chanting amplified with loud speakers. The overall atmosphere was charged with a sense of occasion and excitement, the noise of talk and laughter mingling with chanting, and the distinctive odour of the smoke of incense and candles mixed with the savoury smell of spicy food.

Children continued to race about, and the monk continued the ceremonial part of the occasion, with assistance in tasks such as lighting candles at appropriate times and responsive chants. There were a few mainly older people on the platform with him, fully participating in the prayers, but the majority seemed more interested in the social aspects of the festival. At specified points during the ceremony incense sticks and candles were lit in order to keep the evil spirits away and bring good luck and

prosperity, according to my informants. At one point the monk walked among everyone gathered in the hall, sprinkling them with sacred water, for blessing and protection from misfortune. As the monk may not partake of food after midday, it was important that he proceeded rapidly through the ceremony, eating from each dish offered before him, as an intermediary for feeding the spirits, or ghosts, of the ancestors. At the conclusion of this stage of the ceremony, everyone descended on the food, after which the monk delivered a sermon to which few apparently listened. Children played, men drifted outside to smoke, women socialised and looked after their infants, and the pious, mainly older women, drew near to the monk to listen.

New Year provides an opportunity for Cambodians to respect their elders, as well as for remembering and honouring their ancestors. In Cambodia at some point during the festival, the young people used to throw water over the elders and monks, to bless them, and for the sheer fun of it. As it is far too cold for throwing water in New Zealand, the young people throw talcum powder instead. Until recently, after the ceremony the young would give a performance of traditional Cambodian dance. With so many dancers having grown older and lost interest, and others having moved away with their families, it has become difficult to assemble a group. In earlier years, too, the afternoon was spent playing traditional games, but not now. Instead, people drift away, until the disco organised for the evening draws them together again.

In many respects, when compared with the village Cambodian context, the characteristics of New Year have changed. It is held not in a *wat*, a building of Buddhist learning and ritual, but in a school hall or other such multipurpose hall. In Cambodia, it is the hottest time of the year, very hot indeed, and New Year is also an occasion of conducting rites to ensure a good rainy season and crops, while in New Zealand April is a cool month. In centres such as Wellington, where a monk resides, New Year can be held during the weekend closest to mid-April. In Palmerston North, however, it is observed at the long weekend nearest to the correct dates, a long weekend being necessary to enable people from a distance, particularly the monk, to come. Even so, fewer and fewer people are coming from elsewhere to participate in this family and calendrical celebration. Conversely, the trend is for

Palmerston North Cambodians to go away for the long Easter weekend, with the dramatic decline in numbers a clear statement that the Cambodian community is weakening in terms of "cultural" identity and numbers. Others, I was told, don't come if they happen to have a quarrel with someone who will be attending, or simply can't be bothered to do all the cooking and dressing up.

Those who make the effort (and the preparations are time-consuming) enjoy the occasion, but it is different. Their celebration is tempered with the memories of those who are known to have died, those far away, and those who are lost. It is tempered also by the visible decline in participating families, which unavoidably confronts them with the weakening of their Cambodian Buddhist culture in the foreign land where they now live, along with the fact that theirs is not a homogeneous and strong community. Participants enjoy the delicious food, but much as they savour it now, the feast is a mingling of pleasure and sadness. Memories are triggered of their former misery, and the misery of those still in Cambodia who are so poor. There are so many spirits of the dead to be honoured and fed, so many victims of violent death and death by slow starvation. In addition, under the Khmer Rouge the ranks of monks and elders, the repositories and transmitters of belief and knowledge of ritual, were decimated by execution and starvation. Sok's mother knows the names of the family ancestors going back two generations, names that needed to be inscribed on paper for the ancestor feeding ceremony to be effective. The elders of many families have died prematurely, taking the knowledge of ancestors with them.

In the experience of Eisenbruch (1991, p.677) the opportunity to participate in the ancestor ceremonies provided young Cambodian refugees with a way to mourn their catastrophic losses. These calendrical ceremonies may have a similar function in Palmerston North, although the fact that fewer and fewer people avail themselves of this opportunity raises questions about whether Cambodians themselves perceive the ceremonies in this light. From my observations the ceremonies seemed rather to reflect the changes and dynamics of the Cambodian community itself. The declining interest in these focal points for Cambodian celebrations, where people could collectively display and reinforce their Cambodian and Buddhist identities, mirrors

a weak identity of that aspect of themselves as Cambodian New Zealanders. A falling level of active participation in the rites suggest that few observe Buddhist practices and Cambodian customs in their daily lives. Falling attendance is a measure of the shrinking of the community as families move away, and the declining importance of Palmerston North as a focal point for the gathering of scattered families. Thus these ceremonial occasions have become a metaphor of what is happening in the community generally, and for individuals, what it means to be Cambodian in New Zealand.

Beyond "Little Cambodia" - Global Families

Secondary migration from Palmerston North, particularly north to Auckland and Hamilton, and also to Australia, is well-developed. This movement reflects trends in New Zealand generally, when refugee families move from small towns to major cities, from south to north, and from major cities to Australia (Hawley, 1986, p.67 f; Gallienne, 1991, p.175; Andrew, 1985, p.37). A similar movement from small towns to large cities has also been documented in Australia (Hugo, 1990, p.195). The pattern of refugees initially being settled throughout the country, wherever sponsors were available, reflects that in the United States, where pepper-potting, and later cluster settlement, were deliberate policies to avoid the development of large concentrations and ethnic enclaves, and to speed up the process of acculturation and integration (Khoa and Bui, 1985, p.209 f; Mortland and Ledgerwood, 1987). Refugees soon took matters into their own hands, migrating onward to join larger ethnic communities in major centres.

In New Zealand, Cambodian refugees were drawn north by assumed better job opportunities, the warmer climate, and in particular, to join family already living there, together with the conviviality of being in a large community of their own people. Communities increasing in size and vigour generate a market to attract the establishment of speciality shops, thus improving the availability of desired foodstuffs and goods, and enhancing the attractiveness of such communities (see also Hugo,

1990, p.195). While there has all along been a trickle of secondary migration from Palmerston North, this became a significant outflow in the years 1992 -1994. A dynamic interplay of a complex of factors prompted families to again uproot. Almost always, the greater availability of jobs was cited as a major "pull" factor.

A pattern was becoming established for unemployed families to spend several months in the Hamilton area over summer to pick fruit and vegetables. Not only is this a job for which they have transferable skills, but they are able to work in the preferred group style. The improved income averaged over the year is not so high as to erode their unemployment benefit. At first families stay "Cambodian style" at the house of a friend or relation, but the crowding over the harvesting season becomes difficult for all, giving rise to tension. The next step is for one family to move up permanently, providing a family house to accommodate other related families during the summer months. After a time, closely-related families who wish to live nearer each other will leave one by one. As increasing numbers of families move away, the pull for the remaining ones becomes stronger. Families want to be reunited with friends who have left, and are attracted by the growth in size and identity of the Cambodian community to which people are drawn. There are in addition other "push" factors that participants preferred not to elaborate on, such as moving away to escape ongoing conflict and trouble from certain sectors of the community. Concerns about secondary migration have been expressed in the American context. Westermeyer (1987, p.942) relates higher levels of mental illness with secondary migration, the latter being more common when refugee families are initially isolated from others of their ethnicity. However, as Mortland and Ledgerwood (1987, pp.298 ff) have pointed out, experiments in the United States to settle refugees in clusters have had no demonstrable effect on reducing secondary migration. While policy-makers view secondary migration negatively, from the perspectives of the refugees themselves it represents often the first major decision made by the refugee. After a series of decisions made by immigration officials, sponsors and others affecting the life of the family, now the refugee is regaining control over decisions about where and how they will live.

A viable ethnic minority is linked to better chances for the unskilled to secure employment, and functions as a buffer for mental illness (see Chung and Kagawa-Singer, 1993, p.637). My observations agree with those of Mortland and Ledgerwood (1987, p.310f), that such communities protect against hostile reactions from the dominant society, along with providing information and support for people in transition. If the wider Cambodian community (as distinct from the "little Cambodia" within it) does not in fact fulfil these support functions, then secondary migration in search of such a community is both understandable and desirable. The pattern of secondary migration can also be viewed as evidence of a lack of attachment to the initial place of settlement, even for those who do not move away, a temporariness described also by Meleis (1990, p.369). Being simultaneously grateful for the refuge from violence and hopelessness offered by New Zealand, but unable to forget the violence they and their families have experienced, contributes to such temporariness.

In addition their thoughts are often occupied with the well-being of far-flung kin in the present-time. They refer to relatives "everywhere", as far away as France, Germany, Canada, America, and Australia. Some are as closely related as parents and children; others include cousins, aunts and uncles who may nevertheless be the closest living relatives beyond the nuclear family. It is quite common for an individual to have brothers and sisters, separated through the hazards of escape and resettlement, living in two or three different countries and continents. Describing a similar situation facing Vietnamese refugees, Haines, Rutherford and Thomas (1981) suggest that the boundaries of family and community are thus stretched well beyond traditional boundaries.

Reactions of Cambodians to the scattering of their kin can range from an apparently *laissez-faire* attitude to the heartache of homesickness. One elderly woman was not accepted along with her daughters for settlement in the United States. She describes herself as principally "happy for them", in contrast to another woman similarly separated from her daughter, who is ill with grief for her. In the main, contact is through letters, and international telephone calls. In spite of their poverty, the level of expenditure (on travel and telecommunications) by families on making and

maintaining contact with far-flung kin is very high. I know of no instances of Cambodian New Zealanders visiting their relatives residing in other Western countries, although they say they would like to if financial circumstances permit.

All participants have kin who either never left or were repatriated to Cambodia. It is these they worry about most, as they are frequently very poor, sometimes hungry, in danger from the vast numbers of mines planted throughout the land and from ongoing fighting between government troops and the Khmer Rouge. Appendix 6 shows from newspaper clippings why Cambodians are anxious for the safety of their relatives in Cambodia, and that there is little to attract Cambodian New Zealanders to return permanently, in spite of the difficulties they face. Contact is maintained by letter and the remitting of money. While none of my informants apparently wants to return permanently to Cambodia, most wish to visit. To visit is potentially the most fruitful way of being able to trace "lost" relatives, or at least to establish whether or not they survived. To attempt to do so through a third party is often unsuccessful, as the village family lived in prior to the Pol Pot years may no longer exist, or family members may not have returned there from the places they were moved to during the communist regime or when repatriated from the camps. Regularly, therefore, groups of perhaps ten Cambodians, usually the men, visit Cambodia for a month or so.

A parallel constant concern with family in Vietnam was found by Chan and Lam (1987, p.37 f) in their study of the psychological and socioeconomic adaptation of ethnic Chinese Vietnamese settled in Canada. In their view, a mental preoccupation with the past and with reunion militated against their successful adaptation into Canadian society. My informants also frequently thought about scattered kin, surely unsettling for families who after years of disruption and uncertainty are now trying to put down roots. The desires to reunite with kin and friends, to become part of a larger community, and to improve the family's socio-economic prospects result in refugees uprooting once more, and embarking on another stage of their journey.

Conclusions

This chapter has shown that resettlement in a third country does not spell the end of refugees' troubles. In fact, Ebihara, Mortland and Ledgerwood (1994, p.18) suggest that the consequences of past trauma and the difficulties of adjustment are seldom temporary, but may last a lifetime. (See also Stein, 1981, who argues against viewing refugee problems as temporary events.) A significant proportion of resettled Cambodians demonstrated a very low level of participation in the host society. This group instead maintained a high level of interaction within the Cambodian community, speaking mainly the *khmer* language, and engaging in Cambodian domestic and leisure activities.

On the surface, participation principally in "Little Cambodia", can be viewed negatively, as militating against integration with mainstream society. The Cambodian refugees themselves expressed their earnest desire to be better integrated, but a majority of the participants in the study were seriously limited in their capacity to do so. Illness and mental distress were significant factors in this regard, adversely affecting both their ability to acquire and retain English language, and to secure employment and friendships with *kiwis*. The resultant isolation and poverty appeared to compound ill-health, conditions which fostered a dependence on others to provide for their needs and produce solutions. Thus low adjustment is both a result of impaired health, and itself exacerbates distress and ill-health in a vicious interactive cycle.

My findings convey an alternative picture. "Little Cambodia" offered a vibrant, supportive community to which Cambodian refugees who are already marginalised can belong. Elements of the culture of the country of origin are maintained, including language, exchange of money and goods, sharing food, and playing games. "Little Cambodia" buffers its members from the full impact of social isolation and the stress of rapidly adjusting to a new society. Of central importance to this thesis, "little Cambodia" is intrinsically bound up with the developing system of healing. Here is the context for the practice of self-care techniques, and for the exchange of

medicines and information, described in following chapters. More importantly, "little Cambodia" is the environment in which illness in transition, illness neither Cambodian nor Western in type, are discussed. Here mutual understanding and support is offered. "Little Cambodia" therefore facilitates the well-being of its members, and to itself an essential element of the developing system of healing.

Among the study population, which is characterised by ill-health, poverty and being marginalised, there is evidence of personal courage and tenacity. These qualities which enabled them to survive the previous years of chaos and danger, continue to sustain them in adjusting to living in New Zealand and coming to terms with the realities of Western society. In spite of past trauma and disappointments in entering mainstream New Zealand society, I was struck by how well even marginalised Cambodian settlers were doing, a fact attributable in large part to the social networks of "little Cambodia". At the same time, "little Cambodia" does not represent a revival of "traditional culture", but reflects a new culture that is a unique outcome of living in the New Zealand environment. As I suggest in following chapters, "little Cambodia" and its developing system of healing are probably transitional, fading as the older generation die and the next generation are integrated into mainstream society, and declining as people move away, joining larger Cambodian communities in main centres.

My informants simultaneously participated intensively in the local community of "little Cambodia", and were extensively connected with global networks of kin and friends, with whom they maintained high levels of contact. Palmerston North's Cambodians, therefore, are living in multiple time and space dimensions. The extent to which they are occupied with remembering the past, remembering their personal suffering and that of their loved ones, was addressed in the previous chapter. The present chapter has dealt with their attempts to rebuild their lives in New Zealand society, retaining and re-creating elements of Cambodian culture, and maintaining New Zealand-wide and global social networks. Not surprisingly, in combination these issues make high demands on their mental processes, described by Cambodians as "thinking too much". This phenomenon is the subject of the following chapter.

Note

- [1] Buddhism as practised in Cambodia and the neighbouring countries of Thailand (Siam) and Myanmar (Burma), is based on the *Pali* Canon of scripture (Tambiah, 1970, pp. 32 ff). Although the following discussion describes Buddhism as practised in Thailand, in view of Cambodia's strong historical and cultural links with Thailand (see Chapter 5), it is relevant to Cambodian Buddhism. Buddhism provides its adherents with a cosmology, by which the universe is understood as a coherent, ordered whole. This cosmology accommodates the pantheon of deities and spiritual beings, including demonic beings, as well as the physical world of humans and animals, ordering them into a dynamic hierarchy, the motion of which is explained in terms of ethical and spiritual qualities. Buddhism also provides a system of beliefs and rituals that explain and govern daily living. Tambiah (1970, p.35) goes on to outline the basic Buddhist doctrines of *karma* (fate that is the result of ethical causation), *samsara* (the cycle of rebirths), *nirvana* (final release from *samsara*, annihilation), and *dukka* (suffering).

The Buddhist doctrine of *karma* is particularly significant for understanding suffering for which no obvious explanation is evident. According to this concept, today's calamity or misfortune is attributed to previous sin. Tambiah (1970, p.53) explains this as the outcome of relative stores of acts of merit and demerit. Accrued merit results in a favourable rebirth blessed with happiness, health and prosperity. The reverse is so when demerit outweighs merit, when rebirth is characterised by illness and misfortune. The acts contributing to the balance of merit are believed not to have been committed by the person during the present incarnate life, but during a previous existence. Detachment to life, which includes acceptance of today's suffering, is a means of avoiding the accruing of yet more demerit to the account of one's soul, as explained to me by the Cambodian monk who serves the local community.

Tambiah (1970, p.53) points out that moral and social behaviour are derived from Buddhist precepts. These cover individual, family and village merit-making activities, both on their own behalf and for the benefit of others. He goes on to argue that daily merit-making through the feeding of monks is a role of women more than men, but that the latter also acquire merit by virtue of membership in the household. Moral values are derived from the Five Precepts to which all lay Buddhists subscribe. These are summarised as the avoiding of taking life, not stealing, not fornicating, not lying, and abstaining from intoxicating liquor (Obeyesekere, 1968, p.27). While Buddhism was not a focus of this study, the centrality of Buddhism in the lives of Cambodians is a key to understanding the way they explain and deal with misfortune and distress.

Chapter 7

"THINKING TOO MUCH"

As I pursued my inquiry into illness experiences of Cambodian New Zealanders, the frequency with which participants referred to *gkuet cj'roun*, (pronounced "gitcheraan"), translated as "thinking too much", emerged as a significant phenomenon. In fact, the concept was mentioned in the first interview undertaken, and was raised spontaneously by two thirds of the participants interviewed in the preliminary phase of the study, in the context of being interviewed about illnesses. A thorough exploration of the phenomenon was, therefore, clearly warranted.

My aim in this chapter is to uncover the meaning of "thinking too much" as understood and experienced by those involved in the study. I begin with a brief discussion of the phenomenon in the contexts of health, illness, trauma and adjustment. This is followed by an overview of the relationship of "thinking too much" with the reported illness episodes afflicting the participants, which comprised the starting point for the inquiry. I go on to define and explain "thinking too much", by differentiating the meaning of this concept from closely related concepts. It became clear that the phenomenon cannot be defined in the abstract, but only in juxtaposition to such concepts and in relation to life experiences.

"Thinking too much" is not a novel response to the experience of being a refugee (as implied by Boehnlein, 1987, p.770). Included are accounts of "thinking too much" in pre-war Cambodia and pre-New Zealand life, as well as currently in New Zealand. Manifestations of the phenomenon are then described, and the ways Cambodians deal with it discussed. I will show from the dialogues that these ways of dealing with "thinking" are essentially the same whether the informants are in Cambodia or New Zealand, even though the precipitating life events may be very different.

To conclude the chapter, I raise questions about whether the phenomenon of "thinking too much", which predates the Cambodian genocide and its aftermath, is in fact a *khmer* term for psychiatric disorders. Furthermore, is it possible that the

widespread phenomenon of "thinking too much" influences the ways Cambodians respond to questions in psychological and psychiatric interviews, thus affecting survey findings and psychiatric diagnoses? My contention from the data described in this chapter is that while "thinking too much" does not invariably coincide with symptoms of psychiatric disorder, the lack of precise linguistic and conceptual equivalence has given rise to its being interpreted as such. If indeed this is the case, the prevailing pessimistic view of mental health of Cambodian refugees can be challenged, along with the widespread practice of reinterpreting experiences expressed in the context and language of one culture into the psychopathological language of the dominant biomedical culture where refugees have resettled.

My findings show that contrary to being psychopathological, "thinking too much" is an active process whereby the person troubled by life's circumstances can reassert control over his or her life, working through problems to a solution by "thinking too much."

This chapter is central to the thesis, in bridging the traumatic and stressful life experiences of Cambodian refugees, described in the previous two chapters, with illness, described in the chapters which follow. "Thinking too much", it appears, can both assist the Cambodian refugee in resolving grief, traumatic memories and current stress, and if itself unresolved can lead onto illness. "Thinking too much" thus is central to explaining the interaction of trauma, stress, health and illness in Cambodian refugees. It offers an explanation as to why many Cambodian refugees have overcome overwhelming difficulties, and have gone on to establish new beginnings, along with new communities, in foreign countries throughout the world.

The Concept of "Thinking too Much"

On questioning participants, I found that the phenomenon of "thinking too much" does not itself constitute illness, and while it became clear that "thinking too much" in some cases can lead on to illness, it is not necessarily regarded as a risk factor by

them. Surprisingly, although *gkuet cj'roun* emerged very early in this study, literature on Cambodian refugee health was largely silent on the phenomenon. Boehnlein (1987, p.770) refers in passing to "thinking too much", interpreted "sadness", citing Webb (1984) who relates it to a "moral sickness which affects only refugees and is caused by extreme isolation and loneliness". Other than that, there are two important exceptions, summarised below, both of which report findings of qualitative research oriented toward uncovering cultural perceptions and practices related to health. This in itself is significant, supporting criticisms of the validity of applying Western biomedically-derived instruments cross-culturally to such populations as Cambodians. As the term "thinking too much" is not widely recognised, questions concerning it have not been asked.

The concept is referred to by Frye (1991) in a discussion on cultural themes in health among Cambodian women. The dominant theme proposed is disequilibrium which Frye (1991, p.37) interprets as being rooted to Buddhist philosophy. According to this view, health accompanies the desired state of equilibrium, while illness reflects disequilibrium. Along with so-called "wind illness", "weak blood", and the post-childbirth condition *dtoas*, Frye (1991, p.39) categorises "thinking too much" as an illness of disequilibrium. "Thinking too much" is normally dealt with at a household and spiritual level, with family members ensuring that the "thinking" is not aggravated by such situations as solitude or quarrelling, and there is consensus that alcohol and drugs are best avoided.

The second reference to "thinking too much" was in the context of a study into cultural perceptions of stress held by Cambodian refugees (D'Avanzo, Frye and Froman, 1994). This descriptive study equated the concept of "thinking too much" with "stress", reporting that it was manifested by such phenomena as headaches, heart and breathing discomfort, and by disturbances of concentration, sleep and social activities (D'Avanzo et al, 1994, p.103). These authors go on to causally relate "thinking too much", or stress, to reflecting on past trauma, and current adjustment difficulties including poverty. Like Frye's (1991) findings, this study demonstrated that the state is normally dealt with in domestic and social contexts, such as by

avoiding solitude, sad thoughts and alcohol, and engaging in social and religious activities that distract from one's "thinking" (D'Avanzo et al, 1994, p.104). There was no suggestion that Cambodians regard "thinking too much" as a disease which medicine can treat, and therefore sufferers may not come into contact with the health system.

"Thinking too much" is not synonymous with anxiety, nor with depression, although there appears to be some overlap with these English language concepts and diagnostic categories. Nor does it fall neatly into the psychiatric diagnostic category of posttraumatic stress disorder (PTSD) although, again, there are apparent similarities. While there may be physical as well as psychological manifestations of the state, it is unlike descriptions of somatisation. While *gkuet cj'roum* when sustained and/or extreme can exert a negative effect on the state of health, at the same time it offers a mechanism for working through and resolving personal suffering, thereby being health-giving.

"Thinking too much" therefore sits on the margin between remaining healthy, and becoming ill. Furthermore, it inhabits a borderland between the past life that all remember so vividly, and the present; between the inner mental state and the outer life of everyday responsibilities and activities. It is not at all surprising that Cambodians are preoccupied with their thoughts, considering the severe and sustained suffering this population has experienced under the communist regime in Cambodia, only partially relieved during their years spent waiting in the refugee camps. These vicissitudes endured over many years are then capped by their continued striving to make a place for themselves in their adopted country, all of which can fuel the process of "thinking too much".

"Thinking too much" is a concept embedded in Cambodian culture as a response to undue demands. Even so, the superseding of their former way of life has created enormous demands on such traditional coping strategies of Cambodians. This has stretched to the limits their culturally-preferred ways of resolving those of life's exigencies that may give rise to "thinking too much", as well as their dealing with

the phenomenon itself when it engulfs them. The work of mourning losses and the load of adjustment to the new country, both of which are necessary to rebuilding lives and futures in a strange country, are seen to be potent contributors to "thinking too much".

Encountering the extensive discourses on "thinking too much" which were recorded on tape, SomNaang came to my aid in uncovering and understanding the concept. He provided me with an account of his own experiences (to be reproduced below) which he concluded with this statement:

I do hope that this tiny piece of insight into my personal life/family will help uncover the intriguing phenomenon of *gkuet cj'roum* (or thinking too much through worries). By the same token, I hope you... and other scholars will be able to help those with this kind of problems...it is frightening indeed!

Subsequently, after reading a draft of this discussion, SomNaang commented further, describing how its reading provoked a complex of thoughts and emotions. He hadn't realised, he said, that "thinking too much" was a "*khmer* thing", having grown up in Cambodian culture where this particular way of expressing mental distress was part of the fabric of life.

As a first tentative step toward achieving SomNaang's expressed desire, I draw from participants' experiences and descriptions, SomNaang's explanations, and my interpretations in describing the Cambodian concept of "thinking too much". This description and analysis of the phenomenon of "thinking too much" and the ways Cambodians have traditionally dealt with it throws light on their valiant efforts and tenacity both in adjusting to living in the West, and in relation to their illness experiences.

An Overview of the Relationship with Health and Illness

The focus of this overview is the relationship of "thinking too much" with illness,

and although examples are used for illustrative purposes, details about both the people named and their illness episodes are provided elsewhere in the thesis.

In the first phase of the study, I relied solely on the interpreter's presentation and on-the-spot translation of stories recounted. In the first interview, she conveyed that Mrs Nhim's symptoms of a burning sensation and numbness got worse when she "thought too much" about both past and current difficulties. From this beginning, "thinking too much" as it was phrased, was alluded to frequently.

As my initial exposure to this concept was in the context of asking about peoples' illnesses, at first I gathered the impression that "thinking too much" was intimately related to illness, in particular to mental illnesses, and so-called psychosomatic disorders such as peptic ulceration. Of the twenty-one participants with ill-health, ten described themselves as engaging in "thinking too much". Of these, eight ascribed the onset or exacerbation of their symptoms to "thinking too much", including Mrs Nhim (above). On the other hand, eleven denied "thinking too much", of whom eight suffered serious, even painful and terminal illnesses, including cancer, tuberculosis, gouty arthritis, and coronary artery disease. Added to this, two young women, who became partially paralysed around the time of the births of their babies, also did not refer to "thinking too much" in relation to their paralysis, although the experience was alarming for them. Yet subsequent to the death of one of these infants, its mother, BoPa, progressed to a state of entrenched *gkuet cj'roun* which seriously interfered both with her health and adjustment. Her account is told later in this chapter.

The lack of a clear relationship with illness is well-illustrated in VuTy's family. Theirs is a constant struggle to adequately provide for their large household of four adults (two of whom are chronically sick) and seven children, out of welfare benefits. VuTy denied "thinking too much" despite suffering a progressively painful and incapacitating illness, while his wife, who says she is not sick, "thinks too much" all the time. Her "thinking" revolves around:

NeaRy:...all the life. I have too many children and I want the children to live like every child, to have everything, the education.

The husband is sick, [its] very sad, but I try to forget about it. If I think only about this too much then I also [will] get sick, and the children, and everyone get sick.

Myself: And does VuTy "think too much" because he is always ill?

VuTy: I don't think anything. I just think, I want to be healthy.

Myself: And isn't that "thinking too much"?

NO! [answered simultaneously by three people].

There appeared to be no constant relationship between illness as a factor that exacerbated "thinking too much", nor indeed that "thinking too much" necessarily predisposed a person to illness. Further, there was considerable variation in the extent to which reliving and remembering the past underlay or was a feature of their "thinking too much", and thereby contributed to illness. Nevertheless, their narratives suggest that Cambodians may be more prepared than clinicians to acknowledge the relationship between current illnesses and "thinking too much" about traumatic and painful experiences. Indeed, in this study participants described instances when their belief that "thinking" about past trauma and grief precipitated their illness was apparently dismissed by their attending doctor.

This was brought out clearly by two elderly women described as having "lost the mind". The families of both were quite certain that these illnesses had had their beginnings years before, in those years of extreme deprivation and constant fear. Both described how it was in the refugee camps that memories of these past traumas began to encroach persistently, which continued after their settling in New Zealand. The supposed cause of the mental illness of each from a medical perspective was, however, some other identifiable precipitating factor.

The family of one of these women, Mrs Som, described how their mother had gradually weakened, losing interest in food and in the affairs of daily life. For several weeks she was completely out of touch with real time and people, and according to her family would "speak only to people in Cambodia", many of whom were in fact

dead. She didn't recognise those present, addressing them rather as friends in the village of her girlhood. Family members, who were frequently called on to interpret, described how they suggested to the doctor that her current illness was rooted in her past bereavements and traumas. His reported response was an inconclusive "perhaps", but, he explained, the real reason was chronic alcohol poisoning. Mrs Som had recovered by the time I met her, and it was difficult to equate the spry, cheerful old woman before me with the description of her, while so ill, given by her family. She admitted that she had previously used alcohol, a practice begun while living in the camp in order to deaden the memories of her suffering and traumatic experiences, a practice that she regards as risky and from which she now abstains. The family, therefore, does not dispute that alcohol was a culprit, but underlying the use of alcohol was the urge to free herself from "thinking too much". In this opinion, they received little affirmation from clinicians.

TiDaa's family had similar experiences. TiDaa describes herself as always sad. She can "forget" only when praying, and talking with other old folk. For TiDaa, it was after having had a thyroidectomy, followed three months later with a total dental clearance, a "terrible" experience for her, that she "lost her mind". Although hospital staff reportedly attributed her "lost mind" to traumatic surgery, in her daughter's opinion the underlying reason is her mother's *gkuet cj'roun*. She constantly "thinks too much" about her hard life and how much she has suffered, and especially that she is the only survivor of her generation, that only three of her many children are alive. She "thinks" constantly about how miserable she is, that there is nothing about New Zealand she likes except the times the old people get together to pray and chat. She suffers often from aches and pains and other somatic symptoms, and in respect to these also, her daughter is of the view that it is her mother's "thinking too much" that is the underlying problem.

Sok's mother also "thinks too much" about these things, yet has not "lost her mind". In common with TiDaa, few of her many children survive. She suffers from numerous pains and discomforts, which she ascribes to her past suffering, deprivation and ongoing bereavement, matters about which she always "thinks too much". She

is constantly "upset", apart from the times when she takes her mind off these thoughts by socialising with her friends, playing cards or watching Cambodian videos. On the other hand, many others also frequently remember their sorrows "in the back", such as the Meas family about their escape and BoPa about her lost family, and yet do not necessarily "think too much" nor become ill as a result.

It wasn't only old people but younger ones, too, whose health status seemed threatened by what they described as "thinking too much". VeasNa, who had been imprisoned and beaten unconscious by the Khmer Rouge, now suffers from severe and disabling headaches and a range of other symptoms (to be described fully later in the chapter). Although she was reasonably well while living in the refugee camp, this is no longer the case. As she put it:

When I first came to New Zealand I was sick. Not my body but my mind. There was so much, too much...New Zealand is quiet, peaceful. There is nothing wrong with New Zealand. But I "think" all the time. Something is wrong with myself, my body. I'm sick all the time.

A second person in this study population, SaRom, had also been imprisoned by the Khmer Rouge. He described his intense fear at the time, was unable to sleep, often without food, and close to death from malaria. While in the refugee camp he had major surgery for a bleeding stomach ulcer, and was told at the time by the attendant clinicians that the problem was that he "thought" and worried too much. On arrival in New Zealand, after a brief "honeymoon" period, domestic and other difficulties pressed in on him, and he began to experience severe abdominal pain once more. He acknowledged that he was "thinking too much" about his troubles and relationship difficulties, a situation exacerbated by his fears that this could lead on to another ulcer. This was *gkuet cj'roum*, he responded to my specific question, and even though he wore a smile on his face, his heart he described as unhappy, and his mind busy with "thinking too much". He underwent thorough medical investigations to eliminate a recurrence of ulceration, investigations which proved normal. Clearly, in SaRom's view, his current abdominal pain is a direct consequence of his "thinking too much", a practice which he determines he must control.

Not all those who "think too much" go on to become ill, just as many very ill people claim they do not "think too much". There is, therefore, no constant relationship between the two phenomena. These narratives are significant, however, in that they demonstrate that when such a relationship exists, Cambodians readily recognise and acknowledge it. This is the case even when their views seem not to be supported by clinicians, and indicate the level of interest and insight many have about the origin and progress of their illnesses.

The Meaning of *Gkuet cj'roun*

Gkuet cj'roun is not easily translated into English, nor precisely defined. My attempts to do so suggested that the route to understanding is through exploring related concepts and phenomena, described in this section, and to search for meaning in the contexts in which they occur, outlined in the following section. *Gkuet* means "think"; *cj'roun* means "excessively, a great deal". Together these words mean "to think too much". This is not the same as "worry", as I discovered when asking the Nhims to explain "thinking too much" to me.

You have to put "worry" first...*bpi! baak cjuet* [*bpi! baak* means "difficult"; *cjuet* is "mind" or "heart"; together referring to a difficult, or "hard", state of mind]. When we *bpi! baak cjuet* we think a lot, isn't it...Sometimes we don't stay happy forever. There are times when it is difficult in our heart, isn't it...it is normal, we think a lot [or worry].

"Thinking a lot", or worrying, is distinct, therefore, from "thinking too much" with the former being regarded as a normal response to the ups and downs of life. Mr Nhim claimed that he neither thinks "a lot" nor "too much". After all, there is nothing to worry about in New Zealand, where there is no fighting and there is plenty of food. In contrast, during the Pol Pot regime when they lived on the verge of starvation and in constant fear he also didn't "think too much" but was preoccupied, bordering on being anxious or worried:

When there is danger, that's *prouy cjuet* [an anxious state of mind].

In Pol Pot there was *prouy* [worry, anxiety]...they would kill if wrong, and they would kill if nothing was wrong.

Sok: And today they would kill other people, some day it would be my turn, [we] didn't know.

Mrs Nhim: Day or night, didn't know when...

Mr Nhim:...didn't know, but especially at night...

Mrs Nhim:...didn't say [speak]..just think..

He described how he currently misses his relatives and friends not resident in New Zealand, but that this is not the same as "thinking a lot". In the same way, the Nhims remember the past, but do not "think too much" in relation to their past sufferings.

Relaying my question, Sok asked:

Are you still thinking about those things from AA Pot [a derogatory term for the Khmer Rouge], or have you forgotten all, stopped thinking, or still thinking about it sometimes, back and forth?

Mr Nhim: We are not thinking about anything. We are here. But we think, what is in the future? We don't know what's going to happen.

Mrs Nhim: When we meet we only want to talk about those stories.

Mr Nhim: I do think about AA Pot, but not really "thinking", because it has ended. Like when it had just ended, if we "thought too much" there would [have been] a mess [in the mind or emotions]. I just think, not to allow such [a] regime anymore.

Sok: I don't "think", but sometimes *a'rom* [feelings, state of mind] still goes back.

The *khmer* term the Nhims used to refer to their remembering of life under Pol Pot was *nuek keuhn*, or to "remember vividly". When questioned they agreed that they did actively remember those years, and do compare the present with that time. Moreover, they stated they "won't forget that story. We always tell to the children that this period was like that..." They expressed their concern that their children could

become too comfortable, and forget their past and their identity, but they don't worry about it to the point of "thinking too much".

The distinction between being "healthy" or "well" and "thinking too much" was raised in a separate discussion, this time with BoPa. After the death of her baby, BoPa was constantly "thinking too much", but when I asked her about the state of her health she responded "*sok sub'bai*". [*Sok* means "safe"; *sub'bai* is "happy". Together, this means "I am well, safe, healthy".] However, she went on to explain that while she suffered no sickness, she was actually *ot sub'bai dte* [that is, unhappy and unwell, *ot* meaning "no" or "not"]. BoPa's "thinking too much" centred on her inability to use her limbs around the time of the birth of her baby, which deprived her of the pleasure of handling and feeling her baby for several months, and then the loss of her baby through death; and included the run of bad luck her family was having. All this threatened her well-being, and her sense of happiness and safety, while not making her actually ill. However on further questioning, she indicated that if she went on in this manner, "thinking too much" could lead on to illness. BoPa described her fears of becoming ill if she wasn't able to control her "thinking":

I think that maybe my body will revert to being sick again. [I am] thinking inside my head that I might not be able to walk. Oh! I must stop! I have to stop!. It is like that. [In this way] I try to control my mind.

As BoPa suggest, "thinking too much", therefore, is under the control of the troubled person, a view supported by the Nhims' explanation above. In conversation with the Meas family, they described that for them, engaging in too much thinking and worrying, such as about close kin still in conditions of poverty and danger in Cambodia, endangers their health. Too much "thinking" renders them *ot sub'baai cjuet, ot sork'piep*, which is to say, "no happiness of the mind/heart, no health."

While the Nhims claimed that they had not gone on to "think too much" from any of the related thinking and feeling states, other Cambodian refugees readily described themselves as "thinking too much", and this was usually in relation to the past and

current vicissitudes described in the previous chapters. From their explanations, "thinking too much" as a mental state falls outside the normal, acceptable range of human responses to circumstances, yet it is morally neutral, not necessarily regarded as mental illness or socially deviant. The only allusion to it being abnormal was that of a young New Zealand-educated Cambodian health professional, who described the state as reflecting "emotional problems". Although it undermines one's sense of safety and happiness that together make up the state of wellness or being healthy (*sok sub'bai*), and if unchecked can lead on to illness, it does not necessarily equate with being ill. SomNaang offered that "thinking too much" is a "defense mechanism of coping with stress, uncertainty, confusion, despair, etc."

"Thinking too much", (*gkuet cj'roun*), therefore, is perceived as a state of mind or heart that exceeds an expected and reasonable response to the normal vicissitudes of life. Such responses are described as *bpi! baak cjuet*, or "thinking a lot", and *pruoy cjuet*, high levels of worry and anxiety arising from genuine danger. *Gkuet cj'roun* was on occasion used interchangeably with the term *pruoy cj'roun*, to "worry too much", and with *gkuet klarng*, meaning "thinking very hard", terms which carry similar but distinct meanings. All of these terms are different from mourning, from missing loved ones, and from vividly remembering past traumatic events (*nuek keunh*), even when the previous feeling state accompanies those memories (*a'rom*). These distinctions are significant, particularly when interpreting *gkuet cj'roun* in the light of Western concepts of mental disorders and symptomology.

For example, symptoms of psychiatric disorders that English-speaking Caucasian patients commonly complain of have become the bases for instruments used for diagnostic purposes in clinical settings and in surveys. Using the technique of double-blind translation and back-translation, instruments for use among Cambodian populations and others have been developed (see Cheung and Spears, 1994; Mollica et al, 1987; Mollica et al, 1992). Using the translation-back translation technique, the English phrase, "worrying too much about things" appears in one such instrument (Mollica et al 1987, p.498). This phrase could be variously translated as *bpi! baak cjuet*, *gkuet cj'roun*, *gkuet klarng* or related terms, both in the preparation of an

instrument and in its administration. As all concepts carry subtly distinct interpretations and connotations, it is possible that the findings of some such clinical or community studies do not reflect what participants intended to convey. Furthermore, the same term may mean different things to different Cambodians.

In view of "thinking a lot" and "thinking too much" being prevalent in Cambodian society and readily acknowledged, it is moreover likely that findings of psychiatric morbidity may be misleadingly high. Indeed, both Cheung (1994, p. 17) and Carlson and Rosser-Hogan (1991, p.1548) report a Posttraumatic Stress Disorder (PTSD) prevalence rate of 12.1 and 86 per cent respectively among non-clinic populations. In the absence of information to the contrary, one can only assume that these affected people are nonetheless functioning adequately in their domestic environments, an assumption reported specifically by Mollica et al, (1993, p.584), in which clinically depressed and traumatised residents of a Thai border camp were maintaining functional and social activities.

Furthermore, Cheung (1994, p.22) and Mollica et al (1992, p.113) report recurring thoughts and memories of traumatic events as among the most frequently occurring diagnostic symptoms for PTSD. Yet this present study described such recurrent memories and "thinking" as almost universal among survivors, memories Cambodians regard positively in the light of the resettled survivors' duty to those less fortunate, and as acceptable in relation to the horror and degree of suffering of the past. The possibility that "culture-bound syndromes" exist independent of PTSD and other psychiatric disorders has been suggested (Mollica et al, 1992, p.111), syndromes which "await clarification by ethnographic methods". The findings reported in this chapter do not describe a culture-bound syndrome, in that *gkuet cj'roun* is not an illness. I suggest, rather, that "thinking too much" is an active response to a wide range of different events, yet essentially the same response, varying only in degree. "Thinking too much" thus provides an effective means of resolving major issues. For example, SomNaang was emphatic that *gkuet cj'roun* can be a positive activity undertaken by the troubled person, demonstrated below in his narrative. "Thinking too much" is particularly likely to emerge in conditions of powerlessness,

a striking characteristic of the study population. Yet even when disempowered, the process is subject to the control of the person. Only the "thinker" can stop her thinking, as BoPa explained.

Life Events that Give Rise to *gkuet cj'roun*

"Thinking too much", as I have shown, is widespread among Cambodian refugees endeavouring to adjust to New Zealand. Yet the response is not unique to refugees. My informants described themselves as having been affected by "thinking" since long before coming to New Zealand. One young man traces his habitual "thinking" from the time of the communist take-over of Cambodia, while for a busy young mother, NeaRy, "thinking too much" has been a constant in her life. She has suffered from *gkuet cj'roun* in relation to getting enough food for survival before and during the Pol Pot regime, and afterwards while living in the camps, as well as currently in New Zealand:

Gkuet cj'roun only since coming to New Zealand?

Oh, ever since whenever [that is, for a long long time]...In the village worse than this...in the camp [I] think more than this. As soon as it was getting dark, [there was] fear of robbers...

The phenomenon of "thinking too much" as a response to life's problems is thus embedded in Cambodian culture, along with ways of dealing with "thinking". In pre- and post-war Cambodia, the struggle to get enough food that gave rise to "thinking too much" was apparently not at all uncommon. For example, an old woman related that after her mother's death, when she was still a young girl, she was fully responsible for providing for her old father and younger siblings. Being required to do both field and domestic work, the "work of men" as well as women's work, with no-one to support her, she "thought too much" all the time. Her mind became "hard", as she described it, simply because of the burden and worry of how she would manage all that work and support the family. NeaRy was in a similar situation:

[It was] the same, but worse than this. In the rural areas no-one helped to feed us. Here, [we are] only eight [people], but over there much more than ten, and [we had] no money.

Mother-in-law: And [would] sell land, [and after the] land, everything is gone.

NeaRy: Because we have no money from the unemployed, no money from Social Welfare, and we have to get the money to look after the sick [by selling land].

Poverty among rural Cambodians prior to the Pol Pot regime was, I was told, widespread, with families getting into debt to finance marriages and other ceremonies, to get treatment for the sick, set up a small business, and the like. Very high interest rates charged by money-lenders, together with very low prices for their crops, resulted in some losing their land to repay debts.

Similarly in the extreme poverty after the war, people "thought too much". SomNaang's mother was one of these. She tried to support the remnants of her family by peddling foodstuffs in Phnom Penh's streets. When not doing well she would complain that she was having to "split a strand of hair into ten pieces" in her struggle to assure their survival.

Not everyone struggling to survive in the face of extreme deprivation described themselves as "thinking too much". The concept was not raised in relation to flight to Thailand, for example, when people were literally starving to death and daily living in grave danger. As with current serious illness, there is an apparent paradox here, in that there seems to be less "thinking too much" in relation to the more critical or life-threatening circumstances, illustrated for example in their life under Pol Pot's rule. For NeaRy's mother-in-law, who grew up in rural poverty and had overcome "thinking too much" about how she would feed her family before the war, the "three years, eight months, and twenty days" under Pol Pot were incomparably worse:

The struggling time in Khmer Rouge. Hunger, only have rice water. Let me count, during the Khmer Rouge my brother's family [went] missing; two brothers; younger sister, one family again; my child - the whole family of five; in total five families. From birth I never

saw [such a thing], but I couldn't do anything. [I was] afraid [they would] cut my throat.

At the time she described herself as being "very angry", but in common with many of these participants, had no opportunity then to "think too much" as they had to work too hard by day and were too exhausted by night. Once the immediate life-threatening danger was past, for some their inability to forget could become *gkuet cj'roum*, as illustrated by Mrs Som whose alcohol use in the camp was to counteract her "thinking". The tedium of camp life provided a fertile environment for their memories of past horrors and grief to engulf them in the form of *gkuet cj'roum*. Once the initial excitement and novelty of New Zealand waned, for some "thinking too much" about past events has re-emerged, supporting the findings of D'Avanzo et al (1994, p.101) that *gkuet cj'roum* is related to past trauma.

Old people such as TiDaa and Sok's mother, and Sok herself, are among those who acknowledge "thinking too much" about the terror of the Pol Pot years, as they go back to those years in their memories. None, however, indicated that they attempt to block off these past experiences as a way of overcoming the undesirable state of "thinking too much". On the contrary, they like to discuss these events and their personal tragedies, mutually supporting one another in their suffering, which may serve to alleviate the pain as it resurfaces. While some people such as the Nhims claimed not to "think too much" about faraway family members whom they missed, this was not so for all. Thinking about her separated and missing children was a feature of the "hard thinking" of Sok's mother, those of the Meas family, and TiDaa, to name but a few.

The content of such "thinking" is by no means limited to past events, prominent though these are. Once the ideal image of the West was replaced with the reality of living permanently in New Zealand, Cambodians frequently found themselves "thinking too much", as indicated poignantly by Mrs Nhim (see Chapter 6), in response to living in a very different, unsociable community in which she was acutely lonely. Sok implied something of the initial shock in her question to NearY:

Sok: It's normal now isn't it? Unlike the first time we were here [that is, when we first arrived], when we have so many *gkuet cj'roun* isn't it. It's normal now, by looking at it?

NeaRy: It's not normal.

Sok: Half/half?

NeaRy: No, sixty, more...not normal.

For young people like NeaRy and SomNaang, *gkuet cj'roun* is principally a response to current struggles and pessimism about the future. It was dreams of a better life and opportunities that gave them hope to persevere throughout the communist regime and its aftermath, and when these too seem to elude them "thinking too much" follows. Having just arrived in New Zealand when aged about seventeen years, SomNaang described his first impressions of New Zealand, as being "exciting, everything different, the streets..cleaner, particularly the air...and people...nice." Crossing a street, he thought to himself that "I had better not get run over by a car. I have so much to offer. One day, people will need my help, my skills!"

He described himself as a bright youngster who could spell his name, and knew the French alphabet at the age when most kids in Cambodia were still being spoon-fed. However, as for so many in his generation, SomNaang's ambitions and education were destroyed by Pol Pot. When he was only thirteen and part of Pol Pot's slave labour force he suffered from *gkuet cj'roun*, spending his nights fantasising about his life and a better future, mourning his lost opportunities, and dreaming "of being in another world." New Zealand represented this "other world", but here too he was soon disappointed, as he describes in his own words:

When I first arrived..I wanted nothing but to go to school to continue my education..I would start at seventh form and go to university the year after that...little did I know of the difficulties at school for new settlers. I was very naive back then...Because we bought a fake refugee status card, my date of birth was changed; I was about four years younger than I should be. I did not want to

declare my real birth date...my sister who came to New Zealand before the rest of the family, with one of my cousins ..told me to declare my real birth date as being younger [I] would not be able to earn as much money...I wanted to study, but they wanted me to work...Being forever grateful to my cousin (for getting us to New Zealand) and not wanting to upset her, I declared my real date of birth...When in Wellington, we had another lengthy discussion about me. Being the oldest son of the family (my older brother is missing, presumably dead) I was pressured by my family to work. I bowed to the pressure, as I did not want to put the financial burden on my sisters. In frustration, I broke down and cried in my sister's room, where we had the family discussion....After I had been in New Zealand for three or four years, I thought of committing suicide by fully opening the throttle of my car [here follows considerable detail of his planned suicide]...I was working for ..a bakery at the time..it was an awful job, I was treated like shit by my boss and fellow workers (a Vietnamese and French)..I used to think (and still do) that most of my friends would be doctors or something of that calibre, and here I was in New Zealand working as a bread delivery man...still struggling with sixth form [subjects], being told off and made fun of (and even being seduced by a homo)...I got sick of life and quite often did I think of taking my own life there, right at that corner...[I didn't] not because I did not have the courage to do it...I thought that that was not my way of making my mum proud of me, and not my way of being a grateful son!

SomNaang, now about thirty, persevered to eventually complete a university degree, and has established a family. In SomNaang's case, "thinking too much" was his response to extreme disempowerment, first during the Khmer Rouge regime, and then when obliged by his family and his own sense of responsibility to forfeit his dreams. It was his personal experience in working through the disappointment and despair that for him characterised "thinking too much", along with working toward his hopes, that has highlighted the positive aspects of the phenomenon as a mechanism for resolving problems. In other words, "thinking too much" is itself an active process for problem-solving. The discomfort of "thinking too much" motivates the person to reach the point when "thinking" can be stopped, either because the problem has been solved, or by an act of ill, as in the cases of BoPa and NeaRy. As for SomNaang:

As I am writing this, [it] make[s] me somewhat emotional as I have

come a very long way and achieved so much - not so much academic achievement, but I GOT MY LIFE BACK [sic], with the second chance I was given!..that was what kept me going...hanging [on] to my dreams and the will to survive!

In contrast, NeaRy had no aspirations to continue her own brief education, but held on to hope for her own six children. At present, none are yet beyond primary school, but are showing signs of interest and talent. With her husband's illness absorbing the energies and finances of the family, she sometimes loses hope, and "thinks too much" about their future:

Here I worry about occupation, about [being] sick. When you are sick, there is no job to do and not enough money to pay for things...and when always sick there is no support for growing up children, no capability of support the children. Busy with children getting sick, husband sick and me, and how can we find happiness?...My thought is different from [my husband]. I don't want my children to stop study in the middle to work. I want [them] to study to the end, until they get a job, no matter what. [That is, not to leave school early to get a job, but to complete their education according to what they wish to do].

VeasNa also talked repeatedly of "thinking too much" about the cycle of constant illness, unemployment, poverty, and despair over whether their children would have the education which she saw as the way to a better life.

Exploring the phenomenon of "thinking too much" thus uncovered a pattern of preoccupation with difficulties, and with threats to well-being and sometimes survival. This seems to be mainly with regard to current difficulties, but when losses and past trauma were overwhelming, these can also be the focus of "thinking". Moreover, current or new vicissitudes that set off a person in a pattern of such "thinking" can then be compounded by the memories of earlier events and sorrows about which the individual hasn't previously been "thinking".

In pre-war Cambodia, "thinking too much" affected those for whom events were particularly trying and grievous, but from the time of the Pol Pot regime, including

life in refugee camps, everybody experienced abject misery. Not everyone, however, experienced *gkuet cj'roum*. Indications are that although arrival in New Zealand has brought freedom from immediate threats to life from hunger, lawlessness and fighting, "thinking too much" is nonetheless commonplace. In part this is a response to the demands of adjusting to an alien society, its language and culture, in fact all the work of adjustment discussed in the previous chapter. On top of this is the process of reconciling dreams and fantasies with the reality of the host country, with its cool, cheerless weather, a population that is not always welcoming and friendly, and fewer opportunities than believed for employment and the acquisition of wealth. And on top of this again, along with being free from threats to survival there is now the space to deal with personal bereavements and the traumas so many witnessed and experienced.

Apparent in these accounts of the relationship between life circumstances and the response of "thinking too much" is that the drive to survive, and the hope of being accepted for resettlement by a third country, did for many displace "thinking too much" at the time. However, once resettlement was achieved, the enormity of their past and continuing personal tragedies and struggles presses in on them, with *gkuet cj'roum* being the resultant response. At some point, the vast majority of Cambodian refugees have experienced *gkuet cj'roum*. While for some this is largely overcome, for others "thinking too much" repeatedly re-emerges or is a constant state. This was the case for SubBai and Sok, for whom "thinking too much" related to the war and early adjustment to New Zealand was largely behind them, only to overwhelm them again when they incurred huge debts and lost their jobs.

In the case of others, by their own accounts they did not "think too much" during the traumatic years of the Pol Pot regime, and seemed to weather the camps and introduction to New Zealand, only to be precipitated into a severe state of *gkuet cj'roum* by an event that seems minor in comparison. In BoPa's case, the death of her baby precipitated her into a state of "thinking too much", when loss of her natal family as a teenager and her recent personal illness had not provoked the same response. A consistent and predictable relationship between life events and the

response of "thinking too much" is, therefore, not the case, just as there is no consistent pattern of the relationship of illness and "thinking too much". What does seem clear is that *gkuet cj'roun* entails searching one's mind for a solution to major, even insoluble, problems such as: How can I be reunited with my lost child? How can I repay my debt? and How can we eat? "Thinking too much" can provide a means of working through a problem to its solution. When the problem is insoluble, however, the "thinking too much" can become entrenched, threatening well-being.

Manifestations of *Gkuet cj'roun*

While there is variation among persons and within a single individual between life circumstances and the response of "thinking too much", there is much more agreement on how this state affects people. All described an overworked mind, with insomnia and an inability to think clearly, often accompanied by physical symptoms. NeaRy began by describing her inability to sleep:

I'm afraid that even when I "think" a little I can't sleep, it is like my eyes won't shut. Last night until 3 o'clock I can't sleep. [My head] hurts *smok-smarnh* (which is translated as a complex, complicated, difficult, clouded state of mind). It is suddenly all over the head and hair. When "thinking" nothing appears, so very frustrated...

Sok's reinterpretation: She said she feel[s] like spider web stuck in her head...she can't think because it's stuck like spider web.

Insomnia was common to all, expressed for instance in SomNaang's wondering whether "it was the cold nights, or my feeling of inferiority...hardly did I go to sleep before 2 o'clock in the mornings, which made me very tired when I woke up". Those who described "thinking too much" in pre-war Cambodia also talked of being unable to sleep as they worried over the problems that were overwhelming them. BoPa's nocturnal "thinking" ranged from the realm of planning out a desirable situation, in which she pictured a life in which her youngest child had not died, her husband was not incapacitated and unemployed, and there was hope for the future of the family,

to incorporating present discouragement, future hopelessness, and past mourning in a complex tangle of thoughts:

My brain works out everything, and I say, if there were three children, how happy I would be! [All this] I think in my mind, it all works [out] in here and it is so clear! "I have a house, I have a car, I have money. My [husband's] arm is not sore and we both work." Yes, and when I think too much it's happy! The brain goes on and on. I can't sleep, too happy! And when I get up, nothing. No sleep at all, my eyes are pale, have never been pale like this....Then the hard, [unpleasant] stories. I think about them even more than the happy [ones]. Why so poor, having nothing? Only have [this little] to spend...[after the] rent, food, all gone. Can't afford whatever I want. I don't have anything. Just consider that! How can I be happy? Nowadays I think only about my children's education... The mother is ignorant [that is, uneducated], the father is ignorant. No matter what, we just want these two kids to grow better than the parents....And I think about...I don't have mother, no father, no siblings. It keeps coming back...I see something like my mum harvesting rice...dream of these things, and when I open my eyes I can see these things again.. the mind wanders very far away....

Sok: Don't think too much like this..the Government won't let you die! There might be lots of friends to help some... [to me] This brain...too much working, too much "thinking". Brain factory keep working too much until the morning. She "think" like this, she "think" like that, too much. Yes, she keep chuck that [thought] away, then running back to her again.

"Thinking too much" is work, an activity in the control of the person, and not a process over which the troubled person has no control. The combined effects of lack of sleep and overactive thinking led on to being unable to focus one's thoughts, to concentrate, common to all with whom I explored the phenomenon. SomNaang described his own confused thinking as:

My brain was so filthy with ideas that I wished I could unplug my brain and give it a wash.

While NeaRy's "thinking" revolved round difficulties that were discouraging and depressing, she remained capable of caring for her family and household. On the

other hand, VeasNa and BoPa reached the point of being incapacitated by "thinking too much", and being decreasingly competent to carry out even the most mundane of tasks. VeasNa was often unable to care for her small children and do things like prepare meals, partly because of incapacitating physical symptoms, but also because of her jumbled thoughts. As I will show below, however, such disturbed thought processes going as far as to adversely affect function are seldom brought to the attention of doctors, with the result that medical treatment is rarely offered.

Several described how the English they had once learnt had now completely gone, while others like BoPa were unable to acquire English because of their difficulties in concentrating. BoPa described her mind as "buzzing", and "confused". She was no longer able to carry out handicrafts she was formerly skilled at, such as weaving and sewing, could not retain words of the English language she was endeavouring to acquire, and could not even shop unaided:

When I *gkuet cj'roun* the ears buzz, buzzing, sitting like a crazy person, you know? and when it stops buzzing it becomes a little bit clearer. Now that I'm *lob* [confused], I tell you honestly, I don't know how to think about anything. If I [formerly] did something I would do it thoroughly, but when I started to *gkuet cj'roun* I can't do anything. I don't know where my mind goes, breaking manure and urine [meaning thinking so much she becomes confused]. Seeing this five dollar note, [I] think it is a hundred dollar note, and say. 'Dear, go and pay car insurance', and only five dollar! It's true, and sometimes I go to the supermarket. They got number four and number two [that is, forty-two dollars] but don't know how much it cost. I don't think I can go to supermarket if [my husband] didn't come. And sometimes when the brain is clear [from worries], I know too....I am so angry inside, I want to know and to learn, at least to be able to speak [English] a little bit. I am determined to master the learning. My consciousness just goes away...can't say anything...

Day-dreaming and fantasising about a change of fortunes that is evident in BoPa's account was also a feature of SomNaang's "thinking too much", which he claims is very common among people of his generation. When reality brings these dreams no closer, then "the idea of ending this life seems excruciatingly attractive!"

Alternatively, the fact that the gap between reality and one's dreams remains so wide may provoke anger, rather than avoidance through day-dreaming or suicide. VeasNa, NeaRy and BoPa all described unprovoked outbursts of anger related to "thinking too much". VeasNa's husband complained about his wife's verbal attacks for no reason at all, which in turn made him feel angry, sad, and bewildered, commenting that she is "so angry with me, I don't understand..her mind.." BoPa talked about the way "thinking too much" was much worse when she was alone, so that when her husband returned from an outing she was prone to pick a fight with him over no particular issue. NeaRy explained it in this way:

When *gkuet cj'roun* we feel very frustrated, and when someone speak [whether] right or wrong we still feel very angry.

Sok identified with this, talking about times when she was variously angry with her ailing mother, her quiet and solicitous husband, or her well-mannered children, herself interpreting this as a result of her own "hard" thinking, and not because of their actions.

For some, withdrawal from human interaction was the preferred response to "thinking too much". They declined to go out, and even within the house secluded themselves in a quiet spot in a corner, even in the wardrobe, not wanting anyone to chat with them. This was vividly illustrated on several visits to BoPa's house, when she would busy herself in another room, or alternatively seat herself in a corner most distant from those gathered near the fire. Only gradually did she draw closer to the group, sometimes at the insistence of others. Thus "thinking too much" can lead on to what others perceive as asocial and antisocial behaviour, which results in increased withdrawal or isolation, in turn aggravating "thinking too much". Their awareness of this is reflected in their traditional ways of dealing with family members and friends who are "thinking too much", as demonstrated below.

Although in general physical manifestations do not seem to be as ubiquitous as insomnia, disturbed thinking and behavioural patterns, several referred to such symptoms as headaches, tightness of the head, tightness of the chest, swelling of the

eyes (related to insomnia), and loss of bloom of the skin and eyes. Headaches were so disabling for VeasNa that she was unable to lift her head from the pillow on some days because of the "spinning". She described it as being like "water in the head" that shook and rattled whenever she moved. She couldn't look at anything, couldn't keep her head still because of the pain, and could remember nothing. This wasn't the only physical feature; she also complained of burning eyes, ringing in the ears, joint pain, back pain and abdominal pain.

NeaRy began her description of what *gkuet cj'roun* is like by identifying physical symptoms:

When I "think too hard" my head hurts including the eyeballs, and the chest is very tight. I can't breathe...

Similar physical symptoms were also a feature for Sok, in her case an inability to breathe and palpitations of the heart to the point of passing out. The first time this happened was when she was pregnant in the refugee camp and the behaviour of some close to her was personally distressing. In New Zealand she manifests these symptoms whenever she is "upset", to the point that her husband deliberately stays awake lest she "stop breathing". Specific instances include when she was a patient in hospital, when her mother was ill, and when they incurred huge debts, all problems which Sok needed to struggle with in the search for solutions in her mind. One such episode happened about a year after arriving in New Zealand when she had a tubal ligation, after which she began to fret about being unable to replace a child in the event of one of her live children dying (an understandable concern considering that two other babies had died during the communist regime).

In summary, *gkuet cj'roun* is characterised by an overworking mind that is preoccupied with planning and problem solving, "thinking" that goes on day and night, especially when the sufferer is alone. When problems are insoluble, or overwhelming, "thinking too much" may become compulsive, and lead on to illness. Even so, it is the work, or activity, of the process that characterises "thinking too much", a process that can empower the disempowered. The result includes: an

inability to sleep; forgetfulness; confusion; inability to concentrate and acquire new knowledge and skills; and loss of control of emotions so that social withdrawal, outbursts of anger and weeping aren't uncommon, a similar array of symptoms to those described by D'Avanzo et al (1994, p.103). Sensory and physical disturbances may accompany this, such as noises in the head; pain of the head, stomach, or joints; and effects on vital organs and functions. In the case of some who described themselves as "thinking too much" the only features were headache and impaired sleep.

Most, such as SomNaang, Sok and NeaRy, were able to carry out normal responsibilities, with their "thinking too much" troubling them mainly at night. This was not the case for BoPa and VeasNa, who became increasingly ill and incapacitated when through "thinking" they were unable to produce the solution to problems and improve circumstances. Impairment in turn compounded their "thinking too much". The majority, however, were able to overcome their "thinking too much". SomNaang points out that *gkuet cj'roum* can also be positive, as when the discomfort of "thinking" forces the sufferer to take steps to solve the problems posed by circumstances. Then, "thinking" can become forward-looking instead of circular and repetitive, offering a way out of the present despair as options are thought out and acted on. When there seemed no way out of either their miserable circumstances or inner turmoil, then suicide presented itself as a way of escape, as described by SomNaang. SomNaang knows of young Cambodians, including himself, for whom the misery of the situation that brought on "thinking", and of "thinking too much" itself, is such that to terminate by suicide is an attractive option, or alternatively can provide the necessary motivation to change. Occasionally, *gkuet cj'roum* becomes compulsive, in which case it is "thinking too much" that must be overcome by an act of controlling the process. More usually, through "thinking too much" the adversity is to overcome through the work of problem-solving.

Dealing with *Gkuet cj'roun*

By far the most frequent way of controlling one's "thinking" is to distract or occupy oneself, and people often advise one another accordingly. NeaRy's mother-in-law never sits still, always busy in the kitchen and the garden. Less productively, NeaRy herself would turn on the video, finding that with "the music with picture then I am fine and can forget". When a television set breaks down, therefore, and there is no money for repairs, this is not merely inconvenient but can precipitate fears of not being able to control "thinking too much". NeaRy said as much, describing the frequent breaking down of their set as a source of genuine distress. As the family put it, they were not only ill, unable to work, and therefore poor, but they were now without their principal means of taking their minds off their troubles.

While few Cambodians had owned television sets prior to coming to New Zealand, the principle of distracting oneself from "thinking" has long been practised. One such approach is to engage in games, which, as I frequently observed, continues to be the case. Card playing is a widespread pastime in the society of "little Cambodia", and several times was linked explicitly to providing an enjoyable distraction from "thinking". This was the case for Sok's mother, as well as for a number of the older people. On one of my visits to NeaRy's house she, along with several others, was absorbed in playing cards. She spontaneously commented to me that "this way I forget, don't think".

However, simple distraction is not effective for people whose "thinking too much" has reached the extreme stage experienced by BoPa, who was unable to and did not want to distract herself from her "thinking" although advised to do so by her friends. To the advice that watching television can "dilute" worries, she replied:

No! Not dilute! I'd rather turn it off and sit alone. [If I am] watching TV so the brain is on TV, [it is] not on the TV. My sense just goes away, wanders about...

For BoPa, *gkuet cj'roun* had reached such an intensity that she was unable to

concentrate on television, and far from effectively taking her mind off her troubles, it aggravated the noise of her inner turmoil.

A second common strategy employed was to talk about one's "thinking" with friends, often older and wiser, an approach that was used traditionally. The old woman who described her "thinking too much" as a young orphaned girl in village Cambodia explained:

There is only the old people...the old people who are neighbours..they talk, advise like this and that...

Sok was strongly of the view that talking with friends was the best way of extricating oneself from the bind of *gkuet cj'roum*, citing frequent instances when she had been helped, and had herself helped others. Her position on this had been reinforced by exposure in New Zealand to the benefits of "talking it out", and the help that she had personally received from *kiwi* acquaintances. However, not all agree, and when she put it to NeaRy that she may like to avail herself of such advice, the latter strongly resisted, insisting that for her more effective control of "thinking" was achieved through distracting herself, and by trying to "forget some" by will-power. In her view, to talk about troublesome thoughts with others has the undesirable effect of strengthening the hold of one's thoughts.

Younger Cambodians who had completed their education in New Zealand expressed antagonism to an "untrained, self-appointed person" offering advice, advocating instead the role of professional counsellors or clinical treatment. In view of so many adult Cambodians suffering from "thinking too much", however, it is highly likely that should they come to the attention of professional services, trained counsellors would need to work through interpreters, thereby promoting the development of lay counselling. Illustrated here is another instance of the gap between older Cambodians and young people largely acculturated in New Zealand, suggesting the need for different approaches for those of different generations.

The advice offered by "self-appointed" counsellors is little different in kind to the

advice I myself have been given by friends in times of personal anxiety, and similarly of variable benefit. When the "thinking too much" of Cambodians centres on past trauma and bereavements, on untraced or distant kin, and on current disappointments and difficulties, the sufferer may be firmly reminded that "it is not just you; everyone is like that." This was highlighted when BoPa's "thinking" focused on the death of her baby, at which point all the women in the room insisted that they too had suffered the deaths of their babies in Cambodia, both before and during the war. Likewise, NearY's complaints of their unemployment and poverty that made them worry for their children's future was countered with assurances that they weren't alone in this.

The fact that the sufferings of the Cambodian refugee population, both prior to and after arrival in New Zealand, are collective experiences, has been discussed in Chapter 5. While for some this seems to buffer them from the individual experience of "thinking too much", there are those for whom such assurances have the reverse effect. To be reminded that theirs is not an isolated case, in a well-intentioned attempt to resolve the state of mind by putting it in perspective, can have the effect of heightening personal suffering when the intensity of current suffering is not acknowledged by co-survivors. Such reasoning can also provide the impetus needed to bring under control one's "thinking too much", which emerged in a conversation between BoPa and two other women:

BoPa: When you kept telling me off for saying this and that, thinking about it certainly seems logical.

Sok: Look at me. If I hadn't pulled myself [out] like this for someone not paying I might become ill.

BoPa: Yes, I thought about that.

Sok: Think about it. And Cjey's child is dead, Dt'Rob's is dead, just think about that. First I was very worried [hard thinking] about being cheated with money...and when I thought about it, there is this amount, that amount, the whole village...nearly everyone losing money, people's children dying, my own babies died...

Friend: When thinking about it, as long as there is life, there will

be death. What can you do?. Our fate, being born without the chance to see her face when she died...think like this, it's easier...

This view, that suffering is universal, and therefore one should not "think too much" about personal suffering, is rooted in the Buddhist tradition of most Cambodian refugees. In discussions of the phenomenon of *gkuet cj'roum* with the Buddhist monk, he explained that Buddha taught that as death and loss are part of the cycle of life, excessive attachment to the things of this life is to be discouraged. "Too much thinking" immediately after a loss is understandable, he added, but it should not persist. The "weak-hearted" are more attached, and therefore suffer more. To learn acceptance, not to be attached, then one's heart becomes strong, and a person is able to avoid or overcome "thinking too much". Mr Nhim, who claimed never to have "thought too much" or worried, and is the acknowledged leader of the Buddhist prayer activities, perhaps illustrated this view of non-attachment, and strength of heart.

Although there is wide acceptance of the ideal to be unattached, normally people who are overwhelmed with "thinking" do not look to the Buddhist clergy for assistance. An elderly woman indicated that in pre-war village life a person may consult a monk in much the same way as a respected older neighbour, but when I asked the Cambodian monk about this, he indicated that he was not then and still is not consulted for such reasons. On the other hand, some who are overwhelmed with worries may retreat to a monastery for a period, sometimes in fulfilment of a vow, but also because of the benefits from being in a quiet, orderly environment. It was also pointed out that if one's "thinking too much" was in relation to bad *gkam*, (meaning *karma*, or fate), then a person may go to a monk to *sraucj dtuek*, or be given a "shower", a sprinkling of holy water to bless and bring good luck. In the course of this study, one person considered such a step, but decided against it.

Elsewhere, it has been suggested that the role of Buddhist ritual and clerics in relieving the sufferers of mental distress is significant. In neighbouring Laos, which at the time lacked mental health professionals, Buddhist clerics and rituals played an

indispensable role in the easing of mental health problems (Westerneyer, 1973, pp.181 ff). Regarding resettled refugees, Eisenbruch (1991, pp.674f) asserts that participation in corporate ritual, that honours the spirits of the ancestors, can ease distress related to the bereavements of the scale and violence that these Cambodians have experienced. I was therefore interested to hear from BoPa on her experiences when celebrating New Year and the ceremony for feeding the spirits of the ancestors:

Before, in our country, it's very happy. One went to make them [the ancestor spirits] happy. But when we come here, we still regard it like we were there...as long as we [do it] we are happy. But it's no joy, just *gkuet cj'roum*. When it is the season for this it seems to be clear inside my mind. I want to celebrate too. But sitting with other people for a while, this happy feeling seems to vanish, and that thing [the worries] come back.

Those present pointed out that although they celebrate the calendrical rituals, memories flowed back about "those in the back", those who have died, who are missing, and those who are far away. Memories and homesickness for people "chase away" the happy feelings. She went on to talk about her longing to visit Cambodia in order to carry out a bon ceremony for her dead parents (and perhaps siblings). While it is possible to carry out the ceremony in New Zealand they cannot afford the cost. But more important, it would also lack the vital ingredient of such ceremonies - the joy of being together with such surviving kin as can be located.

Such ceremonies have on occasion been conducted in New Zealand, by Sok's mother, for example. Others such as TiDaa expressed their ambitions to do likewise. It is very costly (about three to five thousand dollars) to carry out *bon* ceremony, in which the monk receives all manner of food, clothes and household goods on behalf of the dead, in order to make the current journeying of the soul more comfortable, and at which "everyone in the village" is feasted over the three days of the ceremony. To make the ceremony represents the highest gift to one's deceased kin, and thereby eases the sorrow of the survivors. There is also the matter of spiritual merit that accrues, as discussed by the three women present:

Sok: When we do the ceremony for the dead, how do we feel? Do we receive the merit?

Friend: Why not? Yes, we feel good too.

BoPa: And inside the body, it's like it's clear again [free of thoughts and other undesirable things].

In other words, they experience a kind of spiritual cleansing, according to the translator.

Overall, therefore, the role of Buddhist clergy and ritual in helping people through *gkuet cj'roun* seems limited and inconclusive. The communal calendrical ceremonies seem to serve more as poignant reminders of their exile and dislocated lives than to provide a vehicle for mourning and settling their grief. The private *bon* ceremony, which several desire to make, is out of reach financially for most, and it seems offers temporary relief only; the chief ambition of Sok's mother is only to carry out another ceremony before she dies, even though only three years have passed since the last one. Finally, the role of ritual in easing *gkuet cj'roun* was raised only in response to my inquiries, and not spontaneously by participants, itself suggesting that it does not have a significant place.

On the other hand, participation in corporate chanting (praying) which was mentioned by several of the older people particularly, offers both the means of distraction and help to become detached. Some regular participants, such as the Nhims, claim to be free of *gkuet cj'roun*. Other participants, however, do complain of "thinking too much", suggesting that as with ritual, so corporate praying cannot be prescribed as a preventive or therapeutic technique for sufferers of *gkuet cj'roun*. While participation is highly valued by some, the benefit they derive is variable and unevenly related to health.

"Thinking too much" is not considered to be a sickness for which one would request medicine. The *gkru khmer*, or traditional healer (literally, Cambodian teacher, or wise person), is not regarded as having a role with respect to "thinking too much". The

response to my questioning was an unequivocal "no, [we] don't get medicine to drink or other medicine for *gkuet cj'roum* or insomnia, nothing." This was confirmed in discussions with the *gkru khmer*, who did not view "thinking too much" as an illness, and therefore not a condition he would treat. It followed, therefore, that "thinking too much" was normally not regarded as the domain of medical practitioners. When questioned on this, NeaRy explained her reasoning:

When I go I get interpreter and interpret only our illness. My doctor asked if there is anything you don't understand and want to talk about to him, but he didn't ask about how you feel and your intention, only about the illness. If you tell [the doctor] about your thoughts and intentions and not your illness it doesn't seem right.

With few exceptions, Cambodians supported this opinion expressed by NeaRy, that it was not appropriate to consult one's doctor about "thinking too much". By extension, to seek medicine for the state was not considered relevant. This supports Frye's (1991, p.39) finding that "thinking too much" is more the domain of the family than the professional healer. BoPa's family doctor checked her regularly, but in response to my question as to whether he prescribed her medication for her mental distress, I was informed:

BoPa: [I] don't know how the doctor can help. If it is me myself [my fault].

Friend: No. That's her problem, her fault. She think like that herself, you know? Not the kind of sickness or something like that. It's her problem, because if she not think like that, she is okay, but when she thinks, it is coming again.

Although "thinking too much" is widely experienced, and to that extent accepted, the means of resolving it is clearly ultimately the responsibility of the sufferer. To experience *gkuet cj'roum* is not blameworthy, but to fail to bring under control one's "thinking" appears to be unacceptable. In resolving "thinking too much" sufferers have the support of family members and friends, and the implicit sympathy of Cambodian community leaders such as monks.

In summary, therefore, as *gkuet cj'roun* is itself not perceived as an illness (even though it can be associated with illness, or lead on to illness if not controlled), neither Cambodian nor Western healing practitioners and medicine have a clear role in helping sufferers of this state. In fact, dealing with *gkuet cj'roun* is very much an individual responsibility, by means of occupying and distracting oneself, and seeking advice from respected friends, which is broadly in agreement with D'Avanzo et al (1994, p.104). It is by will-power and detachment that "thinking" can be controlled. By strength of heart the devout accept that suffering is part of the cycle of life and overcome excessive attachment to things and persons of this life. In these ways they ideally avoid and overcome the distressing and ultimately undesirable state of "thinking too much".

Cases of Severe *Gkuet cj'roun* Requiring Medical Intervention

It is my contention that this state of *gkuet cj'roun*, which is embedded in Cambodian culture in terms of the way the phenomenon is experienced, viewed morally, and dealt with, is appropriately categorised as a psychosocial response to trouble, and not as an illness. Nevertheless, the last two decades of war, flight, and exile have far exceeded the range of stressors of pre-war village life in terms of scale, degree, duration, and predictability. Furthermore, to be resident in their own country would for Cambodians facilitate the espousal of Buddhist values of detachment and acceptance. Such a moral and religious context is in New Zealand much weaker, and indeed was deliberately and brutally destroyed in Cambodia under the Pol Pot regime, with the result that the younger adults are unlikely to be well-grounded in Buddhist traditions. VeasNa, NeaRy and BoPa are among those who were removed from their families at a young age, being reared in atheistic communes.

Among the participants of this study are those for whom the state of "thinking too much" progressed beyond the stage of being able to be resolved using the well-tried and proven ways explained to me, to the point of being severely incapacitating.

Examples of this are the cases of two old women described at the outset of this chapter. Both Mrs Som and TiDaa, who were constantly troubled with "thinking", went on to "lose the mind", as they translated it, necessitating being hospitalised for a couple of months and a couple of weeks respectively. BoPa and VeasNa, both young women, did not lose touch with reality but became deeply immersed in their distress, going on to develop severe psychological and physical symptoms. In their case, this reached the point of their being unable to carry out basic activities of daily living, and unable to acquire the language and social skills necessary for participating in New Zealand society. Their conditions brought them into frequent contact with the health system, with their "thinking too much" treated professionally. While VeasNa was treated pharmacologically with antidepressants, BoPa recovered with counselling-type therapy.

BoPa: BoPa's story has earlier been narrated, of enforced separation from family, involuntary participation in Pol Pot's propaganda and labour machine, her long years in the refugee camp in which her two older children were born and reared, and of being unable to trace her kin. From her account, BoPa was able to control her "thinking" throughout these tumultuous events, and remained basically healthy, until eventually being accepted for resettlement in New Zealand. So it was that BoPa's family came to live in New Zealand where they have no relatives whatsoever. The lack of family support and resultant unconnectedness has been a drawback, as they have had far more than their fair share of tragedy and sickness since coming to New Zealand.

The Cambodian sponsor offered little in the way of support and assistance to BoPa and SomBut, a neglect which was to have negative consequences for them. Other Cambodians filled the void, which stirred up jealousy from the sponsoring family and thus hampered their smooth adjustment. Some seven months after arriving in New Zealand, just before the birth of her third child, BoPa lost the power to walk, a paralysis which eventually progressed to being unable to use her arms (see Chapter 11). After weeks of hospitalisation, and months of rehabilitation as an outpatient, she

regained both sensation and function.

I first met BoPa at about this time. The family of five lived in a low-standard semi-detached state house, with an elderly Cambodian couple occupying the adjoining house, and another Cambodian family in the house opposite. The elderly couple became surrogate parents for BoPa, who was usually to be found in their home when her children and husband were at school and polytech.

She was very proud of her infant son, who seemed a healthy, normal youngster. Not long after this, however, the six-month old boy sickened, and within a week was dead in spite of intensive care and life support. According to BoPa, no cause was found to explain his death. At the time, the parents appeared to be coping with the tragedy well, providing the necessary hospitality to the many who visited, and seeing through burial arrangements. Once the period of initial shock was behind them, however, and members of the Cambodian community returned to their own daily lives, BoPa sank increasingly more deeply into the state of *gkuet cj'roun*. Particularly distressing for her was the fact that for most of her baby's life, because of the numbness of her arms she was unable to feel him and was afraid of dropping him, yet not long after sensation returned the boy died.

Her distress over the baby's death for no known cause then was compounded as all her past sufferings and losses crowded in. She mourned the death of parents whose faces she hadn't seen as they died, while at the same time was distressed that she was unable to get the vivid pictures of the dying of her baby out of her mind. Coming from a background of being part of an extended family in a village context, to now being "just four heads" without kin in New Zealand was more than she could bear. On top of it all, her young daughter was often sick, and now her husband was losing function and bulk in his arms. At the time, an unrelated family had moved in to share their two-bedroom house with them which added to the strain enormously, especially as the old woman was often drunk and constantly criticised her. On the numerous occasions I visited, BoPa's countenance was obviously sad, and she often seated herself in a corner of the room, distant from others. Unlike most Cambodian homes, the walls were devoid of the usual pictorial reminders of Cambodia. There

were none of the usual pictures of Buddha, nor family photographs.

BoPa was unable to remember a single word of English, and both she and her husband were in her view unemployable because of their respective incapacities. There seemed no way out of their poverty and misery, no prospects that life for their children would be brighter. She viewed herself and her family as victims of "bad luck", of a fate beyond remedy and control. The associated powerlessness to turn adversity around seemed to exacerbate her "thinking", a world view revealed in the following conversation:

When thinking about life, it is like, why me, why this *gkam* (fate) is brought upon me. I said like that when I talked to the doctor too. I analyzed, when my son was dying in my husband's arms, why such *gkam*? And when I thought more, how come this *gkam*? How can I not say that it's the *gkam*? I can see with my eyes that everyone else is not like this. I only see us, worse than others...just [been here] for two years, and only us [like this], worse than others, not happy. Oh! it's so complex [confused] in my mind/heart...I go out, come back in the house, and it's still the same, it doesn't seem to be clear in my mind.

When BoPa was increasingly *ot sub'bai dte* (unhappy, unwell) after her baby's death, she reported that her family doctor closely supervised her, calling her every two weeks to ask her about her "thinking". When her blood pressure started to rise, investigations were arranged to exclude any organic reason for her symptoms:

When I *gkuet cj'roun* the ears are all buzzing. The blood pressure was getting high, and I feel that myself. They took me away to have an x-ray (possibly CT scan). They said nothing was wrong, just that my blood was not circulating properly. The doctor says all is normal. It is because of *gkuet cj'roun*, and he just told me "not to think". [And did he suggest how she could stop "thinking"?] He said, if *bpi'baak cjuet* [worry, literally the mind is hard] or something, to go and ask him...to go and chat with him. And if I wanted, there was a person to talk to [that is referral to a counsellor could be arranged]. He said like that.

This contrasts with NeaRy's perception that her doctor is interested "only in illness,

not in the feeling or intention". The pattern in New Zealand for each family to enrol with a general practitioner follows a practice which distributes Cambodian refugee families among doctors, thus giving rise to differing responses to the health problems of their Cambodian patients. The different approaches of these two doctors to the symptoms of "thinking too much" as perceived by the patients is well illustrated by NeaRy and BoPa.

By BoPa's account, the doctor prescribed no medication of any kind, but asked similar questions to the ones I was putting to her. When she explained that she "thinks" about her life in its entirety, that for her there is such an unhappy contrast with the "healthy and happy" lives she believes everyone else is enjoying, I asked what specifically was different. She replied that "the doctor asked me that same question too, I told the doctor once already". She then went on to enumerate her multiple losses and sufferings which she "tries to forget", but without success. In one conversation, Sok had been trying to encourage BoPa to "stop thinking" as everyone had problems and sorrows:

BoPa: The doctor just ask about [how I am], that we should not worry, something like this.

Sok: When *bpi'baak cjuet* [hard mind/heart, hard worrying]...when "thinking" like that myself, this child dies, that dies, it is all the same. What can you do? Our fate, being born without the chance to see her face when she died...When you think about it, as long as there is life, there will be death...thinking like this [with acceptance] is better.

BoPa: Yes, the doctor said like this too, always [there is] death and life, he said like that. That [baby] is already gone, "thinking" will not bring it back to life...

Sok went on to explain to me that she had given a "lecture" to BoPa in the context of a previous interview that was "exactly the same as the doctor". I had been aware on that occasion that BoPa was the object of the outpouring of advice from the three others in the room, although I couldn't understand the content. This presented an

ethical and procedural dilemma, especially as I feared that such advice and possibly scolding could be harmful to BoPa whose emotional state, from her own statements, seemed to be precarious. While to some extent the study provided the catalyst for this particular exchange, I was informed that this kind of mutual self-help does occur from time to time. Thus these interviews documented an example of the way friends can provide the support needed to effectively deal with extreme *gkuet cj'roun*.

Sok [to me]: Last time I give her a lecture, I keep giving her a lecture all the time since I met her...[to BoPa] She said, do you like [mind] me talking to you like this?

BoPa: Yes, I take it. I think about whether [what you] say is right or wrong. If wrong, I would just discard it. If right, I put it on myself [take it in].

BoPa's description of herself as being able to agree or disagree with advice proffered represents a significant departure from her earlier state of global powerlessness. The "lecture" as Sok described it, or "telling off" as BoPa put it, seemed to be effective in providing the impetus and energy needed both for bringing her "thinking" under control, and taking active steps to avoid being the victim.

BoPa went on to describe concrete ways by which she took control of both circumstances and her "thinking", such as by focusing her thoughts on positive as well as miserable occurrences in her life. There was the added strain of another family living in the small house, the old woman's complaints and demands aggravating BoPa's distress. She now took steps to remedy the situation, such as by going to bed early to avoid listening to the old lady harangue her, or going off for a drive in the car. A major element of taking control was to be willing to step outside the vicious cycle of "thinking":

BoPa: When I picked up that letter to read, reading in that letter that my son died like this, it was tighter and tighter [inside, emotionally]. And when you said, why "think" too much, why not let it out? I said, now, to talk about it, who can I tell? You said, I could go and talk to you. First I thought, I didn't say it, I thought

no matter what you asked, I wouldn't talk. Isn't that right? I didn't talk that time? I didn't talk, and even if you talked you wouldn't be able to help me. I thought like that.

Sok: If we just *bpi'baak cjuet* (worry a lot), we can't do anything about it. But when talking about it, we let it out. It feels better.....If [one] talks by oneself, it will be useless, there must be someone to listen. That would be *too* [relieved, eased]. Sometimes husband and wife can talk together but because the two know the same story, talking about it is just the same [as "thinking hard" or "thinking too much"].

BoPa: Yes, and then why talk?. We just stop!

Sok: Yes, because both know about it. But if we say to someone else [outside of the situation] after we talk, we won't hear it anymore. We can confide.

BoPa: Yes, mutual confidence.

Sok: Mutual confidence. And as a matter of fact, I feel sorry for you..I have talked about that with Mum [the oldest person in the Cambodian community] for a long time.

Such explicit "mutual confidence" is unlikely to be a carry-over from traditional Cambodian village society, according to accounts of older participants. Sok and NeaRy referred several times to acquiring the knowledge and skills of "mutual confidence" and comfort when they worked as volunteers in health and helping services in the refugee camps, which has subsequently been reinforced in New Zealand. It was in such contexts that they learned about the benefits of talking over problems with those external to the situation. Traditionally, as described above, troubled people who are "thinking too much" would most likely have consulted respected, older folk. However, after the disruption and dislocation of the civil war and its aftermath, this role is evidently well-filled by strong survivors of a similar age.

Irrespective of whether one's *confidante* is an elder or a peer, the sense of relief is similar.

Sok: We have talked. It is like an abscess about to burst..it hurts so badly, but it doesn't burst. But if it bursts "*pous!*" it is *too* [relief]. Isn't that so? It is like pulling thorns from the chest [a Cambodian figure of speech].

BoPa: It's *too* I'm *too* because you keep telling me, don't just stay unhappy. And when you kept telling me off for saying this and that, thinking about it, it certainly seemed right.

A similar sense of relief is described by Cambodians who are unwell, after being "coined" (see Chapter 10). This widespread home remedy is a first resort for the treatment of nonspecific symptoms such as headache, dizziness and fever. The main benefit described is that an internal build-up of pressure is released through the redness produced by scraping the skin, thus giving the sufferer instant relief. The discomfort that often accompanies illness, therefore, is understood and explained in terms of an internal build-up of pressure. It follows that a remedy that is perceived as relieving that pressure is both effective and acceptable to Cambodian sufferers. In the case of "thinking too much", being able to talk through the concerns that give rise to "hard thinking" indeed provides the desired relief, with its effects as dramatic as the bursting of an abscess, with relief equivalent to that achieved by "coining".

Not only does the approach of talking out the tension reflect the traditional physical technique of "coining", but it is consistent with Western counselling approaches of talking problems out with a trusted "other". This is here illustrated as being advocated and carried out by both BoPa's doctor and Sok, and the ease with which such an approach is grafted into traditional Cambodian ways of dealing with *gkuet cj'roum* suggests an affinity between the approaches. In BoPa's case, although her extreme "thinking too much" brought her into frequent contact with the health system, the approach employed was consistent with the Cambodian approach. The advice of BoPa's doctor and Cambodian friends thus mutually reinforced one another, which undoubtedly gave confidence to BoPa to follow the advice.

VeasNa: Like BoPa, VeasNa is an attractive, married woman in her mid-thirties, but unlike her, she does have some close kin outside of the nuclear family in New

Zealand. These two women also have in common the experience of controlling their "thinking" reasonably well up to the time of arriving in New Zealand, but thereafter the magnitude of their catastrophic life experiences seemed to overwhelm them. VeasNa fled Cambodia with her first husband and child in 1979. After her husband abandoned her, and emigrated to the West taking with him their daughter, she remarried. She arrived in New Zealand with BoNa, her second husband, in the winter of 1990, together with their daughter.

Her life has been a litany of suffering. During the Pol Pot regime she was imprisoned for several months, as she was thought (wrongly) to be ethnic Vietnamese. She described herself as being very sick with malaria and starvation, and was beaten on the head to the point of losing consciousness. On regaining consciousness, she had loud ringing in the ears, and has had frequent and severe headaches since. At the time of the Vietnamese invasion of Cambodia she described her condition as "very bad", but after arrival in the camp and receiving medical treatment for malaria and headaches, she improved. Her first husband used to beat her about the head and verbally abuse her. Her present husband BoNa described her at the time of their meeting as being "sad; I have never seen anyone so sad". Even so, they claim, she was neither ill nor "thinking too much", and was successfully learning English as well as earning an income through sewing.

However, from the time of the birth of their daughter, a year before coming to New Zealand, she has been ill. Her illness began a day or so after the birth with a "shock" to VeasNa's "nerves". The older child tumbled, at which VeasNa leapt up to catch her, in the process "shocking" her nerves still fresh and "unripe" from the delivery (see Chapter 11). Initially she had difficulty breathing, and her headaches became worse. Since arriving in New Zealand her symptoms have worsened, with her previously occasional headaches now constant, and accompanied by visual and auditory disturbances. Her body aches all over and she suffers from insomnia. If she does fall asleep, she is awakened by nightmares. On top of it all, she "thinks" all the time: about her bodily distress; about the children and who will look after them if she dies; about her eldest daughter with her first husband; about their poverty and that

prospects of an education and better life for their two small children are remote indeed.

In contrast with BoPa, distressing physical symptoms have been prominent for VeasNa. The result is that this family has frequently sought medical treatment, beginning when symptoms worsened while still in the refugee camp. When investigations by refugee camp doctors into her breathing difficulties proved negative, they were told that "nothing was wrong". Their experiences in New Zealand in endeavouring to secure a medical diagnosis with treatment have similarly been characterised by negative findings and high levels of frustration. VeasNa has on different occasions had multiple investigations, including blood and urine tests, x-rays, CT scans, ultrasound examinations, and the like. This has been both as an outpatient, and also on two occasions when she has been hospitalised (in relation to pregnancy-related illness, and then for the birth of the child). Her husband (who always interprets for his wife) complained:

The doctor says there is nothing wrong. Then why is she sick all the time? When she goes, the doctor only looks quickly. He is not doing extra tests. Sometimes he doesn't give medicine if I don't ask, and sometimes I am afraid to ask...I don't know how to ask, what point to ask about. In and out, too quickly...

BoNa's reply to my question as to whether their doctor had ever discussed referring his wife to a specialist was in the negative, but he went on to say that if he had the money, he himself would take her to a "private doctor to be properly examined". He also claimed that the doctor had not enquired into his wife's past history or current "thinking too much". On the contrary, when they suggested that her headaches could be related to the beatings she received while imprisoned, he reportedly replied "probably not". From their descriptions, VeasNa's doctor approached her symptoms appropriately in accordance with the biomedical model. Having been unsuccessful in identifying organic causes for her symptoms, which would indicate the appropriate medical management, her doctor endeavoured to reassure them that no disease was detected. However, far from being reassured, their frustration and anxiety increased,

with the doctor's competence and interest being questioned. VeasNa remained distressed and incapacitated, and her husband frustrated and worried. BoNa went on to say:

I do worry a lot by myself. I try not to "think", but I feel very sad myself. There is no-one to talk to, no sponsor. Sometimes I talk to D.(a *kiwi* friend), but she doesn't understand medicine. In the camp my wife was fat, now she is so thin. I am fat, I have never been fat like this before. It is because life is not normal.

Having failed to be helped by medical means, the family tried to manage VeasNa's incapacity with their own resources. VeasNa would sometimes awaken her husband when her body ached, and he would massage her. When she was "thinking too much" and couldn't sleep, he told her stories to try to distract her, and they prayed about their worries. Since her worry over her eldest daughter, whom VeasNa missed desperately, was a focus of her "thinking", they made concerted efforts to maintain contact with the girl, with limited success.

After about three years of trying to find relief from the physical, mental, and economic distress that was dominating their lives, the family left Palmerston North for another city. They had no relatives there; BoNa's only surviving kin were his mother who lived with them and an aunt in the United States. His wife's kin were in Palmerston North. The reasons he gave for onward migration were several, including the warmer climate and better job prospects. It was also his mother's desire, he said, and a son must obey a parent's wish. But chiefly, he explained, they hoped that a change might help VeasNa. However, it has been suggested in the literature that repeat migration may exacerbate health and adjustment difficulties (see Mortland and Ledgerwood, 1987), and indeed VeasNa seemed no better after the move. On the occasions I saw her after moving, VeasNa was if anything worse, with a lower level of interaction with visitors to the house than before, drowsy-looking with a sad countenance, and her movements slow and dragging. At first her nightmares, insomnia, and *gkuet cj'roun* were much worse, as BoNa explained (in English):

She got more and more tired, can't do anything. Feel like lost all memory...like one minute thinking, next minute forgetting and can't think the way you think before. It's hard to breathe, very heavy and sore in tummy. She feel like hot in the skin all the time. In the tissue the water run everywhere, something like that. [And had she had medical investigations?]...Yes, same as here, all the tests again, and a week later, all over again. He can't do anything, nothing wrong. You know, they give panadol, about twenty tablets, [and said] come back [if no better] because the doctor can't see anything wrong. I said, if you can't find out what you are going to do, put her in a hospital or give her to a specialist to look? And he said, wait and see...Until now, [we are] waiting.

Some months later VeasNa was referred to a general practitioner who was experienced in treating Cambodian refugees, having worked in a refugee camp. This doctor prescribed antidepressant medication, which was helping VeasNa to get to sleep. Her appetite improved, and she was no longer suffering from "fever". However, she was more drowsy and still unable to carry out daily childcare and household tasks. Most discouraging is that she continues to "think too much". Her husband tries to help her by encouraging her to focus on the good and positive things in their lives and to dwell less on her sorrows, which, he claims, she tries to do but not very successfully.

The four years of living in New Zealand have for this family been heavily overshadowed by VeasNa's extreme *gkuet cj'roum*, bringing them into frequent interaction with the medical system. It appears from their account of repeated medical investigations, both in the refugee camp and in New Zealand by several different clinicians, that no underlying physical damage or abnormality has been detected to explain her severe and distressing physical symptoms. In VeasNa's case, the health system has been able to offer little in the way of resolution. While BoNa still holds high expectations that a more expert doctor may be found able to treat his wife, in spite of himself, as a "modern" person favouring the "scientific" view, he has moved closer to traditional Cambodian ways of helping his wife through her "thinking too much".

Discussion: As the cases of BoPa and VeasNa illustrate, cumulatively the unprecedented trauma and suffering of the past two decades, dating from the Pol Pot regime and continuing after arrival in New Zealand, sometimes overwhelm the individual and the family with *gkuet cj'roun*. As well, excessive demands are made on the customary tried and proven ways of managing "thinking too much". At this point, the sufferer is highly likely to come into contact with the Western medical system, whether to seek treatment for physical symptoms, or relief from mental distress. However, for a phenomenon which predates both the sufferings of these refugees and the availability to them of Western medicine, professional treatment appears to offer little help. Sophisticated diagnostic technology assists in ruling out a range of organic causes for symptoms of "thinking too much", and psychotropic drugs can offer relief from symptoms of mental distress such as insomnia. Having eliminated organic pathology, reassurance is offered but, as we saw in the case of VeasNa, to be told that "nothing is wrong" only increased frustration and compounded distress.

From BoPa's account, there is little to distinguish the advice she received from her highly-educated and skilled doctor from that of her untrained friends. Whether it was her doctor's solicitousness and advice that brought her out of her extreme state of "thinking too much", the "mutual confidence" with friends, or both in combination, is not really important. What is significant is that these approaches, which are akin to traditional ways of dealing with *gkuet cj'roun*, effectively enabled BoPa to move toward a place of acceptance. She became more able to detach herself from what she had lost through death and misfortune, and indeed from prospective sorrows in respect to her husband's increasing disability and poor prognosis, a detachment from life and its sufferings which is advocated in the Buddhist philosophy in which Cambodian values are embedded.

In the face of the immensity of the suffering of their Cambodian patients, clinicians can themselves be overwhelmed, taking refuge in the medical view of illness in which they have been trained. Both Sok and BoNa, who are frequently called on to

assist with interpretation, described the kind of response occasionally encountered in the taking of routine clinical histories:

Sok: There are some people who ask me to go with them to the doctor. When the doctor asks about the family, (Do you have a husband? How many children? and so on), they could not speak, only cry.

BoNa: This is like me. When the doctor asked, I could not speak. When asked how many family members, I didn't know how to tell him.

Sok: Yes, they can't speak, only tears flowing. Look at my husband, there is no-one else, only him, AA Pot took away to kill and [all] killed in front of his eyes, not allowed to cry, if cried killed...I'm not just saying this, I have experience...Previously so many children, and so many dead...[they] got to the doctor, and just start crying, can't say anything. When crying, the doctor walked out of the room [until they had] cried enough.

When their patient had finished crying, the medical history-taking and examination resumed, but according to these interpreters, seldom was the reason for crying followed through or taken into account in interpreting the illnesses and symptoms of Cambodian patients.

***Gkuet cj'roun* in the Light of Literature on Health of Southeast Asian Refugees Resettled in Western Countries**

"Thinking too much" has been presented as it was unfolded to me, as a culturally embedded state of mind and soul that accompanies negative life events, and for which there are well recognised ways of management and resolution. "Thinking too much" can be seen as a way of resolving suffering and difficulties, and thereby contributing to well-being. In the event that it becomes entrenched and extreme, it constitutes a threat to health, as demonstrated in the cases of BoPa and VeasNa. In view of the scale and degree of tragedy and dislocation that many resettled Cambodians have lived through over the past two decades, it is not surprising that for some "thinking too much" has become dysfunctional. It is more surprising that

although "thinking too much" is widespread, most still are able to address it effectively, and continue normal responsibilities of living.

American psychiatrist Joseph Westermeyer (1985) described his experiences of living with and frequently interacting with Lao people during their years of being repeatedly uprooted and displaced within their own country, as asylum seekers in Thai camps, and as settlers in the United States. His view agrees with the accounts of a number of participants in this study, that on the whole people maintained a positive outlook so long as they were in their familiar territory and geo-cultural region, but seemed less able to sustain their inner strength when faced with the additional task of adjusting to the vastly different language and environment of the host country. It is at this point that refugees may present at clinics, but reported experiences suggest that psychiatric treatment frequently does little to alleviate their profound suffering. Reflected in some of the literature is a growing discomfort with the sensitivity and usefulness cross-culturally of Western reductionist categories, as well as with the implicit bias toward "abnormal" responses to trauma while ignoring human courage and resilience.

Theories on Southeast Asian refugee health have largely been developed from experiences of non-Asian refugees, non-Asian and non-refugee trauma victims, and Asian non-refugees. More recent theories have been developed from specialist psychiatric services dealing with severely traumatised Southeast Asian refugees, which are then generalised to the general refugee population. A review of this literature on health of Cambodian and other Southeast Asian refugees has been given in Chapter 3. It has been shown that surveys of mental health status in particular are confounded by the variety of measuring instruments, as well as by differences in study populations along such variables as ethnicity, education and age, that together limit comparability. Inconsistent and even contradictory findings are variously explained by queries about cross-cultural validity of psychological instruments and procedural and translation concerns related to conducting the surveys.

Findings of high levels of psychopathology do not seem well-supported by the

realities of successful resettlement and courage in reconstructing futures evident among refugee communities. In agreement with Nguyen's (1985) opinion, Mollica (1989, p.91) asserts that "most refugee people in American communities do not have psychiatric disorders, in spite of the trauma they have experienced." This statement has been borne out anecdotally by New Zealanders I have talked with who have had extensive contact with Southeast Asian refugees, and who frequently comment that a misleading picture is conveyed of high levels of psychiatric disorder reflected in literature, conferences, and services concerned with refugee health.

Published studies of refugee health, and the descriptions of my informants of the effects on the body of *gkuet cj'roun*, refer to somatic symptoms. Somatisation is a phenomenon said to occur commonly among Asians, for whom psychiatric illness is described as being stigmatising and shameful (Lin, Carter, and Kleinman, 1985, p.1080). According to this theory, mental distress (denied because of shame) is projected in the idiom of physical disorders, commonly headache, dizziness, insomnia, abdominal pain, and back-ache, and for which frequently no underlying organic cause can be found. In view of the fact that these participants described similar symptoms as manifestations of *gkuet cj'roun*, which is an explicitly recognised response to major difficulties, and as there was no evidence of unwillingness to admit to either "thinking too much" or major mental illness among the study population, the concept of somatisation alone does not assist in explaining the somatic symptoms of the phenomenon of "thinking too much". Furthermore, although there are clear similarities between the symptoms of "thinking too much" and those of depression and anxiety, the very unevenness of the findings of studies on Cambodian refugee mental health, offers little assistance in understanding the Cambodian phenomenon of *gkuet cj'roun*, nor offers ways of assisting those suffering from "too much thinking".

Part of the reason for this absence of "fit" with theories of Cambodian refugee health is the range of severity engulfed by the term *gkuet cj'roun*. Included are people for whom it is easily manageable who do not fit the classic pattern of clinical depression, while at the other extreme are those likely to be suffering from major depression. On

the other hand, it is possible that the readiness with which participants of this study admitted to experiencing *gkuet cj'roum*, and the high level of consensus about manifestations of the state, could explain high depression scores on psychological instruments among a population who have endured profound hardship with relatively little dysfunction, and demonstrate low utilisation rates of psychiatric services. Moreover, the implicit focus on negative psychopathology in many studies obscures the potentially beneficial effects of *gkuet cj'roum*, in providing a mechanism for resolving difficulties and restructuring lives.

The psychiatric category of PTSD has gained popularity in explaining and treating refugee distress. I am not aware of any of the participants of the present study being clinically diagnosed with PTSD. If they happened to attend a psychiatric clinic attuned to the disorder, it is highly likely that people like BoPa and VeasNa would be diagnosed thus, from their clear accounts of intrusive images, obsessive thoughts, nightmares, and emotional numbing. Yet BoPa's precipitating trauma, the death of a child, is excluded from the core criteria of what constitutes a trauma; and VeasNa's obsessive thoughts focus not on a past trauma, but on her current anxiety about her absent daughter's welfare. Being unaware that there is such a disorder as PTSD, Cambodians I talked with expanded rather on the Cambodian concept of "thinking too much" to incorporate both the past traumatic events that they constantly remember, additional griefs since resettling in the West, the "abnormality" and stress of life in New Zealand, and the experience of distressing, even frightening, psychological and somatic sequelae. As a cultural category "thinking too much" seemed as useful and meaningful to Cambodian sufferers in making sense of and resolving their distress, as PTSD is in empowering clinicians trying to "treat" human distress of a magnitude that is commensurate with the trauma and losses their patients have survived.

The sheer magnitude of suffering, the enormity of which clinicians trained in Western therapeutic models are ill-equipped to deal with, was illustrated in the dialogue between Sok and BoNa, above. It is highlighted in Mollica's (1988) outline of the "journeying" of the Indochinese Psychiatric Clinic, in Boston, in trying to ease

the distress of their clients. He describes the funereal atmosphere of the clinic as refugees "infected" both the environment and its staff with their hopelessness, and the testimonies of early patients that the psychiatric interview and examination exacerbated their trauma. Through their initial mistakes, he explains, they experientially began to develop treatment models that viewed the refugees as survivors of torture and violence. Beliefs that objectify distress long-held by Western medical clinicians about Southeast Asian refugee health, they found, needed to be put to one side, or bracketed. These included concepts of "somatisation", "survivor guilt", and "posttraumatic stress disorder". Allowing the subjective experiences of the sufferers to inform the therapeutic processes has given rise to treatment models based on surviving torture and violence.

Thus has developed a currently preferred paradigm for treating entrenched refugee distress and illness, reflected in the establishment of specialised treatment centres such as the Service for the Treatment and Rehabilitation of Torture and Trauma Survivors (STARTTS) of New South Wales, (Reid, Silove, and Tam, 1990) which has provided the model and impetus for establishing a similar service in Auckland. However, it is acknowledged that while it is recognised that torture can cause serious sequelae, the effects on health are as yet poorly understood (see Goldfield, Mollica, Pesavento, and Faraone, 1988).

From the few studies that have been conducted, physical symptoms commonly complained of include headache, impaired hearing, gastrointestinal symptoms, and musculo-skeletal symptoms. The most frequent psychological symptoms are insomnia, nightmares, memory loss, poor concentration, and anxiety with fearfulness. There is growing acceptance that there may in fact be organic causes for symptomology, particularly related to head injury and its neuropsychiatric consequences, and to occult fractures and soft tissue damage (Goldfield et al, 1988, pp.2727 ff). The overlap of symptoms associated with torture and those of PTSD and major depression is apparent, and Goldfield et al (1988) caution against loading the patient with another psychiatric label without first determining whether they meet established diagnostic categories. Attempts by some clinicians to describe a "post-

torture syndrome" have not yet found wide acceptance, and the importance of first determining whether the patient fits an accepted diagnostic category has been asserted.

The "post-torture syndrome" probably fits a number of participants in the study, notably VeasNa and SaRom, both of whom described their torture while imprisoned at the hands of the Khmer Rouge. In contrast, others such as BoPa gave no history of torture or violence. Yet the frequency of sexual violence against Cambodian refugee women, including rape, is well-documented, and women's reluctance to report rape out of shame widely acknowledged (Goldfield et al, 1988, p.2726). Participants intimated that this went on, and was witnessed by them, but without exception excluded themselves and close family members as being victims. I deliberately did not pry out of respect for their dignity, but several were in situations where they would be vulnerable to sexual violation. These situations included being imprisoned, being unaccompanied and unprotected, and being part of a group weakened with starvation and disease lacking strength to protect its members. Among participants are women who demonstrate sudden terror attacks in the absence of objective danger, who are psychically numb, who appear to have abandoned the observance of social etiquette, and whose physical and psychological symptoms are severely incapacitating.

Grounds for rejecting that refugee status is associated *ipso facto* with high levels of psychopathology requiring psychiatric intervention are emerging. For example, in her New Zealand study, by using regression analysis Pernice (1987, pp.85f) found that anxiety is significantly related not to refugee status but principally to being unemployed, and being discriminated against; and depression is related to discrimination and not having close friends, but not to being a refugee. Experienced clinicians working in specialist refugee mental health clinics, where standard therapeutic approaches have had disappointing outcomes for patients, are developing innovative approaches that draw from traditional social and cultural values. For example, the use of story-telling as therapy by Mollica and team (1988, p.310) is deliberate, pointing out that "the importance of storytelling cannot be underestimated

in the traditional life of our patients". Similarly, clinicians working with Mien refugees are learning about their historical and social backgrounds and cultural beliefs, integrating these into treatment approaches (Moore and Boehnlein, 1991). In the Oregon clinic, a social context for long-term psychiatric therapy was being fostered that accepts, even encourages, the use of traditional and alternative treatment, and that integrates cultural and social activities.

Mollica (1988), Eisenbruch (1990, 1991), Pernice (1987) and others advocate that the understanding of refugee health must begin not with its measurement and assessment using models and instruments derived from Western medicine, but from a thorough appreciation of illness as experienced and interpreted from the position of the refugee. The novel approaches described above are a step in that direction. The phenomenon of *gkuet cj'roum* uncovered in this ethnographic study goes further. It offers a framework for developing a therapeutic approach that would incorporate both Mollica's story telling and Eisenbruch's cultural bereavement model. It is entirely consistent with the integrated environment being developed by Moore and Boehnlein (1991).

Mollica (1989, p.92f) goes on to argue that in order to understand the effects on health and symptomology of pre-migration and acculturation stress, ethnologies of illness are essential. A knowledge of the ways the people themselves talk about psychological distress, its manifestations, and the ways they deal with it, are surely fundamental to measuring the true levels of mental disorder, and to developing appropriate modes of treatment in places in the West where Southeast Asian refugees have resettled. In this respect, Pernice (1987, p.54f) points out the lack of congruence between Western psychiatric categories and those defined within the contexts of other cultures, suggesting the limitations of measuring mental disorders cross-culturally using the same instrument, and the prior need to describe disorders phenomenologically.

While I do not claim this presentation and analysis of *gkuet cj'roum* to be an exhaustive study of Cambodian mental distress and disorders, it provides a thorough

unfolding of a ubiquitous response of mental distress to almost insoluble difficulties. Its significance lies in that it predated the trauma and dislocation that brought Cambodian refugees to New Zealand, and as a traditional way of addressing distress, has been expanded to accommodate sufferings of a degree and kind not commonly experienced in pre-Pol Pot Cambodia. Thus the continuation of traditional ways of viewing and dealing with "thinking too much", that is a response to life's vicissitudes and stresses, offers one explanation as to why there is less psychiatric disorder and presentation at treatment services than may be expected. *Gkuet cj'roum* may provide a mechanism for resolving difficulties and restructuring futures, thereby contributing to Cambodian people's well-being and health.

Conclusions

Gkuet cj'roum, a concept embedded in Cambodian culture, was raised by a large number of participants in relation to my enquiries about illness. It was clear that "thinking too much" is neither caused by nor invariably leads on to illness, although the two may be present together. Major problems can tax and overwhelm people, and "thinking too much" offers a way for the troubled person to think through the problem, to find solutions, to plan a better future and work out the steps to bring the plan into being. *Gkuet cj'roum* can become compulsive, particularly when the problems seem insoluble, and in these cases can lead on to illness, as was the case with VeasNa and Mrs Som. "Thinking too much" is therefore located in the borderlands between life's vicissitudes and health. I have shown in the previous chapter that the Cambodian refugees themselves occupy a borderland, being far from the physical and cultural milieu in which they grew up, but not fully absorbed into their adopted society. Difficulties and disappointments in adjusting to New Zealand, which may be related to illness, are also linked to "thinking too much". As a disempowered people, *Gkuet cj'roum* offers a means of personal empowerment. The troubled person both actively engages in "thinking too much", and by an act of will, stops "thinking" when it becomes protracted or entrenched.

To "think too much" is morally acceptable among Cambodians, insofar as the precipitating difficulties which are part of life are acknowledged. However, this ceases to be the case when "thinking too much" is excessive or unduly prolonged. There are recognised, widely-accepted and clearly articulated ways of dealing with the state. Principally, these consist of distracting the person from troublesome thoughts, and being generally solicitous and supportive, including advising the person on how to stop "thinking", and sometimes giving a gentle reproof. While such measures were described as being generally adequate in Cambodian contexts, the severity and enormity of the Cambodian tragedy that resulted in multiple thousands of Cambodians seeking resettlement throughout the world are such that "thinking too much" is more likely to be severe and protracted. Previous traumas are then compounded by adjustment stress and loss of hope as poverty and misfortune in the new country persist, as described in Chapter 6. Moreover, Cambodians have been dislocated from their traditional culture since Year Zero of the Khmer Rouge, and are now settling in a society which does not share their traditions and history. In such circumstances, the traditional ways of resolving "thinking too much" may no longer be adequate.

Although some of the manifestations of "thinking too much" are similar to symptoms of medical disorders, the phenomenon is more appropriately managed as a distressing response to distressing events than as a medical disorder. Once organic disorders have been excluded, more than reassurance is indicated. An alternative is to move toward dealing with "thinking" along the lines with which Cambodians are familiar and comfortable. Traditional wisdom and skills, which many have suspended as part of their acculturation, are thereby affirmed and reinforced. This was demonstrated in BoPa's case, when the approach adopted by her doctor had an affinity with Cambodian approaches. With the two sets of support mutually reinforcing one another, those of her doctor and of her friends, BoPa was eventually able to gain control over her "thinking" and to experience profound relief from her inner pressure.

In concluding this discussion, I contend that refugee support services should be developed around the cultural categories of specific refugee communities, rather than

based on constructs and expectations, implicitly universal, derived from Western medical theories on the refugee experience. In the case of the Cambodian community, there appeared to be no sense of shame attached to "thinking too much". Services that begin by coming alongside the sufferer of entrenched or severe "thinking" in terms of that cultural category, rather than being developed around such features as psychiatric disorder, trauma or torture, could effectively strengthen the person in using familiar ways of overcoming their distressing *gkuet cj'roum*. The case of BoPa offers a possible model whereby the skills and approaches of professional and community resources can mutually support and reinforce one another, and which clearly sits comfortably within the sufferer's cultural framework. Furthermore, the separation of health problems and their treatment from circumstances contributing to their development, a characteristic of Western medical care, is likely to be, at best, only partially effective. The relationship between symptomology and such factors as unemployment, poverty, social isolation and loss of former social competence and status, appears critical to overcoming severe "thinking too much" among resettled Cambodian refugees, and to the restoration of health.

This chapter has demonstrated the challenges posed by cross-cultural health care. Particularly is this so in the case of psycho-social conditions and mental health. However, illnesses of a biophysical nature, the treatment of which from a biomedical perspective should be standard irrespective of cultural background, also present difficulties to both patient and clinician. These issues will be pursued in the following chapter.

Chapter 8

ILLNESS IN TRANSITION: Experiences and Explanations

This chapter focuses on the effects brought about by changes in place of residence, and by the refugee experience itself, on illness experiences of resettled Cambodian refugees. The way symptoms are expressed, explanations offered of causes and appropriate management of illness, and Cambodians' understanding of medical actions and decisions, are the subject of the chapter. The interface between illness experiences and the use of New Zealand's health care system, the focus of the next chapter, further demonstrates the alienating experience of illness itself, alienating insofar as the way Cambodians describe symptoms and their expectations of treatment are generally unfamiliar to clinicians. I will show that illness experiences of Cambodian refugees cannot be divorced from their suffering; indeed, to a large extent their suffering and exile inform perceptions of illness phenomena.

I begin by discussing the distinctions between disease and illness. I go on to summarise the illness phenomena characterising the study population, including a discussion of specific cases of the interrelationships of illness and "thinking too much" with the settlement process. No criteria for type or severity of illness were laid down in selecting participants, with the result that illnesses discussed ranged in severity from the common cold to those which were disabling and even fatal. Narratives recorded included major mental illness as well as physical disorders, and medically treated life-cycle events such as childbirth and ageing. Many participants also experienced "thinking too much", and we have seen that signs of "thinking too much" and symptoms of illness can overlap, as well as the conditions being mutually compounding. There is no evidence of rejection of Western medicine by my informants; on the contrary, they were confident that they would be effectively treated. In their experience, however, Western medical practitioners were unfamiliar with explanations offered by the Cambodians themselves, and medical technology limited in diagnosing and treating certain illnesses. Cambodians themselves draw from a range of theories of illness, which are discussed. The Cambodian system of

healing provides traditional explanations, well-illustrated in Mrs Nhim's case. Explanations directly related to the refugee experience itself include past deprivation and excessive labour, and the adverse effects of New Zealand's climate. Other cultural themes include "nerves", and "black spirit", both of which were frequently alluded to by participants in the study.

I conclude by considering the relationship between illness and a sense of place, and herein lies the significance of the chapter. The phenomenon of resettled Cambodians living in multiple times and places, proposed in Chapters 5 and 6, is also seen in the way Cambodians express symptoms and explain illness. In one sense, resettled Cambodians are in an in between position, a marginal position, with regard both to social location and to illness paradigms. In another sense, Cambodians are in a time of transition, characterised by rapidity and dynamism, through which new ways of expressing and explaining illness are emerging.

Illness as a Socio-Cultural Construct

Illness is described as a human experience of suffering expressed through symptoms, an innate response to such phenomena as stress and assault (Kleinman, 1988, p.3). Kleinman (1988, p.5) goes on to argue that patterns of illness are culturally shaped, such patterns being acquired through socialisation and shared collective experience. It follows, therefore, that within cultural frameworks, there are normal, recognised and acceptable ways of being ill (Kleinman, 1980, p.72). Symptoms that are perceived, expressed and decoded within a given cultural framework, according to this view, are at risk of being misconstrued when presented in a different context.

As a social construct, illness is not synonymous with disease and underlying pathology. However, when a sick person consults a Western medical practitioner, the symptoms of illness are interpreted in the narrow, technical sense of disease theories of biomedicine. Disease refers to biological and/or psychological malfunction occurring irrespective of social and cultural contexts (Kleinman, 1980, p.72). The

dominant metaphor of biomedicine views the body as a biochemical entity, with disease reflecting its disorder (Kirmayer, 1988, p.57). It follows, then, that a major element of the clinical encounter is to search for such abnormalities, and where they are found, to treat them so as to restore acceptable function. In its pursuit to identify and correct biochemical malfunction, biomedicine, (variously referred to as "scientific" medicine and Western medicine), has tended to reduce the body to smaller and smaller component parts, and to reduce disease to single causative agents such as infection by a specific micro-organism.

While a tight definition of "illness" was not used in the recruitment of participants in the study, their collective experiences reflect a divergence between a biomedical view of disease and Cambodian constructs of illness. In the case of resettled Cambodian refugees, this situation is further complicated in that traditional culturally shaped ways of expressing and interpreting illness are themselves undergoing review, in response to the refugee experience and their exile. Although it would have been interesting to have compared the experiences and interpretations of the illnesses described by participants with those of their medical practitioners, this was not done. In the first place, to have attempted to do so would have generated a range of procedural and ethical problems for clinicians relating to the confidentiality of their patients. More important, such a comparison would not have shed light on the ways in which Cambodians express and explain illness at a time of rapid transition, but could have diverted discussion into debate on alternative explanatory models.

A lack of fit between reported symptoms, organic pathology and disease theories resulted with suffering people being assured they weren't, in fact, ill, a frequent occurrence which will be referred to throughout the chapter. Differences of opinion between the suffering Cambodian and the clinician often have the effect of bringing into question the person's experience and even integrity, apparent in the case of VeasNa described in the previous chapter. At the same time, it raises questions about the level of development of medical science. For example, the developing body of knowledge about sequelae of torture argues that there is evidence of underlying organic causes for the severe symptoms of victims who hitherto have been given a

null medical diagnosis (Goldfield et al, 1988, p.2726).

It became apparent in this study that the ability of clinicians to interpret illnesses cross-culturally is limited. Kleinman (1988, p.5) points out that clinicians, too, have been socialised into a particular culturally embedded experience of illness, as well as having been educated into the biomedical model of disease, both of which shape the perspectives by which the clinician reinterprets illness into disease configurations. In the New Zealand clinical context, is it not likely that a null clinical diagnosis may reflect a lack of exposure of the clinician to a range of disorders not commonly encountered? New Zealand's geographical isolation and assimilationist social values render this particularly likely. Furthermore, that clinicians are not familiar with the characteristic ways by which Cambodians experience illness, express symptoms and respond bodily to the environment, are well-illustrated in the narratives that follow.

Overview of Illness Experiences of Participants

The study population of 21 adults known to be suffering illness, and hence invited to participate in the study, were spread over fifteen households, representing about a quarter of Cambodian households in the city. It must be stressed that the high level of illness described for this group is not necessarily representative of the community, and that those who enjoy good health have not told their stories. At the same time, illness phenomena and related experiences among the study population may well reflect those general among resettled Cambodian refugees of a similarly low health status. As the accounts of the narrators were not corroborated by medical information, only one side of the story is presented. That is, the way the sufferers experience and explain their illnesses, and their understanding of clinicians' explanations and treatment regimens.

Included in the study population are individuals who have had one illness after another. Included are SomNieng, Sok, Mr Meas, SaRom, SuBai, TiDaa, and Mrs Kev, VeasNa, VuTy, SomBut, and BoPa, making up more than half of the group of

twenty-one. In about a quarter of the families, several members are continually ill. These include the family of SuBai, Sok, and her mother Mrs Kev; and that of VuTy, his wife NeaRy, his mother with leukaemia, and his sister VeasNa (who lives in her own home); the family of SomBut, BoPa, their daughter and little baby who suddenly died; and Mr Chhum's household, in which his step-son died shortly before he did, and whose daughter-in-law (who lives in her own home) became paralysed after giving birth.

The narratives include communicable diseases, such as tuberculosis, described in literature about health problems afflicting Southeast Asian refugees (see Chapter 3). Chronic disease are included, such as diabetes, cancer and heart disease. Mental disorders such as psychotic breakdown were described, along with illnesses that seem to fall into the category of psycho-somatic syndromes. However, so long as there is a clear clinical diagnosis and treatment, there is little evidence of a search for alternative explanations of the illness.

This is not the case when a biomedical diagnosis and/or treatment are not forthcoming, and reassurances that there is nothing wrong with sufferers do little to allay anxiety. As long as distressing symptoms continue, Cambodian sufferers are far from reassured, often embarking instead on an anxious search for explanations from within the Cambodian system of healing, and drawing from assumed effects of the refugee experience and change of location. For example, connections between illness and past hardship and bereavement, as well as current adjustment difficulties, are made by the sufferers themselves, especially by the aged. A similar phenomenon is apparent in cases where the disease carries a serious prognosis and is said to be untreatable. Intractable and distressing symptoms reach a point of preoccupying and dominating the lives of sufferers and of their families. Those for whom a clear medical diagnosis or treatment is not forthcoming become frustrated with the health system, and express dissatisfaction and hopelessness with life in general. Such issues as maintaining social responsibilities, working, and acquiring English are out of the question, as illustrated in the cases of BoPa and VeasNa (see Chapter 7).

The triad which emerged in this study, of impaired health, unemployment and poverty, going on to adversely affect adjustment, has also been described in the United States (Uba and Chung, 1991, p.221f) and reported among residents of "Site 2" refugee camp on the Thai-Cambodian border (Mollica et al, 1993, p.6). Discussion of adjustment in Chapter 6 was concluded by pointing out that the process of adjustment was seriously hampered for a majority of the participants. Illness and mental distress were shown to be significant factors in this regard, adversely affecting both an ability to acquire and retain English, and to secure employment and friendships with *kiwis*. The resultant isolation and poverty appeared to compound their ill-health in a vicious interacting cycle. Indeed, a number of participants whose illnesses were incapacitating expressed with frustration and longing the sentiment that if their illnesses could be sorted out and successfully treated, then they could learn English, get work, and find life more bearable.

While research on health of migrants and refugees has a well-established focus on the effects of adjustment and acculturation-related stress on illness, this study shows that the adverse effects of illness on resettlement are also significant (see Chapter 6). This is not to say that illness adversely affects adjustment in a lineal cause-effect manner, but simply that it is one of several interacting factors. One result, it appears, is to unsettle families, who uproot and move on once more. Thus illness is one factor in secondary migration, not only a result of migration. As suggested in the accounts that follow, it appeared that illness, along with unemployment and poverty, affects one's sense of being contented and settled. As a quarter of Palmerston North households were included, this alone suggests that the relationship of illness and settlement warrants careful attention. At the same time, illness is not the only factor in secondary migration, as healthy Cambodians, and other Palmerston North residents, move on for a variety of reasons, not least to settle in a more desirable location.

SuBai's household is one example of the way illness resulted in loss of employment, a loss with negative consequences on both economic status and health itself. In turn, the family's sense of attachment to the city was undermined, leading to their

planning to leave. SuBai's malady was diagnosed as glandular fever, a viral condition that can be prolonged and recurrent, and for which symptomatic treatment only is available. Typical of glandular fever sufferers, SuBai had no energy, poor appetite, mild fever, sore throat and coughing. In his low physical state, without outside work to occupy him, SuBai became prey to "thinking too much", about their financial difficulties, about the future, and his past; in Cambodia he had been forced to witness the execution of his father and brother, and was powerless to prevent his infant sons' deaths from starvation.

SuBai's wife had formerly been in employment, until repetitive strain injury had forced her to withdraw. SuBai's loss of employment effectively rendered the family welfare-dependent. They are much poorer now, and the lassitude and illness lingers.

Although SuBai's family are among the longest-settled, a similar complex of illness, low adjustment and secondary migration is observed in recent arrivals. The last Cambodian refugees to be resettled in the area was the family of NaRom. At first their delight in being in New Zealand was obvious, and NaRom was among the fortunate ones to find work quickly, in his case in a plant nursery. It wasn't long before he began to complain of abdominal pain, a repeat of symptoms experienced in the refugee camp when a bleeding peptic ulcer culminated in major surgery. He took sick leave from his work, which often necessitated heavy digging and lifting, sometimes in wind, cold, and rain. However, thorough medical investigations revealed no new ulcer, and his pain was put down to adhesions and scarring from previous surgery. NaRom remained anxious about the pain, to the extent of being able to carry out light work only, and for ever-decreasing hours.

NaRom readily acknowledged "thinking too much", and peptic ulceration is commonly categorised as psychosomatic (Nguyen, 1985, p.270), suggesting a strong relationship with stress in his case. What is less clear is whether adjustment stress gave rise to the symptoms, or the experiences of pain and poor appetite, brought on by unaccustomed physical exertion and reminiscent of the previous serious illness, was itself stressful. Strikingly similar to SuBai's experience is the effect of debilitating illness on the ability and confidence of the sufferer to work and

subsequently, on family finances, flowing on to adversely affect their sense of being settled. Within three years of their arrival NaRom, constantly unsettled and "thinking too much", took himself and his family off to try their luck in another city.

The very act of taking things in hand, and not succumbing to despair, can also be viewed as positive, and may well have favourable consequences if the family's social and economic situation improves with the move. Among my informants, such improvement was not always the case.

Illness was a prominent issue in the lives of my informants, one which had important negative consequences for socio-economic status and for the ability to participate in New Zealand society. These factors together both aggravate "thinking too much", and contributed to secondary migration. In the context of adjustment, then, illness gives rise to considerable suffering. Illness also gives rise to suffering on its own account as sufferers seek relief from their pain and distress, often with limited success, the subject of the following discussion.

Biomedical Explanations of Illness: acceptance and limitations

Cambodians suffering from illness normally apply both self-care techniques and seek assistance from the family doctor, confident that Western medicine will cure the illness. In many cases medical diagnostic procedures will suggest the appropriate treatment, and recovery will follow. In other cases, where there is no available treatment, the illness must run its course; SubBai's glandular fever is a case in point. For a significant number of participants in the study, diagnostic procedures did not result in a clear identification of disease, and attempts to treat symptoms were unsuccessful. In such case, reassurance was offered, but when pain and other symptoms did not abate, reassurance was frustrating and disappointing. VuTy was one such case.

VuTy's family arrived in New Zealand in 1989. VuTy described himself as being fit

and well prior to coming to New Zealand. Some three months previously, however, VuTy had a tooth extracted, a traumatic procedure to which he attributes his progressive health problems. From the time of arrival in New Zealand, VuTy has suffered constant pain, dizziness, occasional nausea and vomiting, and occasional numbness. After about a year of trying various medications with no improvement, VuTy's doctor recommended surgery. Having complete confidence in his doctor, VuTy went ahead with surgery unhesitatingly. Far from improving things, the pain and dizziness have since been much worse, and VuTy periodically has weakness down one side, the same side as both his tooth extraction and the operation, which is also the side on which he has a blind eye. He reported that at the operation the tissue was found to be "bad", but its excision has not resulted in recovery.

VuTy has had numerous investigations, including x-rays, ultrasound, and most recently a scan, but none has shown any organic abnormality to account for his symptoms. According to one of the many persons who assist with interpreting, the doctor, while acknowledging the irreversible damage that has occurred, is of the view that VuTy's continuing symptoms are mainly related to stress and anxiety. Accordingly, the doctor has discontinued the sickness benefit and insists that VuTy attend English classes and get work experience, so as to encourage him to abandon the role of invalid. Repeatedly, VuTy has been told that there is "nothing wrong" on any of the investigations, and that while the damage which occurred in the past can't be reversed or treated, the clinical opinion is that it isn't severe enough to prevent him from working.

Neither VuTy nor any member of his family has worked since coming to New Zealand. They are a large household, and complain bitterly of their poverty and bleak future. VuTy complained that even the little he learned during the decade in the camps he has now lost, but his dizziness and pain interferes with learning. He also claimed that he longs to be well and able to work, but at the same time is having difficulty accepting his doctor's encouragement to do so.

VuTy: I was determined from there [Thailand] that when over here...I want to work...Since I arrived I want to work, and then this

thing started...

Mother: You look at him! If it keeps *sue* [fatigued] like this, how can he work?

VuTy: The doctor said to me to go and find a job, to meet the people at the Labour Department...and when I went to that place they asked 'why did the doctor send me [when I'm sick]...I could do how many days per week?' And I said, 'not sure, very hard to conclude...sometimes can work for one day, sometimes for two days, but after that I don't dare say.' It's very hard to talk to them...they wanted to find the watch repair job for me [a skill learned in the camp].

Wife: And now the doctor said to go and find work...he can work!...it makes me want to laugh!....Sometimes worry, sometimes sick...and sometimes when worry, sick like this... my husband could perhaps do something for an hour or two per week...

Sok: ..so that they [*kiwis*] are not disappointed with us, saying that we come here for so many years and not doing anything...

The question must be asked as to whether VuTy's assertions, that above all else he wants to be well and to work, are credible. It appears that his doctor doesn't think so, when faced with the family's resistance to VuTy's entering the workforce in spite of his professional opinion that VuTy is fit to do so. VuTy, on the other hand, insists that both the severity and the capricious manner with which he is afflicted preclude him from being able to commit himself to working. Those closest to him agree, having known him throughout his life in both sickness and health, and in situations of deprivation as well as plenty, in danger and in safety.

Anti-inflammatory pain-relieving drugs have been tried with limited effectiveness, and when VuTy developed abdominal pain (gastric irritation being a recognised side-effect of anti-inflammatory drugs) antacids were added to his medication. From time to time, when his dizziness has been severe enough to induce vomiting, an injection has been administered, after which he sleeps and awakes feeling much better. The effects of these injections, according to VuTy, last for several weeks. He is regularly taking a tablet specifically for relieving dizziness and nausea, prescribed for

occasional use only but which VuTy is taking every day. Most recently, antidepressant drugs have been added. Not surprisingly, he is now complaining of being very drowsy, but still suffering as before from pain.

The severity of VuTy's symptoms puts this illness experience beyond the realm of being managed with Cambodian self-care, and as it is perceived as different from illnesses known in Cambodia, it is not amenable to Cambodian medicine. For a start, the symptoms experienced are much more severe than is normal for the malady that Cambodians commonly suffer, termed *k'jol*. *K'jol* is characterised by vague symptoms of dizziness, headache, nausea and unwellness, and is explained as being the result of a build-up of internal pressure, or the result of poor circulation. VuTy employs self-care techniques widely practised to release this perceived pressure, such as "coining", "cupping" and "pinching" (described in Chapter 10), with even his children being called on to assist. "Coining", for example, involves scraping the skin very hard with the edge of a coin lubricated with Tiger Balm or Vicks ointment, until the scraped areas are deep red in colour, which they explained gives relief from internal pressure or tension. In the case of VuTy, since his symptoms are different from "normal", relief is transient.

In common with other similarly affected people, the family is therefore largely dependent on Western medicine, which seems to have failed to produce either a clear understanding of the cause of the illnesses, or effective treatment that alleviates VuTy's suffering. Paradoxically, VuTy's disappointment with Western medicine in curing his condition has not undermined his confidence in its capability. As he sees it, the problem lies with the lack of skill of local doctors and their refusal to administer the more powerful injections he requests, rather than with the system itself. Neither does his faith in and dependence on Western medicine stop him from searching more widely for explanations or treatment, which for VuTy lie in a believed damage to "nerves". Reflecting his insistence on this theory, he has arranged for an elderly woman skilled in the art of "nerve massage" to visit early each morning to treat him, and has submitted to acupuncture.

A significant number of participants whose illnesses were distressing, threatening, incapacitating, and even eventually fatal, have had thorough and extensive investigations, yet at times been told that "nothing is wrong", meaning that pathological abnormalities were not found. These included: the two women who were partially paralysed after giving birth, BoPa and RoTaa (see Chapter 11); SomBut and his infant son (deceased); the young man SomDey (deceased); SaRom; VuTy and his sister VeasNa (discussed in Chapter 7). There were instances of investigating the malfunction without establishing the underlying cause, hence medical treatment was at best symptomatic and palliative. The sufferers' worlds and those of their families became circumscribed by their illnesses, their day to day existence defined by suffering.

The phenomenon of Southeast Asian refugees presenting with distressing symptoms for which no organic explanation can be found is widely reported in literature. For example, Nguyen (1985, p.270) listed headaches, aches and pains, dizziness, fatigue, gastrointestinal complaints and insomnia among the somatic complaints with which almost all patients presented. Nguyen described these as a cultural way of expressing mental distress. Similar lists of symptoms are frequently reported which commonly draw on the concept of somatisation to explain the pattern (eg. Lin et al, 1985, p.1082; Baughan et al, 1990, p.566). A minority leave open the possibility that there may be organic explanations (eg Mollica, 1980, p.298).

When clinicians are unable to provide satisfactory answers and treatment, a pattern develops of the sufferers themselves embarking on a search for explanation, drawing from their personal experiences of illness and collective Cambodian knowledge. However, as lives have been so severely dislocated, a personal quest may yield no answers. Some describe their affliction as similar to illnesses recognised in the Cambodian system of healing, but not identical; their illness can be worse; start the same but progress differently; or share only certain features in common with recognised Cambodian illnesses. These differences are variously explained as the after-effects of deprivation, shock, hard labour, and of being in a physical and cultural setting that differs in so many respects from Cambodia, exemplified in Mrs

Nhim's narrative.

The Case of Mrs Nhim

The Nhim family were among the early Cambodian arrivals in Palmerston North, after spending only four years in a refugee camp. With few other Cambodian families with whom to socialise, Mrs Nhim's loneliness and social isolation were at first acute (see Chapter 6). When I interviewed the family, Mrs Nhim was generally seated on the floor reclining against the easy chair, apparently preferring the familiar posture of her village Cambodian background. Her calm facial and bodily expression and quiet speaking as she related her experiences belied the terror she described, her deep shame and loneliness, her bewilderment about the cause and outlook for her illness, and her fears now for her survival.

By the time I met the Nhims, they owned their own home which was alive with healthy house plants, the walls adorned with pictures and paintings by the Nhims' artist son, depicting scenes of village Cambodia, Angkor Wat, Buddha, and Krishna. Family photographs were displayed along with pre-Pol Pot Cambodian currency. In the china cabinet there were ornaments and tropical shells, books, and as for most households, stereo and television equipment. The room was light, warm, and tastefully though not lavishly furnished. All except one of their married children had established their own homes elsewhere in the city, and their unmarried student son and youngest daughter were still living with them. Like many grandparents, the Nhims often minded their grandchildren while their parents worked.

Mrs Nhim and her husband began by describing the illness that has afflicted her since four years after arriving in New Zealand, some five or six years previously. It started with a headache, and then one side of her face became numb, with her skin feeling as though it were burning. At first she tried "coining", but when she got no better, went to her doctor. Like VuTy and others, she has had x-rays and blood tests, and has been examined by hospital specialists, but as far as she knows the cause for

her illness has not been determined. As she herself thought the cause may have been her teeth, she had several extracted, which gave no relief. Neither has physiotherapy helped. She said that she has been tried on about "ten different kinds" of medicine, and still takes steroid tablets, which have not effected a cure. In addition, the treatment resources available in Cambodia are not available in New Zealand. As rural people, the Nhims formerly relied on the *gkru khmer*, and on over-the-counter medicines when needed. Her husband was a lay injector in Cambodia, and was accustomed to purchasing potent medicines from pharmacies and administering them himself. In New Zealand, he could not do this. Although when I first met them Mrs Nhim's symptoms were not as severe as they had been at first, they were nonetheless still troublesome and worrying. The Nhims' chief concern was that in the absence of a clear diagnosis, they didn't know what was causing the illness. Their son mentioned that early in the episode, blood samples were taken from the entire family to investigate the possibility of a familial disorder but he didn't know what the outcome of these tests was. Mrs Nhim commented that there were conditions known in Cambodia of serious headaches and dizziness, but hers was not exactly the same as these. She speculated that her illness could perhaps be that condition, but the cool New Zealand climate may have altered its course and severity in some way. I asked therefore what this illness was called in *khmer*.

Sok: We don't have any *khmer* name, have we, for this dizziness?
We have numb head, [but] I don't know what we call it.

Mrs Nhim: I don't seem to have heard of anyone with such illness.

There appears to be no identical illness in Cambodian disease nomenclature, therefore. They do, however, have their own opinion of the cause of the illness. When living in the refugee camp Mrs Nhim had just had a baby, her youngest, and was in that vulnerable state of "crossing the river" when nerves are "fresh and young" (see Chapter 11). She and her husband were watching Thai soldiers round up black marketeers when suddenly one of them thrust his gun against her husband's neck. She was terrified and badly frightened, and traces her numbness from that time. In *khmer*, sudden fright is termed *pey*, or when severe, *dtok sl'oht*.

At first, Mrs Nhim said, her numbness was like a band being tightened around her head, lasting for about three months. She recovered with the help of Cambodian medicine, to strengthen her "nerves", which she felt had been weakened through giving birth and had rendered her particularly vulnerable to the ill-effects of *pey*. Her present trouble began when they had been in New Zealand for some four years, after her unmarried son got a girl pregnant. Such a thing had never before happened in her family, and she felt ashamed and disgraced. Her difficulties in coming to terms with this were revealed in an exchange with Sok:

[In the camp] I was petrified, and after that the headache started...But when I was better emotionally it went away. And when I got to New Zealand it started from when [the baby came]...Because I worry, I started to become ill...

Sok: You shouldn't worry. In Cambodia we *khmer* like to worry [about such matters]. But if we can think...now it [sexual relations outside of marriage] is normal...Just do as they [kiwis] do, it is normal.

Mrs Nhim: But we are not used to it.

After this second episode her symptoms were much worse, with burning and numbness down one side of her face, and not only above the forehead. The numbness and burning lasted not for a few months only, but for three or four years, and although she has improved, her recovery was not complete. About a year after this conversation, still during the period of the study, Mrs Nhim became acutely ill, requiring immediate admission to hospital. Even after discharge, there still seemed to be no clear diagnosis, as she explained:

I heard [my daughter], who usually goes to interpret for the Cambodian people, say they have not identified the cause yet...my illness is very hard. They do not know for sure what caused it. Once he [the doctor] was very worried and said the nerve system of my brain malfunctioned...

Sok:...entangled or broken?

Mrs Nhim: Not entangled or broken. He said there was some vein that stopped working...blood [has] stopped flowing through...

Sok: So this is attributed to the broken nerve.

BoPa, VuTy, and Mrs Nhim all raised the topic of "nerves" in relation to their experience of illness, and Sok seemed to share their understanding of the meaning ascribed to "nerves". "Nerves" will be developed more fully later in the chapter.

Mrs Nhim went on to put her recent acute illness into the context of illnesses she had previously suffered in Cambodia. The graphic detail of her descriptions demonstrates vividly the level of folk knowledge regarding Cambodian illnesses held by older people such as Mrs Nhim, knowledge which is of limited use to them outside Cambodia.

The thing is, I [have had] stomach aches three times severely, so bad I could I could not stand it..just like when I was sick the other day. It only lasted two or three hours, but I did not think I would live...First I felt hot, then hot and cold as when you have *grun nji-ac*...it started to get very bad, the throat started to be severely sore, and the head was painful, so painful I started to scream...Not just the pain, but it felt as if the head split into two. And the tummy was like someone chopping it into pieces, and it was painfully throbbing inside he stomach...The family doctor was looking because I had lots of clothes around my body, but I was still shivering..

The face felt very hot and half my body went numb and I felt the pain with only half my body... It feels like if I get sick many more times it will be [the] finish.

This particular episode began in exactly the same way as did Mrs Nhim's previous episodes of *grun nji-ac* (a fever when the sufferer feels excruciatingly cold), and especially bore similarities to *grun puoh-vien*, which literally translated means "fever of the intestines" (probably typhoid). This recognised Cambodian illness is characterised by high fever and abdominal agony. Mrs Nhim had suffered from it twice previously in Cambodia. Yet New Zealand is climatically very different, and is considered to pose no risk to feverish conditions like *grun nji-ac* and *grun puoh-vien*. The relationship of *grun* illness to Cambodia as a place was further indicated in a separate conversation with the Meas, who talked about the high prevalence in Cambodia of *grun chanj*, (malaria), which does not occur in New Zealand. Fever and

shaking normally characterise *grun puoh-vien*, but in Mrs Nhim's case, the "numb head" with excruciating headache, was the main feature. As Mrs Nhim explained, it was always the same side of her head which hurt when she started to get sick.

Mrs Nhim was left with a residual heaviness and soreness of the affected half of her body, and the numbness and pain of her head remained with her. Unlike the previous episodes of *grun puoh-vien*, characterised by fever and abdominal pain, and prior experiences of *pey*, both in the camp and in New Zealand, giving her a numb head, this time she had both sets of symptoms, and a sore throat as well. The cause of this recent acute illness, it seems, can be explained by neither Western medicine, having eluded identification by clinicians, nor by the Cambodian condition of *grun puoh-vien* even though its onset bore similarities. Just as the Nhims were at something of a loss to explain the earlier "numb head" in the light of Cambodian illnesses, so they are unable to interpret this recent affliction in the light of Mrs Nhim's prior experiences before coming to New Zealand. Kinloch (1985, p.27) alludes also to confusion in deciding whether an illness is "culture-bound" when the affected person is out of the traditional setting, in this case Samoa. In Mrs Nhim's view, the change in physical environment may have caused the anomalous mixture of symptoms.

When an illness lacks either a Western or a Cambodian name, treatment presents problems. The previously knowledgeable Nhims, who were skilled at self-care and administering injections, were powerless in the face of such an illness, and besides, self-administration of injections was no longer legitimate in the adopted country. The *gkru khmer's* medicine eased the numbness and pain of her head before she came to New Zealand by strengthening her "nerves". Such medicine was not available in New Zealand, and even if it was, the illness had changed in such a way that Mrs Nhim doubted it would now help. As it happened, the hospital treatment for the acute episode was most satisfactory, involving as it did the coveted intravenous drip and injections which the Nhims, in common with so many Cambodians, held to be of maximum efficacy (a subject discussed in Chapter 9).

There was a discernible pattern in Mrs Nhim's narrative of a woman who has merged

her identity with serving her family, and who held fast to traditional Cambodian and Buddhist values, silently suffering when her offspring do not equally embrace and observe these values. Mrs Nhim, it appeared, has for an extended period been carrying a heavy burden first of fear, then loneliness, deep shame, and ongoing loss of cultural values and a way of life from which she derived personal worth. As the life-skills, mores and values that she herself was socialised into became less relevant and were being discarded by her offspring, so too was her sense of worth and of being valued, insofar as the two are inextricably bound together. The status and respect as grandmother and devout Buddhist, that would have been her due in her native Cambodian village, is accorded her only by a small segment of the Cambodian community, and by New Zealand society not at all. In contrast, she is anonymous, unknown, and so deprived of the rewards of a life of devotion to her family and to Buddhist values. This was illustrated poignantly when she sighed over her continuing ill-health and weakness: "It's hard, I don't get my children to do anything, so when I am sick, they don't know what to do." This ageing and ailing Cambodian woman now at her time of need suffered the more as her children, having not been reared into Cambodian culture, were unable to take over her duties and to care appropriately for her.

Mrs Nhim is left with worsening symptoms of a condition that lacks a Cambodian name. Consistent with her observation that she hasn't known such a disease in Cambodia, it did not fall within an existing category of "folk diagnosis". Displaced from the Cambodian geographical and social milieu in which she grew up, Mrs Nhim has not negotiated a place in New Zealand mainstream society, but occupied a place in a society on the margins. Like her social status, her illnesses seemed to fit neither Cambodian nor New Zealand illness categories. As Mrs Nhim was in a lonely place between these worlds, so her bodily afflictions powerfully communicated the loneliness of suffering an unidentified illness. It was moreover an affliction that was closely associated with the strangeness and unpredictability of her exile, first in the camp with its fears and threats, and now in New Zealand, with its cold climate and different cultural values and social behaviour.

Above all, Mrs Nhim's narrative illustrates the endeavours of the Nhims, like many resettled Cambodians, to understand and make sense of chronic, distressing, and threatening illness. Cambodian refugees are not alone in sometimes lacking a medical diagnosis for distressing bodily symptoms, initiating a personal search for meaning. For example, a similar phenomenon was experienced by American sufferers of chronic pain linked to the temporomandibular joint that lacked an identifiable organic origin, resulting in assurances that there was nothing the matter (Garro, 1992, pp. 100ff). For the resettled refugee, however, the process of searching for explanations is enormously complicated by the interaction of traditional views, refugee experiences and present social dislocation. Illustrated in Mrs Nhim's account are Cambodian refugees' interpretations in the light of a constellation of factors, including previous illness experiences, Cambodian explanations of illness, emotional and social concerns, consequences of the refugee experience, and the changes wrought by differences in climate and place. Cambodian refugees draw on these and other themes, themes which are discussed in detail.

Consequences of Hunger and Hard Labour

Subject to starvation, excessive physical labour and protracted anxiety, a great many of the Cambodians who eventually resettled in the West had come precariously close to death. The flood of starved, sick, desperate people who poured across the border to Thailand during 1979 has been well-documented (eg by Roesel, 1988; St. Cartmail, 1983; Burchett, 1981). Insufficient food during the Pol Pot years was widely experienced, with some Cambodian refugees having never regained their former health. The elderly, especially, continue to suffer from a variety of complaints.

Mrs Kev was very near death more than once with the swollen, yellow body resulting from starvation, and is chronically sick. "Everything is wrong", I was told. Her bones and joints ache all over, her breathing and heart are not good, and she has chronic diarrhoea. She also "thinks too much" about her "lost" family members and her past,

occasionally shouting out in her sleep from "bad dreams". Her doctor said Mrs Kev suffers from the problems of old age, and the family agreed with him. For these problems of old age, Mrs Kev had extensive investigations, referrals to specialists, and prescriptions. Sok described numerous x-rays of her mother's painful joints and barium x-rays of her troubled intestine, none of which showed any abnormality. Investigations by specialists into her urinary problems and swallowing difficulties were likewise negative, and these too were put down to the slowing up of the very aged. The family did not dispute the doctor's analysis and felt well-supported in the medical care provided. Nevertheless, in their view underlying factors were her years of deprivation and particularly grievous life, griefs which continued to the present.

In common with many older Cambodians, Mrs Kev habitually chews betel nut, staining already rotten and broken dentition. The main health problem for another elderly widow, Mrs Gket, was related to her rotting and painful teeth, necessitating total extraction. She was not alone in this; TiDaa and a number of other older people have submitted themselves to total extractions in New Zealand. The consensus is that generally in pre-war Cambodia, dentition was excellent, with poor dentition among adults widely attributed to the inadequate food during the Pol Pot years.

Grossly inadequate nutrition is not the only factor to which Cambodian refugees attribute ongoing health problems; excessive physical labour is also blamed. TiDaa was one of the older persons in the community, and wore her hair cropped close to her scalp, in the manner of widows. Her health had been poor for a long time. Prior to the Khmer Rouge regime she had been suffering from headaches and joint pain, troubles she attributed to her "very hard life", having had to do hard physical work from a very young age. During the time of Pol Pot she was too sick to work much, and never had enough to eat. After arriving in New Zealand her condition deteriorated, and TiDaa was often too weak to carry out household duties, and unable to eat or drink. She complained of continually "thinking too much", of being constantly ill with her bones and joints aching, and of suffering from abdominal pain with flatulence and heartburn. Sometimes she shook all over, in a manner similar but not identical to malaria. TiDaa, one of three elderly people in the study described as having "lost the mind" (which she blames on the dental extraction), escaped with the Meas family. They described how near to death she was:

TiDaa nearly died. She just crawled... can't walk...She had the abscesses...her legs were about this big [demonstrating]...She lost her children... she very sick and everyone leave her behind...TiDaa she said she [is] glad to be alive. She [is] supposed to be dead, that's what she said.

Like many, her legs, which had been so grossly swollen, continue to trouble her with their aching.

Mr Meas was also one of those almost-dead refugees, but hasn't suffered miserably in the way TiDaa and Mrs Kev have. Their group was herded through the jungle by the Khmer Rouge for some three months, with little food and only contaminated water to drink, and given little chance to rest (see Chapter 5). Mr Meas became separated from the remnants of his family on arrival at the border with Thailand. He was suffering from malaria, diarrhoea, and *heum* [swelling of face, body, legs and arms as a result of starvation, considered by Cambodians to result from insufficient sugar]. Some refugees in similarly desperate conditions died on first eating food on reaching a refugee camp. As for Mr Meas, in his severely weakened condition he could not at first compete with stronger internees for available food.

By the time I met the Meas, thirteen years later, he looked a fit, relaxed man of retirement age who maintained an active life involved with his family and the community, cultivating a large garden, and cycling to wherever he needed to go. Although he suffered from asthma, had had a recent heart attack, and was recently diagnosed with diabetes (none of which are common conditions in Cambodia) he claimed to enjoy good health. By this he meant that his diseases were well-managed with various medicines, and he did not feel weak, ill, or troubled in mind. Can his chronic medical diseases be attributed to the toll on his body of those years of hunger, hard work and near-starvation? There is little speculation in literature on refugee health about such an association.

In addition to insufficient food and excessive labour, Cambodian refugees suffered from inadequate rest and sleep. NeaRy described frequent sleep deprivation. At the time, she was an adolescent, and as such separated from her family to work in a

cj'laat, or mobile team of youth. Having worked throughout the day, evenings were occupied by attending compulsory "education" (propaganda, as others termed it). When the team were moving to another site, they were sometimes aroused hours before dawn, after only an hour or two of sleep, and marched off into the night. On one occasion, NeaRy fell asleep while walking, waking up only when the party halted. Other participants recall their chronic exhaustion, when after having laboured for fourteen hours or more, they were required to be "educated". In such conditions, people neither grieved or "thought too much", partly because of sheer exhaustion.

Conditions of severe deprivation continued after the collapse of the Khmer Rouge. After the Vietnamese invasion, SaRom's family moved between sojourning in border camps and living on the Cambodian side of the jungle with other guerrilla fighters, always hungry and often in danger. The three older children were all born in the jungle, subject to the life-threatening illnesses rampant in those malarial mountain jungles. SaRom's personal health problems became serious when he and his family were interned in one of the border camps, frequently subjected to cross-fire and to the daily attacks of robbers, and worse still, to constant hunger as the camp, lacking international protection, seldom received aid-donated foodstuffs. The protracted lack of the most basic human needs of food, shelter, and safety characterised years of the life of this family, along with high levels of anxiety and fear.

Against a background of deprivation of basic needs, physical labour was viewed as being particularly risky. TiDaa is among refugees who considers that her chronic aches are a result of too much hard work. VuTy liked to tell of how he used to carry hundred kilogram sacks of rice as a young man in Cambodia. Though slim, he was always fit and strong, and never ill, not even during the Pol Pot regime. He was seldom *k'jol*, that generic malady that includes many vague symptoms that can be the precursors of full-blown illness. In contrast, he now was spending most of his time lying curled up in front of the fire, feeling and looking miserable, sometimes moaning, sometimes dozing, always suffering from the constant pain of his head that at times involved his entire body. On top of that he has suffered from dizziness, sometimes so badly that he couldn't lift his head from the floor without the world

revolving around him. When his dizziness was most severe, he vomited, and at those times even a short trip in his car was unbearable.

VuTy traced his problems to the traumatic tooth extraction carried out a few weeks before the family arrived in New Zealand, a procedure which he claimed damaged a "nerve". On top of this, he explained that he had worked excessively hard under the Khmer Rouge. Labour can result in diffuse "nerve" damage, as VuTy put it, or damage to the bones according to the *gkru khmer*. The *gkru khmer*, who knows VuTy well, explained that such damage, from which many survivors suffer, can be treated by *khmer* medicine, but the illness is not recognised in New Zealand.

If sick like that, we *khmer* have medicine, and the people here don't have...If sick like VuTy, they say that the bones are damaged from lifting things that are too heavy. But if we could use the *nam k'dav* [hot medicine] it might help...being sick like VuTy it is very difficult...

Chronic physical complaints commonly afflicting Cambodian refugees are attributed at a general level to the combination of deprivation of food and rest, excessive work and protracted fear. These complaints include aching bones and joints, abdominal pain and diarrhoea, and rotting teeth. It is also considered that excessive physical work can damage the "nerves" and bones, illustrated in VuTy's account. These complaints are included in the range of symptoms reported which refugees frequently present at clinics, and for which no abnormal pathology can be detected. The phenomenon is variously labelled somatisation, and culturally-ascribed ways of presenting mental distress (see Lin et al, 1985, p.1082; Baughan et al, 1990, p.566; Nguyen, 1985, p.270). The views of the refugees themselves introduce a dimension of common sense and are eminently reasonable. Refugees' explanations challenge biomedical attempts to rationalise clinical failure in establishing a recognised medical diagnosis.

Effects of Climate

It so happened that the majority of interviews were conducted during the cooler months of each year. My overwhelming recollection is of all of us sitting on the floors of the living rooms, huddled as close as we could get to the fireplace, in which a few sticks of wood that never seemed to adequately heat the room were burning. The dimness of the internal light on those grey, overcast wintry days did little to cheer. The ambience contrasts sharply with the hot, sunny and humid climate of Cambodia. New Zealand's climate is not perceived as healthy for Cambodian people. I often asked people what they most liked and disliked about New Zealand, and while almost all claimed they liked "everything", especially the peace from fighting and plentiful food, all specified the climate as the thing they particularly disliked. New Zealanders may also dislike the weather, but my Cambodian informants were specific about its negative effects on health. The climate tends to be blamed for contributing to many illnesses, both causing maladies and exacerbating symptoms. *K'jol* is more severe in New Zealand, as is the common cold. Elderly people in particular were frequently afflicted by such maladies, which they attributed to the cool, windy climate of New Zealand.

One person was Mrs Cjea, a middle-aged woman living with her husband, a *gkru khmer*, in a household with two teen-aged children. On both occasions when I visited, she was feeling poorly, crouching close to the fire even though well wrapped up in clothing. She described herself as "not too bad" health-wise, but she said that as often as one week in three she is sick with 'flu'-like illnesses, accompanied by fever and headache. When living in Cambodia and during her seven-year sojourn in refugee camps, she occasionally had similar ailments, but only in the cool season, and never as severely as in New Zealand.

This view that the damp, windy climate of New Zealand with its long winter presents risks to health, and increases the severity of even minor illnesses, was shared by other participants, including Mrs Gket. Like many, Mrs Gket claimed that she had enjoyed good health prior to settling in New Zealand, including during her eight year

sojourn in refugee camps once she had recovered from the effects of starvation. In addition to the ill-effects of rotten teeth, Mrs Cjea suffered colds and coughs frequently, occasionally with complications requiring antibiotics. Although she formerly self-treated her colds with over-the-counter medications such as paracetamol and the traditional technique of "coining", she now preferred to consult her family doctor, on account of the increased frequency and severity of the illness. Although this study focused on illness experiences of adults, several commented that their children, too, have more and worse coughs and colds in New Zealand, as well as more serious complaints such as asthma, a pattern also observed by Samoan immigrants (Kinloch, 1985, p.33).

The cold weather is perceived as exacerbating existing symptoms, such as the painful joints about which so many of the older people complain, and winter is dreaded. For example, VuTy's family claim that his symptoms worsen with cold weather. During a particularly pleasant and long summer, VuTy improved in every way, only to get worse as the temperatures dropped. However, when VuTy asked whether moving to a warmer area would help, his doctor replied "no". Eventually, though, they did move further north, as have so many of the Cambodian community. As far as many Cambodians are concerned, the cool, windy climate appears to be more than merely an inconvenience. An oft-cited reason supporting secondary migration is their desire for a warmer place to put down their roots.

The perceived adverse effect of cold and damp on health is not confined to New Zealand. Mr and Mrs Meas described graphically and at length the cold of the jungle route they took when escaping to Thailand, Mr Meas pointing out that the fact he "also slept on the ground" was a reason for his coming close to death. They went on to say that they got *grun chanj* [malaria] from sleeping on the ground, as the "ground absorbs energy". Women who have just given birth are held to be particularly vulnerable to the ill-effects of wind and cold, a vulnerability which will be fully described in Chapter 11.

Cambodian refugees' dislike of cold and wind, and their attributing illness to an

inclement climate, has been explained in terms of "wind illness" by some researchers. "Wind" as a theory of illness is described as widespread among Vietnamese by Tung (1980, p.55), Southeast Asians in general (Muecke, 1983[b], p.838), and Cambodians in particular (Frye, 1991, p.38). Frye and McGill (1993, p.26) describe how *k'jol*, or "wind illness", directly influence everyday activities. Wind and cool temperatures are features also of places in the United States where Cambodians have settled, and there, too, exposure to wind is avoided by Cambodians in order to protect their health.

K'jol presents with an array of vague symptoms including dizziness, headache, malaise, fever, fatigue and insomnia. These symptoms are included among those described in medical literature as somatisation (for example Baughan et al, 1990). If indeed *k'jol* is both more frequent and more severe in the cool, windy and wet climate of Palmerston North, as Cambodian refugees claim, it is not surprising that the climate is viewed as a risk to health. Like "thinking too much", the tried and proven ways in which Cambodians address *k'jol* may be less effective when the condition itself changes in response to a changed geographical location. The theme of the ill-effects of the weather is addressed again in relation to childbirth, in Chapter 11.

Shocked and Damaged "Nerves"

A recurrent theme running through Cambodian illness narratives was damage to nerves, a matter about which medical literature on Southeast Asian refugee health is silent. Disorders attributed to "nerves", or *sor'sai*, were frequently drawn on by my informants to explain and treat illness, as the narratives of VuTy and Mrs Nhim illustrated. However, "nerve" disorders from a distinctively Cambodian folk perspective are not synonymous with anatomical nerves and nervous diseases from a biomedical perspective. Misunderstandings between Cambodian patients and clinicians can and do arise when the subject of nerves is raised, given the different concepts ascribed to the same word.

The importance of "nerves" in the Cambodian system of healing is shown by the array of preventive and therapeutic techniques employed to treat disorders of "nerves". Chapter 10 provides a fuller discussion of these techniques, but in brief, the self-care techniques of massage, termed *cjaab sor'sai*, or "nerve massage", are widely practised among Cambodians as a first response to pain of muscles and joints. Among the many medicines compounded by the *gkru khmer*, such as for fever, headache, poisoning, skin infection, nausea, diarrhoea, and so on there is a range of medicine for strengthening "nerves". The practices of moxibustion, widespread among Cambodians, and of acupuncture, introduced during the Pol Pot regime, seem to be related to theories of "nerves", with the burning points and needles respectively applied in relation to the "nerves" responsible for the specific malady.

Mrs Nhim traced her disorder involving *sor'sai* from the time of giving birth, when nerves are said to be "young" or "unripe", when an unexpected fright, upset or exposure to cold is sufficient to produce illness. Physical exertion, exposure to the elements and "thinking" are proscribed in the weeks post-childbirth. Similarly, VuTaa (who "lost her mind"), and RotTaa, BoPa and NeaRy all suffered from disorders of "nerves" in childbirth, the subject of Chapter 11. VuTy ascribed his "nerve" problem both to having worked excessively during the Khmer Rouge regime, and to surgical interventions the outcome of which were beyond his control. He is convinced that the root of his problems is "because of this *sor'sai* troubling me...because sometimes it is sore along here every day." Along with his mother and wife, he is convinced that the nerve was damaged by the tooth extraction, in view of the fact the offending tooth had claw-like roots that "pulled out the flesh" as it came. In VuTy's view, the ear operation he had after coming to New Zealand inflicted further damage to the nerve. VuTy adheres to his opinions in spite of the fact that their family doctor disputes it, and declined VuTy's request for acupuncture on the grounds that his problem was "not with the nerve but with the brain". Probably VuTy and his doctor were "talking past each other" (Metge and Kinloch, 1978), using the same English word to denote quite different concepts.

While for both Mrs Nhim and VuTy "nerves" are the chief culprit in their afflictions,

their understanding of nerves seems to diverge from that which defines them as anatomical entities carrying out specific physiological functions. Of all the narratives described in the study, only SomBut seemed to have a disorder of his nerves endorsed by medical practitioners, yet even here SomBut's understanding of the involvement of nerves does not coincide with the medical view. SomBut began to develop pain in his right arm, followed by loss of normal sensation and weakness, problems which went on to involve both arms. Although SomBut had a large garden and the family were very poor, cultivating their ground was out of the question, they said, as his arm was too "small" to do any gardening. Indeed, most tasks were impossible to perform. As the months have progressed, the weakness and altered sensation in both arms have progressed to involve his speech and swallowing. This motor-neurone disease, with which eventually he was diagnosed, is generally a progressive, terminal disease, running its course over a period of four or five years, confining its victims to wheelchairs and rendering them increasingly dependent on the care of others (information supplied by Motor Neurone Disease Support Group).

The family doctor had arranged x-rays, blood and urine tests, and electromyography. SomBut was given mild pain relief (paracetamol) and physiotherapy, none of which slowed the progression of his symptoms. The investigations initially failed to identify any underlying abnormality, and the verdict that SomBut was then given was that nothing was wrong. He was referred to specialist physicians, "senior doctors", as SomBut described them, adding "those three are the most senior in the entire hospital!" Further investigations were carried out during a few days' stay in hospital. SomBut's wife BoPa explained the outcome to Sok:

BoPa: When staying there, they didn't give any medication. Just taking blood sample, examining excrement, take the x-rays, everything, but no medication...When they examined the backbone, they said nothing is wrong...they told us that this particular nerve did not function at all. This whole nerve..it is caused from the head, and that is why they don't get him to do exercise...

Sok: Oh I see, because the doctor said after they find out the nerve is broken they wouldn't let him have that exercise? Because he worry they go through to the brain? Did they state the reason why his nerve is damaged?

BoPa: The doctor said like this, that it was like plugging the power in the TV, and if the electricity didn't pass through no matter what we do...the TV wouldn't go...they said [the cause] was too deep inside [the brain], couldn't do operation, nothing was possible.

Sok: And does the doctor say he will be *cjea* [that is, recover]?

BoPa: He didn't dare say! He didn't say if he will be *cjea*, because...it is like growing plants. If our seed is good it would grow good, and if our seed not good, the plant would be bad, he said like that.

Again, the concept of "broken" or "damaged nerves" emerged as an important explanation. The possibility of nerve damage had been raised in the early stages, when investigations were negative. SomBut had recounted an episode some months prior to the onset of the weakness when he had been fishing with friends at the beach. He had been bitten by an eel that "charged" when he tried to grasp it, leaving a wound that didn't bleed, but went white and went on to blister and weep a little. He described a burning sensation that accompanied the blistering, like the burn of a fire, similar to snake bite, only not as painful. He showed me the scar, just above the elbow. He wasn't absolutely certain as to whether eel bite was the cause, as he didn't start getting ill until some time later. Further, it was "just a small bite, only skin deep".

The skills of *gkru khmer* are well recognised at treating the bites of all kinds of poisonous animals that are found in Cambodia, including snakes, toads, and insects. SomBut had not consulted the *gkru khmer*, as his was not a case of poison. I pursued the issue of perceived venom, if any, of the eel subsequently with PolGkun, the *gkru khmer*:

Maybe it's *on'dtung cjuek* [bitten by an eel]...It is like snake bite...when danger arrives, it can be venomous [but] is not as powerful as snakes...Maybe it bit on a nerve, and that's why it is like that. But to say it is powerful like snakes, no, for if it had been as powerful as snakes, it would have been death from the beginning.

Although the *gkru khmer* knows how to treat the condition - "that would need *tnam rues*" (that is, medicine from the roots of certain trees) - he is not able to do so for several reasons. First, SomBut hadn't approached him, and as will be explained in Chapter 9, the power of a *gkru khmer's* treatment falls if he puts himself forward to treat someone. On top of this PolGkun does not have the necessary roots from which to prepare medicine. But he concluded by pointing out that:

With this I wouldn't dare...It is their country, it's an eel bite....don't say it is the same [as in Cambodia]. Only those who have learned would know [how to cure], those who didn't study wouldn't know. Maybe they can find a cure through experimentation...

PolGkun implied that even when the injury or illness seems similar, irrespective of whether it occurs in Cambodia or New Zealand, there are nonetheless significant differences attributed to the place, and as such it is the locally-trained healers who are best suited to treat the condition.

As time went by, SomBut began to reject the idea that eel bite was the cause, mainly as several months had elapsed before the onset of weakness. His explanation then shifted to an experience while being massaged by PolGkun's wife for back ache:

First, it was a sprain in my waist, and I went to [have a] *cjaab sor'sai* ["nerve" massage]. And after the *cjaab* [massage] it was *k'njaak* [a sensation of chill in the body]...perhaps it was...getting the wrong nerves or something...the nerves to the neck here...Let's just say it is not the eel bite. The back is better, but the arm start being weak...maybe that one comes from the nerve.

Although they described themselves as "used to *cjaab sor'sai*", it doesn't normally send shivers down the spine in the way it affected SomBut. Nor does the flesh twitch afterwards, as has been the case with SomBut; that is why he concluded that the problem is one of *sor'sai*.

Hospital clinicians also referred to nerves as the underlying problem. Thus SomBut and his doctors were in agreement on the term, but meant different thing by the concept "nerves". A medical cure was not available, however, which is somewhat

baffling in view of the wide range of physical techniques and Cambodian medicines available for problems involving *sor'sai*. SomBut's suspicion that *cjaab sor'sai* had caused his problem in the first place rules out the use of such techniques to treat his problem. Since Cambodian medicine was not available locally, SomBut considered borrowing money to travel to Cambodia, where he planned to consult a powerful *gkru khmer*. The difficulties in raising such a sum, together with SomBut's physical deterioration, led to his abandoning his dream. BoPa bemoans the family's bad fate. At the same time, the search for the underlying cause has taken SomBut and BoPa into spiritual explanations, a theme to be picked up below.

Theories about *sor'sai*, or "nerves", are commonly drawn on to explain illnesses and symptoms, and form a basis for a range of Cambodian healing techniques and remedies. As these accounts show, each individual episode is distinct, unlike a biomedical description of a disorder of, for example, a system of nerves, or an infectious disease. On the matter of the illness being caused by damaged, broken, or non-functioning nerves, it seems SomBut and the doctors, both Western and Cambodian, are agreed. Whether they all mean the same thing in this apparent agreement is less certain. The New Zealand doctors have established that the nerve connections between brain and limbs are not functioning, but as with Mrs Nhim, are not able to explain why this is so.

Cambodians' complaints about "nerves" are readily understood among members of the Cambodian community, in much the same way as "thinking too much" is understood as an expression of mental distress. The narratives presented portray a high level of agreement regarding the meaning of "nerves" among the older adults socialised in the traditional rural Cambodian culture. However, as the problem of "nerves" can somehow be altered through the experience of exile, and Cambodian medicine to treat "nerves" is unavailable, the community is limited in its ability to treat "nerve" problems. Cambodian refugees therefore bring their complaints to medical practitioners, who do not understand the culturally-embedded language of "nerves". Difficulties arise when the language is reconstrued in the anatomical sense by clinicians, giving rise to frustration and increased distress.

"Nerves" as a way of expressing illness has been widely described among societies as diverse as European, Anglo-Celtic, and Latin American. Lock (1989, p.83f) establishes a link between "nerves" and the Hippocratic philosophy that views health as reflecting a delicate balance between the four elements of wet and dry, hot and cold. In systematising medicine, Galen postulated that anatomical nerves (identified in his dissections) constituted the link between mind and body. Major threats to health in ancient Hellenistic medicine included climatic, seasonal, and environmental changes, all of which have been implicated by Cambodian refugees in the downturn of their own health. With the Hellenistic view of health having spread throughout Europe, the Middle East and into Asia, it is not surprising to see both a sensitivity to geographical change and problems with nerves emerging in this population of displaced Cambodians.

Lock (1989, p.85) goes on to describe "nerves" as "the non-verbal language of the powerless...only recently recognised as ubiquitously present throughout the world, and disparagingly termed somatization by the medical profession". When people present at health care settings complaining of "nerves", people who are often poor and marginalised, they are subjected to the reconfiguration of their symptoms into the language of biomedicine, which all too often concludes with a diagnosis of somatisation (Padgett and Johnson, 1990, p.208f). Alternatively, they are held psychologically responsible for the disarray of their nerves and resultant distress, as seems to be VuTy's experience. Although cross-cultural comparisons of "nerves" demonstrate variation in explanations of "nerves", common social characteristics across cultures are apparent. Sufferers of "nerves" are often socially and culturally isolated, as in the case of immigrants (Low, 1989, p.95).

"Nerves" provide a culturally recognised vehicle for expressing distress, and often it can be only when the family and community fail to respond to and relieve the underlying distress that medical help is resorted to (Lock, 1989, p.86f). It is apparent in the case of Mrs Nhim that her distress over her social and cultural dislocation, and the drift between her morality and that of her offspring, is not being picked up and resolved at the levels of her family and the Cambodian community. Rather, she is the

one being urged to accept what is perceived as the *kiwi* way that is so abhorrent to her, thereby adding to her existing emotional load and distress. Her attempts to make sense of her symptoms in the contexts of past illness experiences and exile, and given that Cambodian medicines able to treat "nerves" are both unavailable and inappropriate, reinforce her powerlessness and distress.

When the patient's way of expressing symptoms is reframed in the language of medical mystique or, as illustrated in VuTy's experience, dismissed as not conforming with disease theories, marginality is compounded. By taking seriously the patient's distress expressed in the medium of the body, argues Lock (1989, p.87), the clinician can enter more fully into the sufferer's world, enhancing healing by the very process of taking suffering seriously. A medical encounter which reaches beyond the presenting complaint is thus viewed as the most helpful feature of care for sufferers of "nerves" (Davis and Guarnaccia, 1989, p.6). Eisenbruch (1983, p.323) goes further in pointing out that in the absence of treating a patient in the framework of cultural beliefs, that treatment may be ultimately ineffective.

Spirits and Black Magic

While biomedical theories are limited in explaining some illnesses, such as those related to "nerves", so too are Cambodian theories, as when spirit-intervention as a possible cause for illness is invoked. In narrating their illness experiences, resettled Cambodians draw from natural perspectives on both causation and treatment. Biomedicine sits more or less comfortably with such perspectives. To a lesser extent, Cambodian refugees look to the spirit world to explain and treat illness (see Tran, 1981, p.54). In fact, in my study group, it was only in the cases of unaccountable deaths and very threatening illness that the generally quiescent spirit-related explanations emerged; otherwise, naturalistic diagnoses and treatment were adequate. Prior to settling in New Zealand, spirits as both causes of illness and means of healing were more widespread. Cambodian theories of illness are being displaced by the biomedical model characterising health care in New Zealand, and are becoming

less relevant in a place where both natural and locale-circumscribed spirit powers constitute little threat.

Generally, in the opinion of Cambodians in Palmerston North, the New Zealand context mitigates the power of malevolent forces, as ghosts and spirits are connected to particular geographical features and physical places. My occasional question as to whether spirits followed Cambodians to New Zealand was laughed at, as though I had suggested something absurd. There were times, however, when people avoided big trees, for example, saying that "ghosts live in trees". I was told that you can tell the presence of ghosts by a glimmering blue light, like that of a glow-worm, that briefly flickers. Although informants had witnessed this light in Cambodia, none had seen it in New Zealand. Some participants described their initial fear of ghosts populating New Zealand hospitals, as hospitals in Cambodia, as places where people died, were full of ghosts.

In view of the description by Eisenbruch and Handelman (1990, p.1296f) of multiple cultural explanations offered by the family of a sick boy, including bad fate, an angry ancestor spirit, and unmollified house spirits, I specifically searched for comparable explanations among participants. SomBut's petulant "master" spirit, whom he had long neglected, was the only instance in this study of spirit-caused illness in New Zealand (described below), and this explanation was resorted to only after other explanations had been exhausted. On the other hand, bewailing bad *gkam* and attributing illness to bad luck was more widespread. Even these theories are not resorted to in the first instance, however, but only in the event of a run of misfortune or serious threat.

The annual feeding of the ancestors of one's deceased family (through the intermediary of the monk) is regularly observed, and relates directly to protecting oneself and family from illness brought on by neglected ancestor spirits. This ceremony, known as *bon pjum buend* and held usually between August and September, is an occasion for giving ancestors food and goods needed to ease the journey of the soul. By so doing, the living guard themselves against the possibility

of being victims of neglected ghosts, usually through misfortune such as accident and illness. Judging by the growing number of families who do not participate in such community ceremonial events (see Chapter 6), it appears that fear of the resulting misfortune of illness is not immediate. Reflected in this, perhaps, is an abandonment of practices that were important in Cambodia, but which are perceived as inappropriate in the West.

There are, moreover, practical obstacles to the carrying out of this ceremony in all its traditional detail. Many of the old people who were repositories of family information died during Pol Pot's genocidal reign. On top of this, many families are now scattered throughout the world, so that necessary information is not held by all branches of the family. Many Cambodians simply do not know whether or not their family members are alive or dead, and many of their known dead experienced the most inauspicious of deaths, through execution, disappearance, and suicide, as well as starvation and illness, for whom the proper funerary rituals to set the soul of the deceased on its way safely could not be carried out. In the context of this unprecedented scale of death and overwhelming geographical and social displacement, the belief that neglected ancestor spirits cause illness must be modified if the mental, emotional, and spiritual well-being of survivors is to be safeguarded. My findings contrast with the experiences of Eisenbruch (1991) and Eisenbruch and Handelman (1990), who not only described cases of illness attributed at least in part to the mischief of ancestor spirits, but recommended participation in appropriate ceremonies as a means of protecting and restoring health, and draw from spirit-related illness in constructing an illness questionnaire (Eisenbruch, 1990, p.712f).[1]

Black magic, termed "black spirit", is another matter. The possibility of "black spirit", though remote, was nevertheless real, a view held by Cambodians in several cities, and affirmed by the monk. Even so, a fear of "black spirit" is neither prominent nor constant, but one that is revived only when there seems to be no alternative explanation for misfortune. Illness eventually attributed to black magic is at first treated as any other illness, but as explained by NeaRy, who claimed to be a victim of such malice while living in the camp, it is only after it doesn't respond

to treatment with Western or Cambodian medicine that the theory of "black spirit" is invoked. The scarcity of people in New Zealand able to both work and counter "black spirit", in a New Zealand social context characterised by disbelief in ghosts, spirits and magic, suggest that as an explanation of illness, "black spirit" is not of enduring significance.

The trends described above are illustrated in SomBut's experience. Faced with the information that he had a progressive, terminal disease for which there was no treatment, the family travelled to another city to consult a female *gkru* with a reputation for being able to discern the underlying cause of misfortune. She advised them that the problem lay with SomBut's "master" who had been neglected. The "master" was described to me as the spirit guardian that most male Cambodians have. Although the family have subsequently carried out the recommended ritual to appease the "master", SomBut did not improve.

This was not the first time that SomBut's family have looked for explanation and help from the spirit world. Some two years previously, within months of arriving in New Zealand, BoPa had developed profound muscle weakness and loss of sensation around the time of the birth of her child (described in Chapter 11). The child, who had been well, had a convulsion at about six months of age, was admitted to hospital, and a week later died in spite of life support. From the parent's account, prior to the child's death extensive investigations on both the baby and mother revealed "nothing wrong". I first heard of the baby's illness when I happened to be interviewing VuTaa. I have vivid memories of two grim-looking elderly folk entering the room, announcing that the child's condition was critical, news that subdued everyone present. Only two weeks previously the Cambodian community had buried a young man, and fears were expressed that there could be someone making "black spirit", fears that now began to be voiced again.

I had seen the young 27-year old man, SomDey, only once, a few days before he died. He was in the house of his step-father, Mr Chhum, waiting to be taken to the doctor. That day the house was full of sick people; VuTaa's daughter-in-law (Mr

Chhum's step-daughter) had just given birth to a child, and was resting. She was sleeping in the adjacent room in the very dishevelled fashion that is normal in the early post-delivery period. SomDey was lying on the couch, looking ill, very thin with sunken eyes, and a little jaundiced. And Mr Chhum, in the terminal stages of cancer, was trying to hold my attention, telling me that he needed an injection for his pain. SomDey had been ailing for a couple of months, but investigations had revealed no abnormalities. He was suffering pain, vomiting, extreme lassitude, and from time to time his body would swell up and become jaundiced. These symptoms were compared with *heum*, the last stages of starvation during the Pol Pot regime, when people went yellow, swelled up and died. As there is plenty of food in New Zealand, my informants reasoned, this present illness couldn't be *heum*.

The same day he was admitted to hospital, and died four days later. I was told that toward the end he "lost his mind"; he could neither speak nor understand *khmer* or English (in which he had been reasonably fluent). According to the family, no cause for death was found at autopsy, leaving questions as to why he had died. Not many weeks after SomDey's death, his step-father also died. Soon afterwards, the family moved away to another city. By moving away, they distanced themselves from the place of their bereavements. I was also informed that they had left out of fear of "black spirit".

There were several reasons put forward for SomDey's death. Buddhists, I was told, hold that each person has his or her fate, or *gkam*, and accordingly, it could simply be SomDey's fate to die young. It was also suggested that he had given up the ongoing struggle to survive and resettle, and that acquiring English was too great a struggle for him. Then, having fallen in love with a married woman, some suggested he had died of a "broken heart". This possibility had considerable support, and it also merged with the speculation about "black spirit". Perhaps a relative of the woman had paid someone to make "black spirit" and so caused his death? Perhaps the husband himself was responsible? There is little certainty and less consensus that "black spirit" can be carried out in New Zealand. The reported lack of organic cause for the unexpected death generated the question: "Then why did he die?" Answers

were varied, including social distress, Buddhist belief, and malicious spirits through a human agent. These accounts add to others described in this chapter, demonstrating that Cambodians view illness not only as an outcome of an agent such as a germ, but in its widest emotional, social and supernatural contexts.

In view of the discussion about "black spirit" surrounding SomDey's death, I wondered if Cambodians were thinking that the baby was also a victim of "black spirit". It seemed not as, I was told, "everyone loves babies and no-one would want to hurt them with black spirit". It was later suggested that the death of BoPa's baby was a result of jealousy. A family which should have supported BoPa's family had in fact been neglectful, expressing their jealousy of others who came to their aid by attacking the baby through "black spirit". BoPa related an interesting story, however. Her husband had a dream at the time of the baby's birth. In the dream a widow, an acquaintance of theirs, visited, weeping and pleading for her husband (born as the baby) to be returned. At first SomBut declined, but as she cried so hard and was so miserable, eventually he relented, stipulating only that she must wait a few months until he was bigger and stronger. When no cause for death was found, SomBut recalled his dream, and now believed that the widow had come to reclaim her husband.

Dreaming by Cambodians seems to be of a different order from that of Europeans. For example, some described seeing in a dream the final resting place of a near ancestor, information they did not naturally have, only to learn that this was indeed true when finally they located a family member who was there. In the case of SomDey, dreams also occurred, but this time after his death. His sister dreamed that he came to her while she was in the kitchen to get food; he appeared to an old woman to ask for clothes; and his mother dreamed that he pleaded with her that the family should be kind and good to one another, and stop their quarrelling. Being visited by the deceased in dreams is not uncommon.

Spirit-related explanations did not seem to comfort, or facilitate mourning. The suggestion that the baby had been claimed by his widow did not stop BoPa from

becoming ill with "thinking too much". SomDey's family moved away, distancing themselves from possible malevolent forces. For the Cambodian community, a search for explanation dominated conversations during the few weeks in which these two deaths occurred, but as far as I know, no firm conclusions were made. There are too many unknowns and uncertainties, particularly about the presence and power of workers of "black spirit" in New Zealand, and the multiplicity of changes that affect so many aspects of their lives. A similar search for supernatural explanations in the face of sudden, unexpected deaths has been reported among Lao in Seattle, explanations which also reflected a degree of both adaptation of traditional beliefs to fit the location, and uncertainty as to the likelihood of the phenomenon (Muecke, 1987, pp.277 ff).

Locality and Paradigms of Illness

Cambodian refugees in the main are making a straightforward transition to health care based on the biomedical model. There remain those whose illnesses elude a clear diagnosis and treatment, illnesses which threaten their enjoyment of life, physical and social functioning, and life itself. These Cambodians with seriously impaired health are in an invidious position, especially when symptoms coincide with neither recognised biomedical nor Cambodian disorders. Although my informants were well able to articulate their perceptions of what was the matter, drawing from a range of theories in doing so, it seems they are seldom invited to do so in the clinical context.

The intensity of social isolation and marginality related to settling in New Zealand is central to the refugee experience, and to that extent is a novel situation that demands novel ways of finding expression to their compound distress. When the underlying social and cultural dislocation remains unresolved, which frequently coincides with ill-health and poverty, symptoms of illness and distress may well become entwined and mutually compounding. The socially marginal location of such refugees is itself reflected in illness phenomena, illnesses which fit neither into biomedical nor Cambodian paradigms.

Whereas Western medicine was not accessible for most participants in Cambodia, it was coveted for its assumed potency. As the accepted form of health care in New Zealand, and the system perceived as best suited to "New Zealand" illnesses, Cambodian refugees have no hesitation in letting the family doctor and hospitals take over the treatment of their illnesses. While biomedicine successfully treats cases of illnesses that arise from identifiable organic disorders, it is limited in relieving symptoms expressed in Cambodian idiom. As this study has shown, Western medicine is demonstrably ill-equipped to care for Cambodian people suffering from "nerve"-related illness, from misfortune believed to result from "black spirit", and from symptoms said to be exacerbated by climatic and geographical change. The extensive literature on mental distress of refugees and the poor clinical track record in ameliorating their distress reported in such literature underscores the limitations of medicine in relation to entrenched illnesses. My findings raise questions as to why biomedicine, which has enjoyed huge successes and near universal support in respect to a wide range of diseases, is woefully inadequate in dealing with certain other serious, even life-threatening, illnesses.

A possible answer lies in the limitations in identifying underlying organic pathology, possibly a reflection of the state of development of diagnostic technology rather than an absence of organic abnormalities in the patient (eg Goldfield et al, 1988, p.2726). Secondly, the very unfamiliarity of Western doctors with Cambodian theories of illness, and with the ways in which symptoms are expressed, is a disadvantage in caring for Cambodian refugees whose illnesses do not conform with biomedical disease configurations.

The dominant metaphor of biomedicine views the body as a biochemical entity (Kirmayer, 1988, p.57). This biomedical metaphor contrasts with the Cambodian view that sees illness in its total environmental, historical and spiritual contexts, a view further elaborated in a description of Cambodian healing in the following chapter. This view is embedded in Cambodian culture, the traditional location of which is the geophysical region of Cambodia. As makers of culture, resettled Cambodians in the West are reworking the Cambodian cultural system of healing. As

I will show in the following chapters, a harking back to Cambodian village tradition, to alone explain and treat illness phenomena that seem to fall outside the biomedical paradigm, is of limited use to Cambodian refugees resettled in the West.

Conclusions

This study has demonstrated that Cambodians who have settled in New Zealand readily interact with the Western health care system of New Zealand. Even so, about a third of the study population for whom a medical diagnosis has been made and treatment to control symptoms provided, has not experienced cures, but lives with chronic disease or with distressing symptoms long-term. This includes those chronically poorly with the "problems of old age" and the sequelae of deprivation. Another third of the group involved in the study also suffer from severe and incapacitating illness, but the causes of these illnesses have seemingly not been established.

Common to all, both those who can be "cured" or at least effectively managed within the New Zealand health care system, and those for whom neither diagnosis nor treatment is forthcoming, there is a readiness to accept the biomedical explanations of their disorder. At the same time, in the light of physical and cultural contexts of their homeland, Cambodians draw from other theories which they add to biomedical explanations in making sense of their illnesses. The theory of "nerves" is strong, while that of spirit-related illness is less clear. Illnesses which may be like recognised Cambodian illnesses are thought to be altered in some way by the enormous physical and cultural changes to which Cambodian refugees have been subjected. "Thinking too much", though not itself an illness, is intertwined with illness in the experiences of many, the more so when they find difficulty in making sense of their symptoms, and in having symptoms understood and relieved.

The study portrays Cambodian refugees as people who view and interpret their illness experiences in the widest of contexts, described by past events and hardship, and

current vicissitudes. Cambodian sufferers draw from knowledge shaped by Cambodian cultural contexts, and from knowledge acquired in New Zealand. The phenomenon of living simultaneously in the multiple spaces and times described by their life journey, portrayed in Chapters 5 and 6, is reflected also in Cambodians' search for explanation and healing of their illnesses.

Although it is clear that alternative or complementary theories of illness are commonly held, from their accounts Cambodian patients seldom discuss their opinions with their doctors. As guests and newcomers to the country, as they see it, it is contingent upon them to fit in with the norms and expectations of New Zealand society. The health care system is one cultural and organisational system of their adopted country which Cambodian refugees must learn to negotiate. Their expectations and experiences in doing so are the subject of the following chapter.

Note:

- [1] Possible explanations as to why spirit-related illness is apparently less important in the Palmerston North community than in Cambodia, as well as in countries such as the United States where there are much larger Cambodian populations, is addressed again in Chapter 10.

The description of spirit-related illnesses is based entirely on the views and explanations of my informants, and does not purport to provide a definitive analysis of spirits and the spirit world. In view of the significance of the spirit world for illnesses for my informants in Cambodia, and for resettled Cambodian refugees elsewhere as described by Eisenbruch, it was important to refer to the subject in this thesis. Because spirits as an explanation of illness did not seem to feature as prominently as, say, "nerves", for the Palmerston North community, I did not develop a comprehensive analysis of the subject. Readers interested in the subject are referred to the following work: Ang Choulean (1986) *Les Etres Surnaturels dans la Religion Populaire Khmère*. Paris: Cedoreck.

Chapter 9

NAVIGATING NEW ZEALAND'S HEALTH CARE SYSTEM

Cambodian refugees who have settled in New Zealand appear to suffer a high level of poor health, in that a quarter of Palmerston North Cambodian households are affected as described in the previous chapter. The same high prevalence has been found by other researchers among refugees. Cambodians may express symptoms and explain illnesses in distinctive ways, ways not familiar to New Zealand clinicians, who reconstrue symptoms in the language of biomedicine. While in many cases Cambodian patients' illnesses can be explained biomedically, there are a number of sufferers who are advised that there is nothing wrong with them. The distress Cambodians complained of in the first place is in such cases compounded by their frustration that illnesses are not relieved by biomedicine.

This chapter focuses on the experiences of Cambodian refugees in relation to New Zealand's health care system. With the participants having lived mainly in rural Cambodia, few had had much prior experience with Western health care, other than clinics in refugee camps. The chapter begins with a description of the challenges posed by the influx of Southeast Asian refugees to biomedically based health care systems in the West. Initiatives described reflect the pluralistic health care system that characterised Cambodia prior to the Khmer Rouge regime. I then discuss how prior experience with *gkru khmer* healing practices and Western health care in Cambodia shaped expectations that resettled Cambodians have of health care in New Zealand. As it was predominantly Cambodian healing that was drawn on prior to resettlement, experiences and perceptions related to Cambodian healing are particularly significant. From a background of medical pluralism characterised by informality, being required to interact in New Zealand's highly organised health care system demands considerable adjustment of refugees. The misunderstandings that can arise are illustrated by an account of Mr Chhum's experiences in endeavouring to negotiate the health system.

I go on to discuss the orientation of refugees to the health care system, and describe

experiences of my informants in interacting with the health care system, first in relation to primary medical care, and then to hospitals. Effective health care is not only an outcome of the health care system and its professionals, but is dependent on communication, which for most ill Cambodian adults and their clinicians is complicated by their mutual reliance on interpreters. Patient behaviour and compliance with treatment regimens are regarded as critically important to treatment outcomes. I discuss these issues in the light of the social and cultural contexts of Cambodian patients. Encounters between Cambodians and their clinicians can be complicated by different ways of expressing pain, both non-verbally and descriptively. In this chapter I describe the interpretation of pain by Western clinicians with respect to Cambodian patients in Palmerston North.

I conclude by describing the relative disempowerment of resettled Cambodians in getting the health care they want, compared with their situation in pre-war Cambodia. The paradox is that while in New Zealand there is available the high quality, technologically sophisticated medical care Cambodians have always desired, they are heavily dependent on their family doctors for access to it. Such dependence was not part of their experience in purchasing health care prior to coming to New Zealand. In pre-war Cambodia multiple health care systems were readily available, and people could choose among them.

Health Care Delivery to Southeast Asian Refugees

Many of the published descriptions of Southeast Asian healing practices respond to the presence of refugees in the West. The importance and continued practice of medical pluralism has been well recognised in relation to Southeast Asian refugees resettling in the West, and indeed much of the descriptive information available has come out of studies of refugee health care. The impetus for this interest arose from observations that refugees tended to underutilise services, particularly mental health services, or inappropriately use clinical services. Underutilisation was widely held to reflect stigmatisation of mental illness and an associated somatisation (eg Nguyen,

1985, pp.274f). The effects of traditional theories of illness on utilisation patterns of American health care were empirically studied among the Tai Dam (Bell and Whiteford, 1987) and the Lao (Brainard and Zaharlick, 1989), These studies showed that traditional views both endure and undergo modification in the new environment.

In order to assist clinicians in better understanding their Southeast Asian patients, especially as clinical outcomes were often disappointing, a flurry of commentary articles describing illness beliefs and healing practices appeared (for example, Tung, 1980; Muecke, 1983 and 1983[b]; Boman and Edwards, 1984). A pattern of first applying self-care and traditional care was portrayed, and authors claimed that illness beliefs reflected several explanatory models, such as naturalistic, supernatural and humoral. Cambodians, like other Southeast Asian refugees, demonstrate an essential pragmatism, whereby a range of techniques, medicines and approaches to healing may be sequentially or simultaneously employed (Tung, 1980, p.57; Frye, 1991, p.39).

The practical application in clinical settings of knowledge about cultural backgrounds of patients, reflecting a concern to give culturally sensitive care, inspired other articles (Kinzie et al, 1980; Kinzie, 1989; Frye, 1990; Frye and McGill, 1993; Kemp, 1985; Schriever, 1990). In all these articles, the authors argue in favour of clinicians being aware of pluralistic beliefs and practices, so that Western medical care can be acceptable to the refugee patient. The above articles tend to ascribe general descriptions to all Southeast Asian refugees, irrespective of nationality and social class. Not only is the practice fallacious, but it risks stereotyping refugee patients.

While clinics specialising in the treatment of Southeast Asian refugees may employ workers from those ethnic groups (for example Kinzie et al, 1980), innovative therapeutic approaches which go further have also been described. By incorporating "traditional beliefs" into biomedical treatment, and merging Western with traditional approaches in clinical settings, medical pluralism can be actively supported, not simply tolerated. Such approaches have been successfully developed among Mien (Moore and Boehlein, 1991), and specific cases have been described in which

traditional explanations were incorporated into the management of Vietnamese and Cambodian patients (Eisenbruch, 1983 and 1990).

Medical Pluralism in Pre-Pol Pot Cambodia

The Cambodian system of healing is not featured in the few English language ethnographies of rural Cambodian society carried out prior to the 1970s. Some sources which do describe health services, such as Whitaker et al (1973), do so from a mainly biomedical perspective. Whitaker et al (1973) describe the situation immediately prior to the Pol Pot era. In 1971 there were 367 trained physicians and health officers, and 1,670 nurses (mainly men) available to the civilian population, working in thirteen hospitals concentrated in urban areas, and some fifteen rural health centres. There had been more; the development of Western health care services peaked around 1970, but with the outbreak of large-scale hostilities from March 1970, many hospital facilities were destroyed and training institutions closed down. Military hospitals were maintained for longer, but did not treat civilians even when their injuries were war-related. Added to this, there was an extreme shortage of pharmaceuticals available for government facilities especially from 1972 onward, because of Vietnamese incursions. With medical facilities and supplies deteriorating throughout the Pol Pot regime, Western health care was increasingly unavailable.

The pattern of weak infrastructure and a focus on Western-type health care is also reflected in recent reports on health care in post-war Cambodian society. For example, a WHO report on health conditions in Thai border camps focuses exclusively on diseases, mainly communicable diseases, and Western medical services (WHO, 1986, pp.13, 21). Describing health issues in Cambodia itself, recent reports highlight the fact that by 1979 clinical facilities were largely destroyed, and all but some 45-50 medical doctors had either died or left. Informal Western-type small medical businesses (pharmacies and lay injectors), and Cambodian healing practices, are not usually addressed (Curtis, 1990, p.141; UNHCR, 1991, pp.17f). A report by UNICEF (1990, pp.43 ff) also focuses exclusively on Western health care

in its discussion of health services, and attributes maternal and infant mortality to traditional birth attendant practices. The impression conveyed by these reports is one of grossly inadequate and underdeveloped health services, inaccessible to the rural majority.

According to my informants, Western medical services were provided in Cambodia through a structure of government-run district health centres and hospitals, ill-equipped, poorly staffed, and of low repute. Private hospitals and clinics of higher reputation were located in the capital Phnom Penh and major provincial cities, but were usually inaccessible to my informants. In spite of such experiences, there is no evidence that Cambodians object to having to rely on Western medicine. On the contrary, access to high quality medical care was something poor, rural Cambodians long aspired to. Western-type medicine was highly regarded in Cambodia, a regard which reflected the positive reputations of private hospitals and potent pharmaceuticals. Few outside of the cities had access to reliable hospital care, and while pharmaceuticals were available in some rural areas, they were not affordable to all. The reputations of "modern" hospitals and health care thereby evolved around the mystique of the unobtainable, of those services which were the preserve of the privileged.

Injections were then and still are held to be more potent than medicine taken by mouth, as they are believed to stay in the body longer and to be rapidly effective, faster than equivalent oral medications, and much faster than Cambodian medicines. In Cambodia it was possible to purchase injections and intravenous fluids directly, without prescription, which were then administered by one of the numerous lay injectors. Cambodians in New Zealand are frequently disappointed and frustrated when injections are not forthcoming, seeing this as an example of incompetent staff. This was illustrated when one person blamed disappointing service on the fact that the hospitals were "government", adding that if he had the money, he would go to a private clinic to be properly treated. The resultant sense of helplessness and dissatisfaction is conveyed in VuTy's remark: "We just want to find an injected medicine, just use once and it's cured...but when the doctor won't give... what can

we do?" VuTy was always sickly as a small child, nearly dying several times. In his mother's view, it was the large number of injections he had in the first years of his life which kept him alive, and indeed his mother explained that VuTy was quite well, both during the Pol Pot regime and the decade he spent in refugee camps, because the injections "stay in the body"). The rare occasions when Cambodian patients do receive injections reinforce the view that they are superior. VuTy claimed that each injection he has had in New Zealand for severe dizziness was immediately effective and lasted for several weeks. Similarly, VeasNa's chronic joint pain and headaches improved overall when an acute urinary tract infection was treated with injections.

A favouring of injections gave rise to village people learning the art of administering injections. Mr Nhim had been an injector while in Cambodia, having been taught by another lay injector to *cjaak tnam* [give an injection]. While Mr Nhim did not charge for this service, some grateful patients used to give him a small gift or payment in return. Sometimes he accompanied the patient to the *gkru bpat* [Western doctor, usually a nurse or medical auxiliary] to be examined, or he would purchase medicine directly. As a regular customer of the pharmacy, he could often get a discount on the medicine, further helping the patient. People such as VuTy, who were examined free in military hospitals, still needed to privately purchase prescribed medications and find a lay injector to administer the treatment.

In the environment characterising Cambodia, of uneven development of infrastructure and limited availability of Western-type services, entrepreneurs selling all manner of medicines flourished. In such unregulated, open environments, the sick person with purchasing power retains a high degree of control in buying expert care and medicines. The few who had formerly used Western medicine had tended to use it not as a unitary system of healing, but alongside Cambodian, Chinese, Vietnamese, and Thai medicine, a pattern which continued throughout their sojourn in refugee camps. Western pharmaceuticals were available mainly in pharmacies (the French term being widely used) and village shops. Cambodians could and did purchase

medicines without prescription, including antibiotics and all manner of injectables, often on the advice of a knowledgeable lay person or vendor. Sok was herself a small vendor after the war, going from village to village with her bundle of medicines, using a book on symptoms and their treatment to assist her in recommending medicines. Her medicines were "pure", she claimed, not of dubious origin nor mixed with a substance such as rice-flour to make them go further. The sources of such black market medicines were varied, including Thai, Vietnamese and Chinese products, and increasingly after the collapse of communism, products from the West.

My informants described how they used the rich pattern of medical pluralism, in which they drew from Cambodian, Thai, Chinese and Western approaches. Although the majority of those involved in the present study had had limited access to Western medical care in Cambodia, they were ignorant neither of its offerings nor of its potential. Most of my informants had been poor; Western medicines available in pharmacies were frequently too expensive to use as a first-line treatment, and hospitals too distant and costly to be accessed. Cambodian medicine had been the mainstay of treatment. There were exceptions; with his father being in the military, VuTy's family had access to military hospitals, as did Mrs Kev when married to her first husband, a soldier. With Mr Nhim being a lay injector, the Nhims employed Western pharmaceuticals and also used Cambodian medicine, depending on availability and the nature of the problem. Even the modern "New People" of the cities, who had formerly used only Western medicine, needed to rely on Cambodian medicine during the Pol Pot years when they were forced to live in the countryside with no access to hospital care. They dubbed this medicine "rabbit droppings" (*tnam acj dtun-sai*).

In the event of illness, normally self-care techniques would be tried in the first instance, unless the symptoms were severe or unfamiliar, in which case expert advice would be sought immediately. When availability and finances allowed, people could choose from among a range of treatment options, reflecting both Cambodian and Western approaches. The Cambodian *gkru khmer*, as the more ubiquitous and affordable type of healer, was used most frequently at the first level. A number of

participants commented that generally the *gkru khmer* was very effective in treating the illnesses of children but less so for adults. Lacking choice to do otherwise, even adults generally first approached a local *gkru khmer* for assistance. If the *gkru khmer's* treatment was at first not effective, the diagnosis would be reviewed and another treatment would be tried, and so on until the patient recovered. If the patient's condition remained poor, the next step was to go further afield to a more powerful *gkru khmer*, until such time as the illness was resolved one way or other. According to my informants, families were prepared to sell crops, livestock or land to finance traditional treatment, and if necessary, hospital care for a seriously ill family member who had not improved with Cambodian medicine.

To avoid having to pay out an unknown sum for Cambodian medicine from powerful *gkru khmer*, some people preferred to buy Cambodian medicine from vendors in a market, such medicine being of variable quality and efficacy. Usually Cambodian medicine sold in markets was non-specific such as steaming medicine or energy-boosting medicine; there was also medicine for specific complaints. Opinions of Western oral medications available over-the-counter are tainted by experiences with market-quality Cambodian medicine, possibly adequate if the ailment is minor, but of uncertain benefit. Because of the practice of buying and selling medicines, Sok and others often comment that "Cambodians are expert in treating illness", commonly sharing information and experiences. Having once been able to purchase and administer medicine independently, Cambodian refugees are frustrated by now being dependent on a doctor to prescribe.

During the years of civil war and communism, gold and gems became the unit of currency with which medicines, preferably injectables, were purchased. Published autobiographies (eg Yathay, 1987), and accounts of participants, portray a desperation for "injections" to treat the illnesses arising from extreme deprivation. However, as all forms of Western medicine became increasingly scarce, frequently such medicine was unobtainable even with gold. Some participants first encountered acupuncture during this period, the technique having been introduced by the Khmer Rouge regime as a way of dealing with shortages of medicine. Acupuncture was known as

"scientific needles", or alternatively, "injection without medicine".

The refugee camp clinics often provided the first continuous experience of Western health care. Although the supply of medicines was adequate, these clinics were portrayed by some participants as offering an uncaring service of low quality. In view of the apparently low reputation of Western-type hospitals and their staff in Thailand as well as in Cambodia, it is perhaps surprising that refugees' expectations of the New Zealand system are so high. Finkler (1991, p.221) raises a similar question with regard to Mexican biomedicine. In spite of there being little relationship between recovery from sickness expressed in non-biomedical terms, and medical intervention, the "aura of competence" of biomedicine persists among Mexican physicians and public alike. From the descriptions of my informants, Western medical practice in Cambodia bore little resemblance to its practice in New Zealand. (See also Finkler, 1991, for a critique on the purportedly universal practice of biomedicine.) Nevertheless, the expectations of Cambodian refugees of New Zealand medicine are shaped by their prior experience of Cambodian, Western and other offerings of medicine, that comprised the pluralistic system of healing of Cambodia.

There was little question about the effectiveness of Cambodian medicine, even by those who prior to the Pol Pot era had preferred to use Western treatment. Nevertheless, the effect of *tam* is slow. Oral pharmaceuticals are regarded as effective when the illness is moderate, but when a person is seriously ill they are considered inappropriate. It is largely because of the contrasting rapidity of action and ongoing effect that Western injectables are admired. To appreciate further the basis for these preferences, especially in view of disappointing experiences with Western treatment, it is necessary to explain the practice of Cambodian medicine.

The Practice of Cambodian Medicine

My principal informant on Cambodian medicine was Dta PolGkun, a *gkru khmer* of

renown. His account was augmented by the experiences of the participants.

Rural Cambodians view illness and its treatment in a total context of physical, social, and supernatural factors. In the Buddhist world-view, illness is but one form of suffering that is part of life, and to the extent that the acceptance of suffering denotes nonattachment, so the fact of illness is accepted. One elderly woman explained: "if we swallowed [medicine] and got better, it is better, but if not, then we just resign [ourselves] to our fate". In the first instance, Cambodians normally applied self-care techniques to relieve or avert illness. When symptoms didn't subside spontaneously or after the use of self-care techniques, the assistance of a *gkru khmer* was normally sought. Sok described the appropriate approach:

We must bring five candles and five sticks of incense, a bunch of bananas, five riel [coins]...something like that and ask: "Oh please, could you please come to my house and have a look at my son, he is very sick." That's the formal word...and if you want to give money, you can give the money later, if you think [the medicine] is good.

This standard votive offering, called *dtor'nueb*, made at the time of requesting help, connotes the ritual status of the Cambodian healer, one of many factors that distinguish *gkru khmer* from Western doctors. An analysis of these factors sheds light on the pattern of interaction with the biomedical system and expectations of Cambodian refugees who resettle in the West.

The term *gkru* literally means teacher or master, and includes: one who has knowledge and skills; one who treats or cures the sick; and one who commands respect for being calm. Plate 1 depicts the calm demeanour of *gkru*. The exact area of expertise is denoted by a descriptor, for example *lauk gkru* is a monk. *gkru khmer* occupy an important and often respected position within Cambodian society. In fact, this respect is accorded not only to *gkru khmer*, but also to *gkru bpat*, or Western-type "doctors", a term which included nurses and health auxiliaries, and local lay injectors. The New Zealand family doctor, therefore, slides relatively easily into the

category of *gkru*. There are, however, significant differences between Cambodian and Western-style practitioners. In spite of the view that local doctors are best suited to curing local disorders (see Chapter 8), beliefs based on prior experiences of healing continue to affect resettled Cambodians seeking health care in New Zealand.

There were two *gkru khmer* resident in Palmerston North, both of whom enjoyed a high reputation in their respective areas of expertise. Dta PolGkun [*dta* literally means "grandfather", and is also used as a term of respect when addressing old men], had been a monk for twenty-one years before leaving to marry. Having been a monk for so long, he is regarded as being indisputably "soft-hearted", using his arts only for good and not with intent to harm. In fact, Dta PolGkun explained that even though he knew some healing remedies before he entered the monastery, he seldom practised them while a monk because medicines can occasionally result in unintentional harm. The other, Mr Cjea, a pleasant-faced, white-haired man, claimed that he was especially skilled in curing children's diseases. In fact, he claimed to know what was the matter with BoPa's son who died at six months, and thinks he could have cured him had he been requested to do so, and if he had the necessary medicines. It was also reported that he had other powers, such as magic to make a person fall in love with another, and to make people jealous and hate one another.

Dta PolGkun still had with him raw ingredients he said were endowed with healing properties, including the bones, tusks, teeth, and other substances of animals (see Plate 1). To be effective, these products must be jungle animals, which feed on jungle plants. Dta PolGkun also had dried pieces of bark, roots, and fruits of trees, also gathered from the jungle. While the fragments of minerals and stones are usually from the jungle too, bits of shell and coral are from the ocean, also wild.

Tnam [medicine] is "scraped" by the *gkru khmer* into a powder, using a piece of flint. This process is known as *tnam d'os*. Once Dta PolGkun has ascertained what the patient needs, he would scrape the requisite quantity (usually very small) from a range of raw materials, giving the little packet of mixed powder to the patient to mix and swallow. Most commonly it is mixed with green coconut water, sometimes

with rice water, or occasionally with wine or simply fresh water, depending on the patient's illness and the *tnam d'os*. An alternative method is to boil the roots whole, usually several kinds, with the patient instructed to drink the often bitter concoction, add water and reboil, drink, and to repeat this until the "water tastes like water", or is *saab* [tasteless]. Generally three to four boilings are needed, and it is this method that was commonly described by my informants who had taken *tnam khmer* [Cambodian medicine]. Western medicine, in contrast, always comes ready-made, requiring little effort from the patient apart from taking it as instructed.

Dta PolGkun's explanation of the use of *tnam* illustrates both the world view underpinning the Cambodian system of healing, and the specialised knowledge required:

This is *tnam tro'cjeak* [cold, or cooling, medicine]. This one is *s'beng* [a kind of shrub], and when coughing they [scrape] this one...This one for the *dtoas* [illness after childbirth]...And look at this one, they are very small, but it is very good for *bpues* [poison]...That's hot, *tnam k'dav* [hot medicine] for the woman after "crossing the river"...Take one root of lemon tree, one root of lime tree, one root of *song'ke*, one root of a roseapple tree...these are all medicine...boil them in a new pot with fresh water, and drink to be cured...This one is energising medicine....And this one, it has a hundred uses for someone who knows how...That one is just to relieve the *aab preay* [spirits, ghosts], if they cause trouble they scrape this one to drink...

And so he continued, describing jungle plant products with medicinal properties, as well as exotic animal products such as "snail's teeth", cobra's heads, and bear gall-bladders. His descriptions ranged over conditions that sounded both familiar such as abscesses, and unfamiliar, such as ghost-related illness, *dtoas* and blistered testicles. As well as medicines to cure sickness, he described cool and hot medicines, and energising medicines.

These *tnam* are seldom administered without adding a "spirit word", whispered in Pali. One of the most significant differences between Western and Cambodian medicine is the "blowing" of the Pali word. The Pali word "wakes up" or "warms"

the medicine. Western doctors' ignorance of the technique accounts for the limited effectiveness of oral medications. This limitation does not hold true for injected medicine, for which there is no Cambodian equivalent.

It is like this. The *tnam bpat* [Western medicine] we just buy to swallow. If moderately ill, it may be effective...if very serious, not effective...If you take this *tnam d'os* [scraped medicine] you could swallow it, but it might not be effective, because the Pali, they *dus* [wake up, warm up] the medicine, or something like that...

Nevertheless, Cambodians will take *tnam khmer* without the Pali being blown, such as when they buy medicines in the market or from a vendor. Medicines from these sources are purchased usually when the illness is very minor, or to limit the level of payment. Such impersonal medicines are not considered highly potent, but are adequate for certain conditions. Hence the taking of Western medicine without "blowing" has its precedent. Certain minor complaints can also be treated with Pali alone, without the need for medicine, particularly in the case of the illnesses of children. Dta PolGkun is believed to be a particularly powerful *gkru khmer* because of his knowledge of Pali words (mastered when he was a monk), as well as of herbal healing arts. He is also able to give *s'raucj dtuek*, a ritual shower of holy water to bless or protect against bad luck or danger.

It is the responsibility of the *gkru khmer* to discover what is wrong by interpreting not only the symptoms, but also birth dates, fate, energy, or a combination of these. He also discerns whether the illness of the body has occurred "by itself", or was spirit-related, and if the latter, whether or not through a human intermediary. After the *dtor'nueb* is paid, the *gkru khmer* first gathers information on when the illness began, and looks at the horoscope of the person to see the "fate". On being consulted about SuBai's lingering glandular fever, Dta PolGkun's line of questioning was to establish birth year and date, so as to ascertain whether the illness was "by itself" [purely bodily] or "from outside" [spirit-related, or fate]. In SuBai's case, it was "by itself". In contrast to the *gkru khmer's* approach, the Western doctor asks only about symptoms and when these started. For instance I asked SomBut about his doctor's

response to his theory that eel-bite caused his illness. He explained that he hadn't discussed it with the doctor, as it was up to the doctor to find out what was wrong, not for the sick person to tell them what was wrong. SomBut's response directly reflects the relationship with and expectations of the *gkru khmer*, who is expected to discover the underlying cause of the malady.

Mr Cjea explained that if a sick child was born on a "bad" day he probably couldn't help. For instance, as BoPa's baby began to be sick on a "bad" day in relation to his time of birth, Mr Cjea knew that the child was in danger. He also described how he would initially administer a substance to discover whether the illness was caused by "black spirit" or was simply a physical disorder. If the former, the patient would vomit.

I asked Dta PolGkun how he would go about identifying the cause of the illness and its treatment if I approached him for help:

I would ask what the sickness [symptom] was: Why do you want medicine? What's wrong?...If [it was] headache, [I would] use the steaming medicine...[And did he look at the hand, or feel the pulses?]....There is no need. It depends on the patient, but if we really wanted to know, we would do that too....

By looking at the palm, he explained, he can interpret predispositions, such as wealth, the level of ease or hardship in a life, and how hard the person must work to survive, all of which affect the level of health. Combined with establishing age and birth date, this procedure is termed *preah dti-nairng* [foretelling according to the rules]. While the information obtained in this way does not provide a specific diagnosis, it does enable the *gkru khmer* to "know if this was a sick person". Feeling the pulses gives information about the level of energy in the person, with weak or irregular pulse volume (not pulse rate) indicating low energy. People with low energy are easily fatigued, best treated with medicine to boost the energy, and often have little interest in food. Those with low energy and a "difficult" life, with little return for much hard work, are not healthy people, and are prone to illness. It is not surprising, from this view, that so many Cambodian refugees, for whom life has been

exceptionally hard, see themselves as sick people. Indeed, many of my informants who complained of their hard lives, were low on energy, poor, and unwell.

The Western doctor, in contrast, engages in extensive history-taking about symptoms, and conducts thorough physical examinations, but seems to focus little attention on predisposition to illness. Once the *bpat* doctor has decided on the diagnosis, it was the impression of my informants that he or she will keep trying out different medicines until the patient is better, using a trial and error approach in finding the right medicine. In Cambodian medicine, if recovery doesn't follow the *gkru khmer* will conclude that it was the diagnosis that was wrong. Having reassessed the sufferer, the *gkru khmer* will give a different medicine appropriate for the revised diagnosis. From the very broad view of illness in the Cambodian world view, it is clear that the possibilities and combinations of explanation are limitless. The distinction between the *gkru khmer* and New Zealand doctors was explained by Dta PolGkun:

It is different. We get them [the sick person] to swallow [the medicine], and if they get better then that's it! It was that sickness! If not better, the sickness is wrong... The *bpat* here, if swallow and not right, then: "Oh! it's because of the medicine, wrong medicine!" That's the *bpat* in New Zealand...For us, if we could not fix the problem, we would go and find another *gkru khmer* who knows better than us. There are *gkru khmer*, and there are *bpat* here too, [with] lower levels and higher levels [of power, specialisation].

Knowledge of *tam*, Pali and other healing techniques is usually an oral tradition, learned by a man from his father or another senior male relative. Dta PolGkun, however, had in his possession a very old book in which his grandfather, and his grandfather before him, had recorded recipes, information on materials with medicinal properties, and details about the relationships between the alignment of the stars and the correct dates, times and methods for collecting such materials. Plate 2 depicts information recorded in Dta PolGkun's book. From the detailed information he described, it was obvious that a relatively ignorant *gkru khmer*, who would not know the intricacies of *tam*, might administer medicine that was relatively

ineffective. Furthermore, herein lay an explanation as to why resettled Cambodians showed little interest in obtaining such materials through knowledgeable people visiting Cambodia. The materials purchased might not be collected from the proper source in the correct way.

gkru khmer employ techniques other than medicines and Pali, notably moxibustion, or *oucj*. On small patches of material, prepared from a coconut or similar palm, a plug of "wool" scraped from bamboo or a particular kind of soft wood is placed. These are termed *bpoj*, and are placed on the appropriate area of the body. The *bpoj* are then lit, and smoulder until burnt away. Sok described her own experience of being "burnt" to cure a "sore tummy", during the Khmer Rouge period when medicine was unavailable. The *gkru khmer* measured from the reference point of the navel using his fingers and a length of string, marking off six points. The scars remain. *oucj* was described as "a kind of *gkru khmer*". Mrs Nhim explained that when she has a headache which Western medicine couldn't relieve, even now she would get a *gkru khmer* to "put three *bpoj* in the middle of my head, here..", which effectively rid her of her pain and dizziness.

Dta PolGkun explained that *oucj* was used for non-specific symptoms, such as tired and aching joints, severe headache, and vague abdominal pain. He himself applied moxibustion, and the book he had from his grandfather included a number of diagrams showing the methods of application (see Plate 2). Like acupuncture, each disorder has its specific points such as between the shoulder blades, on the head, around the navel, and so on, which don't necessarily coincide with the bodily site of pain. For example, for abdominal pain burning should be done where the arm flexes. From Dta's explanation, the practice of moxibustion is related to theories of "nerves", with the *bpoj* being placed over the "nerves" to treat the specific malady. Knowledge and skill is needed, as he explained.

Like the *bpat*, like those who are skilled at *oucj*. For example, if we *oucj* the tired and painful joints, [we] extend like this, hold and probe here, never miss...for headache, they measure around the head and from the mouth...But everyone is afraid, maybe *oucj* on

the nerves, and it would damage. But it is not like that, [there are] the *kbon* [rules]...

The "rules" included detailed descriptions on which parts of the body could be treated on which days, with for instance Thursday being avoided to treat the hands and arms. Tuesday is a bad day for any *oucj*, as "Tuesday is fire", and a scar would take too long to heal.

Oucj was used frequently during the Khmer Rouge regime, partly because of the scarcity and expense of Western medicine, and to promote the revival of *khmer* culture. I was informed it was also used as a punishment for alleged malingering, and to discourage such practices. Moxibustion was likened to acupuncture, a form of treatment widely available in New Zealand. Both techniques were probably introduced from China, moxibustion possibly along with the establishment of Chinese communities in Cambodia, and acupuncture in the time of the Khmer Rouge. Related techniques of acupressure and treating by pulses is similarly practised in the Chinese and Cambodian medical systems. Dta PolGkun described the technique:

Here (written in the book) they are talking about dizziness, fever, pain in the hip, arms and legs. They are talking about *cjub'cjo* [treating by applying pressure to the pulses]. In this case, they say how to press the pulses...Sunday, the pulses are on the head, Monday on the tongue, Tuesday on the jaw, Wednesday on the stomach, Thursday on the arm, Friday on the knee, Saturday on the leg...they do it like that, treating with pulses...

While the exploration of origins and comparisons between healing practices described by New Zealand Cambodians and similar practices found in other societies is beyond the scope of this study, Tung (1980) traces to Chinese medicine some of the beliefs and practices of Vietnamese refugees. Documentation of moxibustion in China goes back more than two thousand years. The practice is based upon the theory of "systematic correspondence" (Unschuld, 1985, p.93f). In its simplest, this theory states that there is correspondence between visible phenomena (bodily) and invisible (eg natural balance, demonic, Yin-Yang, and energy or *ch'i*). Manipulation of the visible elements influence the invisible, thereby restoring health (Unschuld, 1985,

p.52). Moxibustion is one of a range of related techniques, including cupping and acupuncture, all of which were described by participants. Moxibustion in particular stimulates *ch'i*, and is thus a general rather than specific healing technique, reflected in Dta PolGkun's explanation that *oucj* is carried out for non-specific ill-health.

The more skilled *gkru khmer* practice healing on the basis of more than one paradigm of illness. This contrasts with Western doctors whose practice is traditionally based on the unified biomedical paradigm, although in recent years, some doctors have added acupuncture to their range of treatment approaches. Cambodians are acquainted with a wide range of approaches and techniques of healing practised by *gkru khmer*, even though they may not understand the theories explaining the practices. From their accounts, Cambodians readily accepted acupuncture when it was introduced during the 1970s, and were willing to try new kinds of medicine and treatment that subsequently became available, such as Vietnamese and Thai medicine. Such prior experience renders Cambodians open to adding still other methods of healing to their already varied arsenal, practices which are found in the countries in which refugees have settled. In many such countries, though, the formal health care system is strongly biomedically based, a factor which constrains the openness of Cambodians to diverse healing practices.

Respected and feared for their learning and power, *gkru khmer* were almost always men. The Pali words have power to heal and to harm. There are the "deceiving *gkru*" who work "black spirit" as well as sell fake medicine, and "greedy *gkru*" who will frighten people into requesting their services as Dta PolGkun explained:

It is like if you were moderately sick, but they claimed that you must not leave this any longer: "You are under someone's spell...would just soon die"...You are afraid of death, *pey* [fright], get more sick. So you give more, and say: "Please, oh please, cure me from this sickness, I will give you five hundred, one thousand riel". That is the crooks. The majority just ask [according to the rule].

In contrast, the "soft-hearted" will look after people for no additional money. The difficulty for the Cambodians is that the fake medicine looks real, and they have no

way of telling apart the deceivers and the genuine. The main protection for sick Cambodians is the expectation that *gkru khmer* refrain from pushing themselves forward, but assist only when asked.

Very occasionally a single *gkru khmer* will both make people ill through "black spirit" and then get them well again through genuine medicine with Pali, thus getting double returns! This uncertainty about the moral status of a *gkru khmer* arises when an unexplained death or other misfortune revives suspicions about "black spirit". "Black spirit" relies on the intermediary of a person with supernatural power, usually a *gkru khmer*. Although *gkru khmer* can be implicated in causing illness, Cambodians are also reliant on *gkru khmer* to avert misfortune.

Not only do *gkru khmer* differ in the kinds of sickness they are especially good at curing, but they vary in their method of healing. Some become possessed by a spirit which reveals the cause of the sickness. It was one such *gkru khmer*, in this case a woman, who advised SomBut that his illness was caused by an offended "master" spirit. Her diagnosis was affirmed by a second *gkru khmer*, a man who relied on the horoscope and reading the palm, who went on to confirm suspicions held by SomBut's family that SomBut was a victim of "black spirit".

Contrasts between *gkru khmer* and Western Doctors

Whereas the *gkru khmer* is normally someone well-known to sufferers, often a rice farmer like themselves, the family doctor is from a different social world who needs to be approached in his office, not in his house or in the fields. The position occupied by *gkru khmer* is intimately related to the total social, cultural and ritual system in a qualitatively different way from Western-style health workers in Cambodia. The latter occupy a peripheral place in relationship to society, a resource to be called on only for treatment, while *gkru khmer* have spiritual powers as well as healing skills, to be drawn on for a range of functions. This gives rise to an

element of uncertainty as to whether the *gkru khmer* is working for harm or good, or both, whereas the *bpat* is morally neutral. At worst the *bpat* may be perceived as not being thorough or caring, but not as potentially using power for harm.

Like New Zealand doctors, *gkru khmer* develop reputations in treating particular disorders, with some having several such specialities. However, a *gkru khmer* may not brag about his abilities and powers; that is for his satisfied patients to do. Mr Cjea had a reputation for curing children and for love magic, while informants described *gkru khmer* in Cambodia with reputations for curing snake-bite, protecting from certain hazards, curing the condition known as *dtoas*, and so on. Dta PolGkun is approached by resettled Cambodians from as far away as the United States for his assistance. Unlike New Zealand doctors whose specialist reputations are largely derived from their education and professional association, *gkru khmer* acquire reputations from their practical expertise, and as their growing reputation draws patients to them from ever further away, so their skill improves.

Although both *gkru khmer* and the family doctor expect the patient to request help, there the similarity in approach ends. For Cambodian medicine to be effective, the sick person must approach the *gkru khmer*, as he himself can spoil the power of his medicine if he volunteers to help. Coming forward is regarded as tantamount to bragging. For the same reason, a *gkru khmer* may not request payment; to do so when administering the medicine spoils the power of the *tnam*. As Dta PolGkun pointed out, although it is against the *kbon* [rules] to demand such rewards, there are those who do so after recovery has occurred. The practice of the family doctor demanding a set fee, viewed in the perspective of Cambodian medicine, risks neutralising the efficacy of his medicine. However, a fee was also demanded in Western medical facilities in Cambodia, including the pharmacies, without apparently destroying its efficacy, clearly setting Western medicine in a category apart from Cambodian medicine even in Cambodia.

The importance of being honest and direct with patients about their outlook is an accepted practice in Western medicine. Dta PolGkun suggested that to do so is

inappropriate for Cambodian patients, a practice he described as "transferring the word". He gave the example of a snake-bite, pointing out that if a victim knew he had been bitten by a snake, he may become critically ill. A wise *gkru khmer* might tell him not to worry; by assuring him that a creature other than a snake was responsible, he might strengthen the person's ability to recover. He put it like this:

Some *gkru* know that. The person is sick to die [to the point of death], but they say: "Oh not to worry, you'll be alright!" So the feeling [or mind] of the person becomes clear [better]...seems to give some energy...what they say is effective [good]...

A *gkru khmer* of Dta PolGkun's calibre demonstrates a depth of understanding of the relationship between illness and the person's psyche, in the context of life events.

In New Zealand there are some Cambodians who regard the *gkru khmer* as the practitioner of choice for certain disorders of children, especially skin disorders such as abscesses. Dta PolGkun has been consulted by people as far distant as Wellington and Hamilton to have their children's abscesses cured. His technique is less traumatic than the surgical drainage used in Western medicine, and healing more rapid. His expertise in treating shingles was also recognised and called upon by several people. Generally in New Zealand, however, the *gkru khmer* treatment is considered inappropriate for local conditions and illnesses, and the family doctor displaces him as the practitioner of choice.

Clinics treating large numbers of Cambodian refugees (and other Southeast Asian refugees) promote the practice of incorporating "traditional healers" into multidisciplinary teams. My findings show that *gkru khmer* are not a homogeneous group of healers, neither morally nor in level of skill. Furthermore, *gkru khmer* are not necessarily trustworthy. The variation among *gkru khmer* has important implications for attempts to combine Cambodian healing with biomedicine. In addition, Cambodian and biomedical theories of illness diverge in important respects. My informants portrayed a holistic view of health in relation to fate and predisposition at birth, and of illness reflecting general energy, the hardness of life, and spiritual forces.

Cambodians are aware of the variability among *gkru khmer*. Cambodian refugees who perceive the Western doctor to be either morally suspect or professionally incompetent are neither shocked nor greatly surprised. However, their ability to abandon that doctor in favour of another, as they would a suspect *gkru khmer*, is compromised both by their vulnerability as refugees, as guests in the country, and by the formality entailed in transferring to another doctor. In Cambodia a person was not registered with a health practitioner of any kind. A sufferer who consulted a *gkru khmer* would have no sense of obligation to remain loyal to that *gkru khmer*, nor even with Cambodian medicine. Rather, the sufferer would go from one to the next, from Cambodian medicine to Western injections, until a cure was effected.

The variable power of *gkru khmer* and different competence of Western-style doctors in Cambodia continues to shape the impressions Cambodians have of New Zealand health care. Commenting on SomBut's progressive, untreatable illness, a friend mused that: "it is hard to understand...the doctors in this city are not very clever with finding out the sickness". He went on to cite other Cambodians whose illnesses were not diagnosed or cured, conveying his disappointed expectation that New Zealand doctors would be superior.

Whereas once Cambodians could directly purchase the kinds of medicine considered as potent and administer it themselves, they are now locked into an unfamiliar system and dependent on the willingness of their doctor to comply with their requests, which by most accounts seldom occurs. On the other hand, they now have available to them the level of hospital care which once was the prerogative of their wealthy countrymen, and for this they are grateful. Paradoxically, in a Western-type health care system which in New Zealand is indisputably superior to its equivalent in Cambodia, the users have far less power to use its technology to meet their requirements.

Cambodians settling in New Zealand therefore need to adjust not only to a formal health care system that is based on a different theory regarding health and illness, but is also delivered in a very different manner. In combination, these differences put the

Cambodian users in a particularly powerless position. The previous knowledge and experiences of Cambodians, together with their ability to seek expert help independently, is exchanged for a position of unavoidable reliance on the family doctor. While for recognised biomedical disorders this reliance works well, it is not the case when their illnesses fall outside the scope of biomedicine. At this point Cambodians' existing distress from their symptoms is compounded by their powerlessness within the health care system.

Whereas in Cambodia the sick were able to directly access help from increasingly powerful practitioners, in New Zealand they are totally dependent on the family doctor to refer them to hospitals and specialists of higher repute for the illnesses afflicting them. This structure in New Zealand is known as the "gatekeeper" role, long the prerogative of general practitioners. In Cambodia there were no gatekeepers in any point of the health care system, and sufferers were able to select from among a wide range of practitioners and systems in their quest for healing.

Mr Chhum's Experiences

Coming from the background described demands major adjustments in making the transition from an unregulated health care system, characterised by medical pluralism and dominated by traditional Cambodian healing, to New Zealand's highly regulated, biomedically based system. While most Cambodians make the transition successfully, there are those whose suffering is compounded by difficulties. One such is Mr Chhum, a middle-aged man who had spent over ten years in a refugee camp. From the time of his arrival in New Zealand until his death some three years later, his life was dominated by serious, terminal illness. It follows that he came into frequent contact with the health care system, an interaction which was unsatisfactory for all parties.

Mr Chhum's family did not appear to be managing either the illness itself or the treatment regimen, nor were they particularly supportive of Mr Chhum. There was

not a great deal of support forthcoming from the wider Cambodian community, and the Chhum's sponsors had given up on them. The Chhums were described to me as a "bad" refugee family, giving the Cambodian community a poor reputation by exhibiting such behaviour as domestic violence, gambling, bad debts, and showing little appreciation for assistance given them. It seemed that the lack of good-will toward them and resulting isolation added to their difficulties in managing painful, terminal illness. So it was that I was drawn in to a greater degree of involvement than for most who participated in this study. At their request, I accompanied the Chhums on visits to the family doctor in order to help them understand what he said. Thus I became acquainted with the clinicians' frustration in trying to care for Mr Chhum, who neither spoke nor understood English, who sometimes took no one capable of interpreting, seldom followed instructions, and failed to keep appointments.

I didn't learn much about his pre-migration life, as he was pre-occupied with his illness and pain. He lived with the family of his second wife, and on the several occasions when he left or was kicked out by his wife's family, he would move in with his son's family on the other side of town. Like all refugees, Mr Chhum had a thorough medical check on arrival, and as the chest x-ray was abnormal, he was promptly admitted to hospital. Mr Chhum was found to have both tuberculosis and cancer of the lung, and on being shown the x-rays was informed that he had a "very bad spot" that needed to be removed. He admitted to having had occasional chest pain for some ten years or so, but because the pain was mild, he declined the surgery offered to him. However, Mr Chhum was advised that unless he had the operation, he would not be permitted to leave to rejoin his family, the reason being that he needed to be "clean" so as not to pass germs to *kiwis*. The impression that refugees needed to be "clean" was common, arising from the initial medical examination, and accompanied by a perceived compulsion to undergo treatment.

So it was that within a month of his arrival in New Zealand, Mr Chhum underwent chest surgery for the removal of the affected part of his lung. He could neither speak nor understand English, and all communication, including giving informed consent

for treatment, took place through an interpreter. The interpreter, however, was not available for 24 hours per day, leaving him isolated for much of the time. He described his extreme fears that he might die alone in a strange country, in a hospital that was "too" quiet, with only his "thinking" filling the silence until he feared he would go out of his mind. In considerable pain and breathlessness, he was unable to articulate his distress. It was only after surgery that the family found out that he had cancer, a condition that is known in Cambodia, and which they seemed to accept very philosophically. For them, the unusual aspect about his disease was that in Cambodia they had only ever heard of cancer on the "outside" of the body, not on the "inside" as in his case.

Since the operation, he was wheezy, a symptom not present prior to surgery, and pain in the area of surgery steadily increased. As the family had the impression that the operation had cured him, they were bewildered as to why he continued to have worsening symptoms. During the few months of my acquaintance, Mr Chhum's overriding concern was with constant pain, declaring that he would rather be dead than suffer unrelieved pain. He couldn't sleep, and took to wandering about the house when the pain got too bad. He could cope with being short of breath, he claimed, but not with the pain. Mr Chhum had engendered considerable frustration with his family doctor and specialist consultants over failure to keep appointments and to ensure continuity of interpreters. A specialist refused to see Mr Chhum again until competent interpreting was arranged. By this time, Mr Chhum's metastatic cancer was causing him a great deal of pain, which his doctor was endeavouring to control.

Mr Chhum's doctors had arranged a course of palliative radiotherapy for the painful bone cancer. The doctor was puzzled and irritated when Mr Chhum failed to complete the course. Later, the doctor attempted to control pain through oral morphine. Mr Chhum had decided that a liquid was simply not strong enough, and the doctor's efforts to control pain were also frustrated when Mr Chhum did not record the doses required to control pain, and then let himself run out of the mixture altogether by failing to keep an appointment. The reason for this became clear when Mr Chhum explained that he had received an appointment to attend a hospital

specialist the same week. Some weeks earlier the specialist had administered an injection (a nerve block) which gave Mr Chhum the most comfortable period since surgery. Mr Chhum was vying for a repeat injection. In his view, the specialist and his treatment was superior to the family doctor, and as it made no sense to him to go to both in one week, he chose to see the one he regarded as the better. Mr Chhum's earlier failure to complete a course of palliative radiotherapy was explained by the fact that he had received no further appointments to "x-ray". Having understood neither the purpose nor nature of the various techniques, his apparent non-compliance reflects an inability to negotiate the health care system, and misinterpretations arising from seeing the New Zealand system through Cambodian eyes.

Over the following few months, Mr Chhum's medications were slowly sorted out, and his pain reduced to a more bearable level. Even then he still complained that the oral medications for relieving pain were not very good, as they didn't at the same time cure his productive cough. Not understanding the uses of his various medications and the regimens for each, Mr Chhum continued to take them in a haphazard manner with dire consequences. Failing to take with food one type of medication that is irritating to the gut, he had an intestinal bleed. He accidentally overdosed on others, not spacing them as advised and taking extra when his pain increased. Muddling his medication resulted in his "losing the mind", necessitating admission to hospital. However, staying in hospital aggravated his precarious mental state, as it was "too quiet" and lonely in hospital, and with no-one to converse with, he began "thinking too much". Not long afterwards Mr Chhum died, thus ending his few years in New Zealand, years that were dominated by illness, misery, severe pain and social isolation.

The Chhums were unusual among Cambodians in their seemingly haphazard pattern of using the health system and of following instructions. Generally people know exactly when their appointments are due, and follow instructions faithfully. Mr Chhum's experience of being left alone while in hospital contrasts with those of others, who had company for much of the time. It was only at his funeral that people

rallied around to fill out the quiet and loneliness of the bereaved home with their laughter and talk. Even here, the family were subjected to criticism, that they did not fulfil customary roles of feeding the guests, but let the guests do all the work of hospitality. The picture is an unhappy one of a displaced, dysfunctional family that has lost touch with normative mores of their own culture, while failing to take on those of the new culture. Lacking both internal resources and external support to cope with a serious illness and death in an unfamiliar place, Mr Chhum died a painful and lonely death. Mr Chhum's undue gratitude to me as "the first person who asked him about his illness" had a note of pathos about it, underscoring the extent to which his New Zealand life was bound up with his illness and his isolation within it.

An Introduction to New Zealand's Health Care System

It is to prevent such situations as Mr Chhum's developing that refugees are introduced on arrival in New Zealand to the way the health care system works. Not only are all refugees subjected immediately to thorough medical examinations, including x-rays and tests of body fluids, but they are also instructed on how to use the health care system of New Zealand. "Health" as a principal focus of the orientation programme provided by the Immigration Reception Centre at Mangere (Guillaine, 1991), is clearly seen that way by the refugees themselves. Refugees are orientated to the formal health care system, a system that is distinctly monocultural, and reflects the dominant Anglo-Celtic sector of non-Maori society.

New Zealand's health care system is characterised by medical care being provided at primary, secondary and tertiary levels. Primary medical care is provided by general practitioners, also known as family doctors, who practice privately in community settings. General practitioners' services are offered for a set fee, a fee subsidised by the Government as a way of targeting assistance. New Zealand residents are encouraged to register with a general practitioner of their choice, thus ensuring continuity of care. General practitioners are described as "gatekeepers" of the health system, controlling access to other services including: diagnostic techniques,

pharmaceuticals, specialist and hospital services, continuing care and home support, and certain social welfare benefits. It is something of a paradox that general practitioners, who are private practitioners, exercise such a level of control over access to the public sector. Similarly, general practitioners exercise control over personal purchasing by patients of most pharmaceuticals through prescribing, although an increasing range of pharmaceuticals is available over-the-counter.

The combination of clinical examinations and an emphasis on health services in their orientation to New Zealand establishes a view that health is of major importance in New Zealand society. From the start it was impressed on Cambodian refugees that they must register with a family doctor, may not purchase medications without prescription as was possible in Asia, and need to comply with medical instructions. In the light of Cambodians' experiences under Pol Pot and then in refugee camps, where non-compliance frequently carried very high risks of recriminations and even execution, there are understandable anxieties if the "rules" are not obeyed. Particular fears were expressed about "getting into trouble" if Cambodian healing techniques were practised, raised by both *gkru khmer* and *chmorb*, as well as in relation to certain self-care practices. Cambodians insisted that they are happy to fit in with the "hospital rules".

Refugees are advised that the family doctor is a first port of call for health problems, which, as has been argued in the previous chapter, may not fit the biomedical disorders family doctors are equipped to deal with. With the general practitioner being a critical person in refugees' adjustment to New Zealand, it is significant that the Cambodians themselves did not choose their doctors. It is stated in the "Manual for Refugee Sponsorship" (Crosland, 1991, p.13) that "it is necessary [for sponsors] to register your family with the local doctor". All participants described how this was done on their behalf, and that medical records from Mangere were forwarded via the sponsors to the family doctors selected for them. Commonly, new arrivals would be registered with the doctor of relatives already settled. Other than that, refugee families were widely distributed among local general practitioners who agreed to accept them, according to the preference of sponsors.

Experiences with Primary Medical Care

The system of primary medical care, with a family doctor providing continuity of first-contact care, is not practised in Cambodia. Even for those few who had used Western medicine, the family doctor was a new experience. Cambodian refugees needed, therefore, to learn to use family doctors appropriately, and in this sponsors become their tutors, validating whether a visit to the doctor was in fact warranted. Cambodians may have little personal control not only in the initial selection, but also in developing a pattern of use of their family doctor.

The distinctive ways with which Cambodians express their complaints have been described in Chapter 8, complaints which the family doctor can often do little to relieve once organic disorders have been ruled out. Frequently in these cases the family doctor becomes the object of refugees' frustration. Perceptions are that the doctor is uncaring, that he or she "just looks quickly", but doesn't adequately examine the person. "If we had the money", said VeasNa's husband, "we would take her to a private doctor to be properly examined", suggesting that family doctors are perceived as "public", or "government", and therefore of inferior standard. Yet the narratives indicate that initially a range of investigations is carried out in response to the patient's reported symptoms, and only when nothing abnormal shows up and symptoms continue along the same lines do doctors resort to "looking quickly" and reassuring the patient that "nothing is wrong".

The second frustration is related to difficulties in getting the form of treatment wanted, that is, injections, or at the very least a prescription. Fearful of provoking anger if they challenged or argued with their doctors, Cambodian refugee patients, already suffering distressing symptoms, endured the added distress of being unable to get the treatment preferred. Some Cambodians accepted the doctor's opinion that there was no treatment available, a verdict which fitted their own view that New Zealand medicine was not suitable for "Cambodian illness". At the same time, the powerlessness of Cambodians to obtain appropriate treatment was aggravated, compounding their burden of suffering.

Some participants were simultaneously highly dissatisfied with their doctor because "the medicines don't work", and defended the doctor, asserting that "he worries very much about me, he's very good" because of repeated investigations and experimenting with different medications. Although a number of participants expressed varying degrees of dissatisfaction with their doctors, only two had actually changed to a new doctor, perhaps a reflection of their ambivalence and dependence. A man who switched doctors after having been "just given pills and never treated" for several years declared his new doctor to be *dol so!* [thorough] in his history-taking and examination. A young woman with tuberculosis left the first doctor with the backing of her sponsor, after he lost all her medical records. He had frequently kept her waiting while other patients came and went, giving her the impression that "he wasn't interested in me".

The need to wait for excessive lengths of time was a common complaint. On one such occasion, when an interpreter and myself accompanied the patient, we waited for almost an hour past the patient's appointment. It so happened that other family members had appointments some forty-five minutes later, and according to the receptionist, the doctor had decided to see them together. It is often the case with Cambodians that a delayed appointment affects not only the patient but also the interpreter, and sometimes a driver. From the doctor's point of view, while at least some of the waiting patients need only the briefest of consultations, Cambodian patients need longer, because of the need to work through an interpreter and to translate mutually unfamiliar terms and concepts, as well as to ensure that instructions are clear.

Paying a fee for the consultation seemed neither to be resented nor to pose a barrier to access. As beneficiaries, most participants attracted subsidies, which kept the direct charge low. Complaints about fees tended to reflect dissatisfaction with the consultation rather than with the fee itself, together with frustration about their dependence on the doctor for access to desired treatment. High levels of satisfaction with the family doctor largely reflected positive medical encounters, in which sufferers' complaints were listened to, thorough examinations undertaken, the nature

of the complaint discussed fully, and the doctor perceived as being caring, understanding and supportive. Arranging investigations and referrals, and furnishing certificates and letters for work-related injury and sick leave, were all viewed favourably. Above all, a compassionate approach was valued, as in the case of BoPa's family when their doctor repeatedly sat with her, asking what was troubling her, and extending assistance beyond the prescribing of medicine:

Sok: The doctor give her a letter, tell her to move from that [damp] house and get one better...not too old, got carpet and something...because her daughter has got the nose problem, her husband has the arm, and she has the brain [mind]...

BoPa: The doctor is prepared to find one that is nice and clean for us...so that my brain will not think too much...the doctor did not attend to other patients much, only me yesterday...

Similarly, a favourable impression was made on SomNieng and her husband. SomNieng's doctor visited the home before her very premature baby was discharged from hospital, and arranged for the adequate heating of their home. To manage symptoms and illness in the wider context described by the person's life events, conditions that may affect a person's "energy", more closely fits the Cambodian view of illness than medical treatment that focuses on disease.

From participants' descriptions, cultural issues were seldom taken into account in providing primary medical care. This is not to say that family doctors were insensitive to the fact that there were differences, but more likely reflects that they did not know the nature of such issues. An exception concerns Mrs Kev, who shortly after arriving in New Zealand fractured her wrist. Her arm was duly immobilised in plaster, but in spite of her familiarity with Western medicine, Mrs Kev couldn't tolerate the cast. Being unable to persuade her to wear the cast, her doctor agreed to it coming off. Being of Asian extraction himself, he reassured the embarrassed family members that he understood old people, and that his grandmother would react in exactly the same way. Occasionally there was outright opposition to a patient's desire to try alternatives to biomedicine, as in VuTy's case when he requested acupuncture.

VuTy's doctor argued that acupuncture wouldn't help VuTy's problem, but as VuTy countered, neither did the doctor's medicine help. Usually, family doctors both knew about and were tolerant of their Cambodian patients' use of traditional self-care, such as "coining", and of the use of Chinese and other medicine.

While the practice of spreading refugee families may lighten the load for a given doctor, the down-side is that understanding the ways in which Cambodians describe symptoms and explain illnesses, and illness-related behaviour of refugees, is not built up.

Few become familiar with the Cambodian system of healing, learning to interpret and treat the symptoms commonly presented in the contexts of Cambodian culture, and in terms of the refugee and exile experiences. This problem is highlighted in a non-scholarly article in a popular magazine reporting on Cambodian women settled in the United States who are functionally blind, but for whom nothing wrong organically has been detected (Wilkinson, 1994). The predominantly Cambodian women, some 150 of them, were scattered among many doctors, with no one doctor seeing more than a few. The doctors are able neither to explain this loss of sight, nor to assist the women in regaining their vision. Similarly, Palmerston North doctors did not accumulate expertise in treating Cambodians with intractable, even life-threatening, illness.

Perceptions of Hospitals

For all their difficulties with the "gatekeeper" role of the family doctor, Cambodians maintain that they consider themselves very fortunate to have such a service. Satisfaction is even more pronounced when it comes to hospitals, when all declared themselves delighted to be able to have free hospital treatment. In view of the generally low standards of hospitals in Cambodia, with family members needing to supply medications and clinical material, as well as feed and look after the hospitalised member, the fact that New Zealand hospitals provide high quality service at no direct cost to patients is regarded very favourably indeed. Yet as with first

contact medical care, their actual experiences with hospitals point to a gap between expectations and experiences.

Cambodians hold similar expectations of hospitals as they do of their doctors. That is, they expect to be treated with fast-acting and potent medication, preferably administered by injection and intravenous fluid. Cambodians therefore tend to be uncomprehending and very frustrated when, after two or three days, they have received no treatment whatsoever. Investigations such as x-rays and blood tests, while accepted as important, are no substitute for injections. As a result, Cambodians who have been seriously ill, requiring intravenous infusions and the like, tend to be very satisfied even when recovery is slow or incomplete.

Not surprisingly, many Cambodians found hospital food not to their liking. It is expected that family and visitors will bring in Cambodian food, which was certainly the case for Sok's hospitalised mother. Mrs Kev was able to feed not only herself but some of her visitors as well, so well-supplied was she. One person commented that: "Cambodians say the hospital is okay, the food is okay, but it isn't. As soon as they can find a telephone, they ring up asking them to bring in rice soup!" (considered a suitable dish for the ill). Of particular importance is providing a new mother with the special foods to "warm" her after giving birth, with such women being very choosy over hospital food but well-supplied by dishes brought from home (see Chapter 11).

Mr Chhum's narrative illustrated that being in hospital can be a very lonely experience, a view endorsed by most who had spent time in hospital. The acute sense of isolation and loneliness arises from a limited ability to communicate, which aggravates the patient's distress to a marked degree. In spite of extended visiting hours, and opportunity for relatives to stay, Cambodian patients may still be on their own for long periods. For example, during the day Mrs Kev received many visitors, who tended to stay for extended periods of time, carrying on their normal socialising. At night Mrs Kev was alone, and lonely. Her English was restricted to a few words of greeting, but even Cambodians who were relatively fluent complained that their ability to communicate in English declines with the stress of being ill and in hospital.

Not only is the social isolation distressing, but an inability to converse can interfere with the patient's potential to benefit from therapy. For example, Sok's mother was discharged sooner than normal after her stroke, without having had the benefit of a rehabilitation programme, mainly because it wasn't possible to explain things and give instructions. For the same reason, provision for respite care for the sake of family care-givers is unlikely to be taken up. Certainly "Grandma" is against the idea, not because she is afraid of hospitals, but because it is lonely and too quiet. The quiet gives space for fears, perhaps about dying in a foreign country, and in the quiet and isolation many begin "thinking too much".

A few Cambodian refugees are frankly afraid of hospitals, particularly when new to New Zealand. In Cambodia hospitals are places where people went to die, I was told, and as such are places frequented by ghosts. The few who were hospitalised within days of arriving in the country, such as those with tuberculosis, admitted that the experience was frightening. Speaking no English at all and separated from their families at the critical time of first arrival, while at the same time being subjected to very unpleasant and intrusive diagnostic tests, was itself alarming. The quiet of the hospital with its unfamiliar noises and smells, gave rise not only to "thinking too much", but aroused fears of ghosts. Such fear has encouraged early discharge, and a reluctance to enter hospital in the first place.

Although fear of ghosts has largely been suspended in New Zealand, certain conditions give rise to its re-emergence. ReakSmey, who admitted to fears of ghosts when hospitalised with tuberculosis soon after arrival, had no such fears when admitted to hospital again the following year, this time for a miscarriage. Sok, who was with her, saw things in an altogether different light, however:

When she rang me I took her straight to hospital, as she was bleeding and bleeding, bigger and bigger [more and more]. SuBai took her kids home and went to look for her husband. But she was bleeding so much, had to have operation at once. There was no-one to sign the form, only me. I was really scared, as blood everywhere, she looked like dying and still smiling. They said it isn't an operation, only a clean-out. When she went to the operation I sat by myself. It was the middle of the night, so quiet, afraid of ghosts, and only me there. I was so scared, too quiet, a lot

of people die in hospital, and if she died it would be my fault.

As it happened, SeakSmey didn't die, but recovered after the surgery and a blood transfusion. Sok, on the other hand, promptly became sick, lost her appetite, and could eat nothing for several days.

The constant availability of nurses is a significant positive factor, with several comparing nursing care with that given by one's family. Several commented that the nurses "look after you like parents", or "like a husband". Such comments make sense in light of the need for close family members to care for the sick at home, and also to carry out the caring role in Cambodian hospitals. The constant attention of nurses enabled BoPa to resolve unfavourable clinical outcomes, such as when her baby died. She asserted that "I don't blame the hospital; the nurses were very good and there all the time...looked after him like parents". Positive experiences were not invariably the case, however. "Some are good, some bad", said RotTaa's husband. "If you ring the bell and can't say what you want in English, the nurse will go away really angry." Another commented on rough handling from a nurse when a particular treatment was refused.

Hospital experiences were both good and bad, therefore. Expectations are high, and disappointments run deep when the preferred treatment is delayed or denied. VeasNa's husband, who had frequently accompanied his compatriots to hospital, claimed that "sometimes the hospital is very hard. They give the papers and nothing. You don't understand. They don't explain. They get angry." Basic difficulties in communicating in English are particularly acute for those in hospitals, but affect interactions with the health care system at all levels and contexts.

Working through Interpreters

Narratives presented have amply illustrated the expectations Cambodians often hold of their doctors regarding access to desired diagnostic and therapeutic techniques, as

well as benefit-related certification. Although the need to go through the family doctor for the majority of health services is new to Cambodians, they develop strategies of achieving desired ends in some cases; interpreters provide one such avenue. Building on this, interpreters become pivotal to gathering and disseminating information on such issues as eligibility for health benefits, rights, and hints on how to get forms signed without making an appointment, a feature of "little Cambodia". It is partly because of the need to use interpreters that experiences with family doctors along with information-sharing become common currency.

At the same time, the need to communicate through an interpreter complicates things enormously for both doctors and their Cambodian patients, and is very much two-way in its consequences. The apparent coercion of Cambodian patients into consenting to hospital treatment may well reflect communication breakdown and rephrasing issues in the process of interpretation. The difficulties posed for doctors have been amply illustrated in Mr Chhum's experience, in whose case irregular interpretation, lacking both continuity and quality, accounts in part for his poor medical management and compliance. VuTy, too, has exasperated his doctor by bringing a succession of interpreters with him in his attempts to understand what is wrong, and in the hope of hearing a more positive verdict, or failing that, to negotiate more effective treatment and better access to social welfare support. From the doctor's point of view, he is required to re-explain with each new interpreter what he has previously made clear. Fresh interpreters, raising questions at VuTy's behest, form opinions of an impatient, uncaring doctor.

A patient who feels frustrated and powerless in obtaining what they want from their doctor may well select an interpreter who can also act as advocate. One person used to take his brother-in-law with him, the latter describing himself as "tough", successful in getting the desired information, and sometimes treatment, from the doctor. When the brother-in-law was no longer available, another person long-settled in New Zealand was selected, whom the doctor reportedly objected to. Other interpreters were then substituted. That patients can pressurise or manipulate their doctor through the way they use interpreters was conveyed:

I've known the family since they first came to New Zealand, and have been used many times [to interpret]. I told the doctor the truth of what they told me, that they didn't trust other interpreters, and thought others didn't know their English well. The doctor replied that he had no trouble understanding them, but the family didn't seem to understand him, and refused to accept that he had done all everything he could.

The doctor may then be put in the position of needing to reassert control over information-giving when working through interpreters, which can confuse the family. Trying to reconcile apparently conflicting or incomplete information compounds existing powerlessness, highlighted by the family's dependence on the doctor's relationship with the interpreter:

Patient: Som [first interpreter] asked the doctor many times before...but the doctor doesn't want to see him again...I make an appointment for Som to come with me, and he didn't want this interpreter, but would rather speak directly to me about it...I am not satisfied, so I took SrouyPol [second interpreter] along. And he didn't tell him anything...

Current Interpreter: Then why did he tell me about it?

Patient: I only heard about it [when he told you], and I am very surprised he hid this so long...A sick person has hope with the doctor, but when the doctor said there is no way I can help, that really hurt, I'm very upset.

Wife: In fact, Som said that the doctor told him that [regarding] the patient's secret problem, he cannot tell another person. He told Som like that.

Current Interpreter: Then why did the doctor tell me?

Wife: The doctor told you because you go with so many patients, you know lots of things. That is why the doctor told you.

Clinicians' efforts to both manage the medical encounter and ensure accuracy in translation can be perceived as heavy-handed. One man who often assisted with interpreting described hospital specialists as "demanding. They tell you to say it exactly as they did. But there aren't always the right words to say!" The interpreters

"don't always understand the medical language, and doctors don't have the time to explain well, and make sure it is understood". A Cambodian with health qualifications argued that unqualified people were not competent for the task of interpreting, lacking as they did a specialised understanding of medical terms. In view of the fact that medically-qualified Cambodians and trained interpreters are scarce, however, the unqualified, voluntary interpreters are frequently called on. They see their job as the faithful translation of the words of each party, leaving no room for personal opinion or knowledge:

If our job as translators is to just translate according to the mouth of the patient, how can we say it differently? You say like this and that, I would just say what you say. And...if they said: "Please give your opinion whether we should tell the doctor or not", we should give them our opinion, shouldn't we?

However, not only are the right words not always available, but there are cultural issues which may interfere with the process of interpreting. For example, an interpreter may refrain from giving information to a patient regarding their prognosis exactly as the doctor told it. The *gkru khmer* had indicated that when a person's outlook is considered bleak, the custom is to reassure the patient that he or she will surely improve, based on a belief that if a person is given no hope, he or she may prematurely relinquish his or her hold on life. It is possible, therefore, that Mr Chhum did not know he had terminal cancer, not because his doctor didn't tell him, but because the interpreter rephrased the message. In the case of VuTy, the family doctor's frankness with him was faithfully passed on by the interpreter. The verdict did not have the desired effect of assisting VuTy in coming to terms with his residual disabilities and symptoms, but instead aggravated his misery.

Nowhere are cultural complications more sensitive than in families. Older people often bring their English-speaking children to assist. Asked whether this presented difficulties, most older folk assured me it did not, adding: "in a family there are no secrets". They further explained that it was "in our culture to help one another", and that since living in refugee camps they had become accustomed to using interpreters.

Two young high school students, often used as interpreters by members of their extended family, didn't find it so easy, however. They couldn't always find the right words or concepts in the other language, and sometimes literal translation wasn't possible. More important, sometimes they were embarrassed to relay the question from the doctor exactly as it was asked because, being younger, they wished to avoid shaming and embarrassing their elders. These young people were thereby put in the very ambiguous position of being *confidante* to their parents' personal affairs, while at the same time being expected to conform to the traditional cultural ways of respecting and obeying parents.

As one New Zealand-educated Cambodian put it, Cambodian children may quickly acquire *kiwi*-accented English, "but their brains still think Cambodian". They thus use grammatically and conceptually incorrect language to convey meaning, with the risk of mistranslating in both directions. The non-English-speaking parents are proud of their children's apparent facility in English, and the doctor easily fooled by the *kiwi* accent, while in the middle the children are struggling simultaneously to find the right words and to avoid embarrassing their elders. The older folk control these matters to the best of their ability. For instance, they will avoid using males when the problem is a female one, or will use their school-age children when they simply require a repeat prescription, but otherwise arrange for the assistance of a more experienced interpreter outside the family. Yet even here, the arrangement can be manipulated, as a patient may be reluctant to admit to certain matters to the interpreter.

Even experienced people can unwittingly find themselves in difficulties arising from their role as interpreters. One woman who thereby became the conveyor of sensitive information from the doctor to the patient subsequently found herself the target of aggression from the family concerned. As she put it, "I only translated what I was told", and thereafter declined to interpret for any except close friends. She wasn't alone in this kind of complication; a young woman who at first was unwilling to talk to me had been deeply hurt by becoming unwittingly embroiled in community conflicts through her role as interpreter. Similarly, a New Zealand-educated person,

who had frequently made her services available, has now withdrawn, finding that the emotional strain became too much. There can be vying among interpreters for the work of interpreting when payment is available for the service, which aggravates existing social tensions.

Usually, interpreting is entirely voluntary. One person was angry at the way the hospital took this for granted, regarding volunteer interpreting as "free. But it is not free. It costs to go there. Sometimes you have to wait for two hours...that is too long." Cambodians employed at the hospital are called on to assist, but claimed one: "It is not always easy...the boss is not happy when called away...we have our job to do." The hospital-employed Cambodians find themselves in a similar position as others who interpret, that by becoming privy to personal and confidential information, social relationships can be strained. Communication, so essential to effective medical care and correct diagnoses and treatment, is thus complicated by voluntary interpreting of uncertain quality and consistency. The issue of accurate translation is a priority for the clinician, a requirement which is difficult to ensure where verbal and conceptual equivalence is limited. The wider issues related to social structures and cultural mores equally confound accurate interpreting.

Compliance with Treatment

A rational patient, argues Kirmayer (1988, p.58), hands over his or her sick body to medical expertise for examination, and complies with the medical regimen. In fact, lack of compliance, as indeed a disappointing clinical response even to regimens strictly observed, is regarded with a sense of moral outrage. The Southeast Asian patient has been widely presented as the "compliant patient", a "good" patient who seldom complains, and is always pleasant, giving every indication of being both grateful for and accepting of Western medicine (eg Tung, 1980, p.58; Muecke, 1983, p.435). However, these authors go on to argue that such appearances conceal the enduring illness-related beliefs and practices, which may well influence the patient's strict compliance with regimens and advice.

For the illness phenomena described in the study, compliance was required with a range of behaviours, including: presenting for appointments; taking medications; not taking certain foods or substances; undertaking more or less activity; and undergoing surgery. While basic communication problems accounted for many compliance difficulties, others arose from conflicts between advice from a Western medical perspective and Cambodian views. The latter was evident in VuTy's case. His doctor recommended more physical activity and work. Such advice directly conflicted with the Cambodian view espoused by VuTy and his family that rest was needed. Having a complete rest, doing nothing at all, was understood by his family to be necessary for recovery. In VuTy's experience, certain activities aggravated his symptoms, lending support to their position that rest was needed. This conflict between Western medicine and Cambodian practices is particularly obvious in the post-childbirth period, and will be discussed in Chapter 11.

Contrasts between the individualism characteristic of New Zealand society, and a family orientation apparent among Cambodians, can affect compliance in both directions. At times sick persons who object to a certain course of treatment may be pressurised into compliance by their family. While such pressure is well-intentioned, it may have serious consequences. For example, TiDaa underwent a total dental clearance against her will, yielding to the combined pressure of her family and the doctor that to do so was in her interests. Not only did she suffer a psychotic episode following the traumatic procedure, but TiDaa has been unable to adjust to wearing dentures. Similarly, Mrs Gket submitted to a total dental clearance under duress and has had great difficulty adjusting. The reverse can also be the case, illustrated by SomNieng's apparent non-compliance with recommended urgent surgery. After being anaesthetized for a Caesarian section, her throat was very painful, and a few months later "big lumps" appeared, due to an enlarged thyroid. She deliberately failed to follow through with arrangements for surgery out of a fear of dying. She was afraid not so much for herself, but because she believed her baby to be too young to survive should she die. About a year later when she began to have difficulty breathing, she did go ahead with having the recommended surgery, after being told that she would die without it.

Commonly, sick Cambodians are limited in their ability to read English, the language in which appointments and instructions are written. Being generally concerned to follow instructions correctly and to "obey the rules", families ensure that such instructions are interpreted, for example by rewriting medication instructions in *khmer*. Mr Meas suffered from several serious chronic diseases, including asthma, diabetes, and coronary artery disease. The medication he had to take daily was considerable, and of such quantity that he used a lady's handbag to carry it about. English instructions on labels of medicines were laboriously copied out in *khmer*, and Mr Meas was enabled to successfully manage his complicated regimen. Compliance with regimens and instructions is the more common, but from time to time this does not happen.

Once, while I was visiting VuTy, he pulled out an appointment for an x-ray the following day. Although he knew the time and place, he did not know that he needed to fast beforehand, being unable to read the accompanying instructions. This kind of incident is not an isolated one, with the result that examinations are cancelled because of inadequate preparation. The same can happen with respect to instructions about treatment. After she was diagnosed as having gout, SomNieng produced a glossy brochure on diet. Not only was she unable to read the booklet, but it was based on a *kiwi* diet which needed to be translated into Cambodian food preferences.

Poor understanding of instructions given in English were not the only reasons for low compliance. The reasons underlying Mr Chhum's apparent non-compliance have been discussed above. Others ceased taking the medication, including antibiotics, if they either did or didn't quickly improve, thought the medication was causing ill-effects, or thought it to be too strong. According to Tung (1980, p.57), Southeast Asians believe Western medicines are not tailored for their constitutions, that the medicines are too strong, too "hot". In the light of such views, abandoning a drug when symptoms persist or worsen is sensible, and to take less than prescribed logical.

This was well-illustrated with ReakSmey. Life in New Zealand began with a few weeks in hospital. After she was discharged, she continued to take medication. About

nine months later, ReakSmey's skin began to itch and blackened, breaking out in a rash; her vision was blurred, and she was "hot inside". She decided that the problem lay with the medication, and in spite of having been instructed that on no account was she to cease, she did stop taking it. In ReakSmey's view, the medicine was too strong for her weakened body, and being as yet new to New Zealand, she did not appreciate that the doctor was responsible for her anti-tuberculosis treatment. In fact, some weeks went by before she went to the family doctor, who then formalised the cessation of anti-tuberculosis treatment. ReakSmey also defaulted at follow-up clinics. Because of the risk to the public health, tuberculosis patients are obliged to present for regular clinical checks as well as comply with medical treatment. Twice ReakSmey forgot to show up for appointments, but on neither occasion was she taken to task.

On the surface, many accounts of compliance failure seem likely to upset those working in the health care system, particularly appointments that are not kept, non-compliance with prescribed medication, and not following dietary and life-style advice. While the irritation of clinicians was in some cases conveyed to Cambodian patients, this was exceptional. In most cases, an exploration of these incidents uncovered a pattern of not understanding, rather than not obeying, and revealed that their behaviour made sense in the context of prior experience with health care. In other cases of non-compliance, perhaps in an effort to accommodate cultural differences, no adverse reaction was provoked.

Expressing Pain

Cultural differences in expressing pain have long been acknowledged, explained for example in the seminal study by Zborowski (1952). At the same time, the expression of pain within a given culture is not standard, in spite of members being socialised to express pain in particular ways. The previous chapter argued that illness symptoms are expressed in distinctive ways among Cambodians, ways that clinicians are unfamiliar with and have difficulty in interpreting. As with illness symptoms, so it

is with pain.

Pain was a prominent feature of illness phenomena described, ranging from being bearable to intense. Joint and muscle pain made life miserable for many, while abdominal pain interfered with enjoyment of eating for others. An exhaustive description on pain and its expression among Cambodians is beyond the scope of the study. However, its non-verbal expression, as well as the verbal language for describing pain, seemed to be unfamiliar to clinicians. As a result, the Cambodian patient in pain may find that it is interpreted in the light of Western cultural norms, which in addition are influenced by biomedical beliefs about pain. Complaints of pain that could not be explained by abnormal pathology were seemingly interpreted as being stress-related, or perceived as being exaggerated.

There was no question about the pathological justification for Mr Chhum's pain, however. Secondary cancer in the bone is recognised as being particularly painful, pain about which Mr Chhum complained constantly, and for the relief of which several different approaches of treatment had been attempted. In view of Mr Chhum's distress from unbearable pain, I went with the family to his doctor. The family doctor responded that if it was so bad, why did Mr Chhum fail to return for a fresh prescription of pain relief? And why had he not completed radiotherapy intended to control pain? He went on to argue that although Mr Chhum complained of terrible pain, he didn't look like a man in pain. In fact, he pointed out, he was sitting there calmly, not grimacing, moaning, nor even restless, as characterises people in pain.

The listing of familiar signs of severe pain suggested that Mr Chhum's doctor interpreted his patients' non-verbal expression of pain against patterns encountered among *kiwis*. Yet I had observed a similar control over non-verbal expression of pain among many Cambodians who claimed that they suffered pain. Such acceptance of suffering and control of non-verbal expression of pain have been explained in the context of the Buddhist world view which endorses acceptance of suffering (Boman and Edwards, 1984, p.40). Tung (1980, p.56) describes stoicism as a highly valued

character trait, which in his view accounts for control over groaning and complaining. Interpreted in the light of Western culture, however, a person who is smiling or frowning that, appears content, is deemed to be comfortable by the clinician, and verbal complaints of pain that are not consistent with the bodily signs may then be dismissed.

Even at home, Mr Chhum seldom fussed about his pain, the signs that it had reached intolerable levels being a top-up of pain killers and alcohol, a wander around the house, and withdrawing into silence. He described his pain on being asked about it, but otherwise appeared stoical. His face was seldom contorted, not even in the final few weeks of his life. Rather, Mr Chhum seemed to exercise a remarkable level of control over his expression of pain. Likewise, a number of women who complained of very severe, incapacitating headache, seldom showed evidence of this in their facial expressions. Mrs Nhim was one who described her headaches as like bands being tightened around her head, yet even when she had such headaches when I was present, her face was usually calm. Similarly, VeasNa would arise from her bed to host a visitor, the main sign of her severe pain being in the way she held her torso and body very still. Elderly folk, Mrs Kev and TiDaa for example, suffered much from aching joints. Again there was little sign from their facial expressions that their bones ached continually, apart from when they changed position. None engaged in groaning and moaning, few were restless and fidgety, with generally the severity and nature of pain being expressed verbally.

An exception was VuTy, who often grimaced, moaned and was restless. However, his conformity with "normal" ways of expressing pain in New Zealand, with which his clinician was familiar, failed to convince his doctor of its stated severity. Like others, VuTy's pain is a particularly distressing feature of his illness, and he went to considerable lengths in describing its nature. The dialogue between himself and Sok illustrates a rich vocabulary for describing and discriminating among bodily sensations, pain, and symptoms of disorder:

Sok: Is it pain like someone pricking needles at you? [*sro'bhun*, or numbness or pins and needles].

VuTy: No, not that. It is half the body being squeezed, ever had that kind of pain? Only one side, and when I'm not well then it becomes painful, hot, and even the head starts thinking and I can't sleep....getting worse and worse, burning...

Sok: So, how do you think you can get any help to stop that pain, that thinking?

VuTy: Sometimes [by itself] it is better, like normal, like before [when] I could drive a car. And sometimes it becomes sick by itself...the head is heavy and I use the "coining". And sometimes my head and face is not clear. It's got noises and sounds 'tok, tok, tok,' and the head becomes hot without being aware of it...Now the eye seems sore, because when opening and closing it pulls, as if stuck...this eye, over the eye-ball, always sore when touched, constantly..It is *sro'gkear* [skin sore to touch]. Sometimes when I walk the ear drum goes 'kleung, kleung' ...and it is sore at this spot too, like people pulling each other...Half the body sore, painful like after we have *grun* [fever], all the bones. It's the joints and muscles that are sore, but only half the body, always there [constant]...but for the very bad pain, the *cjock cjaab*, [a sharp stabbing pain] that's another story!...Very fatigued, the head, cannot lift it up...It seems like *k'njaak* [a spine-chilling sensation through the whole body]...like *s'riev s'ranh* [sensation of cold shivers, as with a chill].

The narrative continued, and by Sok's questions and responses, the descriptions of types and nature of pain were common parlance, comprehensible within Cambodian culture. The descriptors VuTy used were also used by others to describe their pain, SomBut and Mrs Nhim, for example. While the richness of language to describe pain compensates for the lack of non-verbal expression, the language does not resonate with that of biomedicine, nor with Western cultures in which biomedicine was established.

Indeed, although the experience of pain is itself universal, its expression is embedded in cultural systems of healing and social class (Kleinman, Brodwin, Good and Good, 1992, p.1). Such expressions can reflect the physical environment, from which are drawn descriptors to convey, for example, the nature of pain (like the movements of a certain insect), as well as local illnesses, such as Mrs Nhim's "intestinal malaria". The excerpt above reflects pain associated with "nerves", as well as that related to

the fevers, often malarial, which are endemic in Cambodia. TiDaa graphically described her symptoms of psychosis as "noodles running everywhere under the skin, especially in the brain", and has since been unable to eat noodles without remembering her mental distress. A patient who shows little sign of pain non-verbally, but who goes on to state that pain is severe, using such descriptive language, may well not be taken seriously. Not only is there apparent inconsistency between non-verbal and verbal expression, but the language of pain Cambodians use is quite unfamiliar to Western doctors, and may make little sense within biomedical theories of disease.[1]

Dependence and Disempowerment Reinforced

It has been explained above that Western-type medicine was highly regarded in Cambodia, but this regard principally reflected private clinics and the more potent of pharmaceuticals and injections. While pharmaceuticals were available in some areas, they were not affordable to all, and few outside the cities had access to hospital care other than the ill-equipped, poorly staffed government-run district clinics. Those few who had formerly used Western medicine had tended to use it alongside Cambodian, Chinese, Vietnamese, and Thai medicine, a pattern which continued throughout their sojourn in refugee camps. In such unregulated environments characterised by medical pluralism, the patient retains a high degree of control in purchasing all manner of health services and medicines, availability and affordability being the major constraints.

In contrast, the formal health care system of New Zealand is integrated and highly-regulated. To summarise, the health care system of New Zealand is typical of those in the West in being biomedically-based, comprising primary or first contact levels as well as secondary, or specialist referral and other levels. From the perspective of the person seeking medical care, the point of first contact is normally the family doctor, or for those not registered, an emergency service. Without the authorization of the doctor, pharmaceuticals and diagnostic tests cannot be purchased, nor specialist

medical and hospital care accessed. Not able to directly obtain medicines, nor to self-refer to the kind and level of service desired, patients are completely dependent on the family doctor for health care. Even when the patient does not agree with a decision of the family doctor regarding the need for specialist consultations, he or she can find little way to circumvent the system, other than changing to another family doctor who may be more willing to prescribe and refer.

For all its perceived benefits, the technically high quality health care system of New Zealand does have its limitations. Nowhere is this more apparent than for those who are continually ill, yet able neither to manipulate the system to relieve their suffering, nor to find alternatives to the system. The narratives of illness in Chapter 8 show that many Cambodians are troubled by the cool climate; from "thinking too much"; from "nerves", often in respect to fright, working too hard, and upset or shock after childbirth; and from "black spirit". Yet New Zealand's biomedical system of healing and its doctors are not set up to acknowledge or deal with such problems.

Therefore, although Cambodians settling in New Zealand are apparently accepting of and compliant with the pattern of health care delivery as described, their narratives show that it doesn't always work well for them. When symptoms do not abate with treatment and Cambodians are unable to procure the form of treatment deemed effective, particularly injections; and when they are unable to procure referrals for alternative forms of treatment, then their distress related to symptoms can be compounded by powerlessness and frustration. When diagnostic tests fail to demonstrate abnormal pathology or an underlying, treatable cause for a disorder, and when at the same time patients are assured that "nothing is wrong" while they are feeling so wretched and incapacitated, then the misery of Cambodian patients increases. When the illnesses Cambodians present with do not fit biomedical diseases, nor the language familiar to Cambodians to describe symptoms and pain fit Western norms with which clinicians are familiar, the illness experience itself becomes part of the wider experience of being a resettled refugee, marginal to mainstream society, of which the health care system is part.

Some participants described themselves as "ignorant", because of their lack of formal education and halting or absent facility in English. My informants appeared ready to negate their cultural knowledge and skills about illness, reluctant to discuss their views about their illness with their doctors, and embarrassed at admitting a Cambodian theory on illness, especially ghost and witch related illness. The perceived attitudes of members of mainstream society seem to encourage the abandonment of Cambodian theories of illness in favour of those of the West.

At the same time, my informants apparently were knowledgeable about and interested in the function of the body. While Cambodian interpretations may differ from those of biomedicine, such as fright-related illnesses, there is a remarkable ability to understand and willingness to accept the explanations offered by their doctors, together with a continuous process of accommodating these views into their existing knowledge of illness and healing.

This is not reciprocated, however, and generally doctors do not hear the explanations their patients have regarding the illness. In the main, this is because patients are reluctant to articulate their explanations, and doctors seldom invite them to do so. Because Cambodians perceive doctors to be the experts on sickness, it would be inappropriate for them to offer explanations, indeed to do more than give the information the doctor requests. The lack of dialogue and affirmation on their own suppositions regarding the causes and possible remedies of their illness, such as "upset nerves" exacerbated by a cold climate, aggravate the powerlessness that is already a hallmark of their refugee experience. At its extreme, the existing characteristics of displacement and marginality of refugee Cambodians in New Zealand society are reinforced in their interactions with the health care system. According to this interpretation, far from facilitating healing of ill refugees, the health care system by aggravating and compounding powerlessness, itself produces illness.

Conclusions

The differences are differences between the New Zealand health care system and experiences with medical pluralism characteristic of Cambodia. This study has demonstrated the determination with which most Cambodian refugees have managed to find their way around the New Zealand health care system, in the light of the degree of adjustment required. The vast majority learn to negotiate an unfamiliar monopolistic biomedical health care system, in which access to services is controlled by the family doctor as gatekeeper. Some Cambodians go further than accommodating to the system, and develop skills in finding ways around the institutionalised obstructions and controls in order to achieve their ends, but even this yields limited personal control over obtaining desired health services.

Not all Cambodian settlers successfully navigate their way through the system, however, and some end up feeling very powerless and frustrated when their suffering is not eased nor their illness diagnosed. Being unemployed and poor, as so many are, and given that Cambodian remedies are not readily available within New Zealand, other solutions are frequently out of reach. They find themselves, therefore, in a position of having little choice but to continue using a health service as the principal form of health care, one in which they have only partial confidence that they will be healed. Reliance on interpreters by so many is in this situation a potential disadvantage, but can also become a tool for working things to their advantage. More commonly, the existing disempowerment of the patient, already present in the unequal relationship with the family doctor, is extended into Cambodian society through being dependent on the better acculturated of their members. At the same time, hidden costs for interpreters emerged. There is the cost of risking the boss's displeasure by absencing oneself to interpret for others, the unquantifiable personal and social cost of being drawn into other's personal and family crises through the role of interpreting, and the dollar costs related to travel and time.

In spite of their experiences, when challenged Cambodians generally claim they are very happy with their doctor, and with the hospital, declaring themselves to be more

than willing to obey the "rules" of New Zealand regarding health care. Such assurances conceal the less positive experiences of ineffective care and their powerlessness in addressing this, and moreover obscure the actual pattern of dealing with illness that has evolved. Far from conforming exclusively with New Zealand's monocultural health care system as they assert, resettled Cambodians have developed a local system of healing based on traditional self-care, and drawing from available alternative remedies as well as the official biomedical system. It is this local system of healing, a feature of the society of "little Cambodia", through which resettled refugees reassert their Cambodian identity. The evolving system of healing is the subject of the next chapter.

Note:

- [1] Refer to the section on self-care practices in Chapter 10 for a discussion of self-inflicted pain, which makes reference to John Marcucci's (1994) analysis on the practice. For further discussion on the expression of pain, the reader is referred to the thesis of John Marcucci (1986) *Khmer Refugees in Dallas: Medical Decisions in the Context of Pluralism*. Ph.D. dissertation, Southern Methodist University.

Chapter 10

A Cambodian-New Zealand Local System of Healing

Cambodian refugees arriving for resettlement in New Zealand bring with them a richness of experience and knowledge that sets them apart from the people among whom they settle. Taking illness experiences alone, resettled Cambodians draw from both Cambodian and Western theories and treatments. Illness is a major factor in the lives of some Cambodians; about a third of my sample had not experienced cures, but lived with chronic disease, such as gouty arthritis or diabetes, and diseases that were crippling and progressive. Others were constantly poorly with the "problems of old age". In addition were those with incapacitating symptoms long-term for which no organic cause is found, including dizziness, numbness and joint pain.

A significant issue to emerge in this study, not described in other research, is the effect on illness that the change of place is believed to exert, brought about by the forced migration. Effects are both negative, in relation to the aggravating effects of the cool, windy climate, and positive, in being out of reach of many disease vectors, and the malicious spirits and deities that trouble people in Cambodia. On arrival in New Zealand, much past experience and knowledge is put to one side, along with many habits of daily living, as Cambodians set about learning to become New Zealanders. To set aside theories and practices appropriate in the geographical and cultural contexts of Cambodia makes sense when those contexts are abandoned. But to accommodate to New Zealand's systems can sometimes also be difficult and unrewarding. Therefore Cambodians set about creating new theories and practices of healing. This chapter describes the emerging processes of caring for health and illness in the Cambodian community.

Generally speaking, illnesses are initially cared for within the household, by means of home remedies, self-care [1], and perhaps using medicines available over the counter or left over from a previous episode. It is only when the illness cannot be managed within the resources of the household and community, for example when it becomes serious, chronic, or symptoms fall outside the experience of the

household, that the "expert" level of health care is called on. For my informants, in the first instance this was normally the *gkru khmer* in Cambodia, while in New Zealand it is usually the family doctor. As explained in the previous chapter, most participants had not experienced Western medicine as an integrated system, nor were acquainted with family doctors who function as gate-keepers to the health care system. My informants demonstrated pluralistic theories and practices, having used Western-type treatment, Chinese medicine and techniques, and Vietnamese and Thai medicine available from vendors as adjuncts to Cambodian medicine.

The chapter begins by discussing the concept of transition, and the way this is reflected in health care practices. Earlier chapters have demonstrated the level of frustration expressed by those who do not get better, in spite of frequent interaction with health services, and who yearn for Cambodian medicine which they think might cure them. This raises the question of why Cambodians do not more frequently consult the few *gkru khmer* residing in the country. The limited availability of medicines from Cambodia, and the limited relevance of Cambodian medical practices outside of Cambodia offer the partial answer to this question. Cambodian self-care techniques are maintained, however. These techniques and the rationales for them will be described below.

As the narratives presented earlier have illustrated, the Western system of healing is sometimes of limited benefit, particularly in dealing with Cambodian illnesses. With the Cambodian system of healing no longer adequate to explain and relieve illness, and Western medicine often ineffective in relieving distressing symptoms, resettled Cambodians go to considerable lengths in drawing from alternative approaches, to construct a means of addressing illness modelled upon the earlier pluralistic pattern. The result is a peculiarly Cambodian-New Zealand local system of healing, which has developed and is practised in "little Cambodia".

This conclusion challenges the picture conveyed in the previous chapter of resettled Cambodians, as disempowered and marginalised with respect to New Zealand society and its health care system. However, the emergent system of healing described in this

chapter is unlikely to become a permanent feature of the Cambodian community, for it is itself a reflection of the transitional state of the adult generation. Their children, who grow up and are educated in New Zealand, become increasingly socialised into *kiwi* ways of doing and seeing. It is, therefore, principally those who grew up in Cambodia who are likely to retain an essentially Cambodian view of life, a view which sets them apart from the views of both the young generation of Cambodian New Zealanders, and mainstream society in which they live out their days.

People and Healing Practices in Transition

Cambodians living in the Southeast Asian region treated their illnesses in a context of medical pluralism, described in the previous chapter. The mainstay of healing was a set of locally developed approaches which themselves reflect multiple paradigms. Beyond these, exogenous health care systems were also employed. Ill people could and did draw from a variety of available techniques and substances. For example, after VuTy developed complications in the wake of a tooth extraction by a lay Cambodian "dentist", he used both medicine supplied by the refugee camp clinic and the *gkru khmer*, according greater credence to Cambodian medicine with *Pali* in stopping the swelling and bleeding. His wife, too, attributes her recovery from a swollen and painful knee (believed to have been brought on by "black spirit") to the *gkru khmer*, even though she was also treated at the clinic. Again, Mrs Nhim gave birth to her youngest child at the clinic, and thereafter followed through with the traditional practices for women after "crossing the river" (see Chapter 11), and treated later complications with Cambodian rather than Western medicine.

A pluralistic system, with its wide choice of treatment, was not characteristic of New Zealand at the time of the influx of several thousand Cambodians into New Zealand. Although included in their numbers were *gkru khmer*, *chmorb*, lay injectors and medicine vendors, resettled Cambodians soon developed a pattern of reliance on a single practitioner, the family doctor, for advice and treatment. Given that so few of my informants had previously used Western health care as an exclusive system of

healing in Cambodia, the apparent smoothness of their transition to New Zealand's health care system is the more remarkable. Burki's (1987, pp.336 ff) model of "traditional", "transitional", and "modern" ideal types of refugees (summarised in Chapter 5), sheds some light on the apparent ease of transition. According to Burki, the "modern" ideal type adapted best to both refugee camp life and the "West", while the "traditional" and "transitional" types, lacking experience in formal education beyond rudimentary levels, adjusted through imitation. Although "traditional" and "transitional" refugees of these types endeavour to fulfil norms and expectations, and give the impression of agreeing and conforming with norms, these types are characterised by an underlying adherence to traditional cultural mores and their transmission. Burki (1987, p.336) found that ideal types held true irrespective of age, and explained differences in style and apparent success of the adjustment process.

In the case of adjustment to the Western health care system of New Zealand, however, the inclusive and pluralistic nature of the Cambodian system of healing means that the indicator of type is not simply the use of Cambodian and Western medicines respectively, but acceptance of the exclusiveness of Western medicine. In the present study the two translator-transcribers are clearly of the "modern" type, having unquestioningly internalised the Western health care system as modern and scientific, while at the same time disregarding the Cambodian system as "superstitious". Their "modernness" has arisen not only from the fact that their higher education took place in New Zealand, but as urban Cambodians, their families were "modern" in type even in Cambodia, habitually using Western-type medicine prior to the Khmer Rouge period.

Among my informants, however, none reflected the "modern" type as described by Burki (1987, p.340f). A semblance of "modernism" was apparent among young adults, adolescents during the Pol Pot regime, who were removed from the family and village environment in which normally they would have acquired cultural knowledge, and instead were subjected to intense re-education from Year Zero. Included are BoPa, SaRom and his wife RottaNaak, and VuTy's wife NeaRy, all of whom were in mobile youth teams or the Khmer Rouge. These young people were

isolated from the social context in which they would have acquired the understanding and skills of Cambodian medicine. At the same time, the use of Cambodian medicine was unavoidable, in view of the endemic shortage of Western medicines during those years, and in keeping with *khmer* revivalism.

Some, such as NeaRy, later took advantage of the opportunity to learn from the older people while living in refugee camps. In New Zealand she and others unquestioningly accept using Western medicine as the dominant system, readily imitating the values and practices of those about them. At the same time, Cambodian techniques are widely employed, with little apparent sense of underlying differences. With neither Cambodian nor Western medicine having been internalised through socialisation or education, this group reflects a state of permanent transition, of which adjusting to New Zealand is just one more stage.

Some, but not all, of the older people reflect the "traditional" type, the greater part of their lives having been spent in Cambodian village society. They practice Cambodian self-care on themselves and their families, and continue to value traditional healing practices, particularly when Western medicine doesn't relieve distress, and when illnesses are thought to be "Cambodian sicknesses". The narratives of Mrs Nhim and VuTaa reflect the enduring regard they hold for Cambodian medicine for certain disorders, and their helplessness in the light of its unavailability. At the same time, even those who come closest to the "traditional" type appear comfortable with and accepting of the Western health care system of New Zealand, as indeed they were in Cambodia, reflecting the medical pluralism characteristic of the region.

The bulk of the group are best described as "transitional". These have much in common with the "traditional" type, while more actively embracing "modern" ways. Adults of all ages showed "transitional" characteristics, reflecting a socialisation in family and village environments, but wider exposure to and acceptance of other cultures and ideas than was the case for "traditional" types. Like many "traditional" people, the "transitional" Cambodian employed a combination of Western and

Cambodian techniques, both in Cambodia (when available) and in refugee camps. They claim satisfaction with the Western health care system and its "rules", while at the same time not rejecting their own practices. Although "transitional" Cambodians may personally use Cambodian self-care techniques, may prefer Cambodian practices after childbirth, and at times take available Cambodian medicine, they are likely to adopt the purely Western system for their children's health care, raising them to be "modern". The "transitional" position is summed up in the oft-heard phrase: "We are in this country now; we are *kiwis*, do things the *kiwi way*".

Sok's family characterises the "transitional" ideal type. Her mother uses Western medicine as the first line of professional treatment, as she formerly had done in Cambodia. At the same time, she regularly carries out the self-care practice of "coining", and regularly consumes an array of Chinese and Thai medicines that can be purchased in the larger New Zealand cities. One such, a Thai tincture, she takes to enhance the effects of the Cambodian self-care technique of "coining". At the same time, she frequently consults her family doctor, and takes a quantity of daily medication, the effects of which, she says, are enhanced by her regularly "coining". Although the oldest person in the community, she is truly transitional, equally comfortable with any other available approach of healing.

Sok and her husband show a very similar pattern, giving every indication of being conversant with the New Zealand health care system, knowledgeable of and compliant with regimens. As an informal leader in the Cambodian community, and one who avails herself to assist others in learning their way around health and other institutions of New Zealand, Sok is called on from time to time for advice. Generally, she strongly supports the Western health care system as not only proper and appropriate in New Zealand, but as more effective than Cambodian medicine. In her role as interpreter, Sok frequently reinforces clinicians' instructions, demonstrating a level of understanding beyond rote repetition as she does so.

Sok is fully at home with Cambodian medicine, and skilled in self-care techniques, advocating continuing self-care practices such as "coining" and rest, and the use of

alternative remedies. She goes as far as procuring such remedies for friends, such as from one of the Thai shops, writing an order on someone's behalf to an importer of Chinese medicines, or organising the purchase of Cambodian medicine through visitors to Cambodia. For example, when BoPa's husband SomBut was losing the function of his arms, and had been told that there was no treatment, her advice was that they should consult a particular *gkru khmer*, reputed to be skilled in divining the cause. This SomBut did, over a period of three months consulting two different *gkru khmer* as well as a Chinese doctor for advice. At the same time, Sok accompanied him to the doctor and hospital clinic, being equally involved in ensuring that he understood instructions and had all care and support possible from the health care system.

Sok's children however, "do not know Cambodian medicine", having been exposed only to Western medicine since birth. In spite of the three adults in the household personally practising "coining" and applying it to Cambodian visitors almost daily, not one of her children is ever "coined". Growing up in a different physical and social environment, Sok has adopted for them an exclusive adherence to Western medicine. The family is not "modern" in type, however; their "traditional" side appears in their insistence on speaking *khmer* in the home and on the proper respect to elders, in their authoritarian approach to rearing children, and in teaching the children Cambodian customs with regard to the Buddhist faith.

A familiarity with medical pluralism makes even the more "traditional" of Cambodians accepting of Western medicine. Southeast Asian refugees have been portrayed as essentially pragmatic in their use of health care, using approaches that are available, dominant and affordable, with little concern for the underlying philosophies (Tung, 1980, p.57; Frye, 1991, p.39). My findings rather show a pattern of actively creating a unique system of healing from available techniques and sources, unlike those dominant in either Cambodia and New Zealand. Few of my informants seemed to adhere to the position that Western medicine alone is valid, and as supposedly rational and scientific (Kirmayer, 1988, p.59), an exclusive system. The pattern evident in this study was one of viewing Cambodian, Western and

alternative practices as valid, the application and combination of practices depending on the nature of the health problem and the context in which the problem occurs. While the move from Cambodia to New Zealand has rendered many Cambodian approaches irrelevant, traditional self-care techniques are as much in demand as ever.

The Declining Relevance of Cambodian Healing in New Zealand

The contrasts between patterns of accessing health care in Cambodia, refugee camps, and now in New Zealand illustrate the degree of adjustment required of Cambodian settlers. By and large, Cambodian refugees face that transition with a determination and courage parallel to that with which they tackle adjustment to New Zealand generally. At the same time, it is clear that while some episodes of illness are successfully treated with Western medicine, there remain a significant number who continue to suffer pain and ill-health, to the point that their enjoyment of life is seriously compromised or even that their life itself is in danger. Some are of the opinion that these are "Cambodian" illnesses, and as such, need Cambodian medicine to be cured. Yet although there may be *gkru khmer* in the locality, the actual practice of consulting them seems lower than would be expected from opinions expressed.

There is an underlying uncertainty regarding the status of an illness deemed to be like a Cambodian condition, but in some way changed, altered by the windy and damp climate, or perhaps by the medical interventions themselves. Along with such uncertainty is Cambodians' awareness that the doctor is approaching their illness from a different set of premises. For example, the relationship between illness and "nerves", as Cambodians interpret it, is not shared, yet one way or another this belief affects a majority of sufferers, with the illnesses of many women being attributed to upset of the "young nerves" of the woman just after childbirth, and the perceived ill-effect on nerves of excessive work widely experienced during the Pol Pot years. Likewise, perceived ill-effects of change of climate are not affirmed in patients' discussions with doctors, either as a preventive measure in the case of new mothers avoiding going outdoors, or as an explanation for severity of symptoms.

Resettled Cambodians appear remarkably willing to set aside their own theories of illness, and to accept biomedical explanations and associated treatment, in part because of pressure from within and outside the Cambodian community to do so. Often it is only when symptoms don't improve with medical treatment, and especially when sufferers are informed that "nothing is wrong", that Cambodian explanations and treatment are revived. Even at this point the *gkru khmer* themselves may encourage staying with Western medicine. As Dta PolGkun pointed out, the doctors who trained in New Zealand are considered best suited to dealing with diseases that develop there, as in the case of SomBut's eel-bite. Even when an illness or accident seems the same as those occurring in Cambodia, he pointed out that: "Only those who have learned would know how to cure [the illness in New Zealand]; those who didn't study wouldn't know. Maybe the *bpat* [Western doctor] can find a cure through experimentation."

Implicit in this statement is the view that both illnesses and healing practitioners are locally circumscribed, and it logically follows that Cambodian healers no longer have a clear place in the treatment of illness outside of Cambodia. This was not the case during residency in refugee camps, with the physical and cultural environments, and the types of illness, in Thailand and Cambodia being regarded as similar. In conversation with both sick people and *gkru khmer*, explanations for the limited relevance of Cambodian healing fell into three main areas: both natural and spirit-related hazards prevalent in Cambodia, which account for a majority of illnesses, are found not at all or to a limited extent only in New Zealand; and the materials required for Cambodian medicine are not available.

Natural Hazards: *gkru khmer* exercised an important function in protecting people from harm from natural hazards, including man-made dangers. In fact, any of the natural dangers that Cambodians faced in their own country were associated with particular functions of *gkru khmer*, whose reputations were commensurate with the power of their skills to protect and treat. Included here are endemic diseases, such as *grun*, a family of feverish complaints including malaria, which are seldom

experienced in New Zealand. Frequently called on to treat such illnesses, *gkru khmer* were knowledgeable and skilled in the administration of *tam khmer*.

Ankle tattoos were widely used to protect the wearer from being bitten by snakes. Accordingly, there were many kinds of tattoo, according to different kinds of snake. Other than tattoos against snakes and being poisoned, seeds of the lime or cheap little amulets could be worn around the neck, or a small protective rite carried out before walking into snake-infested areas. Dta PolGkun described a wealth of remedies for all manner of snakes and other venomous creatures, but of course in New Zealand, where few such hazards exist, such knowledge is redundant.

Protection from bullets had become very important during the decades of fighting. The tattoo inscribed by *gkru khmer* was believed to protect people from being killed by both bullets and knives. Also employed was the *gon'seng yoind*, the inscribing of words or design on paper or cloth, which worn as a scarf was said to offer protection to the wearer through magical power. Amulets were worn to protect against both natural hazards and malevolent spirits. Women wore amulets both to enable and protect a pregnancy, and children wearing amulets were protected from fevers and skin rashes. Dta PolGkun described how he would prepare *k'se gk'taa* [amulet], inscribing words in *Pali* on rolls of soft metal, often lead or even gold, which would then be worn constantly on a piece of string. Cords could be created simply by speaking *toir-aa* [spirit words], used to protect the vulnerable, such as labouring women from witchcraft, or the convalescing ill from further harm. People fleeing Cambodia through the jungle who found themselves surrounded by the roaring of tigers were protected from attack by the making of a cordon, if the party was fortunate enough to include a *gkru khmer* among their number.

Dta PolGkun was particularly knowledgeable in these areas, having mastered *Pali* as a monk. For example, he used to prepare amulets to protect travellers against robbers; to protect hunters from both wild animals and spirits; and to render soldiers invulnerable to bullets. When not being worn, the amulet was stored on a high place in the house, but to maintain its power candles and incense needed to be burnt before

it on the cyclical holy days (normally every eighth day, and other intervening special days). As Dta put it, there was nothing he didn't know about the preparation of such protective amulets and cordons, but the demand on his skill in New Zealand is minimal compared with that in Cambodia.

Spirit-related Illness: Not only does the Cambodian system of healing reflect an intimate relationship with the natural world, but it is also intricately connected with the world of spirits. As well as mixing medicines, a principal function of *gkru khmer* in Cambodia was to determine whether the illness was "of the body", that is of natural causes, or was caused by spirits. Having determined the cause(s), the *gkru khmer* then needed to treat appropriately with *tam* and *Pali*, and sometimes with counter-magic.

Theories that illnesses may be spirit-related have been alluded to throughout these narratives. Such illnesses can be caused by witchcraft, "black spirit" or magic, ghosts and evil spirits. Sok said that her father, who died in Cambodia, was killed by one of the numerous deities attached to natural features of the landscape, such as a stream or mountain, in his case a mountain spirit. Other illnesses are said to be brought on by malicious or offended personal spirits, such as SomBut's offended "master spirit", and those of a village, a house, and neglected or unhappy ancestor spirits. For example, evil spirits and ghosts, thought to be the spirits of those who died an unnatural death and whose presence was recognised in the flicker of a blue light in a tree, were dislodged by a monk or *gkru khmer*.

Those who die untimely, unnatural or violent deaths are said to become troubled (and troublesome) ghosts, and neglected ancestor spirits also cause trouble. Most of my informants had relatives who died thus, and as many have not been in a position to carry out the appropriate ceremonies for their dead, many Cambodians are logically at high risk of spirit-related illness. Yet there is little sign of active fear, no evidence of the wearing of amulets and of ritual activity. I was informed that those who are afraid of ghosts and evil spirits are most susceptible to being harmed, their own fear,

or *pey*, resulting in sickness.

A thorough documentation of the range of spirits, the kinds of illnesses attributed to them, and the differences among them is outside the scope of this study, principally because such phenomena are locally related to Cambodia as a physical and cultural place, and have limited significance in New Zealand. It was pointed out that:

In New Zealand [Cambodian] people don't wear that. No, not at all, because we don't have the spirit stuff [here] at all...When you're talking to the European doctor, you do not talk about that, but when we live in Cambodia we think like that all the time...

Furthermore, witchcraft, along with other beliefs and practices related to the supernatural, was already declining in Cambodia, along with the process of Westernisation and a strategy of eradication by the Khmer Rouge:

Sok: Do we think there are *aab* [witches] in New Zealand?

Mr Meas: No! No *aab*...I think maybe they were finished by the Khmer Rouge...all the *aab* were shot, and those who knew ran away...because the Khmer Rouge hate things like that...

Sok: ...because the Khmer Rouge don't like all the spirit...also we don't have the temple, we don't have the monk at all, we don't have religion in Khmer Rouge time...[And no *gkru khmer*?]...We got *gkru* just for medicine.

The deities of mountains, rivers, bridges, and the like are said to be locally-defined, harmless away from that locality, and there is no fear of a New Zealand counterpart of this phenomenon. Likewise, village spirits do not seem to have their correlates outside of Cambodia. The roles of the *gkru khmer* in diagnosing spirit agents in illness, and in protecting against and curing resultant illness, are therefore largely irrelevant outside of Cambodia. I was assured that there are no ghosts in New Zealand, the view often being expressed in the context of *kiwis* disbelieving such phenomena. Lingering doubts were occasionally evident in the dislike, even fear, of large trees in gardens, the kind of tree favoured by ghosts, with some Cambodians

cutting such trees down as soon as they took up residence in a house. When it comes to witches, or *aab*, there is a high level of agreement that these, too, are locally-defined. Attack by a witch, described as possession by the spirit of a witch, requires exorcism by a particular kind of healer, again a function not required in New Zealand.

While the hazards related to locally-defined spirits and witchcraft have largely been left behind in Cambodia, illness and other misfortune are occasionally attributed to personal spirits. Rarely, as in the case of SomBut, one's neglected personal *gkru*, or "master spirit", (which only males had) was responsible. An explanation given was that men sometimes made a vow to their "master" when in grave danger, which was then forgotten when rescued. In such circumstances, the "master" could exact revenge through troubling the man or his family, with restoration of regular respect being the remedy. In this study neither ancestor spirits nor house spirits were cited as having caused illness; in fact, the role of personal spirits was overall of minimal importance. The principal form of spirit-ascribed illness in New Zealand is that of "black spirit", for which normally a powerful *gkru* operating through its human host is said to be the responsible agent. "Black spirit" doesn't happen only in Palmerston North, with instances in other cities also having been cited. The monk described a *gkru khmer* who claimed he has the strength to push a house into the ground. Such instances of superhuman strength are not unknown, and it is this power that can be used to harm others. For example, a young man living locally claimed that his personal *gkru* gives him the power to charm young girls with his "magic word", as well as to kill his enemies with his curse. His "master" also protects him from bullets and from the sharpest of knives.

Principally, deceiving *gkru khmer* and *Cjaam* are feared as the human intermediaries, neither of which are numerous in New Zealand. The Muslim *Cjaam* have been historically feared for the power of their spirits and incantations, with *khmer* people allegedly paying for *Cjaam* to put spells on their enemies. Fear of the *Cjaam* was borne out in a number of conversations. The *Cjaam* were concentrated near the rivers, making a living in fishing and butchering cattle for the Buddhist Cambodians

who won't kill meat. Although they spoke *khmer*, *Cjaam* used their own language among themselves. Being different in language, religion, and culture, and not intermarrying with outsiders, *Cjaam* were feared and avoided.

As we saw in Chapter 8, there is considerable uncertainty in particular illnesses as to whether the illness is in fact "black spirit", unless a reputed *gkru khmer* confirms suspicions. This uncertainty in part reflects disbelief prevalent in mainstream New Zealand society, which in turn causes Cambodian settlers to re-examine their own suppositions. In view of the high level of agreement that there is little ghost, spirit, or witch-caused illness in New Zealand, the possibility of magic, too, comes into question. Significantly, the people traditionally attributed with practising "black spirit", the *gkru khmer* and the *Cjaam*, are numerically few in New Zealand. Compared with Cambodia where *gkru khmer* were numerous and active, those few in New Zealand seldom practice, and are generally regarded as being relatively harmless. This is not true for all refugee destinations; for example, some informants stated that *gkru khmer* powerful in magic had settled in America.

Cambodian Medicine: In the event that resettled Cambodians do consult a *gkru khmer*, the requisite skills for determining the cause(s) and remedying the disorder are scarce indeed. The cyclical relationship between skill of a *gkru khmer*, his reputation, the demand on his expertise, and the resultant increase in skill and power, cannot be sustained in New Zealand where the family doctor and Western medicines have displaced Cambodian medicine as the mainstay of illness care. Instances where *gkru khmer* have maintained a small but declining practice have been cited, but even here the range of techniques and treatments offered is severely limited.

The most important explanation is that the *gkru khmer* no longer have access to the raw ingredients needed to compound medicine. Mr Cjea explained that a goodly portion of what he had brought in his luggage was confiscated on arrival. Dta PolGkun, it seemed, had been more successful in keeping intact his collection of *materiel* that he had carried with him, only to have much of it stolen from his house

a few years later. Having meagre stocks, Mr Cjea retreated into treating only relatives, while Dta PolGkun was willing to treat anybody who approached him so long as his stock held out.

To replenish supplies is fraught with problems. As discussed in Chapter 9, *materiel* are gathered from the wild regions of Cambodia or neighbouring regions, principally the jungle, but also the sea. The products of animals feeding on domestic vegetation, and cultivated plants, are not regarded as having the equivalent potency of jungle products. This became very clear in a discussion with Dta PolGkun about the medicinal properties of the stomach of the porcupine:

It is like this. The stomach of the porcupine in this country may not be good...because it does not eat *pro'dteil* [medicinal plants]...Like in our country orchard country is not good...it has to be the jungle, because it is full of medicinal plants...

Both *gkru khmer* have attempted to substitute ingredients, without success. Mr Cjea tried material used in Chinese medicine, while Dta has used a New Zealand fungus that resembled the kind he needed. The only option is to replenish stock from Cambodia. However this does not overcome the risk of having these, too, confiscated by airport officials, in the interests of protecting the local ecology. Aside from this, the delegation of the task of obtaining Cambodian medicine is uncertain. In view of the steady traffic of Cambodians, particularly men, between New Zealand and Cambodia, I asked Dta PolGkun whether he could write a list of required substances for one of these to bring to New Zealand. His response was in the negative, pointing out that even a good and true friend couldn't be entrusted with the task, not because of personal dishonesty, but because of limited knowledge:

[There are] those who want money. If we said [to get] this, they get that...say it is the same, looks the same, but it is different...Those [money-hungry] people just go and buy in the city. If we went personally, we [would] go to buy directly from the "elephant people" [that is, mountain tribal people]...they tell correctly, and they know because they go to find these medicinal ingredients from the forests and mountains themselves...But if we just send a list of

names, they might just send something else...

In addition, there are *kbon* [rules] for collecting *tnam*:

One cannot just go and pick up the medicine...it won't be any good without the *kbon*...they have to have *Pali* to invite the [tree of the medicine]...without inviting, it won't be any good...

Not only do the nature of ingredients and methods of compounding *tnam khmer* set Cambodian medicine apart from Western medicine, but the spiritual relationship between the gatherer of medicinal substances and the "donor" of the ingredients suggested here sheds light on the interrelationship between the natural and human worlds. Where the proper method of obtaining medicinal substances cannot be assured, the power of medicines is in doubt. Ineffective medicines undermine the reputation of the *gkru khmer*, and a conscientious practitioner would prefer not to treat people using dubious ingredients, which benefits neither party.

In view of the number and degree of difficulties in the way of properly collecting *tnam khmer* according to the "rules", Cambodian medicine such as persists among Cambodian communities in the West is likely to undergo modification, becoming more like off-the-shelf medicines of a healing tradition such as Chinese medicine, brought back by travellers to Cambodia, or resembling folk medicine, using garden material believed to have medicinal properties. As an example of the latter, on one occasion VuTy took me into the garden to show me where he had been digging up the roots of a lemon tree and of a grape vine. These he boiled together, and reboiled until *saab* [tasteless], swallowing the mixture in the hope of improving. Someone had told him that this was medicine for "nerves". Considering that the New Zealand soil and species is so different, VuTy wasn't at all sure whether the stuff would work. To summarise, both ordinary Cambodian folk and the *gkru khmer* indicated by their practices and comments that as the Cambodian system of healing is largely defined by locale, it does not have a clear place in New Zealand. In New Zealand there are neither wars nor snakes, the risks of accidentally eating poisonous foods gathered in the forest are gone, and the endemic sicknesses such as malaria are not found here.

The locality deities, spirits and ghosts have been left behind in Cambodia, as have the bulk of the human intermediaries of witchcraft and "black spirit". It was in the protection and treatment of resultant illnesses from such hazards, including endemic diseases, that the Cambodian traditional healers, the *gkru khmer*, derived their significance. The differences in hazards to safety and health therefore result in very large chunks of the *gkru khmer* offerings being redundant.

Cambodians are settling among New Zealanders who disbelieve or know nothing of the illnesses and hazards familiar in Cambodia, especially those related to spirits. When ill, the first contact for expert care has become the family doctor who, being educated and socialised into the biomedical model of health and disease, has espoused a view of illness that is altogether different from the traditional Cambodian view. Chapter 8 depicted the process being undergone by Cambodian settlers of critically examining Cambodian theories on illness, its prevention and treatment. The result is to relegate certain beliefs and practices to the geographical and cultural place that is Cambodia, and to discard or put to one side techniques that would still be relevant in New Zealand, such as the treatment of abscesses, but which can also be treated by Western medicine. Although Cambodian "expert" healing has largely been replaced by Western medicine, self-care [1] has still remained a prominent first line of illness care, care which is an important practice in "little Cambodia".

The Maintenance of Cambodian Self-Care Practices

I became acquainted early on with the related practices of "coining", "cupping", and "pinching", carried out as a first step when feeling unwell, described as *k'jol*. The group of self-care techniques are carried out for the same group of ailments, known as *k'jol*, described as being caused by a build-up of "heat" or "air" or "wind" in the body. Both the techniques and the disorder have been well-described in literature, with explanations of participants in this study being in agreement with other descriptions (see Muecke, 1983[b], p.838; Sargent, Marcucci and Elliston, 1983, p.69; Kemp, 1985, p.45; Tudsri, 1985, p.135; Frye, 1991, p.38; Frye and McGill, 1993,

p.26).

The need to use self-care techniques is as great or greater in New Zealand than in Southeast Asia, because the climate renders Cambodians particularly susceptible to *k'jol*, and ailments such as colds and headaches are more severe. The most common of the techniques, "coining", is an uncomfortable procedure, and for this reason some prefer the technique of "cupping", which achieves the same ends while being less painful. The pattern described is that when people feel unwell, and "coining" or similar techniques do not make them feel better, then they consult the doctor (or in Cambodia the *gkru khmer*). When taking prescribed medicines or Cambodian medicine, many continue to "coin", to complement and enhance the action of medicines.

A few Cambodians have abandoned these practices since arriving in New Zealand, regarding the availability of Western medicines as obviating the need for such techniques, or fearing the doctor's disapproval of such practices (Tudsri, 1985, p.134). People are wary about "coining" their children, partly as it is not an accepted or known practice in the West, but particularly because the marks of "coining" have been interpreted as physical abuse, which has tended to discourage the practice. Several of my informants stated that while their doctors knew that they practised "coining", the doctors neither discussed the matter nor objected. Some Cambodians had never used these techniques, as although ubiquitous, the practices even in Cambodia were not universal.

The symptoms of *k'jol* for which traditional self-care techniques are carried out include dizziness, fainting, headache, pallor, fever, diarrhoea, vomiting, abdominal discomfort, and general malaise. If "coining" is applied promptly, *k'jol* may be stopped from progressing to major illness. Thus "coining" provides a treatment for low level unwellness, as well as first-aid for sudden collapse. Graphic descriptions were given of the latter, when anyone in proximity would pull out a handy coin or equivalent object and start scraping the skin until the person came round! There is also a link between *k'jol* and chronic ill-health, as VuTy indicated when I enquired

after his mother's health:

VuTy: Oh she's got fever and cold. But she has been sick for a long time too. About ten years ago she got the *k'jol*, and asked the people to "coin" because she had too much air. Since then she hasn't been well....Another thing is that she "thinks too much" about the children in the back [the past], and also her energy is weak.

Mother: Sometimes when I am well I sleep well, but when *k'jol* hard to sleep...I have no appetite, and food eaten doesn't seem to give any energy...

VuTy described how he has his children "scrape him with coin" the minute they come home from school, in an effort to ease his suffering. When children are too small to "coin", having them walk along the back with their bare feet achieves the same object. VuTy also had friends and family applying "cupping", and massaging on a regular basis. He did not expect to be cured with these practices, but did experience some easing of symptoms. At the same time VuTy was adamant that his symptoms, such as dizziness, are not like the "normal dizzy" of *k'jol*.

The *khmer* term for "coining" is *koas k'jol*. *Koas* literally means "scraping", usually carried out using the edge of a coin lubricated in Vicks ointment or in Tiger Balm, although the edge of a spoon or other blunt-edged object is sometimes used. Similarly, the term for cupping is *cjoub k'jol* [meaning "cup"], and "pinching" is *cjaab k'jol*. Thus each of this group of techniques is clearly related to the condition of *k'jol*, that collection of symptoms of general unwellness that may accompany or precede illness. Hospitalised Cambodian patients occasionally used "coining", not for the illness for which they were receiving Western treatment, but for the co-present *k'jol*.

The techniques of moxibustion and treating the pulses, described in the previous chapter, also carried out for vague unwellness, are carried out only by skilled *gkru khmer* who have mastered the techniques, techniques which are considered to have long-term benefit. The techniques for the treatment of *k'jol* can be carried out by

anybody, including children. Learning takes place within the home through observation and experience. The incidence of dizziness, headache, and other symptoms of unwellness are indeed frequent, if the stigmata of "coining" and "cupping" are any indication. The effects of the procedures were variously described:

It is like when it is very tight [inside]..it is too hard in the body, until we [do this] to make it light.

Lighter..It is like the balloon that is about to pop, so we help to deflate, to release the air a little.

It is not *cjea* [cured], but sometimes it helps, and after a night's sleep it seems better.

Let's the heat out...when you feel like 'flu' coming, your body is very cold, and after the "coin" or after the "cup" your body warms up again...

All of these techniques cause welts to be raised in the skin. "Coining", is by far the most widespread, creating welts by scraping the skin in a herring-bone pattern over the torso, upper arms, and even the entire body, until very red, with the application of Vicks or a similar ointment enhancing the redness (see Plate 3). The resulting welts take on the appearance of bruises, and heal over the next several days. The darker the marks, the more effective the procedure; informants explained that as dark and unhealthy blood is brought to the surface, its heat is allowed to escape. The procedure of "scraping" hard is painful, but several claimed that when one was really poorly one didn't notice the pain, especially the parts of the body "nearest to the sickness". Having submitted to being "coined" when suffering from a severe cold, I can't say that I agree with this view; it hurt throughout and everywhere. However, the sensation of feeling "heated" following the procedure was indeed my experience; this was explained as "the heat escaping from your body". Some of the old people say that to shower too soon after *koas* is dangerous, as the shower, in turn, "lets the cold in".

Cjoub, on the other hand, works by creating a vacuum inside small glass cups, such as baby food glasses. This can be achieved by placing burning candles over the

hurting body part, commonly the forehead, over which a glass is placed; a vacuum is created when the flame is extinguished. More commonly, an alcohol-soaked swab is lighted, quickly stirred around the inside of the cup for a few seconds, and the heated cups are then inverted over the affected area. The vacuum created by either method causes a round contusion by "sucking" the skin into the cup as it cools, the resultant bruised appearance remaining visible for several days (see Plate 4). The technique is even more effective when the newly raised contusion is then pierced several times with a needle, the cups reapplied, and blood thereby drawn. Generally, the cups are applied over the part of the body that is troubling the person; commonly four cups are applied to the forehead for headache, for example. "Cupping" is said to work in the same way as "coining", by letting the heat escape from the body, thereby relieving the tension that causes the symptoms. Some habitually use "cupping" in preference to "coining", not only because it is less painful, but because it is thought to be more effective.

Just as the demarcation is often blurred between *k'jol*, potentially a precursor of illness, and full-blown illness itself, so there is a blurring between the related sets of techniques. This is seen particularly in the interface between "pinching" and massage. *Cjaab k'jol*, literally "massage for *k'jol*", produces bruising, literally by pinching and releasing skin folds repeatedly over the same site, thereby increasing the circulation of blood to the area (see Plate 4). Of the three techniques to relieve *k'jol*, this is described as the most painful. The practice differs in purpose from another type of massage, that of *cjaab sor'sai* [massage of "nerves"], with the former being specifically to relieve the *k'jol* symptoms of general unwellness brought about by a build-up of heat or air, while the latter treats illnesses attributed to the nerves. While *cjaab k'jol* can be carried out at any time of the day with equal effect, *cjaab sor'sai* is said to be much more effective if carried out first thing in the morning, before the sufferer undertakes any activity. Massage carried out for *sor'sai*, or "nerves", is distinct from self-care carried out for *k'jol*, the former being more explicitly for the treatment of illness rather than vague symptoms.

The disorders of "nerves" treated by *cjaab sor'sai* include pain of the muscular and

skeletal systems, in which case the massage technique involves direct manipulation of the "nerves". The techniques of massage therefore vary according to the body part as well as the practitioner, and include rolling the skin, massaging the neck, and as stated, manipulating the spinal column and joints. However, whereas the practices of "coining", and to a lesser extent "cupping" are ubiquitous, fewer are skilled at massaging. One person told of women who in Cambodia would set themselves up in business as "healing massagers", employing *cjaab sor'sai*, "cupping" and massaging using cups. There were a few, mainly women, in the Palmerston North community reputed to be skilled at massage, skills often called on by those suffering a variety of symptoms attributed to "nerves".

While "coining", "cupping", and massage are the principal self-care techniques used, there are others. For example, pustules on VuTy's back, also perceived as evidence of a build-up of internal heat, were treated with a compress of aloe vera, colloquially known as "crocodile tail". Aloe vera compresses may also be used for the treatment of abscesses, burns, and severe headaches; the substance is effective because of its cooling properties. Although VuTy's family knew of this treatment from Cambodia days, other participants had never heard of it. Rubbing onion over a distended belly was recommended for small children. These were the only such herbal home remedies I came across, but from comments made, there were many used by rural Cambodians in Cambodia and further, remedies probably varied according to locality. As for Cambodian medicine, the non-availability of many such substances, combined with a learned reliance on the family doctor, account for a decline in such practices in New Zealand.

Just as physical and mental manifestations of "thinking too much", not regarded as illness, can merge with symptoms of illness, so too can *k'jol* and symptoms of illness overlap. Added to this, states of *k'jol* and *gkuet cj'roun* [thinking too much] and the approaches to find relief from these conditions are quite distinct, yet there are common symptoms and characteristics. In both, headaches, dizziness and a variety of other bodily symptoms are described. Neither are synonymous with illness states, yet if unchecked can lead on to illness requiring expert treatment. Both may

accompany illnesses, making the illness worse, or themselves be triggered by the illness.

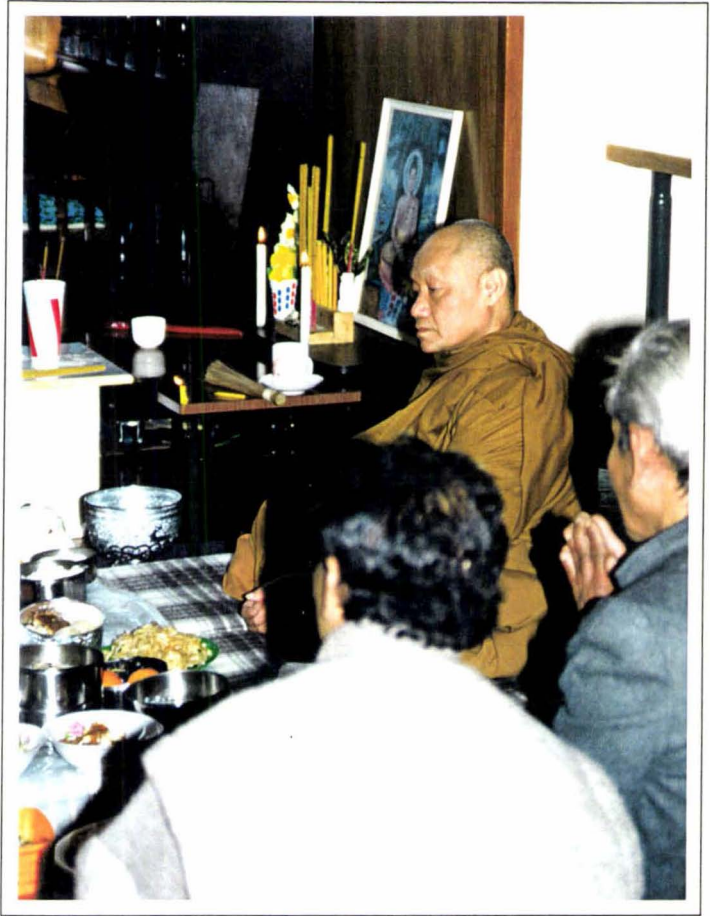
It is significant that the approaches for providing relief of both *k'jol* and *gkuet cj'roum* are in the hands of ordinary people, and not the domain of the expert healer, be this the Cambodian *gkru khmer* or Western doctor. When *k'jol* and *gkuet cj'roum* are co-present with a recognised illness that is being treated by an expert, there is no contradiction in maintaining both self-care and medical treatment simultaneously, as indeed is frequently done. Neither is there any contradiction in continuing to use techniques to relieve *k'jol* when a specific symptom, such as dizziness, is "not like the ordinary dizziness", as both kinds may be present. To "coin" is not seen as an alternative to consulting the doctor, but a practice to relieve the prodromal or accompanying *k'jol*, to make one feel a little better until one can get to the doctor, and as a way of enhancing the doctor's medicines.

In the light of this analysis, literature is misleading that describes build-up of air or wind as kinds of illnesses (eg Frye, 1991, p.38), and the techniques of "coining" and "cupping" as "traditional cures" (Hafeez, 1988, p.197f). Rejecting the interpretations of "coining" from the perspective of biomedicine, Marcucci(1994, p.129) argued that the deliberate infliction of pain by "coining" and related practices is a means of asserting cultural identity, that "reveals the experience of suffering". The absence of grimace and groaning, a characteristic stoicism in the face of severe pain as described in the previous chapter, is apparent also in those submitting themselves to "coining". The practice of mutual "coining" has also been viewed as strengthening and reinforcing family bonds, an expression of caring and concern one for the other (Marcucci 1994, p.135f). The sufferer is thus no longer isolated in his or her suffering, but carries the marks on the body for all the world to see, and sympathise with. In bringing "bad blood" to the surface for the heat or tension to be released, the pain of "coining" brings to the surface the greater internal pain, making visible the inner pain of the sufferer. The practice of such techniques one for another is a feature of "little Cambodia", in which context a socially integrating function is evident.

Regarding the children, the use and acquisition of such techniques is apparently being abandoned. The intergenerational gap, already wide, is in this added dimension further increased in the differing practice of self-care between generations. Children growing up in the West have experienced neither their elders' traumatic life experiences and deprivation, nor "know" the pain of self-care for culturally embedded unwellness. The conditions of *k'jol* and *gkuet cj'rourn*, with their associated self-care practices, are properly viewed as illness prevention, symptom relief, and early intervention measures from the perspective of the Cambodian system of healing. As such, both the expression of symptoms and the techniques to relieve symptoms have meaning within the Cambodian culture, but are not understood externally. Above all, these self-care techniques afford a degree of control over personal health. With Cambodian ways of caring for illness otherwise largely redundant, self-care practices alone are maintained by resettled adult Cambodian refugees, in the context of "little Cambodia".

The Integrating Function of Illness

The socially integrating effects of self-care have been alluded to, with for example "coining" providing an opportunity for family and friends to minister to the sick person. It is hard work, and an all-over "coining" can take over an hour. Preferred ways of caring for the sick are also maintained, which serve to affirm the unity of the Cambodian community. The sick are not left to suffer alone, but are kept company, and the ill and ageing are preferably cared for at home. Rest, quiet, company and tempting food are advocated. The way of life in New Zealand, with its multiple external demands and obligations, is not as conducive as rural village settings to such practices of caring for the ailing, but such are observed in all but the most socially dislocated of families. Paradoxically, serious illness is simultaneously a strain on the family as they endeavour to fulfil their caring obligations, and an opportunity for relatives and friends in the wider community to come together in their common concern for the sick. Thereby illness strengthens social networks in a community that otherwise has few opportunities for togetherness and face-to-face



Merit-making ceremony, to strengthen the ill



Ingredients for Cambodian medicine



Instructions for mixing medicines



Illustrating moxibustion points



Tattoo for protection



Moxibustion burns around navel

PLATE 3 "Coining"



“Cupping”



“Pinching”

interaction.

Clear expectations regarding those close to the ill person were articulated: they are expected to comfort the ill with their presence; to endeavour to relieve their discomfort through a variety of self-care techniques; to ensure the ill receive professional attention as necessary; and to nurture the ill by suspending social obligations and by offering the special foods that are fancied or that are known to be good for the sick. The ill person is permitted to rest; to adopt a passive role in the acceptance of treatment arranged; to let recovery take place at its own pace; and to resume social roles and less-preferred activities only when inclination and energy has returned. It makes sense, therefore, that Mrs Kev is not forced to do anything doctors may advise, such as keeping mobile, if she doesn't feel up to it. It makes sense that so long as SuBai, SaRom and VuTy still have symptoms, they are not eager to return to the work-force even though medically cleared. The Western medical concept of rehabilitation, that is aimed at "working" to accelerate the restoration of health and function, therefore doesn't fit well with the Cambodian way of letting the ill person resume activity and social roles at their own pace.

Instances of hospitalisation well-illustrate the place of the family and friends in the care of the ill. During the hospitalisations of Mrs Kev, TiDaa and VuTaa, all elderly women, the patient was rarely left alone for long, with rice soup and other special foods for the sick being brought. As none of the women spoke English, it was especially important that someone able to translate was either present or readily available. TiDaa's daughter described how she was frequently called by the hospital at very short notice to interpret for her mother during three admissions in short succession, and VuTaa's family seldom left their mother for long during her prolonged stay in hospital. The importance of not leaving the ill to suffer alone was emphasised in many accounts, and when Mrs Kev was in hospital with a stroke and convalescing at home I saw for myself the way this mobilised a wide network of friends to keep company with her. At the same time, the fact that few of that age group are able to converse in English potentially limits the availability and benefit of care. For example, rehabilitation services are of limited use, and Cambodians may

be reluctant to go into a nursing home or hospital even for respite care.

The Cambodian way represents an alternative to the norm in New Zealand society, when the ill are often institutionalised, or cared for by both family and professional care-givers. The Cambodian approach of collectively caring for the sick serves to bring people together, strengthening social networks in the process. This is not to say it is not burdensome, and carries no cost; to care for her mother cost TiDaa's daughter her job, and Mrs Kev's increasing dependence makes progressive inroads into the family's freedom to be involved in activities outside the home. The honour and respect which the elderly in particular are accorded, especially one's parents, are characteristic of the devoted care given when they are sick. There are obvious tensions in caring for the ill and ageing in an industrialised urban society, that contrasts with the more flexible village life in which they were raised. Notwithstanding, several years after resettlement in a society with different views and provisions for caring for the sick, Cambodians maintain preferred approaches.

The society of "little Cambodia" is strengthened as members of family and community come together to show their love and care to the ill, whether they are in hospital or at home. Very occasionally, a Buddhist ritual may be carried out to facilitate recovery, such as a "shower" with holy water, which serves the same function of bringing community members together for a common purpose. After her stroke Mrs Kev vowed to make a special ceremony if she recovered. This she fulfilled about a month after being discharged from hospital (see Plate 1).

Mrs Kev, as the focus and *raison d'être* of the occasion, shaved her hair "like a monk" [2]. All who participated "made merit together", the monk explained, as they joined in the cycle of chants, and collectively received from the monk the showering of "holy water" to bring "good luck". The monk described the ceremony as an expression of gratitude by making a feast for all one's friends and for the monk(s) who officiate. From the monk's perspective, it is through such a ceremony and the collective merit-making that the one weakened by sickness can be strengthened and protected. As far as Mrs Kev and her family are concerned, they carried out the

ceremony mainly to fulfil her vow. There are thus several interpretations of the benefits of the ceremony. In addition, by attracting relatives and friends from as far away as Hamilton and Wellington, it also served the purpose of a celebratory reintegration of Mrs Kev into the Cambodian community, after her serious illness that for a period suspended the normal involvement in community life of herself and her family.

Research on refugee health which is predominantly from a biomedical perspective, and mainly interested in prevalence and management of disorders, has little to say about issues such as the preferred way of caring for the ill and the social function of healing. An analysis of the social effects of illness, and the expectations and obligations of both the ill and the well, falls in the domain of medical sociology. As with biomedically based research into refugee health, sociology too is limited by being developed in and for Caucasian societies of the industrialised world. For example, medical behavioural constructs of illness, of sick role behaviour with its "work" of getting well, and patterns of complying with medical expectations of giving up things, taking things, and doing things in order to hasten recovery are of limited usefulness in explaining Cambodians' illness behaviour. Even in the Western world, there are pockets of disenchantment with theoretical constructs, reflected in the preface to a collection of documented "experiences of illness and treatment" (Davis and Horobin, 1977). Pointing out that sociologists' analyses of illness tend to be detached, objectified, and formal, thus losing the essential humanness of illness, Davis and Horobin (1977) argue for the coherent presentation of the patients' perspectives and experiences.

The Search for Alternatives - Thai and Chinese

The pattern of Cambodians simultaneously drawing from Western, Thai and Chinese medicines, while at the same time as frequently being "coined", is not unusual. Such a pattern of pluralistic treatment was observed with Mrs Kev, SomBut, SaRom, and Mrs Nhim, among others. One such was VuTy, who continues to consult his family

doctor frequently and to reiterate to him his distressing symptoms, while at the same time constantly searching for relief from a variety of other sources. Once when in Auckland he consulted a vendor of Chinese medicine in a market. The fact that the medicine didn't help he attributes to his and the vendor's mutual difficulties in communicating, possibly resulting in his being given the wrong medicine. He tried, unsuccessfully, to arrange for a friend visiting Cambodia to bring back some Cambodian medicine recommended by a friend: "two kinds for dizziness, and five kinds for fever, and nerves". Somewhat inconsistently, though, he has not consulted the local *gkru khmer*, claiming that "he can't help at all with this kind of sickness", as it is "not like normal sickness". After learning with surprise that acupuncture was available in New Zealand, having encountered it in Cambodia, VuTy underwent several courses of treatment, which resulted in temporary improvement.

A small range of Chinese medicines is available locally, but for a wider range it is necessary to travel to Auckland or other major cities. There is considerable traffic in such medicaments, with people purchasing for their friends when they visit another centre, passing on the instructions orally, along with their personal experiences of the medicines. Cambodians will make the trip to Auckland for the principal purpose of seeing a Chinese doctor and getting medicine. SomBut did this, with ill-effect as it happened, as the medicine proved far too strong for him. I, too, was strongly advised to follow this course of action when several weeks of my family doctor's medicine was proving ineffective in relieving my own complaint. Thai shops are located only in larger centres, but as Thai medicines are closest to those with which they were familiar in Cambodia, they are much sought after. The "Widow with One Child" powder favoured by women to restore the body after childbirth can also be purchased at Thai shops. I purchased a packet for a friend on one occasion, and was interested in the reluctance of the proprietor to sell to me a medicine my body was not used to.

When neither self-care techniques nor Western medicine provide relief for distressing symptoms, resettled Cambodians frequently go on to procure such medicines as were formerly available in the markets of Cambodia and Thailand. The context of "little Cambodia" provides a rich and active network of information-sharing on such

medicines: where they can be procured; what are the indications and uses; which are the appropriate prices; and who can provide a purchasing service by virtue of their contacts. As most shops selling such medicines are in the major cities, the latter is important. As with surplus Western medicines, so Chinese and Thai medicines are given to friends, whose symptoms are similar, to try out. Many households produced the various tinctures, powders, liniments and ointments in their possession, mainly for the relief of muscular and joint pain, colds, and to heat the skin. The rapid increase in Asian immigration during recent years (see Chapter 2) is likely to have boosted the supply of Chinese and other Asian medicines. While these may still be limited in range and availability, resettled Cambodians are to some extent able to treat their illnesses in a context of medical pluralism, approaching that to which they were formerly accustomed when living in Southeast Asia.

A Cambodian-New Zealand System of Healing

In contrast to a worldwide system of healing such as the Western biomedical system has become, and major regional systems of healing such as the Ayurvedic or Chinese systems, local systems of healing are circumscribed geographically and culturally. The indigenous system of healing in Cambodia is one such, accommodating as it does theories held by ordinary folk about illness, its prevention, and treatment with medicine as well as ritual (Dunn, 1976, p.135). I have shown that the local Cambodian system of healing is located in a specific physical and cultural place, the country of Cambodia. It is likely that the Cambodian system of healing is also located in an historical place, the Cambodia that existed before the determined and progressive decimation of its population, culture, religion, and natural environment which has been going on over the past few decades.

By the late twentieth century, the Cambodian system of healing was itself mixed, having adapted to and accommodated Western medicine as well as elements of Chinese, Thai and Vietnamese medicine. Prior to leaving Cambodia, people described having limited access to Western medical care, particularly hospitals, yet within those

limitations had considerable freedom in seeking treatment. In particular, they were able to acquire with relative ease the injections and intravenous infusions thought to be more potent than either Cambodian medicines or oral Western medicine. Cambodians were not limited to any particular system of healing, but could and did variously use Cambodian medicine, Western medicine, and latterly, Chinese techniques such as acupuncture. As well, there were in the market place Vietnamese, Thai, Chinese, and Cambodian medicaments for sale, together with low-cost amulets to protect against common dangers. Choice was limited by ability to pay and availability, serious limitations at certain periods and places. In such an unregulated environment the buyer, that is the patient or family, exercises a high degree of self-directiveness and personal control over treatment and ultimately, the course of the illness. At the same time, the buyer has no protection against fraudulent practitioners. Ties of trust and community-based reputation are therefore indispensable to effective treatment of illness.

The wholesale natural and cultural destruction that has driven multitudes of Cambodians out of their own country, and on to seek re-establishment in the West, has in its wake severely weakened the basis of the Cambodian system of healing. In large part, this is because of the intimate relationship of illness and its treatment, as one category of misfortune, to the hazards that frequent Cambodia. Cambodians who resettle in New Zealand are no longer at risk to a wide range of hazards. At the same time, Cambodian healers do not have access to the substances needed to treat even those illnesses that transcend geographical and cultural boundaries, and moreover assert that local doctors are best-suited to treat local diseases, reflecting a truly local perspective on illness and healing. It is not surprising, therefore, that most participants indicate that the non-availability of *gkru khmer* medicine is seldom a problem. It is not portrayed as a grievous loss, and is, they insist, more than compensated for by their access to the coveted high quality Western medicine.

However, closer inquiry reveals that the demise of *gkru khmer* and *chmorb* practices is a significant feature of the cultural dislocation of New Zealand Cambodians, and represents a major reduction in choices of healing. The nonavailability of Cambodian

medicine together with the loss of direct access to Western and other medicaments, is exacerbated by dependence on the family doctor to procure medical treatment. Access to and patterns of use of both *gkru khmer* and Western systems of healing have thus changed dramatically with resettlement in New Zealand. Western health services now available to them are far superior to anything most had experienced prior to coming to New Zealand. However, the gaps between expectations and experiences, and the difficulties in communicating and effectively interacting within the system detract from its excellence. As a result, Cambodians' understanding and use of the health system of New Zealand is not as effective as it might be. Discovering that previous mechanisms for explaining and handling illness are no longer appropriate, at the same time refugees lack the necessary social and other support to learn new strategies appropriate to New Zealand.

In this scenario of change, a Cambodian-New Zealand local system of healing is emerging. The fundamental element, an element which appears to be constant in both Cambodia and in New Zealand, is the practice of self-care. "Coining", "cupping", "pinching", massage, and techniques to manage "thinking too much" are key features of self-care practices. These techniques are arguably more necessary in New Zealand than in Cambodia, with the effects of past deprivation and trauma, current adjustment stress and the change of place all generating the disorders treated by self-care techniques. Equally important, self-care represents the remnants of the Cambodian system of healing, and offers a degree of control over the course of the illness, albeit drastically reduced. In addition, mutual support and community involvement, with at least other Cambodians recognising the stigmata of suffering, are crucial. It was impressed on me that Cambodians who have always used these techniques continue to do so, and if for any reason self-care is not possible, for example in hospital, the sufferer feels very poorly indeed.

A second element of the Cambodian-New Zealand system of healing is the widespread practice of self-treatment with over-the-counter medicines, particularly the compounds purchased in Thai and Chinese shops. As only the less potent of oral Western medicines can be purchased without prescription, and it is often less costly

to acquire these with a doctor's prescription, there is little sign of interest in pursuing the over-the-counter purchase option of Western medicine. Furthermore, as with acupuncture and physiotherapy, both available without referral from a doctor, there seemed to be little awareness of pharmaceuticals available without prescription. Prescription pharmaceuticals are better-known. Word is passed around as to which are effective for the relief of which symptoms, with some people exerting pressure on their doctors to prescribe a particular medication. The less effective medications may be abandoned, and handed out to friends to try if symptoms are similar. After all, it is well-accepted that medicines act differently with different people, and there is a chance that a medicine for a similar-sounding condition will benefit. The sharing of information about medicines, and the medicines themselves, is an example of health care in "little Cambodia".

The Cambodian local systems of healing in Cambodia and in New Zealand differ significantly, yet also demonstrate broad similarities. In each there are elements of self-care, a first measure when ailing, as well as practiced to enhance the action of medicines. Also constant in both countries is the practice of self-treatment with over-the-counter medicines, which includes Chinese, Thai, and Western medicines. The most dramatic difference lies at the level of first-contact expert healer, who in Cambodia was almost always the *gkru khmer*, and who has been displaced in New Zealand by the family doctor. Not only are the systems of healing underpinning practice different, but the relationships contrast in very significant ways. According to those I talked with, both *gkru khmer* and family doctors are perceived as having varied abilities and reputations. While in Cambodia it was the practice to find a *gkru khmer* of higher reputation for identifying the cause of illness if the first one was unable to help, the New Zealand system does not lend itself to such practices. On the contrary, patients are stuck with the family doctor, and even though change is theoretically possible, in practice it is difficult. In any case, such a once-off change doesn't equate with the process of continually trying out different *gkru khmer* of ever-increasing skill and power until recovery is accomplished. When primary medical care is ineffective hospitalisation may be required. At this point the local systems of healing of the two countries again converge, with the differences lying in

the differential quality and availability of hospital services in the two countries. Whereas self-referral to hospitals in Cambodia was possible for those with sufficient social standing and finances, in New Zealand access is limited to referrals by a family or emergency doctor.

Systems of Healing as Mirrors of Exile and Transition

Cambodians settling in New Zealand expect things, including health care, to be different from Cambodia and refugee camps. It is therefore neither surprising nor shocking for them to be expected to adjust to the formal health care system of New Zealand. Nevertheless, this study has demonstrated that the very process of doing so underscores the experience of exile. These conclusions have important implications for their ability to care for illness, and for their health status.

Beginning with the official orientation to the health care system, and reinforced by episodes of illness necessitating contact with the system, the differences between Cambodia and New Zealand are repeatedly brought home to them. Not only are the symptoms often different to their experiences pre-migration, but options for treatment of illnesses are relatively limited. Prior knowledge and experience in caring for illness are not acknowledged, and Cambodians themselves seem ready to negate Cambodian theories of illness and medicine, in favour of those of Western medicine. Caring for illness in New Zealand is characterised by total dependence upon medical experts who are near-strangers, in contrast to community and family based care characteristic of life in Cambodia. Cambodia differs from New Zealand in the absence of state control, and wide range of choices among treatments and practitioners, availability and purchasing power permitting. Although my informants declared themselves to be very satisfied with the New Zealand health care system, their narratives indicated that for many this isn't the case. The strongest evidence is found in the way a Cambodian-New Zealand local system of healing has developed, that incorporates into the official Western health care system, self-care and self-treatment with non-Western techniques.

However, this system appears to be limited to Cambodians born and reared in Cambodian ways. Cambodians who arrived in New Zealand while still in their teens are less likely to care for their illnesses in the manner described as the local Cambodian-New Zealand system. In fact some disregard all except Western medicine as "superstitious" and "ignorant", or more generously, as the best people could do without the benefit of modern development and education. Added to this, even those older Cambodians, who themselves treat illnesses with a mix of remedies and approaches, tend to treat their children differently. The children's health is cared for solely by the family doctor, and Cambodian self-care and non-Western medicines are not tried. At most, children may observe such practices in their home, but few are learning the skills needed to carry out Cambodian self-care, and remain largely ignorant of *gkru khmer* medicine and approaches.

As young Cambodian New Zealanders become more distant from the Cambodian cultural knowledge and values of their parents, the transitional status of the older adults is exacerbated. Paradoxically, the local Cambodian-New Zealand system of healing in these circumstances becomes a symbol of this status, and of their exile from the land of their birth. It is likely that young people will relegate the local Cambodian-New Zealand system of healing to the era of their parents, whose lives were scattered over two continents and three nations, and whose cultural heritage contrasts markedly with their own. As the Cambodian refugees who have settled in New Zealand over the past decade are unavoidably transitional people, the local system of healing that they have evolved to ease their transition is itself transitional. As the older people die, and the younger adults continue to encourage their children in adopting New Zealand ways, it is likely that this local system of healing will decline in importance. In its place, Cambodian New Zealanders growing up in this country are likely to accept the formal biomedical health care system, along with the popular alternatives of the day.

Conclusions

By departing from the clinical and health status survey approaches, this study has succeeded in uncovering the experiences and perceptions of a Cambodian refugee population. While findings do not add to knowledge about disease diagnosis and prevalence, issues that were presented in this chapter include the relationship of transition with healing. Coming from a background of medical pluralism, the finding that Cambodians draw from the growing range of Asian medicines available in New Zealand was expected. I argued that even if Cambodian medicine was available, it has little relevance outside Cambodia and environs. In contrast, Cambodian self-care techniques are highly relevant and maintained. Preferred ways of causing for the ailing are also maintained, in spite of contrary medical advice in some cases. There were some surprises, such as the socially positive effects of serious illness in caring people to come together in face to face contact, as they sought to comfort the sufferer. "Little Cambodia" is the principal contact for the practice of self-care, for sharing of information and medicants, and for caring for the ill. Thus "little Cambodia" is an essential element of the Cambodian-New Zealand system of healing.

While differences between the Cambodian and New Zealand health care systems were expected, the construction of differences at primary and secondary levels demonstrated both advantages and drawbacks for Cambodians settling in New Zealand, compared with health care in Cambodia. My findings have shown that both are truly local systems of healing, regarding illnesses themselves as locally-circumscribed, requiring local expertise in treatment. While both the Cambodian and Cambodian-New Zealand systems of healing are pluralistic systems, the elements comprising each are quite different. The element constant in both countries is the practice of self-care techniques, which provides both continuity and a measure of control over illness and healing. Using the life-cycle experience of childbirth, the following chapter illustrates how these multiple issues merge in a single phenomenon.

Footnotes

- [1] I use the term "self-care" to refer to the popular healing practices of "coining", "cupping", "pinching", and massage. Strictly speaking, these are not "self-care", as a sufferer never performs the practices on him/herself. Always a family member, a friend or a neighbour applies such remedies to the sufferer. Non-expert caring by another has been termed "cover care" (Verschure, (ed) 1980). In the context of Cambodian practices, I prefer the term "self-care", as it reflects the interdependence of Cambodians in domestic and community settings. This contrasts with Western individualism and autonomy, and illustrates the limitation of Western concepts such as "self-care" for non-Western societies.
- [2] The principal transcriber told how he made a vow that he would shave his head like a monk if he had the opportunity to complete his studies. So it was that when he received the results of his final examinations, thus completing his degree, he immediately shaved his head, much to the horrified surprise of his wife! For the Buddhist, such acts are carried out for the purpose of making merit.

Chapter 11
"CROSSING THE RIVER"
Childbirth Practices in Transition

Experiences and interpretations of illness and its treatment, by Cambodians who have resettled in New Zealand, have been unfolded in the previous three chapters, demonstrating important differences between the culture of the New Zealand health care system and that of Cambodian users. Culturally embedded phenomena include explanations of illness beyond the narrowly-defined biomedical model, the manifestation and interpretation of symptoms, expectations of the ill and of those caring for them, and pluralistic healing practices.

These divergences are well-illustrated in the area of childbirth. Unlike illness phenomena, where the very diversity among disorders creates difficulties in identifying patterns and commonalities, childbirth is essentially a universal physiological process, regarded as a normal life process in contrast to being a disorder. Nevertheless, childbirth constitutes a life crisis, and accordingly is treated in very specific ways. In Western cultures, including New Zealand, the characteristic way of managing childbirth is to medicalise the process, although recent years have seen a questioning of this approach. Thus while the actual physiological process of giving birth to a child presumably is constant across races and cultures, the surrounding beliefs and ways of supporting and succouring the woman are not (for example, Park and Peterson, 1991, p 266; Waxman, 1990, pp.188 ff).

This chapter draws together the diverse strands raised in previous chapters, which analyze health beliefs and practices in transition among a Cambodian refugee community. After reviewing literature on fertility and childbirth among Southeast Asian refugee women, I describe culturally prescribed ways by which Cambodians care for their women during and after childbirth. While these traditional approaches largely reflect those prevalent in Cambodia, the persistence of certain practices in New Zealand are described. Explanations of beliefs concerning the vulnerability of the new mother, expressed as a weakness of "nerves", are covered in some detail.

Associated protective practices pick up prominent themes of illness self-care, including avoiding "thinking too much", and in particular, avoiding exposure to cold and wind.

This perceived vulnerability explains the relationship between childbirth and illness affecting a number of the women who took part in this study, a relationship which emerged early in the study. Following a summary of these illnesses, the narratives of two young women are presented, whose paresis (weakness and partial paralysis) around the time of giving birth in New Zealand hospitals, has been previously mentioned. A comparison between the Cambodian way of supporting and assisting the woman giving birth and that of New Zealand hospitals follows, which sheds some light on the phenomena just related. I conclude by exploring the transition made by these women from a Cambodian traditional model of childbirth to a hospital delivery, illustrating the issues identified in the previous two chapters.

A Review of Literature on Fertility and Childbirth among Southeast Asian Refugees

There is little published research about Cambodian traditions regarding childbirth. Of the few cited by Kulig (1990) in her review of literature on the health of Southeast Asian women, most are unpublished dissertations. As she points out, the bulk of this body of literature on women's health is related to fertility and childbearing issues, mostly about obstetrics, fertility and family planning, portraying a view that equates womanhood with motherhood.

The study of Rumbaut and Weeks (1986, p.428) was one such, which set out to explore the levels of fertility among refugees who had recently moved from "high fertility Southeast Asian societies to a low-fertility region". Large family size, postulated as being desirable in an agrarian economy lacking in social welfare provision, may become a financial liability in the United States. In spite of this premise, all groups included in that study showed very high levels of fertility. Next

to the Hmong, fertility was highest in the Cambodian community. An earlier American study similarly found a fertility rate 1.8 times higher than the national average, accompanied by high rates of low-birth-weight infants, and a pattern of older maternal age and lower uptake of prenatal care (Hopkins and Clarke, 1983). It is against such a background of high fertility among Southeast Asian refugees that Kulig's (1988) study on beliefs regarding menstruation and conception was conducted. Having collected a wealth of qualitative data to discover the beliefs and understanding of Cambodian women about conception, which she concludes did not coincide with the Western physiological body of knowledge, Kulig goes on to recommend that the delivery of birth control services needs to take into account the existing level of knowledge and their social contexts.

Based on statistical trends and accepted risk profiles, it was expected that Southeast Asian populations resettled in the West would require high levels of maternity and child health services, along with family planning initiatives. These expectations proved to be unfounded, with Weeks and Rumbaut (1991, p.327) seeking to explain this "contemporary public health enigma". In spite of their high risk pregnancy profiles, very low socio-economic status, and the traumatic and stressful histories of these women, Southeast Asian refugees and other Asian immigrants demonstrated better than average pregnancy outcomes. Based on the indicator of infant mortality, rates among immigrants of Asian origin were not only significantly lower than the national average, but were lower than those of white Americans. They were also significantly lower than rates previously experienced in their countries of origin. Having systematically eliminated age-specific causes of morbidity and death that might explain the phenomenon, including fetal death, these authors conclude that positive socio-cultural factors account for low infant mortality.

While this finding raises questions about the supposed need for Southeast Asian refugees to be taught by professionals on how to care for their mothers and babies, there is at the same time evidence that women, who formerly relied on elders and kin for child-rearing advice, increasingly turn to health professionals for such support after resettling in the United States (Lenart, St. Clair and Bell, 1991). The same can

be said for childbirth. In their inquiry into health care practices of Tai Dam women (from Vietnam and Laos), Bell and Whiteford (1987, p.322) point out that Southeast Asian women do not view childbirth as an illness, but rather as a natural process. Nevertheless, in the United States medical care for pregnancy and childbirth was frequently sought.

Beliefs and practices of Cambodians in particular have been documented. The belief that the woman giving birth is highly vulnerable and at risk of death, described by Frye (1991, p.38) was supported in the present study, as was the view that childbirth is a "cold" state, which must be restored to equilibrium by "hot" treatments, beliefs which remain widespread even after resettlement in the West (Frye, 1991, p.37; Sargent, Marucci and Elliston, 1983). Included are such practices as eating meat, wine, condiments and "hot" medicine, and the practice of "mother roasting", by which the mother is warmed by the burning of a low fire beneath her bed.

Building on this literature, the phenomenon of childbirth was further explored in this study, particularly as pregnancy and childbirth generally bring resettled Cambodian women into contact with the health care system. Much of the information on childbirth-related beliefs and observances was obtained from Mrs Meas, one of the *chmorb*, or Cambodian traditional midwives. When she discovered that I, too, was a midwife she was more than eager to extend my education, and was well placed to do so, being much more experienced than I. With interviews often taking place in the presence of Mrs Meas' family and friends, they would contribute their own opinions and experiences, clarifying and elaborating on Mrs Meas' descriptions. The customary beliefs and practices explained to me from the practitioner's point of view, including a second *chmorb*, were further corroborated by narratives of women's experiences, to which the translator-transcriber added by drawing on the expertise of women of his own family. With both men and women contributing, it became clear that the business of childbirth is by no means solely the domain of women, but skills and practices are known to and involve all.

"Crossing the River"

The woman in childbirth is said to be *chlong dtunlei*, "crossing the river" (alternatively "crossing the sea"), not a little river, but a huge river like the Mekong, the social and economic artery flowing through Cambodia. This metaphor sums up the perceived vulnerability and uncertainty of childbirth, which was explained to me as:

Like being in the middle of the river, when you don't know whether you will get to the other side, [and you] don't know if you [will] sink.

The idiom is not used to refer to any other vulnerable state. It is not used for equivalents in uncertainty and risk, such as having an operation, or embarking on a journey. Thus, its meaning is very specific. I wondered whether the metaphor was used to describe their escape when they literally crossed the river that forms the border between Cambodia and Thailand, and again when they "crossed the sea" between Southeast Asia and New Zealand. Although to thus widen its application made good sense to them, I was assured that use of the idiom is confined to childbirth.

The nuances are illustrated in the following exchange between Sok and Mr Meas:

Sok: She asked why we call it "crossing the river". I stressed that we *khmer* are *pey* [afraid], not sure whether we could complete the crossing.

Mr Meas: Very old word...look, *chlong dtunlei* [crossing the river], *gkout gkoan* [to give birth to a baby], *pro'soat gkoan* [a synonym used to refer to the high-born giving birth]. It's like being a pair, death and birth are a pair. That's why [we use a euphemism].

Sok: But mostly people use "crossing the river". Some say: 'Has your wife "given birth" yet?' ...That's learning how to talk [that is, they don't yet know the correct phraseology]. *Gkout gkoan* is not very nice, the sound is not nice.

Mr Meas:...yes, we use *chlong dtunlei*, because that is very difficult, very tiring..."crossing the river" is tiredness, poverty,

hardship, like us swimming, it's very tiring...

Sok: ...and not sure whether or not [you] can complete the crossing.

"Crossing the river" was thus likened to a new birth, or being reborn. I asked about methods employed to ensure a safe "crossing". The simple answer is that you cannot ensure a safe "crossing", and for this reason they are *pey* [afraid]: "Because in our country the hospitals are far away, [and] we live in remote areas, when we have a baby in the womb, we compare it to being born again after the birth". Nevertheless, there are a number of physical, medicinal, and ritual techniques used for the purpose of maximising the chances of a safe "crossing". Of the former, from the time labour begins, the *chmorb* gently massages the woman's abdomen to keep the baby correctly aligned with the birth passage, and the woman is given foods high in energy and easily digestible to give her strength.

Risks and uncertainties of childbirth are reflected not only in euphemisms, but in the routine employment of ritual in the attempt to control malevolent supernatural forces. Childbirth-related protective practices illustrate those described in the previous chapter, carried out by *gkru khmer* in Cambodia, but which are largely redundant in New Zealand. Broadly, these comprise the channelling of benevolent spiritual power using *pali*, and carrying out rituals to protect against malicious beings, especially witches. The ritual techniques described originated in Hindu and Buddhist mythology, in which these beliefs and practices are embedded. While it is beyond the scope of this study to describe and document these in detail, I have summarised what was explained to me by the rural people who informed me. However, they too were limited in their understanding of where these customs came from and what they mean, as these village Cambodians were reliant on ritual expertise from the *gkru khmer* and Buddhist monk. As risks of childbirth declined with improved maternal health and better access to Western maternity services, so the demand for and practice of these protective techniques also declined. This appears to have been the pattern both in urban Cambodia and in refugee camps and is even more marked in New Zealand, where the culture, with its dominant biomedical health care system, reinforces the shift to medically-supervised births.

Commonly, the *gkru khmer* gives the labouring woman a concoction to drink called *tam s'doh*, into which he has "sprayed" a *pali* word, for the purpose of giving her a quick, easy labour. One person described his eldest sister being given a bowl of water by her *gkru khmer* husband, into which he had carried out *a'gkum kie-ta* [the practice of magic, in this case reciting "magic words" into the water], which reportedly was effective in easing her labour pain and hastening the birth. Making a cordon of protection, such as by sprinkling "holy water" that has been blessed by a monk, or tying a "holy cord" about the woman's girth, are examples of the techniques used to protect from harm during this dangerous time.

In traditional contexts, the woman is believed to be particularly vulnerable to witchcraft throughout her pregnancy, especially those who are not robust, and the "ignorant" who take no precautions to protect themselves spiritually. Steinberg (1959, p.81) goes further in suggesting that by giving birth the woman exposes the entire household to very real danger from the spirit world, necessitating the carrying out of protective ritual. For example, one woman related how in Cambodia the monk used to tie a "holy cord" about the room where she was to give birth, as a barrier to those malevolent beings, to protect both herself and those attending her. The degree of perceived danger is further evident in the practice of cutting the hair of the woman about to "cross the river". In the event of dying in childbirth, she may become a particularly sinister type of "ghost" that has long hair, a hazard to the living that is minimised by the cutting of her hair.

Typically the village woman labours and gives birth in the bamboo-floored house raised above the ground. Blood dripping through the slats poses a danger from "witches licking it up", with the result being a particularly serious form of *dtoas*, the group of childbirth-related illnesses to be described below. These witches are believed to be normal village women by day, but at night the head separates from the body and taking the entrails with it, creeps along the ground in search of its prey. As soon as the woman starts labour, it is the husband's responsibility to physically protect that area beneath the house, usually with branches of a thorn bush, said to prevent the witch from gaining access to the blood. Such beliefs, while strong in

village areas, tended to decline in Cambodian cities, and are not feared at all in New Zealand, with witches supposedly inhabiting villages only.

The woman who has just "crossed the river" is perceived as being in a weak state of body and mind. Sudden, loud noises can startle or alarm her, resulting in *pey* [in this context meaning fright, or shock] and *p'njak* [startle], both of which can cause illness and eventually even death. Therefore, in village Cambodia particular care is taken to ensure that the place where she rests is quiet. Women explained that while absolute quiet was seldom achieved, unexpected noises were eliminated. For instance, the sound of playing children wouldn't startle the mother as the sound was familiar, but sudden crashes and bangs were risky. The protracted years of fighting therefore posed a particular risk.

Furthermore, it is very important that she doesn't "think too much" at this time, as "too much thinking makes her sick, [as] her body is not strong enough" (see Chapter 7). Those around her avoid talking about any issue that may upset her, focusing rather on making her happy. Her particular vulnerability to the ill-effects of "thinking too much" were put like this:

Even if we are *cjea* [normal, healthy] it is not good if we think or worry too much. But no matter what, it's less [risky] than for people with *sor'sai kjej* ["young" or unripe nerves, that is part of "crossing the river"]...they can be really ill.

Similarly, the new mother is protected from anger and jealousy, mainly by giving her what she desires. Neglect and flirtatious behaviour on the part of the husband is particularly risky at this time. One woman told of her first occasion of "crossing the river". At the time she did not know her husband well and "did not yet love him" (that grew later). She described him as being exceptionally attentive to her over those first three months after the birth: "Did he look after me! [He] applied the tumeric, [and] didn't go anywhere. He stayed only by me!"

Immediately after the birth the mother is believed to be "cold", referring to her "inside" state. It is essential that her body be warmed, both through eating "hot"

foods, and by the external application of heat through the practice of "roasting" (also translated "grilling"), and by being proscribed from going outdoors. Warming through eating of "hot" foods persists in New Zealand, and is held to be important for the well-being of both mother and baby. When in hospital, for example, the woman will select from the meal what she can eat according to this belief, and return the rest, with her family supplying her with specially prepared foods from home.

Preparation of these preferred foods was explained by NeaRy, who had just "crossed the river" for the sixth time:

I eat *kor* [sweet and salty braised chicken, pork, or beef]. I eat different food [from the rest of the family]. I wouldn't dare eat sour soup, afraid of wind in the stomach muscles. I don't allow myself to eat sour soup with preserved fish [a common Cambodian dish], I wouldn't dare, as I'm afraid of the baby having [a] blocked nose...

Mother-in-law: [While in the hospital] we took her *kor*, hot food, use lots of black pepper, because black pepper, that's medicine too. Because inside a bit too cold, so we need to make the body warm.

As well as *kor*, the mother is given rice and wine (often mixed with black pepper or ginger), but "cold" foods, such as raw vegetables and fruit, are avoided. After a week or so she begins eating from the family pot, while continuing to avoid sour dishes, along with any foods believed to adversely affect the baby so long as she nurses the child. Similar food preferences and avoidances were found to persist among Cambodians settled in the United States (Sargent et al, 1983), even though there too the practice of "grilling" had declined.

Various kinds of medicine are also administered in Cambodia, compounded from some fifty herbal ingredients found in the forest. All *chmorb* and many village people know how to prepare the more commonly-prepared brews. These are to clear the blood, believed to be "bad blood", increase the flow of milk, improve the appetite, and strengthen the "nerves". From all accounts, such medicines are extremely bitter to take, and one technique to force the new mother to drink the stuff is to give her

a drink of very salty water, making her so thirsty that she then will swallow the liquid! The woman may not refuse the medicine, this being one instance where her wishes may not be indulged. The taking of these medicines should be continued for at least a month, but the longer the period is the better.

The practice of "grilling", as the women translated the term *aing pleurng*, was the norm in Cambodia, but is seldom practised in New Zealand. Neither the correct wood nor furniture is available, and the principle of warming only is maintained, discussed below. In fact the term for the postnatal period is *knong-kei* ["indoors for a month"], during which the mother spends much of the time resting in bed. After the *aing pleurng* is complete, the mother is described as *c'jeinh bpi pleurng* [literally "to come out from the fire"]. The interrelated practices of resting, staying indoors, and being "grilled", therefore, achieve the multiple purposes of allowing the healing of strained muscles from labour; "warming" through the application of heat and being protected from the elements; and the protection of "young nerves" by restricting the amount and type of work the new mother may carry out to light, indoor tasks, and minimising the chance of being frightened by an unexpected incident.

"Grilling" entails setting a fire beneath the bed (not so near as to risk burning), and the woman lies face-down, turning onto her side from time to time. Particular kinds of wood are used, believed to have medicinal properties, with the husband normally responsible for collecting the wood and tending the fire. "Grilling" is carried out for at least three to seven days after the birth. At the very least, even for the poor, remaining indoors was enforced for a week, with "grilling" being carried out for at least the first day, a minimum which even the Khmer Rouge respected. The better-off, however, may continue these practices, at least intermittently, for a month. The wealthy often maintained "grilling" and resting indoors for much longer, as long as three months, or literally "one hundred days", which is said to have been observed by wealthy ethnic Chinese.

A second warming technique widely employed is *ch'pung*, or steaming. Several litres of water are boiled along with a few bundles of lemon grass, a handful of lime

leaves, a large quantity of salt, and a host of vine roots and other herbal ingredients. After these have boiled together for some time, the woman is seated on a stool and the infusion placed in front of her, with both covered with a blanket to keep the steam in. After it has cooled, she bathes in the potion. An adaptation of this technique is still occasionally carried out in New Zealand, although not all ingredients are available. Another method involves heating a quantity of rock salt, which is placed on the woman's abdomen each morning, "to heal the tired muscles and clear the blood". A heated rock or a hot-water-bottle achieve similar purposes, with the latter being adopted in New Zealand.

Mrs Meas told me that one of her tasks as *chmorb* was to massage the new mother being "grilled" with a substance akin to tumeric, mixed preferably with white wine, or if the family was poor with water. The practice is believed to restore a youthful skin, but as SomNaang's sister (who had almost completed her medical training before the war) pointed out, the mixture may also have antiseptic qualities that prevent skin infection and irritation. This is important, because after having "crossed the river" new mothers in Cambodia normally experienced swelling of limbs and face after the birth, along with a scaly dry skin. The new mother's skin is described colloquially as like that of "a lizard shedding its skin like a snake, becoming young again". So long as the skin is "like a lizard's new skin", "coining" and other such techniques are contraindicated for at least three months.

According to my informants, in their experience swelling and peeling of skin does not happen in New Zealand. This difference Mrs Meas cannot explain, though she wonders if it is because of the injections used in hospitals. It is more likely to be directly related to the practice of *aing pleurng*, implied in a discussion with NeaRy's family. After the birth of her baby she explained that she wasn't being massaged with the wine and tumeric mixture, but was applying only hand lotion, because "she is not on the fire, so her skin does not peel like lizard". Along with many Cambodian women, she also liked to take a popular Thai medicinal powder called "Widow with one Child", available in Thai emporia, to aid in the restoration of youthful beauty.

It is important to recognise, as one elderly woman pointed out, that within Cambodia there is variation in these techniques according to geographical area, which includes the *tnam* [medicines] used, and further, that economic development, education, and civil war were accelerating change of these customs long before the refugees settled in New Zealand had fled Cambodia. For instance, in cities charcoal rather than wood was used for *aing pleurng*. The specific foods proscribed varied from place to place, as did some applications to the mother and to the infant's cord stump. The abandonment since settling in New Zealand of "grilling" and tumeric massage is partly attributable to the non-availability of the raw ingredients. More important, with hospital births, the injections and medicines routinely provided are widely held to obviate the need for these traditional practices, reinforcing the existing esteem with which injections are regarded.

What has endured, however, is the widespread practice of not going outside for as long as possible. Among women who have settled in New Zealand the proscription on going outdoors is commonly observed, again to ensure "warming" is maintained and to guard against the particular form of *dtoas* attributed to the burning of wind or rain. With New Zealand's climate being characteristically cool, the observance of this proscription is as strong as ever, reflecting parallel observances to minimise *k'jol*. In the first week or so after the birth, a new mother typically rests very close to the heater, and in spite of the room temperature being high, is generally muffled up in shawls and blankets. A woman described her resentment of her mother's insistence that she stay indoors in a super-heated room for three months, while her *kiwi* counterparts were free to do as they pleased. Her mother, however, assured her that by caring for herself properly, she would be healthier now and more beautiful in older age. The young woman concluded by commenting that "it is strange that you [*kiwis*] don't care, just go on as normal", while others present added uncomplimentary remarks that the results of this neglect are clearly evident in some of the old *kiwi* women!

Several weeks after the straightforward birth of her son, I asked NeaRy if she had yet ventured outside:

NeaRy: No, not yet. I'm not supposed to go outside, too cold. For me, when each child was even three months old I still didn't go outside. (Four of her children were born in the refugee camp.)

Sok: Don't believe it, we are in this country.

NeaRy: It is too cold.

Sok: If it is cold, I don't know, but if not cold, don't worry.

NeaRy: It is too cold.

Mother-in-law: Does she [the researcher] know that our country is not cold?

The grandmother repeated some three times her question as to whether I appreciated the differences in climate, highlighting the perception, especially by older people, of the increased risk posed by New Zealand's climate to health in general, and post-childbirth in particular.

Certainly in New Zealand culture, both medical and general, the widely held view is that there is no reason why normal activities should not be resumed very soon after the birth. Neither is there any reason for mother and baby not to venture outdoors, provided the baby is well-wrapped up. This position is endorsed by the very fact that the mother is expected to go out to clinics for infant welfare and maternal checks after the initial week or so, braving the elements if necessary. Some Cambodians, along with other immigrants such as Thais whose practices are similar, set aside their traditional values, accepting contrasting practices as part of the New Zealand health culture. Others simply do not have their baby's welfare checked, nor initiate the administration of immunisations, until three months or more has passed. When going outdoors is unavoidable, as for example when a medical appointment is necessary, exposure to the elements will be minimised by wrapping up well, being driven in a heated car from door to door.

Expectations that the woman will be pampered and nurtured persist in New Zealand. Her husband is expected to be particularly attentive, and even though he is no longer required to keep witches away and tend the "grilling" fire, there are other ways he

may demonstrate his solicitousness. Most husbands busy themselves with preparing the *kor* ["hot" food] and delivering it to their wives in hospital. The new mother is relieved of housework, shopping and the like, her main occupation being the care of her infant. Traditionally, an infant sleeps with its mother, a practice still observed by some Cambodians settled in New Zealand and regarded by them as being far kinder than the *kiwi* custom of separating the infant from "its mother's heartbeat". The perceived vulnerability of the woman who has just "crossed the river", together with her need to be protected and warmed, to rest and to heal, thus strengthens the conjugal relationship through institutionalised expectations, and incorporates the infant into the family unit in an unhurried and single-minded manner.

"Young Nerves" and "Allergy"

The rationale for the practices described above, many of which persist in New Zealand, is related to theories about "nerves", a concept introduced in Chapter 8. The risk of "nerve"-related disorders in childbirth is thought to be relatively low among some women, because of their own *gkom'laing*, or "energy". These women are unlikely to be subject to *pey* [fright], and are less likely to become ill after eating certain foods. Usually, though, after "crossing the river", "energy" is depleted, leaving the woman very weak and less able to control her mind and body. Generally the woman will return to normal health and strength if the practices and proscriptions described above are followed. Occasionally, however, this does not happen, with the resultant illness termed *dtoas* (pronounced "toar").

After "crossing the river" it is not only the skin which is new, but the "nerves" of the new mother are also believed to be "young", or fresh and unripe. This is described as *sor'sai k'jey* [*sor'sai* means nerves; *k'jey* is unripe, young]. It is when the "nerves" are in this "unripe" state that a sudden shock or fright, *pey*, can have serious consequences. Furthermore, it is this state of "young nerves" that makes the new mother particularly vulnerable to *dtoas*, an illness of variable severity, and translated as "allergy". However, allergy is a misleading term, as it carries specific connotations

in English and in the Western medical culture. *Dtoas* is characterised by such symptoms as shaking of the body, lethargy, diarrhoea, no appetite, reduction in milk flow, with the woman going on to become chronically skinny (see also Sargent et al, 1983). Rarely, she may go insane, but most serious of all is the "sickness of sleeping". The practice of *aing pleurng* and other techniques of heating the mother are explicitly for the maturing and strengthening of the *sor'sai*, as well as to rejuvenate skin and youthfulness, and clear out "bad blood".

There are a wide variety of *tnam khmer* [Cambodian herbal medicines] available for *dtoas*, but by far the best way to manage the illness is to prevent its occurrence by all the means described hitherto. As well as the specific "hot" foods prepared in the first week or so after childbirth, according to custom plenty of nourishing foods are provided throughout the period of her being indoors and "on the fire". One of the purposes of the Cambodian medicines routinely administered after the birth is to boost her appetite. Thus with extended rest and lots of food, the new mother becomes plump, a positive development as Mrs Meas explained:

If fat, in good health, but some people after "crossing the river" just get skinnier and skinnier...that's how we know if *dtoas* or not.

dtoas can be brought on by indiscretion with food, although which exact foods are responsible seems to be somewhat idiosyncratic;. While one woman may be adversely affected by a given food, another is not, and further, the specific types of suspect foods vary from area to area, and over time. The important issue is that if the woman develops symptoms such as diarrhoea, weakness, and poor appetite following childbirth, then it is assumed to be *dtoas*. Once the offending food is identified it is strictly avoided for up to a year, or sometimes longer, and after any subsequent birth. One elderly woman told of her daughter-in-law who in New Zealand insisted on eating everything and on going out of doors prematurely. She went on to develop diarrhoea and weakness, interpreted by the old lady as mild *dtoas*. Not all agree with this interpretation, however. Several young women involved in one discussion

claimed that in New Zealand they can and do eat anything, going on to say that "the *baaraing* (literally European people, used here to refer to white New Zealanders) have never heard of it".

Over-exertion or too much work during those first critical weeks can bring on *dtoas*. Being confined to the warm indoors thereby addresses two concerns, preventing the ill-effects of the cool elements, and ensuring that the new mother is protected from doing any heavy work. After a week or so she may resume light indoor tasks, such as preparing vegetables for a meal, but any lifting, digging, chopping, and other strenuous work is avoided for as long as possible, up to several months. Avoidance of heavy work continues to be observed in New Zealand, although generally speaking, it's importance is lower in a non-agrarian way of life.

Dtoas can take many forms, and there are *tnam khmer* [Cambodian medicines] for each form. In fact, Dta PolGkun had *tnam sor'sai dtoas* [medicine for nerve *dtoas*] in his possession. I asked the Meas how long it took for affected women to recover, in terms of weeks, a few months, or perhaps a year?

Mr Meas: Oh no! Many years...chronic. Sometimes the body is [so skinny]...[she] doesn't eat...can't work. If we [have] *dtoas* a little bit, sometimes we could get cured, but if it was bad *dtoas* it would be difficult.

Mrs Meas: This [food-related] *dtoas*, if in Cambodia we can cure all. Even if they were waiting to die, we can [make them] live...

Mr Meas:...because in our country our *tnam* [medicine] never *dtoas* [in this context used to mean "clash"].

Cambodian medicine, according to the Meas' explanation, works with the body rather than by counteracting its symptoms, and is therefore better tolerated by the person. As the condition of *dtoas* is not recognised in Western medicine, there are no specific medicines in the biomedical arsenal for its treatment. Moreover, Western medicines that may be administered for symptom relief are reportedly poorly tolerated by sufferers of *dtoas*, and perceived as provoking a reaction.

Certain women suffering from *dtoas* go on to recover when they bear another child, but this cannot be predicted, as "it depends on the *rog* [sickness], depends on the person". According to the *gkru khmer* the minor forms of the disorder brought on by foods can be treated simply with a *pali* incantation being sprayed. The increased solicitousness and nurturing shown the ill woman surely also facilitates her recovery.

In view of the apparently pessimistic outlook and difficulty in treating all but the food-related cases of *dtoas*, it makes very good sense to prevent its occurrence by the use of warming foods, medicines and physical techniques, as well as to protect the woman from negative emotions, physical exertion, and risky elements. However, under the Pol Pot regime the population was on the brink of starvation and lacking choice in foodstuffs, with the result that the observance of food avoidances and preferences was out of the question, as was the normally straightforward matter of staying warm and indoors. Further, the situation of so many women who had just given birth during their terrified flight from Cambodia to Thailand has had dire consequences indeed. Mrs Meas knew very many in the refugee camps who were suffering from *dtoas*, resulting from their inability to observe rest from exertion at that critical time of "crossing the river", and who had been *pey* [frightened], often severely. On top of that, though, the constant problem of "thinking too much", even after reaching the camp, was implicated in these cases of *dtoas*. Finally, refugee camp life, with its overcrowding combined with sheer tedium, provided an environment in which dalliances were more likely to take place, giving rise to jealousy, a known cause of *dtoas*.

Dtoas and conceptually related disorders arising from upsets to "young nerves", can also be interpreted as an indicator of distress, an effective medium of communication in the context of Cambodian culture and one which within that context is readily decoded. Inadequate protection and care that cause the woman to develop symptoms of mild *dtoas* can be viewed as a powerful mechanism, drawing attention to the neglect that has driven her to work prematurely for example, or to eat proscribed foods. The culturally approved response is that the appropriate level of attention and nurturing is mobilised, as *dtoas* that is ignored reflects poorly on the family. As a

culturally-embedded phenomenon, therefore, *dtoas* not only communicates distress, but is also demonstrably effective in achieving the meeting of desired ends. This view is supported by the widespread insistence that by far the best way of dealing with *dtoas* is to prevent it by ensuring the vulnerable young woman is protected and nurtured.

Such messages of distress are confused when the physical and cultural context changes. On the one hand, the persistence of *dtoas*-related beliefs by older Cambodians particularly is apparent. On the other, the changing views regarding appropriate practices by Cambodians in New Zealand show that refugee Cambodians readily set aside their traditional beliefs, and accommodate those of the dominant biomedical system of healing. In their narratives it is evident that they conceptualise *dtoas*, along with certain other illnesses, as embedded in Cambodian culture which cease to be relevant outside Cambodia. The opinion of *dtoas* perceived to be held by clinicians, along with the dominant medical model for managing childbirth, distorts both traditional beliefs and the interpretation of symptoms of *dtoas* as an expression of distress.

Overview of Childbirth-Related Illnesses

Of the twenty-one adults with illness experiences who participated in the study, fourteen were women. Of these fourteen, the illnesses of four directly arose from pregnancies and births since arrival in New Zealand. One was RottaNaak, whose perinatal experience was basically normal apart from some common disorders of a minor nature. A "transitional"-type person, her experience illustrates the apparent ease with which most Cambodian women suspend their traditional beliefs and embrace the hospital delivery that is the norm in New Zealand, a transition to be considered in some detail at the conclusion of this chapter.

Two of the four, RotTaa and BoPa, both developed paresis around the time of giving birth, and the fourth, NeaRy, expressed fears that she was going the same way. None

of the locally settled Cambodians I talked with had ever come across such a phenomenon before, and likewise in my personal professional experience, I had not come across any similar complications of pregnancy and birth. Therefore these conditions fell neither into the category of Western maternity complications nor into Cambodian childbirth-linked sicknesses, but were attributed more vaguely in both systems to "nerves", used in conceptually different ways. These narratives are described in detail in the following section.

Among the remainder were three women with serious or intractable illnesses, each of whom attributed the onset of these conditions to "crossing the river" while in flight from Cambodia or while resident in the refugee camps. Although the narratives of their illnesses have already been presented in previous chapters, the particular implications of the circumstances of their childbirth experiences, as they interpret them, in the light of the description of "crossing the river", are discussed.

Mrs Nhim specifically attributes the onset of her "numb head" to being *pey* when in that critically vulnerable first few days after the birth of a child (see Chapter 8). This happened to be the last of her six children, at a time when she was neither young nor in robust health. The birth itself was straightforward, taking place in the clinic in the refugee camp, after which she returned to her home. At the very time when she needed to be protected from "thinking too much" and from negative emotions such as worry, fear, and anger, a Thai soldier thrust his gun against her husband's neck. As she explained, her "nerves" were very fresh, or unripe, and so her terrified reaction had a particularly serious effect. Half her head went numb at that time, but settled down after three or four months of *tnam khmer* [Cambodian medicine] for *sor'sai* [nerves], together with what she described as an improvement of her emotional state. Mrs Nhim does not regard her illness as *dtoas*, but a disorder of the "nerves" brought about by shock just after having "crossed the river". She and her husband pointed out that as Western medicine does not recognise the disorder she developed, there is no medicine available for it. Although *gkru khmer* medicine does exist, its action is slow and it is unavailable in New Zealand. Western medicine is also believed to be required, in view of the influence of New Zealand exigencies on

the progression of her illness.

VuTaa, too, was in terrifying circumstances while her "nerves were still young". In her case, she had given birth to her youngest child as the Pol Pot regime was coming to its end, and the baby was only two or three months old when the family fled Cambodia for Thailand. In that very vulnerable state, when ideally she should have been protected from physical and emotional strain and the elements, she was having to exert herself strenuously, was desperately afraid and worrying excessively, and exposed to cold and rain.

It is the understanding of the family that the illness, which culminated in her "losing her mind" ten years later, began with this experience. She went on to develop signs similar to those of the most serious form of *dtoas* described above, in that after many years of lethargy and sadness, she lost her appetite and became skinny, and eventually lapsed into sleep. Indeed, as her family claimed, in Cambodia she would have died, but fortunately for them Western medicine delivered in the New Zealand hospital enabled her to recover. As others have discovered, though, Western medical doctors do not recognise *dtoas*. In fact, "they have never heard of it!" Thus Western medicine did not cure VuTaa of a condition resembling the normally incurable "sleeping *dtoas*", but of what was diagnosed in the biomedical system of healing as an alcohol-related psychosis, and accordingly, their suggested cause of the illness was apparently dismissed.

VeasNa, introduced in Chapter 7, "thinks too much" all the time to the point of being incapacitated. Although she traces some of her symptoms (such as severe headache and auditory disorders) to having been beaten unconscious by the Khmer Rouge, she describes her "illness" as having begun after the birth of her third daughter, born during her tenth year of residency in refugee camps. Although the pregnancy and birth were normal, while she was still resting and in that stage when her "nerves were young", she had a fright. The incident sounds minor enough; her middle daughter who was sitting on her bed tumbled. VeasNa lunged to catch her, and in doing so her *sor'sai* [nerves] were shocked. The child was heavy, thus forcing

VeasNa to overstrain herself at that time when any strain is dangerous. Immediately, she found it difficult to breathe, and her headaches worsened. She began thenceforth to "think too much" about her worrying symptoms, a state particularly dangerous for women who have just "crossed the river" as explained above. Thus VeasNa falls within the large group of women in refugee camps, described by Mrs Meas, whose *dtoas*-like illnesses are attributed in part to excessive "thinking".

A doctor working in the camp assured her that "nothing was wrong", a verdict repeated in New Zealand. Nevertheless, she continued to steadily decline, lost her appetite and became skinny, unlike her previous plumpness, a pattern which Mrs Meas declares "is like *dtoas*". VeasNa and her husband haven't described this illness as *dtoas*. They talk about her "thinking too much all the time", much of which is related to her distressing symptoms, and the financial and other consequences of her chronic, incapacitating condition. Her husband considers himself "modern" in his outlook, not bound by traditional views, and VeasNa herself grew up in a military family that had ready access to Western medicine. It is nonetheless apparent in her understanding of her illness, that belief in "young nerves", rendering her vulnerable, is significant.

Each of these three women explicitly relate their current illness experiences to events prior to their coming to New Zealand, when in that vulnerable state shortly after birth. Other than VuTaa, who has gone on to recover completely, the causes for their distressing and serious symptoms have apparently eluded identification. While the women have their own thoughts on the matter, these do not fit with recognised biomedical concepts. A similar misfit between perceptions of the patient and Western medical practitioners was described by Eisenbruch (1983), whose Vietnamese patient's "tension headaches" of sixteen year's standing were related by the woman to post-natal neglect. While a misfit, even conflict, between Cambodian and Western medical systems may be understandable concerning events that occurred in Southeast Asia, it is the more surprising to see a similar pattern when the entire episode takes place in New Zealand, as in the cases of RotTaa, BoPa, and NeaRy. Two young women, RoTaa and BoPa, who had previously had uneventful pregnancies and births

in the less than ideal conditions of refugee camps without prenatal care, both received medical supervision of their pregnancies in New Zealand. After the birth of the babies, neither was able to walk for some months.

Childbirth-Related Illness in New Zealand

I first met RoTaa in the middle of winter some four years after she and her family arrived in New Zealand. She was the daughter-in-law of Mr Chhum, and related to a number of Palmerston North families, including one of the two *gkru khmer* in the city. Even though several years had passed since the family's arrival, their rental house was remarkably sparse in its furnishings, and neither she nor her unemployed husband were able to converse in English. Their two older children had settled into primary school easily, and often interpreted for their parents on visits to the doctor and such like. These two children had both been born while the family lived in a refugee camp, having been delivered at home rather than in the clinic with the assistance of a *chmorb*. Her third child was born almost three years after their settling in New Zealand, after a normal pregnancy and birth.

Her troubles began soon after the birth, when she "felt heavy below the waist". At that stage she could still walk unaided, and was discharged home three days after the birth. Thereafter, her symptoms rapidly become worse until she could no longer walk at all. Her legs were swollen, and she was unable to lift them up from the bed. She was readmitted three days later, for what turned into a three month hospital stay during which time numerous investigations were carried out, including tests on blood and spinal fluid, and x-rays. In spite of these, RoTaa reports that the doctors were unable to find out what was wrong and as she understands it, her problem was put down to pressure on nerves during the birth.

Although they personally had not come across an illness quite like this in Cambodia, RoTaa and her husband are fairly sure what went wrong. Their explanation of RoTaa's weak and vulnerable state after childbirth, when "nerves" can be easily

"upset", was the first time I had heard of this set of beliefs on childbirth, which I was to hear over and over again during the following few years. They went on to describe an incident very soon after the birth. RoTaa was sleeping when a nurse came to check her blood pressure, startling her. She explained that as she was jolted awake, she mistook the sight of the nurse dressed in white for a ghost, getting such a *pey* [fright] that the upset of her "nerves" caused the loss of function and swelling. The "nerve" disturbance has also been attributed to another incident, told to me by an unrelated Cambodian who often interpreted for her during her stay in hospital. Having had two children already, RoTaa had been socialised into the need to rest completely during those critical first days. In fact, in Cambodia the mother doesn't even wash herself for the first three days, a task carried out by the *chmorb* who massages her at the same time. In this, her first hospital birth, RoTaa was expected to get out of bed and to shower from the start, but when she appeared reluctant, a nurse "pushed" her out, thereby causing the upset to her "nerves".

Irrespective of how her "nerves" were upset, it took some three months of daily physiotherapy and exercises before RoTaa was mobile enough to be discharged. As she described it, gradually as her legs became lighter, function returned. Even after she went home, she still continued attending physiotherapy as an outpatient. When I first met them over a year later, she still walked with a distinctive gait, and was not yet able to do tasks requiring protracted standing such as pegging out the laundry. Having elected not to have her infant with her while in hospital, as she feared she would not be able to care for him properly, her husband had cared for him during those first months, with the support of a visiting nurse who advised on feeding.

RoTaa and her husband said that if they had been in Cambodia, a *gkru khmer* would have been able to heal her with *tam sor'sai*, [nerve medicine] unavailable in New Zealand. RoTaa's husband's brother, a *gkru khmer*, did his best for her by going to Wellington to purchase Chinese medicine, which proved to be no substitute for *khmer* medicine. They treated the *k'jol* symptoms also present with "coining", symptoms that developed during those three months of limited mobility, such as dizziness and fever, arising from her difficulty in passing urine. Although normally "coining" is

avoided until at least three months after the birth, because of the "new skin" of the new mother, in her case, having not been "grilled", her skin did not "peel like a lizard". Her husband carried this out for her on several occasions while she was in hospital, a practise they endeavoured to conceal for fear of the consequences of "breaking hospital rules". She described an occasion after she went home when she was at the physiotherapy pool, and her embarrassment at the way everyone crowded around to have a look at the "coining" marks.

While RoTaa has recovered from the "heaviness" and loss of function below the waist apart from a residual awkward gait and some weakness, the little family is left with a shaken faith in the hospital. From the perspective of their Cambodian beliefs regarding care of the woman "crossing the river", they rightly "blame the hospital" for causing her illness. Yet at the same time they are fearful that if word gets back to the hospital on this, there will be trouble, especially if they need to use its services again. To describe the hospital as a health risk factor in this case is not far-fetched. It is a risk that can surely be minimised with improved exploration of patient hesitations in complying with hospital routines, and by developing cultural as well as language interpretation services in health care. RoTaa's account, moreover, illustrates how ill-prepared are those professionals working within the health care system in providing expert care in a manner that is safe for those whose cultural background is different.

In contrast, "blaming the hospital" was explicitly denied by BoPa, even without being asked. She does not blame the hospital for her illness that sounds similar, but worse, than that of RoTaa, nor does she blame it for the death of her six month-old son. In fact, she has nothing but praise for the hospital, which she feels has done everything possible, being "like mother and father" to herself and her family. Like RoTaa, she had had two normal births in the refugee camp clinic. Again like RoTaa, she had a normal medically-supervised pregnancy and reportedly a normal delivery. One week prior to the birth, however, she developed numbness and pins and needles from her knees down. Her legs, she said, were weak and swollen, and she could no longer walk or visit the toilet unaided. Her doctor assured her that everything was normal,

and that it was simply the position of the baby causing her symptoms.

After the birth her legs became weaker until she could no longer walk at all, and furthermore she lost normal sensation and strength in her arms. BoPa spent about three months in hospital, mainly having intensive "exercises"; she still laughs with embarrassment over having to cycle, kick footballs, and swim as part of her physiotherapy. Her body was so weak at the time that she had to "have hands clamped to rail, and a machine to lift me up". She also had numerous investigations, of blood and spinal fluid, both before and after the birth, but was told that nothing abnormal showed up. She was questioned about whether there was a history in her family of this kind of illness, but she knows of none. She also was told by the doctors that the problem was the baby pinching a nerve, and that she would recover.

Since this happened within a few months of BoPa's arrival in New Zealand, and since she had no relatives at all in the country, she was acutely conscious of her unconnectedness, but nevertheless soon found a place in the local Cambodian community. A very pretty young woman who always greeted me with a cheerful smile, it wasn't difficult to understand the ease with which unrelated Cambodian families had "adopted" the family. Either she was in their houses, or they in hers, but seldom was she alone. I first met her when the baby was four months old, about a month after she came home from hospital. At that stage she was still experiencing pins and needles down one side of her body, and although she was walking unaided, her gait was not normal. Only a few weeks later, BoPa's baby died. By that time, BoPa's legs were "normal" and her grief was focused on the fact that for the first three months of his life she hadn't been able to feel or fully care for him.

BoPa accepted the doctor's explanation that the problem was a pinched nerve. She herself had never before come across such a condition, and could offer no alternative explanation. She doesn't attribute it to "upset of young nerves" either, as in her case the symptoms began before she "crossed the river", when her "nerves" were still strong. In Cambodia, women occasionally experience mild pins and needles a few days prior to the birth, but thereafter it disappears. As her illness is unknown in

Cambodian culture, BoPa did not pursue the possibilities of either the self-care techniques of "coining" and "cupping", or Cambodian medicine. In addition, BoPa represents the "transitional"-type, who lacked the opportunity of being socialised into Cambodian medicine. Besides, BoPa was so helpless and ill that she was completely dependent on the care and decisions made by clinicians. Her description of that experience a year later demonstrates how life-threatening it was from her perspective:

I thought I would not live. I didn't eat. Let me tell you, I slept so much I didn't eat food given to me. I didn't want to touch food. I said I was not hungry, and they gave me intravenous fluids, sixteen bags, as I didn't eat rice [food]..Because I said to myself to die, let it die [life is over]...what's left?...sixteen bags. And when I had the drips I seemed to feel hungry, and when I was hungry I ate, and they gave the baby to me to hold. [I thought] Oh! I am not dying! Because the doctor said: "One day your legs will all get better, you will have no problems. You must be happy." And I thought...not happy! Because as it was, I couldn't even tear the toilet tissue! Couldn't feel my baby! How could I be happy?...That was like them, secretly putting the drug in to make me hungry! For some time one [side of my] mind thought, "maybe I am not going to die?" And one mind said, "I will not live, because it [the body] is soft!" Because we Khmer say: "If people die their body is soft." Dead bodies are soft, and these arms and legs were dormant [useless]. I thought they were soft [and therefore dead] already. My arm here, it went floppy, and when the nurse came and pushed it this way it went that way, and pushed it that way, it went this way. Oh! truly dead! And when I thought about it, that whole day the tears came down, and I thought, "Before I die, I have to have a good cry!"

BoPa's belief that her condition was mortal was based on a Cambodian view of the relationship between tone of body and imminent death, hence her apparent mental conflict between believing clinicians' reassurances and the evidence of her own body. She was suspicious of the doctors, moreover, in using their powerful medicines to override her own reluctance to eat, hold her baby, and in other ways move toward living. At her bleakest moments, she resisted feeding the baby, claiming she was unable to hold him and that she had no love for him. She described the occasion when she instructed the doctor to make arrangements for the care of her infant, as she was not going to live. The doctor responded that he "wouldn't let her go

anywhere" (that is, die).

At the time she could neither understand nor speak English, and so communicated with her doctors through the intermediary of interpreters. Repeated exhortations to "be happy" suggest that, having ruled out organic causes, BoPa's condition was perhaps regarded as post-natal depression, at least in part, with her loss of sensation and function perhaps being put down to a "hysterical conversion" or somatisation of her mental distress. From her account, no sign of alarm relating to her condition and anxiety about its outcome was conveyed to her, but rather she was reassured, consoled, and encouraged. Her own initial certainty about her imminent demise was, however, reinforced about a month after the birth, when her sponsor visited bringing a bunch of flowers. It was explained to me that in Cambodia if people come bringing the flowers, "that means they are dead." On seeing those flowers, BoPa decided: "This time it is real! Yes, this time I really am dead. My sponsor held the flowers like this, she put them in a glass as I couldn't do it, and kissed me." On learning of the reason for renewed distress, that BoPa believed her condition to be critical, a nurse wheeled her off to other rooms where she could see that everyone had flowers, even though none of them were yet dead!

BoPa had been pregnant at the time of arrival in New Zealand, after a ten year sojourn in camps where she had met and married her husband. She had been unable to trace her own family, last seen when in her teens, or to ascertain whether or not they were still alive. Her description of the hospital staff being "as parents" is particularly poignant in view of her loss of natural parents and family, a comparison which breaks down when on discharge this "parenting" is abruptly terminated. The extremely alarming illness took place in a context of personal and cultural anomie at a time when she was unfamiliar with the culture of New Zealand and its health care system. Although she could laugh when she was telling me about the incident of the flowers and scold her "ignorance", her fear at the time was very real.

Such cultural anomie was not true for the older people of the Cambodian community, nor for some younger people in continuous contact with their parents. As is the case

for many members of non-Western communities living in New Zealand, knowledge and opinion on happenings to their members are common property, not regarded as private information in the same way as among New Zealanders of European descent. So it was that when exploring the concept of "crossing the river" and *dtoas* with the Meas family, that the illness phenomena of several of these women were used to illustrate the issues raised. In their opinion, VeasNa suffered from *dtoas*, having lost interest in food and become chronically skinny after a fright. Two or three others unknown to me were also considered to be afflicted with *dtoas sor'sai*, indicating that the syndrome, as an explanation for serious illness in Cambodian women, is by no means uncommon. During the discussion someone suggested that this was also at the root of Mrs Nhim's problem. In this case, though, Mrs Meas responded in the negative:

Mrs Meas: She was *pey* [shocked].

Friend: She was *pey*, but it was not a normal *pey*.

Mrs Meas: She was *pey* until she was sick. Plenty die from *pey*.

Nevertheless, it was because of the delicate state of her *sor'sai* [nerves] that she was vulnerable to *pey*. Their opinion on RoTaa and BoPa likewise was that it was "because of the *sor'sai*. Everything is to do with the nerves", clearly cases of *dtoas sor'sai*. In RoTaa's case, the decision that hers was a case of *dtoas* was quite straightforward, a typical picture of having been *p'njak* [startled] when her "nerves were unripe". BoPa's case was complicated in that her symptoms came on before she "crossed the river". Even here, Mr Meas' opinion was that "it was not much different from the *sor'sai*", and the exacerbation after she "crossed the river", when she was already weak from illness, would fit the picture of *dtoas sor'sai*. At the same time, these elderly folk who were very knowledgeable in the care of women "crossing the river" had never before come across the phenomenon of women being unable to walk, adding: "Maybe it is the cold weather". Thus it was not the diagnosis of *dtoas* that was brought into doubt by the unknown manifestation of symptoms, but the New Zealand climate that may have altered the manifestation of *dtoas*.

It is of particular interest, therefore, when this peculiarly New Zealand version of *dtoas* goes on to generate anxiety among pregnant Cambodian women in the locality. During the last two months of her sixth pregnancy, VuTy's wife NeaRy developed tingling and some weakness in one hand, and began to worry:

VuTy: My wife thinks about BoPa, afraid about the numbness, now she worries about being numb [paralysed] after the baby [is born] and can't walk.

NeaRy: Now I can make a fist easier than before, but the tip here is still numb.

Friend: Before it was bad. The whole hand was numb, both hands...

NeaRy: I fear that it will be like BoPa. But the doctor said that she guarantees that after the baby is born I would be better again. Not to worry, because she observed many pregnancies like that. I said I'm afraid I might be like BoPa and RoTaa. And she said that the condition is very rare, and not to think about that.

The Cambodian friend who interpreted for her on that consultation added that the doctor had explained to her that NeaRy's symptoms were a common and minor disorder of pregnancy, caused by an excess of fluid in the body, which would correct itself after the birth.

The anxieties NeaRy expressed several weeks before her "crossing the river", accompanied by the beginnings of symptoms, can be interpreted as early warning signals of distress. She was already "upset", as she put it, worrying about her husband's incapacitating illness, their poverty out of which there seemed no escape, differences between herself and her husband regarding the children's education, and the sheer load of work and responsibility that is hers in providing for a large, dependent household. When she voiced her worries about becoming paralysed, her sick husband responded that he "thought of her a little bit, but I'm thinking about myself getting better [which] is of more importance". While NeaRy's indicators of distress were being understood by her family, they seemed not to be mobilising the support she was seeking. She also took her anxieties to her doctor, expressed in the same bodily symptoms. Here, the symptoms were not interpreted as indicators of

distress, and she was responded to in terms of the dominant biomedical model. Nevertheless, she was apparently listened to sympathetically and effectively reassured, and to that extent her use of bodily language in the medical context was more effective than in her own domestic and cultural contexts.

As it happened, the birth was straightforward, and as the doctor had "guaranteed", NeaRy's symptoms thereafter began to subside. However, this was not before her worries increased, and as shown in the following narrative, *dtoas* and "thinking too much" are intimately related:

At the hospital I almost couldn't tear the toilet tissue [one of the features of BoPa's condition]..It only happened [like this] with this child...When I stayed at the hospital I was worried about this hand and started "thinking". Then I couldn't sleep because of "too much thinking", and when [the nurse] came to measure my blood pressure she said it was high up. And when I heard that, I stopped that "thinking"I had a fever when I got home, cold and hot fever, because of the change in the weather. After I recovered from that, I told myself not to imagine things like that [becoming ill like BoPa].

The relationship between "thinking too much" and "nerve"-related illness was quite explicit. NeaRy explained that while her "nerves are young" and body weak, when it is particularly dangerous for her to "think too much", she deliberately acted to protect herself. In fact, a few weeks later when I enquired again about her hands (by then normal), she responded strongly that I shouldn't again raise the subject as it was risky for her to think about negative issues. NeaRy's personal strength is evident in that when her family and the wider community apparently failed to take on the responsibility of protecting her and "keeping her happy", she herself took the necessary action. Nevertheless, through her symptoms she was able to mobilise at least a little attention from the household, with even the self-absorbed VuTy massaging her arms, and her ailing mother-in-law assisting in infant care. The support and reassurances NeaRy received from within the formal health care system appear to have reinforced her personal mental resources and resilience in overcoming "thinking too much".

As the narratives of RoTaa, BoPa, and now NeaRy illustrate, this particular form of

illness, (a loss of normal sensation and function of limbs) straddles two sets of illness beliefs. There are sufficient grounds for Cambodians to regard the disorders suffered by these women as *dtoas sor'sai*. As such, the phenomenon is interpreted within the Cambodian community in terms of being an indicator of distress, and responded to accordingly. Certainly, this was the case for both RoTaa, whose extensive network of kin were mobilised into doing what they could for her, and the unconnected BoPa, who thereby acquired a network of surrogate family who have stuck with her. Although NeaRy's symptoms reflected a recognised condition of pregnancy in biomedicine, enabling her clinician to confidently reassure her, the overlay of her fears and the meanings she ascribed to the symptoms were consistent with the Cambodian syndrome of *dtoas*.

The unusual manifestation of *dtoas*, along with the unavailability of *tnam sor'sai* in New Zealand, severely limits treatment of such illness by traditional means within the resettled Cambodian community. Indeed, there is no practical alternative to relying on the formal New Zealand health care system and its biomedical system of healing for treatment of a Cambodian illness. To do so is simultaneously appropriate, in that the symptoms are particular to New Zealand, and paradoxical, as this is clearly a syndrome embedded in Cambodian culture and not a recognised complication of birth in biomedical theory. The New Zealand health care system is not well-suited to treat disorders which are not known obstetric complications. Having eliminated possible organic abnormalities to explain the disorder, which biomedicine is well-equipped to do, then treatment revolves around restoration of function through physiotherapy, and providing emotional reassurance and support. Thus the recovery of these women from a recognised, but altered, Cambodian childbirth-related illness must take place primarily outside of Cambodian culture, in the context of the New Zealand health care system.

Cambodian and New Zealand Childbirth Practices Compared

It is expected of resettled refugees and immigrants that they accept the New Zealand

way of caring for health and illness. By and large this is indeed what happens, findings of this study being similar to trends reported by Sargent et al (1983). It is mainly when illnesses are not cured or ameliorated in this system that alternatives are considered, including traditional Cambodian approaches. As shown in previous chapters, however, there are important differences in interpreting and treating illness, and the domain of normal childbirth illustrates this most sharply.

For the past fifty years, the vast majority of New Zealand's infants, as in other industrialised countries, have been delivered in hospital. This reflects a trend toward the medicalisation of childbirth that is only recently being questioned by certain groups of women and health professionals, in favour of natural births (see Oakley, 1986; Tew, 1990). In contrast, the vast majority of the Cambodian women interviewed were from rural areas where a hospital delivery was inaccessible, and births at home the norm. Nevertheless, that this was perceived as a high-risk occasion has been made abundantly clear from the metaphorical language used and techniques employed. There is, therefore, no comparison between the Cambodian village-style birth practices and beliefs, and either of the approaches available in New Zealand, namely the hospital delivery by which childbirth is medicalised, and home-births by which childbirth is managed as a natural, family-centred event (Oakley, 1986).

The view of childbirth as a fearful event, based on the collective experiences of Cambodian women, leads them to welcome the opportunity for a medically-supervised delivery. The narratives of illness repeatedly express the high regard in which injectable medications and intravenous fluid administration are held. The administration of these during labour in hospitals is routine, thus further raising the status of a hospital delivery in the opinion of Cambodians. Whereas in village Cambodia the new mother was physically weak and continued to have a vaginal discharge for weeks, their experience in New Zealand is that within days they are "normal". This they attribute to the "clean" techniques and environment of the hospital, the skill of the staff, and the power of the injections. Whatever the reason, the injected medications mean that the bitter Cambodian potions that "clean inside", among other functions, are not required, which is just as well considering the

ingredients are unavailable. It was also pointed out that in New Zealand women are not afraid for their lives from fighting, are not "working too hard", and have plenty of good food to eat.

In New Zealand generally, and the hospital in particular, the traditional practices of "grilling" and massaging are abandoned. Again, this seems to generate little anxiety. The well-heated hospital compensates for the lack of "grilling", and in the case of births during winter months, many Cambodian women prefer to stay in hospital for as long as they can because of the warmth. To do so for at least three days and preferably a week, is moreover in line with their own traditional pattern of remaining indoors for that period as a minimum. Not being "grilled" over the fire leads on to their not developing swelling and cracking of the skin, thus obviating the need for massage with the tumeric-like substance.

On the downside, however, a calm, quiet environment cannot be assured. As RoTaa's story graphically illustrates, the hospital itself can constitute a risk by failing to protect "young nerves" from "upset", simply because of ignorance among staff of the Cambodian precautions after "crossing the river". Several commented on the "loud bangs...loud voices...trolleys...high heels" that are common in a hospital ward, but added: "You get used to it, and also you know it is safe. In hospital, you get used to all that noise". This contrasts with a village delivery; the very fact that everyone deliberately crept about so as to protect the woman from fright meant that an unexpected sound could be particularly jarring.

Of greater importance is the contrast between New Zealand and Cambodian approaches regarding mobilisation after delivery, and a little further on, the resumption of normal activities. I was often questioned on the *kiwi* practice of "pushing" the new mother out of bed at once, in conflict with the Cambodian ideal practice of resting in bed for several days at least. As I tell them, the Anglo-Celtic practices of my own forbears have changed dramatically in no more than two generations (Oakley, 1986, p.1). In my grandmother's day, from her descriptions, the normal confinement or "lying-in", as it was called then, was between a fortnight and

a month after the birth of the child, during which period the mother was relieved of normal chores, and could heal from her labour as well as bond with the infant. A generation later, my mother underwent hospital deliveries which entailed staying in hospital for ten to fourteen days after normal deliveries, with the infant usually separated from her except for feeding. A period of rest was thereby accomplished, but the environment for doing so was far from ideal, giving rise to considerable impatience and frustration. Currently, the pressure is not to rest, but to be up and moving as quickly as possible with the woman expected to care for her own personal hygiene from the start.

For the Cambodian woman, this practice in New Zealand hospitals conflicts with the customary practice of resting very quietly for as long as possible. Though rare, as in the case of RoTaa, this conflict may lead on to serious illness. Mostly, the young women themselves are remarkably accepting of the *kiwi* way of doing things, and make the required adjustment without question, as indeed they do in respect to other aspects of life. For those who are in close contact with an elderly relative, however, to conform to New Zealand practices often means breaking with the Cambodian traditions being advocated by the older folk. This can give rise to tension within the family, adding to the sense of displacement and loss of status already experienced by older people whose values frequently do not coincide with those predominant in the new society.

The last child of one woman, born a few months after the family's arrival in New Zealand, took place in hospital. Being the first of her children born under medical supervision, she insisted that putting aside her own traditions presented no problems personally, but admitted that it was very worrying to her mother, to the extent that they occasionally quarrelled about it. Another elderly woman expressed her helplessness when her daughter-in-law refused to observe her advice, preferring to conform to *kiwi* norms, even after the younger woman became ill. Irrespective of the physiological arguments for early mobilisation, therefore, the practice may not be in the interests of personal well-being nor family health, when viewed in the wider cultural and social contexts.

The most significant contrast between the two approaches lies in the relative importance accorded the three stages of maternity, pregnancy, labour and delivery, and the post-childbirth period. Western medicine places most emphasis on the prenatal and intrapartum periods, while in Cambodian culture it is the "crossing the river" and the period following, up to one hundred days, that is perceived as the critical period. While encouraging a new mother to be up and about normal business, inside and outside of the house, makes sense from the viewpoint of the biomedical model, it is, as we have seen, very risky for the woman adhering to Cambodian ways. Once discharged from hospital to their own homes, they are to a large extent free to conform to whichever practice they prefer, as NeaRy's experience suggests. Even here, however, the expectation that mothers should go out of their home to access health and other services reinforces the message that the period of confinement is unimportant. Thus they are faced with a choice of either contravening their traditional Cambodian ways together with the advice offered by the older people, or of not complying with the expectations of health professionals who have attended them.

The Transition to the New Zealand Way of Childbirth

Cambodian refugees have literally crossed the sea (to borrow their own metaphor) to resettle in New Zealand. The implicit expectation is that they will accommodate themselves to the institutions and norms of their host country, an assumption they themselves hold. In her exploration of the health beliefs of three Cambodian women settled in New Zealand, Tudsri (1987, p.97) commented on the "strong confidence in the western doctor" held by women, who were eager to exchange their traditional ways for Western maternity care.

RottaNaak's account illustrates the ease with which this happens. Being pregnant when she arrived in New Zealand, contact with the health care system was immediate, with the endorsement of her family and sponsors. For her, it was simply a matter of fitting in with the system of her adopted country. Her first three children

were born in the border country between Thailand and Cambodia in the dangerous years of guerrilla warfare. Circumstances were far from ideal from both a traditional Cambodian perspective and that of biomedicine. In fact, having been separated from her family as a young girl, like BoPa her life had been characterised by change and a discarding of the old traditions, with childbirth being just one more instance of this.

RottaNaak's most recent pregnancy was normal, except that she was anaemic, and had lost weight (unusual in late pregnancy) since arriving in New Zealand, attributed to the unpalatable food offered at the Immigration Centre. Once the family arrived in Palmerston North, she was soon receiving regular maternity services, attending clinic when scheduled, having ultrasound examination and being informed of the sex of the child. Her anaemia was treated, and eventually she underwent a normal delivery in hospital. After a week of resting in the warmth of the hospital, by her own choice, she returned to the crowded home shared with a related family. At first weekly, then less often, a nurse visited to advise her on caring for the child. RottaNaak's skin was fiercely itchy, which was being treated in Western biomedical terms as an allergy. Overall, this first experience of a medicalised pregnancy and delivery was straightforward, one which she took in her stride. RottaNaak's experience reflects that of a majority of Cambodian women, who without objection accept the maternity services and delivery facilities offered.

In an early conversation with RottaNaak about her previous experiences, she described the way Cambodian midwives massage the abdomen, and the comfort it gives. Mrs Meas had previously described this practice, from the viewpoint of her extensive experience as a midwife. Once labour began, she stayed with the woman, gently massaging her abdomen, plying her with food to keep her energy up, and during the birth itself, applying gentle pressure to the upper abdomen "to stop the baby going back up". She was emphatic that the massaging and pressure were very gentle, and that no force or interference was used. Sok took up the theme, explaining that this isn't practised in New Zealand, adding: "here you are left alone".

Far from being critical of the relative lack of support given by New Zealand

midwives to labouring women, Mrs Meas insisted that they are "very good", because of the medicines they use and that bleeding finishes so soon. The local *chmorb* no longer practice their skills. As Mrs Meas pointed out: "Look at my daughter (who had recently had a baby). I didn't go to look at her. They live easily here...we have no doubt of the modern medicine". She admitted that a lot of women consult her when in early labour as to when they should be admitted to hospital. She went on to express her fears that if this became known, she may "get into trouble", fears that reflect those described by Sargent et al (1983) in the United States.

She has refrained from applying gentle massage on painful abdomens out of fear, with good reason in the light of the medical opposition an equivalent Samoan practice has attracted (Donnelly, 1993). Donnelly's (1993) argument concerning Samoans is equally applicable to Cambodians. The medical rejection of the practice of massage, and the reasons for doing so, powerfully illustrate how poorly understood are non-biomedical healing practices and beliefs, and further, demonstrate both the lack of "voice" and esteem of ethnic minority groups. This is evident in Mrs Meas readiness to negate her own wealth of knowledge and skill. In spite of her knowledge of the potential ill-effects of the hospital environment, in which Cambodian precautions are ignored, she insists that she is happy about "the hospital rules":

It is like this. These children were born with me in the custom of our country. And when we get to their country, we follow their custom. Their doctors, they have everything, they are clean, and they have *kbon* [rules]...we don't have any rules.

Yet from their own accounts, Cambodians have many rules to safeguard the woman "crossing the river" and her infant. Some of these rules related to the ways the placenta and the infant were cared for. After the placenta was delivered and the cord severed, Mrs Meas, as *chmorb*, used to check that it was complete, then wash it and rub it with salt. Having done that, it would be wrapped and buried in the garden, which if done well would protect the baby from skin diseases and rashes. That this doesn't happen in New Zealand hospitals isn't a worry, Mrs Meas claimed, as "that is the hospital rules", and in any case, some of those skin diseases are not endemic in New Zealand. Mrs Meas was skilful in treating common sicknesses of infants,

knowing how to compound a number of Cambodian medicines. It was common practice, too, to apply a herbal poultice to the baby's fontanelle, and an ointment to the abdomen (compounded of such substances as garlic, pepper, pig's gall bladder, and coconut oil, according to the recipe of one elderly woman). The baby was then swaddled. As Mrs Meas explained, the baby, as well as the mother, needs to be "warmed" and protected!

Cambodian women consistently conveyed the impression that the New Zealand system of hospital births was superior to their own, and that to make the required transition was no hardship. On the contrary, they were grateful to have free access to the type of care that in Cambodia had been the privilege of the wealthy, the educated, and the urbanised. Relating this response to Burki's (1987) model, women of child-bearing age reflect the "transitional" ideal type, characterised by giving birth in hospital, with or without family present, and "unsure whether to follow ethnic or American post-partum rituals" (Burki, 1987, p.345). These women appear to be bicultural in their world-view, having been reared in traditional ways prior to the disruption of their family and society, and the destruction of their traditions from the time of the Pol Pot regime onwards. Nevertheless, as Park et al (1991, p.266) pointed out in relation to Korean women in the United States, who also customarily rest after childbirth and avoid cold, the potential for conflict between traditional and Western ways remains.

Throughout, the women with whom I explored the subject of childbirth tended to devalue their rich tradition of knowledge, including skilled, highly experienced *chmorb* who had successfully delivered scores of infants in the most difficult of conditions. Just as techniques and medicines of Western obstetrics are beneficial (particularly when the birth is complicated), so many of the practices described by these Cambodian women go a long way to providing a safe environment for a normal birth. In particular, there is an array of practices by which the parturient woman is supported and comforted during labour, nurtured and protected in that vulnerable time after the birth, massaged and warmed, relieved of work, permitted to rest and be healed, and to bond with her infant. These practices are at risk of dying out with

the old people, if the pattern demonstrated in this study continues. Factors identified by Waxman (1990, pp.195 ff) that explain the relatively rapid transition of Navajo from traditional to biomedical childbirth also hold true for resettled Cambodians. These include: exposure to and acceptance of the dominant biomedical system; the safe, painless delivery offered by hospital deliveries; and the decline of traditional healers, which in the case of Cambodians involves a perceived illegality of practising.

Conclusions

Practices related to childbirth reflect illness-related beliefs that repeatedly emerged during the study. Issues of "thinking too much", "nerve"-related problems and the dangers of exposure to cold air are not only prominent, but intricately related. This complex of beliefs underpins preventive and self-care practices which persist in the New Zealand environment. In contrast, theories about spirit-related illness, including those of childbirth, are to a large extent relegated to Cambodia, rendering redundant Cambodian traditional healers and their rituals.

In general, resettled Cambodian women appear eager to accept the New Zealand way of childbirth, and argue that they have set aside traditional prohibitions with no ill-effect whatsoever. At the same time, there are those for whom the New Zealand system has proved unsafe, who have suffered serious consequences from this. The most prominent group comprises women such as RoTaa, whose health has been plainly jeopardised. There is also a sizeable group of hidden people, the old people, whose existing displacement and loss of place in Cambodian society is reinforced by the rejection of traditional values and customs by their daughters and daughters-in-law, the latter preferring to conform with a foreign system. Beyond this again is that group of women with serious, often intractable, illnesses which they trace to "shocked nerves" at a time of "crossing the river", prior to coming to New Zealand. There is neither Cambodian nor Western medicine available in New Zealand for such Cambodian syndromes, and they hold to their explanations of their illness while being medically cared for in another cultural milieu. For these women, the experience

of "crossing the river" truly reflects the uncertainty and fear implicit in the euphemism.

As with illness beliefs, supernatural agents, such as witches, believed to be particularly hazardous for the woman "crossing the river", are believed to be locally circumscribed, active only in village Cambodia. With the relegation of such beliefs to Cambodia, together with acceptance of Western medicine which has no place for such beliefs, a large area of childbirth-related protective ritual is redundant in New Zealand. At the same time, the availability of effective Western medicine means that Cambodian medicine is regarded as unnecessary, even if it were available. Rarely, the post-childbirth illness of *dtoas*, an indicator that all is not well, is believed to occur, in spite of the fact that clinicians "have never heard of it". Being a culturally-embedded phenomenon, usually it is correctly interpreted among the Cambodian community, mobilising the necessary attention and support. Within the Western health care system, however, it is likely to be responded to as a biochemical disorder.

Although superficially it appears that most Cambodian women have discarded their traditional childbirth practices in favour of the Western model, these narratives demonstrate a persistence of belief and practice related to "crossing the river". Cambodian women demonstrate an inner strength and courage as they make the adjustments they perceive as required of them, conforming with the "hospital rules" when they have to, but observing traditional precautions when they can. Most prefer to rest, letting others do the work while tired muscles heal. Many maintain the custom of having their babies sleep "close to the heartbeat".

Those around them take care not to upset them, and to talk about things which keep their spirits up, above all avoiding provoking a state of "thinking too much". Special "hot" foods are prepared and eaten, and other foods avoided for an extended period. While the practice of "grilling" has been largely discarded, a very few may still be "steamed", or the local application of heat practised. However, the practice of remaining indoors in a super-heated room, while avoiding exposure to elements,

continues to be widely observed. In other words, the beliefs surrounding "crossing the river" continue to influence the way new mothers are cared for, and are especially evident once the woman has returned home from the hospital.

Beginning with aspirations to have access to Western-style maternity care while still in Cambodia, resettled refugees demonstrate a deceptive eagerness to set aside their traditional beliefs and practices surrounding childbirth, in favour of those of the West. In reality, emerging in the Cambodian community is a hybrid system of beliefs regarding childbirth, parallel to that regarding illness. An acceptance of the biomedical approach is accompanied by a persistence of certain traditional beliefs and practices, and the modification of others in response to the multiple and far-reaching changes that are faced. At the same time, alternative medicines are widely used, and Western practices adapted to suit the preferences of the Cambodian settlers.

The emergent Cambodian-New Zealand system of childbirth reflects the need to reconcile conflict of values within families and between sectors of the community, and to balance this against perceived reactions to traditional practices by the Western medical professionals from whom health care is principally received. The elements of the system reflect pragmatism, which fosters eclectic and pluralistic practices, drawing from among the range of techniques and medicines that happen to be available. Finally, the transitional characteristics of resettled Cambodian refugees are reflected in this system of childbirth they are creating in the new country. Like the Cambodian-New Zealand system of healing described in the previous chapter, the hybrid childbirth practices are likely to be transitional, as the young generation continue the process begun by their mothers of adopting the practices of the dominant Western health care system.

Chapter 12

Conclusions

An Alternative Perspective on Cambodian Refugee Health

Over a period of two decades, Cambodians have experienced civil war, forced labour, starvation, occupation by "liberating" forces and protracted sojourns in refugee camps. Many thousands have left Cambodia permanently, establishing new lives for themselves and their families in countries of the West, including New Zealand. Many Cambodian refugees suffer ill-health, and come into contact with the health care system. Clinical interactions are not straightforward, and outcomes can be disappointing, experiences which have given rise to a substantial body of medical literature about refugee patients. This study adds to that knowledge, taking a different approach from biomedically based literature.

Using the ethnographic method of inquiry, I set about the task of constructing and interpreting illness and health care experiences of resettled Cambodians. This is a community with little prior experience of Western medicine, a factor expected to be significant in the rapid transition they were undergoing. I sought information on the following interrelated topics:

- the illness experiences of Cambodians, and explanations given
- premigration experiences of illness and health care
- self-care strategies employed
- patterns of interaction and experiences with the New Zealand health care system
- effects on well-being of loss of access both to Cambodian healers and to preferred treatment strategies
- processes of cultural transformation that have occurred over the period of asylum and resettlement regarding illness and health care.

Unstructured, in-depth interviews were the principal method to collect data on the

topics. The very fact that interviews were unstructured, conducted through the intermediary of an interpreter, led conversations to range over a wider range of topics than those listed, including traumatic experiences in Cambodia, and experiences of living in a small New Zealand city. I was able to observe patterns of caring for the ill and aged, self-care techniques and self-treatment using a range of medicines. I participated in calendrical festivals and private ceremonies, and witnessed life on the margins, in the "little Cambodia" which provided the principal context for social interaction for most of my informants.

I begin this concluding chapter by revisiting the body of literature on Southeast Asian refugee health, in the light of findings of the study. I will highlight the divergences between views on refugee health portrayed by biomedically based research, and the view generated by this ethnographic study. My findings suggest that an alternative perspective on understanding and managing Cambodian refugee health is required, which has implications for health services provision.

Taking the Cambodian metaphor for childbirth, "crossing the river", I show that Cambodian refugees who have literally "crossed the sea" share many aspects of the parturient woman's transitional and vulnerable status. Through this perspective, the significant themes that emerged in the study are unified. These themes offer fresh insights on refugee health. The perspective accommodates the life experiences which led to Cambodians becoming refugees in the first place. It reflects the transitional status of Cambodian refugees, and the phenomenon of members of the Cambodian diaspora simultaneously inhabiting multiple times and places. To conclude the thesis, I discuss the potential continued usefulness of the perspective in explaining changing theories of illness and healing practices, as Cambodians themselves go on changing in response to new encounters in the new country, and offer suggestions for future research.

The Biomedical Paradigm of Refugee Health Reconsidered

I embarked on the study versed in medical literature on Cambodian refugee health, literature which portrayed resettled Cambodian refugees as suffering from high levels of ill-health across the spectrum of disorders. In particular, previous research depicted refugees as:

- bringing with them high levels of communicable diseases
- manifesting high levels of major depression and posttraumatic stress disorder
- tending to somatise mental distress
- demonstrating high fertility
- maintaining some traditional beliefs and practices.

Cambodian refugees were consistently portrayed as the most traumatised of Southeast Asian refugees, having suffered torture and trauma in the past, and demonstrating persistently high levels of illness, adjustment difficulties and poverty. Medical treatment for mental and bodily illness was problematic and often had disappointing outcomes. Much of the literature reported on clinical populations, and the majority of studies used biomedically based instruments and methods developed among Caucasian populations. Few of these studies presented the pathological findings in the contexts of refugees' pre-migration experiences, and the demands on refugees of adjusting to the new country, beyond acknowledging that such circumstances occurred (see Chapter 3).

The more balanced view has been advanced, that refugees' illnesses are reasonable human responses to catastrophic and inhumane situations (eg Muecke, 1992, p.523). Furthermore, a focus on biomedical disease eclipses the reality that most refugees are not poorly adjusted and ill, and ignores characteristics of resilience. In part as a result of the findings of biomedical studies, refugees have been stigmatised as a drain upon the resources of the host country, as inherently and incurably a sick population. I did not set out to add to the debate on prevalence and kinds of illness. Indeed,

biomedical diagnoses of those involved in the study were not obtained. By selecting Cambodians who were known to suffer ill-health, and whose level of interaction with New Zealand's health care system was high, I am moreover not in a position to describe the successfully adjusting, healthy sector of the refugee population. Nevertheless, characteristics of courage and resilience were evident even among the ill, as I noted from time to time throughout the thesis.

The distinction between disease and illness has been well-made. For example, Kleinman (1988, p.5) and Finkler (1991, p.11) describe illness as the sensation of symptoms and dysfunction, the lived experience of bodily processes that deviate from normal. When the ill seek treatment from a clinician, symptoms are taken and reconfigured into the language of biomedicine, by a process akin to "decoding" (Good and Good, 1981, p.166). Expressions of illness are thereby translated by clinicians into the nomenclature of biomedicine, and diagnosed in terms of diseases which may or may not coincide with the sufferers' experiences and terminology. Indeed, several of my informants, who were indisputably ill, apparently were assured they had no disease. Such experiences are not limited to Cambodians, nor indeed to refugees, but are widespread even in Western cultures in which the system of biomedicine is embedded. Where cultural distances between clinicians and patients are great, however, the chances of a misfit between expression of symptoms and disease taxonomy are likely to be high. Durie (1994, p.194) goes further in warning that fresh problems can be created by clinicians "expecting their patients to fit into a culturally constrained straitjacket".

Biomedicine has variously been depicted as scientific, materialistic, technologically oriented, reductionist, universal and triumphalist (Kleinman, 1988, p.5f; Lock, 1988, p.6; Leslie and Young, 1992, p.2; Good and Good, 1981, p.166). In contrast, illness is portrayed as the embodiment of adverse bodily (pathogenic), environmental and existential conditions (Finkler, 1991, p.11). If the nature of the distinction is accepted, between disease as a biomedical entity and illness as the embodiment of adversity, then the limits of medicine in relieving the distress of Cambodian refugee patients can be better understood. The majority of research on Cambodian refugee

health is biomedically based, representing the scientific endeavour to explain refugees' illnesses and symptoms in terms of biomedical nosology. However, the results are suspect if the premise that biomedicine is neither a universal nor a complete model of health and healing is accepted.

I set out to address these pitfalls by interpreting illness phenomenologically, presenting illness episodes as lived experiences of resettled Cambodian refugees. As Lock (1988, p.4) points out, the strength of hermeneutic research is that it takes into account the cultural and historical contexts of events such as illness. Non-hermeneutic research can only discover what it is specifically looking for. In this thesis narratives collected over a three year period from frequently or chronically ill Cambodians have been presented in the contexts of refugee experiences, exile and adjustment. Accounts provided by my informants in some respects support and in other ways contradict reported experiences of refugee health centres. The experiences of participants support the view that the illnesses of Cambodian refugees may be difficult to diagnose and treat, not easily falling into recognised biomedical nosology. On the other hand, my findings challenge many of the suppositions made about refugees in the context of clinical treatment. For example, whereas Cambodian and other Southeast Asian refugees have been depicted as being reluctant to talk about their traumatic experiences (for example Mollica, 1988; Kinzie, 1989), my informants were grateful for the opportunity to do so, an opportunity of which they made full use.

Mental health theories are commonly drawn on to explain refugee illness and distress, including such disorders as posttraumatic stress disorder and post-torture syndromes. The findings of this study do not support the assumption that trauma and torture are predominantly responsible for ill-health of Cambodian refugees. Although all had experienced traumatic events, the factors my informants identified as responsible for their distressing symptoms were rather related to past starvation, excessive work and the damage done to "nerves". These, together with the stress and loneliness of living in a foreign society often in conditions of poverty, and subject to the effects of cold, accounted for a majority of symptoms of which my informants

complained.

Medical literature frequently categorises as somatisation an absence of underlying organic pathology to explain bodily symptoms, a phenomenon supposedly arising from a reluctance to acknowledge mental distress. Participants in the present study showed no reluctance to admit to mental distress, expressed in the idiom "thinking too much". The admission of "thinking too much" may easily be reinterpreted as a symptom of mental disorder such as major depression, or where there is a history of trauma, as posttraumatic stress disorder. However, I dispute the plausibility of such interpretation, in view of the embeddedness of "thinking too much" in Cambodian life, prior to both the trauma of the Pol Pot regime and to the trauma of flight and exile.

Narratives showed that clinical interaction is often complicated by clinicians' findings of no organic abnormality to explain patients' illnesses, and by patients' disappointment with consultations, whether because the desired form of treatment is not forthcoming, treatment is ineffective, or attempts to reassure are received negatively. My findings of communication difficulties, sometimes affecting the accuracy of medical history-taking, diagnosis and compliance, are also reported in the literature. Also supporting other research, I found that conflicts between the respective illness-related beliefs held by the refugee community and the medical community, largely unspoken, further interfere with clinical interactions. I go further, however, in demonstrating that the language used to describe symptoms and illness, and non-verbal ways of displaying pain, are prone to dismissal and misinterpretation in cross-cultural clinical settings.

Notwithstanding these difficulties and disappointments, in common with experiences widely reported, there was no reluctance among my informants to use Western health care, while at the same time maintaining certain Cambodian healing practices. When the symptoms of which the Cambodian patient complains fit biomedical theories of disease, and treatment is forthcoming, the clinical interaction is generally positive. In contrast, when investigations of symptoms point neither to a disease nor treatment,

frustration and increasing distress frequently result. It is an enigma that Western medicine seems powerless to relieve the very real distress of Cambodian refugee patients, which frustrates and disappoints clinician and patient alike.

With treatment outcomes being poor, and in recognition of the cultural distance between Southeast Asian refugee patients and their Western clinicians, the use of traditional Cambodian healers has been proposed (Eisenbruch, 1992). Some specialist clinics deliver medical treatment, reportedly with some success, in culturally sensitive ways using bicultural staff (for example Kinzie, Tran, Breckenridge and Bloom, 1980; Moore and Boehnlein, 1991). Such services cannot be said to be genuinely bicultural, however, as treatment is firmly located in the biomedical culture.

Other practitioners draw from Buddhist ritual and a range of cultural practices along with Western therapeutic techniques (Eisenbruch, 1991). But my findings suggest that it would be inadvisable to expect too much of Cambodian healers in the West. With both hazards to health and the medicines to guard against or treat those hazards being to a large extent circumscribed within the country of Cambodia, there is little scope for such healing approaches in the countries of the West where Cambodians have settled. In particular, this holds true for spirit-related illness, but applies equally to natural hazards such as endemic communicable disease and venomous animals. Moreover, the social circumstances of the new country have resulted in far-reaching modification and increasing abandonment of Cambodian customs and ritual practices of all kinds. In general the Cambodian community is too small and dispersed to be able to maintain an enduring, separate culture.

With both the Western biomedical system and Cambodian medicine limited in explaining and treating illness of resettled Cambodian refugees, an alternative perspective is needed. Through dialogues between myself and resettled Cambodians, an alternative way of understanding illness and healing phenomena emerged. The perspective straddles the cultural milieu of both Cambodia and New Zealand in which the different systems of healing are embedded, and incorporates the deprivation, trauma, bereavement and exile which describe the refugee experience,

along with transition which characterises the process of resettlement. The emergent perspective can be categorised as neither Cambodian nor Western, although elements of both inform expression of symptoms, explanations of illness, and practices of healing. Symbolised by the metaphor "crossing the sea", this alternative perspective is articulated on characteristics of vulnerability, exile and transition.

Implications of Findings for Health Service Provision

The findings of the study show that although Cambodians with diseases conforming to biomedical disorders may benefit from Western medicine, health services based on biomedical models, including specialist refugee services, have important limitations. These limitations, which are summarised in Chapter 9, emerged repeatedly in the course of interviewing, countering my informants' statements that Cambodian refugees were indeed fortunate in having access to Western medical care. My findings have implications for the provision of health care in New Zealand, and more widely in countries of the West where refugees have settled. In this regard, the experiences of Cambodians have much in common with New Zealand's first people, the Maori.

Biculturalism in Health Care: Maori have not been served as well as non-Maori by the health care system, as morbidity and mortality statistics show (eg Pomare and de Boer, 1988, pp 141 ff). While socio-economic, cultural and genetic factors have been cited as predisposing Maori to disease, Pomare and de Boer (1988, p.22) and Durie (1994, pp.194 ff) also allude to the monoculturalism of health services which alienates and disempowers Maori, adversely affecting both access and health status itself.

Central to the acceptability of Western medicine to peoples of non-Western backgrounds, is the issue of respective concepts of health and illness. Western medicine is popularly depicted as emphasising the physical, material aspects of disease, focusing on individuals in isolation from families and communities (Pomare

and de Boer, 1988, p.22; Kinloch, 1985, p.15f). Kinloch contrasts the Samoan view of illness as an inevitable and unpredictable discontinuity in life's flow, which is not merely an individual affair but one which involves the community. Above all, health is not an individual matter as in Western society, but a family affair (Laing and Mitaera, 1994, p.204f). The Maori concept of health is holistic, embracing spiritual, environmental, family, community, mental and physical elements. Central to health, as to culture, are issues to do with land, language, environment and kinship (Pomare and de Boer, 1988, p.22; Durie, 1994, p.202). Murchie (1984, p.81) explains that the Maori view of health is only partly summed up in the view that a human is a psychosomatic unity, going on to describe the interplay of the "life essence" of every person, and *Hauora* (health), a concept comparable to the Cambodian notion of "energy".

The Cambodian concept of health is depicted in the phrase *sok sub'bai*, literally meaning safe and happy, or well. Drawing from the narratives, explanations of causes of illness portray a comparably holistic concept. The person is viewed in the total contexts of personal, physical, social and spiritual environments, in each of which threats to safety and happiness, and therefore to health, occur. It is immediately apparent that the catastrophic experiences which Cambodians have survived, along with the ongoing difficulties in establishing their lives in the new country, continue to threaten both safety and happiness, thus paving the way for states of illness.

For very different historical reasons, Maori, too, have suffered the erosion of elements that are conducive to health. As the *tangata whenua*, Maori are host to all other peoples in New Zealand, those descended from colonial settlers of largely British origin, and recent immigrants from diverse origins (Royal Commission on Social Policy, 1988, p.14 ff). The monoculturalism and dominance of the biomedical health care system of New Zealand, which does not well address the diversity of New Zealand's population, is being challenged from several sections of the population, notably by Maori (Pomare and de Boer, 1988, p.163f). In view of the comparable all-embracing concepts of health shared by Maori and Cambodians, albeit comprising different elements and embedded in different cultures, along with

common disappointing experiences of Western medicine, Maori initiatives offer a model of self-determination to minority groups such as Cambodians.

Implications for Health Services for Resettled Refugees: Usually, health care for refugees is provided at medical facilities offering health services for the general population. With notable exceptions, there are few specialised refugee health services in countries where large numbers of refugees have resettled. Indeed, such services in New Zealand were established as late as 1995, many years after Southeast Asian refugees began to arrive. An important drawback of specialised refugee health services is that by virtue of their location in large cities, only local refugees potentially benefit. Specialised refugee services are generally based on one of the preferred biomedical models for treating refugee health problems, with posttraumatic stress disorder and torture-trauma treatment being prominent. Such refugee mental health services have suffered from a reluctance among Southeast Asian patients to use the clinics, and clinical outcomes have been disappointing.

My findings show that Cambodian refugees are well able to articulate their personal explanations of the underlying cause of their illnesses, and hold theories about their illnesses and the appropriate management. Cambodians seldom offer such information in clinical settings, however, as it is inappropriate to "tell the doctor" what is wrong, and the doctor is only told what is asked. The implications of this study are that refugee health services can effectively be based on the perspective of refugees, which offers an alternative to basing services on biomedical models which, as we have seen, do not necessarily fit the refugee patient's illness.

In view of the interrelationships among illness, unemployment and poverty, and low integration with society, evident in this study and reported in international research, it would make sense to address in an integrated manner the diversity of needs common to refugees. Health services that are truly comprehensive, making available advice, advocacy and assistance on all aspects of life in the new country, and skilled interpretation services, are likely to be synergistic in effect, ultimately benefitting health status, while at the same time making health care both more relevant and

acceptable.

As the systems of healing and the life experiences of each group of refugees is distinct, it is highly unlikely that clinicians can develop expertise in understanding the cultural and historical backgrounds of more than one or two ethnic groups. Health services based on a truly bicultural model, representing a partnership between the biomedical culture and the refugee community's culture, offers a way toward ensuring that the patient's language of symptoms and illness is understood. At the same time, with members of the refugee community fully involved in tailoring health services to the particular requirements of their community, refugees are empowered, and in the process acquire knowledge and skills in developing support services, and in supporting their people.

The initiation of comprehensive, bicultural refugee support services by the refugee communities themselves will potentially overcome the problem that services are concentrated in major centres. Community-initiated services could be developed in even quite small communities, buying in specialised medical and other services as needed. By better supporting refugees and providing a base for social interaction, such services have the potential to counter secondary migration to major, better serviced cities. The development of bicultural refugee services will require funding, that would normally support biomedical services, to be made available. Funding policy and practices which tend to favour conventional services will therefore need to be relaxed. Models being developed by Maori demonstrate that such innovations are possible and effective, models which can usefully be extended to other sections of New Zealand's increasingly multicultural society. Comprehensive, bicultural refugee support services as proposed are not limited to the New Zealand setting, however, but are potentially workable in any country of the west where refugees resettle.

"Crossing the Sea": an Alternative Perspective

The metaphor "crossing the river", or "crossing the sea", is used by Cambodians solely in relation to a woman in childbirth. However, it has obvious application to all Cambodian refugees who have sought resettlement in third countries. Many of these refugees literally crossed the river that forms the border between Cambodia and Thailand, in their initial flight. After years of sojourning, they again undertook a crossing, this time crossing the sea to unfamiliar destinations, about which they had scant, often idealised, information. New Zealand was one such destination, along with Australia, the United States, Canada, and Europe.

For the refugees making up the resultant Cambodian diaspora, resettlement has been an experience of rebirth, necessitating the acquisition of language, skills, tastes, values and customs deemed more appropriate to their new country than those of the country of their birth. Indeed, the metaphor of rebirth, applied to women who safely emerge from the childbirth experience, is highly pertinent to resettled refugees, reflecting the several stages of the refugee career. Birth and rebirth entail danger and risk to both mother and child, along with a high degree of uncertainty as to whether either will safely emerge on the other side. The very fact of having survived the circumstances in which multitudes perished, including near kin and life-long acquaintances, is itself a rebirth. Being accepted for permanent resettlement by a third country gives an opportunity for a fresh beginning, a second chance, a new life. However, such are the socio-cultural and physical differences between the country of origin, Cambodia, and the country of resettlement, New Zealand, that the process of adjustment can be likened to being reborn into a different world. As the woman who survives childbirth is reborn into a different social status, that of mother, so the social status of the resettled refugee is rarely the same as the former social standing.

To safely accomplish this rebirth, or "crossing the river" "energy", or *gkom'laing* is required. A woman who has plenty of "energy" has strong "nerves" and a strong mind and spirit. She is less likely to "think too much", and is less likely to suffer from "fright", or shock, upsetting the "nerves" and causing illness. Such a person is

also less vulnerable to attacks by malicious beings, be these ghosts, spirits or witches. Nevertheless, even those with plenty of "energy" lose some "energy" during childbirth, and need to observe post-birth rituals for their own protection. It is those who had little energy to start with, however, who are at greatest risk. For these ones "the mind cannot stay still, and the body is very, very weak".

It is not difficult to accept that many Cambodians would be low on "energy" after having suffered extreme deprivation and loss, endured terror, torture, the powerlessness and uncertainty of living in refugee camps, and the trials of adjusting to life in a distant land. That their energy was depleted through protracted deprivation, and "nerves" upset in the events making up their life journey, has repeatedly emerged in narratives. The very fact of living in multiple times and spaces, quite aside from the energy expended in adjusting to the new society, does itself make heavy demands on energy. In the aftermath of such conditions, the risks of "thinking too much", the subject of Chapter 7, and of developing "nerve"-related illnesses, included in Chapter 8, are heightened. On top of it all, like the woman who has just given birth, resettled Cambodians are "cold". It is imperative that the "cold" condition be addressed in order to reduce vulnerability to illness. Yet in the absence of "warming" medicines, and considering the cool temperatures and frequent winds of New Zealand, the warmth Cambodians seek is elusive. Socially, too, the reception of refugees can be chilly, a coolness often experienced in encounters with New Zealand social institutions and neighbourhoods.

Cambodian ways of caring for the woman who has "crossed the river" offers an approach for caring for refugees who have "crossed the sea" and resettled in the West. A quiet, calm environment is needed to avoid the risk of "upset nerves". The person needs to rest, to be relieved from the pressure of responsibilities, and should not undertake heavy work too soon lest the "nerves" are damaged. Warming is essential, and energy needs to be built up. The person shouldn't be left alone, but have congenial company. While my ill informants did not describe themselves as like the woman who has "crossed the river", they expressed the need for rest, warming, avoidance of physical exertion, and congenial company which distracts them from

their troubles and administers self-care. These approaches are reflected in the themes described below.

Themes of an Alternative Perspective on Cambodian Health

The parallels between Cambodian refugees, who have literally crossed the sea to establish new lives in third countries, and the woman in childbirth, who euphemistically "crosses the river", are remarkable, as suggested above. Common characteristics reflect social status, illness risk, approaches to healing and caring. This local Cambodian-New Zealand system of healing, as proposed in Chapter 10 is, however, likely to be transitional in nature, itself reflecting the transitional lives of the adult refugees from whose narratives the system became apparent, as well as the transitional nature of childbirth. The principal themes of this explanatory model of illness phenomena of resettled Cambodian refugees are articulated in the narratives of illness, explanations which are consistently supported by prevalent self-care practices. At the same time, the uncertainties brought about by being in a different physical and cultural location are reflected in their pondering on the progress of their illnesses. The contradictory messages on experiences with Western medicine, and the pattern of drawing from a range of Western and alternative medicines and techniques, similar to pluralistic practices in Cambodia but distinct from it, further reflect a state of being in transition, as yet unsure and undecided.

Six principal themes emerged in the study, which together make up a comprehensive perspective on Cambodian refugee health. The six themes identified reflect:

- illness risk factors
- ways of expressing symptoms and disorder
- Cambodian self-care practices
- the emergent Cambodian-New Zealand local system of healing

- illness and care of the ill in maintaining community
- the relationship of illness and its management with the society of "little Cambodia".

Illness risk factors: as the woman in childbirth is believed to be highly vulnerable to both natural and supernatural hazards, so the refugee is weakened, and vulnerable. Many conveyed that they had little energy and that their body was weak, often explained as the long-term outcome of starvation, excessive work, excessive fear, and other conditions described in Chapter 5, characteristics which again are reflected in the process of childbirth. Included here is the risk to health of the cold climate and of wind, natural hazards in New Zealand that did not pose a problem in Cambodia except when already in a state of vulnerability such as "crossing the river". These findings contrast with those of biomedical research, which are based on past trauma and current adjustment stress as the principal risk factors. The risks which the refugees themselves identify do not feature in published research.

The element of uncertainty, in the case of the woman regarding survival itself, and for the refugee regarding the future, is an added drain on energy. The woman's marginal position, expressed as being on neither shore, but somewhere in the middle of a river, parallels the refugee's socially marginal position, described in Chapter 6. Refugees' marginality is reinforced by the very phenomenon of living simultaneously in multiple times and spaces, described by major episodes of the life journey: being raised in and constantly thinking about one place and era; the destruction of that way of life and many of its people; the multiple places through the world where kin and family now reside; and the locality where they personally have settled. Such a phenomenon contrasts with village society, in which people and their kin were strongly rooted in one place, unlike industrial and post-industrial societies where workers follow jobs.

The scale of contrast between their lives before and since becoming refugees poses major demands on adjustment, quite aside from the fact of their having been

violently uprooted from village life, both of which militate against becoming rooted in the new country. The study revealed the extent of marginalisation of Cambodian refugees, especially marked among those who suffered much from illness, had difficulty in acquiring English and finding employment, and were poor. For these people, social contact was to a large extent derived from "little Cambodia", a society on the margins of mainstream society. Poverty, social isolation and marginalisation all constitute health risks, risks exacerbated for refugees who are already vulnerable, and about which they describe themselves as "thinking too much". The fact that resettled Cambodians perceive themselves as at high risk to illness explains the prevalence of symptoms of illnesses embedded in the Cambodian system of healing, the nature of which comprise the second theme of the paradigm.

Dominant ways of expressing symptoms and illness: the language used to explain that all is not well with the person differs from that commonly used in New Zealand culture, and within biomedical culture. "Thinking too much", the subject of Chapter 6, was widely reported in the context of discussions on illness, yet it clearly did not coincide with illness. In contrast, upset "nerves" were described as causing illness, believed to be brought about by "fright" and "shock" to the "nerves" in vulnerable people, an explanation underlying several illness narratives presented in Chapters 8 and 11. Both women in childbirth and refugees are portrayed as having encountered many situations when their "nerves" can be so affected, and which can set them "thinking". They are thereby particularly at risk to these conditions. The Cambodian condition of *k'jol* (caused by a build-up of heat or wind) was described as a minor illness (or co-present with major illness), which if unresolved can lead on to serious illness. Resettled refugees described themselves as being especially prone to *k'jol*, in common with women "crossing the river".

Symptoms of these three Cambodian disorders, "thinking too much", "nerve" problems and *k'jol*, overlap. For each state of bodily or mental disorder a variety of symptoms were described, including headache, dizziness, muscle and joint pain, loss of appetite, nausea and diarrhoea. A similar array of somatic symptoms occurring in

resettled refugees are often brought to Western clinics, for which frequently no organic abnormality is found, leading on to conclusions that these are cultural ways of expressing mental distress. The findings of this study point rather to these being culturally-embedded symptoms, indicators of both mental and bodily distress, which are understood in the context of the Cambodian culture but make little sense in the culture of biomedicine. Too often, as the narratives show, these symptoms and explanations which cannot be explained by biomedicine, are reinterpreted to fit another category of biomedical nosology, or are dismissed.

These findings are highly significant in understanding the complaints Cambodian refugees commonly present with at clinics, and which are frequently categorised as somatisation or cultural ways of expressing mental distress. There has been scant research on "thinking too much" and *k'jol*, and my findings make an important contribution in extending knowledge of these ubiquitous Cambodian disorders. I have not come across any studies which describe the importance of "nerves" in understanding Cambodians' theories of illness.

Cambodian self-care practices: self-care techniques directly relate to the symptoms of which Cambodians commonly complain. Practices to deal with the above disorders and symptoms are maintained, often carried out in the social context of "little Cambodia". The widespread practice of the techniques of "coining", "cupping", "pinching", and "nerve massage", described in Chapter 10, reflects the prevalence of the disorders which these relieve, along with the maintenance of theories regarding the cause and treatment of disorder. In addition, practices to relieve mental distress, described as "thinking too much", are widespread. Pleasant activities which help distract refugees from their hardships go on in "little Cambodia", such as playing cards, watching Cambodian videos, listening to Cambodian music and socialising in Cambodian ways. Together these comprise informal techniques of mutually supporting one another in not "thinking too much". Seeking advice from respected people in the community is both recognised and widely practised, as it was in Cambodian village life.

This range of self-care practices serves not only to relieve distress, but to communicate that distress, thereby mobilising social support and sympathy. As some narratives show, however, the resources of the Cambodian community to provide the necessary support may be inadequate, reflecting both the prevalence of vulnerability and disorder, and the transitional characteristic of the community itself. While these symptoms as indicators of bodily and mental distress are correctly interpreted by members of the Cambodian community, this is seldom the case among the Western medical community, including young New Zealand-educated Cambodians socialised into Western medicine. Not coinciding with recognised signs of biomedical disorders, clinicians may endeavour to sympathetically relieve the symptoms with Western medicine, often with limited effectiveness, or engage in a process of persuading the patient that there is no illness, exacerbating the patient's distress in the process.

There is a small literature on self-care techniques. The concern of biomedical articles is to warn clinicians that the practices go on and are not injurious to health. Ethnographic studies go further, in analysing self-care practices in the social contexts in which they occur. I have taken previous findings further, by relating self-care practices firmly to Cambodian disorders and symptoms, and by showing how self-care is integral both to an emerging system of healing, and to the society of "little Cambodia".

The emergent Cambodian-New Zealand local system of healing: Self-care practices comprise the core of the fourth theme, which I have portrayed as a local system of healing, a Cambodian-New Zealand system. I have argued that the traditional Cambodian system of healing, as a coherent model that explains and heals illness, has been rendered largely irrelevant with the relocation of Cambodian refugees. The principal Cambodian healers, *gkru khmer* and *chmorb*, have in New Zealand been replaced by the family doctor together with an associated range of health professionals, for the care of both the ill and women in childbirth. The view that local practitioners are best suited for treating local illnesses further supports the redundancy of *gkru khmer* in favour of family doctors.

Along with traditional self-care and a new reliance on Western clinicians, the third element of the local system of healing is the pattern of drawing from available alternative medicines, particularly those of the Chinese and Thai medical systems. The procurement of such medicines involves Cambodians in considerable information sharing and travel, activities going on in "little Cambodia" also reflected in the acquisition of preferred foodstuffs and other items.

Characteristics of the Cambodian-New Zealand system that set it apart from the local system in Cambodia are the limited scope of medical pluralism in New Zealand, and the relative disempowerment of Cambodian refugees in New Zealand to directly access desired treatment. Although ready access to the coveted high technology of Western medicine is conveyed in a very positive sense by the refugees themselves, their dependence on the family doctor to access treatment detracts from the perceived advantages. Their narratives repeatedly convey disappointment and frustration in being unable to procure the kinds of treatment deemed most effective, and their dependence on the family doctor to access specialist and hospital services. Whereas adult Cambodians perceived themselves as formerly being "experts" in selecting medical treatment, an expertise which enabled them to choose from among the wide range of available medicines and services, their exile undermines their confidence in understanding illness, and their refugee status makes them fearful of offending the host society if they go against the "rules".

This theme provides an important contribution to understanding Cambodian refugee health, providing data where there was none available. Although elements of healing practices have been described, for example self-care techniques and patterns of utilisation of Western health care, I have not encountered a description of an integrated system of healing, nor indeed suggestions that such may exist. My findings are also significant in challenging the assumption that "traditional healing", in tandem with Western health care, offers a solution to the disappointing experiences in clinically treating refugee patients. I have shown that many such practices are rendered irrelevant by the change of location, highlighting the fact that the Cambodian system of healing is truly local in character.

Illness and care of the ill in maintaining community: illness provides a means of maintaining the Cambodian community, a view not portrayed in biomedical literature on refugee health, which invariably sees illness negatively. Cambodian ways of expressing distress and disorder are understood within the community, in contrast to mutual unfamiliarity experienced in medical encounters. For example, *dtoas* and problems with "nerves", unknown in biomedical culture, are known and accepted among Cambodians. Within the Cambodian community, therefore, the sufferer can expect to receive both understanding and sympathy, and that the required care will be forthcoming.

Expectations of the sick, and the values underpinning the preferred way of caring for the ill, are described in Chapter 10. Drawing from traditional practices in caring for both women "crossing the river" and the ill, such care is characterised by being nurturant, keeping company with the person, allowing rest, indulging preferences, protecting from any event which may upset weakened "nerves", along with guarding those in a weakened state from further harm. In Cambodia such hazards included spirits, ghosts and witches. In New Zealand cold and loneliness are the principal dangers. Keeping company with and serving the ill enables the ill to rest and minimises the risk that they "think too much". Self-care is practised in the caring context, thereby demonstrating sympathy and compassion for the sufferer, and providing members of the community with the principal means of healing over which they retain control.

I have argued in Chapters 9 and 11 that these patterns of caring, which include encouraging resting indoors, contrast with those of the Western medical culture, patterns which are espoused by New Zealand society. Care of the ill therefore serves the function of bringing members of the Cambodian community together, thus reintegrating the community, and of providing occasions for strengthening and developing shared views and values. This positive aspect of illness contrasts with the negative view consistently portrayed in biomedical literature. My data and analysis on preferred ways of caring for the ill are seldom addressed in literature on

Cambodian refugees, literature which focuses mainly on disease prevalence.

The relationship of illness and its management with the society of "little Cambodia": illness phenomena, the Cambodian-New Zealand system of healing based on self-care practices, and the Cambodian community are intimately related. The social location for the review and modification of traditional beliefs is "little Cambodia". This is also the location for the mutual application of self-care techniques, as it is for the exchange of information about alternative medicines, and indeed the exchange of medicines themselves. Just as illness appears to interfere in complex ways with the process of adjustment to New Zealand society and its institutions, so there is a strong positive relationship between illness and "little Cambodia".

Members of "little Cambodia" are involved not only with present time in the local community, but are intensely occupied with the multiple times and places where their far-flung kin reside. Living in multiple spaces places a high demand on energy, which conceivably poses a risk to health, a parallel to the enervating effect of giving birth. "Little Cambodia", the location where much discussion about "people in the back" and mutual comfort takes place, is likely to mitigate the negative effects of living in multiple spaces.

As I explained in Chapter 6, "little Cambodia" does not provide the principal context for social interaction for all Cambodians. Resettled Cambodians who are "modern" in type, those whose integration with New Zealand society is successful and rapid, and the young who are being educated in New Zealand, both give and derive less from this community on the margins. It is possible, therefore, that like "little Cambodia", the Cambodian-New Zealand system of healing will fade along with the transitional generations of resettled refugees, whose purposes are to some extent served by the informal social institutions they have created.

Conclusions

The findings of this study have led to the formulation of an alternative perspective on Cambodian refugee health, a perspective that diverges from the dominant views based on the biomedical paradigm. As a body, biomedical research portrays Cambodian refugees as traumatised and suffering high levels of sickness. My findings show that resettled refugees are creators of culture in response to both constraints and opportunities in the new country. Although my informants were characterised by being ill, the very fact that they were actively engaged in a process of creating culture and in establishing a Cambodian community, illustrates personal strength and resilience. Such characteristics were also evident in the healthy members of the Cambodian community, who have remarkably overcome obstacles in establishing themselves in the new country, obstacles of poverty, an initial inability to communicate, and disrupted and often minimal educations.

This study has differed from some ethnographic research on refugees' beliefs and practices, which has suffered from its tendency to portray illness and healing as somewhat static, a carry over from the country of origin. My research was based on the assumption that transition characterises resettled refugees. Accordingly, illness and healing systems can best be explained by interpreting phenomena as undergoing transition. The study has produced important information, much of it not previously reported, on illnesses of Cambodian refugees, and their search for healing, within the first decade of resettlement in New Zealand. It also raises questions, for example on the nature of illness, reflecting the state of transition characterising Cambodian refugees. Illnesses which fall neither into Western biomedical nor Cambodian categories perplexed my informants and clinicians alike. What are these illnesses? How can they be treated if they lack a name? The response of my informants was to create a local system of healing, with Cambodian self-care techniques at its core, and drawing from available Western, Chinese and other medicine and techniques. The resultant Cambodian-New Zealand system of healing is unlike both the Cambodian system of pre-Pol Pot Cambodia, and the biomedical system of New Zealand.

I have suggested that the Cambodian-New Zealand system of healing, with its explanations of illness in the changed conditions of New Zealand and its patterns of healing, is itself likely to be transitional, as Cambodians abandon "little Cambodia" and its system of healing, in favour of a form of compliance with mainstream society. This transitoriness need not be the case, however. I conclude by offering that such a transition reflects cultural colonisation by dominant social systems of New Zealand, including the system of healing, a process to which refugees are particularly vulnerable by virtue of their learned compliance and dependence, and persisting marginal status.

Resettlement policy and practices which affirm diversity in social and cultural systems, are less likely to extinguish practices and values. An example is the maintenance of practices of healing which are relevant to the new country, such as the Cambodian-New Zealand system. Such maintenance arguably affects the health status of refugees positively, by its interactive effect on maintaining community and retaining a greater measure of control over health and healing. An example of healthy refugee policy would be to allow refugees to settle in a larger group, rather than being scattered throughout the country. Simply having more people in a locality would enhance the available pool of skills, fostering mutual care, with members offering services to one another. A large-sized group of refugees from a common origin would enable clinicians to become knowledgeable about the way members of the refugee community express symptoms and explain illness, and to develop skills in treating refugee patients. It would be feasible to design facilities specifically to address the needs of the group, and indeed to foster the development of such facilities by the community itself, managed and staffed by its members. Such developments would provide for greater self-determination, and the creation of an environment where there was both better choice and improved control.

The local system of healing, like the Cambodian New Zealand community itself, will not stand still, but as the surrounding society changes, and the circumstances of community members change, so the Cambodian community and its system of healing will continually respond by itself changing. The metaphor "crossing the river" is

therefore enduring, capturing the constancy of transition facing the Cambodian diaspora, and offering a perspective to make sense of continual transition and resultant stress on health and health care.

I have conducted the study among the Cambodian refugee community, a community undergoing transition that is extreme in degree and rapidity, from a rural, peasant way of life, to living in an isolated island-state whose small population is mainly urbanised. Research among Cambodians from educated, urban backgrounds would show the extent to which the findings hold true for all Cambodians, of both rural and urban backgrounds. This study focused on the Cambodian refugees suffering from illness, and who nevertheless were characterised by courage and tenacity. Further research on those who have endured similar experiences of deprivation, trauma and adjustment stress, but who are healthy, would add to our understanding of human resilience. Further ethnographic research among Cambodian refugee communities elsewhere in the West would demonstrate whether the principles underlying the dominant themes hold true among Cambodian who have settled in other countries. Finally, I have suggested that the Cambodian-New Zealand local system of healing, a system comprising both explanations of illness and the healing of illness, is likely to be transitional, fading as older Cambodians pass on and younger Cambodians integrate increasingly into mainstream society. Future studies will show what aspects of the Cambodian-New Zealand system of healing endure, and what aspects are transformed in response to ongoing change.

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TOPICS TO BE COVERED IN UNSTRUCTURED INTERVIEWS

Health and health problems since coming to New Zealand.

Action taken when ill

- home remedies (folk, traditional)
- self-treatment
- GP
- other
- reasons underlying action/choice

Experiences

- expectations
- positive outcome
- negative outcome/frustrations
- cost of primary health care services

Opinion

- satisfaction with consultation, and its outcome
- doctor's view of traditional/folk remedies

Pre-migration issues

- general health and illness
- services available, and preferred
- reasons for leaving Kampuchea, and for migrating to New Zealand

Post-migration issues

- English learning
- social contact and friendships
- employment
- what they like most about living here
- what they like least

GUIDELINES FOR TRANSCRIPTION**Introduction**

It is of paramount importance to realise the significance of transcribing the recorded interviews (recorded on magnetic cassettes) in such a way that what was said should be accurately and objectively translated and transcribed. The translator(s) should also exercise their discretion when there is any additional and personal comment to be made, as this may clarify some points the interpreter failed to interpret during the interviews, due to a large array of factors including personal experience, ability, bounded rationality, misunderstanding, and so forth. During the process of transcribing, it is quite normal to repeatedly listen to a (small) section of an interview, especially when there are several people talking at the same time. The following points should only be considered as a set of guidelines, and not rules.

Guidelines

- *convention for naming participants*: to be able to distinguish all the participants and to make the job of a transcriber somewhat easier, a code can be used as followed:
 - s: the subject or person whom the interview is for (interviewer);
 - i: the interpreter;
 - o: the object or person who is being interviewed (interviewee);
 - m: an object who is a male person (man);
 - w: an object who is a female person (woman);
 - m1: man (object of the interview) number one;
 - m2: man number two, etc.
- *convention for distinguishing English from Cambodian*: all conversations in Cambodian should be enclosed in a pair of parentheses or round brackets like (and). Conversations in English need not be enclosed in parentheses.
- *special Cambodian word(s)*: from time to time, it is necessary to use Cambodian word(s) written in English characters eg. D'OS (meaning to make or formulate GRU KHMER medicine by scrubbing all or some of the ingredients against the stone used for this purpose), as it is much easier to use such words, eg. D'OS instead of writing down its description and sometimes, there is no equal translation, equivalent translation (or there is one, but it is beyond the translator's knowledge!) such as SA'CJU SOR or SA'CJU KIEV (which are white alum and copper sulfate, respectively. These words, while appearing to be common ordinary words for some English-speaking people, can, however, frustrate some translators indeed!). To help identify that a word is a Cambodian word, all letters should be written in capital letters, eg. SA'CJU KIEV and SOR'SAI (nerves). For names (proper nouns), normal rules apply.
- *spelling*: in Cambodian, like in other languages, some syllables in a word are accented (ie. with a stress in the word), eg. R'MEAS (rhinoceros), therefore the apostrophe is used. Due to the limitation of sounds available in the English language, some French sounds (and characters) are used to simulate Cambodian sounds, eg. DTUN'LE (river), KHMER KRÔHÔM (Khmer Rouge), etc. When writing these words, it is desirable to include their actual Khmer scripts

as well - for reference, etc. Alternatively, if using computer to record the transcript, these words with their Khmer scripts should be kept on a separate piece of paper(s). Different people have different ways of spelling Cambodian words in English; spelling convention is entirely up to the individuals, as long as consistency is maintained, of course!

- *personal comments*: these should be encased in a pair of square brackets like (and). These comments should be objectively stated, as what one knows, from their personal experience or background, does not necessarily reflect or represent the entire population or the whole of Cambodia! Reference from a source(s), eg. a dictionary, should be acknowledged, to ensure some standard and to avoid criticism. It is not unusual that a translator does not know what a word or a phrase really means; in this case, an informal description of such word or phrase should be used. Admitting one's ignorance, if it is known, is much better than covering it. Who knows everything?
- *accuracy, not speed*: the significance of the translation can never be emphasised enough; it is, therefore, necessary to transcribe and translate everything as accurate (and objective) as possible. If unable to translate and/or transcribe something, for some reason, state so (using personal comments).

Final Remark

Bear in mind that accuracy and objectivity are more important than speed!

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Publication of Yale University Press]
Mass : The Murray Printing Company.

S : interviewer
O : interviewee
I : main interpreter, Eng
i : another interpreter

All transcribed words in round brackets (&) were in Cambodian, and those in square brackets [&] are my comments. I believe the translation to be approximately 95% accurate, due to unclear sound and/or overlapping conversation, and loss in the translation process such as the equivalent of a word, instead of its exact meaning.

Appendix

- GRUN PUOH-VIEN = the hyphen denotes that in Cambodian, the syllables are one word
= UD has that sound as in 'poor' or 'pour'
= IE has that sound as in 'Vietnam'
= typhoid [English-Khmer Dictionary (1978), Yale University, pp 630]
- KJOL = pronounced kjâl
= short for KJOL DJAB [djâb]; DJ is the hybrid of CH and J
- KJOL DJAB = the TIET [parts, things] inside the body do not function properly, blood does not circulate well, causing dizzy, sweat, cold body [Dictionnaire Cambodgien (1967). Tome I. pp.113]

APPENDIX 4

Facsimile

18 May 1992



**MASSEY
UNIVERSITY**

Private Bag
Palmerston North
New Zealand
Telephone 06-356 9099

Dear

My name is Nicola North. I work at Massey University. I teach the subject of health service management. Previously, I have worked in Asia doing health work.

I am wanting to learn from Khmer people what it is like for them when they become ill, in Kampuchea and in New Zealand. I hope that this study will help Khmer people who have settled here to have the quality of health service they would like.

I am writing this letter to ask your agreement for me to interview you. I asked Mr Lim for advice, and Eng has agreed to translate for me. These and other Khmer friends have said that you have been sick a lot since coming to New Zealand, which is why I am asking you. Probably, two visits will be sufficient. I would like to talk to you together with other family members, if you are happy about that.

All information you give me will remain confidential. You will not be identified by name. If at any time you are unhappy to participate, you may say no (withdraw from the study).

When I have completed this study, I would like to report back to you. I plan to do this verbally, but the written report will be available on request.

Yours sincerely

A handwritten signature in cursive script, appearing to read 'Nicola North'.

Nicola North



MASSEY UNIVERSITY

Palmerston North
New Zealand
Telephone 0631 69-099

FACULTY OF
BUSINESS STUDIES

DEPARTMENT OF
MANAGEMENT
SYSTEMS

Faculty

Handwritten text in Hindi, starting with "निकोला नॉर्थ" (Nicola North).

Handwritten text in Hindi, continuing the message.

Handwritten text in Hindi, continuing the message.

Handwritten text in Hindi, continuing the message.

Handwritten text in Hindi, continuing the message.

Handwritten signature: Nicola North.

APPENDIX 5



MASSEY
UNIVERSITY

Private Bag
Palmerston North
New Zealand
Telephone 0-6-350 4100
Facsimile 0-6-350 4101

RESEARCH
OFFICE

28 November 1991

Ms N North
MANAGEMENT SYSTEMS

Dear Ms North

re: Application "Exploratory study into the Interaction
Between Kampuchean Settlers and the Healthcare Organisation
at the Primary Level" (HEC 91/114)

Thank you for attending the Human Ethics committee meeting on Friday 22
November 1991.

The following points were discussed:

- (i) We note that you will carefully inform the participants how you have become aware of their names and this will be included in your introductory letter.
- (ii) We strongly suggested that it would be inappropriate to consult their health care givers and you agreed that this would not be done.
- (iii) You were aware that the use of an interpreter raises problems of accuracy and of confidentiality. We accept your assurance that you will take particular care of this matter.
- (iv) We note that you will, in a culturally sensitive way, explain your findings to your participants and that your initial letter will inform them that this is what you will do.

Your application is approved.

Yours sincerely,

A handwritten signature in cursive script that reads "Ivan Snook".

Ivan Snook
Chairperson
Human Ethics Committee



MASSEY
UNIVERSITY

Private Bag
Palmerston North
New Zealand
Telephone 06-356 9044

Facsimile

7 May 1992

Professor Ivan Snook
Chairperson
Human Ethics Committee
C/- FACULTY OF EDUCATION

Dear Professor Snook

I am writing with respect to the study I am carrying out amongst Kampuchean settlers (HEC 91/114).

I have been progressing very slowly (more slowly than anticipated) in these initial stages, in contacting formal leaders of the community and proceeding on their advice. However, I am now ready to start collecting data, and arrangements for an interpreter seem very satisfactory. She is translating the introductory letter, to participants, and is quite insistent that I should not ask for written consent. Khmers are highly suspicious about having to sign anything, arising out of their refugee experiences. They habitually refrain from signing teacher's notes relating to their children in school, for example. The advice that Khmer contacts give me is to explain verbally what is written in the letters (they will have both English and Khmer versions), and proceed on their verbal assent.

I attach a copy of the letter in English, redrafted taking into account comments from the Human Ethics Committee, in November, and Khmer advisors.

Recently, I have enrolled in a PhD, in the Department of Social Anthropology, which will be focusing on continuities, discontinuities, and adjustment of Khmer settlers. As this present study will be a precursor to the subsequent research, it is imperative that it doesn't jeopardise the latter. I therefore discussed the issue of consent with my supervisors, Drs I Duncan and A Trlin, who agree that to proceed on the basis of verbal agreement is appropriate, and consistent with the New Zealand Anthropological Association Code of Research Ethics. Their supporting letter is attached.

I have followed through on all points raised by the Human Ethics Committee, as outlined in your letter to me of 28th November 1991.

Yours sincerely

Nicola North



**MASSEY
UNIVERSITY**

Private Bag
Palmerston North
New Zealand
Telephone 04-356 9000
Facsimile 04-350 5600

**RESEARCH
OFFICE**

26 May 1992

Miss N North
MANAGEMENT SYSTEMS

Dear Miss North

Thank you for your letter of 7 May which was noted at our meeting of 22 May 1992. As you know, we also received a letter from Doctor's Duncan and Trlin.

In this matter we are prepared to accept your procedure but some members of the committee are not convinced that the guidelines of the New Zealand Anthropological Association are adequate.

Yours sincerely

IVAN SNOOK
Chairperson
Human Ethics Committee'

Civil war at an end APPENDIX 6

NZPA-AFP BANGKOK. — Cambodia's bloody 12-year-old civil war will officially end today after all four factions agreed to an unconditional ceasefire, Prince Norodom Sihanouk said in a dramatic statement released in Bangkok.

"There is no more war in Cambodia — at least on paper. I hope also on the ground," said the prince, who was flanked by resistance leaders, including Khmer Rouge nominal leader Khieu Samphan, and Phnom Penh Prime Minister Hun Sen.

The announcement came after a hectic 24 hours of meetings in the Thai capital between the prince and all four factions in preparation for the start of the Supreme National Council meeting in Pattaya today.

The council comprises six officials of the Hun Sen Government, and two from each of the guerrilla groups: The forces of Prince Sihanouk, the communist Khmer Rouge, and the Khmer Peoples National Liberation Front.

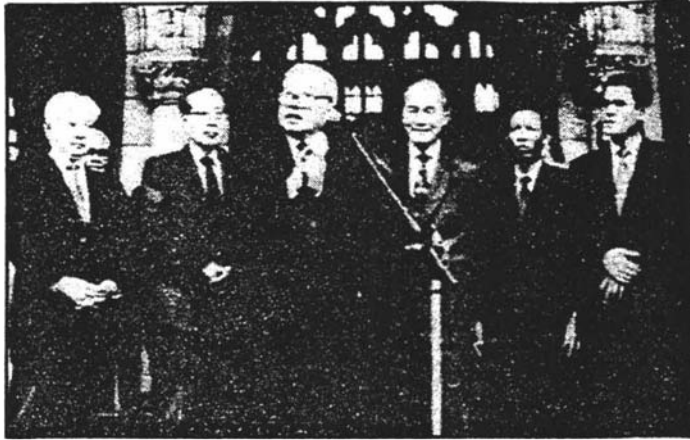
Beaming widely, the 68-year-old former monarch said the council will in the future be headquartered in Phnom Penh and will represent Cambodia internationally.

But the prince admitted there were still problems to be solved in Cambodia's search for a lasting peace, but he described them as details.

One of the key points still to be worked out will be how to monitor the ceasefire and to halt the international supply of weapons to the guerrillas and the Phnom Penh Government.

"We will discuss at Pattaya the problems of weapons and how to monitor the ceasefire," the prince said.

He said the peace plan worked out by the permanent five members of the United Nations Security Council would be used as a working paper.



CAMBODIAN resistance leader Prince Norodom Sihanouk announces the ceasefire in Bangkok.

"The Perm Five plan is good, but on the ground it is difficult to implement all of it. We will go step by step to have a comprehensive settlement," he said.

News of the breakthrough caught diplomats and observers here by surprise.

One diplomat closely linked to the peace talks described the settlement as "simply astounding", while another described it as a "major breakthrough".

However, at least one diplomatic expressed a degree of caution, warning that "the devil is in the details".

Khieu Samphan, also in Pattaya, confirmed the Chinese-backed Khmer Rouge, the backbone of the guerrilla coalition trying to overthrow the Phnom Penh Government, had pledged to observe the ceasefire.

Asked if his faction accepted the ceasefire announced by Prince Sihanouk, the Khmer Rouge leader replied: "Obviously."

It was Khieu Samphan's first public response to the prince's statement.

Although he had stood smiling beside the former monarch as he unveiled the peace plan, he

had made no statement.

The Khmer Rouge, analysts forecast, is likely to engage in some hard bargaining since acceptance of the ceasefire represents a major compromise for the group, which makes up the military backbone of the coalition.

Previously, the Marxist faction, which during a four-year reign of terror from 1975 to 1979 killed millions of Cambodians in the country's "killing fields", had resisted a truce whereby the forces of the warring factions remained in place.

The reason for this was that Phnom Penh controls 80 percent of Cambodia, and, with an end to the fighting, could find itself in a favourable position ahead of United Nations-organised elections.

Other details of Prince Sihanouk's peace plan included how Phnom Penh and the guerrillas would each continue to separately administer the territory they control. While waiting for general elections to be held, the three resistance factions would retain their captured territory in the north-west.

Chronology of conflict

BANGKOK. — Here is a chronology of the 12-year-long civil war in Cambodia which officially ends today:

April 17, 1975: The United States-backed Government in Phnom Penh falls to the Chinese-backed Khmer Rouge led by Marxist Pol Pot. In less than four years, the regime is held responsible for the death by starvation and execution of millions of Cambodians.

December 25, 1978: Vietnam invades Cambodia. Khmer Rouge leaders and forces flee to the Thai border. Deposed monarch Prince Norodom Sihanouk, escapes.

January 7, 1979: Phnom Penh falls to the Vietnamese. The People's Republic of Kampuchea Government is installed and Khmer Rouge leaders tried.

January, 1979: Cambodian refugees pour into Thailand.

Mid-1982: Coalition Government of Democratic Kampuchea formed to represent Cambodia to the UN and unite the resistance factions of Prince Norodom Sihanouk, former conservative prime minister Son Sann and the Khmer Rouge. Prince Sihanouk named head of the coalition and "moderate" Khmer leader Kheu Samphan heads the Khmer Rouge.

December, 1985: Vietnamese and Phnom Penh troops launch an offensive against resistance bases near the Thai border.

December 2, 1987: Prince Sihanouk meets Phnom Penh Prime Minister Hun Sen in France.

July, 1988: The four warring factions meet in Jakarta but fail to agree.

May, 1989: An international conference on Cambodia convenes in Paris. It collapses.

September, 1989: Vietnam stages a withdrawal of the last of its troops from Cambodia. The "withdrawal" is disputed.

October, 1989: Resistance factions seize Phnom Penh positions in north-western Cambodia.

September, 1990: The Supreme National Council (SNC) is formed under a UN-brokered peace plan.

September 17, 1990: The SNC's first meeting collapses over leadership.

November, 1990: Cambodia's seat at the UN falls vacant as the Khmer Rouge responds to formation of the SNC.

December 21, 1990: An SNC meeting in Paris is hailed as a success by the Khmer Rouge.

June 3, 1991: The SNC's third meeting again collapses over leadership. The Khmer Rouge abandons a month-old temporary ceasefire.

June 23, 1991: Prince Sihanouk announces the official end of the war to take effect on June 24.

NZPA-AFP STANDARD JUNE 26 1991

THE HERALD JUNE 19, 1991

Come back home when I call, prince pleads

THE man many tip as a future leader of a united Cambodia yesterday made an impassioned plea for young New Zealand Cambodians to return home as soon as given the word.

Prince Norodom Ranariddh, son of Prince Norodom Sihanouk, told about 400 expatriates in Wellington that a peaceful and united Cambodia was imminent.

The four Cambodian factions — National United Front for an Independent, Neutral, Peaceful and Co-operative Cambodia of which the prince is president; the communist Khmer Rouge; the government of Heng Samrin; and the Khmer People's Nation-

By **ALAN SAMSON**

al Liberation Front — are meeting in Thailand next week.

Prince Ranariddh told his audience the prospects for peace were hopeful. He also said the new regime was likely to be a liberal and free-market state which, he hoped, would be linked to the Association of Southeast Asian Nations.

"We should leave Vietnam and we should leave Laos," he said. Any new government would be "clean" and kept accountable.

An opposition party and a free press would be encouraged.

The prince noted the New

Zealand Government had offered military support in any United Nations peacekeeping venture. He would be briefing Foreign Affairs and Trade Minister Don McKinnon on New Zealand's opportunities in Cambodia's reconstruction. He listed road building, port work, rebuilding schools, and food supply as key areas.

Appealing to young "Khmer intellectuals", he said: "It is up to you. If you want to stay in this peaceful environment you are free to do so."

"Or, when I give the green light, when I call on you to please come, you can help reconstruct Cambodia."



PRINCE RANARIDDH

Historic pact ends war in Cambodia

NZPA-Reuter

PARIS. — Ministers from 19 nations signed a United Nations-brokered peace agreement today aimed at ending Cambodia's 13-year civil war and preventing the hardline Communist Khmer Rouge from repeating atrocities.

The signing of the Agreement on a Comprehensive Political Settlement of the Cambodia Conflict at a one-day conference in Paris set in motion the most ambitious peacekeeping operation in UN history.

French President Francois Mitterrand said the accord turned a dark page in the history of Cambodia. Indonesian Foreign Minister Ali Alatas spoke of "a new era of relationships in South-east Asia".

Despite a mood of self-congratulation, however, doubts remained over whether the accord would be respected in Cambodia, where the

Vietnamese-backed Government that took power in 1979 has battled three rebel factions, including the Khmer Rouge.

Delegates said the Khmer Rouge, blamed for more than a million deaths when they ruled from 1975 until late 1978, must not regain power.

Yet the Paris peace accords give the Khmer Rouge seats in a Supreme National Council that will co-govern Cambodia until UN-supervised elections in 1993.

Relief workers fear the war-hardened guerrillas will not disarm.

"The Khmer Rouge were no ordinary oppressors," United States Secretary of State James Baker told the conference. "In the name of revolution, they used violence against their own people in a way that has few parallels in history.

"We condemn these policies and practices... as an abomination to humanity that must never be al-

lowed to recur." He said the US would support efforts to bring Khmer Rouge leaders to justice. Yet the US and other Western nations backed the rebel alliance that included the Khmer Rouge during the 1980s.

Underlining the mood of reconciliation, Mr Baker said that Washington was ready to start normalising relations with Vietnam, 16 years after the humiliating US exit from Indochina.

He said the pace of progress would depend on Hanoi's co-operation in helping locate some 2300 US servicemen still listed as prisoners-of-war or missing in action.

An exploratory mission of 268 UN experts will travel to Cambodia within days to prepare the way for an 18-month interim administration. Prince Norodom Sihanouk, a symbol of Cambodian unity who played a key role in the peace process and will head the Supreme National Council.

Khmer Rouge mortars villages

PHNOM PENH. — The radical Khmer Rouge mortared central Cambodian villages today after killing 13 civilians and sending 10,000 fleeing in the worst violation so far of the three-month-old peace accord, diplomats said.

The attack prompted envoys of the five permanent members of the United Nations Security Council to call for the urgent stationing of UN soldiers in the disputed area. The five are Britain, France, the United States, China and Russia.

The attacks took place in Kompong Thom province, 150km north of the capital, Phnom Penh. Red Cross workers who re-

turned from the area reported at least 13 dead and 18 seriously wounded in the heaviest mortar attacks on 25 villages around the district capitals of Stoung and Kompong Svay from January 6 to 7.

Jean-Jacques Fresard, chief delegate of the International Committee of the Red Cross in Phnom Penh, said another 14 people had lesser wounds. All were civilians.

It was the worst-known ceasefire violation since the Khmer Rouge and two other terrorist factions signed an internationally sponsored agreement with the Vietnam-installed Government in October, formally ending 13

years of civil war, Mr Fresard said. The attacks were so heavy that whole villages were burned and 10,000 people were forced to flee their homes. They were camped along National Route Six around the district of Sangkor, too afraid to return, he said.

The new refugees brought to 180,000 the number of people displaced by the war inside Cambodia. Another 370,000 Cambodian war refugees live in camps in neighbouring Thailand.

Diplomats said the Khmer Rouge apparently mounted the attacks to hasten deployment of UN peace-keepers to the area.

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Troops ordered to fight on

BANGKOK. — The Khmer Rouge today ordered its guerrillas to fight on, formally ending the first ceasefire of Cambodia's 12-year war.

The group's radio accused the Phnom Penh Government and its Vietnamese backers of trying to destroy a United Nations peace plan for Cambodia and of not implementing the May 1 ceasefire.

The radio announcement instructed the entire Khmer Rouge army to "continue to fight the Vietnamese enemy and puppets through our guerrilla war and people's war until the UN documents are accepted and implemented." The Khmer Rouge had vowed to end the ceasefire before the latest round of peace talks in Indonesia, which ended on Wednesday.

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