SINGLE-SESSION THERAPY IN THE MAJORITY WORLD: ADDRESSING THE CHALLENGE OF SERVICE DELIVERY IN CAMBODIA AND THE IMPLICATIONS FOR OTHER GLOBAL CONTEXTS

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Each year for the past decade the first two authors (Miller & Platt) have been leading student educational exchange and human services trips to Cambodia at the invitation of the psychology department at the Royal University of Phnom Penh (RUPP) and non-governmental organizations (NGOs) in the country. Each year we have collaborated with the third author (Conroy), who works full-time in Cambodia at Maryknoll Mental Health (Cambodia) and also serves as an adjunct professor at RUPP. During these exchanges we endeavor to take Western graduate therapy, social work, and counseling students to Cambodia to conduct service-learning projects. One of our aims is to promote meaningful educational, cultural, and therapeutic exchange experiences in collaboration with graduate students and faculty at RUPP. The students we bring to Cambodia are predominantly from North America, although we have taken students from all over the world. This chapter discusses our efforts to engage with the Khmer (Cambodian) people during these exchanges to address needs without over-imposing our national values (sometimes referred to as "colonialism"). We also work to understand and promote the natural healing methods and rituals of the Khmer people. Many of our activities in Cambodia involve single-session therapeutic encounters. Miller & Platt have worked using single-session therapy methods in other international contexts such as China and Mexico (see Miller, 2014; Platt & Mondellini, 2014) as well as other unique situations such as post-disaster settings (Miller, 2011). In this chapter we will discuss several different types of single-session therapy (SST) modalities we have discovered or modified in collaboration with our Khmer colleagues over the past 10 years working in Cambodia. None of our SST methods occur in a traditional Western-style office settings, as this would be inconsistent with current cultural norms or be simply impractical given the available economic resources. Instead, we adapted our SST methods to fit the surroundings and the cultural mores.

While all three authors grew up and were trained as therapists in the U.S., we have traveled and worked extensively outside the U.S., including Latin America (Platt and Conroy) and Asia (Miller and Conroy) and Canada (Miller). One of the challenges of our work has been making use of the methods and theories from our Western training in non-Western contexts. While the Western world dominates the field of therapy, it ironically is designed to fit for only a minority of the world's population. The Western world from which most models of psychotherapy emanate represents only about 5% of the global population (Arnett, 2008). It has been our experience that while there are many fundamental therapy constructs that transfer meaningfully between cultures, others do not or are completely inappropriate. For example, the importance of the free and well "differentiated" individual is a cornerstone of Western therapy, but will often seem inappropriate or even bizarre in most collectivistic cultures where family and community interconnectedness are of priority importance and individualism is a shrinking consideration. Additionally, the Western single vision of therapy as a service delivered from

well-appointed professional offices on an appointment-only, fee-for-service basis is impossible to appreciate for the majority of the world's population. A recent report from the World Health Organization (WHO) predicts that within the next few decades depression and other untreated mental-health issues will be the predominant contributor to the total burden of disability globally. One of the main reasons for this dilemma will be inadequate clinical service delivery systems in non-Western (majority world) contexts. In our view, SST methods of clinical service delivery may represent one type of innovative strategy to overcome these barriers in parts of the world where the concept of therapy as a treatment for mental issues is still developing. The SST modalities we describe in this chapter represent our humble insights regarding our best efforts to apply SST as it might be conducted for some of these "majority" world settings. We reflect on some of these ideas specifically with regard to our decade-plus experience in Cambodia.

Cambodia in Context

The Kingdom of Cambodia is a Southeast Asian country roughly the size of the state of Missouri, with a population of nearly 14 million people. About 10 % of the population live in Phnom Penh, the capital, with 80% of Cambodians living in rural communities as farmers and manual laborers. The recent history of the country is one of war and genocide[1] as a result of the infamous Khmer Rouge (KR) regime from 1975-1979. The rise of the KR had its roots in the Vietnam War.

In 1965 the U.S. Johnson administration was engaged in the Vietnam War that strove to limit the spread of communism in the region. In an effort to combat the Viet Cong Army (VC) and the North Vietnamese Army (NVA) the U.S. began a bombing campaign in Cambodia in 1965 that escalated under the Nixon administration in 1969 with carpet bombing deep into Cambodia (Brinkley, 2011). The United States ultimately dropped more explosives on Cambodia than all those dropped during the entirety of World War II (Owen & Kiernan, 2006). Conservative estimates list civilian casualties between 50,000 and 150,000 as a result of the bombings. The bombings traumatized the civilian Cambodian population, driving them into the arms of the KR who used the bombings as anti-American propaganda. One-third of Cambodia's population (about 5 million) are survivors of the 1975-1979 reign of the Khmer Rouge, under which an estimated 25% of the Cambodian population died from starvation, overwork, disease, and execution. During the four years that the Khmer Rouge leader Pol Pot was in power, the country suffered massive brutality and complete restructuring of its society where formal education was closed down, religion and class distinctions were abolished, and professors, lawyers, doctors, teachers, engineers, scientists and professional people in any field were systematically murdered, together with their extended families (Hinton, 1998; Miles & Thomas, 2007; Um, 2008). It has been documented that much of the torture and executions were carried out by children and young people, many of whom are now parents (Miles & Thomas, 2007). The Khmer Rouge were overthrown by the Vietnamese army in 1979, but the civil war between the Khmer Rouge and the government of Cambodia continued from 1979 to 1996 and resulted in more traumatizing experiences (Bureau of East Asian and Pacific Affairs, 2011; Hsu, Davies, &

[1] French author, Jean Lacouture coined the term "autogenocide" to refer to the extermination of a group's members by its own people or government (Chandler, 1999). The term was coined to describe killings by the Khmer Rouge to denote that they were carried out by Cambodians, on Cambodians across all society. This is opposed to other descriptions of extermination carried out on a targeted group by "other" groups.

Hansen, 2004).

The Psychological Scars of Genocide in Cambodia

Cambodia's lasting legacy of genocide, prolonged armed conflict, and enduring poverty has left many suffering from post-traumatic stress disorders and other psychosocial problems (Hinton, 1998; Palmieri, Marshall, & Schell, 2007; Um, 2008; Zimmer, Knodel, Kim, & Puch, 2006). A number of studies have described mental- health problems and the psychological scars left by the genocide. Survivors of the Khmer Rouge regime were found to have experienced 12-16 major trauma experiences, including torture, long periods of malnutrition, slave labor, imprisonment, and witnessing atrocities (Kinzie, Fredrickson, & Ben, 1984; Mollica, Wyshak & Lavelle, 1987; Ralmuto, Ann, Hubbard, Groteluschen & Chhun, 1992). A 12-year follow-up study of Khmer youths by Sack, Him, and Dickason (1999) showed that when the children of the Khmer Rouge era of genocide grew up, the symptoms of post-traumatic stress disorder (PTSD) and depression were still very high, 50% and 47% respectively at the first interview in 1983-1984 (four years after the end of the regime). Sack and colleagues (1999) also found that 12 years after the Pol Pot and Khmer Rouge regime, the percentages of the same individuals affected by PTSD and depression were still very high, at 35% and 34% respectively. A study conducted in 2008 by Pham and colleagues (2009) found 35% of Cambodians suffer from some kind of severe psychiatric problem (e.g., schizophrenia, epilepsy, severe depression, and psychosis) and 45% suffer from psychosocial problems (e.g., anxiety, grief, and stunted emotional development). There is little question that the genocide of Cambodia still haunts Cambodian people today (Hinton, 1998; Miles & Thomas, 2007).

The Need for Sufficient Training and a Skilled Workforce in Mental Health

Despite the grave need in the country for mental-health care, Cambodia lacks sufficient information and resources to provide facilities or treatment for the populous (van de Put & van der Veer, 2005). The basic psychiatric services and facilities that had been established in Cambodia prior to 1975 were entirely destroyed by the Khmer Rouge regime. It was not until 1993 when the Cambodian government, with the help of the United Nations, established their first National Health Plan as an effort to address the high prevalence of mental disorders among Cambodians (Somasundarm, van de Put, Eisenbruch, & de Jong, 1999; Stockwell, Whiteford, Townsend, & Stewart, 2005). The dominant method of handling mental-health issues in Cambodia is heavily influenced by the medical model, largely originated in the West (Stevens & Wedding, 2004; Stockwell, et al., 2005). As such, the selection of these models are not always designed to address the needs of the communities facing poverty. Further, the very constrained public mental-health services that currently exist are hampered by a shortage of a skilled workforce, insufficient training programs, and no professional regulation for professionals that provide counseling and therapy. Mental-health professionals are especially needed in Cambodia, a country that is recovering from the trauma of war and genocide, and experiencing high rates of associated mental-health issues.

Historically there has been no concept of "psychotherapy" in the Cambodian language of Khmer, and no equivalent Khmer term for "therapist." In 2007, the faculty of the newly formed Psychology Department of the RUPP began inviting Western experts in family therapy and psychology to help develop their psychology curriculum, in collaboration with Maryknoll Mental Health, RUPP faculty, and administrators. In 2009 the third author (Conroy) helped establish the Masters Program in Clinical Psychology as part of his work with Maryknoll. It is the first graduate psychology program in the country post-Khmer Rouge. Courses and trainings were offered by the authors, a collection of Western experts, and advanced graduate students brought

to RUPP to cover topics such as trauma, brief therapy, child-parent relationships, systemic therapy, play therapy, domestic violence intervention, intergenerational therapy, cognitive behavioral therapy, substance abuse treatment, experiential therapy, structural family therapy, solution-focused therapy, couple therapy, and crisis intervention.

While it is sometimes attractive for the newcomer to Cambodia to focus on the recent history of trauma, the story of Cambodia begins long before the Khmer Rouge. Cambodia's story is also one that must include the fact that it was once a powerful Buddhist and Hindu empire that ruled most of Indochinese Peninsula between the 11th and 14th centuries and represented a rich culture with tremendous natural beauty and societal harmony that continues to this day. Before Vietnam War, it was a thriving modern country with a progressive and peaceful society, often referred to by Westerners as the "smiling nation" because of the peaceful and welcoming demeanor of the people. As it is often true in therapy, we believe it is important to remember the multitude of stories and qualities of those we work with, instead of only seeing the single story of the trauma or problem.[2] We have found that it is essential to maintain some balance of viewpoint that recognizes the multiverse of realities including the problems that often draw our attention, as well as the beauty and resources that often existed long before and are often the most powerful and impressive resources to overcome challenges.

The following section outlines several single-session (or single-encounter) strategies that we have piloted, developed, adapted, and explored in the Cambodian context. Our hope is that our experiences may offer something useful to others who endeavor to engage with other "majority world" contexts where 85% of the world resides. We believe the efforts to adapt, modify (or sometimes reject) Western modes of intervention will be an important step in the next stages of development of mental-health intervention in the global context.

Mobile Team for Mental Health (MTMH)

In 2012 the third author (Conroy), in collaboration with graduates of the RUPP psychology program, started a Mobile Team for Mental Health (MTMH) to journey into the countryside to meet with families who have a member who is mentally ill. The MTMH visited Kampong Thom and Takeo Provinces, where there are few mental health services available. The unit is essentially a van that carries several mental-health staff members into the countryside to meet with families in need of help. While a portion of the population of Cambodia lives in the capital city of Phnom Penh, our experience has been that the majority of people with mental-health issues live in the countryside where there are almost no services. The mobile unit was created to address this need, and travels to these areas on a frequent basis (often monthly) visiting with families and offering assistance where possible. The road conditions are rough by Western standards, and the trip to the countryside often takes all day, or several days. These meetings with individuals and families often involve a single-session with a family. The team works in coordination with the local doctors, officials and resources in Phnom Penh, Siem Reap, and other big cities in Cambodia. Beginning in 2008, Miller and Platt began lecturing at RUPP about our work with Single-Session Therapy (SST) in other contexts (China, Mexico, U.S., Canada, and post-disaster settings) and our Khmer hosts were very interested in the strategies we had employed given the need for access to services in the country. Yet, we must hasten to add that their methods with the MTMH were of their own creation, and we found that we learned

[2] Adichie, C. (2009). The danger of a single story. *TED Talks*. See http://www.ted.com/talks/chimamanda_adichie_the_danger_of_a_single_story.html

more from them (the Maryknoll and Khmer graduates and staff) than we believe they learned from us. Over the past several years we have accompanied the staff of the MTMH during their trips into the countryside and herein offer a few abbreviated and amalgamated examples to illustrate what we learned. We have changed many of the details and collapsed some of the examples to clarify and conceal the identities of those involved.

Example #1: The Family and Son in Chains

During one trip into the countryside with the MTMH, the team had been alerted that there was a family in need of help. Often those in need of help are aware of the unit and ask for help directly, or others in the village are aware of a need and inform someone on the team that a family may need help. In these rural villages there is often a collective informal network of communication that, while rarely formalized, works efficiently to communicate what is happening in the community. Small villages in the countryside of Cambodia are often comprised of a handful of families that struggle to survive through subsistence farming. Their family dwellings are usually made of grass huts that are built on posts about 6 feet off the ground to keep them dry during the floods of the rainy season. Many of these houses are clumped together around the main road. Usually the entire family works together, and in collaboration with the other families in the village. In this situation, the MTMH was summoned by a middle-aged couple who asked for help for their 18-year-old son. The son had become increasingly delusional and prone to wandering off into the road or the countryside. The parents were in desperation because of their inability to watch their son constantly (both worked in the fields). Out of this desperation, the parents had chained their son to his bed to prevent him from hurting himself. While this is shocking to see and we imagine to read about here, it is often the only recourse for families with a severely mentally-ill member. In the Western world this may seem abusive. Yet in Cambodia this drastic action may be the family's only way of caring and providing safety for the family member. We have observed this type of family intervention happen many times throughout these "majority world" contexts given the limited alternatives for the families involved. The team met with both the parents first to get an idea of what had happened to lead to the current situation and find out what might help. While the desperation of the situation for this family was easy to appreciate, the team worked to help the family prioritize their list of concerns and possible ideas about what was needed. The family was eager to talk with the team and seemed calmer as they talked and shared some of their concerns about their son and their situation in general. The team discussed things that had helped in the past, and what was needed for the future. There were several moments in the interaction between the family and the team that seemed helpful. The parents were very worried for their son and did not understand what was happening for him. The team helped by providing basic mental-health information about what could be happening with his mental-health condition and encouraged the parents to take him to a hospital. The team discussed the resources they could provide, including transportation, a referral for help, and possible medication. One of the Khmer team members was also willing to go with the family and help explain what was happening to both the doctors and the family. The family agreed to accept the help and arrangements were made to take him to the hospital. The team also discussed what the family could do in the meantime to help manage the son until they could get further help. The family was greatly calmed to have this chance to talk with someone and to make a plan for the future.

While the single-session encounter with this family would not solve all the dilemmas this family was facing, the team was able to provide a valuable connection to hospital resources that were previously unattainable or unknown to the family. The utility of the single-session for

these types of situations has been highlighted in the past in other settings, such as post-disaster (Miller, 2010). The WHO and the U.S. Surgeon General have commented on the three main barriers to service globally: stigma, cost, and limited access. In this situation the cost and access were predominant obstacles to getting help. The resources often exist for these families in Cambodia through the important work of non-governmental organizations (NGOs) and the church who do the majority share of social services work in the country, yet connecting the resources to the people who most need it is problematic. Also, the family seemed to be helped by the simple act of witnessing their problem, reviewing their situation with an objective and caring professional who assisted them in organizing their thoughts and making plans. The panic this family was experiencing was palpable, and the connection with the staff of the mobile mental-health team and the information about mental-health treatment calmed them greatly. This utility of single-session therapy has been documented in the West since the 1970s with the work of Spoerl (1975) who studied the health records of hundreds of clients to find that many were assisted by reviewing their life situation, education about the therapy process, and allaying irrational fears so as to make it easier for them in future treatment. We believe we saw these factors at work with this family and Cambodia as well. We followed up with the family a year later and were happy to learn that the son was no longer chained to the bed, had been taking medication for his delusions, and that the family had continued to meet periodically with the MTMH staff on subsequent trips to their village.

Example #2: Family Imprisoned and Ostracized by Mental Illness

Similar to the previous example, the MTMH was summoned to a village in the countryside by a mother and father to help with their 24-year-old son. During the daytime the parents had been keeping their son locked in the space under their home, roughly 10 square feet in size. This family had walled-in this area and had been locking their son under the house each day for the past 6 months during the times that the father was away from the home working in the fields. The team met with the parents and the son to help understand what had led up the current situation. The son sat quietly with the family and team during the meeting. The family explained that over a year ago the son had become delusional and while the father was working the field he was left alone in the home with his mother. The son had become increasingly aggressive and sometimes violent with his mother in his delusional state, so the father had taken to locking the son under the home every time the father went away to work in the fields. Compounding the problem, the family had become ostracized by the other villagers because of the son's bizarre behavior.

Understandings of mental-health issues among the village population are sparse, and many families still hold stigmatizing and superstitious views of mental-health problems. The father wept as he told the team about this situation because of his worry for both his son and his wife. Yet, he also explained that the problem of the son's delusional behavior had been helped in the preceding months since he had begun taking anti-psychotic medication that another NGO had helped arrange. He felt that it was likely that the son was no longer dangerous to his wife or the villagers, but that he could not be sure nor would the villagers accept him even if he was better. So the father continued to lock his son up when he was away. The meeting with the team took place in front of the home in view of several other village families' homes. Several of the other village families came out to see what was happening, as it is a fairly rare occurrence for a car with strangers to stop in the village. During the meeting the Khmer MTMH workers talked with the son directly, which seemed a surprise to him as most people had seemed to stop talking to him. He seemed to welcome the chance to talk and became more comfortable talking as the

conversation proceeded. The team asked him directly about his delusions and whether he felt he was a danger to others. He expressed that he knew that he had concerned people in the past but that he felt he was better now with the medications he had been taking. He expressed that, like his father, his main concern now was that the other villagers did not seem to accept that he had changed and continued to ostracize the whole family. In the village being ostracized is a threat to their fundamental survival as a family, as the only way to survive in the village is through collective sharing of resources and collaboration with other families. The team asked if the problem of violence was to return for the son, how do they imagine that it would happen. The family all agreed that it would only happen again if the son stopped taking his medication. As the team talked with the family they asked if it was OK to go and sit next to the son while they talked. Later in the conversation the team member asked if it was OK to take the son's hand as they talked. The son welcomed this. In Khmer culture it is more common than in the West for friends to hold hands when talking together. Later one of the team members explained that they did this to show the other villagers that it was OK to sit next to the son without fear of being hurt by him and to try to normalize talking with him. The team continued to talk with the family about ways to connect with the other villagers again and a plan to make sure that the son would continue to take his medication. They all made an agreement together that they would make sure he continued to take his medication. The team also discussed the concept of "habits" and giving things time. In this way the team seemed to introduce to the family that change may take time and that instead of happening all at once, may instead be more of process of developing new habits with the family. They discussed possible plans for letting the son out during the times when the father was away and how they might know if this plan was working. The meeting concluded with the family agreeing to slowly letting the son out more frequently to give him a chance to show that he was safe. They discussed things that he and others might notice if he was leading up to being unsafe and an agreement was made that they would all work together to look for these signs that he might become violent again.

This case demonstrates some of the ways single-session therapy may be useful in this type of situation. This family seemed to us to be stuck in a situation where the original problem (the son's delusions and aggressive behavior) had created a secondary problem of discrimination and being ostracized by others in the village. This secondary problem threatened the very existence of the family. Even if it was certain that the son's delusions and violent behavior were under control, the family still had the problem of assuring the rest of the people in the village that the change had occurred and that it was OK to be with the family and the son again. The Khmer team member's sensitive realization of this problem and his effort to normalize the son by sitting next to him and taking his hand seemed us to be a powerful intervention to help lead the family out of the prison they had all found themselves in. It has been our experience that in some single-session encounters such as this, the simple introduction of a "source of the new" (to paraphrase Gregory Bateson) can help create new possibilities for families (and villages) that have become stuck in an undesirable situation. Normalization, safety planning, making agreements and providing information all seemed to be meaningful interventions we witnessed in this situation. We followed up with this family a year later and found that they were no longer locking the son up each day and that he had continued to respond well to his medication. The family had begun to engage more with the other villagers and felt they were on their way to becoming more accepted in the community.

Example #3: Mother with Newborn All Alone in the Jungle

The MTMH was summoned to an extremely rural village in a remote jungle location.

While most villages have limited plumbing and electricity, this village seemed especially rustic. There was no visible running water, electricity, or sewer facilities. The team was summoned to a hut comprised of a single 10' x 10' grass and bamboo room on stilts about 4 feet off the ground. The team met with the residents of the hut, a young mother who had recently given birth to an infant son. The team was joined by a female neighbor who knew the mother and offered her support. The team talked with the mother who seemed mildly psychotic, occasionally answering to voices that only she could hear. Yet she was able to communicate effectively with the team who learned that the baby was her first child and had some medical issues that had not yet been treated. The neighbor who joined the meeting said that she was very worried for this young mother and the baby as she felt that the mother was alone and vulnerable. The neighbor had noticed that the mother would become especially delusional in the dark hours of the night and would wander off into the jungle. There was no father or other family members to support her. The neighbor had tried to do what she could to help the young mother, but was unsure if she could be available every time the mother had a need. The team reviewed the mother's concern about the baby's medical issue and asked if they could help arrange for a medical evaluation and treatment for the child. In the remote villages like this one, there is often a village elder who must be consulted before such an action can be taken. While part of the team went to meet with the village elders to get permission to take the mother and child to the hospital the team met with the mother and a gathering group of women who lived in the other huts in the area. The neighboring women (all of them were themselves older mothers) shared their concern for the young mother and their observation that she would sometimes wander off leaving the baby alone. The team collected these women together and asked for their help with the mother, knowing that it would take several days to arrange to take the mother and child into a hospital facility. The team made a plan with the women that they would take turns being with the mother and the baby, and a schedule was established for the following week. The women seemed eager to help, and welcomed the organization that the team member offered through setting up a schedule so that the closest neighbor was not always the one on watch. The team discussed with the collection of neighbors that they had an important role here and that the mother and baby were in danger. The team complimented them on what they had done so far and agreed that the team would do what they could to get the mother help but that it would take time. In the meantime, these neighboring mothers' help would be essential. All agreed and the team made plans for eventual transport to the hospital.

This case highlights several elements of what others have documented regarding the utility of single-session meetings in Western-world contexts. Firstly, the single-session meeting often serves as a "safety net" for the community, helping draw resources to critical situations that might otherwise go unnoticed (Miller & Slive, 2004). This situation posed a severe risk to the mother and especially the infant, who was often left alone in the jungle with unknown and untreated medical issues. Secondly, the single- session intervention served to capitalize on existing but underutilized resources. In this situation, the neighboring women who offered help were the most important resource for the survival of this mother and child. The team was not legally able to remove the child and/or mother without the consent of the village elders, which often takes some time to secure. A short-term safety strategy was required, and the neighboring women were important existing resources, that simply needed some organization to be most effective. Another existing resource was medical intervention for the infant and psychological support for the mother. The team though the resources of the Maryknoll Mental Health was able to provide this; yet as in the previous examples this would not have been possible without the

single-session consultations provided by the MTMH. The authors have followed up on this case over several years and found that the team was able to get the mother and child to a hospital for treatment. The team connected the mother to other resources that allowed her to move to a larger city and into an apartment with modern conveniences such as running water, electricity, and a bathroom. The team had found a way for the child to spend each day in a daycare facility, and arranged for the mother to get a job in the facility so that she could be with her son. The mother had been prescribed medication that was effective in dealing with her psychotic symptoms, which had completely passed.

Example # 4: Single-Session Consultations for Victims of Acid Burn

Over the past decade Miller and Platt have helped organize and participated in several other single-session consultation meetings that have their foundations in our previous single-session work in other contexts. One example includes a single-session consultation day we organized in collaboration with an NGO created to help with the victims of acid burn, a tragic form of domestic violence. The tragedy of acid-burn victims continues after the original assault, as many victims are subsequently ostracized from their families and communities because of their appearance. The Acid Burn Charity is a special NGO that works to help these victims. One activity they organize includes yearly week-long meetings with victims to get together for a jamboree-type event where they can share some time together doing fun activities like singing songs, playing games, and engaging in group activities. This may sound mundane to some, but we witnessed that this was a very special time for many of these people as in their own community back home their injuries are so distracting to others that they rarely feel normal and they end up hiding inside most of the time. At the jamboree they could be out in the open and be free to focus on other things other than their injuries. We worked with the Acid Burn Charity NGO and the Khmer graduates from RUPP to offer a free single-session consultation day for these acid-burn victims at the invitation of the NGO. To our surprise most of the participants welcomed the chance to talk with us. During our time we conducted about a dozen interviews working in therapy teams including one Western therapist paired with one Khmer RUPP graduate. Interviews were conducted in Khmer and translated by the graduate student. Many of the people asked to simply tell the story of how they had been burned and what their life was like before the attack, the attack itself, and what had happened afterwards with their family and relationships. For most people it was the relationships with family and community that was of most importance. They talked about how their appearance (often very severe scarring) had changed their relationships and that this was the thing that was most hurtful. They also felt that they were no longer able to participate in the community normally (except for these events) and missed talking with others normally and having the chance to simply talk. Several carried pictures of themselves that were taken before the acid attacks that they would hold to their chest as the talked as if to say "this is who I am, the one in the picture; not what you see me as now." Several others cried when they talked with us, taking our hands (which is common in Cambodia when talking with friends) and thanking us for the chance to tell their stories.

Finally, we believe it is important to make sure to try our best to take care of our western participants/students during the exchange experience. Given the sometimes stressful nature of the work we believe "self-care" issues and "caring for the caregiver" are important considerations. Part of this process for us is organizing a debriefing meeting at the end of every day to discuss our western participants' reactions and reflections to what we experience each day. A few days before the meetings with the acid burn survivors we also met with the western students to discuss what would likely happen during our visit in an effort to help them mentally

prepare. We also discussed the phenomenon of vicarious traumatization and secondary traumatic stress, how to recognize it in yourself, and how to minimize its negative effects[3]. Finally we gave our western participants the choice to opt out of conducting the interviews and arranged for other activities that day if they wished.

These single-session meetings with the acid-burn victims were very powerful for us and the Khmer staff we worked with. We believe that the single-sessions were important for these people in that it simply gave them a chance for catharsis, or the purging of emotions, feelings and tensions through speaking them out (or other forms of expression like art or music). Fortunately in the years following our single-session consultations the incidence of acid-burn attacks have dramatically declined in Cambodia with increased regulations regarding the availability of industrial strength acid and increased punishments for those who commit such attacks. We believe that these changes were due in part to the efforts of important NGOs, such as the Acid Burn Charity.

Example # 5: Other Single-session Interventions: The Theater of the Oppressed

Humility and trusting in the local experts is the best foundation for presenting single-session interventions. They know the context, cultural values and how difficulties are conceptualized in Cambodia better than any visiting scholars could possibly know. Those preparing Cambodian students for clinical practice must be mindful that many educational and psychological approaches were developed in and for wealthy communities. In order to be relevant and effective, both mental-health education and clinical practices need to be adapted for the economic reality of Cambodia and more approaches need to be developed within and drawn from communities living in poverty. Salvadorian psychologist Martín Baró (1994), a major voice for the need to reconsider the assumptions of mainstream mental health, challenged the field of psychology stating that, "What is needed is for our most basic assumptions in psychological thought to be revised from the bottom up. But this revision cannot be made from our offices; it has to come from a praxis that is committed to the people" (p. 23). Not only do we need to do this type of revision with mental health interventions, but also how we go about teaching them.

A pedagogical method we have found useful for avoiding educational colonialism is "Theater of the Oppressed," a Brazilian-originating approach to creating social change developed by Augusto Boal (1974) that can also be useful as an educational tool. Theater can be used to facilitate a reconsideration of Western conceptualizations of mental health and to open dialogues about Cambodian views of problem conceptualization, healing and change. This process is important because clinical practices primarily reflect only the known world of the wealthy, whereas theater as an educational and clinical approach is useful in exploring conceptualizations and interventions to problems that may not yet exist in the professional literature (Boal, 1974).

One way we have used theater of the oppressed began by dialoguing with the Cambodian students about the social problems they have seen within their local community. Once they had identified the ones they found most relevant, we asked them to create human sculptures with members of the class that illustrated those issues. This created a space for brainstorming and

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[3] See Miller's description of self-care strategies for SST therapists in Miller, J. K. (2011). Single-session intervention in the wake of Hurricane Katrina: Strategies for disaster mental health counseling. In A. Slive & Bobele, M. (Eds.), *When one hour is all you have: Effective therapy for walk-in clients* (pp. 185-202). Phoenix, AZ: Zeig, Tucker, & Theisen.

experimenting regarding what approaches might work best for addressing different problems faced by Cambodian individuals and families.

"What educators need to understand is that it is not about the performance at the end, but the process of using drama, the techniques and exercises, that can open up a world of possibilities in the classroom" (Schaedler, p.142). In our experience, theater can help tap into the creativity and resourcefulness of Cambodian students, which is obviously invaluable in moving toward the goal of developing mental-health conceptualization and practices relevant for their context.

Theater of the oppressed is not only a powerful educational tool within classrooms, but it has been used in more than seventy countries as a way of directly engaging in dialogues with the community. This is often done through the use of varying forms of street theater. Similar to how it is used in classrooms, these public performances can be a powerful tool for assisting members of communities to identify and brainstorm ways for addressing issues impeding their full expression of basic humanity and the resulting mental-health implications (e.g., domestic violence, human trafficking, homelessness, poverty, etc.). Given the heaviness of the topics that theater of the oppressed can often touch on, single-session therapy may complement and provide additional resources to community members desiring additional support (Platt & Bobele, Unpublished manuscript). We have found that creating three teams of mental-health workers with three distinct roles has been helpful. One group is engaged as actors who create a performance based on common presenting problems. For example, this first group may create a sculpture depicting a scene related to domestic violence. The second group acts as facilitators of street dialogues and engages with community members that begin observing the scene. This second group may offer community members who express interest or appear in distress the option of talking one-on-one with a member of the third group, therapists guided by the concepts of a single-session approach. We have found it useful to either set up a small, perhaps more private space off to the side of where performances are taking place or to have the street performances occur near existing traditional mental-health clinics.

Second-Order Intervention in a Majority World Context

While we, as Western outsiders, have tried to introduce something useful during our work in Cambodia, we have also benefitted greatly from the indigenous ways of healing and the creative work of other NGOs we have observed from the Khmer people we have worked with over the years. We have witnessed many efforts of NGOs to intervene in Cambodia, many with regrettably limited or what would seem to us to be only "first- order" solutions. First-order strategies are often those that offer content help (such as giving someone a meal) but are not sustainable in the long run (like teaching someone to fish and therefore feeding themselves). We have observed that outsiders often resort to first-order solutions but struggle, as we have at times, to find "second-order" sustainable interventions. This, we believe, is often the dilemma of the single-session therapist, so we will share some our reflections on this issue here.

One interesting "second-order" effort we have observed includes the work of *Friends*, a local organization working with Cambodian street children, their families, and the community to develop creative projects that effectively support the children to become independent and productive members of the community. The pathway that leads many children to become trafficked in Cambodia (and around the world) is that they have no other way to make a living. While giving them money in the short term may help a little, helping them find healthy ways to make a living on their own is much more effective. There are dozens of activities that *Friends* engages in to help these families, but one of the most effective activities we have observed is that

they teach young people to earn a living on their own by training them to be restaurant workers. To the outsider it may seem unremarkable, but in our view it is very remarkable. *Friends* accomplishes this by running one of the best restaurants in Phnom Penh, staffed by formerly homeless children that they have taken in and trained to run the restaurant. Meanwhile, they also provide other important educational and support services for their families that lead to healthy self-support. During each visit to Phnom Penh we have taken our U.S. and Western students to the *Friends* restaurants, met with their staff to learn about their methods, and enjoyed some of the finest meals we have had during our visits to Cambodia.

We believe that another way to create second-order solutions is through education. Over our decade of work in Cambodia we have endeavored to provide important educational experiences for the Khmer students at RUPP, that in some instances we believe capture some of the elements of single-session therapy. SST has its roots in attempting to provide a meaningful and lasting impact through a limited therapeutic experience. This is the spirit of our educational exchanges at the RUPP. During our lectures at the university we are always mindful to ask, "What is needed and wanted?" instead of what we want to talk about. We defer predominantly to what our Khmer hosts want versus what we want to do, unless we believe what is asked for might be harmful. We were once asked by a Khmer hospital to give them the machinery to conduct electro-convulsive therapy (electroshock therapy). While one of our team members actually had the resources to make this happen we declined, because we could not clearly see how it would helpful, and could see many ways it might be harmful. This has also been our orientation in our single-session therapy: Find out what the client wants and, when possible, give it to them unless we believe it might be harmful.

Another second-order type activity we have engaged in is teaching by taking U.S. and Western students and training them how to become teachers and interventionist themselves. During our first encounters in Cambodia we took other professors and it seemed to us less useful than our other experiences taking students and creating cultural exchange experiences. We felt the Khmer students would be helped more by exposure to their peers from other cultures (other students learning to become therapists) instead of exposure to Western professors telling them what to do. In this way, there is an efficiency to the experience and we avoid the "banking" experience of education that often occurs when there is a larger hierarchical difference between the "teacher" and the "student." In our exchange experiences we are all "students" and "teachers" and strive to create true two-way sharing of information and expertise. Occasionally our Western participants return to Cambodia to continue working with the Khmer students or Cambodian NGOs, eventually developing a career as international therapists. Sometimes the Western students we bring decide to simply stay in Cambodia for a term to volunteer with Maryknoll Mental Health, another NGO, or work at RUPP. Sometimes the Khmer students we meet with make important connections during the trip that allow them to come to the U.S. to continue their education and one-day return to Cambodia and become the first generation of U.S. trained professors to teach in the country post-Khmer Rouge. Like in single-session therapy, we are always looking for efficiencies in the way we work so as to capitalize most on the therapeutic potential of the moment we have together, realizing that this moment will lead hopefully into some brighter future.

Closing Thoughts about *Minority World* Therapists Working in the *Majority World*

Our work in Cambodia has been some of the most powerful and impactful work of our careers. Yet, at times it has been some of the most discouraging and heart-wrenching work. When encountering the severe and seemingly hopeless situations we have seen in these majority-

world contexts it can be easy to become overwhelmed and be tempted to give up. The Western students we bring to Cambodia are often overwhelmed at first and sometimes deal with their anxiety about what is happening by simply giving up, or pronouncing overarching judgments. Yet, we know it is not helpful to let these feelings win out, as it only leads to other similar feelings and little action in the direction of growth and change. Instead we advise others entering this work to *maintain a sense of optimism* about the work. Get involved, and believe that your efforts can and will make a difference. Avoid sitting back and criticizing what is happening because we have found doing so is often linked to the overwhelming sense of helplessness and need to gain the illusion of control over the situation. While it may offer some comfort to do so, it will not help.

Likewise, we advise that therapists *avoid providing more help than is being asked for*. We have found that like in single-session therapy, more is not better, *better is better* (Miller & Slive, 2009). Sometimes when becoming overwhelmed by some of the desperate situations that people encounter in the majority world it can be tempting to try to rush in and provide more help that is requested or even healthy for the situation. For instance, we have found that simply giving money in poverty situations is not always helpful, and many times is even harmful. Sometimes the child who is begging for money on the street is trapped in a situation where he is kept as a beggar by an older handler who profits from the child's efforts. Simply giving the child money in this situation might help in the moment, but almost certainly will not help him escape his overall situation. Likewise giving money to NGOs that are simply fronts to collect money and do little to address problems only perpetuate the problems.

Seek sustainable solutions versus short-term fixes. As the American naturalist Henry David Thoreau (1854) admonished us, "*It is not enough to be busy, we must be busy doing the right things."* Simply intervening without respecting the system as it is, can create worse situations. For example, condemning the mother that sells her child into slavery is easy as a Western outsider, yet often mothers in this situation are only trying to feed the remaining children they have at home. Sustainable solutions are harder to come by, but essential for meaningful change.

Our work in the majority world has also taught us the importance of maintaining a position of *humility and curiosity* about what is happening. Often things that initially seem strange or unexplainable to us will make sense once we know the entire context that led up to the current situation. As privileged Westerners is it common for those we work with in the majority world to imbue us with more power, intelligence, and ability than we deserve. It can be tempting for the Western therapist to accept this invitation to power, but our advice is to reject it and instead maintain a position of humility and "not knowing" curiosity as is common among some of our best single-session therapists.

We encourage therapists engaging in this work to recognize the healing power of simply creating a place or space for people to *tell their stories* and appreciate their sorrows and accomplishments. Some situations that therapists will encounter in the majority world become overwhelming, or fill the Western therapist with the desire to fix the situation. Many times there is no easy "fix" to the situation. Yet it is very helpful to provide a chance to witness the story and provide the ability for people to tell it out.

In closing, we agree with the words of Ignacio Martín Baró (1994) when he tells us, "*What is needed is for our most basic assumptions in psychological thought to be revised from the bottom up. But this revision cannot be made from our offices"* (p.23). Martín Baró insisted that psychology should be developed in relation to the social and historical conditions and

aspirations of the people it is meant to assist. He believed that students of psychology should learn to analyze human behavior in the particular contexts where it happens. In his writings and lectures he rejected the comfortable yet false idea of impartial psychology of the minority world in favor of what we have come to think of as a "majority world" practice. Single-session therapy seems one ideal strategy for better meeting the needs of those living in majority world contexts.

References

Adichie, C. (2009). The danger of a single story. TED Talks. See http://www.ted.com/talks/chimamanda_adichie_the_danger_of_a_single_story.html

Arnett, J. J. (2008). The neglected 95%: Why American psychology needs to become less American. *American Psychologist*, *63*, 602-614.

Berryman, P. (1987). *Liberation theology: The essential facts about the revolutionary movement in Latin America and beyond*. New York: Pantheon.

Brinkley, J. (2011). *Cambodian curse: Modern history of a troubled land*. New York: Perseus Books.

Bureau of East Asian and Pacific Affairs (January 28, 2011). *Background note: Cambodia*. Retrieved February 19, 2011, from http://www.state.gov/r/pa/ei/bgn/2732.htm.

Chandler, D. (1999). *Brother number one: A political biography of Pol Pot*. Thailand: Westview Press.

de Jong, J. , I., Komproe, M., Van Ommeren, M., El Masir, M., Araya, N., Khaled, W., van de Put & D., Somasundaram. (2001). Lifetime events and posttraumatic stress disorder in 4 postconflict settings. *Journal of the American Medical Association, 286*, (5), 555-562.

Freire, P. (2007). *Pedagogy of the oppressed.* New York: Continuum.

Hsu, E., Davies, C., & Hansen, D. (2004). Understanding mental health needs of Southeast Asian refugees: Historical, cultural, and contextual challenges. *Clinical Psychology Review, 24*, 193-213.

Kinzie, D., Fredrickson, R., Ben, R. (1984). Post-traumatic stress disorder among survivors of Cambodian concentration camps. *American Journal of Psychiatry, 141*, 645-650.

Mair, M. (1988). Psychology as storytelling. *International Journal of Personal Construct Psychology*, *1*, 125-138.

Martín-Baró, I. (1994). *Writings for a liberation psychology.* Cambridge, MA: Harvard University Press.

Miles, G., & Thomas, N. (2007). 'Don't grind an egg against a stone': Children's rights and violence in Cambodian history and culture. *Child Abuse Review, 16*, 383-400.

Miller, J. K. (2011). Single-session intervention in the wake of Hurricane Katrina: Strategies for disaster mental health counseling. In A. Slive & Bobele, M. (Eds.), *When one hour is all you have: Effective therapy for walk-in clients* (pp. 185-202). Phoenix, AZ: Zeig, Tucker, & Theisen.

Miller, J.K. (2014). Single session therapy in China. In M.F. Hoyt & M. Talmon (Eds.), *Capturing the moment: Single session therapy and walk-in services* (pp. 195-214). Bethel, CT: Crown House Publishing.

Miller, J. K. (2008). Walk-in single-session team therapy: A study of client satisfaction. *Journal of Systemic Therapies, 27* (3), 78-94.

Miller, J. K., & Slive, A. (2004). Breaking down the barriers to clinical service delivery: Walk-in family therapy. *Journal of Marital and Family Therapy, 30*(1), 95–103.

Mollica, R., Wyshak, D., & Lavelle, J. (1987). The psychosocial impact of war, trauma and torture on Southeast Asian refugees. *American Journal of Psychiatry, 144*, 1567-1572.

Owen, T., & Kiernan, B. (October 2006). Bombs over Cambodia. *The Walrus Magazine*, 62-69.
Palmieri, P., Marshall, G., & Schell, T. (2007). Confirmatory factor analysis of posttraumatic stress symptoms in Cambodia refugees. *Journal of Traumatic Stress, 20*(2), 207-216.
Pham, P., Vinck, P., Hean, S., & Stover, E. (2009). *So we will never forget: A population-based survey on attitudes about social reconstruction and the extraordinary chambers in the courts of Cambodia.* Human Rights Center of California Berkeley. Retrieved on February 20, 2011, from http://escholarship.org/uc/item/74x685xm#page-1.
Platt, J. J. (2012b). A Mexico City-based immersion education program: Training mental health workers for practice with Latino communities. *Journal of Marital and Family Therapy, 38*, 352-364. doi: 10.1111/j.1752-0606.2010.00208.
Platt, J. J. (2013). Stepping over a baby's head: Thoughts on privilege, humanity and liberation. In M. E. Gallardo (Ed.), *Developing cultural humility: Embracing race, privilege and power* (pp. 199-221). Thousand Oaks, CA: Sage.
Platt, J. J., & Laszloffy, T.A. (2012) Critical patriotism: Incorporating nationality into MFT education and training. *Journal of Marital and Family Therapy*, 1-16, Retrieved from doi: 10.1111/j.1752-0606.2012.00325.x
Platt, J. J., & Mondellini, D. (2014). Single-session walk-in therapy for street robbery victims in Mexico City. In M.F. Hoyt & M. Talmon (Eds.), *Capturing the moment: Single session therapy and walk-in services* (pp. 215-231). Bethel, CT: Crown House Publishing.
Realmuto, G., Ann, C., Hubbard, J., Groteluschen, A., & Chhun, B. (1992). Adolescent survivors of massive childhood trauma in Cambodia: Life events and current systems. *Journal of Traumatic Stress, 5*(4), 589-599.
Sack, W. H., Him, C., & Dickason, D. (1999). Twelve-year follow-up study of Khmer youths who suffered massive war trauma as children. *Journal of the American Academy of Child and Adolescent Psychiatry, 38*(9), 1173-1179.
Stevens, M. J., & Wedding, D. (Eds.) (2004). *Handbook of international psychology*. New York: Brunner-Routledge.
Stockwell, A., Whiteford, H., Townsend, C., & Stewart, D. (2005). Mental health policy development: Case study of Cambodia. *Australasian Psychiatry, 13*(2), 190-194.
Spoerl, O. H. (1975). Single-session psychotherapy. *Diseases of the Nervous System*, 36, 283-285.
Thoreau, H. D. (1854). *Walden*. Chicago: University of Illinois.
Somasundaram, D., van de Put, W., Eisenbruch, M., & de Jong, J. (1999). Starting mental health services in Cambodia. *Social Science & Medicine, 48*, 1029-1046.
Um, K. (2008). Cambodia: A decade after coup. *Southeast Asia Affairs, 2008*(0), 107-120.
Van Maaren, P. (2012). Mental health a tough challenge for Cambodia. *Phnom Penh Post.*
van de Put, W., & van der Veer, G. (2005). Counselling in Cambodia: Cultural competence and contextual costs. *Intervention, 3*(2), 87-96.
Zimmer, Z., Knodel, J., Kim, K., & Puch, S. (2006). The impact of past conflicts and social disruption on the elderly in Cambodia. *Population and Development Review, 32*(2), 333-360.