The psychological distress and positive mental health of people with physical impairments & their families: Kampong Cham province in Cambodia 2015.

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1. Executive summary of the study findings

Health and well-being within the Khmer context, is to have a functional body and to live within a hygienic environment. Despite participants being able to identify some symptoms of psychological distress, there is minimal understanding of mental well-being across all key stakeholders including people with disabilities themselves, family members and carers community members and leaders and key service providers.

Disability remains predominantly viewed through the medical lens as a symptom to be fixed. People with disabilities are perceived as objects of pity and the charity model remains the underlying framework of disability in Cambodia. The social model of disability in Cambodia remains rudimentary and the rights of people with disabilities remain largely unrecognized. Government laws and policies for people with disabilities according to the United Nations Convention on the Rights of Persons with Disabilities (UNCRPD) are unevenly upheld by non-government organizations and government involvement remains minimal.

People with physical impairments and their families experience significant psychological distress as a result of a variety of internal and external factors. These mainly include lack of livelihood, poor accessibility, social exclusion, stigma and discrimination, family conflict and the lack of employment. Additionally, the level of physical impairment is a major determinant of the degree of psychological distress. The studies have found that men with congenital disability and those who have had road traffic accidents displayed greater signs of psychological distress. Women with disabilities and carers face substantial domestic violence and abuse within the family and display high levels of psychological distress.

Both community members and service providers have a minimal understanding on the lived experiences of people with disabilities and their families. However, the community was identified as a major source of psychological distress and positive mental health. Significant stigma and discrimination has been identified as happening mostly within the community. However, respondents identified having relationships and receiving informal encouragement as paramount for their self-esteem and optimism. Service providers have identified their lack of knowledge of working with people with disabilities and express the need for further training and have identified NGOs as the expertise in the area.

There is a clear need for further education on mental health and on disability by all key stakeholders. Additionally, people with disabilities and their families require assistance that involves both social and psychological assistance.

Therefore, future services should consider an integrated approach, which addresses both internal and external barriers, which are interdependent to psychological distress. Lastly, there needs to be continued effort in raising awareness for the rights of people with disabilities in the public and private sector and for women with disabilities and carers.

2. Introduction to the context (including the literature review)

Introduction

People with disabilities are one of the most marginalized and disadvantaged groups in the world (Palmer, 2011). Landmine injuries, road traffic accidents, disease and congenital disability all contribute to making Cambodia the highest number of disability per capita in the world (Carter, 2009; Gartrell & Hoban, 2013; Jegannathan, Kullgren, & Deva, 2015). Despite being the most rapid growing, post-conflict economy in the world, this development remains unsustainable and significantly impeded by the high number of people living with a disability (Cantor-Graae, Chak, Sunbaunat, Jarl, & Larsson, 2014; Durham & Hoy, 2013; Morgan & Tan, 2011; Stockwell, Whiteford, Townsend, & Stewart, 2005; Vanleit, 2008; World Health Organization, 2011; Zimmer, 2006).

Poor social and economic infrastructure create extremely vulnerable and disabling environment for those who suffer from physical impairments (Seponski, Lewis, & Megginson, 2014). As a result, individuals with a physical disability and their families experience exponential barriers to services and have higher psychosocial needs (Gartrell, 2010; Mollica, Brooks, Tor, Lopes-Cardozo, & Silove, 2014; Palmer, 2011). Despite some volume of literature examining the mental health of those suffering from landmine injuries, there has been very little research on the psychosocial needs of people with other types of causes of physical impairment and their families (Cantor-Graae, et al., 2014; Mollica, et al., 2014).

Study Objective

Therefore, this literature review aims to achieve three major objectives.

- Firstly, to understand and identify the psychosocial needs of people with physical impairments;
- Secondly, to develop an understanding of the lived experiences of individuals who have physical impairments, their carer's and family; and

- Lastly, consider how the needs of people with physical impairments are met as well as outline existing barriers to psychosocial health service provision.

Overview of the Social Model

Prior to the social model of disability, the medical and charity model saw people with disabilities as a medical problem to be fixed or individuals to be pitied (Handicap International 2012). However, the social model underpinned by the UNCRPD emphasizes citizenship, access, choice, participation, positive self-image, shared responsibility and accountability by all key stakeholders (Handicap International 2012). Transition phrase mission: people with disabilities are disadvantage not because of their individual characteristic but as a result of limitation imposed on them by the environment & external barriers

It is important to recognize the difference between the human rights model which emphasizes that people with disabilities possess civil, economic and social rights (World Health Organization, 2011). However, the social model identifies that people with disabilities experience three types of barriers including, institutional, environmental and attitudinal barriers (Handicap International, 2009).

Firstly, institutional barriers includes the lack of policy and legislation to ensure that people with disabilities are able to fully participate in society (Handicap International, 2009). Secondly, environmental barriers considers the lack of physical infrastructure such as inaccessible buildings that prevent access to services and significant life opportunities (Handicap International, 2009). Lastly, attitudinal barriers exist within people's attitudes and preconceptions which causes stigma and discrimination against people with disabilities (Handicap International, 2009).

The social model does not negate the medical needs of people with disabilities, but allows them to take ownership of their lives and puts them at the center of treatment rather focus only on the impairment (Handicap International & French Agency for Development, 2015; Hughes, 2010). The ultimate goal of the social model is to maximize the rights of people with disabilities and ensure equal opportunity (Hughes, 2010). Additionally, this report will follow the major shift in language as a result of the social model from "disabled persons" to "people with disabilities" (Handicap International & French Agency for Development, 2015). The social model was a crucial foundation for the development of the Disability Creation Process used by Handicap International.

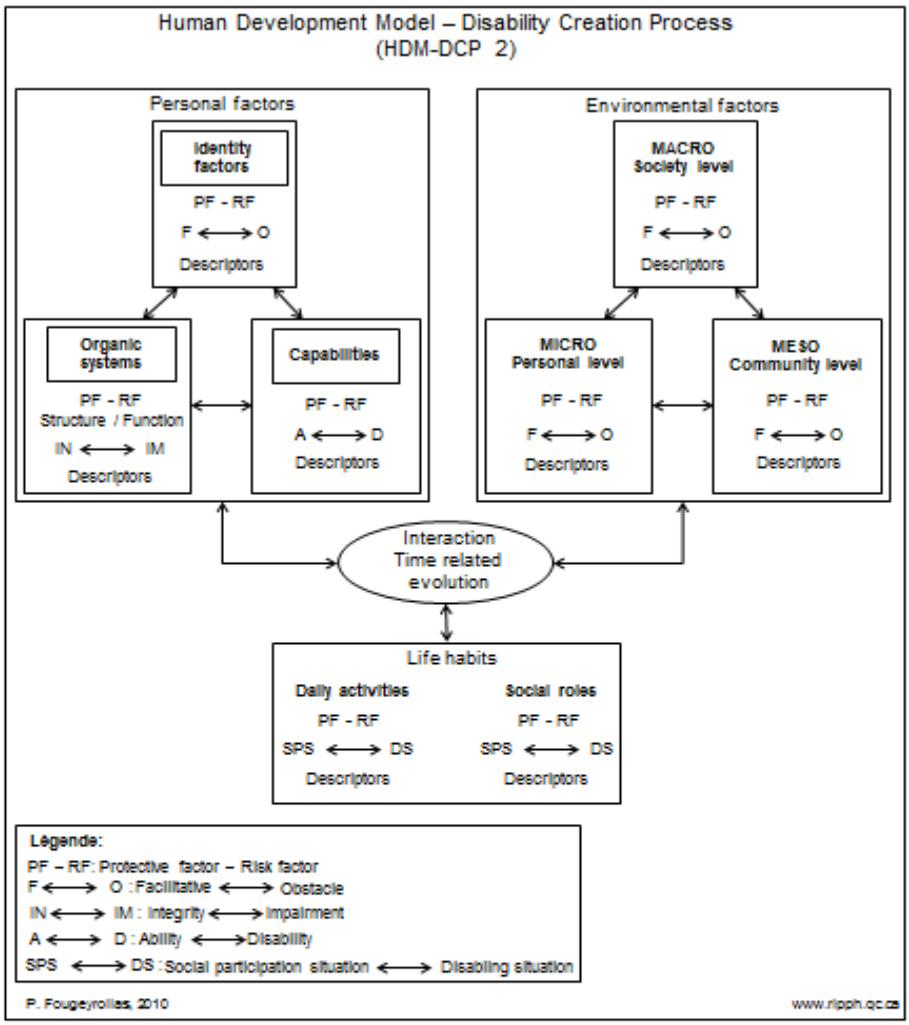
Overview of the Disability Creation Process

The term “impairment” is understood as “the actual loss of functions in an individual caused by an injury or illness which can be congenital or acquired later in life” (Handicap International, 2012). An impairment may be physical, intellectual, sensory or mental (Handicap International, 2012). Whereas disability is “the result of the interaction between the persons with impairment and attitudinal and environmental barriers that hinder their full and effective participation in society on an equal basis with others” (Handicap International, 2009). This view highlights the different definition of impairment to disability and the societal and environmental barriers that prevents the full participation of people with disabilities in society (Handicap International, 2012; United Nations Development Programme, 2015; World Health Organization, 2011). Notwithstanding the medical model, the aim of the DCP is to emphasis environmental factors, effectively address stigma and break the poverty and disability cycle (Gartrell & Hoban, 2013; Parnes et al., 2009; World Health Organization, 2011). Therefore, every attempt to reduce a disability should be action directed towards societal and environmental factors rather than the person with the disability.

The Disability Creation Process (DCP) is a comprehensive framework developed by the Quebec classification of disability and used by Handicap International to provide a thorough understanding of disability. Specifically, the DCP examines how personal factors and the external environment, interact to cause a disability within an individual’s life (Handicap International 2012). Additionally, the model allows for a greater appreciation of the evolving nature of disability and is used as a comprehensive tool to assist people with disabilities and their families in overcoming their disability. It is an adaptation of the human development model in the area of disability. It uses the central notion of social participation as resulting from interaction between personal factors and environmental factors. The interaction between personal and environmental factors can limit the full realization of a person’s life habits.

The DCP developed and used by Handicap International drew upon the three major theoretical foundations including the DCP in Canada, the International Classification of Functioning, Disability and Health (ICF) by the World Health Organization and the definition of disability according to the United Nations Convention on the Rights of Persons with Disability (UNCPRD) (Handicap International 2012).

The Disability Creation Process



The "risk factor" consists of an element within an individual's life and within the environment that may contribute to deterioration in the person's development or physical functioning (Handicap International 2012). An example of a risk factor element within a person's life and the environment could be alcohol addiction and poor traffic control. When these risk factors eventuate they are considered a "cause" of impairment (Handicap International 2012).

The "personal factors" consist of the individual's unique characteristics such as age, gender and sociocultural identity (Handicap International 2012). Organic

systems and aptitude are two major categories that make up personal factors (Handicap International 2012). Organic systems encompass the body components including the muscular systems, skeleton system and ocular systems (Handicap International 2012). In contrast, aptitude is the possibility of an individual to accomplish a physical or mental activity, which can include language ability and other skills (Handicap 2012).

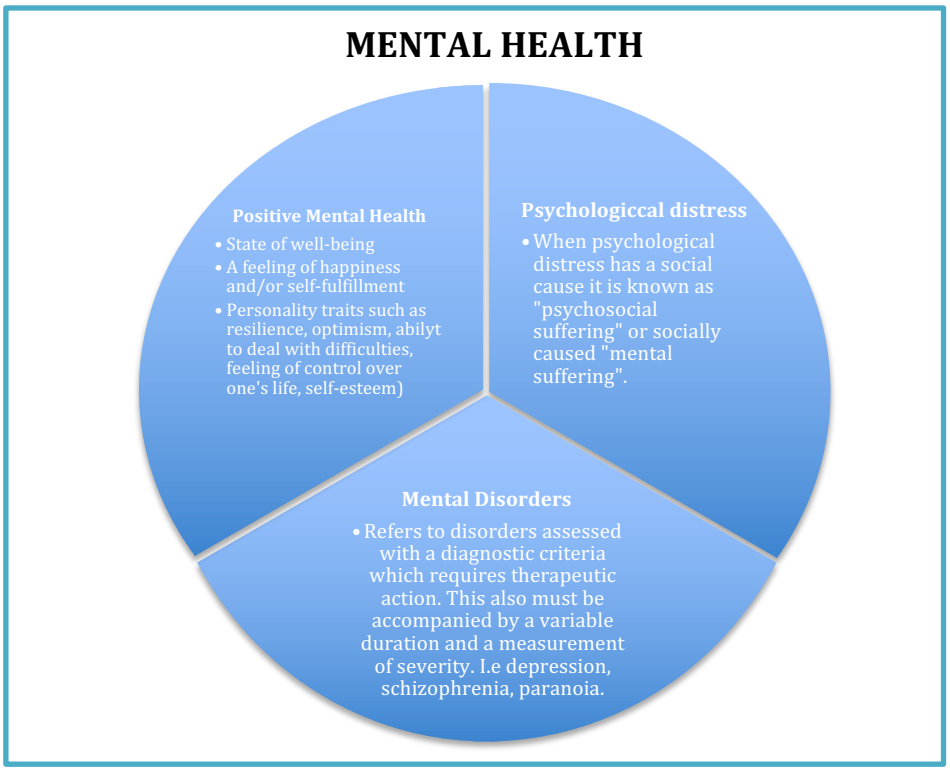
"Environmental factors" include any social or physical aspects within the surrounding environment or context that can impact life habits (Handicap International 2012). Social aspects may include political-economic factors or socio-cultural factors (Handicap International 2012). However, physical aspects include things such as architectural design or nature (Handicap International 2012). There are two major aspects to environmental factors including facilitators and obstacles. Specifically, facilitators are things that promote life habits whereas obstacles (barriers) are things, which hinder the actualization of life habits (Handicap International 2012).

"Life habits" are the everyday activities or a social identity that is maintained by the individual according to their socio-cultural context and characteristics such as age, gender, personal care and identity (Handicap International 2012). Life habits eventuate to ensure an individual's well-being and survival throughout their life (Handicap International 2012). Yet, life habits can either be categorized as social participation and a disabling situation (Handicap International 2012). Social participation includes the full realization of one's life habits (Handicap International 2012). In contrast, a disabling situation consists of only partial or non-realization of one's life habits (Handicap International 2012).

An "interaction" is the point where personal factors, environmental factors and life habits meet and influence one another and creates a disability (Handicap International 2012). Additionally, the interaction between these three factors is dynamic, complex and always shifting according to the change within key dimensions change (Handicap International 2012). The culmination of institutional, attitudinal and environmental barriers, hinder the social life of people with impairments, which lead to a situation of disability. As a result, people with disabilities are vulnerable to a range of mental health issues. This study aims to identify the barriers and facilitators in society that will effectively address the rights of people with disabilities be included in civil society.

Overview of Mental Health

The term "mental health" includes three overarching categories including psychological distress, mental health disorders or illness, and positive mental health (Handicap International, 2011).



Handicap International's (HI) definition of mental health includes psychological distress, mental disorders and positive mental health. Linked to WHO definition, it is understood that physical and mental health are interdependent and is not defined by the absence of disease (Handicap International, 2011). For the purposes of this study, psychological distress and positive mental health will be the primary focus, whereas mental health disorders will be omitted. The reason for omitting mental health disorders within this research was to ensure the scope was not too large, and secondly that HI are dealing primarily in the Rehabilitation Centre with issues of psychological distress and wellbeing.

Psychological distress is a "state of disquiet which is not necessarily symptomatic of a pathology or mental disorder" (Handicap International, 2011). It includes people suffering from disabling injuries and traumas" (Handicap International, 2011). However, it is the presence of non-severe or temporary, symptoms of psychological trauma, anxiety and depression which do not meet the criteria for diagnosing mental disorders (Handicap International, 2011). Psychological distresses are a reaction to stressful situations such as migration, exile, natural disaster, existential difficulties (Handicap International, 2011). "This type of distress does not necessarily lead to the onset of mental disorder and is not pathological but can be severe enough to warrant its inclusion in a negative definition" (Handicap International, 2011).

Mental disorders which consists of a mental diagnosis according to the Diagnostic and Statistical Manual of Mental Disorders (DSM-5) or the International Classification of Diseases (ICD-10) (Handicap International, 2011). An example of this can include diagnosis such as clinical depression, psychosis, anxiety personality disorders, schizophrenia or paranoia (Handicap International, 2011).

Positive mental health refers to the "either to a state of well-being, a feeling of happiness and/or self-fulfillment or to personality traits such as resilience, optimism, ability to deal with difficulties, feeling of control over one's life and self -esteem" (Handicap International, 2011). "This is a positive state of balance and harmony between the structures of the individual and those of the environment they have to adapt to" (Handicap International, 2011).

Mental health and psychological distress may lead to a "psychosocial disability". The causes of a psychosocial disability may include poverty, homelessness, a breakdown within the family and social relationships and unemployment (Handicap International, 2011). When these situations adversely affect the social life, social skills and their ability to take care of oneself, this should be considered as a psychosocial disability (Handicap International, 2011). Specifically, the loss of these capacities may hinder the capacity in terms of behavior, language, intellectual activities, the ability to protect oneself or to ask for assistance (Handicap International, 2011). This study will attempt to identity risk factors that could lead to a psychosocial disability.

Overview of the Khmer Rouge

An estimation of two million people or a quarter of the population in Cambodia were killed during the Khmer Rouge (McLaughlin, 2012). Specifically, the Khmer Rouge destroyed significant civil infrastructure including the justice, health and education system (McLaughlin, 2012). This devastation caused by the Khmer Rouge has had a significant negative impact on the economy, society and physical and psychological health of Cambodians (Cardozo et al., 2012; Hein, 2015; Mollica, et al., 2014; Seponski, et al., 2014).

It is important to recognize that psychological distress can be transmitted to the current population and the future generation even after the Khmer Rouge (McLaughlin, 2012). Physical impairments caused my landmines planted during the war might relate some psychological distress as a result of the Khmer Rouge (McLaughlin, 2012). Despite the connection between landmines and the Khmer Rouge, many authors recognize that much of the psychological distress and

mental disorders of Cambodians are caused by poverty, violence and the lack of human rights (Jegannathan, et al., 2015; McLaughlin, 2012). However, this review recognizes the influence of the Khmer Rouge but is cautious that it is not the sole responsibility, nor should it overshadow other present day influences that contributes to the psychological distress of people with physical impairments (McLaughlin, 2012).

Disability - Statistics

Recent years has shown the official prevalence used by the Royal Government of Cambodia of people with disabilities in Cambodia is 4% (Handicap International France, 2009). Yet, the Asian Development Bank argues that 9.8% is a more accurate statistic (Cordier, 2014; Zook, 2010). However in 2012 Cambodian Socio-Economic Survey estimated the disability prevalence rate in Cambodia at 5% (National Institute of Statistics Ministry of Planning, 2013). Additionally, it is estimated that between 10.1% and 15.6% of children age 2-9 years old have a disability and an impairment respectively (Handicap International, 2011/2012). It is important to consider that the World Disability Report states that the prevalence of people with disabilities in developing countries are between 10%-15% of the global population (World Health Organization, 2011). As a consequence of significant discrepancies in data, many authors are cautious on the statistics of people with disabilities in Cambodia and suspect that the actual data remain significantly under reported and inconsistent (Cordier, 2014; Palmer, 2011; Zook, 2010).

A major reason to this lack of data remains the difficulty in obtaining data of those living in rural and remote areas (Mollica, et al., 2014; Zook, 2010). It has been identified that the majority of people living with a disability are located in rural areas and are highly likely excluded from major data collection (Palmer, 2011). Moreover, authors point out that census data is also severely skewed as it only captures questions that relate to severe impairments (Palmer, 2011). Discrepancy and double up of data collection was also highlighted as another problem due to the coexisting disabilities such as “deaf-mute” in census data (Durham & Hoy, 2013). It is also argued that most international literature has been limited to these hospital databases and those who are unregistered remain excluded from data (Bendinelli, 2009; Durham & Hoy, 2013). As a result, neither census data nor peer-reviewed journals are able to present a clear view of the number of people with disabilities in Cambodia (Mollica, et al., 2014; Palmer, 2011).

Types of Impairments

People with visual impairment remain the highest number of people experiencing a disability at 30% (Handicap International France, 2009). This is followed by 23.5% of people with a mobility impairment and 15% of people experiencing a hearing difficulty (Handicap International France, 2009). However, the largest causes of impairment includes old age (26.7%), disease (25.8%), accidents (11.4%) and congenital (8.7%) (Gartrell & Hoban, 2013; Handicap International France, 2009). Poverty and inaccessibility remain the dominant social determinant of disability in Cambodia (Carter, 2009). Yet, over 50% of all causes of disability in Cambodia are preventable (Carter, 2009).

Amputees as a result of landmines injuries are the largest category of people with physical impairments in Cambodia (Durham & Hoy, 2013). Consequently, it is not unreasonable that a substantial volume of studies has revolved around this type of injury (Bendinelli, 2009; Mollica, et al., 2014; Zook, 2010). However, there are a growing number of people with paraplegia caused by gunshots and road traffic accidents (Durham & Hoy, 2013; Parnes, et al., 2009). Despite a substantial volume of research, the quality of data remains relatively inadequate to identify the psychosocial needs and total long term impact of the physical impairments in Cambodia (Mollica, et al., 2014).

A minimal amount of literature adequately addresses intellectual and cognitive impairments (Jegannathan, et al., 2015). As a result of the lack of research, people with a mental and intellectual impairment remains the most poorly served within the community of people with disabilities and lack the most infrastructure and services (Handicap International, 2011). Similarly people with speech, visual and hearing impairments, remains under-researched (Palmer, 2011). However, for the purposes of this research, there will be a larger emphasis on the lived experiences of those who physical impairments.

Disability – Landmine Injuries

Studies have identified that the pattern of injuries such land mine injuries are correlated to specific locations as a result of war (Durham & Hoy, 2013). Antipersonnel landmines were used to strategically create large wounds and permanent long term disability (Bendinelli, 2009). Estimates from the Landmine Monitor Report 2011 by the International Campaign to Ban Landmines (2011) evaluates that around 648.8 km^2 of land in Cambodia is contaminated with unexploded ordnance (UXO) and explosives remnants of war (ERW). In other words, there are approximately over 10 million antipersonnel landmines in Cambodia (Durham & Hoy, 2013; Gartrell & Hoban, 2013; World Health Organization, 2011). Furthermore, these contaminated areas are located in most impoverished and rural areas where 80% of civilians live with extremely poor health (Durham & Hoy, 2013; Gartrell & Hoban, 2013). As a result, the most

vulnerable population in Cambodia are at the highest risk of obtaining a landmine injury (Durham & Hoy, 2013; Gartrell & Hoban, 2013). In the event of an injury, hospitals are mostly inaccessible and beyond the means for these victims (Bendinelli, 2009).

There is a large difference between the physical injuries obtained by landmine injuries between children to adults (Bendinelli, 2009). The majority of landmine injuries were more associated with male who were prone to explore the fields (Durham & Hoy, 2013; Mollica, et al., 2014). Among men, a common pattern showed that adults had a significantly higher number of lower limb injuries ranging from 28% to 39% when compared to 27% to 28% torso injuries and 5% to 31% vision loss (Bendinelli, 2009; Cardozo, et al., 2012; Durham & Hoy, 2013). However, that children had injuries in the upper body, mostly head injuries, neck, upper limbs, trunk injuries, vision loss and bilateral blindness due to land mine injuries and explosives remnants of war (Bendinelli, 2009). There has also been data that shows that females and children are experiencing a higher rate of land mine injuries (Bendinelli, 2009). A major reason is the larger female and children population after the war (Bendinelli, 2009). It is important to note that the largest physical impairment among children is cerebral palsy (Bachani et al., 2011). Despite significant statistics, these data lack implications on the long term effects and costs of the disability which is detrimental to highlighting the significance of the issue for policy change (Bendinelli, 2009).

Women with Disabilities

Cambodia belongs to group of countries with the lowest gender inequality index in the world (United Nations Development Program Cambodia, 2010). It is estimated that between 20%-25% of women in Cambodia experience domestic violence (McLaughlin, 2012). However, women with disabilities experiences significantly more abuse and violations of their human rights set out by the UNCRPD and the Optional Protocol (United Nations, 2006, 2009).

Women with disabilities in Cambodia are at higher risk exploitation, stigma and violence (Astbury & Walji, 2014; Parnes, et al., 2009). Specifically, women with disabilities in Cambodia experience significant abuse, neglect, disdain and have the least access to health care (Astbury & Walji, 2014). Additionally, this study found that women with disability were vulnerable to psychological (43.8%), physical (18.4%) and sexual abuse (4.2%) (Astbury & Walji, 2014). Specifically, psychological violence can include coercive control such as restricting the rights to education, seeking help and accessing health care (Astbury & Walji, 2014). Consequently, women with disabilities in Cambodia possess lower rates of literacy and income and are excluded from access to education and health care (Astbury & Walji, 2014; United Nations Development Program Cambodia, 2010).

Physical violence may include the purposeful removal and intentional damage to their aids, equipment and mobility (Astbury & Walji, 2014). Additionally, intense forms of physical violence such as stabbing, shooting, or throwing acid on women remains acceptable in the event of a disagreement or an argument with their partners (Astbury & Walji, 2014). Due to significant risks of abuse, around 28% of women with disability do not attend school, ¾ are unlikely to get married and most will continue with their birth family (Astbury & Walji, 2014).

Despite the fact that women with disability experience violence 2½ more times, over 57% of women with disability do not inform others of abuse or seek help from available services (Astbury & Walji, 2014). As a result, violence as well as disability exacerbates the level of mental disorders including depression, anxiety, posttraumatic stress disorder (PTSD), and suicide ideation (Astbury & Walji, 2014). Therefore, women with disabilities must be recognized as much more vulnerable, stigmatized and excluded when compared to women without disabilities and people with physical disabilities (Zook, 2010).

Carers of People with Disabilities

The World Health Organization (WHO) predicts that by 2050 there will be an increase between 115%-581% in carers of people with disabilities in the Global South (Cordier, 2014). Specific to South East Asian cultures, the care of a child or adult with disabilities in Cambodia is unpaid, time consuming, rigorous and may require a life time commitment (Cordier, 2014). However, it has been estimated that 80% of carer's are women including, the mother, sister, wives or grandmother of the person with a disability (Cordier, 2014). A similar study of people with a disability in North East Thailand found that the care of persons with disabilities to associated to the family rather than to the society (King & King, 2011).

Often the carer may also experience a role reversal and become the breadwinner (King & King, 2011). Specifically, the carer will need to find a source of income but also ensure sufficient finances for treatment and ongoing rehabilitation (King & King, 2011). In some cases, women may choose to leave their husbands with a disability in order to seek another individual who is able to provide for their needs (King & King, 2011). These unpaid carer's experience limited assistance from the government and are lacking the required training and support (Cordier, 2014).

In circumstances where the carer must work to provide an income they may leave the person with a disability at home alone (King & King, 2011). Often, the carer's capabilities are extended beyond their ability to provide effective care for others and themselves (Cordier, 2014). Additionally, carers may experience

stigmatization and discrimination as a result of taking care of the people with disabilities (Handicap International, 2011). It is also possible that carers are partly blamed for the disability that has occurred (King & King, 2011). The severe shortage of literature regarding the psychosocial issues of carers demands critical attention and further investigation.

Disability – Mental Disorders

Only one study specifically examined the correlation between a disability caused by a landmine injury and the psychosocial outcomes (Cardozo, et al., 2012). This study focused on a range of mental disorders but also psychosocial determinants to positive mental health (Cardozo, et al., 2012). The results from the study showed that 74% of people with depression often have vision impairments, experienced multiple traumatic events and torture (Cardozo, et al., 2012). In contrast, 62% of people who experienced anxiety were those who had torso injuries (Cardozo, et al., 2012). Lastly, 37% of people with PTSD were those who had lost a higher number of limbs due to landmines and have experienced torture (Cardozo, et al., 2012).

In terms of positive mental health, the study found that "empowerment", i.e. finding meaning and being involved in social activities had a beneficial impact on the psychosocial wellbeing of people with disabilities (Cardozo, et al., 2012). Specifically, this included having an education, earning an income, belonging to a religious or involvement with a political party (Cardozo, et al., 2012). In contrast, rumination and avoidance regarding the injury, associated pain and receiving special assistance, increased the rates of depression and anxiety (Cardozo, et al., 2012). It is important to note that there is a growing amount of international literature which has found that anxiety and depression have a serious effect on physical functioning, social skills and labor capacity (Dubois et al., 2004). This indicates the potential of a psychosocial disability but requires further research.

In conclusion, the study showed that the level of mental disorders were significant higher with those who have a disability which has been caused as a result of landmines (Cardozo, et al., 2012). Although this study was one of the first to be conducted, the major weakness of the study remains exclusively in the province of Siem Reap (Cardozo, et al., 2012). Therefore, similar and larger work is needed across other types of impairments and it other areas of Cambodia.

Disability – Cultural Construction & Lived Experience

Introduction

Presently, people with disabilities in Cambodia are viewed as individuals to be pitied and helped through charity from governments, the community and non-

government organizations (NGOs) (Gartrell & Hoban, 2013). Both social norms and religious beliefs create barriers at the micro, mezzo and macro level for people with disabilities (Durham & Hoy, 2013; Palmer, 2011; Parnes, et al., 2009; Seponski, et al., 2014; Zimmer, 2006; Zook, 2010). As a result of the lack of a human rights based approach, people with disabilities face substantial discrimination, are stigmatized and are socially and economically marginalized (Cordier, 2014).

Disability – Health Construct

Individuals with a congenital disability face two general assumptions (Gartrell, 2010; Gartrell & Hoban, 2013). It is assumed that disability is caused as a result of the lack of vaccinations, poor internal health and poor nutritional health during pregnancy (Gartrell, 2010; Gartrell & Hoban, 2013). The literature shows a pattern that people with disabilities are associated with having a brain damage or as having nerve damage (Gartrell, 2010; Gartrell & Hoban, 2013; Palmer, 2011). It is argued that this idea resulted from the erratic and unusual behavior demonstrated by people with disabilities (Gartrell, 2010). This promotes an image that people with congenital disability are considered to be useless, untrustworthy, unable to learn and without any significant value (Gartrell, 2010; Gartrell & Hoban, 2013; Palmer, 2011).

The belief in karma also plays an important part on the lived experiences of people with disabilities, although it's influence is more associated to a physical impairment that is obtained later in life (Bachani, et al., 2011; Gartrell & Hoban, 2013). These beliefs enhance the view that people with disabilities are emotionally unstable, immature, lack social skills and should be excluded in important decision making (Gartrell, 2010). As result of significant stigma, people with disabilities face discrimination on multiple institutional levels and especially when trying to obtain loans (Gartrell, 2010).

Disability – Religious Construct

Theravada Buddhism is the main religion in Cambodia and 85% of population hold this belief (Carter, 2009). Literature highlights that identifying the influence of Buddhism to everyday stigma is a gross oversimplification of the lived experiences of people with disabilities (Carter, 2009). Religion is interconnect with culture and plays a major influence in shaping how disability is understood, perceived and managed in Cambodia (Carter, 2009). As having a disability has significant connotations with karma, the associated stigma has implications on aid funding allocation, the construction of stigma, the tradition of pity and the establishment of social hierarchies (Carter, 2009). Religious discrimination against people with disabilities is experienced across the community, local and national level (Carter, 2009). In summary, some literature argues that religion

infused stigma systematically excludes people with disabilities from the fundamental aspects of citizenship and equal social membership in Cambodia (Gartrell, 2010).

Disability – Labor Construction

Cambodia's growing economy and workforce is one that requires significant physical labor and man power (Gartrell & Hoban, 2013; Palmer, 2011). Consequently, ethnographic research found that having a disability contributes to the loss of labor power and household income (Gartrell, 2010). Similarly, people with disabilities in Thailand are considered only as valuable as their ability to be productive (King & King, 2011). As a result, people with disabilities are considered a burden to society and devalued among their counterparts (King & King, 2011). Specifically, people with disabilities are considered as unable to participate in reciprocal relationships that contribute to the welfare of the family (Carter, 2009; Cordier, 2014; Gartrell, 2010; Vanleit, 2008). Yet, it is estimated that the cost of excluding people with disabilities from employment can cost up to 7% of the gross domestic product for low income countries such as Cambodia (Buckup, 2009; Sæbønes et al., 2015). This figure is considered an understatement as it does not consider the financial loss of the family (Buckup, 2009; Sæbønes, et al., 2015). Therefore, further significance should be placed on the impact of unemployment and underemployment of people with disabilities to the economy of Cambodia (Buckup, 2009; Sæbønes, et al., 2015).

It has been found that the general population associate people with disabilities as only capable of begging and are dependent upon the goodwill and pity of others (Gartrell, 2010). Additionally, many people with disabilities are underemployed and restricted to poorly paid work (Gartrell, 2010). As a result of attitudinal barriers, people with disabilities are excluded from education, work, employment and civil life (Gartrell & Hoban, 2013). Authors argue that discrimination against employment remains one of the subtlest yet most inescapable of all types of inequalities faced by people with disabilities (Bhalla et al., 2013; Gartrell & Hoban, 2013).

Studies have found that people with disabilities believe that the most appropriate solution to their problems is to contribute to their household work and finances (Gartrell & Hoban, 2013). A study on cultural norms in Cambodia found that successful people without disabilities are considered to be in "big work", which implies power, status and respect (Gartrell, 2010; Gartrell & Hoban, 2013). Whereas people with disabilities are socially confined to "small work", or menial jobs such as cooking and cleaning (Gartrell, 2010). In circumstances where people with disabilities are restricted to "small work" such as childcare, cooking, cleaning, or collecting firewood, they are categorized as

have the lowest working value in society (Gartrell, 2010). As a result, the research revealed that people with disabilities who have substantial achievement, are perceived as a threat and a disruption to social hierarchies and cultural norms (Gartrell, 2010). Specifically, people with disabilities challenge the current relationship associated with "big work" and physical ability (Gartrell, 2010; Gartrell & Hoban, 2013). Therefore, the view of people with disabilities in Cambodia remains narrowly focused on their negative limitations and inability to contribute and participate in society (Gartrell, 2010).

Disability Specific Services

Rehabilitation Services

One study identified that services towards disability in Cambodia remains predominantly skewed to towards physical rehabilitation (Zook, 2010). In reviewing the literature, the author found a series of significant factors that contribute to this bias including, a lack of knowledge of other types impairments, the absence of qualified physicians to treat other impairments and the insufficient advocacy of other disabilities for policy reform (Zook, 2010). The study also recognized that the same word for "rehabilitation" in Khmer is also used with criminals (Zook, 2010). Consequently, this connotation implies that people with disabilities are seen as a problem to be fixed which continues to reinforce the medical model of disability (Zook, 2010). Therefore, the author highlights that people with disabilities may face further stigmatization as a result of accessing rehabilitation services (Zook, 2010).

Non-government organizations (NGOs)

The majority of literature identified programs for people with disabilities as predominantly run by international NGOs with minimal support from the Cambodian government (Astbury & Walji, 2014; Gartrell & Hoban, 2013; Zook, 2010). However, some authors emphasized that many internationally funded programs often lack cultural sensitive and reinforces "pity" and disempowers people with disabilities (Gartrell & Hoban, 2013). More recent attention has been focused on the lack of an inclusion of people with disabilities in the design of programs and policies (Gartrell & Hoban, 2013). Recent studies have found that social enterprises initiated by NGOs often fail and exacerbate further stigma (Gartrell & Hoban, 2013). Therefore, authors challenge the role of NGOs as having the potential to reinforce reliance, dependence and passivity (Gartrell & Hoban, 2013). However, there are reports of recent rights based and inclusive programs that promote the involvement of people with disabilities in program design and implementation (Gartrell & Hoban, 2013; Zook, 2010).

The aim for these programs emphasize the integration of people with disabilities and others in the community to reinforce normality, a sense of dignity, meaning and self-respect for people with disabilities (Zook, 2010). A considerable amount of literature emphasize that NGO services are required to develop a greater understanding of the barriers and stigma people with disabilities faces (Astbury & Walji, 2014). Consequently, services must minimize these barriers and become sensitive to the fact that that people with disabilities have difficulty articulating needs and overcoming multidimensional barriers themselves (Astbury & Walji, 2014; Gartrell & Hoban, 2013). The large volume of literature highlights the limited amount of collaboration between formal help with non-formal help, which diminish the potential to maximize attitudinal and behavioral changes at the village and community level (Astbury & Walji, 2014). In conclusion, services for people with disabilities remain predominantly run by NGOs but particular attention must be paid to processes that include people with disabilities at every level.

Overview of Mental Health

Introduction

There is a large volume of published studies describing poor mental health as a significant strain on the social, economic and developmental growth of Cambodia (Cantor-Graae, et al., 2014; Cardozo, et al., 2012; Hein, 2015; Seponski, et al., 2014). International literature claims that as a result of uneven distribution of funds in low-income countries, 90% of those suffering from poor mental health receive 10% of the available mental health resources (Seponski, et al., 2014; World Health Organization, 2011). Several recent studies on the national health budget in Cambodia, found that between 0.02% to 1% (approximately $30,000 per annum) of the total health budget has been allocated to mental health (McLaughlin, 2012; Schunert et al., 2012). Another study highlighted that there is an estimation of 0.23 psychologists per 100,000 people to meet the mental health needs in Cambodia (Astbury & Walji, 2014). From these findings, it is clear that mental health has been severely neglected issue in Cambodia.

Mental Disorders

The first research on the prevalence of mental disorders in Cambodia was conducted by Dubois et al. (2004) on a sample of 1,320 people aged over 20 years in the province of Kampong Cham. This study showed that, 42.4% of the respondents reported symptoms that met the DSM-IV criteria for depression and 7.3% the criteria for PTSD, 53% presented symptomatic anxiety symptoms as defined by HSCL-25. Regarding social functioning, 25.3% presented social impairment due to a health condition or an emotional condition. A more recent and larger study was conducted by the Department of Psychology at the Royal

Phnom Penh University (Schunert, et al., 2012). The study found that there was a higher level of mental disorders among female and male children, respectively aggression (11.5%), child abuse (10% - 8%) and suicide (0.8%) (Schunert, et al., 2012). The suicide rate of children and adolescence in Cambodia is 2.6 times higher than the average number of suicides globally (Schunert, et al., 2012). Probable mental disorders ranging from the highest to lowest included anxiety (31.7% female/18.4% male), depression (19.7% female/10.2% male), PTSD (3.1% female/1.4% male) and schizophrenia (0.6% female/0.2% male) (McLaughlin, 2012; Schunert, et al., 2012).

The key findings of the study found that children and women experienced a significantly high level of mental disorders (Schunert, et al., 2012). Despite being the first large scale research, caution is advised when interpreting the data as there were two major limitations to this study. Firstly, there was an over presentation of female participants due to the lack of male participants during the harvest season (Schunert, et al., 2012). Secondly, as no clinical examinations took place during the data collection, the prevalence of mental disorders only remains probable (Schunert, et al., 2012). As a result, these findings do not confirm the actual number of people with mental disorders in Cambodia.

The only factual data of the prevalence of mental disorder in Cambodia was collected in 1999 and exclusively within an outpatient and clinical setting (Jegannathan, et al., 2015; Somasundaram, van de Put, Eisenbruch, & de Jong, 1999). This data indicates that the most common forms of mental disorders including 18% of people suffering from anxiety, 18% of schizophrenia, 15% from epilepsy and 15% of psychosis (Jegannathan, et al., 2015; Somasundaram, et al., 1999). However, other forms of mental disorders include organic psychosis (4%), PTSD (3%), mania (3%), somatization (2%), intellectual disability (2%) and other types (5%) (Somasundaram, et al., 1999). However, both the study by the Royal University of Phnom Penh and the study by Somasundaram, et al., (1999) also found that women possessed a higher degree of mental disorders when compared to men. In comparison to the higher number of male patients expected in psychiatric clinics across the globe, the mental health of women in Cambodia requires particular attention (Schunert, et al., 2012; Somasundaram, et al., 1999). Both studies infer that women will continue to be the largest group requiring mental health services (Schunert, et al., 2012; Somasundaram, et al., 1999). A possible reason for this statement is the high level of violence that women with Cambodia experience such as intense forms of physical violence and domestic violence (Astbury & Walji, 2014).

Neurological Disorders

Emerging research has found that trauma symptoms lesson overtime and other psychological symptoms such as mood disorders can take precedent (Cantor-Graae, et al., 2014; Jegannathan, et al., 2015). Jegannathan (2015) argues that mental health research in Cambodia is overtly trauma focused. More recent literature has highlighted that other mental health problems and neurological disorders including anxiety, mood disorders, psychosis, attention deficit hyperactivity disorders, seizure disorders and autism are equally gaining ground in Cambodia (Jegannathan, et al., 2015; Zook, 2010). Supporting this view is the joint report by World Health Organization (WHO) and Handicap International indicating that neurological disorders are the most concerning pathologies in the 21st century (Handicap International, 2011). Additionally, forecasts of neurological disorders are estimated to increase by 50% by 2020 (Handicap International, 2011).

Psychological Distress

A great deal of literature on psychological distress has focused on addressing poverty and discrimination as major contributors (Jegannathan, et al., 2015; Palmer, 2011; Seponski, et al., 2014). Specifically, the research found that the unequal distribution of resources especially in low income countries and the lack a of human rights model had a negative effect on mental health (Seponski, et al., 2014). As a result in the lack of material for basic needs, poverty was prolonged and continued to exacerbate poor mental health (Seponski, et al., 2014). This can include the lack of shelter, food, access to education and healthcare and basic mental health needs (Seponski, et al., 2014). Social factors such as the lack of basic needs, financial worry, family welfare, socioeconomic insecurity, human resource constraints and intimate partner violence also contribute to significant psychological distress (Cantor-Graae, et al., 2014; Jegannathan, et al., 2015). However, recent studies have begun highlighting the importance of understanding cyclical life events, the context of family and the influence of poverty, war and natural disasters on psychological distress (Seponski, et al., 2014). As a result, life events as a result of extreme poverty must be considered, as it is a major contributor to long term trauma and significant psychological distress (Seponski, et al., 2014)

Positive Mental Health

There remains very little studies on positive mental health and the major emphasis on mental disorders (Seponski, et al., 2014). When compared to the emerging literature of post-traumatic growth and positive change, there is minimal consideration on such benefits as a result of suffering in Cambodia (Zoellner & Maercker, 2006). Therefore, more research attention needs to be given in this area of mental health in Cambodia.

Mental Health – Lived Experience

Many studies have attempted to explain how both external factors and internal factors are interconnected and influence living experiences (Mollica, et al., 2014). Firstly, one study found that there was a strong correlation between mental health problems and decreased health and physical functioning (Mollica, et al., 2014). Respondents who had PTSD and depression experienced lethargy and found difficulty participating in daily routines and activities (Mollica, et al., 2014). Secondly, the study established the fact that personal and social factors such as age and gender is correlated to poor mental health outcomes and individual living experiences (Mollica, et al., 2014). Specifically, females experienced a higher level of depression and PTSD (Mollica, et al., 2014). Thirdly, ongoing threat to security were found to exacerbate mental disorders and every -day living (Mollica, et al., 2014). The author highlighted that transition from a totalitarian regime and consolidating a democratic government is also an ongoing traumatic experience (Hein, 2015; Zook, 2010). However, the study concluded that daily stressors were substantially more critical in triggering adverse psychiatric reactions and psychological distress than historical trauma (Cantor-Graae, et al., 2014; Mollica, et al., 2014).

Mental Health – Cultural Construction

Historically and culturally, mental health in Cambodia has often been minimized and denied (Hein, 2015). A major reason includes the lack of knowledge of mental health and the significant stigma around mental disorders (McLaughlin, 2012; Schunert, et al., 2012). Hein (2015) found that stigma is the largest contributor to the silence, fear and ignorance within communities regarding mental disorders. Additionally, the author links the cause of this perception to the long term politically agenda to portray mental disorders as insanity (Hein, 2015).

A number of authors have found that Cambodians believe that the cause and origin of mental disorders is multidimensional including religious, spiritual, psychological, biological and physical (Coton, Poly, Hoyois, Sophal, & Dubois, 2008; Seponski, et al., 2014). From a spiritual perspective, Cambodians believe that psychological symptoms are the results of curses, karma, witchcraft and ancestral influences (Coton, et al., 2008; Seponski, et al., 2014). Psychologically, Khmer people also associate a mental disorders as a result of having a “weak” heart, overworking, too much thinking, or possessing a brain or nerve damage (Coton, et al., 2008; Seponski, et al., 2014). As the Khmer culture sees the body and mind as an interconnected unit, having a disability also constitutes to having a weak mind (Carter, 2009; Gartrell & Hoban, 2013; Vanleit, 2008). Biologically,

it is also possible to believe that a mental disability stemmed from heredity (Coton, et al., 2008). In general, people with mental disorders are often regarded by other educated members of society as being unable to recover and require medical treatment (Hein, 2015).

Mental Disorders – Culturally Experienced

Mental disorders such as PTSD and panic disorders are culturally experienced in Cambodia (Hinton, Hinton, Um, Chea, & Sak, 2002; Hinton, Um, & Ba, 2001a, 2001b; Hinton, Pich, Chhean, & Pollack, 2005; Schunert, et al., 2012). There are three major symptoms, which have been studied extensively and are acknowledge as the local manifestation of PTSD and panic disorders (Hinton, et al., 2002; Hinton, et al., 2001a, 2001b; Hinton, et al., 2005; Schunert, et al., 2012). Specifically this includes the wind attack, the sleep paralysis ("ghost pushes you down") and the weak heart syndrome (Hinton, et al., 2002; Hinton, et al., 2001a, 2001b; Hinton, et al., 2005; Schunert, et al., 2012). People who experience such symptoms are severely stigmatized by the community and people with schizophrenia are often treated inhumanely (Hinton, et al., 2002; Hinton, et al., 2001a, 2001b; Hinton, et al., 2005; Schunert, et al., 2012). Particularly in rural areas, people with schizophrenia experience caging and chaining from months to years (Schunert, et al., 2012). As a result of significant macro influence, remain the major factors that prevent people from accessing care in Cambodia (Hein, 2015; McLaughlin, 2012; Schunert, et al., 2012; Seponski, et al., 2014).

Mental Health Services Overview

Introduction

Most published research identifies that mental health services in most low-income countries such as Cambodia institutionalize, pathologies people with mental disorders (Handicap International, 2011; McLaughlin, 2012; Schunert, et al., 2012). Specifically, there are accounts of violence, torture, rape, sexual assault, forced injections and unsanitary living conditions for those who are institutionalized (McLaughlin, 2012). Additionally, many research urges that this type of mental health service remains inhumane, rudimentary and unsustainable (Handicap International, 2011; Schunert, et al., 2012). Literature challenges the need for more primary and acute psychological therapies but for increase in promoting community (Seponski, et al., 2014; Stockwell, et al., 2005). Despite significant efforts from NGOs to develop more community based mental health services, the lack of funding and effective collaboration among key stakeholders continue to prolong this process (McLaughlin, 2012; Schunert, et al., 2012).

Almost all literature emphasizes the limited number of psychiatrists, psychologists, and mental health workers available in Cambodia (Astbury & Walji, 2014). Specifically, authors estimate that there are 350 mental health care providers and 35 psychiatrists working in 10 different hospitals (Seponski, et al., 2014; Stockwell, et al., 2005). In other words, there is one psychiatrist to 530,000 people in Cambodia (Coton, et al., 2008). Apart from public and private hospitals, community services are scattered, under trained and almost entirely inaccessible to those living in remote and rural areas (Coton, et al., 2008; Seponski, et al., 2014). Despite a major focus on mental disorders, only minimal provisions have been offered to those who are extremely ill (Coton, et al., 2008). Particularly, schizophrenia is often completely poorly understood and as a result under detected (Coton, et al., 2008). Consequently, the overwhelming lack of research on Cambodia's mental health presents a major setback towards policy implementation and sustainable change (Seponski, et al., 2014).

Recent studies suggest that the lack of evidence based practice, limited understanding of mental health, poverty, natural disasters and war also render mental health services ineffective (Seponski, et al., 2014). The research found that many mental health services in Cambodia are overtly focused on diagnosing treatment and historical trauma (Seponski, et al., 2014). Authors argue that more attention but examines present issues, environmental factors and the underlying human rights issues (Gartrell & Hoban, 2013; Seponski, et al., 2014). These specifically includes, abject poverty, social vulnerability, domestic violence, corruption and the lack of access to basic human rights such as poor nutrition and limited access to education and health care (Seponski, et al., 2014). The location of the therapy were also important aspects that rendered mental health services unsuccessful (Seponski, et al., 2014). The lack of understanding the shame associated with obtaining mental health services was a major setback in individuals assessing services (Seponski, et al., 2014).

Lastly, the financial situation of most poor individuals were a major barrier in obtaining effective mental health care (Seponski, et al., 2014). Specifically, the limited financial resources were insufficient for long term care when compared to other pressing daily financial needs (Seponski, et al., 2014). As such, most individuals often access only a limited amount of mental health therapies without any continuation of the service (Seponski, et al., 2014).

Multidimensional Health Care

Cambodians engage in a multidimensional health care experience including both Western and traditional remedies (Somasundaram, et al., 1999). Specific to mental health, Cambodians seek engagement in a range of services such as Buddhist spirituality, herbal healing and Western psychology (Coton, et al., 2008;

Mollica, et al., 2014). Studies have found that traditional interventions have been found extremely helpful for those suffering with psychological distress (Somasundaram, et al., 1999). A wide range of factors specifically, socio-economic, socio-cultural, socio-political, race, religion, family support, education, awareness of services and the interpretation of disorders all contribute to health care decision making for Cambodians (Coton, et al., 2008).

Prior to seeking help from traditional healers, Cambodians engage in a series of remedial activities including recreation, Chinese herbal medicines, alcohol, gambling and support from close family and friends (Schunert, et al., 2012). At the point when symptoms do not alleviate, Cambodians will begin seeking help from traditional healers, incantations, fortune-tellers and monks (Coton, et al., 2008; Morgan & Tan, 2011; Schunert, et al., 2012; Seponski, et al., 2014; Somasundaram, et al., 1999). When symptoms increase or are not alleviated, a general practitioner may be sought to prescribe medication including Chinese medicines as well as Western services (Seponski, et al., 2014; Somasundaram, et al., 1999). Consequently, Cambodians will have spent a significant amount of money and up to two decades of remedial and traditional help, prior to accessing a Western mental health service (Seponski, et al., 2014). However, it is important to emphasize that the scarcity of Western mental health services as well as cultural norms majorly shape this pattern of decision making (Coton, et al., 2008).

Western Service

Similarly to rehabilitation services, most mental health services are led by Western NGOs (Schunert, et al., 2012). However, studies have found that many Cambodians do not understand the degree of difference between psychological and psychiatric needs (Somasundaram, et al., 1999; Zook, 2010). Research has found that most Cambodians have a high perception of Western services as predominantly distributing prescriptive drugs (Somasundaram, et al., 1999). It is argued that this type of mental health service are unsuitable for the range of psychological needs in Cambodia (Somasundaram, et al., 1999). As a result, there has been an influx of psychological needs into acute mental health facilities, which have caused overcrowding and an exhaustion of resources (Somasundaram, et al., 1999). Moreover, as acute psychological treatment require long term followings, Cambodians whom are found to neglect follow up appointments may not benefit in the long run (Somasundaram, et al., 1999). Yet, authors have found that in order to meet the expectation of Cambodians for service, mental health providers often prescribe placebos which have found to be somewhat effective (Somasundaram, et al., 1999).

Authors caution the focus on providing more Westernized mental health services, as this would under-utilize other resources and exacerbate poverty (Somasundaram, et al., 1999). Additionally, research found that many mental health services were ineffective due to the lack of cultural sensitivity (Seponski, et al., 2014). Statistics show that around 75% of the services in most developing countries lack the consideration of a human rights focus and an understanding between what constitutes to becoming cultural appropriate (Mollica, et al., 2014; Schunert, et al., 2012; Seponski, et al., 2014). In essence, services remain power imbalanced towards the expert, unaccountable to the community, insensitive to the unique needs of the community and absent of the need for advocacy for access, gender, economic and social inequities (Seponski, et al., 2014). As result, most authors claim that much of the mental health services in Cambodia remain irrelevant and in effective (Seponski, et al., 2014).

Yet, there are some evidence based, Western mental health services that practices with a culturally inclusive framework (Seponski, et al., 2014). Recent evidence has found that cultural sensitivity requires a deeper understanding on the unique construction of each community specifically it's history, political landscape, culture, gender, social and economic inequity (Seponski, et al., 2014). However, it is recommended that an equal amount of community services as well as clinical hospital services be provided in order to effectively meet the mental health needs of Cambodia (Schunert, et al., 2012). This can include traditional healers, community workers, community development, social work, public health, evidence based research, advocacy and policy change (Hein, 2015; Mollica, et al., 2014; Somasundaram, et al., 1999).

Determinants of Care

A few recent studies found that physical results, knowledge of mental health and facilities were influential in the choice of care (Coton, et al., 2008; Morgan & Tan, 2011; Somasundaram, et al., 1999). Although accessibility and poverty are major constraints, distance and finances were the least influential aspect in choosing the type of care (Coton, et al., 2008). Lastly, education was found to be the major predictor in choosing Western medicine (Coton, et al., 2008).

Overview Barriers

Barriers are pivotal in understanding obstacles and challenges, which shape the lived experiences of people with disabilities (Palmer, 2011). According to the social model, barriers all fall into three overarching barriers including the attitudinal, environment and institutional barriers indicated by the WHO (Gartrell & Hoban, 2013; World Health Organization, 2011). These barriers are a

major influence to the psychosocial needs of people with disabilities (Vanleit, 2008; Zook, 2010).

An overwhelming theme across all literature remains to be environmental barriers such as accessibility and mobility (Zook, 2010). Firstly, the design and construction of Cambodian rural homes are significant obstacles for people with movement related impairments (Vanleit, 2008). Specifically, Cambodian dwellings are built on high stills and often do include toilets (Vanleit, 2008). Moreover, rugged surfaces and muddy fields are a considerable challenge for those who have wheelchairs and other prosthetics (Vanleit, 2008; Zook, 2010). Major health care facilities located in the capital city are overcrowded, have narrow doors, multiple floors and inaccessible bathrooms, making accessibility for people with physical impairments extremely difficult (Vanleit, 2008; Zook, 2010).

Attitudinal barriers are also a considerable obstacle for people with disabilities. Authors highlight the government system of Cambodia as being infused with conflict, corruption, limited in human resources and have minimal funding (Seponski, et al., 2014). As a result, reforms for people with disabilities remain a low priority (Seponski, et al., 2014). Poor policy for people with disabilities limit life activities and further induces social exclusion (Handicap International, 2011). Consequently, people with disabilities continue to experience significant inequality, discrimination and stigma (Gartrell & Hoban, 2013; Palmer, 2011; Seponski, et al., 2014). These barriers are a major source of psychological distress for people with disabilities (Gartrell, 2010).

Poverty - Disability

Extreme poverty has an interdependent and cyclical relationship to psychological distress, mental disorders and disability (Gartrell & Hoban, 2013; McLaughlin, 2012; Palmer, 2011; Seponski, et al., 2014; World Health Organization, 2011). Specifically, it is argued that poverty perpetuates disability and that eradication of poverty cannot happen without including people with disabilities (Carter, 2009; Gartrell & Hoban, 2013; Parnes, et al., 2009). Yet, it is argued by several authors that the view that poverty is monetary remains narrow, oversimplified and rudimentary (Palmer, 2011; Seponski, et al., 2014). Authors argue that poverty must be seen and understood as a barrier to care on multiple levels (Palmer, 2011; Seponski, et al., 2014).

In Cambodia, disability has a direct and indirect impact on the individual, the family and the community (Durham & Hoy, 2013). Specifically, people with disabilities and their families face the loss of income, productivity and assets, exhaustion of resources and debt in order to meet travel and burdensome

medical expenses (Durham & Hoy, 2013; Palmer, 2011; Zimmer, 2006). Moreover, members of the family are prevented from earning an incoming and other activities in order to become full time carers (Cordier, 2014). These multidimensional strains and the inability to accumulate savings majorly contribute to significant social isolation, poor mental health and long-term intergenerational poverty (Durham & Hoy, 2013; Palmer, 2011).

Palmer's (2011) comprehensive critical literature on poverty in middle to low-income countries provides an extensive insight into the multidimensional poverty and social disadvantage faced by people with disabilities and their families. The first view includes the "basic needs approach" which considers deprivation of basic necessities including food, safety, clean drinking water, sanitation facilities, secure home, access to education and information (Palmer, 2011; Seponski, et al., 2014). More than 40% of the population in Cambodia lives below $1.25 USD a day and medical expenses are a considerable burden families with disability (McLaughlin, 2012). Specifically, people with disabilities and their families are required to redistribute their income towards these medical expenses, which prolongs pre-existing poverty (Cordier, 2014; Gartrell & Hoban, 2013). Secondly, the "capability approach" examines one's ability and their characteristics including age, gender and health status to convert means and resources into well-being (Palmer, 2011). Particularly, people with disabilities who face significant discrimination are often not able to obtain income and contribute to their families (Palmer, 2011). Lastly, the "economic resource approach" examines whether an individual's income is below the poverty line and their ability to cover the cost of their basic needs (Palmer, 2011). Palmer (2011) highlights the fact that people with disabilities in Cambodia face all three approaches to poverty. As a result, people with disabilities lack the funding to engage in care and services that they require (Palmer, 2011).

People with disabilities also experience poor social capital (Palmer, 2011). Social capital includes the value and benefits obtained from community interaction and support (Palmer, 2011). However, as a result of social discrimination and isolation, people with disabilities and their families are not able to leverage on social capital (Palmer, 2011). As a result, people with disabilities in Cambodia are considered the poorest among the poor and the largest and most marginalized people in the world (Gartrell & Hoban, 2013; Palmer, 2011; Stockwell, et al., 2005).

Poverty – Mental Health

Poverty has also been found to impact on mental health (McLaughlin, 2012). The extreme lack of resources creates an environment conducive to poor psychiatric health due to insecurity, uncertainty and vulnerability (Seponski, et al., 2014).

Specifically, poverty induces a socially frail psychosocial environment that exacerbates mental disorders (Parnes, et al., 2009; Seponski, et al., 2014). A frail social environment can include having lower birth rates, a lack of immunization coverage, a high rate of access to education, unemployment, underemployment and poor accessibility (Palmer, 2011; Parnes, et al., 2009). A study found that significant poverty and indebtedness is highly correlated to suicide (Jegannathan, et al., 2015). Specifically that when basic needs are not being met, mental health care remain a low level priority (Seponski, et al., 2014). It is clear that poverty creates a disabling environment of extreme hardship, social exclusion and powerlessness (Palmer, 2011; Seponski, et al., 2014). Therefore, central to policy change in Cambodia is the need to view poverty with a multidimensional perspective and to encourage and more integrated services (Palmer, 2011; Seponski, et al., 2014).

3. Study methodology

Study Objective

Based on the background described in the previous chapter, the aim of the research is to answer the following questions:

- To what extent is psychosocial wellbeing affected by individual and family experiences of disability?
- What are the current psychosocial coping capacities/strategies of people with a physical or mental disability and their families?
- To consider how the psychosocial wellbeing of people with disabilities compares with people without disabilities.
- To explore what current mental health services exist? Are those services accessible & inclusive of people with disabilities?
- What is the community response to people individuals with physical and mental disabilities?
- Who are the stakeholders, what are their approaches and experiences with dealing with people with different impairments, mental health issues? Is there any interest in partnering with HI & LD
- What are the existing barriers people with disabilities & their families face in accessing psychosocial health services?

Mixed Method Approach

The study methodology included a mixed method of quantitative and qualitative research using an iterative approach to ensure the best possible research

outcomes. The iterative approach uses the incremental analysis of each stage to help build, refine and improve processes and methodologies of the upcoming phases. The five-stage data collection process included a comprehensive literature review, focus group discussions (FGD), semi-structured interviews and surveys. Embedded within the research design is the inclusive process which ensures that people with disabilities are meaningfully and effectively participating in each process (Handicap International & French Agency for Development, 2015). The development of each research tool was conducted in conjunction with a person with a disability, the local Khmer team, Louvain Corporation, Queensland University of Technology and Handicap International.

Selection and Sampling Methods

The selection criteria for participants in the FGD, semi structure in-depth interviews and surveys include purposive sampling of people with disabilities and their families, community leaders and volunteers and key service providers within the province of Kampong Cham. A total of 230 participants were selected for this research project, which included an equal amount of male and females among each target group. A Khmer interpreter was present during the FGD and semi-structured in-depth interviews and a voice recorder was used to collect all the discussions Participants were explained about the research study and were required to sign consent forms to ensure voluntary and full participation. Expectations about the research were explained to participants at the beginning of each session and all questions pertaining to mental health services were referred to the appropriate staff at the PRC.

Qualitative Data Collection

Literature Review

The first stage included an in depth literature review of disability and mental health in Cambodia. A total of 60 articles were found which included grey literature and peer review journals from academic databases. The results from Scopus, EBSCOhost and PubMed databases using the keywords: “Khmer”, “Cambodia*”, “disability*”, “impairment”, “mental”, “psycho*”, “social”, “illness*”, “problem*”, “issue*”, “service*”, “care*” and “women” showed 40 relevant peer reviewed articles. Journals from 2000 – 2015 were chosen to ensure a contemporary review of literature. It is important to note that one seminal study from 1999 by Somasundaram, D. J., van de Put, W. A. C. M., Eisenbruch, M., & de Jong, J. T. V. M will used in this literature review, to draw upon the only study in Cambodia of people who have been clinical diagnosed with mental disorders.

Focus Group Discussions

The FGD was selected as a method to draw out views, options and the thoughts of key stakeholders in a short period of time. The questions were designed in conjunction with a colleague with a visual impairment, the Khmer team and partner organizations involved in the project. A total of 14 FGD were conducted with the total number of participants being 112 participants interview. The groups were run with men and women with disabilities separately to ensure that gender specific issues could be raised. The focus group discussions had the following selection criteria. The specific criteria for selection included people with disabilities included all ages, an equal amount of males and females across four types of impairments, those who demonstrated signs of psychological distress and a combination of established and new beneficiaries of the Physical Rehabilitation Centre. The same selection criteria were used to select family members. Two groups of community members were chosen according to commune location being Boh Khnour and Speu. However, two groups of service providers were chosen according to health centers including Chamkam Leu Referral Hospital and the Physical Rehabilitation Centre.

There were a total of eight FGD conducted among people with physical impairments from the Physical Rehabilitation Centre (PRC). The selection criteria included those who are suspected of having psychological distress, psychosocial disability, or positive mental health. The eight groups consists of the following:

- 2 groups of people with a disability caused by landmine injuries (male and female)
- 2 groups of people who has a disability due to road traffic injuries (male and female)
- 2 group groups of people who has a congenital disability (male and female)
- 2 groups of people with a physical disability caused by disease (male and female)

Two FGD were conducted among key stakeholders including health center staff, referral hospital staff, PRC staff and NGO workers. One group consists of, one manager, one head of physiotherapy, three social workers and two mobilization officers. The second group consisted of three nurses from Chamka Leu Referral Hospital and three nurses and two social workers from the Transcultural Psychosocial Organization Cambodia.

Two FGDs were conducted with family members and carers of those who have a physical disability from PRC. Lastly, two FGD was conducted with members of the community including communes, village health volunteers from two communities, Bok Knor and Speu.

Semi-structured in-depth interviews

There were 17 in-depth interviews conducted in total with the following key stakeholders.

- 4 stakeholders including:
    - 1representative of Provincial Health Department/Technical Unit in Health Promotion at Kampong Cham
    - 1 Operational Districts/Supervisor/Evaluator for the Health Centre and Hospital
    - 1 Chief of Disabled People Organization (DPO), Kampong Cham
    - 1 Executive Deputy of PoSVY
- 2 stakeholders:
    - 1 Doctor from the Referral Hospital Kampong Cham
    - 1 Head of Psychiatric Unit at Kampong Cham
- 5 stakeholders:
    - People with a physical impairment who demonstrated significant signs of psychological distress, psychosocial disability and positive mental health.
- 3 stakeholders:
    - Families and carers of those with a physical impairment who demonstrated significant signs of psychological distress, psychosocial needs.
- 3 stakeholder:
    - Influential community members

Quantitative Data Collection

Survey

The survey collection consists of 150 participants who have a physical impairment from all catchment areas of the PRC. This number also would consist of an equal amount of female and male participants. Two volunteers recruited from the PRC were people with physical impairments. The researcher and a staff member conducted a two-day training to explain the research study, the survey and to practice using the survey.

Limitations of the Research

A considerable limitation to the research includes the fact that all the participants involved in this research were recipients of the services provided through the Physical Rehabilitation Centre (PRC). The findings show that these services are factors that contribute to positive mental health. Specific services can include physiotherapy, social work support, livelihood support and

counseling. Therefore, the results of the findings may not represent that situation fully of those who have not accessed PRC services, however it can be concluded that for those who have not accessed the PRC services their situation may well be even more challenging.

There were major time constraints that during data collection period. As a result of this, live transcription was applied in order to provide more time for data analysis. Additionally, due to the lack of human resources, back translations of the transcriptions were not a viable option. However, extra clarification was made during the interviews to ensure a clearer understanding of each statement or idea that was verbalized by the respondents. As a result of time constraints, the analysis between the relationship of themes and other demographic variables other than gender and type of impairments were not conducted.

There were some language barriers as a result of the low level of education by participants and the lack of understanding of mental health. However, considerable efforts have been made to ensure understanding and that the Khmer interpreter and the research would debrief to ensure any points that were unclear. The Khmer interpreter was also a person with disabilities and was able to provide a better understanding of the context to the researcher when required.

One of the original survey collectors trained by the research had to return to their homeland. Therefore a replacement collector was assigned and trained by the focal person based in Kampong Cham province. An early limitation of the survey collection was that participant's ages between 0-10 were selected and family members and carers completed the surveys on behalf of the participant.

4. Quantitative Findings

Demographics

A total of 126 surveys were collected among people with physical impairments of both genders.

Impairment cause	Female	Male	Total
Congenital	22	17	39 (31%)
Disease	11	24	35 (28%)
Landmines	13	19	32 (25%)
Road Traffic	0	20	20 (16%)
TOTAL	46 (37%)	80 (63%)	126 (100%)

Part 2: Disability

The first question aimed to discover how people with disabilities view themselves; these were their responses in order of the most common answers to least. The majority of respondents identified themselves as being proud. In contrast, people with disabilities also saw themselves as pitiful. What is interesting in this data is the extreme contrast between feeling proud and pitiful. The third highest view among people with disabilities is not being strong. Only third of the respondents identified as having less rights compared to others in the society.

Concept of Self	TRUE FEMALE	TRUE MALE	FALSE FEMALE	FALSE MALE
Proud	100%	96%	0%	0.3%
Pitiful	98%	100%	0.1%	0%
Not being strong	81%	81%	20%	19%
A useful member of the community	67%	67%	33%	32%
Knowledgeable	61%	67,5%	39%	31%
A medical case	56%	41%	43%	59%
Having poor health	52%	43%	48%	58%
Unable to do anything	43%	46%	57%	54%
Having less rights	37%	36%	63%	64%

Part 3: Definition of happiness

The table below illustrates how people with disabilities define what it means to be happy. The respondents voted hygiene, having good physical health and having money. The following table shows all the aspects encompassing happiness among people with disabilities from the highest to lowest.

Concept	Female	Male
Hygiene	78%	74%
Good body/physical health	78%	70%

Having money	78%	73%
Healthy mind	59&	65%
Sleeping well	54%	55%
Having friends	39%	55%
Feeling safe	23%	19%

Part 4: General feelings in life

The table below describes the general feelings that people with disabilities experienced. Only a third of the respondents felt worried, regret, upset, embarrassed, lonely and angry all the time. Most people with disabilities identified feeling regret, upset and worried frequently. Additionally, they felt angry, upset, embarrassed, grief and loss sometimes. However, the majority of respondents also said they did not feel suicidal, the need for alcohol or felt like giving up.

All the time	Female	Male
Worried	26%	27%
Regret	22%	19%
Upset	15%	13%
Embarrassed	13%	16%
Lonely	9%	15%
Devalued	7%	0%
Grief/loss	4%	4%
Overwhelmed	4%	4%
Angry	2%	0%
Crying/Giving up	2%	1%

Frequently	Female	Male
Regret	50%	40%
Upset	48%	39%
Worried	43%	29%
Angry	33%	20%
Crying	29%	19%
Embarrassed	26%	16%
Grief and loss	24%	15%
Overwhelmed	22%	13%
Lonely	17%	12%
Unable to sleep	13%	6%

Dizziness	11%	6%
Afraid/scared	9%	3%
Devalued	7%	5%
Giving up	2%	4%

Sometimes	Female	Male
Crying	60%	36%
Angry	52%	58%
Grief/loss	43%	49%
Dizziness	40%	36%
Embarrassed	33%	35%
Upset	30%	48%
Unable to sleep	28%	27%
Afraid/Scared & Devalued	24%	29%
Worried	20%	31%
Overwhelmed	20%	29%
Lonely	17%	18%
Need alcohol	4%	25%

Part 4a: Confidence before and after impairments.

The questions below were used to measure how disability impacted on confidence. The respondents identified that they have loss of confidence as a result of disability.

Confidence	Female	Male
impairment	Sometimes	Sometimes
After impairment.	Never	Never

Part 5: Depression, Anxiety and Stress Score. DAS-21

The Depression, Anxiety and Stress Scores (DAS-21) was as a tool adopted to measure the level of psychological distress for people with physical impairments. However, a significant amount of data could not be used as a result of discrepancies within the data. To ensure accuracy in the DAS-21 scores, only 70 results were used including 27 female responses and 44 male responses. The results below are measured according to the DAS-21 scales.

The results show that men had extremely severe stress compared to women. However, women still showed extremely severe depression and severe anxiety and stress levels. These results confirm the hypothesis that people with disabilities experience a high level of psychological distress. However, whether they experience a higher level of psychological distress compared to people without disabilities requires further data of the psychological distress of people without disabilities.

Female Scores	**Depression: 16.76**	**Anxiety: 7.80**	**Stress: 30.5**
27 respondents	Extremely Severe	Severe	Severe
Male	**Depression: 14**	**Anxiety: 6.9**	**Stress: 30.5**
44 respondents	Extremely Severe	Moderate	Extremely Severe

Part 6: Impact on life

When asked what was the impact on the lack of income in the respondents life. The participants identified that the lack of income impacted on family, accessing services and hindered progress in life.

Impact on life	**Female**	**Male**
Family	98%	96%
Services	37%	39%
Lack of progress in life	36%	33%

Part 6.a: Impact on social relationships

In terms of social relationships, respondents identified that there was no difference in relationship before and after the impairment. This is rather surprising, as the focus groups and individual interviews showed isolation as a factor of concern. It is hypothesized that this part of the survey was not understood correctly, as the instructions to filling in this section means that there must be considerable impact.

Part 6.b: Types of discrimination

When asked about what types of discrimination respondents experienced, being blamed, teased and having bad words or swear words spoken too, were the most common experiences. These experiences were identified equally by both genders.

Types of discrimination	Female	Male
Being blamed	65%	68%
Being teased	50%	54%
Bad/swear words	29%	24%

Part 6.c: Impact on expectations

In terms of the impact of disability on expectations, participants identified that their hopes for mobility, work and marriage were the most affected. The single most striking observation is the higher number of females indicating that the expectation for marriage was mostly affected.

Expectations	Female	Male
Mobility	56%	65%
Work	55%	66%
Marriage	73%	52%

Part 6.d: Impact on family

Participants identified that the largest impact on the family as a result of disability includes needing to be reliant on their partner and discrimination towards family members. It is important to note that more males indicated becoming more reliant when compared to females. Females experienced a higher number of being cheated upon, however men experienced more divorce from female partners.

Impact on family	Female	Male
Depending/reliant on partner	73%	81%
Discrimination to family members	50%	50%
Being cheated on	27%	4%
Divorce	0%	25%

Part 7: Services

When asked what services were the most and least accessed, exercise, free service and physiotherapy were the most accessed service, this is likely due to respondents being PRC clients. In contrast, material needs, livelihood and budget for education were the least accessed service.

Often	Female	Male
Exercise	84%	87%
Free service	84%	79%
Physiotherapy	74%	62%
Food & shelter	70%	70%
Counseling	59%	55%

Never	Female	Male
Material needs	93%	88%
Livelihood	69%	69%
Budget for education	66%	82%
Travel allowance	65%	63%

Part 7a: Services that contribute to positive mental health

The following table identifies the types of positive mental health mechanisms that are being used. Respondents identified that encouragement, peer support, having good relationships and socializing were the most important part of accessing services. They identified these as helpful in enhancing the sense of well-being.

Aspects that contribute to feeling good about life	Female	Male
Encouragement from others/peer support	96%	99%
Good relationship	82%	73%
Socializing	38%	25%
Finance/earning an income	29%	32%
Assistive devices	18%	25%
Awareness against discrimination	16%	13%

Part 7b: Location of services

Almost all participants identified as being located in Kampong Cham and accessing services in the PRC.

Part 8: Future Services

When asked about what future services the respondents would like, they identified 10 services as extremely important. These interestingly don't match with the services they identified that contribute to positive mental health, (see 7a)

Very Important	Female	Male
Assistive devices	100%	100%
Awareness raising of the rights/needs of people with disabilities	100%	100%
Government support for people with disabilities	100%	100%
NGO support for people with disabilities	100%	100%
Assistance with old ageing	100%	100%
Free health care	100%	98%
Counseling	98%	100%
Mental health services	98%	97%
Job opportunity/employment services	85%	74%
Getting I.D poor cards	85%	78%

5. Qualitative Findings

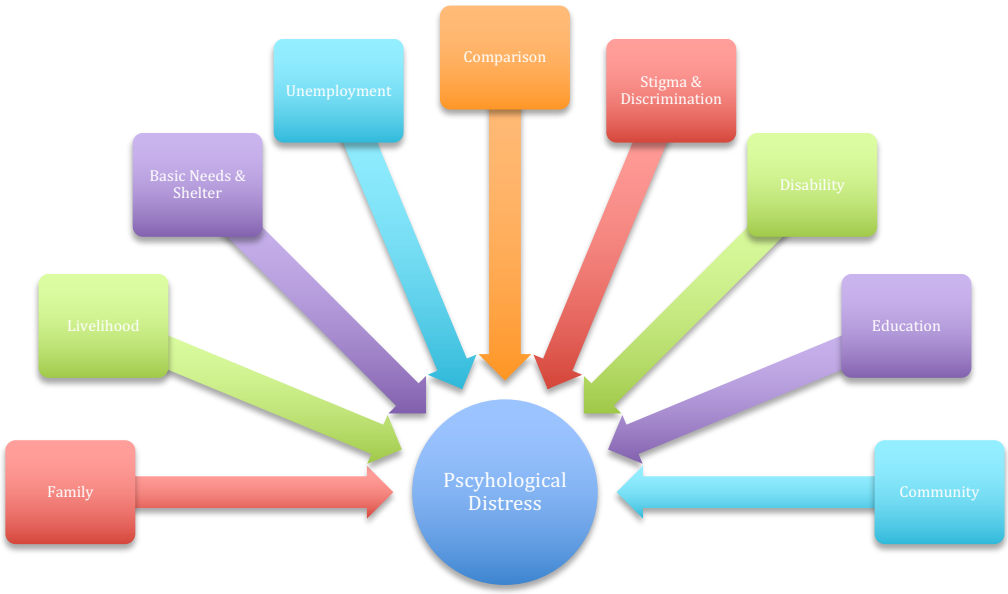
People with physical impairments and their families

1. The understanding of health and well-being within the Khmer context

The largest concept of health and well-being among both men and women with physical disabilities and among people with congenital disabilities revolved around being hygienic. Participants described having good hygiene such as accessing clean food and water, having a clean body through taking a bath and washing hands, and being in a clean environment such as a tidy and clean home. A larger proportion of women with disabilities describe having a good and functioning body and having no bodily illnesses, as well being.

The second largest concept of health and well-being was identified by participants as having income. The majority of participants expressed that income was associated with basic needs and livelihood. A smaller group of respondents identified that the lack of income as related to access to education. A very limited amount of participants identified income as effecting relationships with relatives and the wider community. A small amount of females with disabilities identified that socializing with other individuals with families with a disabilities was important to health and well-being.

2. How sadness, depression, distress anxiety (psychological distress) affect people with physical impairments and their families?



a. Livelihood

It has been identified across all focus groups that livelihood was the biggest contributor to psychological distress. Specifically, income was mentioned as the largest source to livelihood. Most participants identify the lack of welfare/social support and services provided by the government. However, families and people with disabilities often express that the expenses for medical treatment, travel expenses and medication become a major drainage on income, which contributes to their psychological distress. Many participants also reported the loss of assets including the selling of land, equipment and vehicles in order to meet daily living expenses. These participants reported significant psychological distress as a result of the loss of assets. Some male participants identified that the lack of livelihood affected their status within the community, which increased their psychological distress.

b. Basic Needs & Shelter

The lack of basic needs is often correlated to diminishing livelihood. Almost all participants express significant psychological distress as a result of the lack of food due to the inadequate income. Some participants expressed sadness that they lived in poorer living conditions as a result of the depletion of income. A small amount of participants identified anxiety as a result of the lack of safety in their home and in their community due to gangs.

c. Unemployment

Respondents identified that unemployment as a paramount cause to psychological distress. Participants explained that if the partner needs to become a carer then there is double loss of income. Specifically, respondents described the need to find external assistance, which may include obtaining loans and selling assets such as farmlands and motorbikes. People with disabilities and their families have described feelings of intense stress from being in debt and when asked for repayment of their loans. Respondents also identified the loosing of assets contributed to low self-esteem and a low sense of status in the community.

d. Family

Family was equally expressed as a major concern for all groups. Most people with disabilities identify dependents in the family such as children, partners and ageing parents as a significant source of concern. However, participants expressed to a great degree that the responsibility to take care of old ageing parents causes a substantial level of psychological distress.

e. Comparison

People with disabilities and their families have identified comparison as a source of psychological distress. For one participant, this was identified as a major source of suicide ideation. Individuals with a disability were comparing themselves against other families, siblings, and other people's children who are able to progress in life. An example includes one career saying that they couldn't walk, had to sell their motorbike and never owned a car as they had hoped like everyone else. There were also mothers that would compare their child to their other children and their friend's children. One participant said that his wife would lie to her work colleagues regarding her husbands' disability in order to save face. The lack of honor that the person with disability brings on the family was identified as a source sadness and psychological distress.

f. Stigmas and Discrimination

People with disabilities and their families identified stigma and discrimination as a major source of psychological distress. Participants, who had acquired impairment later in life, experienced a higher level of psychological distress. Participants commonly descried that neighbors become less friendly when compared to before. In one instance an English teacher was believed to be unable to control his class as a result of arm impairment. Additionally, the participants also identified that there is a strain and distancing from close relatives who used to admire his advice. Respondents identified that the lack of value on the opinions and views of people with disabilities isolates them in engaging in meaningful activities such as community decisions and confines the individual in their homes.

g. Impairment

The severity of impairment was a major determinant of the level of psychological distress associated to every living. A large amount of people with disabilities and their families considered daily tasks as a source of major psychological distress. Participants expressed the challenges of rural of infrastructure and significant environmental barriers especially when needing to use the toilet. Some participants have identified that despite having prosthetics the environmental barriers still make life extremely difficult for them, especially on poorly built roads. The level of dependence or independence was also a major determinant for psychological distress. For example, a substantial volume of participants identified that being highly dependent on their partners for everything was a source of high stress and sadness. In contrast, participants with assistive devices expressed less psychological distress as a result of their ability to be dependent.

h. Education

People with disabilities identified that not being able to attend school was a source of high psychological distress. Participants described environmental and attitudinal barriers such as long distance, inability to walk in the rain despite having the prosthetics and severe bullying and name-calling as being associated to education. One community health volunteer recounted that she knew one male adolescent with a disability who wanted to buy poisonous pills to commit suicide as a result of being unable to attend school.

i. Community

The community has been identified as a major source of discrimination, social exclusion and stigma, which contributes to psychological distress for people with disabilities and their families. People with disabilities and their families

described experiences of teasing, blame, and swear words, feelings of disgust, being looked at, mocking and harassment by the community members. Carers may experience significant blame for the child having a disability. In one case, the neighbors told the mother she should have let the doctors' injected medication to kill her daughter as a newborn instead of letting her live. As a result of significant discrimination, people with disabilities become isolated from the community and experience loneliness, which further exacerbates psychological distress.

Females with physical impairments

Almost all women identified sadness or "difficult in heart" as the most common feeling with physical impairments as a result of the lack of income. A large majority of participants identified the reason of sadness to not being able to do anything and expressing a different life. Some respondents expressed sadness as a result of feeling physically weak, loss of limb and loss of friends as a result. A few respondents expressed feelings of embarrassment due to having a weak leg and being divorced. A small amount of participants identified feeling nervous as a result of their inability to make an income, difficult in wearing shoes and discrimination and bullying at school. Only one participant said that they were angry because the community had encouraged her husband to divorce her as a result of the disability.

Family was identified being directly impacted as a result of psychological distress. Psychological distress made decision-making and conflict resolution with others and family members more difficult as they were constantly annoyed, were impatient and stressed. Conflict in the family can include saying bad words to each other, clashing with one another and feeling constant anger. In terms of social life, female respondents expressed feeling a lack of interest, being unable to socialize and feeling isolated and embarrassed.

There were general symptoms that were described by women with physical impairments including having severe headaches, dizziness, anxiety, body aches and a shaking heart. Some participants identified that they had to take medication and intravenous therapy to lessen the severity of the headaches and others had contemplated suicide. Only a few mentioned that they were sad because they stayed at home, lived alone, had poor balance and were unable to demand for better living conditions. Among female participants, who have identified that psychological distress impacted their daily life, specific examples included the inability to concentrate in daily activities such as work and studies, to think of new ideas and energy levels.

Some participants explained feeling undesirable and unsuitable for marriage was a significant source of sadness. One participant asked her husband to divorce her, as she wanted to protect him from embarrassment. Another participant said that her neighbors urged her husband to divorce her due to the disability. Some women shared that they were divorced once they obtained impairment.

Males with physical impairments

Males with a disability described a significant amount of psychological distress as a result of the wife needing to become the breadwinner and sole support for the family. Specifically this includes not being able to provide for the children's education. When asked what psychological distress did the males with physical impairments felt, the participants described feeling hopeless, stressed, anxious, scared, and a sense of grief and loss.

A second major reason for their psychological distress was identified as poverty. Specifically, participants associate poverty to poor living conditions, having poor parents, having low salary and no food. Other reasons that contributed to psychological distress include a variety of reasons including the disability, discrimination and being unable to contribute to the well-being and needs of the family.

Male participants who had road traffic accidents frequently expressed that they felt scared every-day and were easily traumatized. Specifically they expressed feeling scared of being in a car, being on someone's back or riding on the back of the motorbike. These symptoms may suggest signs of posttraumatic stress disorder.

Men with congenital disability demonstrated high levels of psychological distress that may lead to a psychosocial disability. Men with congenital disabilities express very little motivation during the interviews and have identified no source of positive mental health. One participant described feeling disempowered to remove his psychological distress. The participant mentioned that they have ideas but are unable to act upon them. Some participants felt disempowered to walk outside their homes and felt like that they had no more future. Among men with congenital disabilities very little positive mental health was identified. The only support identified included having relationships, socializing, having purpose, and being empowered and receiving assistive devices. There is little recognition of mental health issues or any solution to symptoms to mental health issues.

Families and Carers

Almost all carers expressed the significant hardship and duties related to caring for a person with a disability as a major source of sadness and distress. These carers often highlight the lack of family support, government support and poor living conditions they live in. Additionally, a large majority of carers reported that they lacked income to provide for themselves, the person with a disability and other dependents in the family and felt anxious about the future. Many carers often sell their assets and quit their jobs in order to become full time carers. Some carers expressed that they became isolated as a result of needing to become a full time carer and this made them feel lonely and sad.

Some carers identify that physical violence and emotional abuse from the people with disabilities of whom they are caring for, was a major source of psychological distress. Respondents described being blamed by the person with a disability, complaining and anger. Mothers who are often carers mentioned psychological distress as a result of the discrimination and bullying the children with disabilities face at school. A few carers mentioned that they had lower self-esteem and felt embarrassed as a result of their child who has a disability.

A considerable amount of carer's also described experiences of discrimination as a result of the child with a disability. For example, one respondent explained that she was blamed for her lack of education during pregnancy, which has resulted in the child obtaining a congenital disability. Significant psychological distress experienced by the carer may produce consequences such as blaming the person with a disability, wanting to leave the child with disability behind, becoming physically violent such as throwing things, wanting to run away and becoming emotionally violent and raising one's voice or shouting.

3. The positive mental health (optimism, self-esteem) of people with physical impairments and their families

The Physical Rehabilitation Centre (PRC) has been identified as the most dominant source of positive mental health among all people with disabilities and their families. Participants have identified that the PRC provided them with direct emotional and tangible support. Respondents gave similar examples including counseling, rehabilitation, assistive devices, advice on how to live in society, budget for education, shelter, food, financial assistance, material goods and physiotherapy.

The second largest source of positive mental health was directly to regaining ability to perform basic tasks. This is often described by participants as being able to engage in daily activities such as walking, working, bringing water, cooking and doing whatever they want. Carers and family members also acknowledged that seeing people with disabilities gain mobility was a source of

their joy and provided a sense of hope for them. The third source of informal psychological support identified by all participants is encouragement. Most participants identified that encouragement came from family members, the community and the staff at the PRC. Lastly, both people with disabilities and carers identified that keeping busy and entertained provided relaxation and relief from psychological distress. These included watching television, going to a scenic place, meeting friends, and singing as helpful.

Females with physical impairments

The largest aspect to happiness for women with disabilities was obtaining assistive devices that allowed them to be active and mobile. The activities identified included being able to work, carry water, cook, drive a motorbike, go to the market, wash clothes, clean the dishes and clean the house. A smaller amount of women expressed that being able to join traditional events, being independent and seeing others with similar problems contributed to feelings of happiness.

When asked about what contributed to positive mental health, females with physical impairments identified that encouragement and having work were the two important aspects. However, for families and carers it was seeing the child or person with disabilities get better. Religion, being active and gaining ability was identified as somewhat significant factors to positive mental health.

Males with physical impairments

In contrast to females, income was a major contributor to positive mental health for males with physical impairments. It was clearer among males with landmine injuries that progress was an important aspect of positive mental health. Other reasons that helped positivity included having a skill, being able to support parents, socializing, religion and having self-confidence.

4. To identify how psychological distress and positive mental health affect barriers and facilitators to services.

No participants identified that psychological distress (sadness, anxiety or distress) deterred them from engagement in services. However, positive mental health played a greater role in facilitating services. All groups identified regaining mobility as a major encouragement to return to service. A large number of people with disabilities and family members expressed that they were willing to overcome obstacles in order to meet with the supportive staff and others who shared similar experiences.

Community

5. The community understanding of psychological distress and positive mental health

When asked what psychological distress (sadness, anxiety or distress) meant, the community associated psychological distress mainly to chronic disease, poor living standards and poverty. Poor living standards included a lack of shelter and food. However, poverty was considered as living in poor conditions and owing money to people. Other reasons were given to explain psychological distress such as not having a way forward, unemployment, and lack of education, having too many children, compared to others and having no one to depend on. A few participants expressed that thinking a lot and being unable to sleep contributed to psychological distress. One respondent mentioned that lack of intellect is psychological distress.

The community identified that people with disabilities and their families experience anxiety, sadness and suicide ideation respectively. Participant associated anxiety to the lack of ability, low education, lack of income and unemployment. Sadness was attributed to divorce, discrimination and poor hygiene. However, suicide ideation was described when sadness and anxiety is exacerbated by discrimination such bullying and harassment.

The community identified counseling as a source of positive mental health. However, doing good, giving donations, working and receiving referral to mental health services were also common themes around positive mental health. Fewer activities were outlined as contributing to positive mental health including medicine, activities, and going to the doctor helpful for positive mental health.

6. What is the community response to people with physical impairments?

The main concept of disability among the community revolves around the notion of pity. Additionally, community members identify that with people with disabilities they are always in lack and require help. However, community leaders, key volunteers and members are aware that people with disabilities face and their families face significant discrimination and are vulnerable members of society. Specifically, most commune chiefs recognized that people with disabilities and their families are ostracized and rejected within the community. The community chiefs identified that they have made efforts to promote the rights of people with disabilities, fundraise from NGOs, reduce poverty and help make their lives better. Additionally, a community leader mentioned that he informs his team to pay attention, not ignore and treat people with disabilities and their families equally.

From conducting the interviews most community members and service providers admit that there is a lack of recognition, lack of confidence in ability and skills, a poor expectation of work performance and disbelief in work capacity of people with disabilities. Despite promoting people with disabilities to work hard, there is a severe limitation of appropriate job opportunities for people with disabilities or their family members who are full time carers. For example, one carer had to work irregularly to assist the child to get treatment but was fired and blamed for her inconsistent work schedule. For carers and people with disabilities, they express feeling hopeless and extremely stressed as a result of inflexible job opportunities.

7. The role of the community in effecting barriers and facilitators to services.

The community has identified that they provide a significant level of informal support such as encouragement, information distribution and charitable deeds. They have described their roles as providing items like noodles, rice, some budget and some chickens. The community volunteers were identified as playing a major role in raising awareness and distributing general information about public health, basic mental health, social services and domestic violence. One volunteer in the community expressed that there is a lack of available human resources within the community to meet all the needs of the family with children with disabilities. On some occasions the community leaders and volunteers encourage other villagers to help support people with disabilities and their families with material goods.

The community volunteers identified significant abuse for people with severe disabilities and may be the only source of detection. Specifically community volunteers were able to identify that when the people with disabilities have grown older, families and people move on and there is less care and attention towards them. A community volunteer gave an example of parents that were required to earn an income, who left the person with a disability alone without any meal in the house until their return. Although the community volunteer asked the families to take care of the person with a disability there was no action implemented and the advice was ignored. In contrast there are also cases of children who were neglecting the parent with a disability.

Service Providers & Stakeholders

8. The stakeholders understanding of psychological distress and positive mental health

The general view of the stakeholders towards people with disabilities is pity, the inability to work, lacking education and have poor living conditions. However, the degree of knowledge regarding the challenges and the level of psychological distresses that people with disabilities and their families face vary significantly between service providers. In general, service providers felt they were able to address general macro problems that cause mental health issues including the issues of poverty, lacking food, poor shelter, gender inequality, poor agriculture, not owning land, domestic violence, discrimination and alcoholism. Additionally, service providers were able to equate these issues to the lack of government influence, lack of human resources, lack of resources and the lack of research regarding the disability sector within Cambodia. Almost all service providers acknowledge that people with disabilities and their families face substantial attitudinal barriers within the community.

Mental health service providers stated they were able to address significant problems among the general population such as depression, suicide ideation, sleeping problems and psychosis but had very little contact with people with disabilities. Almost all service providers identified that discrimination by family relationships would often have an effect on psychological distress. When asked about strategies for positive mental health, most service providers said they offered friendly services, encouraging people with disabilities to avoid depression, get educated and that "one day they'll get honored for succeeding in life".

Service providers who are in high positions held a strong medical view, held common stereotypes and had little understanding about the psychological distress of people with disabilities and their families. This group described people with disabilities as lacking capacity, lacking the ability to achieve and lack the ability to think, are mostly beggars, don't have a future and experience discrimination. Yet, the respondents in high positions admitted that they lack knowledge and direct experience when working with people with disabilities. Specifically, they often explained that the frontline workers were trained but this information is not transferred through to leadership positions. They also explained that the demand on their role within a resource poor environment has not allowed them the availability to join these training events. As a result, most projects and policies lack the consideration of people with disabilities. One comment by this group was made that as people with disabilities are less productive therefore they are less valuable. Another comment was that people with disabilities become the responsibility of neighbors and pagodas.

Service providers in middle management were more aware of the macro, mezzo and micro challenges that people with disabilities face which constitutes to psychological disorders. They identified difficulty in finding employment,

struggle to perform work, lack opportunity and lack income. They were also able to relate these factors to poor quality of life, impacts on marriage, family conflict, discrimination, bringing dishonor to the family and domestic violence. Additionally, a service provider expressed that parents will often encourage their children to divorce their partner with a disability. Some service providers mentioned that families would hide people with disabilities and those who were married to a person with a disability had no future.

The head of the Disabled People's Organization (DPO) provided considerable insight on the psychological distress of people with disabilities. Specifically, that people with disabilities experience high levels of stress and anger as a result of discrimination and unemployment. Additionally, the respondent identified a comprehensive view of disability and other complex barriers including the psychological distress caused by puberty among young people with disabilities, the lack of inclusive education and high level of sexual abuse and discrimination among women with disabilities.

9. To what extent does psychological distress and positive mental health affect barriers and facilitators to services for people with physical impairments and their families?

Service providers experience significant frustration when providing services for people with disabilities. They identified experiencing abuse and frustration for the person with a disability. As well as this they stated family members would attend appointments instead of the person with a disability. As a result of this, service providers were not able to diagnose the illness and the family had incurred loss due to travel expenses to the hospital. Those who had experience working with people with disabilities described that the clients were angry, annoyed and impatient quickly. However, they also mentioned that people with disabilities experience significant opportunity loss as a result of travelling and are required to wait all day to be seen for appointments. Some providers offer extra medication to help people with disabilities and their families avoid travelling multiple times to services. Traditional healers were identified as a source of psychological distress as they drain finances on people with disabilities and incur further psychological distress. Some field interviews revealed that given the preconceptions related to mental health issues at the community level, visiting traditional healers could also help people to be better accepted in the community as they have tried to cure themselves following the traditional way. Some people with disabilities obtain debt to pay for traditional healers, which causes further psychological distress.

Who are the stakeholders, what are their approaches and experiences with dealing with people with physical impairments?

Service providers and community leaders have identified that advocacy and promoting international events that emphasize the rights of people with disabilities is critical. Raising awareness about lived experiences of people with disabilities to high-ranking officials and institutions such as hospitals, the government and the private sector is essential.

Service providers and community leaders also identified legal assistance for people with disabilities as paramount when dealing with people with disabilities and their families. Some service providers acknowledge that there is very little implementation of disability law and a lack of law to protect people with disabilities. Participants identified that people with disabilities and their families require assistance when they face accidents, domestic violence, abuse and other legal needs. Specifically, the chief recommended that education and warning to families about punishment if they abuse people with disabilities would help reduce the violence that happens in families. Education for families affected by disability includes how to have resilience and avoid abuse towards people with disabilities. Additionally, the community chief also mentioned that he would point people with disabilities to authority if they have needs regarding people and avoid becoming frustrated. The community chief said that once the need has been identified such as needing a job, they would contact or liaise with NGOs to help find them a job. However, service providers also acknowledge that the lack of budget and human resource is a major barrier to implementing legal assistance for people with disabilities.

Training of other government sectors that are not disability related was identified as an important strategy to increase the rights of people with disabilities. However, the community and service providers regarded NGOs as the main source for educating government sectors and providing awareness on the rights for people with disabilities. Additionally, NGOs were also regarded as the main source of support and avenue for employment for people with disabilities. It has been identified that community leaders and volunteers actively promote these hopes to people with disabilities that “one day” an NGO may provide free education and a job. Additionally, high-level officials identified that they should be involved training and workshop run by NGOs. However, service providers mentioned that international NGOs should help educate and raise awareness about policies and research for people with disabilities. Only a few service providers mentioned the need for further mental health education and training.

a. The current mental health services existing, are those services accessible & inclusive of people with physical impairments?

Service providers have identified that there are mental health services available at the hospital and health centers. However, service providers described that they have had very little exposure to people with disabilities and their families. Service providers identified that raising awareness regarding mental health through radio and poster are ineffective and home visits are the preferred way of transferring knowledge. Additionally, service providers explained that the individuals with disabilities and their families that had low-level educations required engagement with the information in order for the information to be effectively received.

In terms of accessibility, some service providers were able to identify the importance of carer's in accessing health care, the need for more awareness within the community regarding health services and the difficulties of travelling to services for people with disabilities.

b. What are the existing barriers people with physical impairments and their families face in accessing services e.g. physical, attitudes, practices, policies?

i. Lack of Knowledge

People with disabilities and their families experience services that lack appropriate design and sensitivity of their needs and lived experiences. Front line service providers at the health centers described the lack of accessible building facilities, the lack of appropriate processes for people with different types of impairments at the hospital (i.e. people who have a visual impairment or hard of hearing) and lack of toilet facilities for people with disabilities at the hospital. Respondents in high positions admitted that they have had no contact with people with disabilities and lacked the knowledge of their needs. They mentioned that many frontline workers would receive training but knowledge is not transfer to their level. Additionally, high-ranking officials identified that people with disabilities have not been included and considered in the design of services. As a result, people with disabilities experience significant adversity when using public services.

Service providers also explained that they do not have a clear understanding of the specific needs of people with disabilities including the prevalence rates of impairment in their community. The specific information that they identified to be useful included the number of people who required education, the number of male versus female individuals with disabilities, those who required financial assistance and those who needed assistance with employment. One comment

made was that people with disabilities don't experience barriers and challenges when accessing services. As a result, services for people with disabilities remain inconsistent among government services and NGOs.

ii. Lack of Resources

People with disabilities and their families do not receive access to government assistance and programs as a result of poor implementation. Specifically, the lack of human resources and budgets were the major source of their inability to action out these policies from the government. A service provider identified expressed that despite new laws being enforced by the government on disability, there has been very been a limited amount of implementation of those laws. Specifically, a charity box and a committee were formed for people with disabilities as a result of legal requirements but these programs have not been implemented. Some service providers ascertained that the community also lacked the necessary resources to effectively help people with disabilities and their families and this role belonged to the government. They have also indicated they many NGOs do not adhere to the rights of people with disabilities and were not able to operate practically according to policies.

iii. Charity Focused

Most service providers see people with disabilities as recipients of charity. However, this view is enforced as they expressed that people with disabilities and their family often request for monetary assistance. Despite this view, many service providers acknowledge this type of assistance as unsustainable.

Discussion on additional findings and conclusions

As a result of rich data obtained from the research, these themes have emerged that fall outside the scope of this research. However, this information provides additional depth and insight into the current discussions around mental health issues faced by people with disabilities. The additional discussions will address major themes that have emerged within the macro, mezzo and micro paradigm.

Macro: Collective Well Being

Disability impacts the individual and the entire family unit however this is even more evident within a collectivist culture such as Cambodia. It is clear that well-being is shared collectively within the family and especially for both the carers and of people with disabilities. People with disabilities are highly concerned about how their situation has impacted their families including their children, partners and parents. Similarly, family and carers experience significant psychological distress due to the lack of accessibility, uncertain future and

discrimination people with disabilities face. The complex dynamic that happens within a family that experiences a disability is the shift in roles and responsibilities and the lack of income.

Macro: Lack of rights for people with disabilities

People with disabilities and their families have very little knowledge and understanding about their rights. However, they are direct recipients of significant violations of human rights. At present there is a severe lack of advocacy and protection for people with disabilities and their families within the community against discrimination. Cares have expressed their frustration at the lack of authority against discrimination by commune chiefs within the village.

Macro: Institutional & Attitudinal Barrier

International literature has identified two universal norms that people with disabilities adopt in order to survive including, normalization and acquiescence (Tower, 2003). Normalization includes denying the disability and trying to portray an image of normality (Tower, 2003). This worldview often held by government and the public suggests that people with disability should "try harder" and be able to meet the same expectations of people without disabilities (Tower, 2003). However, the belief that once people with disabilities who achieve normality will be successful and be genuinely accepted in society is false (Tower, 2003). The idea of normalization is often strenuous, unachievable and unsustainable by people with disabilities (Tower, 2003). The view of normalization can also be considered as fundamentally viewing the problem of disability through the medical lens (Dupré, 2012). Specifically the medical model focuses on "fixing" a disease which can be healed (Dupré, 2012).

In contrast acquiescence is the norm of accepting the image of people with disabilities as vulnerable and behave accordingly to societies expectations in order to benefit from the charity of the community (Tower, 2003). However, this norm perpetuates the charity model and drives the persons with a disability to remain voiceless, disempowered and towards learn helplessness (Tower, 2003). The acquiescence model is conflicting against the social model as the person with a disability must behave in a non-conflicting and non-complaining attitude to maintain the norm (Tower, 2003).

From the research, all groups of people including the persons with a disability, families and carers, service providers and community leaders at all levels share both these views interchangeably. However, it is more apparent among community leaders and service provides to encourage the view of normalization. Although it has been identified that encouragement is given, it is infused with the notion of normalization. In one case, a mother of a young woman with a

disability said that her daughter felt significant pain from her prosthetic, was unable to maintain the workload and eventually had to quit. Most individuals with a disability who have assistive devices and have learned new skill sets remain unemployed and undesirable by most employers in Cambodia. This is especially true if the person with a disability is of old age.

It is possible that community members and service providers hold the view of normalization at a very superficial level. This shows that there is a lack of understanding on the reality of the lived experiences and a lack of a thoughtful process on helping people with disabilities. As people with disabilities eventually realize that the notion of normalization is futile, they will revert to the norm of acquiescence. Participants have all identified that the government has little or no real involvement in supporting people with disabilities. It is important to note that there are different degrees of acquiescence among people with disability as a means of survival.

It is important to recognize that often people with disabilities are among those with a low level of education and were in jobs that demanded physical labor such as farming. The lack of a limb, soft skills and education leave the person with a disability with very limited job opportunities. Additionally, the growing capitalist and market economy in Cambodia continues to emphasize the value of people as commodities. Along with the lack of advocacy for the rights of people with disabilities, the substantial environmental, institution and altitudinal barriers make obtaining a job almost impossibility.

Mezzo: The Concept of Pity & Attitudinal Barrier

The main concept of disability in Cambodia revolves negatively around the notion of pity. This concept perpetuates the norm of acquiescence, the charity model and continues to negate the social model. Most people with disabilities themselves, family members and the community member's associate disability with charity. As a result, the charity model remains infused in care, accessibility and relationships. As disability in Cambodia is view through the lens of Buddhism and entrenched pity, the lack of social welfare makes the norm acquiescence inevitable and encouraged.

Pity plays a critical part in the lived experiences of people with disabilities. As people with disabilities are seen to be unable to engage in a reciprocal relationship with society, they get eventually get socially excluded. As a result of the distancing relationships, fewer friends and a diminishing support network, people with disabilities must actively engage within the pity model to survive. The absence of support and government welfare makes the combination of pity and the norm acquiescence inescapable for people with disabilities. The lack of

alternative options makes people with disabilities in Cambodia trapped in a cycle of charity and the view of pity and the norm of acquiescence become more entrenched.

As people with disabilities engage in the norm of acquiescence, pity and charity becomes the ideal image and role of NGOs. There are significant preconceptions and of expectation held by people with disabilities, families, community leaders and service providers for NGOs to provide financial assistance, jobs and general help to people with disabilities. This view that is held by all key stakeholders perpetuates disempowerment, the charity model and further reliance on charity.

From these findings, it is clear that the social model as enshrined in the United Nations Convention for the Rights of Persons with Disabilities, and ratified by the Cambodian government, remains at the embryotic stage in the country. The concepts of adaptation of environment barriers, the renegotiations of the social definitions of people with disabilities and inversion of disability stereotypes in Cambodia remain minimal (Tower, 2003).

Macro: Unemployment

Unemployment for the people with disabilities has a considerable and detrimental impact on the family specifically partners and children. It is the norm that two members of the family are removed from the work force, including the person with a disability and the partner becoming full time carers. A major reason of the double loss of income is contributed to the environmental barriers and lack of appropriate facilities in rural homes. Specifically, the constructions of rural homes are devoid of the assistive devices available in the Global North that make living independently an impossible option. Therefore, not only are the partners removed from work to become full time carers, but also the role of carers is extremely important and much more laborious when compared to the Global North. Often these adjustments are a matter of survival rather than choice.

It is important to consider that loosing assets and resources continues to minimize opportunities for people with disabilities and their families and is a major contributor to a loss of status, low self-esteem, social disintegration and psychological distress. When people with disabilities and their families enter the cycle of poverty they begin to experience a lack of basic needs, a lack of support, a lack of solutions and a lack of opportunities for the future. An example includes children needing to quit school in order to help provide for the family. In other instances, the lack of basic needs means poor quality meals and living conditions. These aspects makes individuals with disabilities and their families loose confidence, become vulnerable to sickness and obtain more discrimination

as a result of being poor. In some cases families are required to sell all their valuable assets and beg in order to survive. It is clear that disability perpetuates and prolongs poverty and is identified as a major source of significant psychological distress and family conflict for individuals with disabilities and their families. It is also understandable that income is seen as the solution for their psychological distress.

Mezzo: Community & Attitudinal Barrier

The community has been identified as a major source of social exclusion, discrimination and stigma. Poverty and being unable to participate in a reciprocal relationship with the community was also identified as a reason to social isolation. Specifically this includes the ability to be able to contribute to physical labor such as building roads and financially contributing to social events. The view that people with disabilities are associated with begging, are unable to physically contribute and require pity from the community becomes a major hindrance towards social exclusion. For example, people with disabilities expressed that they are "cut off", refrained and are excluded from invitations to social events such as weddings and traditional celebrations.

This pertinent view of needing pity is also a major deterrence for people with disabilities as they consciously avoid attending special ceremonies at the pagoda or events due this particular stigma. Although there are some cases when the person with a disability is willing to help, there seems to be a lack of appropriate opportunities to action this. This isolation does not only involve the individual but often the whole family. As a result, the entire family experiences exclusion from civil society and psychological distress. Specifically, the family describes that people avoid talking to them at social events.

However, becoming socially isolated not only largely impacts on the psychological distress of people with disabilities but also becomes a barrier to accessing care. The community has also been identified as a source for accessing social services. As a result, it is important to note that being socially excluded from the community can mean that people with disabilities and their families are excluded from necessary social services that are provided through community leaders. For example, the lack social networks impact on getting information regarding treatment, which are often passed through word of mouth. There are also other cases of people receiving help such as transport to PRC. Other samples include not being able to obtain services such as getting ID poor card.

Participants have identified that they purposely deny attending events as a result of being teased or discriminated against by the community. One participant

identified that she did not want to travel anymore and is unable to participate in household activities.

Mezzo: Community & Discrimination

The discrimination from the community is significant against the child with a disability. One example used was that the neighbors did not allow their children to play with the child with a disability. The assumption was that the disability would transfer to the other children. This type of discrimination equally affects both the mother and father of the child with a disability.

There are some cases when the community says to the parents that the child with a disability will never recover. In one case the parent was told to put the child away in a center and that the child will be a burden to the family in the future. Despite significant discrimination by neighbors, all carers say that they would not give up on caring for the child. Additionally, discrimination does not affect the willingness to care for the child but psychological distress impacts the quality of care.

Mezzo: Roles and Responsibility

An emerging theme that has arisen in this research is the perceived role of male and female in the Cambodia context and how they impact psychological distress. There is a theme around males with a disability about the psychological distress as a result of the wife needing to become the breadwinner and the male not being able to provide and support the family. Specifically this includes not being able to provide for the children's education.

In contrast a common role for women in Cambodia is to be a supporter in the family. As a result, there was a major theme of blaming oneself for being reliant among women with disabilities. It seems like being dependent and relying on family members is a significant source of psychological distress. There seems to be guilt and self-blame that is connected to becoming reliant on others. This may be directed to the role of women having the role of a supporter and having a disability is a direct contrast to this. Although this has been mentioned some participants stated that psychological distress came from a lack of having anyone to depend on and the lack of support. The lack of having support can prevent participants in accessing care.

It is also important to consider that carers and women with disabilities have multiple roles within the family and are not isolated to just caring for the people with disabilities. There could be the addition of a sick child or ageing parents. In addition to this is the Khmer expectation for women to serve and look after parents. As a result, they can also become extremely restrained in their ability to

do any other activity. One example includes the carer not having enough time to eat.

Mezzo: Lack of education

Cambodians with a low level of education make job opportunities limited to hard labor such as farming.. As a result, people with disabilities with the lack of education or a low level of education are at an extreme disadvantage when applying for jobs. One participant identified that they felt “extremely stuck” and significant psychological distress. Therefore, it is imperative that people with disabilities receive education to help break the cycle of lack of opportunity towards employment.

Micro: Daily living experiences

An interesting theme to consider is the difficulty that people with disabilities face with their personal care such when needing to use toilets with access issues linked to the developmental context. This includes considering the lack of infrastructure and significant environmental barriers within rural areas. As a result, this is a major cause of psychological distress. It is important that the severity of disability will have an impact and determine the level of psychological distress. Participants have identified that despite having prosthetics the environmental barriers still make life extremely difficult for people with disabilities. This includes poorly built roads. Similar to adapting to limitation, many males with a disability expressed the grief and loss of their previous life and their abilities and skills prior to the impairment.

People with disabilities and their families also face a disappointment in their personal and professional goals. For example, both parents (husband and wife) initially wanted to become a tailor and motorbike repairer but now both have had to stop pursuing this as a result of their child who has a disability.

Micro: Carers

Being a carer for a person with a disability is a highly demanding role physically and emotionally. Carers are not limited to partners, who are often female, but children and ageing parents. It is important to consider the extreme lack of basic needs, social support and environmental barriers Khmer people face. As a result, carers for people with disabilities in a developmental context are extremely difficulty and will look very difficult compared to the Global North. Carers are often restrained and have a limited amount of social life and become isolated from the community. It is important to consider the lack of infrastructure, which makes caring for children in rural homes extremely difficult.

Carers are pushed the limit in terms of the role as a carer. One has mentioned that she had no time to relax or sleep. It is also important to consider the effort required in maintaining the treatment for the child including travelling time and loss of opportunity to work. Carers are often needed 24/7 during the day and the night for the children with complex needs as the child may be crying all night requiring the mother to soothe the child. Sometimes the carer may feel unwell yet are unable to care for themselves as a result of the excessive work required to care for the child with a disability. For carers with small babies who are required to work as a result of having no partner, take the babies to inappropriate work environments that may affect the child and the person working. For example, mothers have the child with a disability on her back in the hot sun while fishing. Carers say that the full time role of carer makes them lack the energy to work during the day. Although the carer spends the most time with the person with disability, it seems that families only engage in encouragement, financial support and physical care for the people. There is a lack of evidence suggesting that families in Cambodia provide adequate emotional and mental health support.

Micro: Family

Family was expressed as a major concern for all groups. However, it is important to consider the collectivist Khmer culture and the greater emphasis to take care of old ageing parents which may cause a greater degree of psychological distress. As a result, the inability to adhere to these expectations causes a significant feeling of shame and embarrassment.

Another example of family expectation was that young mothers were disappointed about their children with a disability compared to what they have expected for them. This includes grieving for their potential, future and the expectation to have a “normal” child. Similarly, the lack of knowledge about the rights for people with disability and the lack of welfare support for people with disabilities make the “unknown future” of these children a cause of significant psychological distress for mothers and carers. It is possible that this expectation is related to the expectation of the child being able to take care of the family later in life. In one case the mother identified that the significant pity she felt for her child made her considered committing suicide. This was also linked to the expectation that the child would grow up to have an education. She considered that her child having a disability was a major lost.

Family conflict was also raised as they experience arguing, clashing, wife getting angry and blaming the person with a disability. In some cases, the carers experienced a divorce as a result of having a child with a disability. Specific examples include the husband not listening to the wife or helping with the care

of the child with a disability. Women with disabilities experience significant family conflict to the point of divorce. Other types of conflict include saying bad words to each other, anger towards each other, clash, husband stop working and participants needing to sleep elsewhere as a result of family conflict.

Family discrimination and stigma often happen from those closest to the family including close relatives and neighbors. Discrimination of the child with a disability can happen among siblings. Other types of discrimination by neighbors and close relative can include being called names, being pestered by curious neighbors and being told that the person with a disability is not worth finding treatment. There is also a theme that relatives distance themselves from the family as a result of the disability. It is unsure whether this distancing is similar to the distancing that also happens as a result of poverty. This has been identified as a source of major psychological distress.

Positive Mental Health

Peer Support & Disability Culture

The concept of disability culture is the identification of values, beliefs and experiences shared among people with disabilities (Tower, 2003). It is clear from the findings that the Physical Rehabilitation Centre (PRC) is a place that embodies the disability culture. Most respondents describe feeling relieved when they are able to share their stories to those who have similar experiences. Specifically, mothers with children who have congenital impairments were greatly encouraged when they saw improvements for other children with similar impairments. Similarly, people with amputations who see others with prosthetics become hopeful that they would be able to walk again.

Encouragement

The greatest source of informal psychological support identified by all participants is encouragement. However, the encouragement given reinforces the norm of normalization. There is uncertainty whether this encouragement helps or hinders the psychological distress of people with disabilities. Yet, it is possible that the human connection is a more valuable experience than the words spoken through encouragement.

Despite, encouragement is a large theme in positive mental health it has been identified that most people within the community and even close family members are poor and are unable to contribute with material needs. As a result words of encouragement become a large part of positive mental health. Encouragement may come from close family members, relatives and individuals within the community.

Psychological Distress

Low value/low self esteem

A large majority of people with disabilities have a negative view of themselves. They say things such as "no one likes me", "my mother hates me", "I am lazy", "I think bad about myself". However, it seems that their sense of value is entirely based on their ability to perform and their ability to recover. Apart from being able to work, they have very little sense of intrinsic value. This gives insight into the lack of advocacy and awareness the rights of people with disabilities. As the reality of obtaining a job or regaining a job remains extremely difficult, the failure to do so may continually reinforce a low self-esteem of being invaluable and useless in society and become a major source of psychological distress.

Disability, Income and Social Life, Community and Other Relationships

Psychological distress caused by the disability, income, the community and other close relationships includes feeling of a loss of confidence, low self-esteem, anxiety, feeling stuck, upset, annoyed, loneliness, sadness, worry, unable to sleep, alcohol consumption, suicide ideation, regret, responsible, anger, tense, difficult and lacking in motivation.

Community

There is a significant disparity between the efforts made to address the rights of people with disabilities by the community leaders and the impact it has on people with disabilities and their families. Despite efforts by the community chief said fundraise from NGOs and stakeholders to improve the community, help make life easier for people with disabilities and reduce poverty, this is seldom the reality. As a result, there is a risk that the needs and psychological distress of people with disabilities are ignored throughout time while effort seems to be made among community stakeholders.

Although, the community leader mentioned that he informs his team to pay attention not ignore and treat people with disabilities and their families equally, this is also not experienced in real life. In contrast people with disabilities and their families express that the community is a major source of discrimination and psychological stress. Yet, a common proposed solution remains the norm of normalization. A common suggestion by community members and service providers is that if people with disabilities become successful that the community will honor, congratulate and find pleasure with them. There is no evidence of this from the data.

6. Recommendations

Recommendations based on literature review

Research Implications - Psychosocial Issues

The aim of the literature review has been to identify the psychosocial needs of individuals with disabilities, to gain further understanding about their lived experiences, and to identify existing barriers to accessing services. The review found that the type of impairment is a strong determinant of psychosocial issues (Palmer, 2011). There is a large emphasis on physical disability and mental disabilities, however those with an intellectual and sensorial impairment are less researched (Cordier, 2014; Coton, et al., 2008; Gartrell & Hoban, 2013; Zook, 2010). Despite their growing number and influence in decision-making, research on parents and carers of people with disabilities in Cambodia remain severely limited (Cordier, 2014; Coton, et al., 2008). Additionally, women with disabilities who experience significantly different psychosocial issues are also under researched (Astbury & Walji, 2014). It is not unexpected that data regarding community members are absent, yet this proposes a significant barrier towards understanding their influence on psychosocial issues. Moreover, data of services providers and individuals without a disability is also missing. Lastly, there has been no research on the issues experienced by those with comorbid impairment and illnesses. As a result of these severe gaps in literature, future research must aim to establish an understanding of the psychosocial issues of each population group. The findings should be used to frame future services and support for these key groups.

Research Implications - Lived Experiences

In the attempt to understand the lived experiences of people with disabilities, a large theme emerged around structural barriers for those with a physical disability. This includes the lack of infrastructure specifically in rural homes, schools and even hospitals in capital cities (Vanleit, 2008; Zook, 2010). Yet there has been minimal mention of the lived experiences of those with other types of impairments and those of carers and parents (Cordier, 2014; Coton, et al., 2008). There are common ideas around lived experiences of all people with disabilities and their families including poverty, stigma and discrimination (Gartrell & Hoban, 2013; Palmer, 2011; Seponski, et al., 2014). Specifically, most literature highlighted the exclusion of basic rights such as the right to have education, work and participate in civic society due to stigma (Astbury & Walji, 2014). However, only a limited amount of literature examined the physical illness and psychosomatic symptoms that are experienced due to a mental disability (Dubois, et al., 2004; Mollica, et al., 2014). Additionally, one significant study

found gender specific issues of such interpersonal violence (Astbury & Walji, 2014). There has been some literature that draws attention to the importance of daily stressors rather than historical trauma as a trigger to psychosocial issues (Cantor-Graae, et al., 2014; Mollica, et al., 2014). Equally important, is the focus on psychosocial suffering which stem from daily stressful situations rather than historical trauma (Handicap International, 2011; Jegannathan, et al., 2015). This can include examining the social environments that creates disability, vulnerability and social insecurity (Handicap International, 2011). Despite the need to appreciate the lived experiences of people with disabilities, almost all studies remained entirely negative. Future research must use existing data to build upon a more comprehensive understanding of lived experiences that also focuses on strengths and factors that contribute to positive mental health. This can include examining personality traits and factors that contribute and maximizes resilience, self-esteem and optimism (Handicap International, 2011). Lastly, there is a need for more local research being conducted through the lens of Cambodian academics, which will provide a more in-depth understanding of the cultural context and lived experiences of people with disabilities (Simcox & Strasser, 2010).

Research Implications - Barriers to Services

It is not surprising that the emphasis on physical disability has resulted in a large volume of literature on structural and environmental barriers in accessing services (Vanleit, 2008; Zook, 2010). There are some data, which focuses on issues such as poverty, institutional constraints and cultural beliefs which effect accessing services (Palmer, 2011; Seponski, et al., 2014). However, there remains an incomplete understanding of the types of barriers experienced by the range of impairments. However, it is apparent that services are culturally insensitive and lack integration (Seponski, et al., 2014). Furthermore, it is unclear which support remains the most effective (Coton, et al., 2008). An interesting finding showed that education and the awareness of services is a major determinant in service seeking behavior for parents (Coton, et al., 2008). However, this topic needs to be further explored across all types of impairments. These results may provide a greater understanding on the specific interventions in order to bridge and close the barriers towards support. Further research must be undertaken to ascertain ways to further empower people with disabilities and their families in overcoming barriers and engaging in services. Exploration of types of support beyond physical rehabilitation and acute psychiatric services is required. This can include examining community support intervention and prevention, personal recovery, psycho-education and community recovery frameworks (Hein, 2015).

Research Implications: Recovery Framework

The recovery framework that focuses on living with a mental health problem is advocated as an imperative framework for victims of trauma in Cambodia (Hein, 2015). Although this concept is recognized worldwide, only one literature by Hein (2015) has proposed this as a solution to psychosocial wellbeing in Cambodia (Wyder & Bland, 2014). This alternative framework proposed by Hein (2015) in his critical analysis of PTSD in Cambodia, views PTSD as a collective experience that is shaped by society. Specifically, the meaning associated with trauma is significantly influenced and constructed by cultural norms and power relationships (Hein, 2015). Additionally, the author argues that whether an experience is traumatic is entirely dependent on the subjective experiences of the individual (Hein, 2015). Therefore, the subjective traumatic experience is central in predicting a positive or negative mental health impact (Hein, 2015). From this theoretical viewpoint, several authors highlight that a paradigm shift from clinical cure to client empowerment and prevention is required in services and policies (Cantor-Graae, et al., 2014).

In addition to the one on one narrative technique used in Western recovery model, Hein (2015) promotes the sharing of collective stories within a collective therapeutic relationship (Hein, 2015). Yet, the logistical challenge remains the severe shortage of mental health services as well as the stigma associated with seeking help which has prevented the full effectiveness of this collective model (Hein, 2015). Moreover, there remains a significant amount of debate regarding the risk of re-traumatizing and psychological damage when sharing the stories, especially in association with the Khmer Rouge (Hein, 2015). Therefore, a collective recovery model remains dormant due to ethical and structural challenges in Cambodia (Hein, 2015). On that note, Hein (2015) argues that education and empowerment to engage in self-support recovery is the solution to mental health recovery in Cambodia.

Research Implications: Cultural Sensitive Framework

Poverty alleviation, a human rights framework and a culturally sensitive framework have been regarded as central to providing effective mental health services to people with disabilities (Astbury & Walji, 2014; Palmer, 2011; Seponski, et al., 2014). The research findings from Seponski (2014) recommends that poverty elimination, enhancing family relationships and improving the physical health of individuals should be conducted in conjunction with therapeutic interventions (Seponski, et al., 2014). It is also recommended that basic mental health counseling and psycho-education within a community context would be more appropriate in Cambodia rather than individual and highly specialized mental health treatments (Seponski, et al., 2014). Specifically this includes a group therapy model which uniquely address the corruption within politics in Cambodia (Seponski, et al., 2014). Additionally, the mental

health services must uphold processes that promote fairness, equality and advocacy as central when providing services (Seponski, et al., 2014). This includes promoting and fighting for the rights of people who are most marginalized, seeking to help alleviate the severe poverty and attempting to change public policy (Seponski, et al., 2014).

Research Implications: Integrated Services

There has been significant emphasis for the need for an integrated mental health care system that is underpinned by evidence based research, inclusivity and cultural sensitivity (Coton, et al., 2008; Gartrell & Hoban, 2013; Hein, 2015; Jegannathan, et al., 2015). Specifically, there needs to be services that examine the context of socio-historical, socio-economic and cultural systems that contribute to disability and mental health (Seponski, et al., 2014). Moreover, there needs to be more research, which validates traditional approaches, such as traditional healing, self-treatment, family consultation and spirituality in community mental health (Coton, et al., 2008; Mollica, et al., 2014). A key argument includes the understanding of culture, beliefs and expectation that traditional healers can provide (Coton, et al., 2008). However, as the majority of people with disabilities and individuals suffering from mental health issues live in rural areas and are extremely poor, an emphasis on community prevention and care is central (Gartrell, 2010).

Recommendations based on study findings;

1. Education on mental health by service providers including Louvain Cooperation and Handicap International.

Education on the mental health needs of people with disabilities and their families for all stakeholders is paramount.

1. Education on the importance of mental health alongside physical health.
2. Education for people with disabilities to understand high levels of psychological distress, which are mostly ignored, unknown and unaware.
3. Assisting families in understanding the psychological needs of people with disabilities.
4. Education on what mental health is and the psychological needs of people with disabilities to community members and service providers.
5. Education on the expectation of mental health care is and looks like. Many individuals with disabilities and their families expect medication as a form of treatment, a shift in this would be beneficial.

6. Education on the results of mental health recovery to be realistic. This includes specifying that the objective of the treatment be centred on relationship of support and recovery.

2. Education about disability (Disability Creation Process) by Service Providers including Handicap International.

The current perception of people with disabilities remains underpinned by the charity and medical model, which perpetuates stigma, discrimination and reaffirms negative stereotypes.

1. There also needs an equal amount of education to all key stakeholders regarding the lived experiences of people with disabilities. Although some service providers were able to identify some correlation between external environments and psychological distress, their knowledge remained rudimentary.
2. The DCP is a highly useful tool that can be used to demonstrate the complexity of disability and help key stakeholders to develop a high level of awareness of their role and of other factors that impact people with a range of impairments including those who face mental health problems and their families. For example, poverty and domestic violence are often linked together.

3. Education on rights for people with disabilities (Social Model) by Service providers including Handicap International and people with disabilities themselves as peer educators.

Education on the social model needs to increase to shift the dominant charity and medical view of disability, which continues to perpetuate significant stigma and discrimination.

1. This education is required for all key stakeholders as neither people with disabilities nor service providers genuinely understand the rights of people with disabilities.
2. Most important, this education needs to provide how the social model can be implemented on the ground level and within the developmental context. The problem remains the lack of understanding on implementation of policies.
3. This education also needs to move beyond the disability sector and to other government sectors such as education, health and employment.

4. Advocacy and awareness (Educational and Community Level) by service providers and the community and Disabled Peoples Organizations (DPOs).

Advocacy and awareness should happen concurringly with education in a way that is engaging and involves dialogue. One-way communication through media outlets such as TV, radio and posters may be have limitation and be ineffective. However, raising awareness in an educational way at the community level has been identified as more effective, especially for populations with low-level education.

1. All key stakeholders have expressed raising awareness on the rights of people with disabilities was paramount.
2. Raising awareness on the lived experiences of people with disabilities and their families, especially on psychosocial distress, discrimination, family conflict and domestic violence.
3. Raising awareness on the lived experiences of carers.
4. Advocating for the rights of women with disabilities especially within the family, health care and employment.
5. Advocating on protecting women with disabilities from domestic violence and sexual abuse.
6. Awareness on mental health and de-stigmatisation

5. Training by NGOs/ service providers, especially Handicap International and Louvain Cooperation.

The inability to implement laws and policies for people with disabilities in a way that is functional has been highlighted by service providers as a major barrier. Additionally, it is important to recognize that people with disabilities also require training and preparation when meeting with service providers in health settings. NGOs have been considered as the prime source for this training and the expert for services for people with disabilities.

Service Providers

1. Training needs to involve high-ranking officials where the design of policies and projects occur.
2. Training needs to facilitate an environment where high-ranking officials can have direct contact people with disabilities. This allows them to alter their perspective of inability to empowerment and break the perception of “us and them”.
3. Training/coaching frontline service providers on how to treat people with disabilities when providing health services.

People with Disabilities

1. Preparing people with disabilities to become more aware of how they present themselves with soft skills enhancement when accessing services.
2. Training people with disabilities on communication and how to navigate communication breakdown while accessing services.

6. Inclusion of people with disabilities in all processes by all service providers and the community.

People with disabilities are often forgotten and left out on processes that involve services for them.

1. People with disabilities need to be included in the education, training and design of programs and policies that involves them.
2. Encourage people with disabilities to express their opinions and ideas.
3. This is to adhere to the rights of people with disabilities and help ensure services are practical and functional in reality.
4. To keep people with disabilities at the fore front and in the minds of all key stakeholders.

7. Peer & Family Model by service providers.

Almost all participants have identified that relationships with others who share similar experiences and informal encouragement are the greatest sources of positive mental health. Therefore, relationships at the PRC, at home and within the community should be promoted and encouraged as a major source of mental health support for people with disabilities and their families. As such, further considerations for service providers to supply a mechanism for the following approaches:

- Family support, family networks and family groups.
- Peer support and peer groups.

Additionally considerations could be made in terms of:

- Fostering positive mental health
- Behaviour management
- Conflict resolution
- Protection issues (i.e. domestic violence, intimate partner violence)

8. Integrated services during design and implementation by service providers and community leaders.

As psychological distress is connected to psychosocial issues, it is critical to consider a holistic and integrated approach. As disability is complex and is a

result of external and internal environments, mental health services cannot be in isolated from assistance for livelihood, employment or education. It is equally important to consider providing mental health assistance in settings such as within one's home, within the community or at the health centers and hospitals as well as PRC. In designing a service for people with disabilities services must consider how to avoid additional expenses and opportunity costs for the family.

1. Stigma associated to mental health
2. Gender sensitive
3. Cultural sensitivity
4. Time & cost to travel
5. Opportunity lost for the person with a disability and their family
6. Opportunity lost for the carer to go to work
7. Dependents at home
8. Availability of carer
9. Accessibility
10. Staff having knowledge about people with disabilities

10. Better accessibility for People with Disabilities by service providers.

There continues to be poor accessibility for people with disabilities in health centers that provide medical and mental health treatment. Specifically, further consideration needs to be given to:

1. Ramps, toilets and waiting area for people with disabilities.
2. Appropriate signage for people with other types of disabilities.
3. A system that is user-friendly and priorities people with disabilities and their families
4. Communication information to reach people with disabilities and their carer in accessible forms using pictorial, braille and symbols. As well as systems and training of staff to communicate and work with people with disabilities.
5. Provision of outreach community services that reach out to the most vulnerable who cannot get to the services

10. Research

There needs to be further consideration on the psychological distress of other types of disabilities besides people with physical impairments. These may include people with other types of impairments but also in other contexts including those who do not receive services from the PRC and in other provinces.

Current research opportunities include:

- The prevalence rate of psychological distress of people with other types of impairments.
- The prevalence rate of mental disorders among people with physical impairments.
- The prevalence rate of mental disorders among people with disabilities across all types of impairments.
- The above topics targeting people outside the services of the PRC.
- A study on barriers and facilitators for families of people with disabilities.
- An in-depth study on accessibility to services for other programs within HI.
- A study on other services that people with disabilities and their families access besides the PRC.

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7. Appendix

Appendix 1

Focus Group Discussion Guide: People with physical impairment (12 questions):

Identification of psychological distress and positive mental health:

1. How do you feel about life right now?
2. Please describe what health and wellbeing is to you?
    a. What makes you happy?
        i. *Physical and mental well-being, disease free, full of physical movement and feeling happy*
    b. What makes you sad (anxious, depressed)?
        i. *Illness, no work, discrimination*
3. Please tell me what you think distress means?
    a. Where does feelings of sadness, anxiety and depression come from?
        i. *Thinking a lot, karma, infections, poverty, natural disasters, lack of employment, lack of income.*
    b. How do you think feelings of anxiety, sadness or depression can be cured/supported?
        i. Traditional healers, meditation, medicine, money, encouragement
    c. What feelings do you think help us to be happy in our lives?
        i. Optimism, self-esteem, confident
4. How does anxiety and sadness and depression… (psychological distress) affect/impact on your life (well-being)?
        i. ***Emotionally****: upset, frustration, lack of motivation, exclusion, isolation*
        ii. ***Body:*** *Stressful, tired, exhausted, overwhelmed.*
        iii. ***Self Esteem (Stigma):*** *Feeling bad as a result of negative perception, believing in karma and feeling condemned, feeling the need to compensate.*
5. How does having optimism, self esteem… (positive mental health) affect you and your life?
        i. *Better self esteem, socialising*

Lived experiences with psychological distress and positive mental health (social life, relationships, family)

6. How does sadness, depression (psychological distress) affect/impact on your social life?

i. *Limited access to education, work/livelihood activities and participation in community/social life (sport…).*
ii. *Difficulty, unable to help others, one-sided relationship*

b. Your relationships/colleagues/neighbours (positive and negative)?
   i. *Impatient, becoming negative, unable to control feelings, lonely*

c. Your family (positive and negative)?
   i. *Economic growth, less happiness compared to other family, stigma – reminded that family has a disability*
   ii. *Lack of savings, loss of income, lack of inclusion in decision making*

7. How does your community have an effect/impact on your feelings of sadness or anxiety (psychological distress)?
   i. *Loss of opportunity to volunteer lack of support from neighbours or discrimination/stigma or say bad word/impairment*
8. What are your experiences in your community, how does your community have an effect/impact on your feelings on your self-esteem, and happiness (positive mental health)?
   i. *Encouragement, feeling supported*

Access and barriers to services (please consider services beyond the PRC)

9. What types of support do you receive for your sadness or anxiety (psychological distress)?
   i. *Awareness/inclusion/and employment/counselling/medicine*

b. What things make it difficult for you to access these services/support/no support
   i. *Distance, infrastructure, transport, finances, attitude (Discrimination)etc.*

a. What things make it easy for you to access these services/support/no support

10. What types of support do you receive for self-esteem, optimism, happiness (positive mental health)?
    i. *Money, job, yoga, meditation, pagoda, village head, church, no support*

b. *What things make it difficult for you to access these services/support/no support*
   i. *Distance, infrastructure, transport, finances, attitude etc.*

b. *What things make it easy for you to access services/support/no support*

11. What support do you think you need for sadness, anxiety or depression you may feel (psychological distress)?
    I. *counselling (someone to talk things through and share problems*
    II. *groups of other people to be in contact with who share common problems*
    III. *medicine*
    IV. *family support and understanding*
12. Any other additionally information you would like to share?

Appendix 2

Family and Carers (12 questions): Identification of psychological distress and positive mental health:

1. How do you feel about life right now?
2. Please describe what health and wellbeing is to you?
    a. What makes you happy?
        i. *Physical and mental well-being, disease free, full of physical movement and feeling happy*
    b. What makes you sad (anxious, depressed)?
        i. *Illness, no work, discrimination*
3. Please tell me what you think distress means?
    a. Where does feelings of sadness, anxiety and depression come from?
        i. *Thinking a lot, karma, infections, poverty, natural disasters, lack of employment, lack of income.*
    b. How do you think feelings of anxiety, sadness or depression can be cured/supported?
        i. Traditional healers, meditation, medicine, money, encouragement
    c. What feelings do you think help us to be happy in our lives?
        i. Optimism, self-esteem, confident

4. Can you describe your experience of living with family members who have a physical impairment?
    a. What are the negative/difficult aspects?
        i. *Sad, embarrassed, low expectation of income, discrimination or stigma*
        ii. *Difficulty, unable to help others, one-sided relationship, tired*
        iii. *Stressful, tired, exhausted, overwhelmed.*
        iv. *Feeling bad as a result of negative perception, believing in karma and feeling condemned, feeling the need to compensate.*
    b. What are the positive aspects?
        i. *Happy, proud*
        ii. *Two way relationship*
        iii. *Coping well……*

5. How does sadness, depression or distress you may feel (psychological distress) impact on your care for your family member with a physical impairment?

Lived experiences with psychological distress and positive mental health (social life, relationships, family):

6. How does sadness, depression (psychological distress) affect/impact to your social life?
        i. *Limited access to education, work/livelihood activities and participation in community/social life (sport…).*

ii. *Difficulty, unable to help others, one-sided relationship*

b. Your relationships/colleagues/neighbours (positive and negative)?

i. *Impatient, becoming negative, unable to control feelings, lonely*

c. Your family (positive and negative)?

i. *Economic growth, less happiness compared to other family, stigma – reminded that family has a disability*

ii. *Lack of savings, loss of income, lack of inclusion in decision making*

7. How does your community have an effect/impact on your feelings of sadness or anxiety (psychological distress)?

i. *Loss of opportunity to volunteer lack of support from neighbours or discrimination/stigma or say bad word/impairment*

8. How does your community have an effect/impact on your feelings on your self-esteem, optimism and happiness (positive mental health)?

i. *Encouragement, feeling supported*

Access and barriers to services (please consider services beyond the PRC)

9. What types of support do you receive for your sadness or anxiety (psychological distress)?

i. *Awareness/inclusion/and employment/counselling/medicine*

b. What things make it difficult for you to access these services/support/no support

i. *Distance, infrastructure, transport, finances, attitude (Discrimination)etc.*

c. What things make it easy for you to access these services/support/no support

10. What types of support do you receive for self-esteem, optimism, happiness (positive mental health)?

i. *Money, job, yoga, meditation, pagoda, village head, church, no support*

b. *What things make it difficult for you to access these services/support/no support*

i. *Distance, infrastructure, transport, finances, attitude etc.*

d. *What things make it easy for you to access services/support/no support*

11. What support do you think you need for sadness, anxiety or depression you may feel (psychological distress)?

V. *counselling (someone to talk things through and share problems*

VI. *groups of other people to be in contact with who share common problems*

VII. *medicine*

VIII. *family support and understanding*

12. Any other additionally information you would

Appendix 3

Focus Group Discussion Guide: Service Providers/community members

Knowledge about psychological distress and positive mental health:

1. What does well-being (feeling happy and healthy) mean to a Khmer person?
    a. What makes people happy?
        i. *Physical and mental well-being, disease free, full of physical movement and feeling happy*
    b. *What makes people sad?*
        i. *Illness, no work*
2. Please tell me what you think distress means?
    a. Where does feelings of sadness, anxiety and depression come from?
        i. *Thinking a lot, karma, infections, poverty, natural disasters, lack of employment, lack of income.*
    b. How do you think feelings of anxiety, sadness or depression can be cured/supported?
        i. Traditional healers, meditation, medicine, money, encouragement
    c. What feelings do you think help us to be happy in our lives?
        i. Optimism, self-esteem, confident
3. What types of mental health problems (depression, anxiety, stress) do you think people with physical impairments have?
        i. *Cannot perform work properly, other people reject them.*
        ii. *Suicidal*
        iii. *Unable to earn money for family, therefore families will not look after them. Considered as outsiders.*

Attitude on psychological distress and positive mental health:

4. How does sadness, stress, anxiety, depression (psychological distress) affect people with physical impairment and their families?
5. How does optimism, feeling of control, self-esteem (positive mental health) affect people with physical impairment and their families?

6. How does sadness, stress, anxiety, depression (psychological distress) affect people with physical impairments and their families <u>access</u> services?
7. How does optimism, feeling of control, self-esteem (positive mental health) affect people with physical impairments and their families <u>assess</u> services?

Practice with those who have psychological distress and positive mental health:

8. How are you supporting people with anxiety, sadness, stress, anxiety, depression …… (psychological distress) who have a physical impairment?
9. What are the challenges you face when you provided services/supports to people with physical impairment and their families who experience sadness, stress, anxiety, depression (psychological distress)?
        i. *Slow recovery/progress and lack of motivation*
10. What are best ways to support people sadness, stress, anxiety, depression (psychological distress) with physical impairment and their family?
    a. *Encouragement*

b. Collaborate with hospitals to check accessibility

11. What are the best ways to support self-esteem and optimism (positive mental health) in people with physical impairments and their families?
12. Any other additionally information you would like to share?

END

Appendix 4

Mental Health Survey for People with Physical Impairments

To be completed by field team members. The person completing the form MUST make it clear in the Disability Type category box what type of impairment the individual has. The information gathered in this interview will help to understand the mental health of people with disabilities. Please ensure the consent sign if formed PRIOR to completing this survey.

INTRODUCTION

Thank you very much for making time available for this short survey. My name is…… and I am working as a (eg. volunteer) with Handicap International. One of my tasks are assist you complete this survey and clarify any points of concern. This feedback will help us further understand the needs of people with physical impairments. All responses will be confidential so please be open and do not hesitate to express your views.

Do you agree to participate in this survey? ☐ Yes ☐ No (end of interview)

Interviewer: _____

Date of survey: _____

PART 1: Socio-demographics (please ensure all the following are completed)

1. Name of respondent:
2. Age:
3. Gender:
4. ID file number:
5. Cause of impairment (please tick one):
    a. □ Landmines/UXO
    b. □ Road traffic/accident
    c. □ Disease
    d. □ Congenital
6. Nationality:
7. ID Poor Card Level:
8. Level of education:
9. Religion:
10. Ethnicity:
11. Location of village:
12. When did you receive your impairment (year):
13. Other health conditions (i.e blood pressure, diabetes):
14. Marital Status:
    a. □ Married
    b. □ Divorced
    c. □ Widowed
    d. □ Single
15. Role in the family (i.e father, mother, child):
16. How many members are in your household?:
17. Previous occupation of the person with disability before the disability:
    a. How much income per month (riel):
18. Current occupation of person with disability (i.e. unemployed, part time work, volunteer):
19. Who is the current income earner:
    a. How much income per month (riel):

Where possible the person with a disability to complete the following sections (if they need support then this can be provided)

PART 2: Disability

Which of the following statements applies to you? **As a person with disabilities, I view myself as….**	**True**	**False**
a. Knowledgeable		
b. Proud		
c. A useful member of the community		
d. A medical case		
e. Pitiful		
f. Having poor health		
g. Not being strong		
h. Unable to do anything		
i. Having less rights		

PART 3: What does it mean to be happy?

Which of the following are most important to you?	**Please rank the following from (1: least important to 5: most important)**
20. Hygiene	
21. Good/healthy body/physical	
22. Healthy mind	
23. Having money	
24. Sleeping well	
25. Having friends	
26. Feeling safe	

PART 4: General feelings in life

1. How often do you feel the following?	**Never (0)**	**Sometimes (1)**	**Frequently (2)**	**All the time (3)**
27. Angry				
28. Regret				
29. Upset				
30. Lonely				
31. Embarrassed				
32. Worried				
33. Suicidal				
34. Unable to sleep				
35. Need alcohol				
36. Dizziness				
37. Afraid/scared				
38. Crying				
39. Grief/loss				

40. Giving up				
41. Overwhelmed				
42. Devalued				

Which of the following statements do you agree with?	Agree	Disagree
43. Confident before the disability		
44. Confident after the disability		

PART 5: DASS-21

*Please read each statement and circle a number 0, 1, 2 or 3 which indicates how much the statement applied to you **over the past week**. There are no right or wrong answers. Do not spend too much time on any statement.*

The rating scale is as follows:

0 Did not apply to me at all
1 Applied to me to some degree, or some of the time
2 Applied to me to a considerable degree, or a good part of time
3 Applied to me very much, or most of the time

	0	1	2	3
45. I found it hard to wind down				
46. I was aware of dryness of my mouth				
47. I couldn't seem to experience any positive feeling at all				
48. I experienced breathing difficulty (eg, excessively rapid breathing, breathlessness in the absence of physical exertion)				
49. I found it difficult to work up the initiative to do things				
50. I tended to over-react to situations				
51. I experienced trembling (eg, in the hands)				
52. I felt that I was using a lot of nervous energy				
53. I was worried about situations in which I might panic and make a fool of myself				
54. I felt that I had nothing to look forward to				
55. I found myself getting agitated				

56. I found it difficult to relax				
57. I felt down-hearted and blue				
58. I was intolerant of anything that kept me from getting on with what I was doing				
59. I felt I was close to panic				
60. I was unable to become enthusiastic about anything				
61. I felt I wasn't worth much as a person				
62. I felt that I was rather touchy				
63. I was aware of the action of my heart in the absence of physical exertion (eg, sense of heart rate increase, heart missing a beat)				
64. I felt scared without any good reason				
65. I felt that life was meaningless				

PART 6: Impact upon life

What are the most significant difficulties you experience since having a disability? (Please choose only 3)	
a. Lack of income (if you choose this, answer the questions in BOX 1)	□
b. Social Relationships (if you choose this, answer the questions in BOX 2)	□
c. Discrimination (if you choose this, please answer the questions in BOX 3)	□
d. Expectations (if you chose this, answer the questions in BOX 4)	□
e. Family Relationships (if you choose this, answer the questions in BOX 5)	□

BOX 1: How does the lack of income affect you? (Please tick the top 3 multiple choice)

☐Family
☐Self esteem (status)
☐Services
☐Living standards
☐Discrimination
☐Lack of progress in life
☐Unable to obtain education
☐Social life
☐ Others _____

BOX 2: Social relationships (please skip this for those who have a congenital disability) Before having a disability my relationships;	**Excellent**	**Very good**	**Good**	**Fair**	**Poor**
3. With Friends were					

4.With Neighbours were						
After having a disability my relationships:						
3. With Friends are						
4. With Neighbours are						

BOX 3: What kind of discrimination do you experience? (Please tick only 3)

□ Being blamed
□ Being teased
□ People being unfriendly
□ Bad/swear words
□ Others being disgusted by disability
☐ Hate from others
☐ Lack of respect by others
☐ Lack of value by others
☐ Others thinking that the disability will transfer to them or other family members
☐ Others encouraging husband/wife to leave the person with a disability
☐ Discrimination from siblings
☐ Others _____

BOX 4: What do you hope for in your future? (Please tick only 3)

☐ Mobility
☐ Work
☐ Education
☐ Marriage
☐ Others (please specific): _____

BOX 5:Family (Please tick only 3)

☐ Abuse
☐ Being cheated on
☐ Depending/reliant on partner
☐ Discrimination to family members
☐ Divorce
☐ Domestic violence
☐ Others _____

PART 7: Services

	How often did you receive the service				**From who did you receive the service from?**				
1. How often do you receive the following services? (Please tick the ones that apply)	**Never**	**Rarely**	**Sometimes**	**Often**	**NGO**	**DPO**	**CBO**	**SHG**	**GOV**
a. Counselling									

b. Physiotherapy									
c. Material needs (clothes, books, pens)									
d. Travel allowance									
e. Livelihood									
f. Budget for education									
g. Food & shelter									
h. Free service									
i. Exercise									

2 What helps you feel better about life? (Please pick 3 options)	
a. Encouragement from others/peer support	□
b. Good relationship	□
c. Socialising	□
d. Services/involvement at PRC	□
e. Religion (meditation/pagoda)	□
f. Leisure activities	□
g. Finances/earning an income	□
h. Assistive devices	□
i. Awareness against discrimination	□

Location

Please tick all the location of services you receive:
☐ Kampong Cham ☐ Chamkar Leu ☐ Physical Rehabilitation Centre (PRC) ☐ Others _____

PART 9: Future Services

What services will be most useful for you in the future? (Indicate 5 most important services and rate accordingly)	**Very important**	**Somewhat important**	**Neutral**	**Somewhat unimportant**	**Unimportant**
☐Job opportunity/employment services					
☐Counseling					

☐Mental health services					
☐NGO support for people with disabilities					
☐Home visits					
☐Education					
☐Medication					
☐Social events at PRC					
□ Getting ID poor cards					
☐Free health care					
☐More health care facilities					
☐Assistance with old ageing					
□ Assistive devices (prosthetics, crutches or orthotics)					
☐Awareness raising of rights/needs of people with disabilities					
☐Government support for people with disabilities					

Thank you for participating in this survey.
END

Appendix 5

People with Disabilities Interview Tool

To be completed by field team members
The person completing the form MUST make it clear in the Disability Type category box whether the person has a disability or not.

Introduction; The information gathered in this interview will help to understand the mental health of people with disabilities. The information shared in the interview will not be linked to any individual by name.

Part 1: Basic Information about the person with a disability/person without a disability

<table>
<tr><td colspan="2">Name
Optional</td><td>Age</td><td>Sex</td><td colspan="2" rowspan="2">Disability Type</td><td colspan="3">Marital Status</td></tr>
<tr><td colspan="2" rowspan="2">Roles in the family:</td><td colspan="2" rowspan="2"></td><td colspan="2">Married</td><td></td></tr>
<tr><td>Physical</td><td></td><td colspan="2">Divorced</td><td></td></tr>
<tr><td colspan="2" rowspan="2">Status of the person in the family</td><td colspan="2" rowspan="2"></td><td>Sensory</td><td></td><td colspan="2">Women Headed Household</td><td></td></tr>
<tr><td rowspan="2">Cognitive/Intellectual</td><td rowspan="2"></td><td colspan="2">Widowed</td><td></td></tr>
<tr><td colspan="2" rowspan="2"></td><td colspan="2">Single</td><td></td></tr>
<tr><td colspan="2" rowspan="2">Income earner</td><td colspan="2" rowspan="2"></td><td>Mental</td><td></td><td colspan="3">Type of home</td></tr>
<tr><td rowspan="2">Health conditions, if so detail</td><td rowspan="2"></td><td>No Disability</td><td></td><td>Temporary</td><td colspan="2">Permanent</td></tr>
<tr><td colspan="2" rowspan="2">Unemployed</td><td colspan="2" rowspan="2"></td><td rowspan="2">Reid</td><td colspan="2">Brick</td></tr>
<tr><td rowspan="2"></td><td rowspan="2"></td><td colspan="2">Other</td></tr>
<tr><td colspan="2" rowspan="2">Income Generation Activity (Type)</td><td colspan="2" rowspan="2"></td><td rowspan="2"></td><td rowspan="2"></td><td>Clay/Sans</td><td></td></tr>
<tr><td colspan="3"></td></tr>
</table>

Part 1	
a. What does it mean to be “a person with disability”?	**Responses**
a. Perception before/after (Beggar/dependent/bad luck)	
b. Their role to yourself, family and society	
a. Karma/poverty/stigma/suicide	
b. Impact of these beliefs to yourself/family/well being	
Part 2	
a. How has disability impacted your life?	**Responses**
b. What was it like before/now?	

c. Level of independence/dependence/mobility levels /physical pain	
d. Impact on present goals/dreams/worldviews/future/family norms	
Part 3	
a. What has changed/why has it changed?	**Response**
b. Ability/lifestyle	
c. Family structure/each role/responsibilities before/after disability (married/divorce)	
d. Living standards/income/expenditures/what was cut	
e. Impact on yourself/children/relatives/neighbours/friendships	

f. Impact feelings and well-being	

Basic Needs & Livelihood	
a. What difficulties do you face in the following;	**Response**
b. Land/Physical assets c. Shelter quality and facilities d. Own land/farming plot/garden	
e. Safety f. Secure environment, feelings of threat, violence, conflict	
g. Food /water a. Getting enough food for all the members of your /yourself/household? b. Getting enough drinking and cooking water for yourself/ all the members of your household?	
h. Livelihood? i. Income generation activity/work/job j. Income (money, savings, debts) k. What was it like before/after? l. Effects on feelings? m. Impact on well-being and family?	

Educations and Vocational Training

a. How has your opportunities changed?	**Response**
b. Vocational training/job/career	
c. Motivation/time/availability?	
d. What was it before/what are they now?	
e. Effect on feelings?	

Emotional Well-being Part 1	
a. Please describe your emotions as a person living with a disability?	**Response**
b. Sad/happy/lonely/isolated/angry	

c. Cause/effect	
d. Triggers/impact?	
e. Suicide Ideation	
Emotional Well-being Part 2	
f. Can you describe how the following affects your emotions and vice versa?	**Response**
g. Family/neighbors/community	
h. Studies/work/social life	
i. Poverty/discrimination/government	
Emotional Well-being Part 3	

j. What does counselling/encouragement look like?	**Response**
k. Who/why/how/what is said?	
l. How effective?	
m. The impact?	

Community Social and Civic Life Part 1	
a. How has your community life been affected?	**Response**
b. Attending SHGs/DPO/District Federations	
c. Attending ceremonies such as marriages, funerals or initiation ceremonies	

d. Attitudes/beliefs/expectations regarding the community?	
e. What was it like before/what has changed?	
f. How does this impact your feelings, well-being and your family?	
Community Social and Civic Life Part 2	
g. How has discrimination impact you and your family?	**Response**
h. Poverty/gender/disability/religion/cultural norms?	
i. Person with disability, you, family	
j. What was it like before/what has changed?	

k. How does this impact your well-being and your family?	
Community Social and Civic Life Part 3	
l. What does it mean for you and your family to be included?	**Response**
m. Invitations/being informed/being treated as normal	
n. What was it like before/what changed?	
o. How does this impact your feelings, well-being and your family?	

Support and Relationships	
a. How have your social relationships been affected?	**Response**
b. Who? Social networks/work colleagues/	

c. What was like it before/what changed?	
d. How does this impact your feelings, well-being and your family?	

Recognition, respect, being heard	
a. How has your sense of "self value" changed as a result of a disability?	**Response**
b. One's rights/respect/opinions/value in society	
c. What was like it before/what changed?	
d. How does this impact your feelings, well-being and your family?	

Services and Accessibility Part 1	
a. What are the difficulties you face in in the following?	**Response**

b. Physical Accessibility a. Moving into & out of your home b. Moving around your home c. Using areas of your home, toilet, kitchen, bedroom	
c. Information Access a. Health care information b. Leaflets on service information c. Equity fund information d. ID Poor Card	
d. How does this impact your feelings, well-being and your family?	
Services and Accessibility Part 2	
e. What services are you accessing?	**Response**
f. Medication/Physiotherapy/Counselling?	
g. How did you find out/who informed you/why?	
h. Facilitators/barriers?	

i. Why/how long/who?	
j. Effective/ineffective? (Good/bad/helpful/unhelpful)	
k. Strengths/weakness/what's missing?	
l. Impact on family?	

Services and Accessibility Part 2	
m. What are the impacts of needing to access services?	**Response**
n. Needing a carer/need budget for travelling?	
o. Effect income opportunity/expenditures?	

p. Effects on family/any dependents at home?	
q. Expected impact on well-being and family?	
Services and Accessibility Part 3	
r. What are the best ways to support people with disabilities?	**Response**
s. Psychological distress/mental health/general health	
t. Accessibility/inclusion/anti-discrimination/training on disability	
u. Financial assistance/emotional support	
v. Excepted impact on well-being and family?	

Appendix 6

Family and Carers of People with Disabilities Interview Tool

To be completed by field team members
The person completing the form MUST make it clear in the Disability Type category box whether the person has a disability or not.

Introduction; The information gathered in this interview will help to understand the mental health of people with disabilities. The information shared in the interview will not be linked to any individual by name.

Part 1: Basic Information about the person with a disability/person without a disability

<table>
<tr><td colspan="2">Name
Optional</td><td>Age</td><td>Sex</td><td colspan="2" rowspan="2">Disability Type</td><td colspan="3">Marital Status</td></tr>
<tr><td colspan="2" rowspan="5">Roles in the family:</td><td colspan="3">Married</td></tr>
<tr><td>Physical</td><td></td><td colspan="3">Divorced</td></tr>
<tr><td>Sensory</td><td></td><td colspan="3">Women Headed Household</td></tr>
<tr><td rowspan="2">Cognitive/Intellectual</td><td rowspan="2"></td><td colspan="3">Widowed</td></tr>
<tr><td colspan="3">Single</td></tr>
<tr><td colspan="2" rowspan="2"></td><td>Mental</td><td></td><td colspan="3">Type of home</td></tr>
<tr><td>No Disability</td><td></td><td>Temporary</td><td colspan="2">Permanent</td></tr>
<tr><td colspan="2" rowspan="2">Status of the person in the family</td><td colspan="2" rowspan="2">Health conditions, if so detail</td><td rowspan="2">Reid</td><td colspan="2">Brick</td></tr>
<tr><td colspan="2">Other</td></tr>
<tr><td colspan="2">Income earner</td><td></td><td colspan="2" rowspan="3"></td><td>Clay/Sans</td><td colspan="2"></td></tr>
<tr><td colspan="2">Unemployed</td><td></td><td colspan="3" rowspan="2"></td></tr>
<tr><td colspan="3">Income Generation Activity (Type)</td></tr>
</table>

Part 1	
b. What does it mean to have "a person with disability" in the family?	**Responses**
c. Perception before/after (Beggar/dependent/bad luck)	
d. Their role to yourself, family and society	
c. Karma/poverty/stigma/suicide	
d. Impact of these beliefs to yourself/family/well being	
Part 2	
e. What are your experiences living with "a person with disability"?	**Responses**
f. Feelings, negative/positive experiences	

e. Impact to yourself, family and community	
f. Impact on present goals/dreams/worldviews/future/family norms	
Part 3	
g. What has changed/why has it changed?	**Response**
g. Family structure/each role/responsibilities before/after disability (married/divorce)	
a. Living standards/income/expenditures/what was cut	
b. Impact on yourself/children/relatives/neighbours/friendships	
c. Impact feelings and well-being	

Basic Needs & Livelihood	
n. What difficulties do you face in the following;	**Response**
o. Land/Physical assets p. Shelter quality and facilities q. Own land/farming plot/garden	
r. Safety s. Secure environment, feelings of threat, violence, conflict	
t. Food /water c. Getting enough food for all the members of your /yourself/household? d. Getting enough drinking and cooking water for yourself/ all the members of your household?	
u. Livelihood? v. Income generation activity/work/job w. Income (money, savings, debts) x. What was it like before/after? y. Effects on feelings? z. Impact on well-being and family?	

Educations and Vocational Training	
f. How has your opportunities changed?	**Response**
g. Vocational training/job/career	

h. Motivation/time/availability?	
i. What was it before/what are they now?	
j. Effect on feelings?	

Emotional Well-being Part 1	
n. Please describe the emotions you feel as a result of caring for someone with a disability?	**Response**
o. Sad/happy/lonely/isolated/angry	
p. Cause/effect	
q. Triggers/impact?	

r. Suicide Ideation?	
Emotional Well-being Part 2	
s. Can you describe how the following affects your emotions and vice versa?	**Response**
t. Family/neighbors/community	
u. Studies/work/social life	
v. Poverty/discrimination/government	
Emotional Well-being Part 3	
w. What does counselling/encouragement look like?	**Response**
x. Who/why/how/what is said?	

y. How effective?	
z. The impact?	

Community Social and Civic Life Part 1	
p. How has your community life been affected?	**Response**
q. Social events/attending/ being part of support groups such as Parent Groups, Women's Groups, and Social Groups.	
r. Attitudes/beliefs/expectations regarding the community?	
s. What was it like before/what has changed?	
t. How does this impact your feelings, well-being and your family?	

Community Social and Civic Life Part 2	
u. How has discrimination impact you and your family?	**Response**
v. Poverty/gender/disability/religion/cultural norms?	
w. Person with disability, you, family	
x. What was it like before/what has changed?	
y. How does this impact your well-being and your family?	
Community Social and Civic Life Part 3	
z. What does it mean for you and your family to be included?	**Response**
aa. Invitations/being informed/being treated as normal	

bb. What was it like before/what changed?	
cc. How does this impact your feelings, well-being and your family?	

Support and Relationships	
e. How have your social relationships been affected?	**Response**
f. Who? Social networks/work colleagues/	
g. What was like it before/what changed?	
h. How does this impact your feelings, well-being and your family?	

Recognition, respect, being heard	
e. How has your sense of "self value" changed as a result of caring for someone with a disability?	**Response**

f. One's rights/respect/opinions/value in society	
g. What was like it before/what changed?	
h. How does this impact your feelings, well-being and your family?	

Services and Accessibility Part 1	
w. What services do you help the person with disability access?	**Response**
x. Medication/Physiotherapy/Counselling?	
y. How did you find out/who informed you/why?	
z. Facilitators/barriers?	

aa. Why/how long/who?	
bb. Effective/ineffective? (Good/bad/helpful/unhelpful)	
cc. Strengths/weakness/what's missing?	
dd. Impact on family?	
Services and Accessibility Part 2	
ee. What are the impacts of needing to access services?	**Response**
ff. Needing a carer/need budget for travelling?	
gg. Effect income opportunity/expenditures?	

hh. Effects on family/any dependents at home?	
ii. Expected impact on well-being and family?	
Services and Accessibility Part 3	
jj. What are the best ways to support people with disabilities?	**Response**
kk. Psychological distress/mental health/general health	
ll. Accessibility/inclusion/anti-discrimination/training on disability	
mm. Financial assistance/emotional support	
nn. Excepted impact on well-being and family?	

Appendix 7

Community Member Interview Tool

To be completed by field team members

Introduction; The information gathered in this interview will help to understand the mental health of people with disabilities. The information shared in the interview will not be linked to any individual by name.

Part 1: Basic Information about the community member

Key Informants Frame *This tool is to be completed by the field team member to record discussions.* **Introduction;** The information gathered in this group will help to understand the mental health of people with disabilities. The information shared in the interview will not be linked to any individual by name.				
NAME (FIRST,LAST)		**GENDER**		
AGE		**TIME IN ROLE**		
POSITION		**DATE**		
LOCATION		**Other** **Please detail**		

Disability Part 1	
c. What does it mean for someone to have a "disability"?	**Responses**
d. The individual, family and society	
e. Perception before/after (Beggar/dependent/bad luck)	
f. Karma/poverty/stigma/suicide	
g. Belonging/future/role	
Disability Part 2	
h. What are your experiences of having someone with "a person with disability" in the community?	**Responses**
i. Attitudes/beliefs/expectations/perceptions	

j. Feelings, negative/positive experiences	
k. Compared to people without disabilities?	
Disability Part 3	
l. What changes do you think they experience in the family and why?	**Response**
m. Family structure/each role/responsibilities before/after disability (married/divorce)	
n. Living standards/income/expenditures/what was cut	
o. Impact on children/relatives/neighbors/friendships	
p. Impact feelings and well-being	

Basic Needs & Livelihood	
aa. What difficulties do you think people with disabilities and their families face in the following?	**Response**
bb. Land/Physical assets cc. Shelter quality and facilities dd. Own land/farming plot/garden	
ee. Safety ff. Secure environment, feelings of threat, violence, conflict	
gg. Food /water e. Getting enough food for all the members of your /yourself/household? f. Getting enough drinking and cooking water for yourself/ all the members of your household?	
hh. Livelihood? ii. Income generation activity/work/job jj. Income (money, savings, debts) kk. What was it like before/after? ll. Effects on feelings? mm. Impact on well-being and family?	

Support and Relationships	
i. How do you think their social relationships will have been affected?	**Response**

j. Who? Social networks/work colleagues/community/	
k. What was like it before/after disability?	
l. What would have changed? Why?	
m. Effects on feelings	

Educations and Vocational Training	
k. How has their opportunities changed?	**Response**
l. Vocational training/job/career	

m. Motivation/time/availability?	
n. Effect on feelings?	

Emotional Well-being Part 1	
aa. What emotions do you think people with disabilities feel as a result of a disability?	**Response**
bb. Annoyed/impatient/inexperienced/unsure/scared/hopeless/sad	
cc. Why? (poverty/lack of capacity/abuse)	
dd. Cause/effect	

ee. Triggers/impact on family/community?	
ff. Suicide Ideation?	
Emotional Well-being Part 2	
gg. How do you think the following affects the emotions of an individual who has a disability and vice versa?	**Response**
hh. Family/neighbors/community a. Seeing others progress b. Unable to borrow money/lack capital c. Unable to send children to school	
ii. Studies/work/social life	
jj. Poverty/discrimination/government	
kk. Gender/disability/religion/cultural norms	
Emotional Well-being Part 3	

ll. What does emotional support look like for a person with disabilities?	**Response**
mm. Who/why/how/what is said? nn. medicine/encouragement/counselling/doctors/empathy	
oo. How effective?	
pp. The expected impact?	

Community Social and Civic Life Part 1	
dd. What difficulties do people with disabilities experience when trying to be involved in the community?	**Response**
ee. Social events/attending/ being part of support groups such as Parent Groups, Women's Groups, and Social Groups.	
ff. Lack of access/discrimination/lack of money/lack of time/fear	

gg. Attitudes/beliefs/expectations regarding the community?	
hh. Compared to someone without a disability?	
ii. How does this impact their feelings, well-being and their family?	
Community Social and Civic Life Part 2	
jj. What support are you currently providing for people with disabilities within your community?	**Response**
kk. Up skilling/donations/encouragement/material goods	
ll. Facilitators/barriers/challenges	
mm. Why/how long/who?	

nn. Impact on person with disability/family/community?	

Community Social and Civic Life Part 3	
oo. How the community deal with discrimination?	**Response**
pp. Poverty/gender/disability/religion/cultural norms/person with disability/family	
qq. Why/how/when/who	
rr. How does this impact their feelings, well-being and their family?	

Community Social and Civic Life Part 4	
ss. How the community deal with abuse and domestic violence?	**Response**
tt. Person with disability and their partners/children/parents	

uu. Reporting/responding/advising/responsibility	
vv. Suicide/suicide contemplation	
ww. Impact on family and community	

Community Social and Civic Life Part 5	
xx. What does it mean to be included in the community?	**Response**
yy. Invitations/being informed/being treated as normal	
zz. What was it like before disability/what changed and why?	
aaa. How does this impact individuals, families and the society?	

Community Social and Civic Life Part 6	
bbb. What are the best ways to support people with disabilities?	**Response**
ccc. Home visits/conduct fund raisers in the community/talking	
ddd. Accessibility/inclusion/anti-discrimination/training	
eee. Who/when/how/where/why	
fff. How does this impact individuals, families and the society?	
n. What was like it before/what has changed?	
o. How does this impact their feelings, well-being and their family?	
Community Social and Civic Life Part 7	

p. How can the community play a role in increasing the sense of respect/recognition for someone with a disability?	**Response**
q. One's rights/respect/opinions/value in society	
r. Individual with disability/family/community	
s. Effects on feelings	

Appendix 8

Service Providers Interview Tool

To be completed by field team members

Introduction; The information gathered in this interview will help to understand the mental health of people with disabilities. The information shared in the interview will not be linked to any individual by name.

Part 1: Basic Information about the service provider

Key Informants Frame *This tool is to be completed by the field team member to record discussions.* **Introduction;** The information gathered in this group will help to understand the mental health of people with disabilities. The information shared in the interview will not be linked to any individual by name.				
NAME (FIRST,LAST)		**GENDER**		
AGE		**TIME IN ROLE**		
POSITION		**DATE**		
LOCATION		**Other** **Please detail**		

Disability Part 1	
h. What does it mean for someone to have a "disability"?	**Responses**
i. The individual, family and society	
j. Perception before/after (Beggar/dependent/bad luck)	
k. Karma/poverty/stigma/suicide	
l. Belonging/future/role	
Disability Part 2	
q. What are your experiences of working with "a person with disability"?	**Responses**
r. Attitudes/beliefs/expectations/perceptions	

s. Feelings, negative/positive experiences	
t. Compared to people without disabilities?	
Disability Part 3	
u. What changes do you think they experience in the family and why?	**Response**
v. Family structure/each role/responsibilities before/after disability (married/divorce)	
w. Living standards/income/expenditures/what was cut	
x. Impact on children/relatives/neighbours/friendships	
y. Impact feelings and well-being	

Basic Needs & Livelihood	
nn. What difficulties do you think people with disabilities and their families face in the following?	**Response**
oo. Land/Physical assets pp. Shelter quality and facilities qq. Own land/farming plot/garden	
rr. Safety ss. Secure environment, feelings of threat, violence, conflict	
tt. Food /water g. Getting enough food for all the members of your /yourself/household? h. Getting enough drinking and cooking water for yourself/ all the members of your household?	
uu. Livelihood? vv. Income generation activity/work/job ww. Income (money, savings, debts) xx. What was it like before/after? yy. Effects on feelings? zz. Impact on well-being and family?	

Support and Relationships	
t. How do you think their social relationships will have been affected?	**Response**

u. Who? Social networks/work colleagues/community/	
v. What was like it before/after disability?	
w. What would have changed? Why?	
x. Effect on feelings?	

Educations and Vocational Training	
o. How has their opportunities changed?	**Response**
p. Vocational training/job/career	

q. Motivation/time/availability?	
r. Effect on feelings?	

Emotional Well-being Part 1	
qq. What emotions do you think people with disabilities feel as a result of a disability?	**Response**
rr. Annoyed/impatient/inexperienced/unsure/scared/hopeless/sad	
ss. Why? (poverty/lack of capacity/abuse)	
tt. Cause/effect	

uu. Triggers/impact on family/community?	
vv. Suicide Ideation?	
Emotional Well-being Part 2	
ww. How do you think the following affects the emotions of an individual who has a disability and vice versa?	**Response**
xx. Family/neighbors/community a. Seeing others progress b. Unable to borrow money/lack capital c. Unable to send children to school	
yy. Studies/work/social life	
zz. Poverty/discrimination/government	
aaa. Gender/disability/religion/cultural norms	
Emotional Well-being Part 3	

bbb. What does emotional support look like for a person with disabilities?	**Response**
ccc. Who/why/how/what is said? ddd. medicine/encouragement/counselling/doctors/empathy	
eee. How effective?	
fff. The expected impact?	

Service and Accessibility Part 1	
ggg. What are the difficulties that people with impairments face in terms of:	**Response**
hhh. Information Access d. Health care information e. Leaflets on service information f. Equity fund information g. ID Poor Card	
Service and Accessibility Part 2	
iii. What services are you providing for people with disabilities?	**Response**
jjj. Health/mental health/physiotherapy	

kkk.Facilitators/barriers/challenges	
lll. Why/how long/who?	
mmm. Impact on person with disability/family/community?	

Service and Accessibility Part 3	
nnn. What challenges do people with disabilities experience when accessing these services?	**Response**
ooo.Discrimination/lack of information	
ppp. Needing a carer/need budget for travelling?	

qqq. Effect income opportunity/expenditures?	
rrr. Effects on family/any dependents at home?	
sss. Expected impact on well-being and family?	

Service and Accessibility Part 4	
ttt. What are the best ways to support people with disabilities?	**Response**
uuu. Psychological distress/mental health/general health	
vvv. Accessibility/inclusion/anti-discrimination/training on disability	
www. Suicide/suicide contemplation	

xxx. Collaborate with hospitals to check accessibility	

Service and Accessibility Part 5	
yyy. How can service providers play a role in increasing the sense of respect/recognition for someone with a disability?	**Response**
zzz. One's rights/respect/opinions/value in society	
aaaa. Individual with disability/family/community	
bbbb. Effects on feelings	

7. List of persons met during the study process and salient points of the meetings

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