Truth, Trauma, and the Victims of Torture Project: Helping the Victims of the Khmer Rouge

A project of the Documentation Center of Cambodia in collaboration with the Transcultural Psychosocial Organization Cambodia

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The Documentation Center of Cambodia (DC-Cam), in collaboration with the Trans-cultural Psychosocial Organization Cambodia (TPO Cambodia), recently completed a two-year pilot project whose main objectives were to document the events that occurred under the genocidal Khmer Rouge regime (1975-1979), identify people who continue to be traumatized by this experience and the years of civil war and upheaval that followed, and to provide psychological care for traumatized individuals, including both victims and perpetrators.

As noted in the Victims of Torture (VOT) Final Report: "The Documentation Center of Cambodia (DC-Cam) and the Transcultural Psychosocial Organization Cambodia (TPO Cambodia) believe that both recording the traumatic events perpetrated by the Khmer Rouge and proactively working towards solutions to help people address the past are crucial. DC-Cam's objective is to document the crimes of the Khmer Rouge regime with the goal of promoting the rule of law, accountability, national reconciliation and recovery. TPO Cambodia's mission is to alleviate the suffering of Cambodian individuals and families subject to long term stress and trauma through culturally-specific programs" (VOT Final Report 2005:2). Given that the forthcoming tribunal to prosecute former Khmer Rouge leaders will likely begin operation this year, these goals are indeed crucial, both to promote truth and understanding, and to offer psychological care to those most likely to be re-traumatized by the proceedings.

A recent article in the *International Herald Tribune*, written by journalist Seth Mydans (2006), underscores the concerns of both the Director of DC-Cam, Youk Chhang, and the Director of TPO Cambodia, Dr. Sotheara Chhim. The article focuses on the challenges that the Cambodian people face as a consequence of Cambodia's recent history of genocide, and the challenges that they will face as the wounds of the past will inevitably be reopened during the tribunal process. In the article, Dr. Chhim makes reference to the survivors who will once again have to look at their past, the younger generations who will learn about this past, and the possibility of a resurgence of anger at the perpetrators by victims. Dr. Chhim is quoted as saying "I believe everybody has suffered. Everybody has inside some memory, some past trauma. But their abilities to cope are different." Dr. Chhim's feelings that all Cambodians have suffered echoes Youk Chhang's suggestion that "all Cambodians who lived during the Khmer Rouge regime should be considered victims of torture and have therefore suffered some kind of trauma" (see Identifying Trauma Victims)

Indeed, a recent epidemiological paper by TPO Cambodia cites statistics that show alarming rates of psychological disorders and trauma for Cambodians (VOT Final Report 2005: 1).

Effectiveness and Cost-effectiveness of Mental Health Intervention in Cambodia 2004

Cambodians who experienced violence	81%
Cambodians who suffer from Post-Traumatic Stress Disorder (PTSD)	28.4%
Cambodians who suffer from mood disorders	11.5%
Cambodians who suffer from anxiety disorders	40%

An additional indication of the urgent need for trauma therapy in Cambodia can be found in the high percentage of Cambodian refugees in the United States who suffer from Post-Traumatic Stress Disorder (PTSD). In his article, Mydans makes reference to a recent study conducted by the National Institutes of Health and Human Services in the United States. The study showed that 62% of Cambodian refugees living in the United States suffer from PTSD and 51% from major depression, as compared to rates of 3.6% PTSD and 9.5% depression in the general population. The study also cites statistics for trauma related events that throw into harsh relief the level of violence suffered by Cambodians during the Khmer Rouge period: 54% of the refugees in the study reported being tortured, 90% had a friend or family member murdered, and 99% reported starvation.

US Department of Health and Human Services: National Institutes of Health: HIH News, August 8, 2005 (Cambodians in the United States)

Cambodians who suffer from depression	51%
Cambodians who suffer from PTSD	62%
Cambodians who were tortured during the Khmer Rouge period	54%
Cambodians who had a family member murdered during the Khmer Rouge period	90%
Cambodians who reported starvation during the Khmer Rouge period	99%

In Cambodia, the problem of widespread psychological suffering is compounded by the lack of an infrastructure capable of providing adequate mental health care. According to TPO Cambodia, there are currently only 26 psychiatrists in Cambodia, a nation of approximately 11.5 million people. Indeed, as noted in the original VOT project proposal, these additional statistics underscore the lack of resources in Cambodia:

Health Care Statistics from: Mental Health Subcommittee 2000, page 3

There are 26 trained psychiatrists in Cambodia who serve a population of approximately 11.5 million Cambodians
There are only 9 national and international organizations that address the needs of the same population
There are only 100 general practitioners who have had only 12 weeks of mental-health training in Cambodia

Project Structure

Project History

The idea for the VOT project was conceived in 2000, when the First Secretary of the Royal Netherlands Embassy, Mr. Cees Kieft, visited DC-Cam. At this time, Mr. Kieft suggested the creation of program involving TPO Cambodia that would benefit both organizations (Mr. Youk Chhang, personal communication). Mr. Chhang recalled, " At that time I personally was not ready for the project because I believe that all Cambodians have been effected by the Khmer Rouge legacy. I asked who among this victimized population was going to help others. Mr. Kieft replied that those who were less traumatized would help those who had more severe PTSD. I called it a Khmer process."

Once the conceptualization of the project had been worked out, DC-Cam and TPO agreed to initiate a pilot project. Each organization drafted papers discussing their projected roles; these were formed the basis of a pilot-project proposal finalized by a DC-Cam advisor, Professor Jaya Ramji, and submitted for funding in October 2002. With $7,000 in support from the Royal Netherlands Embassy, a one-year pilot project was undertaken from January through December 2003. Staff members began identifying potential project sites, conducting interviewees, and conducting counseling sessions (VOT Final Report 2005:8).

While the results were encouraging, project staff "determined that longer-term intervention would be required to help them identify and explore ways to manage the psychological difficulties they were experiencing. We also recognized the need to develop culturally appropriate approaches and specific techniques for assisting victims of torture" (VOT Final Report 2005:8). These understandings also strengthened DC-Cam's April 21, 2003 proposal to USAID's Victims of Torture Program, which approved funding for this initiative on July 10, 2003. The VOT project began when the funds were disbursed in January 2004 (VOT Final Report 2005:9).

Project Objectives

The VOT Project was created and timed to coincide with the upcoming tribunal to prosecute former high-ranking members of the Khmer Rouge. This timing reflects the concern that the tribunal process will re-awaken memories that have the potential to re-traumatize victims of the regime. The project addresses both the need to provide mental health support services for people (both perpetrators and victims) who suffer from trauma related disorders, and to document the events that occurred during Democratic Kampuchea (hereafter "DK"), the period of Khmer Rouge rule. As the tribunal unfolds, VOT envisions the possibility of an expansion of the project beyond the provinces included in the pilot, with the final goal of helping trauma victims nation-wide.

The VOT Project is premised on the general understanding that, in order to meet the psychological needs of individuals, the problems and challenges of communities must also be addressed. The dual focus on communities and individuals is especially critical since victims and perpetrators in Cambodia often live in the same villages and communities. As part of its goal of healing the psychological wounds of the Cambodian people, VOT has sought to foster a climate in which communication and understanding is possible between victims and perpetrators. Indeed, to promote reconciliation between former Khmer Rouge cadres and their victims, VOT staff brought together twenty-five victims and twenty-five perpetrators from the pilot areas on a three-day trip to visit genocidal sites. The goal of this component of the VOT Project, called the "Journey to Search for Truth and Reconciliation," was "to jointly acknowledge the truth about what happened during the Khmer Rouge regime" (Summary of the Documentation Center of Cambodia's Activities 2005: 3.1).

A recent article in the *Boston Globe* by Ker Munthit (2005) that reported on the journey stressed how the project was clearly building a much needed foundation for understanding and reconciliation for the Cambodian people. The article notes that although forgiveness, as one might expect, did not come easily to all, "most of the victims said they understood the circumstances that compelled their traveling companions to act as they did." In two interviews that the evaluation team had with project participants (one with a survivor, and one with a perpetrator) the responses were very positive. Indeed, the perpetrator, who said that as a consequence of his experience he was writing a book about the DK period, even contributed an article about the journey to DC-Cam's magazine *Searching for the Truth*; the victim, living in a Khmer Rouge dominated zone, echoed the sentiments of the perpetrator and asked for a copy of the film *S21: the Khmer Rouge Killing Machine* to show in her community.

Organizations Working on the VOT Project

The Documentation Center of Cambodia (DC-Cam) is an independent research organization that has become the main source for documenting and educating Cambodia and the world about the Khmer Rouge genocide. The center gathers, archives, and disseminates information about the Khmer Rouge and the victims who suffered under their regime. Among its projects are the publication of a monthly Khmer and English language magazine, *Searching for the Truth*, radio broadcasts, a project that aims to map mass graves throughout the country, a genocide education project, an accountability project, and a public outreach project.

The role of DC-Cam in the Victims of Torture project was to document life under the Khmer Rouge and, in the process, to identify potential subjects for psychological care and to refer them to TPO Cambodia for counseling and therapy.

The Transcultural Psychosocial Organization Cambodia (TPO Cambodia) is a locally operated NGO that runs a Mental Health Program in five provinces in Cambodia. TPO Cambodia provides culturally sensitive counseling, therapy and treatment for people suffering from mental health problems. TPO Cambodia also gives mental health education and training courses on psychological care and counseling in local communities.

The role of TPO Cambodia in the Victims of Torture project was to provide training to the DC-Cam staff and to treat people who were found to suffer from a wide array of psychological disorders.

TPO Cambodia Mental Heath Office Locations

- Phnom Penh (main office)
- Pursat
- Battambang
- Banteay Mean Chey
- Kompong Thom

VOT Project Staff

The VOT Project Staff consisted of team members from both DC-Cam and TPO Cambodia. Each organization has dedicated staff members to the VOT project who have been trained in at least most if not all of the following professional skill areas: documentation, research, interviewing skills and mental health care.

Name	Position	Organization	Gender
Dr. Sotheara Chhim	Psychiatrist	TPO (Director)	Male
Mr. Lo Leang	Psychologist/ Trauma Counselor	TPO Cambodia	Male
Mr. Leap Seang	Psychologist/ Trauma Counselor	TPO Cambodia	Male
Mrs. Sok Andeth Korm	Psychologist/ Trauma Counselor	TPO Cambodia	Female
Mr. Sophearith Choung	Project Leader	DC-Cam	Male
Mr. Meng-Try Ea	Project Staff Member	DC-Cam	Male
Mr. Socheat Nhean	Project Staff Member	DC-Cam	Male
Ms. Savina Sirik	Project Staff Member	DC-Cam	Female
Mr. Sokoeun Kong	Project Staff Member	DC-Cam	Male
Ms. Utara Norng	Project Staff Member	DC-Cam	Female

VOT Project Activities

Training

In order to conduct effective and meaningful interviews in the first year of the project, TPO Cambodia provided one training session over the course of 11 days to DC-Cam personnel, one of whom, Mr. Sophearith Choung, is currently the DC-Cam leader of the VOT project. The training focused on basic techniques for identifying clients suffering from psychological disorders, in particular PTSD. It also introduced staff members to simple forms of treatment, such as muscle relaxation techniques, breathing exercises, anger management, emotional processing of trauma memories, and Buddhist ways of coping with trauma. DC-Cam staff members were also taught how to administer the Harvard Trauma Questionnaire (HTQ), the primary tool used to make baseline determinations about which participants suffer from PTSD (see below). The training session was attended by 24 members of the DC-Cam staff, and was not limited to those participating in the VOT project. Of the five DC-Cam staff members currently assigned to the project at the time of this evaluation (January 2006), two of them, Mr. Sophearith Choung and Ms. Utara Norng participated in this particular training session, which was held prior to the start of the VOT project (Meng-Try Ea, another VOT staff member who received the training and was initially involved in the project, is now studying abroad.)

No additional follow-up training was provided to DC-Cam staff members in the second year of the project. In the second year, two DC-Cam staff members participated in two TPO Cambodia organized conferences on mental health issues. One DC-Cam staff

member (Mr. Sophearith Choung) and one TPO Cambodia staff member (Dr. Sotheara Chhim) also attended a 5-day conference on trauma related issues in Sydney, Australia.

In the earlier stages of the pilot, TPO Cambodia counselors accompanied DC-Cam staff members on field trips to assist them in identifying interviewees who needed treatment. The counselors provided feedback and guidance to the DC-Cam staff in conducting interviews, and helped determine which interviewees were suffering from PTSD.

First Year Training 2004

Location	Sponsored by:	Training Description	attended by
Cambodia	• Organized by TPO Cambodia	• 11 day training on trauma-related issues with focus on identifying trauma victims in the field	• 24 DC-Cam staff members

Second Year Training 2005

Location	Sponsored by:	Training Description	attended by
Cambodia	• Sponsored by Inter-Church Cooperation Agency (ICCO) •Organized by TPO Cambodia	• One-day conference on the efficacy and cost effectiveness of mental health care in Cambodia	• One DC-Cam staff member (Mr. Sophearith Choung)
Cambodia	• Sponsored by Japanese International Cooperation Agency (JICA)	• One-day conference on Empowering the Community through Mental Health and psychosocial rehabilitation: the achievements of TPO Cambodia in Kampong, Thom Province	• Two DC-Cam staff members (Mr. Socheat Nhean and Mr. Sophearith Choung)
Australia	• Sponsored by Royal Australian and New Zealand College of psychiatrists (RANZCP)	• Psychiatry in a changing world 40th Congress	• One DC-Cam staff member (Mr. Sophearith Choung) • One TPO Cambodia staff member (Dr. Sotheara Chhim)

Identifying Trauma Victims

Torture Victims Relief Act of 1998 (Section 2240(1) of Title 18 Definition): "Severe mental pain or suffering means the prolonged mental harm caused by or resulting from the intentional infliction or threatened infliction of severe physical pain or suffering, or the threat of imminent death; or the threat that another person will imminently be subjected to death, severe physical pain or suffering."

Under the definition of torture outlined by the Torture Victims Relief Act of 1998, and as DC-Cam Director Youk Chhang suggests, all Cambodians who lived during the Khmer Rouge regime should be considered victims of torture. For the purposes of the VOT project DC-Cam and TPO Cambodia focused on a target population using the following criteria:

- Close proximity to a mass grave or to a detention center
- A minimum population of 50 or more people
- A significant number of victims of torture and their families
- A significant number of disabled individuals (due to war or other violent causes)

Pilot Project Areas

In the initial phases of the pilot, VOT chose to target locations in two provinces: Kandal and Takeo. These provinces were chosen because of the likelihood that a high number of people living there are victims of the Khmer Rouge. Both provinces have sites that have been clearly linked to the Khmer Rouge network of security centers and district prisons that once blanketed the country. Information from DC-Cam's extensive mapping project also shows that there are several mass graves located in these areas.

In each province, the project focused on a district (Kandal Stung in Kandal and Tram Kok in Takeo) that was shown to have both mass graves and prisons. The locations were also chosen for their close proximity to Phnom Penh (a base for both TPO Cambodia and DC-Cam) and their accessibility from the city by paved road. This close proximity and accessibility made it possible for the VOT team to make numerous trips to these locations. In many cases overnight visits were made to ensure adequate time, enable follow-up and to continue to build rapport with the villagers in each province.

Later in the first year of the pilot, VOT added a more remote location in Chhouk district, Kampot province, where many of the residents are former Khmer Rouge cadre. In Chhouk, the project centered on Ta Ken Koh Sla community, one of the last bastions of KR control and the site of the Koh Sla Dam, a forced labor project during the DK regime. VOT added this location, which remained a Khmer Rouge stronghold until negotiations between the Khmer Rouge and the government ended the fighting in 1996, in an effort to include more perpetrators in the project activities. VOT staff told the evaluation team that former Khmer Rouge cadres and solders were often reluctant to participate in the project

because they fear reprisal by members of their communities or prosecution in the forthcoming tribunal. In two interviews that the evaluation team participated in with perpetrators, the interviewees were very reluctant to speak honestly about their experiences during the Khmer Rouge regime (one perpetrator said that although he felt "guilty," his guilt stems from having been "tricked" into believing in the ideology of the Khmer Rouge, rather than his own actions). To foster good relations between residents in this area and project members, VOT designed a strategy to build trust that included regular visits with community leaders, and the construction of simple improvements, such as signs pointing the way to the community.

The three pilot areas were also chosen because of the potential for interviews to yield evidence relevant to the prosecution in the tribunal of Ta Mok, former Secretary of the Southwestern Zone, who presided over the region under DK rule.

Interviews/Assessment

To identify potential trauma victims, team members asked local authorities to help identify villages where there existed a high concentration of traumatized individuals, particularly those who had been imprisoned or tortured. The community leaders were critical in helping determine which locales were most appropriate, who the individuals were, and where they lived. By clearly explaining the objectives of the project, VOT staff was able to establish a rapport with the community leaders, actively engage these leaders in the project, and establish credibility.

Once the leaders understood the project objectives, VOT staff requested and then obtained permission to work in the village for the duration of the project. VOT staff members were able to obtain information about people's activities, events, resources, and local power structures. This information helped determine the likelihood that a given community/village might have a social environment that fosters a climate in which torture and mental health concerns can be openly discussed and addressed.

VOT staff then moved towards identifying individual subjects for extensive interviews. The interviews were conducted to determine whether subjects suffer from mental health disorders, to understand the nature of their symptoms, and to determine whether or not they suffer from Post Traumatic Stress Disorder (PTSD). Prior to the interview process, team members asked subjects for permission to conduct the interview, take pictures, and record the interview with audiocassettes. The interviews were structured generally around a version of the Harvard Trauma Questionnaire (HTQ) that had been slightly modified to meet the context of Cambodia. HTQ is a diagnostic tool used to diagnose PTSD. HTQ includes questions about trauma events, such as torture, brainwashing, and starvation, and possible symptoms of mental health disorders, such as emotional numbness, recurrent memories and trouble sleeping. The answers to these questions produce a score that helps the interviewer determine whether respondents have PTSD (the baseline score for PTSD was 2.5). Drawing on this information, DC-Cam staff consulted with TPO Cambodia

staff to identify highly traumatized individuals. TPO Cambodia then determined the appropriate course of treatment (VOT Final Report 2005:14).

As part of its two-fold goal, DC-Cam staff incorporated questions into the interview process about the experiences participants had during DK rule. These questions functioned as a "second" section or segment of the interview. They were generally asked at the beginning of the interview and were included as part of the broader goal of documenting abuse and of establishing a context and possible causes for the symptoms. Project members reported that these questions were also instrumental in helping to build a base of trust between the interviewer and interviewee. Most importantly, these questions helped the participants clearly connect their traumatic symptoms to their past experiences during the Khmer Rouge regime.

In their interviews with perpetrators, project members assured participants that their responses would be used solely for purposes of establishing a historical record of the period. Questions about the upcoming tribunal to prosecute former leaders of the KR were also included. These questions, which were generally asked toward the end of the interviews, focused on whether respondents knew about and understood the reasons for the tribunal, and whether they feel the tribunal is an effective means of addressing the abuses committed by the Khmer Rouge. Project members also asked respondents whether they felt it was important to document the abuses committed during DK, and whether the history should be taught to younger generations of Cambodians.

VOT staff made great efforts to establish the critical trust needed to ensure meaningful interviews and to minimize any re-traumatization of the victims. As Megan Wittaker, a psychology intern from Yale University who worked with the VOT team noted in a field report, "The VOT staff makes great efforts to reduce the chances for re-traumatization, such as visiting the interviewees in their own homes and seeking to establish a rapport with the interviewees that breeds a sense of trust and genuine concern."

The identification and interview of trauma victims took place from February 2004 through December 2005. During this time, DC-Cam VOT project members conducted a total of 302 interviews in the three pilot provinces. Of the people interviewed, 214 were victims who suffered either directly or indirectly (for example, through the loss of loved ones) under the Khmer Rouge; the remaining 88 interviews were conducted with former Khmer Rouge cadres, including prison guards and soldiers (VOT Final Report 2005: 3, 7).

Summary of VOT Interviews Conducted 2003-2005

Province	Interviews Conducted	Interviews Conducted	PTSD Victims Identified	PTSD Victims Identified
	Men	Women	Men	Women
Kandal	31	67	9	39
Takeo	49	74	11	29
Kampot	65	16	3	4
Totals	145	157	23	72

(Abbreviated version of chart from VOT Final Report. This chart does not make reference to sub-districts and number of villages. For this information please refer to VOT Final Report Table 2, page 14.)

Based on the referrals from DC-Cam project members, TPO Cambodia counselors visited the pilot locations and conducted three more rounds of interviews. In these sessions, TPO Cambodia counselors assessed how candidates may respond to the stress of speaking about their experiences in treatment, and to determine what kind of treatment each participant would receive.

The interviews consisted of the questionnaires and surveys developed by TPO Cambodia counselors (see the VOT Final Report). The questionnaires included topics on general mental and physical health, a checklist of PTSD symptoms and their severity, and a questionnaire to elicit the experiences of victims during DK. To gauge how victims currently feel about members of the Khmer Rouge, project members also developed and conducted a Forgiveness Measure survey. The survey was used to determine the level of trust victims have for perpetrators, the degree to which they may want to take revenge, and whether they were willing to forgive the people responsible for their suffering.

During the evaluation, DC-Cam staff emphasized that questions of forgiveness, revenge, and trust administered by TPO Cambodia were particularly significant in the context of Cambodia, where perpetrators live freely among their victims, sometimes in villages alongside one another. Transcriptions of interviews show that many of the victims who live near perpetrators still fear retribution for speaking about their experiences. Interviews with perpetrators indicate a reluctance to speak honestly about their experiences for fear of being subjected to prosecution or revenge.

Documentation

Throughout the dual process of documentation and referral VOT staff members recorded the recalled experiences of both survivors and perpetrators in the form of taped interviews. This documentation is part of the broader aim to record the Khmer Rouge genocide for truth, memory, and understanding, and to provide an archive of materials that can be used by victims, researchers, journalists and anyone else who is interested in educating people about the dire consequences of genocide.

To create a permanent historical record of life under the Khmer Rouge regime, VOT has been transcribing the interviews from audiocassette and filing them in a database. At the time of this report, VOT had transcribed 275 of the interviews for a total of 9,461 pages (VOT Final Report 2005:15). Project members have also translated a number of these interviews into English, and written brief summaries in English and Khmer of their contents. These materials, which include photographs taken during the interviews, will become part of DC-Cam's database and will be available both for educational purposes and as potential evidence in the forthcoming tribunal.

VOT Two-Year Project Results: Filing Activities (VOT Final Report 2005: Table 4)

Years	Trauma Questionnaires Registered	Cassettes Registered	Photos Registered	Transcriptions Registered	Victims with PTSD Registered
Year 1	142	189	189	108	49
Year 2	102	314	329	167	46
Total:	244	503	518	275	95

Treatment

After identifying participants for psychological intervention, TPO Cambodia counselors visited the pilot areas twice a month to provide counseling and treatment. The therapy sessions, which took place from January to September 2005, included all 66 people referred by DC-Cam. However, only 60 of them received counseling and treatment from TPO Cambodia (VOT Final Report 2005:18). Given the reluctance of former Khmer Rouge to speak about their feelings and experiences, most of the participants came from the provinces that had more victims than perpetrators: 35 in Kandal, 26 in Takeo, and 5 in the Khmer Rouge dominated province Kampot (VOT Final Report 2005:18). The treatment consisted of individual counseling sessions as well as group therapy and psychiatric care, with some of the participants receiving more than one form of therapy.

Individual counseling sessions were held for victims whose trauma symptoms were the most severe. Trauma victims told the evaluators that these counseling sessions were very beneficial. Some of these participants also received psychiatric care in the form of antidepressant medication and vitamins (although in many cases clients were quite worried that they might not have access to medication in the future and that they might

not have follow-up care). During a visit in a pilot area, the evaluation team arrived in a village at a time when most of the clients who had been treated in the pilot were arriving at the end of their medication. They also were concerned that they had not had a follow-up visit by a TPO Cambodia counselor. VOT team responded to this emergency by contacting TPO Cambodia and taking the villagers to the local government clinic for immediate follow-up care and medication when needed.

Clients told evaluators that the sessions in which life under the Khmer Rouge was discussed seemed to be among the most beneficial since clients saw these sessions as opportunities to discuss traumatic memories that in many cases had long been repressed. These "discussions about life under the Khmer Rouge" also build upon the advice that some clients received after consulting with monks, nuns or family members who were willing to discuss the client's memories of life under the Khmer Rouge.

In addition to providing a forum to discuss their experiences under the Khmer Rouge, some group sessions focused on behavioral problems, such as alcoholism and domestic violence, that may have broader consequences for the community. Indeed, in an interview with the evaluation team, TPO Cambodia Director Dr. Chhim stressed the importance of raising these issues and, when possible, referring clients to other organizations (NGOs) to get help with these problems. Dr. Chhim suggests that one shouldn't underestimate the impact that these other issues may have on trauma that may have originated for clients during the Khmer Rouge regime.

The group and individual treatment sessions were based on Cognitive Behavioral Therapy techniques (CBT), developed by Devon Hinton (MD, PhD.; he is also the brother of the VOT evaluation team leader, Alex Hinton), that have proven successful in treating Cambodian and Vietnamese refugees in the United States. TPO Cambodia counselors administered the CBT techniques to individuals and groups over the course of 12 sessions. Each session followed the sequence of treatment established in the CBT manual. (The VOT Final Report notes that only 8 sessions were conducted in Kampot, which was added later to the project. The report does not indicate which sessions from the CBT sequence were omitted in that location). The CBT manual was slightly modified to more effectively meet the cultural context of PTSD victims in Cambodia. Since all of the participants in the pilot are Buddhist, a session was added toward the end of the sequence to discuss Buddhist ways of dealing with trauma. This session was part of the broader goal of creating a culturally appropriate approach to trauma that includes aspects of local healing traditions.

Following the sequence outlined in the CBT manual, counselors began treatment in sessions designed to educate participants about trauma and trauma related symptoms. Central to CBT is the idea that understanding and talking about trauma is essential to the treatment process. Indeed, one of the central symptoms of PTSD is a desire to avoid recalling and talking about the events that caused trauma. In this regard, the CBT techniques dovetail with DC-Cam's long-term goal of alleviating trauma in Cambodian society through education. Participants were taught that the symptoms they experience, such as shortness of breath, headaches, cold limbs, sleeplessness and panic attacks, are

the consequence of the traumatic experiences they endured. By helping them understand the origin of their symptoms, the sessions aimed at alleviating anxiety and reducing the level of stress that attends anxiety and causes panic.

The CBT sequence used by TPO Cambodia includes sessions devoted to muscle relaxation and breathing retraining. Both the breathing and muscle relaxation techniques were designed to alleviate the physical and emotional arousal that attends anxiety and can trigger panic attacks. These methods were also taught to participants when they experienced panic and anxiety during interview sessions. During their visits to the pilot locations, TPO Cambodia also distributed brochures to remind participants how to use the techniques to alleviate symptoms and do the exercises. Relaxation techniques were also emphasized as an effective way of dealing with anger. In another session devoted to anger management, participants were taught to recognize how anger can be triggered and how feelings of anger can escalate into moments of panic. During the evaluation team's interviews in the field, clients expressed a desire for more of these kinds of sessions and for additional training material or reference materials. In fact, one client specifically requested brochures or handouts she could share with others in her community who, as she said, "suffered silently."

To alleviate symptoms associated with anger and panic, counselors also drew on the Buddhist conception of mindfulness. Indeed, the CBT manual emphasizes that Buddhist philosophy and healing approaches bear a remarkable similarity to many of the Western techniques developed to help trauma victims (Outline of CBT Manual, p. 6). Mindfulness involves focusing consciousness and the senses on the present moment to prevent dissociation. The technique has been shown to help victims whose trauma may include numbness, or who dwell excessively on past trauma events. In two interviews that the evaluation team observed, clients mentioned the importance of learning how to manage anger and directly related this to their Buddhist beliefs and to advice they have gotten from local monks. In one interview a client specifically mentioned the need to go to a temple and speak to a monk whenever feelings of anger or reprisal emerged.

In a final note on the importance of the interviews in the field, the evaluation team noticed that most of the interviewees were genuinely pleased to see the team return, and were interested in meeting with them again. Interviewees in many cases expressed how important they felt this project was and how interested they were in receiving and reading the DC-Cam's magazine *Searching for the Truth.*

Project Issues/Problems

Training

During the pilot phase, the project, while generally quite successful, was hampered by some problems related to staff training. As noted above, during the first year, DC-Cam staff members received eleven days of local training (by TPO Cambodia staff) and no international training; in the second year, DC-Cam staff received neither local nor international training, though they did attend two local and one international conference (VOT Final Report 2005:3). Unfortunately, three of the five current members of DC-Cam's VOT project staff (Mr. Socheat Nhean, Mr. Sokoeun Kong, and Ms. Savina Sirik) joined the project after the TPO Cambodia training session. Only the current project team leader, Mr. Sophearith Choung, and one staff member who is now studying abroad, Mr. Meng-Try Ea, received this crucial training -- though Ms. Utara Norng received part-time training from TPO Cambodia and all current staff members received supplemental instruction by TPO Cambodia staff in the field. Moreover, in their evaluations of the training seminar, several DC-Cam staff members indicated that, while they thought the training was beneficial, they wanted more.

Such comments, made in 2004, echoed those expressed by DC-Cam VOT staff members during our evaluation in January 2006. To enhance the efficacy of the project, DC-Cam staff members yearned for further training with regard to: administering their diagnostic tools (particularly with given Harvard Trauma Questionnaire questions that the interviewees and even at times the interviewers had trouble fully understanding); dealing with gendered responses (some men, particularly the former Khmer Rouge in Kampot, seemed wary of the stigma associated with mental health problems and often gave muted responses to the questions; rape, in turn, was also a very difficult topic for women to discuss, especially with men); taking more effective notes (this is crucial since the staff are simultaneously documenting life-histories and trying to assess the interviewee's state of mental health); understanding various treatments (ranging from breathing and meditation exercises to medications); and working with monks and traditional healers to enhance local treatment options.

Assessment/Diagnosis

At present, the key initial diagnostic tool for assessing PTSD is the Harvard Trauma Questionnaire (HTQ), which DC-Cam VOT staff members administer toward the end of their interviews (see above). Although the sample is limited, the results are startling: almost a third of the interviewees (31.45%) score for PTSD, a rate that slightly exceeds the incidence found by a TPO Cambodia study (28.4%).[1]

[1] DC-Cam Victims of Torture Final Report (2005:4) and Effectiveness and Cost-effectiveness of Mental Health Intervention in Cambodia, 2004, cited in DC-Cam Victims of Torture Final Report 2005:1). The slightly higher incidence in the VOT

Nevertheless, DC-Cam VOT staff members encountered several problems with the HTQ. First, the HTQ, which was developed abroad, contains several questions that are either culturally inappropriate or difficult for some Cambodians – particularly poor and sometimes even illiterate farmers – to understand (for example, question #23 on "craziness" and question #29 on "splitting"). Indeed, some of the VOT staff admitted that they found it hard to understand and explain the meaning of some of the questions, though this may in part be due to a lack of sufficient training as noted above. Moreover, sometimes the interviewees gave responses that did not parallel their nonverbal cues (facial expression, affect) or that suggested a lack of understanding of or willingness to take the questionnaire. At times, this lack of willingness or interest in taking the questionnaire, particularly among the recent Khmer Rouge defectors from Kampot, made it difficult to administer the HTQ. Indeed, during the second year, over a third (56 of 158) of the interviews were conducted without the trauma questionnaire (in year one, the figure was only 2 out of 144 interviews) (VOT Final Report 2005:3).

Gender issues also emerged. Women were assessed as having a much higher incidence of PTSD (46% versus 16%) (VOT Final Report 2005:5). One explanation might be that Cambodian women are more predisposed toward trauma. A more likely explanation, however, is that the diagnostic tools have a gender bias and need to be refined to accurately assess the incidence of PTSD among men. More broadly, such issues about the HTQ raise questions about how it might be modified to be more effective in Cambodia (or even be replaced by another diagnostic tool) and/or supplemented by other assessment techniques (see below on MDEMI).

Capacity

When initially conceived, the VOT project was premised upon the assumption that all of the individuals who were identified as suffering from PTSD would receive treatment. During the first year of the project, this assumption proved warranted. In the second year, however, the number of people referred to TPO Cambodia declined steeply (from 49 to 17) and 36 of the 46 people identified as having PTSD went untreated (DC-Cam Final Report 2005:3). In addition, there was a steep rise in the number of people who were interviewed without being given the trauma questionnaire (from 2 to 56) (DC-Cam Final Report 2005:3).

While there were a variety of reasons for these trends, ranging from difficulties of distance to the problems encountered in Ta Ken-Koh Sla, the major reason was capacity. When originally formulated, the pilot project proposal called for TPO Cambodia to treat 10-15 people each year of the study, a number in keeping with its staff size. When large

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project may be due to the fact that two of the sites selected for the pilot project are located near major Khmer Rouge prisons and that the clients selected are not random.

numbers of people scored for PTSD (49 and 46 in Years 1 and 2, respectively), however, the problems intensified. Despite its staff limitations, TPO Cambodia eventually agreed to take on all 49 of the PTSD-identified villagers in the first year and seventeen more during the second year. Besides leaving 38 people untreated (2 the first year and 36 the second year), TPO Cambodia, which was already stretched to its limit, had difficulties counseling everyone who had been referred to it (DC-Cam Final Report 2005:21). These problems are not the fault of TPO Cambodia; they are a result of circumstances (TPO Cambodia staff limitations and the high incidence of PTSD).

Treatment

Due in part to this situation in which TPO Cambodia was asked to treat a far larger number of patients than expected, several problems concerning treatment emerged. (The problems were also due to other factors, such as the fact that TPO Cambodia, which did not yet have field offices in the pilot project areas, had to work out of its Phnom Penh headquarters. This required additional travel time and made it more difficult to provide regular follow-up treatment to those patients living in more remote locations.) While almost everyone we talked with spoke highly of the services TPO Cambodia had provided, many expressed the desire for more follow-up. This problem was particularly urgent in the cases of patients to whom TPO Cambodia had prescribed psychotropic medications. In Kandal Province, for example, we met with project participants who had begun to self-regulate their medication (for example, by taking half doses) when it appeared that their medications were going to run out and they were uncertain when TPO Cambodia staff would return (the pilot project had concluded by this point). They also seemed hesitant to visit regional government clinics, perhaps because of cost. Some interviewees also stated that they had begun to forget how to do the breathing and relaxation exercises TPO Cambodia staff had taught them, and they did not take the initiative to read an instruction booklet TPO Cambodia staff had provided.

Project Scope

Given such problems, consideration must be given to if and how the project could be expanded. At present, the VOT project is clearly making a significant impact in documenting mass murder, assessing the incidence of trauma, and treating those individuals who have been identified as having PTSD – most of whom are poor farmers who have extremely limited (or even non-existent) access to mental health care. Nevertheless, as suggested above and as would be expected given that this is a pilot project, problems emerged regarding treatment, capacity, training, and assessment/diagnosis, and the evaluation team was faced with the crucial task of ascertaining how the problems might be resolved and the overall functioning of the program improved for a possible expansion.

Project Recommendations

Assessment/Diagnosis

One of the central difficulties that DC-Cam staff encountered concerned the use of the Harvard Trauma Questionnaire (HTQ), which often proved difficult to administer and understand. Accordingly, we recommend a number of strategies be taken/considered to enhance trauma assessment in a possible national expansion.

The HTQ may be modified in slight ways to make it a more effective assessment tool. To address the problems of comprehension interviewees have with a handful of the HTQ questions, the DC-Cam VOT team, working in consultation with TPO Cambodia and international mental health experts (such as Maurice Eisenbruch, Devon Hinton, or Richard Mollica), should slightly modify the language of the questionnaire. Prior to such modifications, the DC-Cam VOT staff should receive additional training on the background and administration of the questionnaire – training that should be supplemented by periodic "refresher" courses of study (see below).

Both of these changes will enhance the DC-Cam staff's ability to administer the questionnaire and to make a more valid diagnosis. In addition, we suggest that the VOT team restructure the questionnaire so that there is space for them to write comments after given questions when appropriate. Such annotation will provide a running record of problems of translation, understanding, and engagement with the questions. Some DC-Cam staff members indicated that, at times, an interviewee's verbal report did not square with the preceding interview and the nonverbal cues they evinced when answering a given question. It is imperative that the interviewee's self-reports always be indicated. However, the above annotation system could be combined with a very basic coding system that scored verbal reports (for example, by making a square shape in the appropriate box), the interviewer's estimation of the score based on nonverbal cues (indicated by a circle), or the interviewee's lack of understanding about a question (indicated by a triangle).

In cases where the interviewee has time constraints or appears troubled by the questionnaire, the DC-Cam staff members might be given leeway to administer a more streamlined version of the questionnaire that excludes questions unrelated to the PTSD score. In particular, the questions on head injuries could be eliminated. And, interviewers should keep in mind that, in such situations, it is also possible to get a PTSD score by asking a truncated set of "symptoms" (the first 17) questions. Lastly, to gain additional information about interviewees who they suspect are traumatized or who do not engage with the HTQ, DC-Cam staff could be trained to administer a brief case history that obtained information about the problems and treatments (for example, from medical clinics, traditional healers, monks, Buddhist lay experts, fortune tellers, spirit mediums) they sought after (and even during) the DK period. This case history survey could be loosely organized in a linear fashion from 1975 to the present. Such information could be crucial to signaling patients who suffered from trauma in the past, provide a second way of obtaining useful information about patients – particularly men -- who do not score for

PTSD yet display signs of trauma, and help to determine who should be referred for treatment. It would also provide valuable background information about coping strategies during and after DK that would be of interest both to DC-Cam and TPO Cambodia. In fact, this case history method might be applied to everyone**.** Along these lines, it would be quite useful to ask all interviewees what problems they face on a daily basis so that additional interventions may be implemented in conjunction with mental health care (see below on "the dream scenario").

In cases where the interviewers believe that the interviewee is traumatized but may not have understood the HTQ (or to confirm the assessment of the HTQ), they might consider applying a supplemental measure, such as the Mental Distress Explanatory Model Schedule (MDEMI), a questionnaire that has been developed and tested with Cambodians by Dr. Maurice Eisenbruch. Last, if the above recommendations don't solve the existing problems, the VOT project should consider working to create a new, culturally-sensitive questionnaire. The development of a new questionnaire, however, would take considerable time and effort. Even if it were deemed necessary, the project should proceed in the meantime by using a modified version of the HTQ.

Training

It is clear that, if a national project is to go forward and be effective, additional training is essential. First and foremost, the DC-Cam VOT staff -- many of whom have never undertaken a relevant training workshop -- must receive (additional) training both in mental health issues and, especially, in administering the Harvard Trauma Questionnaire. Such basic training should be supplemented by periodic training sessions that would serve both as "refresher" courses and as a way of introducing new instruction modules. During our joint meeting with DC-Cam staff and TPO Cambodia's Managing Director, Dr. Sotheara Chhim, everyone agreed that such training would be beneficial. There was also a consensus that, to be more effective, DC-Cam and TPO Cambodia staff should have regular monthly meetings and perhaps even periodic "retreats" and jointly attend relevant conferences. In addition, to increase capacity (see below), we recommend that DC-Cam's VOT staff be given more extensive training in techniques that are of direct and immediate use to interviewees, including breathing and relaxation exercises, anger management, mindfulness, meditation techniques, and methods of working with indigenous "therapists," such as traditional healers, monks, and Buddhist lay experts (Hinton n.d.; Somasundaram, van de Put, Eisenbruch, and de Jong 1999).

To the extent possible, this training should take place in conjunction with TPO Cambodia. Since TPO Cambodia is already overextended in terms of staffing, however, we recommend that third party Khmer-speaking experts in Cambodian mental health and diagnostic techniques, including the HTQ, be enlisted to provide additional short courses of training. Possibilities include three world authorities on Cambodian mental health, Dr. Maurice Eisenbruch, Dr. Devon Hinton, or Dr. Richard Mollica. Dr. Hinton, for example, could provide training on the HTQ and in the utilization of the breathing, relaxation, meditation, anger management, and other techniques outlined in his CBT manual, which

already is central to TPO Cambodia's treatment. Dr. Eisenbruch, in turn, could provide training on administering the HTQ and working with monks and traditional healers. Such individuals could provide the training either in Cambodia or abroad. Ultimately, it might prove useful to have one DC-Cam VOT staff member trained to become a mental health "trainer" so that he or she could train in-house staff more rapidly. To this end, it also would be highly useful to send a DC-Cam VOT staff member for study abroad in a relevant Masters program.

Capacity

One of the most significant problems that emerged during the pilot project was the inability to treat everyone who had been identified with PTSD because demand outstripped TPO Cambodia staff capabilities. To increase capacity so that the project may go national, we recommend the adoption of a more flexible strategy that is suited to locality. We envision a scenario in which DC-Cam's VOT staff would continue working with TPO Cambodia to the maximum extent possible. When TPO Cambodia reaches its staffing limits, however, we recommend that DC-Cam turn to alternative sources of mental health support. Local government mental health clinics constitute one possibility, though questions exist about their accessibility, cost, and ability to provide services such as on-going counseling. The problems may be mitigated by the opening of a new center of the National Mental Health Program (NMHP) that will undertake an ambitious program to rapidly increase the number of mental health clinics throughout Cambodia; in fact, Ka Sunbaunat, the Director of the NMHP, has indicated that the government has mobile mental health teams that will be able to treat up to 100 trauma victims in each province (Sophearith Choung interview with Dr. Ka Sunbaunat, Director of the NMHP).

A promising alternative or supplementary activity would be to focus on building local mental health capacity. This could be done by enlisting the support of locals who provide a form of "indigenous therapy," including monks, nuns, traditional healers, and Buddhist lay practitioners. Such individuals already have the knowledge and training to help PTSD-identified individuals cope with their trauma in meaningful terms and through techniques such as meditation, ritual process, and breathing/relaxation exercises (Hinton n.d.; Somasundaram, van de Put, Eisenbruch, and de Jong 1999).

Since TPO Cambodia has staff limitations, we recommend that the VOT project be expanded to include a second partner specializing in the provision of mental health services. A strong candidate for partnership is a new project on "Cultural Competence in Supporting Cambodians Recovering from Conflict" (CULCOM). Run by Professor Maurice Eisenbruch -- a Khmer-speaking transcultural psychiatrist and medical anthropologist with an international reputation for his work on PTSD in Cambodia (he was also an inaugural consultant and advisor to TPO Cambodia) -- this project is specifically aimed at increasing the utilization of "local therapists," including monks and traditional healers. The project has involved the Buddhist Institute and would welcome the chance to work with DC-Cam (Dr. Maurice Eisenbruch, personal communication). If such a partnership were to be formed, the VOT project would be able to expand more

rapidly into a variety of areas, including ones where TPO Cambodia is not working, and to build local capacity by utilizing pre-existing indigenous therapies (ranging from breathing techniques to Buddhist meditation) and providers (monks, Buddhist lay people, nuns, traditional healers). CULCOM already has a database of over 1,400 monks and healers from all over the country upon which it can draw (Eisenbruch, personal communication). CULCOM could also revisit the sites of the pilot project – particularly areas where patients went untreated – to further enhance local mental health capacity. Moreover, as part of this partnership, Dr. Eisenbruch and his wife, Dr. Renata Volich Eisenbruch, a cross-cultural psychologist who has worked in Cambodia and with TPO Cambodia, could help provide DC-Cam VOT staff with some of the needed training discussed above.

Such partnerships may indicate yet another way to build mental health capacity in the Cambodian countryside, what we came to call "the dream scenario" during our evaluation. In a few, select locations – preferably sites where there is a strong incidence of trauma – we recommend that the VOT project enlist the services of a variety of partners (for example, NGOs working on alcohol and domestic abuse, poverty alleviation, educational enhancement, health, mental health, Buddhism) to create an umbrella project aimed to improve the life of locals through a concerted and coordinated effort. In our interview with Dr. Sotheara Chhim, he noted that mental health problems are linked to a variety of (often interrelated) problems – the lingering effects of past trauma, alcoholism, domestic abuse, poverty, lack of education or awareness about mental health issues – that may best be addressed through such a multi-pronged effort. We recommend that this sort of umbrella "dream scenario" be implemented whenever possible as the project goes national.

Treatment

If the aforementioned strategies are pursued, the VOT project will emerge with the ability to provide a more flexible and locally-adapted set of treatments to local populations. Ideally, in all cases, PTSD-identified individuals would at a minimum be educated about their condition (through instructional meetings with more highly trained VOT staff and/or their partners, through educational posters and booklets, and through regular access to relevant radio programming), trained in breathing, relaxation, and meditation techniques, and connected to indigenous therapists who can help alleviate their symptoms. In cases where the services of TPO Cambodia can be drawn upon, treatment can be expanded to include individual and group therapy and, in extreme cases, medication. (We were very concerned about the distribution of medication to people in the countryside. It is extremely difficult to monitor the intake of such medications, which in some cases -- such as the antipsychotics and the antidepressant Amitriptiline -- can be dangerous and have strong side-effects and therefore may pose serious risks to patients. TPO Cambodia has done an admirable job of assessing who needs such medications, but we found a worrying tendency for some patients to self-regulate at times. Indeed, we would recommend that medications be given only when it is certain that the patients can be monitored and receive regular follow-care and disbursements of medication.) In still

other situations, it might be possible to enlist the services of local government clinics to augment treatment, though again care must be taken with regard to the prescription of medications. In the best of all scenarios, the VOT staff would head an umbrella project of partners that would undertake a multi-pronged effort to treat patients and alleviate given conditions that exacerbate mental health problems (see above**).** As noted above, while this "dream scenario" requires a great deal of coordination and effort and will only be possible in select areas, it holds the greatest promise for improving the lives and psychological health of survivors.

Project Scope

The above recommendations lay a strong groundwork for an effective and rapid expansion of the VOT project on a national scale. There are a number of factors that will go into the selection of future project sites, ranging from staff development to the documentary needs in light of the forthcoming tribunal. We would like to make a few points and suggestions to contribute to this process of deliberation. First, to augment capacity, it would be useful to locate projects sites near existing provincial TPO Cambodia clinics (located in Pursat, Battambang, Banteay Meanchey, Kompong Thom) and, secondarily, government mental health clinics located throughout much of the country (clinics in Phnom Penh, Kandal, Takeo, Kampot, Kampong Cham, Kampong Thom, Siem Reap Battambang and Pursat are staffed by psychiatrists; in Kampong Speu, Kampong Chhnang, Svay Rieng, Kratie, Ratanakiri, Stung Treng, Preah Vihear, Oddar Meanchey, Bantey Meanchey, and Pailin clinics are staffed by general practitioners).

Expanding the project to include partnership with CULCOM would facilitate the expansion of the project to almost any other part of Cambodia. Second, we would encourage Phnom Penh to be considered as a project site. Although people living in Phnom Penh have more resources than people living in the countryside, many of them were explicit targets of the DK regime (as "new people"). Third, victims of torture, including people from Phnom Penh, could be located through targeted advertising, such as a call for former DK prisoners and torture victims in *Searching for the Truth*, the DC-Cam and TPO Cambodia radio programs, and even Cambodian media outlets such as newspapers and television programming. Fourth, we recommend that given groups who were particularly targeted by the Khmer Rouge, such as Chams, ethnic Vietnamese communities, and other minorities be encompassed by the project. And, fifth, the project might also target areas around some of the most massive Khmer Rouge prisons and mass grave sites, such as Kong Pring (estimated 25,000 victims) or Wat O Trakuon (estimated 32,690 victims) in Kampong Cham, Chong Chroy in Kampong Chhnang (estimated 70,00 to 150,000 victims), Munty Santesokh M-13 in Kampong Speu (estimated 30,000+ victims), or Tuol Sa Phlorng in Kampong Thom (estimated 100,000-150,000 victims).[2] Regardless of which sites are ultimately chosen, we strongly believe that, if enhanced as per our suggestions about training, treatment, assessment, and capacity, the Victims of Torture project can be expanded successfully on the national level. Such an expansion is

[2] These estimated are from DC-Cam's "List of Democratic Kampuchea Burial," which was last updated on January 5, 2005.

of extraordinary importance due to the lack of mental health services in Cambodia, the high incidence of (largely undiagnosed and untreated) people suffering from PTSD, the need to build local capacity and help traumatized individuals reintegrate into society, and the necessity of documenting the mass murder of the past – particularly since the tribunal is about to begin.

Miscellaneous Recommendations

(a) *Confidentiality*: We recommend that VOT staff hold discussions about protecting the confidentiality of interviewees. For example, a story was published in *Searching for The Truth* (Special English Edition, First Quarter 2005) about Pich Kalyan, "Former Prisoner of Sang." The article mentions her name, home district, and psychiatric referral. At a minimum, we recommend that such individuals be informed that such information will be published and asked if they would prefer that a pseudonym be used.

(b) *Education*: We recommend that, in each village that DC-Cam and TPO Cambodia staff visit, they distribute a large poster that, in visually engaging graphics and basic language, educates people about mental health issues and the upcoming tribunal. (TPO Cambodia has already developed such a poster.) In addition, education can be promoted through the distribution of radios and information about radio programming (see above).

(c) *Gender*: We recommend that the VOT staff retain its current gender balance. More information is needed about gendered responses to trauma, but, based on our observations and discussions with VOT staff, it seems clear there are gender issues and that, at times, a male or female staff member may be required to most effectively carry out an interview.

(d) *Interview Process*: At present, DC-Cam staff sometimes switch interviewers after the initial documentary interview is completed. We recommend that the same person conduct the entire interview. This may be strenuous for the interviewer, but it will enable that person to establish rapport with the interviewee and more effectively obtain information and evaluate the interviewee's state of mental health. In addition, we'd recommend that leading questions be reformulated (for example, question 20 on vindictiveness may lead the response to question 28 on Buddhism, since it invokes a popular Buddhist saying).

(e) *Radio Distribution Program*: Since increasing awareness about mental health issues is an important part of alleviating suffering (not just of traumatized individuals but also their families who must cope with their problems), we also recommend that funding be sought to provide each PTSD-identified family with a transistor radio and batteries to enable them to listen to the weekly TPO Cambodia broadcasts about mental health and DC-Cam broadcasts about the genocide and upcoming tribunal.

Summary Recommendation

We strongly recommend the pilot program be expanded as quickly and to the greatest extent possible (the scope of the expansion will depend on the enhancement of capacity) in accordance with our recommendations. There is clearly a crucial need both to document the Khmer Rouge atrocities and to assess and treat mental illness in Cambodia. To date, Cambodia's mental health capacity is minimal, particularly in the countryside – in part due to the fact that almost all of Cambodia's psychiatrists were killed during or fled the country after DK. For the most part, the VOT program has successfully achieved its goals of documenting the genocide, assessing the trauma of interviewees, treating individuals with mental health problems, and helping them to better understand, cope with, and treat their problems. Indeed, informal self-reports from interviewees who have been diagnosed with PTSD indicate that the program has been successful in increasing their confidence and alleviating symptoms ranging from insomnia to anxiety (VOT Final Report 2005:2**).** With modifications, we are confident that the project, which has extraordinary potential and is of enormous importance in light of the upcoming trial and the current state of mental health in Cambodia, can be simultaneously expanded and enhanced -- particularly in areas where the "dream scenario" can be implemented. Ultimately, the overarching goal of this project is to improve the lives of Cambodian survivors. Bringing together their distinctive skills, DC-Cam and TPO Cambodia have paved the way for a unique and highly promising way of achieving this objective.

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