

CAMBODIA'S HIDDEN SCARS:

TRAUMA PSYCHOLOGY IN THE WAKE OF THE KHMER ROUGE

AN EDITED VOLUME ON CAMBODIA'S MENTAL HEALTH



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Searching for the Truth: Memory & Justice

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Cambodia's Hidden Scars: Trauma Psychology in the Wake of the Khmer Rouge
An Edited Volume on Cambodia's Mental Health

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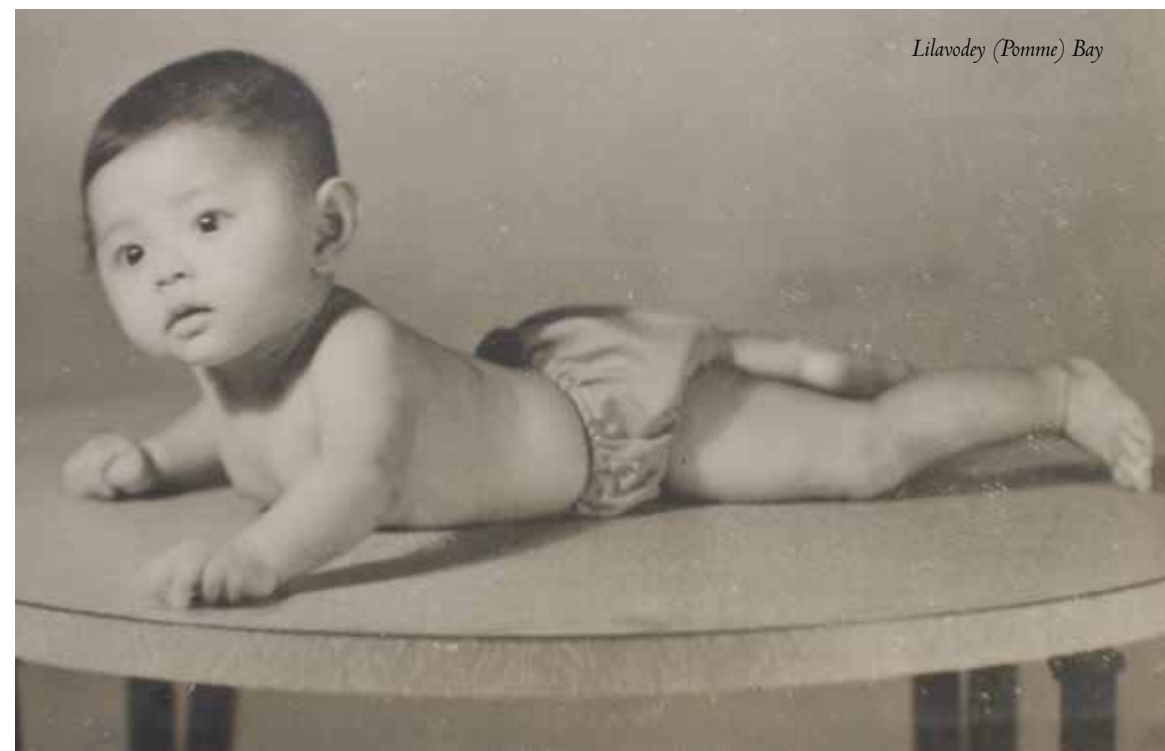
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*This book is dedicated to
the Victims and Survivors of the Cambodian Genocide.*

*To the children of Sophany and Sarit Bay:
Sophanouvong (Paul) Bay (1969-1976)
Botum Kunthea (Pine) Bay (1970-1976)
Lilavodey (Pomme) Bay (1974-1975)*

Murdered by the Khmer Rouge.



Lilavodey (Pomme) Bay

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INTRODUCTION



Daryn Reicherter (M.D.) is a Clinical Assistant Professor in the Department of Psychiatry and Behavioral Sciences of Stanford University's School of Medicine.

On April 17th, 1975, schoolteacher Sophany Bay was with her three children in her home when Pol Pot declared the “year zero” and the Khmer Rouge invaded Phnom Penh. With her infant and two toddlers, she was savagely driven from her home, witnessing the massive, brutal murders of peaceful citizens who showed any resistance. For Sophany, the forced evacuation of her home at gunpoint and subsequent journey into hell was the beginning of a nightmare that, in many ways, has continued to this day.

Sophany was dragged through the history of Cambodia’s darkest time. She can relate in vivid detail how she lost everything; how her children were starved and murdered; how she was tortured; how she was violated; and how she escaped. She can tell you the history of the Khmer Rouge from the perspective of a crime victim and a survivor. She can tell you how her experience still haunts her today; how this trauma has tormented her mind throughout her life; and how it continues.

KHMER ROUGE HISTORY

After the fall of Phnom Penh in April of 1975, the Khmer Rouge ravaged Cambodia and attacked the soul of a culture. The years that followed have been well documented as a history of terror. Cambodia was closed to the outside world under the Khmer Rouge. Only glimpses and stories of Pol Pot’s horrible vision were known beyond Cambodia’s borders. For those living under his rule, the terror of oppression was ever-present, and the trauma is unforgettable.

“To keep you is no benefit, to destroy you is no loss” became the popular slogan of the Khmer Rouge toward their victims. Hundreds of thousands of the people were driven to rural areas in shackles to dig their own mass graves. Khmer Rouge soldiers beat victims to death with metal bars and hoes, or simply buried them alive. A Khmer Rouge extermination prison directive ordered, “Bullets are not to be wasted.”

The savage reign lasted more than three years, and its terrible history is now well known. It was characterized by brutal oppression and extremes of violence in which the Khmer people endured more suffering, loss, and trauma than most of us can even imagine. The methods of persecution and terror are among the most evil known.

Pol Pot’s Cambodia began with terror and quickly slipped into crimes against humanity and even genocide that culminated in a paranoid self-destruction of the perpetrators themselves.

By the end of the Khmer Rouge era, even the perpetrators of the massive violence had broken down into a self-consuming, failed regime. The mass graves that litter Cambodia were filled with the bodies of the Khmer people lying alongside the bodies of those who began the killing.

PSYCHOLOGY AS A TARGET OF TERROR UNDER THE KHMER ROUGE

The Khmer Rouge violence was characterized by savagery. The brutal terror also had an intentionally *psychological* component. The Khmer Rouge mission to obliterate Khmer culture and start anew made the mass psychology of the Khmer people a target for the regime. This nefarious goal was implemented through calculated targeting of deeply-rooted principles of the Khmer culture and society. By obliterating such deeply held values, the psychology of a people commonly becomes a target.

Terror generally has the psychological purpose of dominating the victim into powerlessness. The very purpose of terror is to undermine psychological will and to shock an entire populace into submission. Under Pol Pot, the psychological aim was, in part, just that: oppression of the people through psychological dominance. The Khmer Rouge went a step farther with a broad-based and specific attack against important cultural and religious icons with particular symbolic relevance. The defilement of Khmer religion, Khmer art, Khmer familiar relations, and the Khmer social class structure undermined deeply-held societal assumptions. It also destabilized the mass psychology that was secure in those realities. In order to change a people, the Khmer Rouge had to change the minds of the people. To “restart civilization,” it was necessary to change the fundamentals of a civilization’s psychology. Cambodia’s psychology was thus altered in damaging and enduring ways.

MENTAL HEALTH CONSEQUENCES OF TRAUMA

In societies that experience war and genocide, trauma significantly impacts the people’s psychology. The ripple effects of this damage are often incalculable. These consequences are known all too well from the history of the world’s conflicts and the aftermath of terror and violence. Cambodia’s story follows the same pattern.

There are well-established statistics demonstrating a higher prevalence of trauma-related mental health disorders in post-conflict societies. This theme is seen throughout the world. Cambodia is a prime example. Studies have been done in Cambodia estimating and revealing the increased rates of post-traumatic stress disorder (PTSD) and major depression, among other major mental health disorders. Estimates may vary from report to report, but the reports always demonstrate a greater prevalence of mental health disorders as compared to societies that have not experienced such disruptions. The burden of such a high prevalence of societal mental illness on a post-conflict society is staggering.

Specific mental health disorders are often the subject of enquiry when statistics are generated examining the psychology of people in post conflict societies. The diagnostic criteria, however, are very limited and do not capture the holistic effect of conflict on the cumulative psychology of a population. Although high rates of PTSD, other anxiety disorders, or depression are indicators of a heavy burden of psychological distress on a society, the full suffering of a people cannot be measured in this way, nor can the psychological impact on future generations.

EXTRAORDINARY CHAMBERS IN THE COURTS OF CAMBODIA

The long-awaited establishment of the Extraordinary Chambers in the Courts of Cambodia (ECCC) has created a prime opportunity to examine the mental health effects of society-wide crimes against humanity. The resurfacing of old emotions is everywhere in Cambodia with the Court’s and the world’s attention turned to the 30-year old crimes of the Khmer Rouge. Those “hidden scars” are no longer silent. The Court cannot help but find itself immersed in the psychology of trauma. The survivors’ needs must be addressed.

PURPOSE OF THIS VOLUME

In documenting the history and the crimes of the Khmer Rouge, the Documentation Center of Cambodia (DC-Cam) realized that trauma-related mental health problems are ubiquitous in post-genocide Cambodia. After countless interviews with survivors, the same patterns of psychological trauma presented again and again. These hidden scars would open again and again to reveal a profound suffering that is known well to the field of psychology, but is also intrinsic to the documentation of genocide. So intrinsic, in fact, that DC-Cam decided to include trauma-related mental suffering as a category of their documentation and a major area of concern for the legacy of Cambodia.

Documenting crimes against humanity goes beyond chronicling the wicked history of perpetrators and interring the bones of the victims left behind. Documenting international crimes must include an examination of the psychology of the survivors who endure and lament for those who did not. Cambodia and beyond, the psychological scars in the wake of such a history is essential to the telling of the story. This volume attempts to bridge the interdisciplinary inquiries into Cambodian history, the launching of an international court of justice, and the efforts to mend the mental suffering of a nation.

Part I considers the phenomena of trauma’s effects on human psychology and in Cambodia in particular. It offers a statistical and theoretical overview of the mental health consequences at the individual and societal levels. It examines the multigenerational effects of severe trauma and how such effects continue to impact the nation and its movement forward.

Part II explores the interplay between trauma psychology and the ECCC. It looks at the

psychological effects of the work of the Court on participants, witnesses, and Civil Parties. The concept of justice as it relates to trauma psychology is examined. It also critiques the Court's reaction to the psychological state of the survivors. Finally, it raises questions about reparations as a form of accountability for the mental health of survivors.

Part III examines the resources for interventions and for the treatment of mental suffering in Cambodia. It critiques the public and private mental health system in Cambodia as it relates to the treatment of trauma-related mental health. This is accomplished through a series of inclusive studies extracting the opinions of mental health providers and administrators struggling to meet the incredible need in a complicated and highly burdened system.

CALL FOR ACTION

The psychological consequences of trauma are so ever-present in post-conflict societies that it seems to be an assumed part of surviving. This volume, however, is intended also as an instrument of advocacy. In particular, it is intended to advocate for the idea that trauma-related psychological problems must be expected and accounted for in the documentation of genocide and crimes against humanity. This fact does not need to be rediscovered for each society that survives unspeakable atrocities. Rather, such reactions can be predicted and must be factored into any understanding of the history of crimes against humanity and efforts to offer justice for such atrocities. It is part of the living history of violence that cannot be forgotten.

This volume is also intended to advocate for respect for the survivors' psychology in the justice process. Tribunals do a good job of sifting through evidence to provide an accounting for the commission of international crimes. They may undertake this primary task to the exclusion of the needs of survivors, however. The ECCC has shown some progress in this area relative to other international tribunals. Any international court must operate under the assumption that preserving the psychological health of the survivors is a sacred and indelible part of the justice process and not an afterthought.

In addition, this volume is intended to advocate for improvements in the allocation of resources for the mental health of survivors. In Cambodia, the burden of trauma-related suffering is overwhelming.

The movement toward healing has been pioneered by a system that is under-resourced and over-taxed. It is an injustice to survivors that three decades after the Khmer Rouge era, their minds cannot rest because they lack access to resources for mental health. This volume advocates for the much needed and long-awaited improvement in resources for mental health for the country. With the Khmer Rouge's crimes and justice process at the forefront

of people's minds, the Kingdom must attend to the hidden scars of the survivors.

Sophany Bay crawled out of Cambodia through Thai refugee camps and eventually immigrated to the United States. She is now a community leader, an activist, and a preserver of Khmer culture. She became a mental health specialist and has devoted her life to the delivery of mental health services for survivors of the Khmer Rouge. She is Civil Party 1 in Case 002 before the ECCC against the regime leaders. She will finally have her day in court.



PART I
THE EXPERIENCE OF TRAUMA IN CAMBODIA

THE IMPACT OF WAR AND GENOCIDE ON PSYCHIATRY AND SOCIAL PSYCHOLOGY

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Psychological suffering is a well-known consequence of war and genocide. War affects everyone it touches, from soldiers to civilians. The destructive consequences are most often calculated by the number of lives lost, through statistics showing the number of people disabled, or by the monetary value of property damaged or destroyed. In addition to the physical damage, however, war, political conflict, and genocide produce profound psychological consequences for individuals and entire societies.

It is well known to Western psychologists that the profound trauma incident to war and genocide causes mental health suffering and dysfunction. This fact, however, is not necessarily appreciated across disciplines or across cultures. Indeed, the consequences of war on psychology are often misunderstood or overlooked. Unfortunately, they are ever present and hugely problematic.

The mass psychological effect on post-conflict societies is difficult to measure or even to estimate because of a gap in our understanding of the way in which individual psychological damage affects the behaviors of whole societies. This gap may be partially bridged, theoretically, by understanding the mental health consequences for individuals and the subsequent risks for pathological behaviors. The consequences on individual psychology are tragically apparent in the statistics of the observed social consequences in post-conflict societies.

Post-conflict societies manifest high burdens of mental suffering, increased prevalence of mental health disorders, and increased tendencies toward many forms of systemic social dysfunction. The dysfunction starts at the individual level and is magnified by the scale of the conflict. From the individual to the family, from a kinship group to a village, the ripples of mental suffering disrupt functioning on multiple levels with consequences for entire societies. These effects are increased in a multigenerational transfer of maladaptive functioning. While it may be too simplistic to imply causality, there is a predictable pattern to this cross-generational connection. Mental health is culturally nuanced, varying from culture to culture, but grave outcomes and dysfunction are the rule—worldwide—in the wake of war and genocide.

RECOGNITION OF MENTAL HEALTH IN GLOBAL HEALTH

In the past, international health organizations tended to focus mostly on the physical effects of war. In recent decades, however, major health organizations have turned their focus to the consequences of war on a nation's social psychology. Mental dysfunction and suffering as a result of political violence is now recognized as a major public health problem. The consequences of mental health disorders for human health and on social function have come to the attention of the world's health organizations as a major, worldwide problem. Indeed, the World Health Organization (WHO), the United Nations (UN), the United Nations Infant and Children's Emergency Fund (UNICEF), and other international health agencies have highlighted the severely debilitating mental health effects of war on massive numbers of people.¹

The resolution of the WHO Executive Board in January 2005 urged that support be given for “implementation of programmes to repair the psychological damage of war, conflict[,] and natural disasters.”² For example, the WHO reports that conflicts, wars, and civil strife are associated with higher rates of mental health problems.³ The WHO estimates that globally:

10% of the people who experience traumatic events will have serious mental health problems and another 10% will develop behavior that will hinder their ability to function effectively. The most common conditions are depression, anxiety[,], and psychosomatic problems such as insomnia, or back and stomach aches.⁴

MENTAL HEALTH DISORDERS ASSOCIATED WITH WAR AND GENOCIDE

Research conducted in post-conflict settings demonstrates that war greatly increases the risk for developing mental health disorders. Studies examine the prevalence of mental health disorders as defined by the Diagnostic Statistical Manual of Psychiatry (DSM-IV)⁵ or by the International Classification of Diseases, 9th Revision (ICD-9)⁶ and show great increases

in predictable mental health disorders like post-traumatic stress disorder (PTSD), depression, and other specific “disorder” states. Studies also show tendencies toward the development of other social problems that are related to these mental health disorders, like domestic violence or alcohol abuse. Most of these studies are either based on specific diagnostic criteria or rating scales for mood or anxiety.

A major mental health disorder that is most often associated with war trauma is PTSD. PTSD is defined in the DSM-IV as a specific anxiety disorder that may result from extremes of traumatic experience. This is not the only mental health disorder expected to see increased in a population as a consequence of war. Other anxiety disorders are also seen at higher frequencies, as are severe mood disorders like depression. Somatoform disorders (physical manifestations of psychological stress) are also more prevalent in post-conflict settings.

Furthermore, psychiatric disorders will often occur simultaneously with each other. In the alternative, one disorder may create a heightened risk of another. For instance, anxiety disorders are often linked with mood disorders, so PTSD and depression will often occur together in the same individual. Similarly, an anxiety disorder like PTSD may increase the likelihood of an individual’s alcohol use, so PTSD and alcohol dependence are often co-occurring disorders.

These mental health co-morbidities that result from societal trauma are grave. Alcohol and other substance use disorders are extremely common among persons with PTSD.⁷ For example, as many as 75% of combat veterans with lifetime PTSD also met the criteria for alcohol abuse or dependence.⁸ Research has identified PTSD as a mediating factor in the relationship between veterans’ combat experience and its negative effects on the veteran’s family. To some extent, veterans’ anger is associated with troubled family relationships and secondary traumatization among family members.⁹ Destructive social issues like domestic violence increase after war¹⁰ and may be exacerbated by substance use disorders. Increased alcohol consumption among traumatized civilian war survivors was associated with higher levels of child abuse in Sri Lanka.¹¹ Also, veterans who have comorbid trauma disorders in addition to PTSD are more susceptible to using violence against their intimate partners.¹² The perpetration of violence is a common occurrence for persons affected by violence and by PTSD. While there is not necessarily a direct link between the violence of war and these outcomes, the correlation is clear and the connection is not difficult to understand.

POPULATIONS AT HIGH RISK IN WAR

Situations of war and atrocity may disproportionately affect certain populations, placing them at greater risk of experiencing trauma and poor mental health outcomes.

Veterans

An obvious at-risk population is soldiers involved in violence on the front lines of conflict. Studies of American veterans of the Vietnam War conducted between 1986 and 1988 estimated lifetime prevalence of PTSD at 30.9% for men and 26.9% for women. At the time of the study, 15.2% of males and 8.1% of females were currently diagnosed with PTSD.¹³ In a different American study on Gulf War veterans, PTSD was found at a prevalence of 12.1% in a population-based sample of 11,441 veterans. The estimated overall prevalence of PTSD in the Gulf War veteran population was 10.1%.¹⁴

Civilians

More frequently in the late twentieth and early twenty-first centuries, civilian populations have suffered the major impact of war. Particularly troubling has been the use of “ethnic cleansing,” torture, and genocide as weapons of war, placing civilians at great risk of harm. In the 1994 genocide in Rwanda, at least 800,000 civilians were systematically killed over the course of 100 days. Other devastating consequences, including lack of food and sanitation, also result in staggering numbers of civilian deaths. In the war in the Congo, an estimated 5.4 million people died over the five-year period from 1998 to 2003. Most were civilians, and most died from starvation and disease. This extreme exposure to violence greatly increases the risk of developing mental health problems.

Women

The use of gender-based violence and mass rape as a weapon of war and a tactic of genocide has also become more common and has gained more attention in recent years. Such violence had previously been considered an unfortunate consequence of war, but is now being recognized as an intentional wartime maneuver. In 2008, the U.N. Security Council passed a resolution naming sexual violence as a war crime, a crime against humanity, a form of torture, and a constituent act of genocide.

Estimates of rapes of women during the 1994 genocide in Rwanda are between 250,000 and 500,000. During the civil war in Sierra Leone, at least 50,000 women were victims of gender-based sexual violence. During the conflict in Bosnia and Herzegovina, between 20,000 and 50,000 Muslim women are estimated by the United Nations to have been raped. In the Congo, approximately 200,000 women and girls have been raped. Rape is used as a method of destabilizing, terrorizing, and controlling civilian populations. Rape is highly correlated with the subsequent development of PTSD.

In all of these conflicts, perpetration of rape as a weapon of war has had devastating effects on the social fabric of societies and the mental health of women. It is used as a method for humiliating women and their families. The consequences—including unwanted pregnancies and children, diseases, social stigmatization, and familial rejection—frequently may result in

a near complete breakdown of family structure.

Children

Children are very often victims of war. Like other civilians, they may be injured or killed. There are two other specific conditions, however, that occur frequently in the context of conflict. First, children may lose their parents or guardian figures. There are incredibly high numbers of these Orphans and Vulnerable Children (OVC) in post-conflict settings. UNICEF has highlighted OVC as one of the most worrisome issues facing children in the modern age. Second, new trends show increases in the use of children as soldiers in Africa and Asia. These two conditions are highly correlated with childhood trauma and subsequent serious mental health pathology.

LASTING AND INTERGENERATIONAL EFFECTS OF WAR AND GENOCIDE

There is a major concern over the long-term effects of psychological trauma on survivors and their children. It has been well documented that the psychological effects of war trauma may be long lasting. Such impacts can also affect parenting styles and perpetuate maladaptive behaviors in the next generation. Much of the data that is known on this topic comes from studies of survivors of the Jewish Holocaust of World War II.

The Holocaust witnessed the genocide of approximately six million European Jews during World War II throughout Nazi-occupied territory. Of the nine million Jews who resided in Europe before the Holocaust, more than two-thirds perished, leaving about two million survivors.¹⁵ The survivors are at risk for emotional disorders and adjustment problems, including emotional distress, depression, anxiety,¹⁶ posttraumatic stress disorder,¹⁷ and chronic pain.¹⁸ Moreover, Holocaust survivors with PTSD report more depressive symptoms than those without PTSD.¹⁹ A recent study conducted by the Center for Research on Aging of the Israeli Myers-JDC-Brookdale Institute found that two-thirds of Israel's 220,000 survivors experience some form of distress, and this number increases to three-quarters of survivors aged 80 years or older.²⁰

In a recent meta-analysis of seventy-one individuals, Barel and colleagues found that Holocaust survivors were less well adjusted than their comparisons and showed substantially higher traumatization in the form of posttraumatic stress symptoms and greater psychopathological symptomatology.²¹ There were no significant effect sizes, however, in several other domains of functioning (e.g., physical health, stress-related physical measures, and cognitive functioning), and Holocaust survivors showed remarkable resilience.²² In another study, researchers observed that a high proportion of Holocaust survivors who had experienced trauma more than 60 years earlier continue to experience major depression.²³ Moreover, the researchers found that depressed survivors had significantly more comorbid symptoms, such as anxiety and PTSD, than depressed non-survivors.

Keilson created the term “sequential traumatization” to refer to the accumulation of traumatic stresses confronting Holocaust survivors before, during, and after the war.²⁴ According to Danieli, the effects of trauma may become intergenerational when they affect families and succeeding generations.²⁵ In the words of Dekel and Goldblatt:

Whereas intergenerational transmission of different kinds of trauma is presently well established in both the empirical and clinical literature...the mechanisms by which trauma and/or its symptoms are transmitted are scarcely known and lack empirical base.²⁶

Yehuda and colleagues observed a higher prevalence of lifetime PTSD, mood disorders, and anxiety disorders in offspring of Holocaust survivors than in controls.²⁷ In addition, the presence of maternal PTSD was specifically associated with PTSD in adult offspring. In an earlier study, Yehuda and colleagues also found an increased vulnerability to PTSD and other psychiatric disorders among offspring of Holocaust survivors.²⁸ This was true in both community and clinical subjects.

Two meta-analyses have investigated secondary (children of survivors) and tertiary (grandchildren of survivors) traumatization in Holocaust survivor families. Van IJzendoorn and colleagues found evidence of secondary traumatization in clinical and select samples. The researchers, however, did not find similar evidence in non-select samples (i.e., participants drawn from the entire population of Jewish households that reside in a given area), in non-clinical samples, nor in samples that included survivors in the community who did not seek professional help.²⁹ Additionally, Sagi-Schwartz, Van IJzendoorn, and Bakermans-Kranenburg did not find evidence for tertiary traumatization in Holocaust families and interpreted these findings as a sign of resilience, even when the Holocaust survivors were profoundly traumatized personally.³⁰

Although other survivor cohorts may not be as well studied, the outcomes from the Holocaust on survivors and on subsequent generations has become a motif for how many psychologists think about the long-term consequences and intergenerational influences of genocide on populations.

MEASURED MENTAL HEALTH CONSEQUENCES OF CURRENT AND RECENT CONFLICTS

Much data have been generated examining the mental health consequences of war. Conflicts around the world suggest different rates of diagnosable disorders. There are many different variables, including cultural and gender factors, that may predict greater or lesser rates of trauma-related mental health disorders.

The specific differences between the statistical rates of mental health disorders are less

important for the purposes of this Chapter than the *gross* increases in rates observed in post-conflict societies. Unsurprisingly, global data show that trauma-related mental health disorders are far more prevalent in post-conflict countries than in peaceful countries. Furthermore, a review of statistical information from studies in conflict regions suggests a very high statistical prevalence of mental health disorders in post-conflict states. A number of examples are described below.³¹

Afghanistan

Afghanistan has experienced conflict for more than two decades, resulting in the displacement of a large segment of the population, loss of family members, and loss of security for surviving civilians. Two recent studies found high numbers of persons who had experienced multiple traumatic events. An increase in the number of traumatic events experienced was associated with higher rates of psychiatric symptoms. The first study involved a national survey of 799 Afghani adults aged fifteen years and older. It found symptoms of depression in 67.7% of respondents, symptoms of anxiety in 72.2%, and PTSD in 42%.³² Additionally, 62% percent of respondents reported experiencing at least four traumatic events during the previous ten years. Scholte and colleagues found lower levels of distress, but symptoms of depression were still observed in 38.5% of respondents, symptoms of anxiety in 51.8%, and PTSD in 20.4%.³³

Algeria

The Algerian civil war began in 1992 after the Algerian military staged a coup d'état to prevent the Islamic Salvation Front (FIS) from being elected into power.³⁴ Violence and a bloody civil conflict ensued, causing an estimated 150,000 to 200,000 deaths and approximately 15,000 people forcibly disappeared.³⁵ FIS and other armed terrorist groups also massacred civilians to punish communities and to warn them against withdrawing their support.³⁶ In 2007, Algeria suffered an upsurge in violence, including suicide bombings that targeted government and foreign interests.³⁷

As a result of the massacres, there are countless Algerians who have lost everything—family members, supportive social structures, and their most basic possessions. The number of massacres counted by the National Observatory of Human Rights was 299 until 1997. Additionally, hundreds of villages experienced violent raids. Although the large-scale massacres have stopped, mass killings of entire families or groups of people still continue to occur in some areas of Algeria.³⁸ De Jong and colleagues found a 37.4% prevalence rate of assessed PTSD.³⁹ Women manifested more PTSD symptoms than men.⁴⁰ Notably, 91.9% of Algerians reported experiencing conflict-related events after twelve years of age. The results of an epidemiological survey conducted by the Algerian Society of Research in Psychology (SARP) found that the degree of distress was high: 27% to 48%. Moreover, 18% and 28% of respondents met criteria for PTSD and depression, respectively, and

27%-38% scored high on the Global Severity Index.⁴¹ Distress was especially high in women and younger people. People who were exposed to traumatic separations from their family or to threatening situations, and people who were deprived of basic resources were most at risk.

The Balkans

The conflict in the Balkans has been widely studied. The dismantling of the former Republic of Yugoslavia began with Slovenia's declaration of independence in 1991, which was followed by Croatia in 1991 and Bosnia-Herzegovina in 1992. The fighting between Slovenia and the Yugoslav People's Army lasted only ten days, but the brutal wars fought in Croatia and Bosnia-Herzegovina continued until 1995. Hostilities lasted in Kosovo from 1998 to 1999.⁴² According to the International Center for Transitional Justice (ICTJ), nearly 140,000 people were killed in the region during the conflicts, and almost four million others were displaced.⁴³

A study of former Bosnian refugees who remained in the region found that 45% continued to exhibit psychiatric disorders and disability three years after an initial assessment, and 16% had developed PTSD, depression, or both.⁴⁴ In addition, a cross-sectional survey of Kosovar Albanians aged fifteen years or older found that 17.1% reported symptoms of PTSD and a high prevalence of exposure to traumatic events.⁴⁵ For those aged sixty-five years or older, persons with previous psychiatric illnesses or chronic health conditions, and those who had been internally displaced, mental health status and social functioning significantly decreased as the number of experienced traumatic events increased.⁴⁶ High levels of posttraumatic stress symptoms, grief symptoms, and massive exposure to traumatic wartime events were found in a community sample of 2,796 children, between nine and fourteen years old, who were living in Bosnia-Herzegovina.⁴⁷

Rwanda

From April until mid-July of 1994, the genocide in Rwanda resulted in the deaths of an estimated 800,000 people, most of whom were Tutsis.⁴⁸ Nearly four million people were displaced; two million of whom fled into exile in neighboring countries. Survivors were exposed to scenes of unmitigated violence and masses of dead bodies.⁴⁹

In a random survey of 2,091 eligible adults in four communes in Rwanda, 518 (24.8%) met symptom criteria for PTSD. The adjusted odds ratio (OR) of meeting PTSD symptom criteria for each additional traumatic event was 1.43.⁵⁰ Thus, the more an individual was exposed to traumatic events, the greater the likelihood was that he or she would report PTSD symptoms. In addition, the prevalence of PTSD symptoms was higher in women than in men. Of 2,074 respondents with data on exposure to trauma, 1,563 (75.4%) were forced to flee their homes, 1,526 (73.0%) had a close member of their family killed, and

1472 (70.9%) had property destroyed or lost.⁵¹ Importantly, respondents who met PTSD criteria were less likely to have positive attitudes towards the Rwandan national trials and less likely to develop a shared vision and sense of collective future, which suggest that societal interventions should consider the effects of trauma if reconciliation is to be realized.⁵²

Sri Lanka

The conflict between the majority Sinhala and minority Tamil population lasted for nearly thirty years.⁵³ An epidemiological survey found that 94% of the study population had experienced war stresses and psychosocial sequelae were seen in 64% of the population: somatization (41%), PTSD (27%), anxiety disorder (26%), major depression (25%), alcohol and drug misuse (15%), and functional disability (18%).⁵⁴

Somalia

A study of combatants in Somalia found high psychiatric morbidity and use of khat, which is classified by WHO as a drug of abuse. Khat chewing was significantly more frequent among subjects with PTSD (66.2% versus 34.6%), and khat chewers with PTSD consumed significantly higher quantities than khat chewers without PTSD.⁵⁵ A UNICEF Study found evidence of psychological effects of the prolonged conflict situation in a high proportion of a sample of 10,000 children.⁵⁶ In addition, more than a quarter of children (26%) reported being exposed to a serious or traumatic event caused by conflict. Nearly all mental health services have been disrupted in the country.⁵⁷

TRAUMA AND CAMBODIA

Cambodia has a unique history of traumatic experience that puts its population at high risk for the development of mental health disorders. The Cambodian experience is of particular importance because multiple risk factors for developing poor mental health outcomes are present.

The Khmer Rouge era launched a historical epoch that combines many of the conditions most likely to result in psychiatric and behavioral changes. War and genocide were combined with famine and poverty during the Pol Pot regime. Constant threat of violence and torture was in the background of systemic forced labor. Gender-based violence was common throughout. All of these factors raise the risk for developing mental health problems. Political instability and violence coupled with unstable living conditions continued long after the Khmer Rouge fell from power. Millions of Cambodians suffered profound trauma during the Khmer Rouge regime. Studies have found that both Cambodian residents and Cambodian refugees have high levels of psychiatric symptomatology associated with trauma.

For example, De Jong and colleagues found a 28.4% prevalence rate of assessed PTSD in a

sample of Cambodians randomly selected from a community population. Risk factors for PTSD within this population included psychiatric history and current illness. Youth domestic stress, death or separation in the family, and alcohol abuse in parents were associated with PTSD.⁵⁸

A survey of 1,320 Cambodians living in the Kampong Cham province aged twenty years or older was conducted to determine the prevalence of psychiatric symptoms and its association to impaired social functioning.⁵⁹ Of the respondents, 42.4% reported symptoms that met DSM-IV criteria for depression, 53% displayed high anxiety symptoms, and 7.3% met criteria for PTSD. Furthermore, 29.2% had depression and anxiety symptoms, and 7.1% had triple comorbidity (PTSD, depression, and anxiety).⁶⁰ With regards to social functioning, 25.3% reported being socially impaired, and 22.3% were classified as having significantly impaired physical activities due to a health problem.⁶¹ Respondents over sixty-five years with co-morbid symptoms for depression, anxiety, and PTSD, or respondents who had experienced violent events had an increased risk for social impairment compared with others.⁶²

More recently, in a national probability sample of 1,017 Cambodians, Sonis and colleagues found that 11.2% of adult Cambodians living in Cambodia had current probable PTSD.⁶³ Of the 813 adults older than thirty-five years who were at least three years old during the Khmer Rouge era, the prevalence of probable PTSD was 14.2%.⁶⁴ Probable PTSD was significantly associated with mental disability (40.2% versus 7.9%) and physical disability (39.6% versus 20.1%).⁶⁵ Respondents with high levels of perceived justice⁶⁶ for violations perpetrated by the Khmer Rouge were less likely to have probable PTSD than those with low levels (7.4% versus 12.7%).⁶⁷

More than 85% of Cambodians in a displaced-persons camp on the Thailand-Cambodia border reported that, during the Khmer Rouge regime, they lacked food, water, shelter, and medical care, and that they experienced brainwashing and forced labor. In addition, 54% reported murder of a family member or friend; 36% reported experiencing torture under the Khmer Rouge regime; and 17% reported rape or sexual abuse. Furthermore, during the refugee period of 1989-1990, more than 80% said they were in fair or poor health, felt depressed, and had a number of somatic complaints despite good access to medical services. Of the refugees, 55% met the criteria for depression, and 15% met criteria for PTSD. Finally, 15% to 20% reported health impairments limiting activity as well as moderate or severe bodily pain.⁶⁸

In a study of the 586 Cambodian refugees between thirty-five and seventy-five years old who lived in Cambodia during the Khmer Rouge reign and had relocated to the largest Cambodian community in the United States (Long Beach, CA), all participants had been

exposed to trauma before immigration. Indeed, 99% had experienced near-death due to starvation, and 90% had a family member or friend murdered. High rates of PTSD (62%) and major depression (51%) were also found. PTSD and major depression were highly comorbid in this population (42%), and each showed a strong correlation between measures of traumatic exposure and symptom burden. Additionally, older age, poor English-speaking proficiency, unemployment, being retired or disabled, and living in poverty were also associated with higher rates of PTSD and major depression.⁶⁹

Adolescent Cambodian refugees, who were child-survivors, have high levels of stress exposure and trauma symptoms.⁷⁰ Starvation and seeing dead bodies were the most frequent traumatizing events, reported by 91% and 89% (respectively) of the sample; 57% of males and 40% of females reported torture of an acquaintance. Based on self-reports of PTSD symptoms, 37% met criteria for PTSD. Age was strongly related to reporting higher trauma exposure.⁷¹ Likewise, in a sample of Cambodian refugees attending a psychiatric clinic in the United States, 56% met DSM-IV criteria for PTSD.⁷²

Beyond the individual statistics for mental health disorders, Cambodia endured traumatic extremes on a societal level. Bizarre social conditions like forced marriages, the separation of families and kinship groups, and relocation of children (away from their parents) were implemented during the Khmer Rouge period. In fact, the Khmer Rouge made every attempt to *ban* family life. In addition, the Khmer Rouge purposefully engineered the elimination of religion and the execution of religious leaders in a culture entirely connected to Buddhism. Most culturally relevant constructs became a target of destruction under the Khmer Rouge.

The unique insults to Khmer social order and culture had profound implications for psychological outcomes. It is unclear, however, exactly how these inconceivable and radical social conditions changed Khmer psychology. It is also unclear how these singular changes relate to Western measurements of mental health pathology.

UNMEASURED MENTAL SUFFERING FROM WAR AND GENOCIDE

In most studies on psychiatry and psychology in post-conflict settings, statistics are generated based on very specific diagnostic ideas—such as rating scales for PTSD or depression—leaving much of the psychological *suffering* undocumented. As psychiatrist Duncan Pendersen writes:

The PTSD model has important limitations in capturing the complex ways in which individuals, communities, and larger groups experience massive trauma, socialize their grief, and reconstitute a meaningful existence.⁷³

Therefore, it is likely that much of the psychological distress and social dysfunction resulting

from war violence is poorly captured in the studies that examine the mental health pathology of post-conflict populations with the Western PTSD model. This does not make the suffering or the risks for its consequences on human behavior any less real. These consequences are just more difficult to analyze and quantify for statistical reporting.

Psychological suffering and behavioral dysfunction that does not fulfill criteria to be included into established categories may not be reflected in statistical reports reflecting the mental health impact of war and genocide. Pendersen continues:

The health impact of political violence and wars should be examined not only along the lines of sheer number of casualties and trauma related disorders among survivors, but also on the individual and collective levels. Indirect effects such as disintegration of the family and social networks, disruption of the local economies, dislocation of food production systems and exodus of the work force have profound implications in the health and well-being of survivors.⁷⁴

Often mental health problems “present” as other medical issues like headaches, pain, or stomach ache, and the psychological component is undetected (even though it is primary). While there may be serious mental health pathology, it would likely not be reported as a disorder.

There are also war-related psychological issues that are not necessarily described as disorders, but have grave outcomes for people and disrupt behavior. Extremes of grief and loss are internalized psychologically in different ways, but usually result in suffering and anguish and often influence social function. Specific violations and personal injuries from war can cause anger and resentment or disillusionment and an inability to trust. These psychological changes are difficult to measure, but they negatively affect people’s lives, relationships, and behaviors. In addition, existential psychological changes may occur, such as loss of religious beliefs or isolation from cultural values.

As with the disorder states described above (PTSD and depression), these forms of psychological suffering are multiplied when vast percentages of the population are victimized. This amplifies the risk for behavioral disturbance in the population. While these other forms of suffering may be harder to quantify, it is not difficult to understand how these issues cause dysfunction in an individuals’ family, interpersonal relationships, and occupation. Psychological suffering will have a more profound effect on society when it is highly prevalent within a given population. Greater numbers of persons with debilitating psychological problems and maladaptive behavior are correlated with an increased sociological effect.

SOCIAL SUFFERING IN POST-CONFLICT AND POST-GENOCIDE SOCIETIES

Trauma-related mental health problems are associated with a broad spectrum of inter-related social problems. It is difficult to establish a causal relationship between the psychological manifestations of traumatic experience and the catastrophic social conditions that are observed in parallel in post-conflict societies. The social problems that coexist with mental health problems in post-conflict societies, however, are widespread across multiple spheres of human experience. Amid the greatly inflated prevalence of mental health disorders and psychological suffering are dire social conditions like poverty, economic collapse, political instability, or continued conflict and violence. Medical anthropologist Arthur Kleinman states:

Social suffering results from what political, economic, and institutional power does to people and, reciprocally, from how these forms of power themselves influence responses to social problems. Included under the category of social suffering are conditions that are usually divided among separate fields, conditions that simultaneously involve health, welfare, legal, moral, and religious issues.⁷⁵

The interplay between social psychology and sociological problems in post-conflict societies is not completely understood in academic circles, partially because of the lack of interdisciplinary examinations of the parallel phenomena. The overlap between psychiatric and social problems after war, however, is recognized. As more importance is placed on mental health by global health programs, greater appreciation for the effects of psychological and behavioral changes at the societal level will be understood.

The psychological dysfunction becomes a factor in a complicated web of social dysfunctions that feedback on each other and amplify problems. Kleinman goes on to describe the interconnected sequence:

A vicious spiral of political violence, causing forced uprooting, migration, and deep trauma to families and communities, while intensifying domestic abuse and personal suffering, spins out of control across a bureaucratic landscape of health, social welfare, and legal agencies.⁷⁶

CONCLUSIONS

War and genocide create immeasurable landscapes of suffering in the post-conflict period. The impact on human psychology is grave. This has been demonstrated again and again by sampling survivors of political conflict with psychological measurement instruments and by studying behavioral changes. While these surveys show clear trends toward higher rates of mental health pathology and pathological behaviors, it seems clear that these studies do not

capture the total negative impact of war and genocide on mass psychology. These studies consistently demonstrate alarming changes in psychology with percentages of trauma-related mental health disorders that are overwhelming.

The mental health consequences of war and genocide go beyond the level of the individual and have implications for social systems. Pathological behaviors like domestic violence and substance abuse disorders are linked to trauma-related mental health disorders and are seen at worrisome rates in post-conflict societies. Furthermore, there is a clear, negative intergenerational influence of pathological psychology.

While mental anguish and suffering from trauma and loss have been evident throughout the history of war, mental health pathology in post-conflict settings is only now becoming recognized as a global public health issue. Global health agencies are focusing more and more attention on the issue and acknowledging it as a major element in the overall consideration of disease burden.

More attention to mental health in post-conflict countries is needed. Often the public health system is damaged by the conflict or struggling to meet the general health needs of the population. Within these systems, mental health resources are often under-represented or stigmatized and, therefore, lacking. Emphasis is usually placed on other areas of healthcare without addressing the major individual and social impacts of untreated mental health problems. Global trends recognizing mental health as an important area of public health may bring the issue of mental health to the attention of healthcare policy makers in post-conflict settings, leading to improved resources for survivors.

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2 THE EFFECT OF THE KHMER ROUGE ON THE MENTAL HEALTH OF CAMBODIA AND CAMBODIANS

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The Khmer Rouge regime in Cambodia (1975-1979) was one of the most brutal of the twentieth century. In terms of deaths per total population, it ranks very high among genocidal regimes. After millions were killed by execution, starvation, and disease, survivors were left with multiple and long-standing psychiatric disorders. Our Chapter focuses on those disorders and the tragic legacy of the Khmer Rouge on the mental health of Cambodians at home and across the globe. For the past thirty years the authors have worked with Cambodian refugees who have come to the United States and have resided in Portland, Oregon. Here, we review the literature of psychiatric treatment of Cambodian refugees, specifically focusing on epidemiology, symptoms, child and family issues, medical problems, prognosis, and treatment, with a special emphasis on treatment of refugees in our Intercultural Psychiatric Program at the Oregon Health and Science University (OHSU).

EPIDEMIOLOGY AND SYNDROMES ASSOCIATED WITH TRAUMA AMONG CAMBODIAN SURVIVORS

Our group published the first report of posttraumatic stress disorder (PTSD) among survivors of Cambodian concentration camps in 1984.⁷⁷ This occurred soon after the diagnosis of PTSD was formulated in 1980 in DSM-III, the American Psychiatric Association's third edition of the Diagnostic and Statistical Manual of Mental Disorders.⁷⁸ We evaluated thirteen refugees and found that they all met the criteria for PTSD with hyperactivity, numbness, intrusive thoughts, nightmares, and avoidant symptoms. Since that time, there have been multiple reports throughout the world of psychiatric disorders among Cambodian refugees. In 1991, Carlson and Rosser-Hogan reported on a random sample of

refugees who were not psychiatric patients and found that 86% had PTSD, 96% had high dissociative scores, and 80% suffered from clinical depression.⁷⁹ Multiple other studies within and outside of Cambodia have indicated a high percentage of patients with psychiatric disorders. An exception was a study that found a PTSD prevalence of only 12.1% among 223 refugees in New Zealand.⁸⁰ In a study of 1,000 households in Thai refugee camps at Site 2 on the Thai/Cambodian border, a high prevalence of trauma and psychiatric symptoms was found among refugees. The authors noted that cumulative trauma continued to affect psychiatric symptom levels a decade after the original traumatic events.⁸¹ A more recent study of 1,017 Cambodians in Cambodia found a current PTSD prevalence rate of 11.2% overall, 7.9% among younger people and 14.2% among older people.⁸² Probable PTSD was significantly associated with mental disability.

Clearly, PTSD and depression are the most prevalent disorders in Cambodian Khmer Rouge survivors. Multiple other disorders, however, have been found. For many years the validity of PTSD cross-culturally was questioned in the literature, specifically, whether or not PTSD can be applied cross-culturally.⁸³ This has been examined carefully and, almost universally, observers have found that trauma symptoms among Cambodian refugees are very similar to those observed among other trauma survivors.⁸⁴ In addition, a report on Khmer adolescents noted that PTSD surmounts variants of language and culture.⁸⁵ A factor analysis study of PTSD symptoms in Cambodian refugees using the Cambodian version of the Harvard Trauma Questionnaire provided further evidence of the validity of a PTSD finding among four correlated factors—re-experiencing, avoidance, emotional numbing, and hyperarousal.⁸⁶

Among Cambodian refugees, there are other psychiatric conditions that co-exist with PTSD. We reported on posttraumatic psychosis among Cambodian refugees in our Intercultural Program.⁸⁷ In this study of the first 100 refugees treated in our program, seven had clear psychotic symptoms that required hospitalization, including hallucinations, delusions, and severe agitation. There was no documented family history of psychosis among these patients prior to the Khmer Rouge era, giving some indication that severe trauma can lead to psychosis in some individuals. A study in Thai refugee camps found that traumatic brain injury was strongly associated with depression, with a weaker association with PTSD.⁸⁸ Brain injury represented 4% of the total traumatic events and contributed to 20% of the total symptom score for depression and 8% for PTSD.⁸⁹ Anger induced panic attacks have been found in 58% of Cambodians suffering from PTSD, and many of these individuals manifested a fear of death due to bodily dysfunction during anger-induced panic and arousal.⁹⁰

Somatization—complaining about physical symptoms with no identifiable physical origin—is often the presenting complaint among Cambodians with depression and PTSD.⁹¹

Our own experience has indicated that, indeed, Cambodians complain of somatization, but with sensitive and supportive interviewing, they will readily acknowledge psychological and emotional distress from the traumas and losses of the Khmer Rouge era. Hinton, Hoffman, Pitman et al. reported orthostatic panic attacks, i.e., attacks generated by moving from lying or sitting to standing, among Cambodians attending a psychiatric clinic.⁹² Hinton, Pich, Chhean et al. also found that 49% of patients attending a psychiatric clinic had at least one episode of sleep paralysis in the previous twelve months.⁹³ The prevalence rate of sleep paralysis was much higher in PTSD patients than in non-PTSD patients. Sleep paralysis was associated with post-sleep paralysis panic attacks, indicating a great deal of stress caused by the phenomenon.

Risk factors associated with PTSD and major depression were studied among Cambodian refugees in Utah, and it was found that a greater degree of war trauma increased the risk of both PTSD and major depression.⁹⁴ In addition, refugees who experienced a high number of resettlement stresses in the previous year increased the risk of both PTSD and depression, whereas having financial stress increased the risk of major depression. In a study of acculturation and psychiatric morbidity in New Zealand, it was found that those who were older, widowed, less educated, had a shorter duration of stay in New Zealand, and had lower socioeconomic status were less acculturated.⁹⁵ Overall, the least acculturated were found to have the highest rate of psychiatric morbidity.⁹⁶

Regarding addictions, although gambling is thought to be endemic among Cambodian refugees, during a face-to-face interview with a subsample of 127 community subjects, it was discovered that only 13.9% met the criteria for lifetime disordered gambling.⁹⁷ The breadth of trauma exposure and marital status were significant predictors of disordered gambling. Problem-drinking also has been found among Cambodian refugees, but in a study by D'Amico, Schell, Marshall et al., the rate of consumption and alcohol use problems were found to be very low.⁹⁸ In the thirty days prior to the interview, only 26% reported any alcohol consumption and only 2% reported heavy drinking.⁹⁹ Recent alcohol consumption was not related to the degree of trauma exposure or psychiatric distress.¹⁰⁰

REACTIVATION

Among the more predominant aspects of PTSD, especially among refugees, is the tendency for remissions and exacerbations of symptoms. New stresses, especially those that are personally threatening, can reactivate the entire syndrome even after a period of quiescence. Our group found that this phenomenon occurred during the attacks of September 11, 2001. Among our refugees from Indochina, Bosnia, and Somalia, there was a reactivation of symptoms, partly related to the widely televised images of the destruction of the World Trade Center. PTSD patients reacted the most intensely, with increased hyperarousal symptoms, including nightmares about their original traumas. Generally, the symptoms

remitted after two or three months as the perceived threats receded.¹⁰¹

PTSD hyperarousal also can be reactivated by other traumatic stimuli. In a laboratory study among Cambodian refugees and Vietnam combat veterans, we measured heart rate responses to traumatic video scenes from a wide range of traumatic events. The Cambodians with PTSD had the most reactions, as measured by behavior and heart rate changes. These tended to occur during all scenes, not just the specific Cambodian trauma scenes, indicating a general non-specific arousal. Interestingly, the Vietnam veterans had few reactions, while a control group was intermediate in physiological responses.¹⁰² It has been our clinical experience that symptoms are exacerbated in the initial psychiatric evaluation when patients discuss their history, but such symptoms are then ameliorated during treatment. Others have found that, although Cambodian survivors are willing to talk about their traumas, such disclosure alone does not appear to benefit patients, and it is not the sole goal of treatment.¹⁰³

In summary, clearly victims and survivors of the Khmer era have suffered severe and chronic psychiatric morbidity. PTSD and depression, which coincide about 80% of the time, are the most frequently described diagnoses. The symptoms seem to be very similar to those found in Western cultures. A few patients will have severe psychosis and a smaller number will have traumatic brain injuries. Additionally, anger, panic attacks, and sleep paralysis have also been described. Disordered gambling is a problem but not as high as feared, and alcohol consumption is relatively low among Cambodian refugees, probably reflecting the influence of Buddhism. Resettlement stress increases symptoms, and low acculturation probably increases psychiatric morbidity. One of the most significant findings is the chronic nature of PTSD among many survivors, and the fact that symptoms can be reactivated by actual traumatic events such as accidents or deaths of family members, or vicarious ones such as viewing violence or destruction.

MEDICAL PROBLEMS AMONG CAMBODIAN SURVIVORS

An early report from Cambodian refugee camps in Thailand indicated multiple common diseases such as pneumonia, diarrhea, measles, and meningitis.¹⁰⁴ Others reported that infectious diseases were seen in 75% of those initially screened and examined, and significant effects of chronic under-nutrition and vitamin deficiency were seen.¹⁰⁵ The original rate of malnutrition among children, which was 15% in 1979, was reduced to 1% a year later.¹⁰⁶ Public health measures were very important in reducing the course of communicable diseases. In a 1990s study of a Cambodian refugee community in California, chronic illness and prolonged depression were replacing infectious diseases and other health problems originally brought by refugees when they settled in the U.S.¹⁰⁷ In a community survey of 381 Cambodians in Massachusetts, 44% reported fair or poor health.¹⁰⁸ The demographic most likely to report fair or poor health were older female Cambodians who were unable to work due to disability, had spent a smaller portion of their life in the United States, and had

been unable to see a doctor.¹⁰⁹ In a multicultural blood pressure study done in Minnesota, it was found that the mean diastolic blood pressure among Hmong and Cambodian girls was greater than those of black and white children of the same gender.¹¹⁰ Particularly, the odds ratio¹¹¹ for hypertension was 1.49 for Cambodian girls relative to black and white subjects.¹¹²

We have been struck by the high prevalence of diabetes and hypertension among our refugee psychiatric patients. In our recent study of refugees from Vietnam, Cambodia, Somalia, and Bosnia, the prevalence of hypertension was 42% and diabetes 15.5%. This was significantly higher than U.S. norms, especially for groups younger than 65. Body Mass Index (BMI) was related positively to diabetes, and BMI and age were related to hypertension.¹¹³ It is also our clinical impression that the prevalence of dementia is increasing as the Cambodian population is aging in the United States. Studies of American veterans with PTSD indicate a higher prevalence and incidence of dementia in older veterans with PTSD.¹¹⁴ It is quite likely we will see a higher prevalence and incidence of dementia in older Cambodian refugees.

CHILDREN AND FAMILIES

The events of the Khmer Rouge period have left a large stamp on families and the structure of Cambodian society at home and abroad. During the Khmer Rouge era, families were forcefully separated, with each generation segregated into labor camps. When families were together, children were encouraged by the state to inform on their parents, and family authority was replaced by Angkar, the term given to the obscure, all-powerful supreme authority of Cambodia during the Khmer Rouge era. For children, the traditional formation of identity was greatly altered so that they were encouraged to identify with the all-powerful state and reject, and even, betray their families. Elders in the family no longer occupied roles of authority based on their age or experience.

After the fall of the Khmer Rouge regime, the country was required to rebuild upon a shattered social foundation. The Khmer Rouge specifically targeted leaders in politics, law, medicine, education, religion, and the military, so there were few people who were able to take leadership roles in the redeveloping country. This struggle over the past few decades has been further complicated by the intense grief experienced by most Cambodians related to the incredible loss of life during the Khmer Rouge era.¹¹⁵ The long-term effects of death and violence on individuals and families in all sectors of society have significantly affected the ability of children and young adults to form a stable sense of identity.

In addition, for children and families who immigrated to the United States, France, and Australia, the pressure of acculturation has further challenged traditional Cambodian values that previously enabled families to confront challenges throughout the life cycle. For

example, after migration, elderly refugees have had to live with a diminished status both within families and in the society at large due to a lack of language proficiency, little or no formal education, and no work skills for urban-developed countries. Children's greater proficiency with the host country's language frequently has led to the reversal of traditional generational roles, as the children become the communication facilitator and culture broker between the family and the majority society.

Furthermore, the normal life cycle separation of the young adult from the family presents additional challenges for refugee families. Because of the extensive loss of life during the Khmer Rouge era, Cambodian refugee families may be more affected by culturally-expected separations that are routine in Western societies, such as leaving the family home for college or moving to another part of the country after marriage. Chronic depression and PTSD can adversely affect the stability and nurturance of family relationships, and symptoms also can be exacerbated at times of significant family life cycle transitions.

Studies of depression and PTSD in Cambodian families have shown extensive comorbidity,¹¹⁶ but each condition follows a different course over time, with depression related to acculturative pressures that lessen over time and PTSD related to war-time stressors being more chronic and clustering within families.¹¹⁷ When Cambodian-American children and adolescents have been studied in community settings over time, they generally function quite well despite a continuing high prevalence of PTSD.¹¹⁸ At least for Cambodian adolescents living in North America, an adverse connection between symptomatology and scholastic achievement¹¹⁹ or social adjustment¹²⁰ should not be assumed. In fact, the maintenance of core values despite the Khmer Rouge attempts to destroy them, amid the implicit family duty to succeed, may foster resilience among adolescents with an intergenerational legacy of trauma.¹²¹

It is important to emphasize, regardless of the ultimate affects of the Khmer Rouge trauma experience on Cambodian individuals and families, that the intensity and length of the persecution experienced by Cambodians has few parallels in the twentieth century. Based upon research related to a large number of traumatized populations throughout the world over the last several decades, it would be expected that Cambodians, either those emigrating or remaining in the country, would experience great individual and collective distress and dysfunction. This distress would be expected to have strong impacts beyond individuals and families in its adverse effects upon functional social structures in education, law, health, and other areas of civil society.

FOLLOW-UP AND OUTCOME

Although there have been numerous studies of the prevalence of PTSD, depression, and social functioning among Cambodians, there are few long-term studies that examine the

course of conditions over time or responses to treatment. The studies that do exist show a variable course among those in treatment, with cyclic improvement and exacerbation of symptoms and functioning over time.¹²² Differences in who improves and who does not are not always explainable by conventional risk factors such as the degree of violence exposure, current stresses, physical health, or the extent of social support.¹²³ Recent studies of community populations in both the United States and Cambodia show a significant and continuing prevalence of PTSD among those who experienced Khmer Rouge atrocities. In a community sample in Long Beach, California—the largest Cambodian community in the U.S.—PTSD and major depression were highly comorbid (i.e., they occurred together),¹²⁴ and were associated with older age, poor English language proficiency, unemployment, retirement or disability, and poverty.¹²⁵ In Cambodia, a national probability sample found that PTSD was significantly associated with both mental and physical disability.¹²⁶

TREATMENT

A variety of approaches for the treatment of depression and PTSD exist among traumatized populations, and among Cambodians specifically. The range of approaches that seek to relieve suffering and disability include biological, psychological, and family/social interventions. Biological approaches, most commonly pharmacological, seek to diminish or eliminate PTSD hyperarousal symptoms such as nightmares, sleep disturbances, startle reactions, and intrusive thoughts of prior trauma. Medications that target excitatory neurotransmitters that contribute to these PTSD hyperarousal symptoms have been found to be the most effective, specifically prazosin¹²⁷ and clonidine.¹²⁸ Antidepressants, both tricyclics and SSRIs, can be effective for PTSD irritability and comorbid depression, but they have not been found to be effective for core PTSD hyperarousal symptoms such as nightmares.

By controlling hyperarousal symptoms and depression, medications can create a foundation for addressing broader psychological and social dysfunction in traumatized populations. Avoidance, isolation, shame, hopelessness, spiritual concerns, and the search for meaning among trauma survivors can be effectively addressed by a combination of individual psychotherapy, family therapy, and social interventions, depending on the wishes and needs of those seeking help.¹²⁹ Meaning in any society will be influenced by a person's culture, social and secular values, and by religious traditions.

Success in meeting the needs of those seeking help will correlate with providers of health and mental health services successfully bridging cultural beliefs and healing rituals that co-exist in the acculturating group and the majority society. In fact, Cambodians appear to be quite open to multiple forms of treatment to relieve psychiatric distress.¹³⁰ For example, in a recent representative sample drawn from the largest Cambodian refugee community in the U.S., there was a strong and positive correlation between seeking complementary and

alternative medicine (CAM) alongside Western sources of care for mental health problems. This result runs contrary to perceptions that the use of CAM inhibits seeking Western mental health treatment.¹³¹

Two of the most common CAM treatments used by Cambodians are coining and cupping. Both treatments are commonly used by family members of the ill individual and traditional healers to diminish somatic symptoms associated with distress and anxiety. Coining is a dermabrasion technique in which the edge of a coin is rubbed proximally to distally along the distressed person's limbs to draw out and away from the body what are believed to be contributors to the person's symptoms. Health care providers may see red streaks running up and down the patient's arms and legs. Cupping employs a heated glass jar placed on the skin, commonly the forehead, to draw away by suction the offending elements believed to be causing the patient's symptoms. Providers most commonly may see a circular bruise in the center of the patient's forehead.

Contemporary Western psychotherapeutic approaches for treating PTSD may also have benefit for Cambodian trauma survivors if they are used with sensitivity towards cultural variables. Clinicians need to be cautious about using psychotherapeutic approaches that focus on exposure to and disclosure of previous trauma.¹³² Modifying exposure-based cognitive behavioral therapy (CBT) by using metaphors and a culturally relevant process can be effective and acceptable to Cambodian patients.¹³³ At its core, CBT is based on the central premise that cognitions and thoughts contribute to emotions and behaviors, and a central goal of treatment is to help the client unlearn unwanted thoughts, reactions, and behaviors. Culturally-adapted CBT was found to be effective in improving not only psychometric measures, but also the systolic blood pressure response to orthostasis among Cambodian refugees with pharmacology-resistant PTSD.¹³⁴ This indicates that CBT positively contributed to the stabilization of dizziness caused by the sudden lowering of blood pressure during panic episodes.

Common to all approaches to trauma healing among Cambodian refugees is the fact that although physical and psychological distress is experienced individually, it often arises from, and is worked out or resolved, in a social context. The role of the healer, in a social context, is to aid in reestablishing equilibrium between the survivor and his/her environment. The effects of the violence of the Khmer Rouge era have been pervasive and have included poor physical and mental health, the disintegration of families and communities, destruction of economic infrastructure, and the imposition of a general culture of fear into daily life.¹³⁵

For any treatment approach to be optimally successful in Cambodian populations, there needs to be proper attention to these multigenerational legacies of trauma. The prevailing style of communication in Cambodian families, which includes an avoidance of

intergenerational conflict, also contributes to a frequent lack of resolution of disagreements and continuing anxiety for parents and children.¹³⁶ The lack of a complete nuclear family, the frequent lack of extended family support, and the extensive change in, or loss of, traditional cultural values leads to confusion in parents and children regarding the proper behavior expected of each generation.¹³⁷ Among Cambodian refugees in the U.S., parent-child anger and conflict,¹³⁸ and child abuse and neglect in the context of parental substance abuse and mental illness,¹³⁹ make it imperative that family and social factors be addressed in treatment programs. Family therapy can help parents and children address the process of cultural change and enhance the family's ability to negotiate between the cultural worlds of the home and the host countries.¹⁴⁰

Regardless of treatment approach, clinicians can assist individuals and families in slowly rebuilding connections to the lost or altered connections to sociocultural foundations that contribute to identity, meaning, and hope. Clinicians and social institutions that serve Cambodian individuals and families can be important catalysts for future healing and growth, facilitating the considerable strengths that communities have built during many years of survival and perseverance.

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3 PTSD SEVERITY AND KEY IDIOMS OF DISTRESS AMONG RURAL CAMBODIANS: THE RESULTS OF A NEEDS ASSESSMENT SURVEY

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This Chapter reports on the results of a needs assessment survey of rural Cambodians that was undertaken by the Documentation Center of Cambodia (DC-CAM) as part of their Victims of Torture (VoT) project. The project was conceived by the Director of DC-Cam, Youk Chhang, and implemented by VoT project team leaders, Kok-Thay Eng and Sophearith Choung. The purpose of this project was to document experiences under the Khmer Rouge, to identify rural villagers with significant distress, and provide services to those suffering from posttraumatic stress disorder (PTSD). Members of DC-CAM went to rural villages in Kampot, Takeo, and Kandal provinces and asked local officials (for example, the commune or village chief) and villagers who among them was known to have psychological problems or difficulties due to hardship and suffering experienced during in the Pol Pot period. If, after an interview and assessment, it was determined that the individual did indeed have significant mental health concerns, he or she was provided with psychological services, including referrals and modest funds to visit the closest mental health clinic (usually located at the provincial capitol or in Phnom Penh) and to purchase any prescribed medications.

TABLE I.
The Cambodian Symptom and Syndrome Inventory (C-SSI).
The Somatic Symptom Cultural Syndromes Subscales

<u>SOMATIC SYMPTOMS</u>	<u>CULTURAL SYNDROMES</u>
Dizziness	<i>Khyâl</i> attacks ¹⁴⁴
Standing up and feeling dizzy	
Blurry vision	Standing up and feeling poorly to the point you feared fainting, <i>Khyâl</i> overload, or heart attack
Tinnitus	
Headache	
Neck soreness	
Palpitations	Neck soreness to the point you feared your neck vessels would burst
Shortness of breath	
Cold hands and feet	
Sore arms and legs	“Heart weakness”
Weakness	
Poor appetite	<i>Khyâl</i> arising from your stomach, making you fear you might die of asphyxia
	“Thinking too much”
	“Ghost pushing you down” (sleep paralysis)

Note: Table 1 is an abbreviated version of the C-SSI

To date, what little formal knowledge we have about mental health in Cambodia has come from a handful of instruments, such as the Harvard Trauma Questionnaire¹⁴¹ and the Hopkins Checklist.¹⁴² During a pilot version of the Victims of Torture project, DC-Cam team members noted that some of the questions asked by such instruments were not culturally sensitive.¹⁴³ After discussing these issues, the authors agreed to include a newly created Cambodian Symptom and Syndrome Inventory (C-SSI), devised by Devon Hinton (DH) based on work with Cambodian-Americans in a Massachusetts clinic, as an addendum to the existing assessment survey. The authors hoped to seek a more culturally sensitive means of assessing psychological distress in Cambodia. Specifically, the C-SSI includes symptoms and syndromes that are key aspects of the presentation of trauma-type distress

that are found among Cambodian refugees (see Table I), but that are not among the seventeen symptoms listed in the PTSD criteria. In this study, the investigators found the C-SSI to be a highly effective and culturally sensitive measure.

HISTORICAL BACKGROUND

Cambodians have endured prolonged conflict and, often, traumatic experiences. On April 17, 1975, after a brutal civil war in which perhaps 500,000 Cambodians died and many more were injured, displaced, or impoverished by the fighting, the Khmer Rouge took power. Over the next three-and-a-half years (April 17, 1975 to January 6, 1979), the Khmer Rouge, a group of Maoist-inspired radicals led by Pol Pot, implemented a series of radical socio-economic reforms in an attempt to enable Cambodia, renamed Democratic Kampuchea (DK), to make a “super great leap forward” into socialism.¹⁴⁵ Economic activity was dramatically reshaped as the Khmer Rouge collectivized the means and modes of production. Money, markets, and courts disappeared. Freedom of speech, travel, religion, and communication were severely curtailed.

In their effort to create a pure society of revolutionaries who would be loyal primarily to the state, the Khmer Rouge rusticated the cities, banned Buddhism, and splintered families, who were often separated for long periods of time while they labored, sometimes day and night, on starvation rations. Spies crept about at night searching for signs of subversion. Meanwhile, the Khmer Rouge established a security apparatus that targeted suspect groups—former soldiers, police, civil service personnel, professional, the educated, the urbanites—for reeducation, imprisonment, torture, and often murder. By the time the Khmer Rouge was overthrown in January 1979 by a Vietnamese invasion, almost a quarter of Cambodia’s eight million inhabitants had died of disease, starvation, overwork, and execution.

The difficulties, however, did not cease with the end of the Pol Pot period. During the Vietnamese-backed invasion, many Cambodians died, caught in the crossfire between the Khmer Rouge and Vietnamese soldiers. Khmer Rouge soldiers sometimes even used civilians as human shields. Many Cambodians died of starvation, shelling, gunfire, illness, and other causes during that forced displacement.

The suffering of Cambodians continued for more than a decade (1979-1993), as hundreds of thousands of refugees lived in difficult circumstances in camps along the Thai-Cambodian border. Some of these camps were highly militarized and subject to forced recruitment and shelling as a new civil war, enmeshed in Cold War politics, broke out. This war pitted the new Vietnamese-backed, People’s Republic of Kampuchea government against the Khmer Rouge (who, after being routed by the Vietnamese troops, had been propped back up and rearmed and supplied by an odd coalition of Thailand, Cambodia, the United States, and other allies) and some smaller resistance groups.¹⁴⁶

Even after a peace deal was brokered and the refugees were repatriated as part of a UN-sponsored election held in 1993, the new Royal Government of Cambodia continued to battle the Khmer Rouge, who pulled out of the 1993 elections. The internal conflict continued until 1999 when the movement finally collapsed after Pol Pot's death and a series of defections. In addition, Cambodian villagers experienced extreme economic difficulties, including diminished or no rice harvest due to floods or droughts, which gave rise to the threat of starvation. Tens of thousands of refugees who were resettled in the United States, France, or other countries have had to deal with not just adapting to an entirely new socio-cultural *milieu*, but also with the loss of family members and social support structures.

People in Cambodia had far less access to mental health care than the populace of other developing countries since almost all of the psychiatrists and psychiatric nurses were either killed by the Khmer Rouge or fled abroad, and the country was subject to international sanctions until the peace agreement was in place. Refugees who fled to the border and/or were later resettled abroad were often treated by mental health systems that were challenged by Cambodians and other refugee groups because of culturally different ways of understanding and dealing with trauma. Eventually, attempts were made to create more culturally sensitive diagnostic instruments for Cambodian refugees, such as Richard Mollica's Harvard Trauma Questionnaire.¹⁴⁷ That instrument, however, simply combines an assessment of the 16 DSM-III-r criteria¹⁴⁸ with an addendum of symptoms (such as guilt) that pertain to all traumatized refugees. As a result, it is neither culturally sensitive nor specific. Even today, most Cambodians living in Cambodia have little or no access to mental health care and continue to use local methods of healing, including "coining" and massage, purchasing medicines that alter somatic flow and balance, and visiting a monk or traditional healer.

THE STUDY

Building upon the small but growing literature on mental health in Cambodia, this Chapter seeks (a) to help us better assess the current psychological suffering of a group of Cambodian villagers who were identified as distressed and (b) to determine whether the newly created Cambodian Symptom and Syndrome Inventory can supplement existing assessment instruments by evaluating trauma in a more culturally sensitive manner, which takes into account local idioms of distress. One of the authors (DH), who is fluent in Cambodian and the medical director of a mental health clinic that specifically treats Cambodian refugees, developed the instrument while working for over 10 years with the Cambodian population in Lowell, Massachusetts.¹⁴⁹ The particular items of the SSI and their meaning in the Cambodian culture, including the relationship to PTSD severity, have been documented in multiple articles.¹⁵⁰

Specifically, the Cambodian Symptom and Syndrome Inventory (C-SSI) was added to the suite of measures that the Documentation Center of Cambodia was using in its Victims of

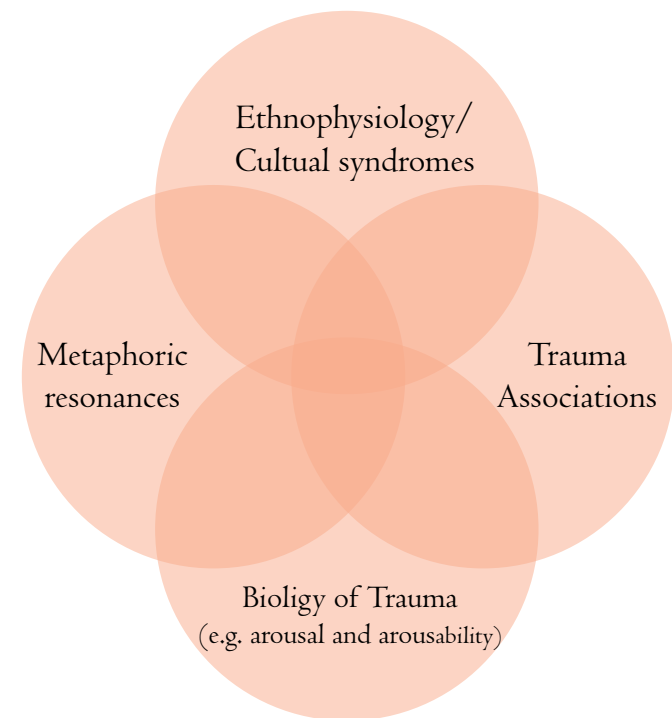


Figure I. Dizziness and the Four Symptom Dimensions in the Cambodian Context.

Dizziness may relate to each of these four processes for certain individuals. For other individuals, dizziness events may involve all four dimensions in reciprocating interaction: trauma causes dizziness (e.g., a predisposition to dizziness upon standing) and that dizziness gives rise to trauma associations, metaphoric associations, and fears of disordered ethnophysiology.

Torture project. These instruments included the PTSD checklist (to assess PTSD symptoms), the trauma items of the Harvard Trauma Questionnaire (to assess Pol Pot period trauma events), and the SF-3 (a measure of self-perceived health and impairment in physical functioning).

Cross-cultural research indicates that many of the seventeen PTSD items listed in the DSM-IV manual—such as nightmares, startle reflexes, and vivid unwanted recall of trauma events—are a core part of the universal response to trauma. Other DSM-IV PTSD items like amnesia or numbing seem to be a much less salient aspect of the trauma response in non-Western cultures.¹⁵¹ The Cambodian Symptom and Syndrome Inventory (C-SSI) was designed to survey symptoms and cultural syndromes that are a key part of the response to trauma in the Cambodian context, but that are not among the DSM-IV PTSD criteria. Below we review the items of the C-SSI, and then we turn to the structure and results of the survey.

CAMBODIAN SYMPTOM AND SYNDROME INVENTORY C-SSI

The C-SSI consists of two main parts: culturally emphasized somatic complaints and key cultural syndromes (see Table I).

Somatic Complaints Assessed in the C-SSI

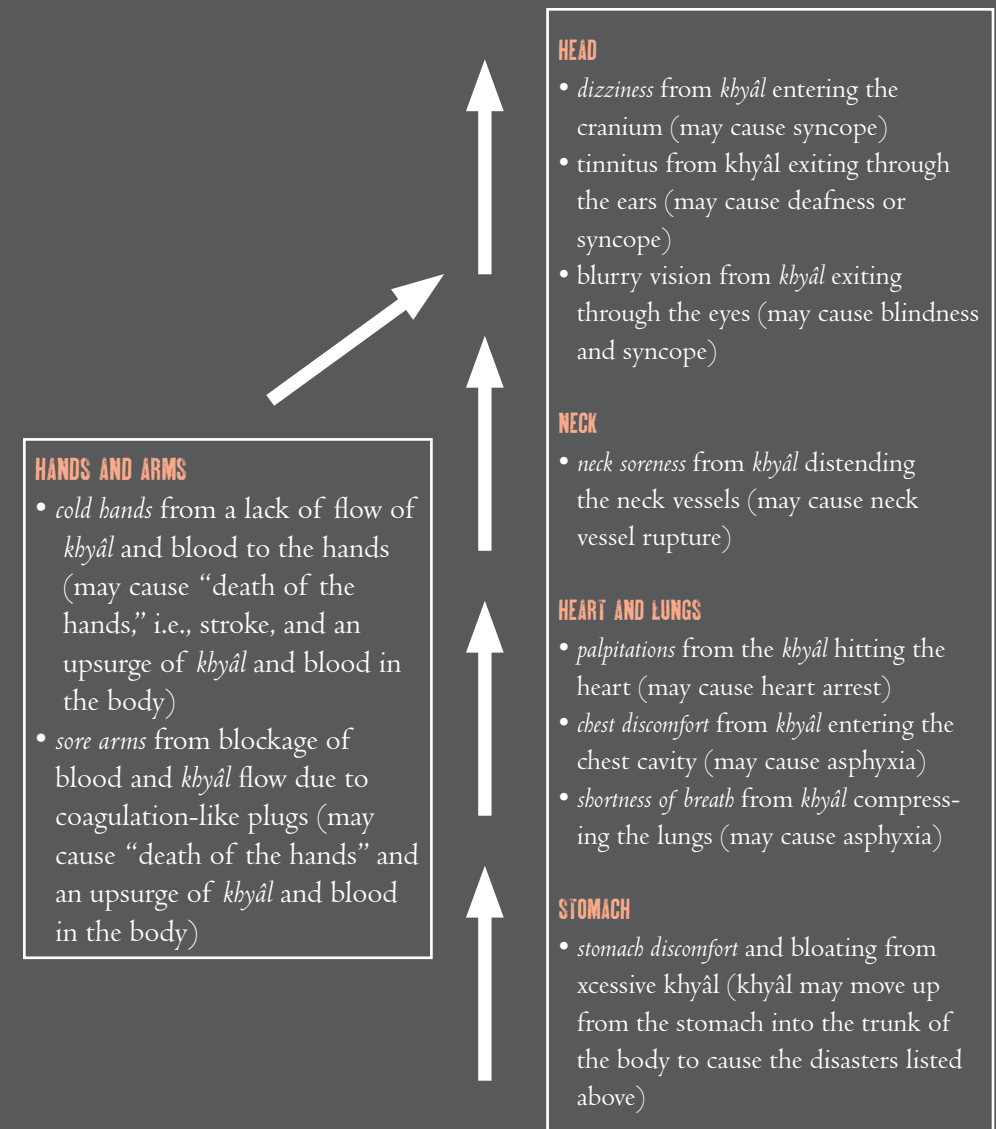
The Cambodian C-SSI assesses the twelve somatic symptoms listed in Table I. To understand why these symptoms are common among traumatized Cambodians, each of these culturally salient symptoms can be thought of as being generated by four key interrelated processes: the biology of trauma (e.g., trauma-caused arousal and arousability); ethnophysiology¹⁵²/cultural syndromes; metaphoric resonances; and trauma associations. These processes might also be called four symptom dimensions, and their elucidation involves a four-dimensional symptom analysis. In Figure I, we depict these four symptom-dimensions for dizziness using a Venn diagram. The number of processes involved in producing a symptom is individual to each patient. For example, symptoms of dizziness are over-represented in the Cambodian culture as compared to other traumatized groups. Let us examine how these four processes or dimensions apply to the Cambodian C-SSI somatic symptoms and result in those somatic symptoms being salient in the Cambodian cultural context.¹⁵³

The Biology of Trauma

Cambodians experienced extreme and prolonged trauma during the Pol Pot period. Trauma such as this can result in changes in the nervous system and psychological state that produces a constant state of anxiety. This high state of arousal can help generate all the culturally-salient symptoms mentioned above. Autonomic arousal, for example, can lead to palpitations, shortness of breath, dizziness (from effects on the balance system), neck soreness (from muscle tension), and cold extremities (from vasoconstriction).

Trauma results not only in an activated aroused state of the nervous system; it also increases arousability or the tendency for anxiety and arousal to be rapidly induced by any of multiple causes. These causes range from sounds, so-called “startle,” to emotions. For example, a trauma victim worrying about a problem, such as the acting out behavior of a child or not having money to buy food, may rapidly become very anxious and experience multiple somatic symptoms. This easily activated nervous system may cause palpitations, dizziness, and neck soreness. Arousability is found in the trauma victim with respect to a variety of emotions, such as anxiety, stress, anger, and even pained, nostalgic recall of the dead. As indicated above, certain stimuli may provoke arousability, as in the classic example of a noise-caused startle or response to trauma reminders, which are two of the DSM-IV PTSD symptoms.¹⁵⁴ By bringing about this combination of arousal and arousability, the psychobiology of trauma may help lead traumatized Cambodians to have extreme emotional states and multiple symptoms, such as the somatic symptoms set forth in the Cambodian SSI. Cross-cultural differences in biology also seem to explain why certain C-SSI symptoms

FIGURE 2. A khyâl attack: Ethnophysiology, symptoms, and associated disasters.



The arrows represent the flow of *khyâl* and blood up in the body during a *khyâl* attack. Normally *khyâl* flows downward in the direction opposite of these arrows, exiting the body through the hands and feet, through bodily pores, and down the gastrointestinal tract.

Table 2. The interpretation of somatic symptoms in terms of a *khyâl* attack:
Correlated physiological state and feared consequence

SYMPTOM	CORRELATED PHYSIOLOGICAL STATE	FEARED CONSEQUENCE
Dizziness	A surge of <i>khyâl</i> and blood into the cranium	Syncope, “ <i>khyâl</i> attack,” and “ <i>khyâl</i> overload” (<i>khyâl</i> koeu)
Tinnitus	A pressure-like escape of <i>khyâl</i> from the ears, with tinnitus being called “ <i>khyâl</i> exits from the ears,” or <i>khyâl</i> ceuny taam treujieu	Deafness, <i>khyâl</i> attack, and syncope
Blurry vision	A pressure-like escape of <i>khyâl</i> from the eyes	Blindness, <i>khyâl</i> attack, and syncope
Headache	A rush of <i>khyâl</i> and blood into the head and its vessels	Syncope, blindness, and <i>khyâl</i> overload
Neck soreness	A surge of <i>khyâl</i> and blood into the neck vessels	Bursting of the neck vessels, the occurrence of <i>khyâl</i> attack or <i>khyâl</i> overload
Nausea	Excessive <i>khyâl</i> in the stomach and abdomen and the <i>khyâl</i> threatens to rise upward in the body	<i>Khyâl</i> rising upward from the abdomen into the body to cause asphyxia, cardiac arrest, and various cerebral catastrophes—a <i>khyâl</i> attack and <i>khyâl</i> overload
Palpitations	<i>Khyâl</i> presses on the heart and cause palpitations, having risen upward from the stomach or limbs. The limbs have blocked vessels, and so the heart must work harder to pump blood and <i>khyâl</i> through the body. This also results in palpitations.	Cardiac arrest and all disasters associated with a weakened heart, such as poor circulation in the limbs, which results in coagulation in the limbs and causes a surge of <i>khyâl</i> and blood upward in the body
Shortness of breath	<i>Khyâl</i> surges upward from the limbs or stomach to press on the lungs and cause shortness of breath	Asphyxia, the occurrence of <i>khyâl</i> attack or <i>khyâl</i> overload
Soreness in the legs	Blockade of the flow of <i>khyâl</i> and blood at the joints, with sore joints being called “plugged vessels” (<i>cok sosai</i>) or “blocked <i>khyâl</i> ” (<i>Sla khyâl</i>)	“Death” of the limbs from a lack of outward flow along the limbs, a surge of <i>khyâl</i> and blood upward in the body to cause the various disasters listed above: asphyxia, heart arrest, neck-vessel rupture, and syncope
Cold hands or feet	Blockage of the flow of <i>khyâl</i> and blood in the limbs	“Death” of the limbs from a lack of outward flow along the limbs, a surge of <i>khyâl</i> and blood upward in the body to cause the various disasters listed above

SYMPTOM	CORRELATED PHYSIOLOGICAL STATE	FEARED CONSEQUENCE
Poor appetite	A direct effect of excessive bodily <i>khyâl</i>	Poor food intake may result in weakness, which in turn causes various physiological consequences: dizziness on standing, palpitations upon exposure to stimuli, and a predisposition to <i>khyâl</i> attacks.
Out of energy	Serious depletion of the bodily energy supplies, a direct effect of excessive bodily <i>khyâl</i>	The body is depleted, which may cause a weakened heart, possibly resulting in heart arrest and in <i>khyâl</i> attacks. This is because the weakened heart does not adequately pump and circulate the <i>khyâl</i> and blood, resulting in plugs in the limbs that then bring about an upward surge of <i>khyâl</i> and blood into the trunk.

have the salience they do: trauma may have biological effects that increase motion sickness and dizziness upon standing.¹⁵⁵ Indeed, certain Asian populations, such as Cambodian refugees, appear to be particularly predisposed to both of these symptoms.¹⁵⁶

Ethnophysiology and Cultural Syndromes

Ethnophysiology and syndrome concerns may lead Cambodians to be hypervigilant to the somatic symptoms listed in the C-SSI. The symptoms are thought to indicate an ethnophysiological disturbance and the occurrence of a cultural syndrome. These concerns are particularly great when the person is in a self-perceived vulnerable state. Hypervigilance towards somatic symptoms increases these very somatic symptoms by attentional amplification. Even a slight symptom like incipient dizziness may be perceived, and the anxiety experienced upon noticing one of the feared symptoms, or even anticipating that it will occur in a certain situation (such as upon standing up), may induce a given symptom by the physiology of fear. The result is a vicious cycle of worsening symptoms that leads to panic as fear worsens the symptom and then the worsened symptom causes yet more fear. Through this combination of attentional amplification and the physiology of fear, cultural syndromes lead to the worsening of symptoms associated with those syndromes.

The C-SSI symptoms are thought by Cambodians to possibly indicate the onset of a “*khyâl* attack,” or “wind attack.”¹⁵⁷ In a *khyâl* attack, blood and a wind-like substance called *khyâl* surge upward in the body to cause various somatic symptoms and potentially various bodily catastrophes. For example, neck soreness indicates a surge of *khyâl* and blood into the neck, which may rupture

those vessels or cause dizziness. A surge of *khyâl* into the head may cause fainting or death. A neck-focused or dizziness-focused panic attack may then occur as part of a vicious cycle of worsening symptoms.¹⁵⁸ Figure 2 sets forth the Cambodian conceptualization of the pathophysiology of a *khyâl* attack. Table 2 depicts the *khyâl* symptom, associated ethnophysiology, and feared consequence. Other fears and syndromes associated with the C-SSI somatic symptoms are discussed in the cultural syndrome/ethnophysiology section.

Metaphoric Dimensions

The cultural salience of many of the C-SSI somatic symptoms is increased by important metaphoric resonances in Khmer, the Cambodian language. For example, distress is often described through tropes of spinning, such as when one says “my son shakes me,” or *koun kreulôk khyom*, meaning “he bothers me” or “my brain is spinning,” or *wul kbueu khabaal*, meaning “I am overwhelmed.” Neck soreness is another common trope, as when Cambodians speak of a problem that “arrived to my neck,” or *dâl gâ*, meaning “I cannot take it anymore,” or “carrying a heavy load at the shoulder,” or *reek thnguen*, meaning “I am overburdened with responsibility.”

Consequently, if a Cambodian thinks about a current problem, it may bring about dizziness and neck soreness, what may be described as metaphor-guided somatization. Similarly, if dizziness or neck soreness occurs for some reason (such as anxiety) that symptom may evoke all the life issues encoded in the mind by the associated somatic trope. For example, dizziness might evoke conflicts with children or financial concerns. This process may be labeled symptom-caused metaphor-network activation.¹⁵⁹

Trauma Associations to Somatic Sensations

The C-SSI somatic symptoms are also experientially salient owing to their association with trauma. Many Cambodians have endured extreme traumas that are linked to multiple somatic symptoms brought about by strong fear. This fear is experienced in the trauma-evoked somatic symptoms that are now linked to the memory of the trauma event.

Certain somatic symptoms are prominent among Cambodians because the specific somatic symptom was strongly and specifically induced by the nature of Khmer Rouge-era trauma. In respect to dizziness, almost all Cambodians were forced to do slave labor while starving, which caused great dizziness and, not uncommonly, syncope. In addition, Cambodians were often struck in the head by the Khmer Rouge as a punishment, or Cambodians may have witnessed executions and/or have seen corpses. These experiences may have led to a mixed state of fear, nausea, and dizziness. Many Cambodians suffered from severe malaria during the Khmer Rouge era, which caused extreme dizziness and other symptoms. With regard to neck soreness, the most common form of slave labor was being forced to carry heavy loads of dirt balanced at the neck on a pole, which produced extreme discomfort. Some people

survived execution after being struck on the back of the neck with a club. Neck soreness also occurs during malaria bouts.¹⁶⁰

If a Cambodian experiences one of those symptoms (e.g., dizziness) for any reason, the symptom may bring to mind the trauma event that featured that somatic symptom, such as being threatened with death and feeling dizzy, or doing slave labor and feeling dizzy. This may be described as somatic-symptom activation of the trauma network, with the activating of the memory network worsening the somatic symptom through somatic flashback and arousal. Alternatively, thinking about the trauma event (“I remember being threatened with death” or “I remember doing slave labor while starving”) may bring about the somatic symptom experienced during the trauma event by a somatic flashback and by the physiology of fear, so that trauma recall induces a somatic response.¹⁶¹

Cultural Syndromes Assessed in the C-SSI

The C-SSI also assesses for cultural syndromes that are prominent aspects of Cambodian responses to trauma. Figure 3 illustrates how such syndromes are generated among trauma victims. In the Cambodian SSI, the person is asked seven questions about how much he or she has been bothered by the seven cultural syndromes listed in Table I.¹⁶² Of note, in Cambodia, the concept of PTSD is usually not familiar to laypersons and so is used infrequently to explain their symptoms.

As described above (see Figure 2 and Table 2), Cambodians greatly fear *khyâl* attacks. Most Cambodians consider *khyâl* to be a potentially pathogenic element.¹⁶³ In a healthy state, *khyâl* flows throughout the body alongside the blood and exits the body by passing through the hands and feet, by exiting through the skin pores located all over the body, by the action of burping, or by downward movement through the gastrointestinal tract. Sometimes the normal flow of *khyâl* suddenly becomes disturbed, and it surges along with blood upward in the body toward the head, causing the symptoms and disasters described in Figure 2 and Table 2. Such an event is referred to as *kaeut khyâl*, literally “to become *khyâl*,” or less frequently, *khyâl chap*, “caught by *khyâl*.” We translate these two terms as a “*khyâl* attack.” (*Khyâl* attacks are a subject of concern to rural and urban Cambodians, including those with high levels of education.¹⁶⁴

A particularly severe *khyâl* attack may occur upon standing, causing what is called “wind overload” (*khyâl koeu*)—an event that is greatly feared. Other common causes of *khyâl* attacks are worry, anxiety, or fright, including nightmares. In the survey, we ask how much the person was bothered by *khyâl* attacks in the last month as well as about ethnophysiological concerns associated with those *khyâl* attacks, such as: *khyâl* hitting up from the stomach to the point of fearing death by asphyxia; neck soreness to the point of fearing the neck vessels would burst; or standing up and feeling poorly to the point of fearing fainting and *khyâl*

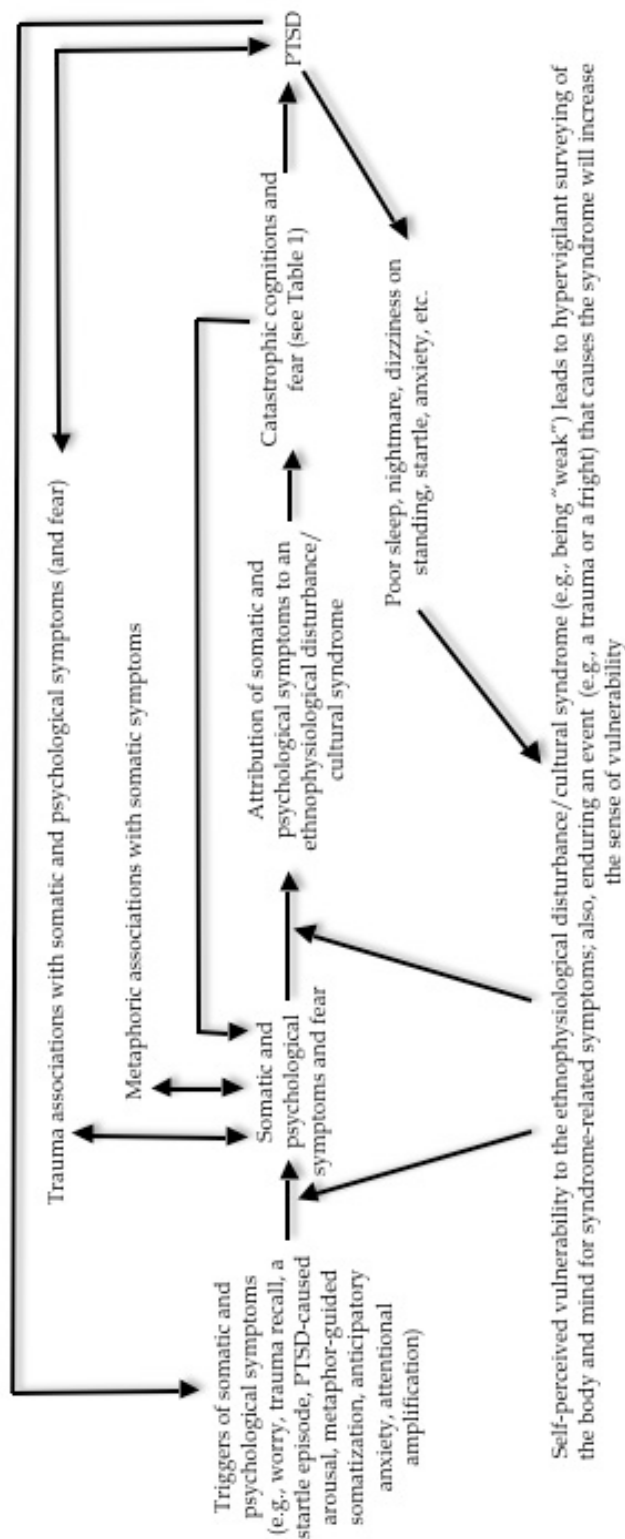


Figure 3. The Multiplex Model of the Cultural Syndrome-PTSD interaction among patients with PTSD.

This bio-cultural model shows how the cultural syndrome is generated, how it worsens certain somatic and psychological symptoms (particularly those considered part of the syndrome) and PTSD itself. All of these elements combine to create a vicious cycle. These processes often cause panic-like cultural syndromes. Catastrophic cognitions worsen syndrome-related symptoms by producing fear, which will induce symptoms by activation of the autonomic nervous system and by attentional amplification (or the searching of the mind and body for feared symptoms). The treatment received for episodes of the cultural syndrome and the personal and interpersonal effects of having the syndrome will profoundly influence the course of the cultural syndrome and its phenomenology.

FIGURE 3.

overload.

Many Cambodians worry that heart weakness may cause heart arrest, produce strong reactivity to stimuli such as sounds and smells, and predispose them to certain negative emotional states like being easily frightened, frequently becoming angry, and not being able to stop worrying. Heart weakness is also thought to cause dizziness upon standing up, palpitations, and shortness of breath (the heart drives breathing by a piston-like action). A weak heart is thought to pump blood and *khyâl* poorly, thereby predisposing a person to having cold extremities and *khyâl* attacks. Heart weakness is viewed as having a number of causes, including poor sleep, poor appetite, and excessive worry. If a Cambodian notes in him- or herself any of the processes that can weaken the body (e.g., worry, poor appetite, or poor sleep) or any symptoms that indicate bodily weakness (e.g., startle, smells sensitivity, palpitations, or frequent *khyâl* attacks), he or she may fear having heart weakness and imminent heart arrest. This fear often leads to a constant hypervigilant surveying of the body and emotions for any symptoms of heart weakness. If any such symptom is found, it will likely be interpreted as a harbinger of heart arrest or a *khyâl* attack.

The C-SSI also assesses the cultural syndrome called “thinking a lot” (*kut caraeun*). This complaint describes a mental state with the following characteristics: (a) one thinks of upsetting topics, such as current problems (e.g., money problems or problems with children), past trauma events (e.g., during Pol Pot period), and separation from loved ones due to their death or to living far from them; (b) one has a hard time not thinking about these things; and (c) one thinks about these things to the point that the thinking is considered damaging because it may deplete one’s mind and body, predispose one to heart weakness and *khyâl* attack, and overheat one’s brain to the point that there is permanent memory loss, a state of forgetfulness, or even insanity. Worry, “thinking a lot” episodes, and standing up are three of the most common causes of *khyâl* attacks.

Because of its prevalence in the Cambodian population and its strong association with PTSD and trauma, we also assessed one sleep-related complaint—sleep paralysis.¹⁶⁵ Because sleep paralysis is given a culturally specific meaning in the Cambodian context—it is referred to as “a ghost pushes you down” (*khmaoch sangot*)—we consider this a cultural syndrome. In sleep paralysis, the person suddenly finds him- or herself unable to move or speak, and sometimes sees a shape coming towards his or her body. In the clinical setting, Cambodian patients often describe seeing a shape, usually a black shadow, during almost all episodes of sleep paralysis. The person often experiences chest tightness and shortness of breath as the shape approaches and pushes down on the body. Cambodians often consider this to be a dangerous assault by a malevolent being, such as the ghost of a person they saw killed during the Pol Pot period or of a person who died in the house in which they are now living.

THE NEEDS ASSESSMENT SURVEY

The purpose of the needs assessment survey was to examine, in a culturally sensitive manner, the current psychological state of rural Cambodian villagers who had been identified as highly distressed. The assessment measures assessed PTSD severity as well as trauma events and self-perceived functioning. The C-SSI was included in the survey since we believe that an inventory of culturally specific symptoms and cultural syndromes should accompany a culturally-sensitive assessment of any traumatized group.

In this section, we examine the prominence of culturally specific complaints (as assessed by the C-SSI) for patients with various levels of PTSD severity. To examine the validity of C-SSI items for this group as compared to DSM-IV PTSD items, we also investigate the relationship of past trauma events to PTSD severity and to the C-SSI in order to determine which scale is a better indicator of past trauma and a better depiction of trauma-related symptomatology. To further examine the validity of C-SSI items for this group as compared to DSM-IV PTSD items, we also explore the relative ability of the measure of PTSD severity (PTSD Checklist [PCL]) and the C-SSI to predict self-perceived health. We also present cases of particular individuals.

Method

As part of their Victims of Torture project, DC-CAM staff went to three provinces in Cambodia and interviewed villagers who had suffered greatly during the Pol Pot period and evinced signs of continuing psychological distress. At the onset of the interviews, team members explained the goals of the interview and survey to participants, who were asked whether they wished to participate. Those who agreed to participate were interviewed about their experiences during the Khmer Rouge regime and assessed for psychological distress. The needs assessment included the PCL (a measure of PTSD), the seventeen-item trauma-event section of the Harvard Trauma Questionnaire (to assess the severity of Pol Pot traumas), the SF-3 (a measure of self-perceived health and functioning), and the C-SSI (a measure of culturally specific complaints and syndromes). Participants and local officials were given basic mental health information, including instruction about the use of relaxation and breathing techniques to reduce stress. Those scoring for PTSD were referred to government clinics, where they received counseling and, if appropriate, medication.

Needs Assessment Measures

PTSD Checklist (PCL). The PCL assesses how much each of the seventeen *DSM-IV* PTSD criteria has bothered the patient in the last month. Each item is assessed on a 1–5 Likert-type scale: 1 (*not at all*), 2 (*a little bit*), 3 (*moderately*), 4 (*quite a bit*), and 5 (*extremely*). The Cambodian version of the PCL has excellent test–retest (at one week) and inter-rater reliability ($r = .91$ and $.95$, respectively).¹⁶⁶ In the current study, we used a conservative cut-off score of 34 for assessing probable PTSD.¹⁶⁷

Cambodian Symptom and Syndrome Inventory (C-SSI). In order to profile the response to trauma in a culturally sensitive way, we created a scale that assesses symptoms and syndromes that are particularly salient in the Cambodian population. Each item is assessed on a 0–4 Likert-type scale, asking the patient how much he or she was bothered by certain somatic symptoms or syndromes in the last 4 weeks: 0 (*not at all*), 1 (*a little bit*), 2 (*moderately*), 3 (*quite a bit*), and 4 (*extremely*). The C-SSI items, which are listed in Table I, can be divided into two types: (1) twelve somatic symptoms and (2) seven cultural syndromes. The current survey is the abbreviated version of the C-SSI; there is a longer version that assesses other symptoms and syndromes.

Harvard Trauma Questionnaire: Trauma Event Section. The Harvard Trauma Questionnaire, which was developed initially for evaluating Southeast Asian populations,¹⁶⁸ has been extensively used for evaluating trauma victims. It contains a section that evaluates for seventeen trauma events, including such events as imprisonment, torture, and lack of food and water. In the current survey, patients were asked whether they had experienced any of the seventeen trauma events.

General Health Questionnaire: Three-item version. Researchers increasingly assess the impairment in self-perceived health functioning among patients with psychological problems.¹⁶⁹ One component of self-perceived health and self-perceived impairment of health relates to actual physical health. Impairment is worsened by hypertension, diabetes, and other actual illnesses. Psychological illnesses, such as PTSD and other co-occurring conditions like panic disorder, however, lead to multiple somatic complaints, low energy, and decreased ability to engage in exertion. Specifically, sufferers will experience decreased energy due to these illnesses, more dizziness and other symptoms limiting exertion, and a tendency for any symptoms induced by exertion to be perceived as indicating a serious problem of health, with those concerns causing panic and the immediate stopping of exertion. Therefore, one key part of self-perceived health and limitations in physical functioning is related to psychological disorders such as PTSD.

Brief measures of self-perceived physical health have been extensively used. For this survey, three items of the SF-36 were used. The SF-36 has been shown to be a reliable instrument in Cambodian populations.¹⁷⁰ One item used assesses self-perceived general health: (1) How good is your health?; the remaining two assess self-perceived impairment in physical functioning: (2) Does your health limit you in your ability to do activities such as moving a table or carrying groceries?, and (3) Does your health limit your ability to do activities such as climbing several flights of stairs? Item one, self-perceived health, is rated on a 1–4 Likert-type scale: 1 (*excellent*) to 4 (*poor*); self-perceived functioning is rated on a 1–3 Likert-type scale: 1 (*no, not limited at all*) to 3 (*yes, limited a lot*).

Results

The average age was 60.3 ($SD = 10.1$), and 63% were women. PTSD was extremely common; in fact, all participants scored for PTSD (a score on the PCL of 34 or over). The mean PCL score was 57.2 ($SD = 13.5$), with an item mean of 3.4 ($SD = 0.8$) on the 1–5 Likert-type scale. The C-SSI score was very elevated as well, with an item average of 2.0 ($SD = 0.90$) on the 0–4 Likert-type scale. The two scores were highly correlated ($r = .61$). To further examine the relationship of the PCL score to the C-SSI, we then divided the PCL scores into three levels of severity, namely, mild PTSD (2–2.8), moderate PTSD (2.9–3.8), and severe PTSD (3.9–5).

We then examined the severity of the C-SSI score and individual C-SSI items at each level of PTSD severity. In the mild PTSD group ($n = 24$), the average C-SSI score was 1.6 ($SD = 0.7$). In the moderate PTSD group ($n = 18$), the average C-SSI score was 1.9 ($SD = 0.8$). Finally, in the severe PTSD group ($n = 24$), the average C-SSI score was 2.6 ($SD = 0.6$). These correspond to statistically different results.¹⁷¹

Table 3 compares the severity of each of the C-SSI items at each level of PTSD severity. As indicated in Table 3, all C-SSI items were increasingly severe at each level of PTSD severity. Certain items were highly elevated. Dizziness was extremely prevalent in the severe PTSD group, much more so than symptoms like palpitation and shortness of breath. In addition, the three groups of PTSD severity were well differentiated by dizziness. Other items that were extremely elevated in the severe PTSD group were standing up and feeling dizzy, blurry vision, physical weakness, heart weakness, and “thinking a lot.” As we hypothesized, patients articulated fears of the occurrence of the various syndromes and associated ethno-physiological disasters, such as fear of dying from neck-vessel rupture and fear of having “weak heart.”

In the severe PTSD group, among the seventeen trauma items in the Harvard Trauma Questionnaire, the average number of experienced trauma items was 8.2 ($SD = 1.6$). The trauma event total was more highly correlated with the C-SSI than the PCL ($r = 0.61$ versus $r = 0.41$). The higher variance in the trauma event total can be explained by the C-SSI (36% versus 16%). One item that was highly correlated to both scales was imprisonment ($r = 0.52$ and $r = 0.46$, respectively).

In terms of self-perceived health, we found that most patients considered themselves to have poor health (mean score = 3.4 [$SD = 0.51$], with a “4” indicating poor health) and had limitations in the ability to do basic activities like lifting and climbing the stairs (mean score = 2.3 [$SD = 0.7$], with 2 meaning “limited a little” and 3 indicating “limited a lot”). We then examined the correlations of self-perceived health functioning (the average of the three items) to PCL severity and to the C-SSI to see which was a better indicator of self-perceived

C-SSI Item	MILD PTSD	MODERATE PTSD Mean (SD)	SEVERE PTSD Mean (SD)	F Value
Dizziness	1.0 (0.9)	2.3 (1.6)	3.7 (0.9)	26.1*
Standing up and feeling dizzy	2.3 (1.2)	2.9 (1.7)	3.4 (0.9)	3.8*
Blurry vision	2.3 (1.8)	2.7 (1.9)	3.6 (0.7)	6.4*
Tinnitus	2.0 (1.8)	2.3 (1.5)	2.8 (1.4)	4.1*
Headache	1.3 (1.2)	1.5 (1.4)	2.6 (1.9)	4.4*
Neck soreness	1.6 (1.5)	2.3 (1.7)	3.1 (1.5)	6.1*
Palpitations	0.5 (0.9)	1.0 (1.6)	1.8 (1.4)	3.9*
Shortness of breath	0.6 (0.9)	0.9 (0.8)	1.7 (1.4)	4.2*
Cold hands and feet	0.5 (1.0)	1.7 (1.9)	1.9 (1.5)	6.2*
Sore arms and legs	2.1 (1.9)	2.7 (1.6)	3.5 (0.7)	10.6*
Weakness	2.7 (1.2)	3.0 (1.7)	3.8 (1.4)	5.8*
Poor appetite	1.6 (1.2)	2.3 (1.6)	3.5 (1.0)	12.1*
Khyâl attack	1.5 (1.5)	2.1 (1.1)	2.8 (1.4)	5.2*
Khyâl hitting up from your stomach, making you fear you might die of asphyxia	0.8 (1.6)	1.3 (1.8)	1.9 (1.7)	3.3*
“Weak heart”	1.3 (1.5)	1.7 (1.0)	3.0 (1.5)	7.8*
Standing up and feeling poorly to the point you feared fainting, khyâl overload, or heart attack	1.0 (1.6)	1.8 (1.4)	2.6 (1.9)	4.9*
Neck soreness to the point you feared the neck vessels would burst	1.4 (1.8)	1.7 (1.9)	2.2 (1.8)	3.9*
“Thinking too much”	2.8 (1.2)	3.4 (0.4)	3.7 (0.4)	18.9*
Sleep paralysis	1.0 (1.3)	1.2 (1.2)	2.1 (1.4)	5.1*

* Indicates a statistically significant result. The SSI is rated on a 0–4 Likert-type scale. The severity of PTSD is rated on the PCL scale: mild PTSD, PCL score of 2–2.8; moderate PTSD, a PCL score of 2.9–3.8; and severe PTSD, PCL score of 3.8–5.

Table 3. Degree of being bothered by various Cambodian SSI items (somatic symptoms and cultural syndromes) in the last month. Comparison of those rural Cambodians with mild PTSD, moderate, and severe PTSD.

health functioning. The C-SSI was slightly more related to the total score of the self-perceived health scale than to the PCL score ($r = 0.38$ versus $r = 0.31$).

DISCUSSION

In this Chapter, we have reported the results of a needs assessment for rural Cambodians who were identified by fellow villagers as having suffered greatly during the Pol Pot period and as still being distressed. We found that all of those interviewed had PTSD, in many cases extremely severe PTSD. We found that they had very high scores on the Cambodian C-SSI and that the severity of the C-SSI and its items increased significantly across each of the three levels of PTSD severity. This illustrates that a Cambodian with significant PTSD not only has PTSD symptoms, but also has several other culturally salient somatic symptoms as well as bouts of and fears about several culturally-specific syndromes. We also found that the surveyed rural Cambodians had experienced many trauma events and had low self-perceived health. Among these Cambodians, the C-SSI was a better indicator of the severity of past trauma events and self-perceived health than the PCL. This suggests that the C-SSI captures a core aspect of the response to trauma.

We found that some of the C-SSI somatic symptoms and syndromes were extremely elevated in this group. Dizziness was a particularly severe complaint, one that was the best differentiator among the various levels of PTSD. The four-dimensional analysis described in earlier in this Chapter reveals why dizziness is such a prominent complaint in the Cambodian context (see Figure 2). In particular, it is associated with the biology of trauma and anxiety, particularly among Asian populations. It is also a key indicator of ethnophysiological disturbance (*khyâl* rushing into the head during a *khyâl* attack) and a key symptom of several syndromes (e.g., weak heart, *khyâl* attacks, and *khyâl goeu* upon standing). Finally, dizziness has extensive metaphor resonances in the Cambodian language (e.g., spinning images in expressions used to convey distress), and it is associated with multiple trauma events (e.g., slave labor when starving, head blows, malaria events). Other authors have noted the prominence of this complaint among Cambodians and, more generally, Asian populations.¹⁷² Kleinman and Kleinman¹⁷³ found dizziness to be one of the three paradigmatic distress complaints (along with exhaustion and pain) in China, and a recent survey of a student population in the United States found dizziness complaints to be particularly elevated in the panic attacks of Asian populations as compared to White and African American students.¹⁷⁴

In addition, weakness was a very severe complaint. It has been noted that Cambodians, and many other Asian groups, are very concerned with bodily energy, a key symptom to which they attend.¹⁷⁵ This explains the common use of multiple traditional medicines and other means to increase bodily energy in the given cultural context. As indicated above, weakness is feared by Cambodians because it leads to heart weakness and predisposes one to *khyâl*

attacks.

Poor appetite was also a prominent complaint; this symptom is feared because of its role in producing weakness and hence vulnerability to heart weakness and *khyâl* attacks. Indeed, poor appetite is itself a symptom of a *khyâl* attack.

Sore arms and legs, which are associated with blocked flow of *khyâl* were also a very prominent complaint. Another prevalent symptom was blurry vision.¹⁷⁶ Finally, the complaint of “thinking a lot” was extremely elevated. This is not surprising given the financial and other problems of these rural groups and given the fact that this highly traumatized group is beset with disturbing trauma memories.

CONCLUSIONS & RECOMMENDATIONS

This chapter reveals that PTSD symptoms are just the “tip of the iceberg.” When PTSD is present, so too are multiple other somatic symptoms and syndromes. Clinicians should be aware that those somatic symptoms and syndromes are often of equal or more concern to the person than the PTSD symptoms and that these symptoms and syndromes are more correlated to past trauma events and self-perceived functioning. In other words, the somatic symptoms and syndromes serve as better past-trauma indicators and self-perceived-health-functioning indicators.

Some of the cultural syndromes have PTSD symptoms as key symptoms. For example, startle or rapidly becoming angry are key symptoms of “weak heart.” It should be emphasized that, if Cambodian villagers are usually unfamiliar with such biomedical concepts as “PTSD,” they are keenly aware of and concerned about both culturally-emphasized trauma-related somatic complaints (e.g., dizziness or neck soreness) and culturally-emphasized trauma-related syndromes, like *khyâl* attacks, weak heart, or “thinking a lot.” This is the culturally meaningful ethnopsychological conceptual system most directly relevant to their lives.

The biology of trauma will help generate a potential “symptom pool.” PTSD symptoms represent one part of this potential symptom pool. In addition, symptoms in this pool are produced partly by the biology of trauma and stress (e.g., through arousal and arousability). They will be more or less salient in a particular culture for multiple reasons.¹⁷⁷ Because of their extremely dysphoria-inducing and disruptive effects, certain PTSD symptoms—such as poor sleep, nightmares, unwanted recall of the trauma, and anger—will almost always be prominent in a traumatized group. These symptoms, and others in the symptom pool, however, may be interpreted in terms of the local ethnophysiology, ethnopsychology, and cultural syndromes, which results in certain symptoms being highlighted and amplified. Depending on the ethnophysiology and cultural syndrome to which the particular symptom

is attributed, the person will have certain ideas about the cause, severity, and indicated manner of redress of the symptom. Finally, certain symptoms in the symptom pool that are linked to the biology of trauma and stress also may be amplified by metaphoric resonances and trauma associations.

We would encourage those researchers and clinicians working in other cultural settings to create symptom and syndrome inventories (a locally specific SSI) to supplement the PTSD scale. In this way, a more adequate depiction of the local response to trauma can be attained and the symptoms and syndromes of concern in that locality can be addressed. This will increase empathy and efficacy, and result in more experience-near understanding.¹⁷⁸

We also emphasize that there needs to be a four-dimensional analysis of each symptom and syndrome in such an inventory. In addition, to assessing the three meaning dimensions (ethnophysiology/cultural syndromes, metaphoric resonances, and trauma associations), the analysis must include a careful examination of frequent causes of the symptom: arousal and arousability—to worry, to anger, to noises, to stress, and to trauma reminders. All these are key aspects of trauma-related disorder and the biology of trauma, which helps generate somatic and psychological symptoms that are interpreted according to the three semiotic dimensions (Figure 4). Only through a four-dimensional analysis can the meaning, manner of generation, and method of treatment of symptoms and syndromes become clear.

The current Chapter highlights the need for services to be developed for traumatized Cambodians. The survey demonstrates the high level of PTSD and culturally related symptoms (SSI). Services should be developed that address the patterns of symptomatology that cause so much distress and disability. At present, few treatment options exist for Cambodians either in respect to medication or psychological treatment.

END NOTES

- I41 The Harvard Trauma Questionnaire provides a list of trauma events and trauma symptoms, such as PTSD symptoms, that apply to all cultural groups.
- I42 The Harvard Trauma Questionnaire and the Hopkins Checklist instruments assess anxiety and depression severity and do not assess culturally specific symptoms.
- I43 These instruments assess general traumas and symptoms that may be related to trauma rather than delineating traumas and symptoms specific to the Cambodian population.
- I44 In a *khyâl* attack, blood and a wind-like substance called *khyâl* surge upward in the body to cause various somatic symptoms and potentially various bodily catastrophes. See subsection “*Ethnophysiology and Cultural Syndromes*” for further description.
- I45 ELIZABETH BECKER, *WHEN THE WAR WAS OVER: CAMBODIA AND THE KHMER ROUGE REVOLUTION* (1998); DAVID P. CHANDLER, *VOICES FROM S-21: TERROR AND HISTORY IN POL POT’S SECRET PRISON* (1999); Alexander Laban Hinton, *Why Did They Kill? Cambodia in the Shadow of Genocide*, in *II CALIFORNIA SERIES IN PUBLIC ANTHROPOLOGY* (2005).
- I46 WILLIAM SHAWCROSS, *THE QUALITY OF MERCY: CAMBODIA, HOLOCAUST, AND MODERN CONSCIENCE* (1984); FIONA TERRY, *CONDEMNED TO REPEAT? THE PARADOX OF HUMANITARIAN ACTION* (2002).
- I47 R.F. Mollica et al., *The Harvard Trauma Questionnaire: Validating a Cross-cultural Instrument for Measuring Torture, Trauma, and Posttraumatic Stress Disorder in Indochinese Refugees*, 180(2) J. NERVOUS & MENTAL DISEASE 111 (1992).
- I48 The DSM-III-r has almost the same PTSD criteria as the DSM-IV-r.
- I49 Lowell is home to the second largest Cambodian population in the United States.
- I50 See, e.g., D.E. Hinton et al., *Khyâl Attacks: A Key Idiom of Distress among Traumatized Cambodia Refugees*, 34(2) CULTURE, MED., & PSYCHIATRY 244 (2010).
- I51 For a review, see D.E. Hinton & R. Lewis-Fernández, *The Cross-cultural Validity of Posttraumatic Stress Disorder: Implications for DSM-5*, DEPRESSION & ANXIETY (forthcoming 2011).
- I52 Ethnophysiology refers to a cultural group’s conceptualization of the workings of bodily physiology.
- I53 On the multidimensional analysis of somatic symptoms, see also, D.E. Hinton & B.J. Good, *A Medical Anthropology of Panic Sensations: Ten Analytic Perspectives*, in CULTURE AND PANIC DISORDER 57 (D.E. Hinton & B.J. Good eds., 2009); A. Kleinman & J. Kleinman, *How Bodies Remember: Social Memory and Bodily Experience of Criticism, Resistance, and Deligitimation Following China’s Cultural Revolution*, 25 NEW LITERARY HIST. 707 (1994). For a detailed description of the four processes in respect to “tinnitus” in the Cambodian context, see D.E. Hinton et al., *The ‘Multiplex Model’ of Somatic Symptoms: Application to Tinnitus among Traumatized Cambodian Refugees*, 45 TRANSCULTURAL PSYCHIATRY 287-317 (2008).
- I54 D.E. Hinton et al., *Worry and its Relationship to PTSD among Traumatized Cambodian Refugees: A Path Analysis*, Soc. SCI. & MED. (forthcoming).
- I55 D.E. Hinton et al., *A Psychobiocultural Model of Orthostatic Panic among Cambodian Refugees: Flashbacks, Catastrophic Cognitions, and Reduced Orthostatic Blood-pressure Response*, 2 PSYCHOL. TRAUMA: THEORY, RES., PRAC., & POL’Y 63 (2010).
- I56 See *id.*; D.E. Hinton & B.J. Good, *A Medical Anthropology of Panic Sensations*, *supra* note I3.
- I57 D.E. Hinton et al., *Khyâl Attacks: A Key Idiom of Distress among Traumatized Cambodia Refugees*, 34(2) CULTURE, MED., & PSYCHIATRY 244 (2010).
- I58 D.E. Hinton et al., *A Unique Panic-disorder Presentation among Khmer Refugees: The Sore-neck Syndrome*, 25(3) CULTURE, MED., & PSYCHIATRY 297 (2001).
- I59 For a discussion of the metaphors associated with dizziness, neck soreness, and tinnitus in the Cambodian

context, see D.E. Hinton & B.J. Good, *A Medical Anthropology of Panic Sensations*, *supra* note 13. For how these processes relate to American expressions such as “back pain,” see D.E. Hinton & R. Lewis-Fernández, *The Cross-cultural Validity of Posttraumatic Stress Disorder*, *supra* note 11.

I60 D.E. Hinton et al., *Cultural Anthropology and Anxiety Diagnoses*, in *CURRENT PERSPECTIVES ON THE ANXIETY DISORDERS: IMPLICATIONS FOR DSM-V AND BEYOND* 245-274 (D. McKay et al. eds., 2009).

I61 D.E. Hinton, *The ‘Multiplex Model’ of Somatic Symptoms*, *supra* note 13.

I62 For more on these syndromes, see D.E. Hinton et al., *The Khmer “Weak Heart” Syndrome: Fear of Death from Palpitations*, 39 *TRANSCULTURAL PSYCHIATRY* 323 (2002); D.E. Hinton et al., *Kyol Goeu (“Wind Overload”) Part I: A Cultural Syndrome of Orthostatic Panic among Khmer Refugees*, 38 *TRANSCULTURAL PSYCHIATRY* 403 (2001); D.E. Hinton et al., *A Unique Panic-disorder Presentation among Khmer Refugees*, *supra* note 18.

We asked about specific ethnophysiology fears that are part of those syndromes. That is, we asked not only about *khyâl* attacks, but also fear of “neck vessel” rupture. If a somatic symptom strongly activates one of the three meaning dimensions (the four symptom dimensions include a biological-causation dimension and three meaning dimensions), such as ethnophysiology concerns, it can also be referred to as a syndrome: “sore neck syndrome.” For the three symptom-meaning dimensions, see Figure 4.

I63 D.E. Hinton et al., *Khyâl Attacks: A Key Idiom of Distress*, *supra* note 17.

I64 For a description of how Cambodians treat *khyâl* attacks through the use of “coining” and other methods, see *id.*

I65 D.E. Hinton et al., *“The Ghost Pushes You Down”: Sleep Paralysis-type Panic Attacks in a Khmer Refugee Population*, 42 *TRANSCULTURAL PSYCHIATRY* 46 (2005).

I66 D.E. Hinton et al., *Anger, PTSD, and the Nuclear Family: A Study of Cambodian Refugees*, 69 *SOC. SCI. & MED.* 1387 (2009).

I67 S.D. McDonald & P.S. Calhoun, *The Diagnostic Accuracy of the PTSD Checklist: A Critical Review*, 30 *CLINICAL PSYCHOL. REV.* 976 (2010).

I68 R. Mollica et al., *Dose-effect Relationships of Trauma to Symptoms of Depression and Post-traumatic Stress Disorder among Cambodian Survivors of Mass Violence*, 173 *BRIT. J. PSYCHIATRY* 482 (1998).

I69 D.E. Hinton et al., *The SF-36 among Cambodian and Vietnamese Refugees: An Examination of Psychometric Properties*, 29 *J. PSYCHOPATHOLOGY & BEHAV. ASSESSMENT* 38 (2007).

I70 *Id.*

I71 $F(2, 63) = 8.1, p < .001$

I72 D.E. Hinton & B.J. Good, *A Medical Anthropology of Panic Sensations*, *supra* note 13.

I73 A. Kleinman & J. Kleinman, *How Bodies Remember*, *supra* note 13.

I74 T.L. Barrera et al., *The Experience of Panic Symptoms across Racial Groups in a Student Sample*, 24(8) *J. ANXIETY DISORDERS* 873 (2010).

I75 D.E. Hinton, *The Khmer “Weak Heart” Syndrome*, *supra* note 22; D.E. Hinton, *The SF-36 among Cambodian and Vietnamese Refugees*, *supra* note 29.

I76 Others have noted blurred vision’s salience as a complaint among Cambodian populations. See Y. Caspi et al., *Relationship of Child Loss to Psychiatric and Functional Impairment in Resettled Cambodian Refugees*, 186 *J. NERVOUS & MENTAL DISEASE* 484 (1998).

I77 See EDWARD SHORTER, *FROM PARALYSIS TO FATIGUE: A HISTORY OF PSYCHOSOMATIC ILLNESS IN THE MODERN ERA* (1992) (discussing “symptom pools”).

I78 See D.E. Hinton & R. Lewis-Fernández, *Idioms of Distress Among Trauma Survivors: Subtypes and Clinical Utility*, 34(2) *CULTURE, MED., & PSYCHIATRY* 209 (2010) (discussing the clinical utility of evaluating idioms of distress).



4 INTERGENERATIONAL TRANSMISSION OF TRAUMA STEMMING FROM THE KHMER ROUGE REGIME: AN ATTACHMENT PERSPECTIVE

Nigel P. Field (Ph.D.) is a core faculty member in the PhD Program in Clinical Psychology at Palo Alto University's Pacific Graduate School of Psychology. He specializes in the area of interpersonal loss, with particular interest in the function of the continuing bond to the deceased in adjustment to bereavement and the role of culture in the nature of the continuing bond. His current work also includes a focus on human perpetrated trauma with special emphasis on genocide and intergenerational psychological effects of such trauma in a Cambodian context.

The enduring impact of the Khmer Rouge regime on the mental health of Cambodians is well documented. In a recent study examining the mental health of Cambodians, 14.2% of first generation survivors of the Khmer Rouge were found to currently have posttraumatic stress disorder (PTSD)—more than six times higher than the rate of current PTSD in a national sample of Americans.¹⁷⁹ In a separate survey study, 11.5% of Cambodians met the criteria for major depression,¹⁸⁰ while 40% had an anxiety disorder.¹⁸¹ The long-term negative impact on mental health of trauma-exposed refugees who relocated to the United States after the end of the Khmer Rouge is even more striking. This is shown in a recent study of Cambodians living in Long Beach, California, the largest such community in the United States, where the incidence of current PTSD was alarmingly high at 62%.¹⁸² The high incidence of current PTSD and other mental disorders reported in these studies attests to the lasting negative psychological impact on a sizable portion of those who survived the Khmer Rouge.

In present-day Cambodia, over 60% of the population were born after the end of Khmer Rouge.¹⁸³ Although the hostilities continued well after the demise of the regime in parts of Cambodia, and many individuals were exposed to the stressors of living in Thai refugee camps for years following the collapse of the Khmer Rouge, a significant percentage of present-day Cambodians were never directly exposed to the hostilities of the Khmer Rouge

and its aftermath.¹⁸⁴ Knowing this, it is important to determine whether the offspring of survivors of the Khmer Rouge show evidence of secondary traumatization—or indirect negative psychological effects of trauma—from growing up with parents who lived through the Khmer Rouge. A full understanding of the psychological consequences of the Khmer Rouge on Cambodia as a whole requires such an intergenerational perspective on trauma. In this chapter, I introduce an attachment theory perspective on the effect of trauma on the parent-child bond as an explanatory framework for intergenerational transmission of trauma among survivors of the Khmer Rouge and their offspring. According to this perspective, unresolved trauma, as it affects the quality of parenting, is a mechanism for explaining secondary traumatization in the offspring. In this context, and informed by related work in the Holocaust literature, I present findings from my research, which examines the effects of trauma on the parenting styles of Khmer Rouge survivors and the psychological impact of this trauma on their offspring. As will be elaborated, my studies demonstrate that parents who continue to experience elevated PTSD symptoms linked to trauma exposure during the Khmer Rouge are more likely to have children who are less psychologically well-adjusted, and such intergenerational effects are attributable to the detrimental impact of parents' trauma on their ability to function as effective parents.

ATTACHMENT THEORY BACKGROUND

The British psychiatrist John Bowlby was the founder of attachment theory. This theory grew out of his early work on the lasting negative psychological effects of early maternal deprivation and naturalistic observations¹⁸⁵ of children's emotional response to separation from their parents.¹⁸⁶ Bowlby sought to explain these effects by positing the existence of a built-in tendency in the child to organize behavior so as to maintain proximity to a parent along with a disposition to form a strong, affectional bond or *attachment* to the parent and the critical role of attachment in the child's emotional development.¹⁸⁷

This attachment system, one of a number of instinctual behavioral systems found in humans and other primates, is said to serve an important survival function in motivating the infant to seek physical proximity and protection with a primary caregiver, or *attachment figure*, under conditions of perceived threat or stress.¹⁸⁸ Internal and external stressors, including illness, fatigue, unfamiliar settings, and separation from the attachment figure, serve to activate the attachment system.¹⁸⁹ Characteristic signals of crying out and attempts to move toward the attachment figure follow from activation of the attachment system. Adopting a goal system perspective on attachment, Bowlby described the attachment system as functioning much like a thermostat: it is activated by perceived threat and accompanying anxiety, and turned off by the comforting presence of a physically and emotionally available attachment figure.¹⁹⁰

Playing a complementary role to the child's attachment system, the parent's instinctual *care-*

giving system is similarly activated when the child is perceived to be under potential threat or in response to the child's distress signals. Upon its activation, the caregiver initiates a set of actions that serve to establish physical proximity to the child, thereby providing protection and comfort. The care-giving system response is terminated upon assurance that the child is no longer under threat. In providing protection, the care-giving system, in coordination with the attachment system, together evolved to serve a basic survival and fitness function in promoting the transmission of parent's genes to subsequent generations.¹⁹¹

Beyond protecting the infant from external threat or harm, the attachment-care-giving bond serves as the foundation for the child's developing capacity toward increasing psychological autonomy. This process develops via internalization of functions initially supplied by the attachment figure. Such functions include the capacity for organizing thoughts and behavior, and for managing and communicating emotion. These functions are crucial to healthy psychological development. Through repeated experiences of attachment figure sensitivity and responsiveness to the child's attachment signals, the developing child builds a *secure* internal working model of attachment. This model includes the belief that others will be physically and emotionally available when needed and a sense of self as capable and as worthy of receiving care.¹⁹² Such secure attachment is believed to be an important resilience factor in coping with stress, including the ability to tolerate and modulate distressing emotions and to make effective use of social supports when needed.¹⁹³

One of the most robust findings in the attachment research literature is the concordance between the parent and child's attachment.¹⁹⁴ The quality of parenting is the key factor that explains these intergenerational correspondences. Securely attached parents—themselves the recipients of sensitive and responsive care-giving during their formative years—are able to accurately read their child's attachment cues and respond contingently.¹⁹⁵ Attachment theory also identifies different variants of insecure attachment as an outgrowth of sub-optimal parenting.¹⁹⁶ Of particular relevance toward understanding the effects of trauma on the parent-child bond and its implications for the intergenerational transmission of trauma is the most extreme variant of insecure attachment known as *disorganized attachment*.

Disorganized attachment can be identified as early as age one in Ainsworth's Strange Situation—a controlled setting for examining the young child's affective response to brief separation from and subsequent reuniting with a primary attachment figure, typically the mother.¹⁹⁷ A securely attached child exhibits distress when the mother is instructed to exit the room, thus leaving the child alone or with a stranger, and relief upon her return—typically running toward the mother and embracing her at the time of her re-entry.

In stark contrast, the disorganized child exhibits disoriented and contradictory behavior when the mother re-enters the room, such as freezing, appearing dazed, or displaying

concurrently opposing approach and avoidance expressions.¹⁹⁸ For such children, the attachment figure appears to be a source of fear. Because arousal of fear elicits an attachment system-based instinctual tendency to approach the primary caregiver for comfort, the child is faced with an approach-avoidance conflict if the mother is the source of fear. Consequently, the child is left with no viable attachment strategy for terminating his or her distress and thereby said to be *disorganized*.

Among disorganized toddlers from community samples for which there was no evidence of maltreatment, it was found that the mothers of these children were more likely to have experienced unresolved childhood losses or abuse early on in their lives.¹⁹⁹ Thus, in these cases it appeared that the effect of the mother's past trauma was transmitted to her child, even though her child had not been directly exposed to comparable trauma. The incidence of disorganized attachment, however, was much higher among children exposed to domestic violence and among those children who were maltreated.²⁰⁰ In addition, maternal psychopathology—such as depression and psychotic disorder—increased the likelihood for the child having disorganized attachment.²⁰¹

It is believed that major disturbance in care-giving lies at the heart of disorganized attachment. This disturbance instills a sense of helplessness in the child as a result of not being able to turn to the caregiver for comfort when under duress, either because the caregiver is the direct source of threat or, more indirectly, when the caregiver exhibits an extreme lack of responsiveness and inability to soothe the child.²⁰² Because the young child is highly dependent on the caregiver for affective homeostasis (i.e., internal stability), even when no overt maltreatment is involved, major lapses in care-giving attunement and lack of responsiveness to the infant's distress signals can be experienced as traumatic. Such *relational trauma*—referred to as *hidden trauma* since it may not stand out as traumatic to an outside observer—can have an insidious effect on the child's attachment capabilities.²⁰³

Disorganized attachment identified in the Strange Situation is an early expression of integration failure at the behavioral level with implications for later dissociative psychopathology and personality disturbance.²⁰⁴ Under conditions promoting disorganized attachment, the child must *defensively exclude* attachment-related thoughts and feelings as the only recourse to terminating the sense of helplessness and overwhelming distress precipitated by failed care-giving. In other words, such experiences become *split-off* as a separate or *segregated* representational system.²⁰⁵ Although defensively warded off under normal conditions, these segregated mental representations may intrude into awareness. Such intrusions may take the form of dysregulated²⁰⁶ attachment-related thoughts, feelings, and behavior under conditions of perceived threat that serve to activate the attachment system.²⁰⁷ These experiences can take on the quality of traumatic memories as described in the PTSD literature wherein the individual feels or acts as though past trauma were happening in the present.²⁰⁸ Highly

constrictive states of mind may also coexist, reflecting defensive efforts to block awareness of such traumatic content.

There is accumulating evidence that disorganized attachment is a risk factor in the development of psychopathology.²⁰⁹ Longitudinal studies have shown that disorganized attachment assessed in the Strange Situation between ages one and two was predictive of internalizing symptoms of anxiety and depression. It is also associated with externalizing disruptive behavioral symptoms at age six²¹⁰ and later dissociative symptoms in adolescence and early adulthood.²¹¹ What is striking here is how the quality of mother-infant interaction in the first year and a half of life is predictive of psychopathology into adulthood, thus highlighting the importance of early maternal care on later mental health.

INTERGENERATIONAL TRANSMISSION OF DISORGANIZED ATTACHMENT

When children with disorganized attachment stemming from failed care-giving grow up and become parents, they are at risk of replicating disorganized attachment with their own children. In other words, they are prone to engender a sense of helplessness and fear in their own children, similar to what they experienced in childhood, thereby transmitting disorganized attachment to the next generation.

Solomon and George provided support for such effects by showing a link between a mother's account of her own childhood experiences of helplessness in the face of unpredictable, and out-of-control or abandoning parenting.²¹² In this account of care-giving of a six-year-old child, who had previously been identified as having disorganized attachment in the Strange Situation at age one, the mother described herself as overwhelmed and helpless in her role as a caregiver. This paralleled her experience as a child, which interfered with her ability to provide security and comfort to her own child. For such a mother, the child's bid for attachment and distress signals served to activate emotional pain and reactive rage stemming from her own thwarted attachment needs during childhood, thus immobilizing her care-giving function. This pattern's negative impact on care-giving was reflected in the mother's reported behavior toward her child: the mother adopted either a more openly punitive stance, characterized by angry confrontations and power struggles in which she construed her child as unmanageable and herself as helpless to control her child's behavior or her own anger, or a passive-withdrawn and role-reversal orientation toward her child.²¹³ In either variant, the mother conveyed inability to comfort and protect her child.

Among the more openly punitive mothers, the child reciprocated with hostile-controlling behavior toward her, involving fits of rage and acting out characteristic of an externalizing orientation. Among passive and role-reversal mothers, the child was more likely to adopt a parentified²¹⁴ type of controlling stance toward the parent, which was characterized by helpfulness or attempts to improve the mother's mood.²¹⁵ This controlling behavioral stance

toward the mother among six-year-olds who were previously identified as having disorganized attachment in the Strange Situation Task at ages one to two has been replicated in a number of studies.²¹⁶

It is noteworthy that, in a doll-play method for assessing attachment,²¹⁷ these controlling children produce highly dysregulated scenarios involving portrayals of their parents as frightening, abusive, abandoning, or helpless, and themselves as out-of-control and helpless to obtain protection. In other words, these children conveyed a similar sense of helplessness and disorganization to that shown behaviorally in the Strange Situation when these children were toddlers except that now these states were demonstrated at the *mental representational* level.²¹⁸

The child's sense of helplessness conveyed in the doll-play paralleled the mother's account of helplessness in her own childhood attachment experiences and in her role as a caregiver to her child. It thus appears that this sense of helplessness stemming from failed care-giving is what is transmitted from mother to child.²¹⁹ The child's controlling behavior is thought to function as an attempt to regulate this sense of helplessness by controlling the mother as the source of attachment-related dysregulation.²²⁰

Intergenerational effects of parents' unresolved loss and trauma may also occur indirectly through its effect on the marital relationship and the broader family system. In a psychologically healthy conjugal bond, both partners serve as an attachment figure to each other wherein there is a healthy balance between providing and receiving care.²²¹ Those individuals who remain unresolved with respect to past attachment-related trauma, however, exhibit a hypersensitivity to rejection and perceived abandonment stemming from experiences of failed protection in childhood. They are more likely to misinterpret their partner's behavior as threatening and themselves as helpless and unprotected.

This dynamic may lead to hostile confrontation, resulting in violence and abuse that, in turn, will instill extreme fear in their child.²²² A parent who is under threat of being physically abused will also be compromised in her role as a caregiver because her attachment concerns for her own safety will compete with—and may take precedence over—her care-giving function in such circumstances. In fact, any major life stressor may serve to activate the attachment system (and its attendant detrimental effects on care-giving) among parents with unintegrated childhood attachment-related trauma.²²³

EFFECT OF KHMER ROUGE ON ATTACHMENT AND PARENTING

The Khmer Rouge can be assumed to have had a profound effect on attachment and care-giving. Its objective to dismantle the traditional Cambodian family unit by separating children from their parents and housing them in communal settings run by strangers in an

attempt to foster allegiance to the state rather than the family, encouraging children to denounce relatives and friends, and uprooting families from their communities was a major assault at the attachment-system level.²²⁴ Witnessing torture, execution, and starvation, and the ongoing threat of personal harm further added to the sense of vulnerability, horror, and loss.²²⁵ Thus, the profound loss and trauma experienced during the Khmer Rouge by children and adolescents placed them at risk on a large scale for disorganized attachment and other variants of insecure attachment.

Even young children with less developed cognitive capacities—who are therefore less capable than an adult of comprehending the dangerousness of the external situation—register trauma as a function of their parents' ability to contain their own fear and remain in the role of an effective caregiver. Parents who are exposed to organized violence, such as that experienced during the Khmer Rouge, are known to lose all sense of self-efficacy in their ability to protect and comfort their child. In fact, their child's distress signals may serve to compound their existing stress, further contributing to the collapse of the parent's care-giving function.²²⁶ Although some children exposed to such profound care-giving failures or precipitous separation from their caregiver (and the attendant fear and sense of helplessness) may have been too young to remember these experiences, this history is encoded non-verbally in implicit memory, and therefore, has implications for the child's attachment security and emotional development.²²⁷

In determining the impact of trauma and its intergenerational effects, it is essential to consider the period of time over which the ordeal occurred. Exposure to prolonged and repeated trauma is known to have a more debilitating effect on mental health than exposure to a discrete single-episode traumatic event.²²⁸ It has also been shown that the linkage between disorganized attachment identified at the behavioral level in the Strange Situation and later psychopathology in adolescence and early adulthood is stronger among children who have experienced repeated, major life stressors throughout childhood.²²⁹

For many Cambodians, exposure to trauma began well before the beginning of the Khmer Rouge as a result of extensive bombing inside Cambodia by the Americans during the Vietnam War, which resulted in heavy casualties and displacement of civilians.²³⁰ It also continued for years after the formal end of the Khmer Rouge through pockets of ongoing fighting throughout the country and exposure to trauma in Thai refugee camps.²³¹ Hypothetically, the extended period of exposure to major stressors experienced by a child growing up during the regime could include a five-year-old child being displaced by US bombing linked to the Vietnam War in 1973, separated from his or her family by the Khmer Rouge at age seven, placed in a slave labor team or conscripted into the army at nine, and moved to a refugee camp along the Thai border in his or her early teens.²³²

Exposure to major stressors may not end there. Upon returning to his or her community in the late 1980s, this young adult would have been faced with poverty, possible expropriation of his or her land, exposure to landmines, lack of access to healthcare and education, and continuing civil war in some areas. In addition, he or she may be unable to locate missing family members or confirm whether they are dead. Beyond this, he or she now may face the demands of being a parent.

These challenges all appear in the context of a social and political infrastructure dominated by widespread corruption and knowledge that those who perpetrated the Khmer Rouge atrocities largely remain immune to justice.²³³ Such unrelenting stress serves to foster a sense of futility and hopelessness in addition to pre-existing trauma. The high incidence of chronic mental disturbance among first generation Khmer Rouge survivors attests to this.²³⁴

In light of exposure to such extreme and protracted trauma and ensuing mental disturbance, the Khmer Rouge survivor's ability to function as an effective parent may be seriously compromised. In more extreme cases, his or her children may be under threat of neglect or abuse. Therefore, growing up with a parent exposed to this degree to trauma is likely to have significant psychological impact on the child. This is consistent with research findings on the effect of maternal PTSD and other trauma-related psychopathology on the mental health of the offspring.²³⁵

The high incidence of violence experienced by Cambodian youth aged twelve to fifteen in a national survey conducted between 2001 and 2004 might be understood as partly a consequence of the impact of parents' Khmer Rouge-related trauma on their parenting ability.²³⁶ The children in the survey were born after the end of the Vietnamese occupation and, therefore, were unlikely to have witnessed military conflict. Their parents, on the other hand, would have been born during the Vietnam War era and were children during the Khmer Rouge. The results of this study indicate a high lifetime rate of exposure to violence: 47% reported physical punishment by parents and 29% by teachers, 37% experienced peer bullying, 14% reported sexual abuse, 22% witnessed the rape of another child by an adult, and 48% had knowledge of a child in the community having been sold. These results attest to the prominence of exposure to violence and abuse, and to failed protection. Although not addressed in the survey, one might suspect that a high incidence of physical and emotional neglect would also be found.

The prominence of domestic violence in Cambodia today may also reflect the longstanding consequences of Khmer Rouge-related trauma. It is estimated that fifteen to twenty-five percent of Cambodian women are beaten by their husbands.²³⁷ Traditional gender roles, wherein a woman is expected to be subservient to her husband, are held to be the main cause for the high incidence of domestic violence in Cambodia.²³⁸ While it is important not to

overlook such socio-cultural explanations for abuse, the impact of early trauma and loss as a distant cause for domestic violence and its effect on the offspring should also be considered. As previously mentioned, a spouse with unresolved childhood attachment-related trauma may be more likely to interpret a marital partner's behavior in a negative light, thus increasing the likelihood for violence.²³⁹

HOLOCAUST RESEARCH FINDINGS ON PARENTAL STYLES IN SECONDARY TRAUMATIZATION

The literature on the psychological effects of the Holocaust on the offspring of concentration camp survivors has set a precedent for examining transgenerational effects of trauma stemming from genocide and large-scale organized violence.²⁴⁰ There is evidence of longstanding effects of exposure to the Nazi regime on unresolved trauma and PTSD symptoms among Holocaust survivors.²⁴¹ Moreover, maladaptive parenting styles have been identified in the Holocaust literature with implications for the psychological health of the offspring.²⁴²

Role-reversal parenting is one type of maladaptive parenting identified in the Holocaust literature.²⁴³ In role-reversal, a parent turns to a child to meet his or her unmet childhood needs.²⁴⁴ In effect, the parent acts helpless and seeks reassurance or direction from the child while the child assumes a complementary dominant position in providing comfort and guidance to the parent. The child's need for support and guidance is thus neglected. Long term negative consequences for the child's psychological well-being may result from the child's curtailment of his or her own attachment needs by taking on the care-giving orientation toward the parent. As noted earlier, parent-child role reversal is linked to disorganized attachment in the child.²⁴⁵ In remaining unresolved with respect to their past trauma and loss, such parents are likely to be emotionally fragile and ineffective in their role as a caregiver, thereby promoting parentification in their child.

Role-reversal parenting in Holocaust survivors was shown in a study by Eland, Van der Velden, Kleber, and Steinmetz, as reported in Bar-On, et al.²⁴⁶ Interviews were conducted with thirty Jewish offspring of Holocaust survivors living in Holland and a matched control group of non-Jewish Dutch children. Relative to the control group, the Jewish children characterized their parents as more dependent on them for emotional support and reported that they had adopted a more supportive role with their parents. They also reported feeling more responsible for their mothers' emotional needs and had more frequent phone contacts with them relative to the control group.

Similar results concerning the effects of parents' trauma on parentification among second-generation Holocaust survivors were found in a study conducted in Israel by Brom, Kfir, and Dasberg.²⁴⁷ This study compared offspring of Holocaust survivors with Jewish offspring whose parents had not experienced Nazi persecution; the offspring of Holocaust survivors

showed a greater tendency toward guilt, more difficulty identifying and following through with personal choices, and a tendency toward enmeshment with parents.

Finally, in a study comparing Israeli cancer patients who were WWII concentration camp survivors with a control group of matched Israeli cancer patients who had never been exposed to a concentration camp, Baider and Sarell found that the former showed a greater tendency toward role-reversal.²⁴⁸ The role-reversal served to foster a parentified orientation in their offspring.²⁴⁹

A second type of parenting style that may be an outgrowth of prior childhood exposure to loss and trauma is over-protectiveness. Holocaust survivors may be likely to regard the world as a more dangerous place. As a result, they may feel an excessive need to shield their family from such dangers, thus adopting an overprotective orientation toward their children.²⁵⁰ In serving to discourage independence, overprotective parenting interferes with the development of the child's autonomy. Support for this tendency toward overprotective parenting among Holocaust survivors is reflected in offspring's accounts of their parents as having seemed overly concerned about their child's security and a tendency to overreact to their child's exposure to minor risks.²⁵¹ Also, in line with this, Brom et al. found that, as an outgrowth of parental overprotection, daughters of Holocaust survivors indicated greater separation-individuation problems compared with matched controls.²⁵²

Finally, a rejection parenting style is more prominent among Holocaust survivors. Yehuda, Halligan, and Grossman found support for greater emotional abuse and emotional neglect among adult children of Holocaust survivors relative to matched controls being largely attributable to parental PTSD symptom severity.²⁵³ Moreover, the extent of childhood abuse and neglect experienced by the offspring was predictive of their own PTSD symptom severity and mean urinary cortisol secretion levels, which is a physiological indicator of stress.

PARENTAL STYLES IN SECOND-GENERATION EFFECTS OF KHMER ROUGE-RELATED TRAUMA

Knowing that survivors of the Khmer Rouge experienced comparable profound trauma to that encountered by Jews during the Nazi regime, similar effects on the quality of their parenting and its implications for psychological adjustment in the offspring might also exist. My students and I examined this question in a program of research on intergenerational transmission of trauma stemming from the Khmer Rouge and its aftermath through its impact on the parent-child bond. This work sought to extend to a Cambodian context the Holocaust literature on the impact of parents' trauma on the quality of their care-giving as a mechanism through which the effects of trauma is transmitted to the offspring.

In the Holocaust literature on secondary traumatization, the typical study design involves

comparing a group of Jewish offspring of Holocaust survivors with a control group of Jewish offspring whose parents were not directly exposed to the Holocaust on measures assessing various aspects of psychological functioning. Differences identified between the two groups can be assumed to stem from differences in parents' trauma exposure linked to the Holocaust.²⁵⁴

This type of design is not possible in a Cambodian context, however, since virtually all Cambodians living at the time of the Khmer Rouge were exposed to some degree of trauma. Therefore, it was necessary to implement a within-group correlation design. This study compared first-generation Cambodians by the degree to which they were exposed to trauma during the Khmer Rouge and continue to suffer the psychological effects of such exposure vis-à-vis the mental health of their offspring. It was our hypothesis that a positive association between parents' *current* Khmer Rouge-related trauma symptoms (reflecting their unresolved trauma) and offspring's indices of psychological adjustment would constitute support for secondary traumatization.

In the first of a series of studies, Field, Om, Kim, and Vorn recruited 200 students between ages sixteen and eighteen (and thus born after the Khmer Rouge) from three high schools in Phnom Penh.²⁵⁵ The students completed a set of measures that included perceived severity of parents' current PTSD symptoms stemming from the Khmer Rouge, parents' Khmer Rouge-related trauma exposure, anxiety and depression measures of their own psychological adjustment, and their experience of parenting styles that included role-reversal, over-protectiveness, and rejecting parenting. Perceived current PTSD symptom severity, as linked to the parents' experiences during the Khmer Rouge, served as a proxy for parents' unresolved trauma. The role-reversal measure included items addressing parental helplessness or incompetence, use of guilt to elicit the child's care, demands for the child's attention, seeking direction from the child, and treating the child as a sibling or spouse substitute.²⁵⁶ The overprotection measure assessed the extent to which each parent was viewed as controlling as opposed to autonomy-giving (e.g., "invaded my privacy" or "tried to make me feel dependent on her/him"). The rejection scale was comprised of items addressing the extent to which each parent was regarded as rejecting and cold as opposed to showing warmth and affection (e.g., "made me feel I wasn't wanted" or "did not praise me").²⁵⁷

In support of the intergenerational transmission of trauma, teenagers who rated their parents as having more severe current symptoms stemming from Khmer Rouge-related trauma exposure also rated their parents as more role-reversal in their parenting. This, in turn, was linked to higher anxiety and depression in the teenager. Thus, the results suggested that role-reversal parenting was a mechanism through which parents' perceived Khmer Rouge-related trauma symptoms affected their child's psychological adjustment. The mother's overprotective parenting was similarly shown to partially mediate the relationship

between her perceived trauma symptoms and the child's anxiety and depression. These results are thus in keeping with an attachment theory perspective on quality of parenting as a mechanism for intergenerational transmission of trauma.

An important limitation of this initial study involved relying on the children's ratings of the parents' trauma. It is possible that these ratings did not accurately represent parents' actual level of current trauma symptom severity and that the child's own level of distress may have been influenced these ratings. In an attempt to address this shortcoming, a second study was conducted involving forty-six mothers who survived the Khmer Rouge and their sixteen- to eighteen-year-old high school student daughters.²⁵⁸ Consistent with the first study's findings, mothers' current Khmer Rouge-related trauma symptom severity ratings were predictive of their daughters' level of anxiety, such that those who reported higher hyperarousal²⁵⁹ trauma symptoms had daughters who also reported higher anxiety symptoms. More importantly, a role-reversal parenting orientation was shown to partially mediate the relationship between the mothers' and daughters' symptoms, thus replicating the finding in the previous study regarding role-reversal parenting as a mechanism for explaining secondary traumatization.

In an extension of this work to a Cambodian-American refugee sample, Muong and Field compared secondary traumatization in a clinical versus community-based sample of mothers and daughters.²⁶⁰ The goal was to determine whether secondary traumatization would be especially prominent among treatment-seeking families when compared with their non-clinical counterparts. Not surprisingly, the fifteen mothers in the clinical group had significantly higher PTSD scores than the seventeen mothers in the non-clinical group. In fact, twelve of the fifteen mothers in the clinical group had PTSD scores above forty-four—the cutoff for a diagnosis of PTSD on the PTSD Checklist.²⁶¹ Similarly, daughters in the clinical group had significantly higher anxiety, depression, and role-reversal scores relative to those in the community sample.

In keeping with findings of the previous studies, more pronounced role-reversal parenting among mothers in the clinical group explained the relationship between their higher PTSD symptoms and their daughters' more severe anxiety and depression relative to mothers and daughters in the non-clinical group. At clinical levels of PTSD symptoms, these results confirmed how a mother's Khmer Rouge-related trauma affected her daughter's psychological adjustment by fostering role-reversal parenting.

In an extension of the previous study, this study also examined parent-child communication regarding the mother's experiences during the Khmer Rouge. A mother who was more role-reversal also reported greater motivation to communicate with her daughter about her past trauma in order to gain comfort. Thus, an attempt to elicit comfort from her daughter regarding her Khmer Rouge-related trauma attests to the mother's continued preoccupation

and distress stemming from her past trauma as the basis for her role-reversal parenting.

Finally, these findings for role-reversal parenting were replicated among offspring of former Khmer Rouge members in a study comparing children of former Khmer Rouge members with those whose parents were not former Khmer Rouge members.²⁶² Many rank-and-file members of the Khmer Rouge are known to have had limited privileged status and were themselves exposed to considerable trauma.²⁶³ Similar evidence for secondary traumatization in offspring of former Khmer Rouge members thus might be expected to be equivalent to that found in the offspring of those individuals who were victimized in this way by the Khmer Rouge.

Fifty teenage children, ages sixteen to eighteen, whose parents were former Khmer Rouge members and a comparison group of fifty children whose parents were not former members of the Khmer Rouge were recruited from a high school in Kampot province in which the student body was composed of offspring of both former Khmer Rouge members and non-Khmer Rouge parents. Participants were given a similar set of measures to that given in the initial Field et al. study as well as additional measures addressing attitudes toward the Khmer Rouge.²⁶⁴

While both groups reported relatively high Khmer Rouge-related trauma exposure in their parents, no significant differences were found between the two groups with regard to the extent of Khmer Rouge-related trauma exposure and trauma symptoms in their parents, or in ratings of their own anxiety and depression. Surprisingly, limited group differences were found in attitudes toward the Khmer Rouge: both groups tended to view the Khmer Rouge in a negative light. A noteworthy finding was that, irrespective of group affiliation, those who rated their parents as higher in trauma symptoms also reported higher anxiety and depression. Moreover, similar to the findings in the previous studies, role-reversal parenting was found to partially mediate the effect of perceived trauma in parents on the child's anxiety. Thus, this study demonstrated that secondary traumatization as transmitted through the parents' trauma could extend to the offspring of former Khmer Rouge members, indicating that this phenomenon may be generalized to all second-generation Cambodians. In summary, the results across this set of studies provide consistent support for intergenerational transmission of trauma through the effect of parents' trauma on their parenting particularly with respect to its impact on role-reversal parenting. To the extent that the severity of parents' trauma symptoms can be taken as indicative of attachment disorganization, these findings cohere with the attachment literature on role-reversal as an expression of failed care-giving among parents with disorganized attachment, which engenders a similar sense of helplessness and disorganization in their children. In future studies, attachment patterns should be assessed in addition to trauma symptoms and other measures of psychopathology in both parent and offspring as a more direct test of

disorganized attachment transmission stemming from parents' Khmer Rouge-related trauma.

CONCLUSIONS & RECOMMENDATIONS

Critics may argue that the attachment theory approach toward intergenerational transmission of trauma overlooks broader economic, sociological, and political factors that might better explain the mental health of second-generation Cambodians. Given the degree of stress encountered daily by younger generation, post-Khmer Rouge Cambodians as a result of poverty, lack of access to adequate medical resources or education, and widespread corruption, it could be argued that the impact of past trauma stemming from the Khmer Rouge is far outweighed by these contemporary factors in explaining the mental health of Cambodian youth today. Moreover, to the extent that the Khmer Rouge impacts second-generation Cambodians, it may be through its more direct effect on the current socio-economic and political infrastructure as opposed to its indirect effect via the parent-child attachment bond.

Certainly, a comprehensive understanding of the longstanding effects of the Khmer Rouge and the mental health of present-day, second-generation Cambodians requires a multidisciplinary approach that goes beyond a psychological focus to include the interpenetration of sociological, economic, political, anthropological, and historical factors.²⁶⁵ In addition, interventions to improve the mental health of Cambodians cannot ignore, and may be of limited success without addressing, these broader contemporary societal stressors. The attachment perspective on secondary traumatization introduced in this chapter does not negate these broader structural factors in understanding the legacy of the Khmer Rouge on the mental health of Cambodians. In fact, it attempts to articulate at the psychological level how these other factors might impinge on mental health.

According to attachment theory, these social factors can have an impact on the quality of care-giving—both directly through creating stress in the family, such as coping with poverty and other hardships, and indirectly in activating unintegrated past trauma. The functioning of the care-giving system needs to be understood in relation to other behavioral systems and in certain circumstances may compete with the goals of other behavioral systems.²⁶⁶ Thus, the quality of care-giving may fluctuate depending on the demands of other behavioral systems and particularly the attachment system.

The many ongoing stressors Cambodian parents face in their daily lives, which often leads to substance abuse and domestic violence that further impacts the ambient level of stress. Their own attachment concerns activated by these stressors may compete with providing quality care to their children. Compromised care-giving as a result of exposure to such stressors may be evident to some degree, independent of whether the parents' loss and

trauma is unresolved. That said, attachment disturbance stemming from early loss and trauma will affect how current stressors are interpreted and coped with, thus amplifying their effect on care-giving. Consistent with this, first-generation Holocaust survivors were shown to experience more intense distress in response to Gulf War missile attacks on Israel relative to a matched control group.²⁶⁷

Exposure to major stressors may also have a comparable psychological impact on the offspring of Khmer Rouge survivors. Again, findings in the Holocaust are in accord with this. For example, children of Holocaust survivors who served in the Israeli military had a higher incidence of combat-related PTSD relative to those whose parents were not exposed to the Holocaust.²⁶⁸ Similarly, women diagnosed with cancer whose parents were exposed to the Holocaust reacted with greater distress relative to those diagnosed with cancer whose Jewish parents were not exposed to the Holocaust.

Knowing that many Cambodians are exposed to ongoing and repeated major stressors that might serve to activate their pre-existing unintegrated attachment-related trauma, similar effects should be expected among second-generation Cambodians. Given the prominence of current broader societal stressors regularly faced by second-generation Cambodians, it would be easy to attribute their stress response exclusively to these current stressors. This, however, would overlook the contribution of attachment-related trauma linked to their parents' Khmer Rouge-related trauma as a distant cause of their stress response that becomes activated in the context of such stressors. Intergenerational effects of trauma could thus easily be overlooked in explaining the mental health of the offspring of Khmer Rouge survivors.

The attachment literature on intergenerational transmission of disorganized attachment and the findings reported in this chapter on role-reversal parenting in Khmer Rouge survivors indicates that secondary traumatization should be given consideration in identifying factors contributing to the mental health of second-generation Cambodians. These findings also suggest that psychosocial interventions focusing on the effects of the Khmer Rouge on the mental health of Cambodians should include attention to such secondary traumatization. This might necessitate intervention at the family-system level and addressing generational boundary disturbances reflected in role-reversal parenting and parentified offspring.

Intervention could also include a psycho-educational component to educate families on the effects of trauma on parenting and the experience of growing up with parents who have been exposed to trauma. An important component of this may require educating the offspring about the Khmer Rouge atrocities that their parents endured. This is especially important since Cambodian children may have limited knowledge of this era as a result of their parents' silence on the topic and the exclusion, for political reasons, of this history in

the school curriculum for a number of years. Linked to this, it would be important to encourage more open dialogue between parents and offspring about the Khmer Rouge and the parents' experiences. This would also serve to remedy any mystification that the children might experience with respect to their parents' response to the parents' past trauma. Finally, interventions to address the high prevalence of substance abuse and domestic violence need to be integrated with treatment of underlying trauma as a possible root cause.

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PART II
THE IMPACT OF TRAUMA ON THE
EXTRAORDINARY CHAMBERS IN THE COURTS
OF CAMBODIA



5 POST-TRAUMATIC STRESS REACTIONS AND SECONDARY TRAUMA EFFECTS AT TRIBUNALS: THE ECCC EXAMPLE

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Cambodians who lived through the Khmer Rouge era have endured and survived some of the worst human rights atrocities known to human kind. Now, more than three decades after the Vietnamese invaded Cambodia and brought about the end of the Khmer Rouge reign in early 1979, the Extraordinary Chambers in the Courts of Cambodia (ECCC) has started to prosecute a small number of the Khmer Rouge leaders who are still alive. Cambodian survivors are providing testimony in the ECCC proceedings and some have been able to participate in pre-trial and trial processes as Civil Parties.

This Chapter will summarize common psychosocial effects of trauma and examine these effects in the context of Cambodian survivors. We will discuss how trauma and other posttraumatic sequelae²⁷⁰ might impact a survivor-witness' memory and ability to testify in court. The potential risk for retraumatization or secondary traumatization of legal representatives, adjudicators, interpreters, and other staff of the ECCC will be highlighted. The implications for the well-being of the ECCC staff and court proceedings will be discussed and recommendations will be presented.

This Chapter draws from multiple sources: the clinical and research literature on primary

and secondary trauma, including among Cambodian survivors; the authors' clinical experience with Cambodian survivors in the U.S. and on the Thai-Cambodian border; the authors' experience with Cambodian and other survivors in U.S. Federal Immigration Courts; and the second author's experience on two occasions with interpreters at the International Criminal Court in The Hague. It is the aim of this Chapter to provide an understanding of the effects of human-induced trauma, so that courts, such as the ECCC, can adequately do their work without doing disservice to traumatized witnesses or staff.

PSYCHOLOGICAL CONSEQUENCES OF TRAUMA

Our world is rife with examples of traumatic events accompanied by devastating consequences, dating back to its earliest recorded history. A trauma is generally thought of as a highly stressful event that overwhelms the individual's ability to cope. Common peri-traumatic (occurring at the time of the trauma) and posttraumatic responses include feelings of intense fear, helplessness, loss of control, powerlessness, and sometimes the threat of annihilation. Risk factors for developing traumatic stress and that shape the extent and type of symptoms a survivor experiences include variables that are specific to the survivor and stressor characteristics. In addition, the nature and extent of support, resources, and social response received by the survivor will shape a survivor's response to trauma.²⁷¹ Natural events such as earthquakes can produce such reactions, but human-induced trauma adds the problem of producing distrust of other humans. Indeed, controlling a populace through terror is often one of the intended goals of military and police in repressive regimes, because such a reaction inhibits the political organization of an opposition. A situation of state terror can also inhibit court trials. The impact of human-perpetrated trauma tends to last longer than that produced by natural disasters, because while one can more easily learn to trust that the earth won't shake frequently, one's foundation of trust in other people is often shattered and takes years to recover, if ever. The courts must recognize this difference in people whose victimization occurred many years in the past.

Posttraumatic Stress Disorder

A major historical turning point in the field of traumatic stress came in 1980 when the diagnosis of posttraumatic stress disorder (PTSD) first appeared in the American Psychiatric Association's *Diagnostic and Statistical Manual* (DSM), Third Edition.²⁷² The diagnosis of PTSD was largely developed due to the need to categorize the distress experienced in Vietnam War combat veterans. Previously, persistent symptoms of distress following a trauma were seen as influenced by the person's character. With the advent of the diagnostic category of PTSD, posttraumatic distress was now viewed primarily as a result of the traumatic stressor. The diagnostic criteria and understanding of the construct of PTSD has evolved during the intervening years.²⁷³

Many survivors of trauma—but not all—develop full-blown PTSD and/or clinical

Box I: DSM-IV-TR diagnostic criteria for PTSD (APA, 2000)

- A. The person has been exposed to a traumatic event in which both of the following were present:
- (1) the person experienced, witnessed, or was confronted with an event or events that involved actual or threatened death or serious injury, or a threat to the physical integrity of self or others
 - (2) the person's response involved intense fear, helplessness, or horror.
- B. The traumatic event is persistently re-experienced in at least one of the following ways:
- (1) recurrent and intrusive distressing recollections of the event, including images, thoughts, or perceptions
 - (2) recurrent distressing dreams of the event
 - (3) acting or feeling as if the traumatic event were recurring (includes a sense of reliving the experience, illusions, hallucinations, and dissociative flashback episodes, including those which occur on awakening or when intoxicated)
 - (4) intense psychological distress at exposure to internal or external cues that symbolize or resemble the traumatic event
 - (5) physiological reactivity on exposure to internal or external cues that symbolize or resemble the traumatic event.
- C. Persistent avoidance of stimuli associated with the trauma and numbing of general responsiveness (not present before the trauma), as indicated by at least three of the following:
- (1) efforts to avoid thoughts, feelings, or conversations associated with the trauma
 - (2) efforts to avoid activities, places, or people that arouse recollections of the trauma
 - (3) inability to recall an important aspect of the trauma
 - (4) markedly diminished interest or participation in significant activities
 - (5) feelings of detachment or estrangement from others
 - (6) restricted range of affect (e.g., unable to have loving feelings)
 - (7) sense of a foreshortened future (e.g., does not expect to have a career, marriage, children, or a normal life span).
- D. Persistent symptoms of increased arousal (not present before the trauma), as indicated by at least two of the following:
- (1) difficulty falling or staying asleep
 - (2) irritability or outbursts of anger
 - (3) difficulty concentrating
 - (4) hypervigilance
 - (5) exaggerated startle response.
- E. Duration of the disturbance is more than one month.
- F. The disturbance causes clinically significant distress or impairment in social, occupational, or other important areas of functioning.
- Specify: Acute (if duration is less than three months) or Chronic (if duration is three months or longer), and With Delayed Onset (if onset of symptoms is at least six months after the stressor).

depression. Many others experience at least some of the distressing symptoms of these conditions, which can negatively affect their functioning and sense of well-being. PTSD has three clusters of symptoms: the re-experiencing of the traumatic event, avoidance of trauma-related stimuli and numbing of general responsiveness, and persistent hyperarousal. All six of the DSM-IV-TR²⁷⁴ diagnostic criteria must be met for a person to be diagnosed with PTSD (see the Box I for the criteria).

Populations that have been exposed to high levels of violence and war—such as combat veterans, refugee, and torture survivor populations—have a higher estimated prevalence of PTSD than other groups. The prevalence of PTSD in four post-conflict societies was estimated to be 37% in Algeria, 28% in Cambodia, 18% in Gaza, and 16% in Ethiopia.²⁷⁵

CROSS-CULTURAL APPLICATION OF THE PTSD CONSTRUCT

The role of culture is critical in determining the expression of symptoms (e.g., somatic complaints, culture-bound syndromes), conceptualization of problems (e.g., cultural bereavement²⁷⁶ versus PTSD), causes ascribed to illnesses, causes of trauma, meaning of trauma/distress, coping efforts, and healing practices.

PTSD is perhaps the most commonly thought of psychological outcome of trauma, but it does not begin to capture all of what a traumatized person experiences. Briere and Scott note that PTSD should, at least partially, be considered culture-bound in the sense that it most closely reflects the posttraumatic responses of Anglo/European people.²⁷⁷ Great attention has been focused in recent years on the cross-cultural assessment of the impact of psychological trauma and its consequences.²⁷⁸ The construct of PTSD has been criticized from a transcultural perspective as imposing a Western medicalized approach, requiring avoidant/numbing symptoms that may not be found typically in survivors from some cultures, and failing to include somatic and dissociative symptoms often found in non-North American populations.²⁷⁹

A recent review found considerable evidence of the cross-cultural validity of PTSD.²⁸⁰ In particular, the authors noted: (1) cultural syndromes may be a key part of the response to trauma in particular cultures and (2) further cross-cultural study is needed to determine the prevalence of somatic symptoms, the relative salience of numbing and avoidance symptoms, and the way in which trauma-caused symptoms are interpreted in the shaping of symptomatology across cultures.

Cultural syndromes may develop within a specific cultural context in response to trauma. Some traumatized Cambodian refugees have been found to suffer from *weak heart syndrome* (*kbsaoy beh doung*)²⁸¹ that can cause calamitous cognitions and somatic symptoms and is believed may lead to various dangerous physiological problems such as a *wind attack* (*khyâl*

Box 2: DSM-IV-TR criteria for Major Depressive Disorder (APA, 2000)

Major Depressive Episode

A. Five (or more) of the following symptoms have been present during the same 2-week period and represent a change from previous functioning; at least one of the symptoms is either (1) depressed mood or (2) loss of interest or pleasure.

Note: Does not include symptoms that are clearly due to a general medical condition, or mood-incongruent delusions or hallucinations.

- (1) depressed mood most of the day, nearly every day, as indicated by either subjective report (e.g., feels sad or empty) or observation made by others (e.g., appears tearful). Note: In children and adolescents, can be irritable mood.
- (2) markedly diminished interest or pleasure in all, or almost all, activities most of the day, nearly every day (as indicated by either subjective account or observation made by others).
- (3) significant weight loss when not dieting or weight gain (e.g., a change of more than 5% of body weight in a month), or decrease or increase in appetite nearly every day. Note: In children, consider failure to make expected weight gains.
- (4) insomnia or hypersomnia nearly every day.
- (5) psychomotor agitation or retardation nearly every day (observable by others, not merely subjective feelings of restlessness or being slowed down).
- (6) fatigue or loss of energy nearly every day.
- (7) feelings of worthlessness or excessive or inappropriate guilt (which may be delusional) nearly every day (not merely self-reproach or guilt about being sick).
- (8) diminished ability to think or concentrate, or indecisiveness, nearly every day (either by subjective account or as observed by others).
- (9) recurrent thoughts of death (not just fear of dying), recurrent suicidal ideation without a specific plan, or a suicide attempt or a specific plan for committing suicide.

B. The symptoms do not meet criteria for a Mixed Episode.

C. The symptoms cause clinically significant distress or impairment in social, occupational, or other important areas of functioning.

D. The symptoms are not due to the direct physiological effects of a substance (e.g., a drug of abuse, a medication) or a general medical condition (e.g., hypothyroidism).

E. The symptoms are not better accounted for by Bereavement, i.e., after the loss of a loved one, the symptoms persist for longer than 2 months or are characterized by marked functional impairment, morbid preoccupation with worthlessness, suicidal ideation, psychotic symptoms, or psychomotor retardation.

attack). *Khyâl attacks* were found nearly always to meet the criteria for panic attacks and were strongly correlated with the severity of the refugee's PTSD.²⁸² Mollica and his colleagues at the Harvard Program in Refugee Trauma have identified local folk diagnoses that they call categories of emotional distress that go beyond Western mental health conceptualizations in traumatized Cambodians: *Cuum Noeur Aarupey* (spirit possession, not found in the DSM); *Tierur-na-kam* (a Torture-Trauma syndrome that is a newer concept similar to the Western construct of PTSD); *pruoy cit* (similar to major depression); and *pibaak cit* (reactive depression).²⁸³

Major Depressive Disorder

Persistent depression has been found in many studies of those who have been chronically traumatized.²⁸⁴ Major Depressive Disorder is one of the primary psychiatric outcomes of trauma, regardless of the type of trauma. In some populations, depression is more prevalent than PTSD.²⁸⁵ Severe traumatic events that have led to the development of posttraumatic stress may also cause symptoms of depression to develop or worsen and survivors may have co-morbid PTSD (i.e., and depression).²⁸⁶

Other Posttraumatic Outcomes

The symptoms of distress that are found in the DSM-IV-TR diagnostic criteria of PTSD are generally thought of as fear-based symptoms. A host of other types of symptoms also frequently follow exposure to trauma, including anhedonic/dysphoric symptoms,²⁸⁷ guilt/shame symptoms, dissociative symptoms, aggressive/externalizing symptoms, and negative appraisals about the world and oneself.²⁸⁸

Often, neither depression nor PTSD captures the full range of distress of trauma survivors. Survivors often have complex presentations,²⁸⁹ especially those who have experienced human-perpetrated traumas (e.g., survivors of torture and other human rights violations) and have been chronically exposed to trauma (e.g., repeated child abuse). Among the many possible outcomes of trauma are depression (traumatic or complicated grief, major depressive disorder, psychotic depression), anxiety (generalized anxiety, panic, phobic anxiety), stress disorders (PTSD, acute stress disorder, brief psychotic disorder with marked stressor), dissociation (depersonalization, amnesia, fugue, identity disorder, or other forms of dissociation), somatoform responses (somatization disorder, conversion), drug and/or alcohol abuse, and a variety of complex posttraumatic outcomes.²⁹⁰

Complex presentations in traumatized individuals may include any, or all, of the following: personality difficulties in areas such as identity and affect regulation, tension reduction behaviors²⁹¹ in the absence of adequate ability to regulate affect (e.g., substance use, bingeing and purging, self-mutilation, compulsive or indiscriminant sexual behavior, suicidality, other problems with impulse control or forms of externalizing anxiety reduction strategies),

psychosis, dissociation, sexual problems, somatic symptoms, cognitive distortions, and self-blame, guilt, and/or low self-esteem.²⁹² Cumulative exposure to interpersonal traumas has been found to be associated with dysfunctional avoidance—a relationship that is mediated by reduced ability to regulate affect and posttraumatic stress.²⁹³ In situations of human-perpetrated trauma, the survivor's capacity to trust others, form healthy interpersonal bonds, retain a positive sense of identity, maintain his or her faith in a system of justice, and sustain existential meaning and hope may be greatly damaged or compromised.

The psychological literature includes many studies that have found an association between dissociation and trauma in some traumatized individuals.²⁹⁴ The relationship, however, is complex.²⁹⁵ Episodes of dissociation during and after a trauma are often conceptualized as a psychological defense mechanism,²⁹⁶ whereby the traumatized individual learns to protect him- or herself from the physical and psychic pain associated with the trauma by disconnecting or separating him- or herself from it. Dissociation involves the disruption in a person's usually integrated functions of memory, perception, consciousness and identity, and the compartmentalization of his or her experience. The traumatic experience becomes stored in the person's memory as isolated or disconnected fragments of various emotional states and sensory perceptions. The person may not be able to remember and recount some, or all, aspects of his or her trauma. Persistent dissociation has been found to be associated with trauma and PTSD in some traumatized individuals,²⁹⁷ and the survivor may experience symptoms of depersonalization, amnesia, derealization, and/or fugue²⁹⁸. Trauma may have an impact on memory years later as a result of symptoms of persistent posttraumatic dissociation in those survivors who experience this phenomenon.

PTSD and Depression Rates In Traumatized Populations

By the time they reach adulthood, many people around the world have experienced some trauma in their lives. The possible consequences of trauma exposure are many. PTSD and depression, however, are two of the most common psychological sequelae found in trauma survivors. In the United States, while approximately half of the population has been exposed to one or more traumatic event(s) that would qualify as a trigger for PTSD, only about 8% go on to develop PTSD.²⁹⁹ Past 12-month prevalence rates of PTSD and depression in the general U.S. population are relatively low (3.5% for PTSD and 6.7% for major depression).³⁰⁰

The rate found in refugees and torture survivors is higher.³⁰¹ One review of the literature found that refugees who have resettled in Western countries could be approximately ten times more likely to have PTSD than their age-matched counterparts from the general population where they are residing.³⁰² Studies of torture survivors have found a high prevalence of psychiatric disorders (14 to 74%), with PTSD, depression, and co-morbid PTSD and depression being the most prominent diagnoses.³⁰³ Torture survivors generally had even higher rates of these disorders than those found in matched trauma survivors who

had not been tortured. Torture and refugee experiences are associated with high rates of suicidality, especially in those with PTSD. In one review, 40% of refugees with PTSD made suicide attempts.³⁰⁴ While this review has focused on the negative consequences of trauma exposure, it should be noted that the lives and identity of survivors are not wholly defined by the fact that they survived trauma. Many survivors are resilient, possessing enormous strengths that have enabled them to endure and survive their experiences, as well as persevere and thrive in their lives.

POSTTRAUMATIC SEQUELAE IN CAMBODIA AND IN CAMBODIAN REFUGEES

Between 1975 and 1979, the Khmer Rouge killed approximately two million Cambodians. In 1975, the population of Cambodia was estimated at 7.1 million. An additional one million were killed in the civil wars prior to and following the Khmer Rouge era.³⁰⁵ Cambodians who survived the Killing Fields and remained in Cambodia, and those who fled as refugees, have experienced extremely high levels of trauma.³⁰⁶ Not unexpectedly, therefore, they have a high prevalence of psychiatric disorders.

In a representative community sample of 490 Cambodian refugees in the U.S. who lived through the Khmer Rouge regime in Cambodia more than two decades earlier, almost two-thirds (62%) of Cambodians surveyed suffered from PTSD, 51% suffered from depression, and 42% had suffered from both PTSD and depression in the past year.³⁰⁷ These rates are six to seventeen times higher than the U.S. national average for adults. The findings from this community-based random sample and a longitudinal study of Cambodian refugees in psychiatric treatment for ten or more years indicate that posttraumatic conditions in Cambodians are often chronic in nature.³⁰⁸ It is common for traumatized individuals to experience fluctuating symptoms, with periods of exacerbations and remissions in response to traumatic triggers.³⁰⁹ For example, Cambodian, Vietnamese, Somali, and Bosnian psychiatric patients experienced reactivation of their posttraumatic symptoms upon viewing scenes of the 9/11 World Trade Center attacks on television.³¹⁰ Among Cambodian refugees treated at psychiatric clinics in the United States, similarly high rates of psychopathology have been found (92% PTSD,³¹¹ 56% PTSD,³¹² and 60% panic disorder³¹³). In one treatment study in the U.S., high concurrent diagnoses of PTSD and depression were found in Southeast Asian refugees along with significant social and medical disabilities associated with their traumatic experiences.³¹⁴ Among all patient groups, Cambodian women without spouses had the most severe impairments.

In addition to the psychiatric conditions noted above, traumatic brain injury (TBI) (also called traumatic head injury (THI)) is known to be a common experience of many survivors of torture, including among Cambodians who lived through the Khmer Rouge regime. THI can result from blows to the head, anoxia (from water-boarding, near drowning, and suffocation), strangulation, and other head injuries. In a study with Vietnamese ex-political

prisoners who were tortured, THI was found to have harmful effects on their brains and to be correlated with depression. The authors concluded that PTSD and depression resulting from THI can be associated with difficult to treat chronic post-concussive symptoms.³¹⁵

Cambodian refugees in the United States have been found to have unusually high rates of serious chronic physical health problems that jeopardize their functioning, quality of life, and longevity when compared to the general U.S. population and other Asian immigrants. This is true even when matched on demographic indicators often found to be associated with poor health.³¹⁶ Among 459 refugee psychiatric patients (Vietnamese, Cambodian, Somali, and Bosnian), 42% had hypertension and 15.5% were diabetic, significantly higher than rates found in the general U.S. population.³¹⁷ In this study the rates of hypertension and diabetes for Cambodian patients were 51% and 41%, respectively (compared to 25% and 11% for the same diseases in a semirural part of Cambodia).³¹⁸ The literature on the relationship between trauma, PTSD, and chronic physical health problems is growing³¹⁹ and attests to the fact that this issue warrants further investigation.

In a study of displaced Cambodians on the Thai-Cambodian border using multistage area probability sampling,³²⁰ 15% were found to suffer from PTSD, 55% suffered from depression, and 20% reported health impairments.³²¹ Mollica, Poole, and Tor³²² found symptoms of depression in two thirds of the Cambodian participants in another study on the border and PTSD in one third. High rates of cumulative trauma and a positive dose-effect association between exposure to trauma and symptoms were found.³²³

The lifetime PTSD rate among the population in Cambodia has been estimated to be over twenty percent.³²⁴ A study in post-armed conflict societies (i.e., Algeria, Cambodia, Ethiopia, and Palestine) found that psychiatric disorders were common, and that PTSD was associated with exposure to violent armed conflict as well as other stressors.³²⁵ In this study, the rate of PTSD, mood disorders (depression and dysthymia), and anxiety disorders in a multi-step random sample of 610 Cambodians were 28.4%, 11.5%, and 40%, respectively. The rates of incidence were higher in the sub-set of 494 Cambodians exposed to armed conflict associated violence: 33.4% with PTSD, 13.2% with a mood disorder, and 42.3% with an anxiety disorder.

IMPACT OF TRAUMA ON MEMORY AND THE ABILITY OF SURVIVOR-WITNESSES TO TESTIFY

The sequelae of trauma can have a profound effect on the ability of Cambodian survivors to testify effectively in ECCC proceedings. Several factors can greatly interfere with the ability of survivors to provide a consistent and coherent narrative account of their relevant trauma experiences in formal court proceedings. The impact of head trauma can have a negative impact on their functioning. The nature of the traumas they endured, as well as symptoms experienced by those who suffer from PTSD and/or depression may also hinder

their testimony. This inability to testify effectively is made worse by the fact that they must do so in front of authorities, individuals who perpetrated atrocities, their family members, and their fellow countrymen and women. These testimonial problems may occur even if a given survivor does not meet the full criteria for PTSD or Major Depressive Disorder. The problems that these survivor-witnesses exhibit in court may contribute to their testimony being found unreliable or not credible. It is critical that the court be knowledgeable or educated about these issues in victims and witnesses.

The experiences of Cambodian survivors vary. Among the various contributing factors are age and region during the Khmer Rouge reign. There were, however, some commonalities experienced by many that are particularly salient in helping us to understand the presentation of survivors called upon to bear witness to the atrocities they experienced in a court of law. The following examples are drawn from the works of historians,³²⁶ researchers on the mental health consequences of the Killing Fields,³²⁷ and reports provided to the authors during the course of clinical work with Cambodian survivors in the U.S. and on the Thai-Cambodian border and during training in Cambodia.

The persecution experienced by Cambodians at the hands of the Khmer Rouge amounted to torture and genocide and frequently included daily forced, hard labor with starvation rations. Not surprisingly, people lacked access to basic health care. In addition, many survivors were beaten for stealing food (loosely defined to include the ingestion of rodents or other creatures they captured in the fields) when they were starving. Some individuals lost family members who were killed for such infractions. The “new people” (Cambodians particularly singled out for persecution by the Khmer Rouge) lived for nearly four years under a constant death threat. They endured frequent political brainwashing sessions by the Khmer Rouge during which time “enemies” of *Angkar* (the organization or the ruling body of the Khmer Rouge) were taken away to be killed for such things as stealing food or for having worked for the former government. They sometimes saw dead bodies and encountered or heard about mass graves.

Cambodians were forcibly separated from family members and in extreme cases family members, including children, were forced to spy on or make false accusations against other members of the family—accusations that might result in death for the accused. Many had loved ones who were executed by the Khmer Rouge or died due to starvation or illness associated with the conditions imposed by the Khmer Rouge. In some cases, survivors lost dozens of extended family members, sometimes leaving them without any relatives. They often saw their loved ones die without being able to do anything to save them or to ease their pain. Cambodians endured the threat of being severely punished or killed if Khmer Rouge cadre caught them crying or expressing anger when their loved ones died. Typically, they were not allowed to bury or mourn their loved ones, or even to know where they were

buried. Some were detained and tortured in such facilities as *Tuol Sleng* (Security Prison S-21). These are just some of the many types of persecution that Cambodian survivor-witnesses at the ECCC have experienced.

The complexity, scope, intensity, and duration of the traumas experienced by survivors of the Khmer Rouge era makes it particularly difficult for them to quickly or concisely summarize or even describe their trauma.³²⁸ This can be compounded by their mental health status³²⁹ and the understandable mistrust that some survivors have towards government officials and authorities as a result of their experience with human rights violations under the Khmer Rouge regime.

Impact of PTSD and Depression Symptoms

One common symptom of PTSD and Major Depressive Disorder (disorders with high rates of incidence among Cambodian survivors of the Killing Fields) is impairment of the ability to concentrate. This inability to concentrate can make it difficult for the survivor to focus on lengthy and complex questioning in ECCC proceedings and to respond to questions with all of the relevant facts. Avoidance of traumatic reminders, including avoiding thinking or talking about one's traumatic experiences, is one of the hallmarks of PTSD for many survivors. Not wanting or being able to talk in detail about one's traumatic experiences may compromise a Cambodian survivor's ability or willingness to provide adequate information or details that are relevant in court. The survivor may not be able to tolerate or cope with the associated distress that such testimony would likely evoke. Individual differences, of course, exist in the extent of distress and the ability of survivors to tolerate and function with the distress.

Clinicians who work with Cambodian survivors (including the authors) have noted that many survivors have not discussed the details of their experiences within their family or with others, generally because they consider it to be too painful.³³⁰ Currently, the traditional mental health resources in Cambodia are limited and have tended to be directed toward treating Cambodians with severe forms of mental illness (e.g., psychotic disorders, bipolar disorder, and profound depression). Providers have not been able to adequately reach the huge numbers of Cambodians with symptoms of posttraumatic distress. Many Cambodians will not seek treatment unless they are in crisis, and their efforts to cope with their symptoms have not been successful.

The Transcultural Psychosocial Organization (TPO) in Cambodia has established innovative psychosocial services that are community-based and culturally sensitive. The TPO aims to address a broad range of challenges faced by survivors and community members and provide a mental health response to address the large scale human suffering of the population.³³¹ TPO's services importantly focus on capacity building and sustainability. The TPO also

builds on culturally-mediated, protective factors and the indigenous coping strategies of the people.

Mollica and his colleagues have conducted training for primary care physicians in Cambodia to allow these physicians to appropriately assess and treat various mental health problems.³³² Parts of Cambodia remain without adequate (or any) service providers for those struggling with the symptoms of posttraumatic stress. Many people have access only to individuals who practice traditional modalities of healing (e.g., *Kruu Khmer* or traditional healers, monks, mediums, and traditional birth attendants).³³³ That reality, along with the lack of tradition of seeking mental health services, and the stigmatizing connotation of the Khmer word for mental health (i.e., "*kuot*" which connotes someone who is deranged or insane) means that many Cambodian survivors have not had the formal opportunity or encouragement to discuss their traumatic experiences in any depth.

The pervasive desire among many Cambodian survivors to avoid revisiting these traumas³³⁴ may further challenge their ability to recall and recount relevant aspects of their traumas in a court of law.³³⁵ Many Cambodian survivors, like numerous other trauma survivors, have learned over time to avoid thinking and talking about their traumas. This is a self-protective mechanism that enables them to minimize their fear and other painful emotional responses to what happened to them and reduce the risk of being flooded with intrusive traumatic memories. This mechanism enables them to function more effectively in their daily life. It is a survival strategy—one that must be suppressed to testify in court about their trauma and to heal.³³⁶

Efforts to avoid or forget past traumas may hinder or obstruct the survivor's ability to remember or recount details of his or her traumatic experiences that may be deemed to be important in court. This ability can be further damaged when the events happened many years prior, as is the case in Cambodia. Even in the absence of trauma, a person's ability to recall details about all aspects of their experiences tends to be compromised over time. Accurate recall is further compromised with trauma, in part due to two common posttraumatic stress symptoms: avoidance and the inability to recall aspects of the traumatic experiences. If Cambodian survivors have been psychologically invested for several decades in avoiding thinking about or talking about what happened to them, they may not have had the opportunity to integrate their memories or to sufficiently revisit the details to be able to accurately recount them.³³⁷

Other posttraumatic and depression symptoms commonly found in Cambodian survivors also have been observed in court settings and can clearly interfere with successful courtroom proceedings. Many survivors suffer from a variety of sleep disorders as a result of intrusive memories that prevent sleep, nightmares, and being constantly vigilant and on-guard. Sleep

deprivation can diminish the ability of the survivor to testify effectively due to exhaustion, which can lead to or exacerbate the survivor's poor concentration, memory loss, and increased irritability. Increased irritability or outbursts of anger may alienate court personnel. Substance abuse, often used to self-medicate and manage distress, can also interfere with performance in court.

Flashbacks during court proceedings may occur when the survivor feels as though he or she is reliving the trauma in the present. The survivor's recalling and retelling of his or her traumatic experiences and his or her meeting of other witnesses or perpetrators in court can provoke these flashbacks. These flashbacks can be disruptive of the court proceedings and lead to confusion on the part of the court staff members who witness the flashback. Survivors who, while in court, present partial or intermittent memory loss concerning their experiences during the Khmer Rouge era may be determined by adjudicators to be lying, if these problems are not understood by a court as evidence of their symptoms of posttraumatic distress.

The examples above are some of the most frequent ways that posttraumatic symptoms have manifested in asylum court settings in the United States.³³⁸ Ideally, all survivors appearing in court would receive official clinical support. At the very least, the education of lawyers and judges about the manifestations of posttraumatic symptoms is critical where severe human-induced trauma is an issue, especially in the context of war crimes trials.

Normal Autobiographical Memory Versus Traumatic Memory

In addition to understanding the common range of posttraumatic responses that may be found in survivor-witnesses, it is vital to understand the different types of memory and how trauma affects memory. Such an understanding will be invaluable in facilitating comprehension of ways survivor-witnesses may present in court. It may also provide insights into alternative explanations for inconsistencies and memory deficits in witnesses who may otherwise be found to be credible.

Autobiographical memories involve the recall of events from one's personal history, generally about normal everyday events. The psychological mechanisms involved in forming normal autobiographical memories versus those in traumatic memories are significantly different in ways that are relevant to one's ability to testify.

Normal memory, in someone without significant head trauma or cognitive impairment, entails the relatively easy and elective construction of a verbal narrative about mundane things such as what the individual did yesterday or what happened on a vacation last year. The person is able to give a story about the events that includes a beginning, middle, and end. High levels of emotion, however, have been found to result in impaired memory of

non-traumatic events.³³⁹ The person's memory may be updated or refreshed by examining collateral information available to them (e.g., looking at vacation photos). With normal memory, the person is well aware that the events occurred in the past.³⁴⁰

Traumatic memory, in contrast, is re-experienced in the moment of recall, not as a memory of events from the past. Unlike normal memories, traumatic memories are typically unintentionally evoked. Instead, traumatic memories are generally provoked or triggered by things that remind the person of past traumatic events. These types of memories are *implicit*, involving sensations and emotions. The trigger may resemble only one aspect of the experience (e.g., the tone of a person's voice, his facial expressions, or the size of the room); it need not be identical to the original trauma.

Often the person does not initially have a complete verbal narrative for his or her traumatic experience. The memory of the trauma may contain fragments of sensory impressions, such as images, sensations, smells, sounds, and/or emotional states. Therefore, when asked to describe or recount a traumatic event (such as when Cambodian survivor-witnesses are asked to testify about traumatic events before the ECCC), trauma survivors may have enormous difficulty in providing a coherent and consistent verbal narrative account. In addition, because traumatic memories are triggered, it is likely that different aspects will be recalled or emphasized depending on the specific triggering events in the given testimony or interview. The witness or interviewee may only report impressions or fragments that evoke similar feelings as those he or she felt at the time of the original trauma. Some of the common feelings that may be stirred up are those of fear, sorrow, deep suffering, anger, shame, humiliation, and/or guilt.

Impact of Trauma on Memory

Individuals who feel highly anxious when giving a public speech know all too well the distress of experiencing temporary memory deficits induced by the perceived or felt stress of the situation. Many people who must undergo an important oral exam or testify in court for their first time have had similar challenges with memory in those highly stressful situations. The ability of survivors of human rights abuses, including Cambodian survivors, to give a coherent, consistent narrative account of their trauma is frequently compromised due to several key factors, in addition to the stress inherent in testifying in court.

Sometimes survivor-witnesses are asked about aspects of their experiences that are less important to them than the aspects about which they want to testify. In response, they may try to provide testimony about parts of their traumatic experiences that the court deems irrelevant or lacking pertinence to the legal matters at hand, and as a result, survivor-witnesses may be redirected or interrupted. This can be frustrating for the survivor-witness. Testifying can also be confusing when he or she is asked to speak about certain details out of context or not in chronological order. These challenges may be intensified by the distress

of testifying in formal proceedings in front of powerful officials and those responsible for his or her torture.

In a study with refugees with no motivation to fabricate or embellish accounts of trauma, Herlihy and Turner found that discrepancies in accounts of the refugees' experiences were common, especially when the refugee had PTSD, there was a long period of time between interviews, the details required were peripheral to the refugee's experiences, and the content was traumatic to the refugee.³⁴¹

With traumatic memories, the person going through the trauma tends to focus on and have less difficulty remembering central details (e.g., major themes of the narrative that were most meaningful to him or her or the emotional content) rather than precise, specific details that were peripheral to his or her experience (e.g., the exact number of people present in the room, the color of the wall in the room in which he or she was gang raped, exactly how many times he or she snuck out into the fields at night to search for something to eat). In providing testimony, such witnesses may struggle when asked about details that to them were peripheral to their story. For example, survivor-witnesses may have difficulty remembering the precise date that they saw their family massacred. Adjudicators in legal proceedings, however, may have a different impression or opinion about what should have been central to the survivor's experience and thus remembered. These adjudicators may easily reach erroneous conclusions, including an adverse credibility finding, if they rely only on their own cultural and experiential assumptions of centrality.

Herlihy and Turner, in their study of discrepancies in accounts of refugee trauma over time, concluded that it is dangerous to assume that asylum seekers are presenting fabricated histories of persecution and trauma only on the basis of discrepancies between interviews, even in cases in which the interviews are conducted only weeks apart.³⁴² Those asylum seekers who may appear to adjudicators to be the most incredible may actually have endured the most severe trauma. For example, those who seem to respond vaguely to direct questions about key elements of their claims may appear to the adjudicator to be lying while in reality they may be dissociating or avoiding talking about painful aspects of their trauma. These lessons are relevant as well in the case of Cambodian survivor-witnesses at the ECCC.

As previously noted, trauma can also have an impact on memory years later as a result of persistent posttraumatic dissociation in those survivors who experience this phenomenon. When trauma memories are reactivated, such as when Cambodian survivors provide testimony about their experiences during the Khmer Rouge regime, those who have developed the capacity to dissociate may use this protective mechanism to control or reduce their level of psychological distress in the moment.³⁴³ Testifying about one's traumatic experiences is a time of high arousal that tends to invoke defensive strategies in the witness, particularly if they are feeling threatened. Such feelings of threat may occur during an

aggressive cross-examination that feels like interrogation (as if they were on trial themselves). During the *Duch* trial at the ECCC, the defense counsel (and at times Duch himself) challenged the credibility of some of the witnesses' testimony, including the veracity of their claimed experiences and the accuracy of their memories. Some survivors (including a few who were not accepted as Civil Parties to the ECCC) were found by the Court to lack adequate proof or evidence of their harm. This lack of evidence included proof of being held and tortured at the notorious Tuol Sleng, a former high school that was turned into a torture center and otherwise known as Security Prison 21 (S-21). This type of situation could cause a survivor-witness with a history of dissociating to dissociate in court. In such a dissociated state, the survivor-witness may not be able to remember or recount some, or all, of the trauma, including aspects of the trauma that the adjudicators believe are salient to the case. Their distress may manifest overtly as "spacing-out," an inability to concentrate or focus on the proceedings, a flashback, the expression of intense emotional or physiological distress, or even a state of speechless terror. Any of these reactions could negatively impact the survivor-witness' performance in court.

Demeanor of the Survivor-Witness

The survivor-witness's demeanor and presentation may vary based on such factors as culture, personality, the type or extent of education, life experiences, the historical and societal context, and coping strategies. Survivor-witnesses may display a demeanor that the adjudicator finds incredible, such as a flat or blunted affect and emotional numbness when recounting their trauma rather than displaying intense emotions. Alternatively, an adjudicator, believing that a survivor-witness is overly emotional or hysterical, may disbelieve the witness' story of trauma, and/or its impact. The adjudicator may believe the witness desires some secondary gain. Either way, the judge may conclude that the person is lying.

Trauma professionals understand that a survivor-witness may not behave as expected. Both demeanors described above (lacking emotion and overly emotional) are possible posttraumatic reactions and should be considered in the context of the survivor's history, psychological condition, and affect-regulation skills (i.e., the ability to self-regulate emotions). When recounting a traumatic event, different individuals, and even a single individual, may manifest enormous variations in demeanor over time and in different contexts.

One of the authors (MB) has encountered variable demeanor in the hundreds of Cambodian survivors with whom she has worked since 1987. These individuals may recount their trauma histories and the impact on their lives in clinical sessions, during forensic psychological evaluations, while preparing to testify in United States Federal Immigration Court, and during their actual testimony. Many Cambodian survivors have displayed acute expressions of pain and suffering, have great difficulty containing or controlling their intense emotions, and have manifested physiological reactions as they struggle to regain their composure and

articulate their traumatic experiences. Other survivors, or the same survivors at other moments in time, appear emotionally numb and more detached from their emotions as they speak about their traumas.

Many, including those who watched their loved ones die or be carried off to be killed, quickly learned that it was dangerous to feel or express any emotion during the Khmer Rouge regime. These survivors trained themselves not to cry and learned not to show or feel anger or other strong emotions, because the alternative may lead to being beaten, tortured, or killed.

Some survivors have spoken of becoming the “walking dead,” a phrase used by a number of the author’s (MB) Cambodian clients. When their family died, they typically had to leave the corpse and go to work. Generally, they would not be allowed to properly mourn or bury their dead. Most survivors were exquisitely trained during the Khmer Rouge regime, some at a formative age in their development, to shut down their emotions and become numb in order to survive. Decades after the fall of the Khmer Rouge regime, some survivors have achieved an adequate sense of safety and stability, such that they feel able to let themselves fully feel and express their emotions. Others, however, have not been able to achieve this. Regardless of their demeanor, many of the Cambodian survivors (not unlike other survivors of torture and other human rights atrocities) experience a worsening of negative mental health symptoms in the days and weeks after sharing their traumatic experiences.

Recommendations for Psychological Preparation & Support of Survivor-Witnesses

Given the great potential for retraumatization and for compromising survivor-witnesses’ ability to testify, the Court should make resources available to adequately prepare and support these witnesses. Specifically, psychological preparation is strongly recommended to facilitate a witness’ understanding of the court process, the scope and purpose of his or her testimony (including the limits of the testimony that he or she will be asked to supply), as well as the reasons why certain questions may be asked. In addition, preparation regarding how to manage the stress associated with court participation, as well as anticipating and managing any symptoms of posttraumatic distress triggered in the process, can enable survivors to provide their best testimony. Furthermore, ongoing support before, during, and after their testimony would be beneficial to ensure the well-being of survivor-witnesses and to encourage more witnesses to come forward and participate in the process.

The impact of testifying in tribunal proceedings, such as the ECCC, can last for some time. Often a survivor-witness may struggle with reactivated or intensified traumatic memories, nightmares, flashbacks, or other symptoms that may warrant clinical intervention or peer support. Many will not have the resources to access the care that they need. Institutional support from the Court is recommended to ensure that essential services are available when

the witnesses return home.

SECONDARY OR VICARIOUS TRAUMA

Not only is it essential to attend to the psychosocial impact of testimony on survivor-witnesses, it is also important to be aware of and address the possibility of retraumatization or secondary/vicarious trauma in the staff of the ECCC.³⁴⁴ The staff at war crime tribunals and in other human rights settings are frequently exposed to, if not inundated with, detailed accounts of severe human-perpetrated trauma. These accounts come in many forms, including the testimony of survivor-witnesses, transcripts of proceedings, and various documents and exhibits (some of which may include graphic visual images). The victims they encounter have variously suffered the traumas of war, physical, sexual, and psychological torture, genocide, and other gross human rights violations. Moreover, an unknown number of staff will have histories of human-induced trauma not revealed to their colleagues. Such survivors may be motivated to seek work in the courts out of a sense of justice or out of sympathy for survivors.

The ECCC adjudicators have a difficult role that is not limited to the challenge of making complicated determinations about witness veracity. Adjudicators, attorneys, interpreters, and other court personnel at the ECCC are at risk for developing symptoms of secondary trauma or, in some cases, being re-traumatized in the course of their work. This may also be true for outside professionals who work with the court (e.g., police, forensic doctors, and translators). The effects of vicarious or secondary trauma have been studied most in psychotherapists³⁴⁵, somewhat in lawyers³⁴⁶ and judges,³⁴⁷ and least of all in interpreters.³⁴⁸

Secondary Traumatic Stress Defined

Secondary trauma refers to the psychological signs and symptoms that result from ongoing interaction with traumatized individuals. In human rights, work with trauma involves contact with experiences of intense pain and suffering, extreme fear, humiliation, and loss of self. [Survivors tell n]arratives about bodies destroyed by land mines, and about children and women systematically raped, tortured, and left to die. The lingering effects on professionals exposed to situations that implicate annihilation may generate psychological difficulties produced by the survivors’ accounts of their traumatic experiences and the professionals’ reaction to such accounts. By becoming a witness to these atrocities, these may become part of the professionals’ consciousness, leading to a potential incorporation of the histories of the traumatic experiences.³⁴⁹

Secondary traumatic stress, also known as vicarious trauma, refers to a person’s reaction to exposure to very stressful and traumatic events that happened to others. Secondary trauma can develop when court personnel become so overwhelmed by exposure to the intense

traumatic material of witnesses and victims in the course of their work. In the context of human rights or war crimes tribunals such as the ECCC, such overwhelming exposure may happen frequently or repeatedly. Secondary trauma generally develops over time, as a cumulative result of repeated exposure to the traumatic experiences of others. It can, however, develop quickly when a professional is confronted with a case that is particularly traumatic or challenging.

Secondary Traumatic Stress: Associated Characteristics

Secondary traumatic stress can profoundly impact professionals—often in ways similar to the directly traumatized individuals with whom they work. Psychotherapists and other mental health professionals who work with trauma survivors have been found to develop some symptoms of PTSD or depression much like those experienced by their traumatized clients. This is true even if these professionals have not experienced significant trauma themselves.³⁵⁰

These symptoms may also appear in court personnel who work in settings in which violations of human rights are adjudicated.³⁵¹ Court personnel who develop secondary traumatic stress may find that they are preoccupied with thoughts about the atrocities they have read or heard about through their work. They may feel overwhelmed and contaminated by the trauma material and may find it challenging to maintain effective and appropriate boundaries between their personal and professional lives.³⁵² Affected court personnel may develop symptoms in response to their secondary exposure to trauma encountered in testimony. For example, they may avoid triggers, such as activities that remind them of witnesses' trauma—or indeed, avoid the witnesses themselves in court by withdrawing.

It is important to note that not all vicariously traumatized professionals will develop PTSD or depression.³⁵³ These individuals may, however, develop intrusive traumatic thoughts, fear, anxiety, problems sleeping, nightmares, loss of energy, increased and uncharacteristic forgetfulness about important matters, depression, and other characteristic symptoms of distress. As Saakvitne and Pearlman found with mental health trauma specialists,³⁵⁴ the intensity and extent of the impact of these symptoms in court personnel will tend to be less than that experienced by the primary survivor.³⁵⁵ Some seasoned professionals, however, protect themselves by leaving the work because of their unattended secondary trauma.

As a result of exposure to the suffering of others, secondary trauma changes the professional deeply in harmful ways. It involves the cumulative effect of this exposure on their memories, feelings, cognitive schemas, self-esteem, and sense of safety.³⁵⁶ The professional's sense of self may be negatively affected and their assumptions about themselves and the world may be significantly altered or shattered. Similar to the primary survivor of trauma, a secondarily traumatized staff may find that they no longer feel invulnerable or protected from trauma.

While prior to their exposure professionals may have assumed that trauma happens to other people, they may begin to feel personally at risk. The world may become a more frightening place—a place that is no longer orderly, predictable, or easily comprehended. They may become fearful and begin to view themselves as powerless against such forces.³⁵⁷

The Risk of Retraumatization & Secondary Trauma Among Court Personnel

In situations of retraumatization, the person who was a victim of primary trauma in the past has some or all of his or her former symptoms triggered and reactivated. In the legal settings with which we are concerned, the trigger is generally the trauma history and the testimony of the plaintiff, witness, political asylum seeker, or other party to the proceedings. A person's retraumatization, vis-à-vis their own traumatic life experiences, may be exacerbated by secondary trauma as well.

ECCC personnel who have developed posttraumatic reactions from their own traumas may be more at risk of being re-traumatized by their work or developing secondary trauma, especially if there are strong similarities between aspects of their own traumas and the material that they are exposed to at work. The particular triggers may be different for different personnel. The ECCC is a hybrid institution with many Cambodian staff members who are victims themselves and/or who know victims. Court interpreters may be particularly vulnerable if they personally, their loved ones, or their friends have experienced trauma similar to that of the victim-witnesses. Many of these interpreters, chosen for their language expertise, necessarily come right out of the same countries and trauma settings as the victim witnesses, and sometimes out of the same battles or prisons.

Why Secondary Traumatic Stress Develops

Secondary traumatic stress typically develops due to the accumulation of experiences. In this context, the accumulation is generally due to exposure to multiple cases. It is possible, however, for secondary trauma to appear suddenly. This is even true of seasoned professionals who have worked in the legal trenches on extremely traumatic cases and who have previously not struggled with secondary trauma. Many judges and attorneys have been socialized to believe that they should be able to handle working with traumatic and otherwise tough cases without undue affect. They are typically trained to keep their emotions separate from their work, and the culture of the field typically views becoming emotional about one's case as unprofessional.

Sagy's study of asylum lawyers found that the lack of emotional support provided to lawyers working with highly traumatized clients was a key factor associated with the lawyers' secondary trauma and burnout.³⁵⁸ When signs of secondary trauma emerge, attorneys and judges may be left with a feeling of disruption or powerlessness and find that it is hard to tell their colleagues what they are experiencing. Additional factors that may increase a legal

professional's vulnerability to developing symptoms of secondary trauma include prolonged traumatic exposure (the more prolonged the more risk), working too many hours without adequate rest periods; great demands in his or her personal life, and significant isolation from others in his or her personal and/or professional life. In addition, the lack of training received by attorneys regarding how to work with trauma survivors has been found to contribute to their secondary trauma.³⁵⁹

A survey of United States federal immigration judges found that workload and time demands, problems with the infrastructure, challenges to their esteem, psychological and health issues, and fraud were their most common workplace challenges.³⁶⁰ Of these factors, challenges to esteem were most closely associated with judges' level of burnout, while psychological/health issues and fraud were closely associated with secondary trauma.

Secondary trauma was also found in Kosovo-Albanian interpreters serving trauma survivors in their work with the Danish Red Cross.³⁶¹ The researchers identified that the interpreters' distress was related to triggers of their own traumas before they fled Serbian persecution in Kosovo. In particular, their clients' stories evoked anxiety about the well-being of family members left behind in Kosovo. This distress was also linked to the perceived lack of recognition and respect they received for their difficult work.

Secondary Traumatic Stress in Court Personnel: Impact on Self, Relationships, and Work

When secondary trauma develops in those who work in the legal arena, it typically transforms them (sometimes permanently) and affects not only their professional life, but their personal life as well. Secondary trauma can change the professional. It can alter or interfere with relationships with colleagues and performance at work. The effects of secondary trauma may cause judges, attorneys, and their interpreters to fail to fully hear, or to not hear accurately, the traumatic testimony of survivors. Avoidance of traumatic content may affect the way that judges or attorneys interpret or probe during examination of a witness. The effects in some court personnel may be severe enough to cause them to leave this area of law or to leave their profession.

Some attorneys may find that they begin to emotionally distance themselves from their traumatized clients in response to the traumatic material presented. This may negatively impact their ability to fully listen to and represent their clients, in addition to making informed decisions for their clients.³⁶² The result can damage the attorney-client relationship if clients feel that their attorney is insensitive to their experiences and pain.³⁶³ The affects of secondary trauma may also compromise the ability of attorneys to maintain appropriate boundaries and roles, such that they become overextended in their work role.³⁶⁴

Recommendations for Change: Training, Supervision, Mentoring, and Support

It is essential for the Court to build systemic support for its staff to prevent the negative effects of secondary traumatic stress. If such support is not provided, court personnel may be at risk for engaging in ineffective or unprofessional behavior, becoming sick, and/or burning out and leaving the field. Without institutional support from their employer, many court personnel may lack the means to obtain help or may not seek out the help they need.

Staff members who work at the ECCC and other human rights and war crimes tribunals are vicariously exposed on a regular basis to significant trauma. They routinely hear stories of torture, genocide, and other severe forms of persecution. They are at risk for developing secondary traumatic stress, which can be disruptive and distressing. Thankfully, it is not necessary to suffer the effects of secondary trauma forever; it is possible to recover. In order to recover, however, adequate training, self-awareness, support, and an effectively implemented plan is needed. Further, professionals need to be informed about the phenomenon of secondary traumatic stress, so that they may develop skills to prevent it and address the symptoms if they emerge.

A recent study of U.S. immigration judges concluded with a number of recommendations to alleviate the judges' symptoms of secondary traumatic stress and burnout.³⁶⁵ Among the many recommendations, the authors called for meaningful training and ongoing education for judges. They stressed that judicial independence must be insured and that judges be provided with sufficient tools and support staff, as well as adequate administrative time. The authors advocated that trained group facilitators should be provided to allow judges opportunities to connect with each other and support one another in the difficult work they do.³⁶⁶ These recommendations are relevant and valuable in other judicial settings, including human rights tribunals such as the ECCC. Specific training should be provided to the ECCC judges about secondary traumatic stress and ways to prevent and manage it. In addition, peer support groups could be formed for court personnel to provide outlets for supporting one another in the stressful work of the court.

Education about the effects of secondary trauma, mentoring, and adequate support or supervision may be helpful to court personnel struggling with the impact of exposure to traumatic material. Interpreters, for example, may benefit from training and supervision by mental health trauma professionals who can help the interpreters understand their own reactions to the traumatic material presented by the survivor-witnesses.³⁶⁷ Sagy offers several additional suggestions for attorneys working with traumatized clients that may help to prevent or minimize the development of secondary traumatic stress or burnout.³⁶⁸ Her recommendations include training regarding how to effectively work with traumatized clients, setting up systems of support (similar to those recommended for, but not well established by, the International Criminal Court) so that attorneys have outlets to talk

about the difficult emotions arising from their work, and the institutional recognition and legitimization of secondary trauma so that staff are not left alone to deal with their distress.

One model of training and support that could be adapted and used for staff at the ECCC was developed by the Institute for the Study of Psychosocial Trauma (ISPT)³⁶⁹ regarding secondary trauma and self-care for clinicians, primary responders, interpreters and legal professionals who work with traumatized populations.³⁷⁰ ISPT's model addresses the professionals' personal motivations for working with traumatized populations and connects it to larger issues of purpose and meaning.³⁷¹ The model is delivered through a combination of lectures and group work. Professionals are also provided avenues for addressing any past traumas that they may have experienced, are taught ways to prevent the development of secondary trauma, and are taught strategies for taking care of themselves.

It can be difficult for legal professionals to admit to their colleagues, others, or themselves that they are experiencing symptoms of secondary trauma, particularly given the culture of their workplaces. The ability to admit the impact of the work, however, can be an important strength. This demonstrates professionalism and provides an opportunity to develop a self-care plan, enhance job performance, and promote better service to the trauma survivors with whom legal professional interact.

Ideally, the courts would take the lead in providing clinical consultation to court leadership, group and individual counseling to staff, and clinical support to victims and witnesses.³⁷² Our experience, however, shows that lack of funding may prevent these services from being offered. In addition, the problem of secondary trauma is only just becoming understood in legal circles. This may mean that lawyers, interpreters, judges, and others must take care of themselves in settings where exposure to trauma is high and institutional pressure to ignore secondary trauma requires handling as many cases as possible.

Even in such circumstances, there are steps that individuals can take to care for themselves.³⁷³ Those experienced in these matters advise that it is important to take personal time engaging in activities away from work. Equally important is self-awareness concerning the impact of secondary trauma. The manifestation of secondary trauma symptoms is not always obvious. Several assessment tools are available to assist in monitoring one's responses over time. One such tool is the *Professional Quality of Life Scale* (ProQOL),³⁷⁴ which is a thirty-item, self-reported measure of the positive and negative aspects of helping others that have experienced trauma. This tool covers secondary trauma.

Another assessment tool for professionals who help others is the *Secondary Traumatic Stress Scale* (STSS),³⁷⁵ which was developed to measure the secondary traumatic stress symptoms associated with indirect exposure to the traumatic experiences of others. The STSS is a

seventeen-item, self-administered scale covering symptoms of intrusion, avoidance, numbing, and arousal (similar to the symptom clusters found in PTSD).

In addition to tracking one's responses to the work over time, self-reflection will be helpful in linking factors in one's personal life to the symptoms.³⁷⁶ A self-care assessment worksheet developed by Saakvitne and colleagues can be used to track five realms of one's life: physical, psychological, emotional, spiritual, and workplace/professional.³⁷⁷ It can provide insight and stimulate thinking about a sustainable plan to promote one's well-being over time, including among those who choose to continue working in settings where they are regularly exposed to traumatic material.

If court personnel find that they are not monitoring themselves regularly, it may be a warning sign for secondary stress. The personal information gleaned from such self-assessment, reflection, and monitoring can be useful in making personal decisions, such as how long and to what extent they want to continue to be exposed to secondary trauma in their work. It may also provide a valuable foundation for promoting institutional recognition and care for the problem of secondary trauma among personnel who work at the ECCC or other tribunals.

CONCLUSIONS

Cambodian and other survivors of gross human rights violations are frequently re-traumatized by participating in international tribunals such as the ECCC. These courts must understand the impact of trauma on these survivors. ECCC proceedings should ensure that the questioning of survivor-witnesses is constrained to reduce retraumatization and that the discounting of survivors' testimony because of the effects of trauma. Psychological preparation and support during and after testimony is highly recommended for the Cambodian survivor-witnesses who participate in the ECCC proceedings. Additionally, the courts should provide institutional support for their staff, such as having a clinician on staff to attend to the impact of secondary trauma in court personnel and interpreters. Threats to victims and witnesses are not unknown before or after testimony, and this surely will affect their willingness to make court appearances. Strong psychological support and witness protection must be in place to safeguard witnesses and their families.

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6

TRAUMA IN THE COURTROOM

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Addressing widespread trauma is crucial for any society emerging from mass atrocities. Advocates of criminal accountability processes contend that trials can help victims heal from trauma by providing justice and enabling at least some survivors to tell their stories. Numerous studies, however, suggest that involving victims in judicial proceedings carries real risks of retraumatization if the proceedings are not appropriately designed and conducted. Moreover, trauma can impact survivor testimony and thus the efficiency and credibility of the judicial proceedings. This chapter discusses and critiques the efforts of the Extraordinary Chambers in the Courts of Cambodia (ECCC) to deal with the multiple challenges of involving traumatized survivors in courtroom criminal proceedings.

We focus in particular on the ECCC's first trial against Kaing Guek Eav *alias* Duch, the former chief of office "S-21" (the Khmer Rouge torture and interrogation facility at Tuol Sleng), "S-24" (the prison work camp at Prey Sar), and the Choeung Ek Killing Fields. That proceeding involved the active courtroom participation of numerous survivors, including a handful of witnesses and some of the ninety Civil Party applicants³⁷⁹—individuals who joined the criminal proceedings to allege injuries as a result of Duch's criminal conduct. Many described suffering from trauma during the Pol Pot years. We examine some of the apparent immediate effects of courtroom participation on those survivors and analyze the ECCC's institutional efforts to balance the needs of trauma survivors against other goals of the criminal process, including the interests of pursuing the truth, conducting efficient trials, and upholding rights of the accused.

We find that legal innovations developed by women's and children's rights advocates regarding retraumatization should be expanded to include other categories of people who

require protection, including anyone testifying about extreme abuse. Moreover, the *Duch* proceedings have underscored the fact that mass crimes courts must be equipped with the staff and resources to administer meaningful psychological support for victims. It is unfortunate that the ECCC has not taken advantage of offers to provide psychosocial training to judges and staff thus far, and we strongly encourage them to do so as soon as possible.

THE EFFECTS OF TESTIFYING ON TRAUMA SURVIVORS

There is significant scholarly debate regarding the effects of courtroom testimony—and participation in truth commissions—on trauma survivors. The available evidence is mixed, and the debate will be difficult to resolve without many more detailed empirical studies.³⁸⁰ Nevertheless, key victims' rights groups have argued that survivor participation has therapeutic potential.³⁸¹ That argument has gained considerable currency among proponents of transitional justice,³⁸² and it encouraged the drafters of the Rome Statute of the International Criminal Court (ICC) to provide the first opportunity for victims to participate and seek reparations in international proceedings in addition to serving as witnesses.³⁸³

The ECCC takes the ICC model one step further by enabling trauma survivors to participate in the pre-trial and trial process as Civil Parties.³⁸⁴ Unlike witnesses, Civil Parties have formal legal representatives who appear in the courtroom sessions beside the prosecutors. In the *Duch* case, the Court also reserved seats for selected Civil Parties at each hearing.³⁸⁵ Civil parties may also seek remedies; although the ECCC does not provide them with the prospect of financial reparations, the Statute does allow for "collective and moral reparations."³⁸⁶ The ECCC Civil Party mechanism in the *Duch* case thus offered certain victims a particularly deep and extended form of participation in the courtroom process.³⁸⁷

The Pain of Living with the Past

Mass atrocities leave deep physical and emotional scars on victims, and the Cambodian case is certainly no exception. Studies have shown that vast numbers of survivors of the Khmer Rouge regime suffer from post-traumatic stress disorder (PTSD) and related mental and physical ailments, such as depression, alcoholism, and domestic abuse.³⁸⁸ Many Civil Parties who appeared before the ECCC—both survivors of the prisons over which Duch presided and relatives who lost loved ones there—complained of suffering acute emotional distress from trauma that they experienced during the Democratic Kampuchea period. Civil party Ly Hor described being "scared of other people" and "mentally ill" as a result of his severe beatings during the Khmer Rouge regime and said that he lived with "anger and traumatization."³⁸⁹ Civil party Chhin Navy, who lost her husband at S-21, referred to herself as "mentally ill" and expressed little interest in living. Ouk Neary, who was four years old when her father was detained at Tuol Sleng and then murdered, reported

experiencing suicidal thoughts much later in life:

[W]hen my son was three years old, when he was close to me and when my companion was speaking to me, I was thinking only of one thing; was to break away, to extricate myself from reality and jump out of the window for reasons I could not fathom myself.³⁹⁰

Civil party Chum Sirath, who lost two brothers and a sister-in-law in S-2I, described survivors' emotional dichotomy of wanting both to remember and to forget:

I have struggled constantly every day and night not to forget the suffering, the misery of my siblings because this is my obligation for the dead ones. However, at the same time I have tried to forget, to forget that because I also have the obligation for the survivors who are living with me. The feelings that I have on both sides have been continuing for 34 years. I could not separate the two feelings, or which side should I choose and forget the other one?³⁹¹

He pointed out that while the stories shared by Civil Parties differed, they all “had the same point; that is the despair, the despair and the feeling of not understanding of what happened and the sorry and the pain which happened with us for more than 30 years.”³⁹² Indeed, almost all Civil Parties demanded to know the truth, sought explanations for abuses committed against them or their family members, and asked about the fate of lost loved ones.³⁹³

Cathartic Courtroom Experiences

Arguments that courtroom participation benefits trauma victims are based on the notion that both justice and truth-telling are conducive to coping with psychological injuries. Some analysts argue that seeing justice done can help victims heal after they have suffered serious rights violations.³⁹⁴ In addition, some contend that victim participation can be therapeutic by giving victims an opportunity to express their suffering, win acknowledgment (and perhaps modest reparations), and build a sense of solidarity and empowerment with other survivors.³⁹⁵ Dr. Yael Danieli has found that “the ability to participate actively in the proceedings . . . may assist victims to take back control of their lives and to ensure that their voices are heard, respected, and understood.”³⁹⁶

For example, asked why she felt able to speak of her experiences at Tuol Sleng and Prey Sar, a witness who had had difficulty testifying a few days previously stated, “I tried to make myself strong in order to find justice for my parents, my siblings[,] and my uncles today.”³⁹⁷ Witness Bou Thon, speaking of her abject grief at the loss of her family and her (thus far

failed) efforts to forgive and forget, likewise emphasized, “I tried to be here at the Court to find justice for my husband and my children.”³⁹⁸ In response to a question asking how he copes mentally with the torture he suffered at Tuol Sleng, Chum Mey said that he pays attention to the Court and “would really like the court to find justice.”³⁹⁹

One refrain in the proceedings was the momentousness of victims' opportunity to express themselves directly to Duch—often to reject his pleas for forgiveness. For example, Ou Kamela, the daughter of an S-2I victim, said in a letter read in Court, “On behalf of my father, I refuse to express the slightest amount of pity. On behalf of my father, I request that justice be handed down.”⁴⁰⁰

Some victim-participants expressed optimism that participation in ECCC proceedings could help them heal from trauma, both by delivering justice and enabling them to engage in truth-telling. Chum Mey was among the most explicit, saying:

My feeling, after I received the summons to appear before this Chamber, was so exciting, so happy. I was so clear in my mind that I would testify to shed light before this Chamber, to tell the truth. I felt so relieved. If I were not able to come before this Court to testify . . . my mind [would be] so disturbed, so bothering, and I wanted to get it out of my chest.⁴⁰¹

Ouk Neary also expressed the desire to achieve catharsis through truth-telling by quoting the documentary film-maker Rithy Panh, “The older you become, the more the history of the genocide comes back to you in an insidious way, a bit like a poison that has been distilled into your body bit by bit. The only way to relieve things is to testify.”⁴⁰²

S-2I survivor Bou Meng said that he had sought and received psychological counseling and medication, but found coming to the ECCC emotionally difficult, “I [could] not even eat my lunch today because I was overwhelmed.”⁴⁰³ Nevertheless, he said toward the end of his testimony, “[M]y chest seems to be lighter. [After a]ll my statements to the Judges and to the lawyers and the rest, I [feel] much better now.”⁴⁰⁴

Risks of Retraumatization

The evidence that courtroom participation helps traumatized survivors heal is subject to much dispute. A number of qualitative studies suggest that confronting tormentors in a formal judicial setting can re-traumatize victims and at least temporarily set back their recovery.⁴⁰⁵ Confronting abusers can be frightening, and challenges and clarifying questions from judges and defense counsel can make traumatized witnesses feel that *they* are on trial rather than their tormentors. For example, during the *Duch* trial, defense counsel twice reminded a Civil Party of her oath to speak the truth while demanding to know why the

number of siblings she mentioned in her complaint and her testimony were inconsistent.⁴⁰⁶ This appears to have unsettled the victim, who had already required courtroom support from the Transcultural Psychosocial Organization (TPO), a group working with the ECCC to provide mental health services. Moreover, victims' ability to participate is circumscribed by the judicial forum, where victims are constrained to providing information that is legally relevant instead of what they consider to be significant and the order and pacing of their accounts are controlled.⁴⁰⁷

Recalling past abuses, even ones from so many years ago, can itself cause anguish. Many survivors who spoke at the *Duch* trial emphasized the difficulty of revisiting the past, saying that speaking and hearing about the Khmer Rouge brought back traumatic memories. Civil party Chum Mey, a survivor of S-21, said, "I cry every night. Every time I hear people talk about Khmer Rouge, it reminds me of my [deceased] wife and kids. I am like a mentally ill person now."⁴⁰⁸ Chin Met, who survived beatings and other abuses at Prey Sar, said that in general, "I do not want to talk about my suffering to anybody or to my family members because every time I recall I suffer emotionally."⁴⁰⁹

A number of international authorities have emphasized the need for sensitivity to trauma victims in the courtroom. The UN Economic and Social Council has issued guidelines on protections for child victims and witnesses,⁴¹⁰ the UN Special Rapporteur on violence against women has encouraged courts to establish victim and witness units with expertise in trauma related to sexual violence,⁴¹¹ and the UN High Commissioner for Human Rights has endorsed both positions.⁴¹²

Other internationalized criminal tribunals have acknowledged the possibility of retraumatization and have sometimes taken this risk into account when issuing decisions. In the *Nsabimana* case, the International Criminal Tribunal for Rwanda (ICTR) denied the defendant's motion for a separate trial and affirmed the appropriateness of a joint trial both to increase efficiency and to "avoid the unnecessary pressure and trauma caused to victims and other witnesses who may be repeatedly called upon to testify in separate trials."⁴¹³ Prosecutors and defense attorneys have also invoked the risk of retraumatization to justify motions to make special arrangements for certain witnesses or keep them from being recalled.⁴¹⁴

The ICC has been more explicit and forward-leaning than the *ad hoc* ICTR and International Criminal Tribunal for the Former Yugoslavia (ICTY) tribunals. The ICC Trial Chamber has held that "there are particular special[] needs to be taken into account for child and elderly victims, victims with disabilities, and victims of sexual and gender violence when they are participating in the proceedings," and chambers may order "special measures to facilitate [their] testimony."⁴¹⁵ The Chamber also held that "protective measures are not favours but

instead are the rights of victims."⁴¹⁶ Notably, the ICC Statute includes a provision indicating that special protective measures *shall* be implemented for victims of sexual violence or child victims or witnesses.⁴¹⁷ Thus, at the ICC, the defense bears the burden of showing that such protective measures should not apply.⁴¹⁸ Importantly, however, the Trial Chamber did acknowledge the need to balance such measures against the rights of the accused, particularly when considering requests for witness anonymity.⁴¹⁹

Given the time elapsed since the demise of the Democratic Kampuchea regime, none of the witnesses or Civil Parties in the *Duch* trial was still a child at the time of the proceedings. Many Civil Parties were women, but allegations of sexual violence were not prominent in the case. Some Civil Parties were elderly and could merit special protective measures on that basis, but most did not fit neatly into the categories of vulnerable victims singled out by the ICC, other internationalized courts, and UN authorities. In that sense, the *Duch* trial exposed a blind spot in the existing normative regime for victim protection.

Facing the Accused

Confrontations between survivors and the defendant present special risks of retraumatization, especially in cases involving acts of violence committed by the accused against the victim in question. International courts have tried to address this issue. The ICC does not explicitly protect victims from confrontations with the accused, but its Rules of Procedure and Evidence do require judges to be "vigilant in controlling the manner of questioning a witness or victim so as to avoid any harassment or intimidation," particularly in cases of sexual violence.⁴²⁰ The ICTY and ICTR enable chambers to adopt protective measures, such as one-way closed circuit television screens or partitions in the courtroom, as the ICTY used in the *Delali* and *Tadi* cases.⁴²¹ The Special Court of Sierra Leone (SCSL) also enables witnesses to testify behind screens or from outside of the courtroom for similar reasons, and the court used that measure when involving child witnesses in the *Sesay* trial.⁴²² The SCSL Trial Chamber also acknowledged, however, that the use of screens and similar devices needs to be balanced against the accused's right to a fair and public hearing.⁴²³

The *Duch* trial provided further evidence of the difficulty that some survivors have facing the accused. In at least one instance at the ECCC, a potential Civil Party refrained from joining the proceedings out of fear of retraumatization. Hav Sophea, whose father was detained at S-21 and sent to the Killing Fields, explained that her mother was unwilling to be a Civil Party because "she does not want to face the accused."⁴²⁴

Duch's active engagement in the trial—as if he were his own expert witness—and freedom to comment in detail on the merits of each witness' account likely made testifying even more stressful.⁴²⁵ While witness Bou Thon was on the stand, Duch issued a compelling and detailed confession, apparently moved by what he saw as her straightforward testimony, her

bravery in speaking, and her obvious suffering and pain.⁴²⁶ Hearing the confession upset Bou Thon, who broke down, and a Civil Party lawyer requested that the Trial Chamber make Duch stop speaking. The Trial Chamber refused.⁴²⁷ This was a prime example of how the interests of the legal process—here, the interest of obtaining Duch’s full expression of remorse—sometimes cut against the interests of sparing an individual victim from emotional distress.

Hearing Graphic Details of Crimes

Graphic courtroom depiction of crimes can also heighten the risk of retraumatization. For some Civil Parties in the *Duch* case, observing the proceedings brought on considerable emotional distress. Seventy-year-old Civil Party Im Sunthy, whose husband was an S-21 victim, said, “[I]t has been more than 30 years, but time only intensifies my grief. I have never been happy[,] and I have been terrified and living with trauma.”⁴²⁸ Her testimony had to be rescheduled because she passed out during the testimony of another Civil Party. She explained:

When I come to these hearings to be part—to observe the hearings at this Tribunal, I have visualized the brutality of the regime, and when [Civil Party] Robert Hamill put the photo of the person who was seen struggling in a pool of blood, it really shocked me, because I could imagine how difficult life could have been for my husband at that time, and I could not really control my feeling at that time, and [so] I passed out.⁴²⁹

Such episodes again present dilemmas for judges and prosecutors because details that unsettle survivors may in some cases be important in articulating the case for conviction and the magnitude of the crimes alleged.⁴³⁰ The vulnerability of victims who are showed graphic evidence of past crimes underscores the need for psychological support inside and outside of the courtroom—a topic addressed later in this chapter. Judges and prosecutors should also be attuned to this possibility and take precautionary measures, such as providing for the ongoing presence of psychological support staff.⁴³¹

Having Veracity Questioned

Retraumatization may also occur when the truth of a victim’s account is questioned. As Jamie O’Connell has noted, “Judicial proceedings may challenge victims’ account of what happened, and thereby exacerbate their loneliness, alienation, confusion about what happened, and sense that they might be responsible for the horrors that befell them.”⁴³² During the Democratic Kampuchea period, as often happens in times of upheaval, many people’s family records and photos were lost or destroyed, making formal legal proof of events difficult. As a consequence, during the *Duch* trial there were numerous instances when the defense challenged victims’ stories due to a lack of documentation.

Civil party Lay Chan, an alleged survivor of S-21, said, “I never talk about my past experience. And it has been kept in my mind for so long, and every time it bursts out, I feel stuck.”⁴³³ Due to a lack of documentary support, Duch’s defense lawyers challenged the veracity of Lay’s claim that he had survived imprisonment at S-21.⁴³⁴ At least in this instance, however, the national defense lawyer notably exercised care in doing so, adding, “I don’t really contest your suffering during the Khmer Rouge regime.”⁴³⁵

During the S-21 trial, the primary source of documentation was the S-21 archive, originally compiled by Duch and with which he exhibited expert familiarity, putting witnesses in the disturbing position of having their veracity judged by the accused. For example, at trial, child survivor Norng Chanphal testified about his experiences at S-21. Duch responded by admitting that his mother and siblings had suffered, but expressed doubt that they had been detained at S-21 because there were no documents filed attesting to their detention there. Regarding Norng Chanphal’s father, Duch said, “[B]efore I saw this piece of document, I thought his father would have died somewhere else, at another security office, however, with this document I acknowledge that his father suffered and died in Tuol Sleng.”⁴³⁶ When the prosecution later submitted Chanphal’s mother’s S-21 biography into evidence, Duch said, “I accept this document that it belongs to the S-21 document and also the handwriting.”⁴³⁷

When the Duch verdict was announced, the Trial Chamber also ruled on whether the admitted Civil Parties had proved that they were victims of harm as a consequence of Duch’s actions. The claims of two Civil Parties who asserted that they have been detained and tortured at S-21 were rejected due in large part to a lack of corroborating documentary evidence.⁴³⁸ Several Civil Parties who claimed to have lost relatives at S-21 were likewise denied recognition on this basis.⁴³⁹

According to research conducted by the Transcultural Psychosocial Organization, the day after the verdict reading, those Civil Parties who were rejected “reacted with intense emotional distress” and viewed it as shameful and a personal failure “as they could not fulfill the felt obligation to seek justice for the spirits of their relatives.”⁴⁴⁰ One Case 001 Civil Party said, “I feel so exhausted. I feel pain in my head, in my chest. I feel so much ashamed. I am here to find justice for my mother, who was killed at S-21. In the past, no one could understand my suffering. Now I smile, but inside there is a lot of pain.”⁴⁴¹ Significantly, the trauma went beyond those rejected. A Civil Party applicant in Case 002 expressed apprehension about his future participatory role, “We lost all evidence, because the prisons were destroyed right after the regime...We were so painful, but now we are painful again. I am suffering; I feel so much pain.”⁴⁴²

EFFECTS OF TRAUMA ON TESTIMONY AND THE TRIAL PROCESS

As discussed above, judicial proceedings can affect victims’ emotional well-being in a variety

of ways. The converse is also true: survivors' emotional states can have important impacts on the proceedings by affecting their testimony and disrupting the trial. At times, revisiting traumatic memories may lead survivors to become confused or to suffer from memory loss. Emotional distress can give rise to anger or accusations that threaten the impartial tenor of the proceedings. Lastly, traumatized witnesses frequently (and understandably) break down or veer away from specific discussion of the defendant's alleged culpable conduct, challenging the efficiency of the trial and at least potentially prejudicing the proceedings against the accused. The ECCC has had to deal with all of these issues to some extent, seeking to balance the rights of trauma survivors against other important interests.

Inaccurate or Confused Testimony

Concerns about the reliability of testimony sometimes exist when trauma survivors take the stand. Ample scientific research has shown that victims of trauma often experience significant memory impairment after suffering severe emotional distress.⁴⁴³ This may include losses of general memory function or the “dissociation” of traumatic memories into incoherent parts. Victims sometimes experience vivid flashbacks but have difficulty articulating what they are thinking and feeling.⁴⁴⁴ This has obvious relevance in a criminal proceeding. Ironically, the very seriousness of the injury a victim suffers may impair his or her ability to recount the offense in an accurate and credible manner. The result can be a courtroom exchange that casts doubt on the victim's credibility and the defendant's culpability. Incongruent testimony raises the risk that guilty offenders will go free (or that defendants will be wrongly convicted) and complicates the effort to arrive at a definitive truth about episodes of mass atrocity.

The possibility that trauma impairs the accuracy of a witness's testimony has been raised at other tribunals. The very first witness in the *Lubanga* case at the ICC began to describe his experiences as a child soldier in Lubanga's Congolese militia but quickly recanted his testimony, later explaining, “A lot of things went through my mind. I got angry and wasn't able [to testify.]”⁴⁴⁵ The episode precipitated a debate on the extent to which vulnerable victims should be prepared for the courtroom environment—a proposition that risks jeopardizing the rights of the accused if preparation veers into coaching witnesses.⁴⁴⁶

At the ICTY, the defense in the *Furundžija* case challenged a witness on the basis that PTSD impaired her ability to recall events correctly and that her testimony should therefore be expunged.⁴⁴⁷ In the *Aloys Simba* case at the ICTR, defense lawyers sought to exclude the testimony of Witness KS, arguing that “the witness appeared visibly upset and traumatized, which calls into question her capacity to testify, including the validity of her oath and the reliability of her recollections.”⁴⁴⁸ In both cases, the defense challenges were unsuccessful, as the courts found insufficient evidence that trauma had in fact impaired the reliability of the witnesses on the most crucial facts.⁴⁴⁹

The ICTY went even further in the *Kunarac* case, overlooking “minor discrepancies” among young witnesses alleging unlawful detention and sexual abuse due to the passage of time:

[T]he experiences which the witnesses underwent were traumatic for them at the time, and they cannot reasonably be expected to recall the minutiae of the particular incidents charged, such as the precise sequence, or the exact dates and times, of the events they have described.⁴⁵⁰

Thus, in certain cases, the appearance of trauma can lead courts to give witnesses (or Civil Parties) the benefit of the doubt rather than concluding that their testimony is unreliable.

In a few instances, Civil Party accounts at the ECCC have been inconsistent. The testimony of Civil Party Ly Hor was particularly confused. A confession transcript from S-2I provides strong evidence that Ly Hor was in fact a survivor of the prison at Tuol Sleng, as he alleged. He had difficulty, however, understanding questions from lawyers and judges in the courtroom, and his disjointed oral testimony contradicted his written statement. Judge Silvia Cartwright lamented, “This Civil Party has been very poorly prepared for this morning's experience.”⁴⁵¹ Afterward, Ly Hor said he did not know what happened during trial; he had become confused and could not think clearly.⁴⁵² Even though there were documents submitted attesting that someone named “Ear Hor”—the name Ly Hor allegedly went by at the time—was detained at S-2I, in its judgment the Trial Chamber expressed doubt whether they were one and the same person, and thus found Ly Hor's Civil Party application inadmissible.⁴⁵³

Civil party Chin Met suggested that her trauma was impairing her memory. She said, “Emotionally I am more forgetful now. I remember less at present . . . sometimes I [have been] blamed that because I think of the Khmer Rouge past a lot that's why I am now more forgetful.”⁴⁵⁴ She did not specify whether her impairment related to short-term memory loss or memories from the DK era. Although defense lawyers did point out discrepancies between her testimony and written statement,⁴⁵⁵ her Civil Party status was nevertheless recognized in the judgment.⁴⁵⁶

Emotional Testimony: Concerns about Fairness and Efficiency

In addition to concerns about reliability, emotional testimony also raises issues related to the overall tenor and length of the courtroom proceedings. The interest in victim participation does not exist in isolation; it must be balanced against the defendant's right to a fair and speedy trial.⁴⁵⁷ In some instances, trauma survivors experience powerful emotions that lead them to express rage or distress in the courtroom or to give lengthy accounts of their personal experiences and pain. While their outbursts or digressions may be understandable and morally justified, they can consume a considerable amount of time, lead

away from relevant facts, and jeopardize the impartiality of the courtroom atmosphere. Trials are not truth commissions, and fairness requires focusing on the guilt or innocence of the accused.⁴⁵⁸

One risk of emotional testimony is that it may bias the proceedings against the accused by appealing to impulses for revenge. In a number of instances, Civil Parties addressed Duch angrily during the trial. Chum Mey said, “So I would like to tell this to Duch; that Duch did not beat me personally, directly, otherwise he would not have the day to see the sunlight. I would just like to be frank.”⁴⁵⁹ Robert Hamill, whose brother Kerry was killed at S-21, expressed his desire to see Duch suffer the type of anguish he inflicted on others:

Duch, at times I’ve wanted to smash you—to use your words—in the same way that you smashed so many others. At times, I’ve imagined you shackled, starved, whipped[,] and clubbed viciously—viciously. I have imagined your scrotum electrified, being forced to eat your own faeces, being nearly drowned, and having your throat cut. I have wanted that to be your experience, your reality. I have wanted you to suffer the way you made Kerry and so many others.⁴⁶⁰

Trial Chamber President Nil Nonn politely, but consistently reprimanded Civil Parties for issuing verbal attacks on Duch. For example, he asked Hamill to refrain from using harsh words toward the defendant, explaining that the courtroom was not the appropriate venue “for any revenge or abusive words.”⁴⁶¹ He asked Neth Phally to “avoid using this venue as the place where you seek vengeance.”⁴⁶² He reminded Civil Party Chum Sirath to “control your emotion” and “focus on the facts,” rejecting the argument by Sirath’s Civil Party lawyer that Sirath’s outburst was “part of the process of coping with the suffering...[and] is part of the story that he wants to tell ...”⁴⁶³ President Nil explained his reasoning:

The Chamber of course acknowledges your emotion, your feeling and the suffering which you have been bearing for so many years, and the Chamber tries not to interrupt your statement...[but] the main focus of our proceedings is to find justice. It is not the opportunity to make revenge or to affront anybody, including the accused.⁴⁶⁴

In addition to changing the dynamics of courtroom discourse, emotional testimony can present efficiency concerns. In the *Duch* trial, some trauma victims found it difficult to testify in a concise and coherent fashion. President Nil acknowledged that difficulty when addressing Civil Party Bou Meng, who broke down when speaking of his torture at Tuol Sleng. Nil said:

Uncle Meng, please try to recompose yourself so that you would have the opportunity to tell your story. As you have stated, you have been waiting for this opportunity to tell your accounts, your experience[,] and the sufferings that you received from those unjust acts; from the torture committed by the Khmer Rouge, as well as the ill treatment on your wife. So please try to be strong, recompose yourself so that you are in a better position to recount what they did on you so that the public and the Chamber who are participating in this proceeding or the Cambodian people as a whole as well as the international community to hear, to understand the acts committed by the Khmer Rouge clique on you and that they would express the pityness on you as you received those ill treatment from them. So do not let your emotion overwhelm you. So try to grab the opportunity to tell your accounts to the Chamber as well as to the public. Uncle Meng, do you understand what I said?⁴⁶⁵

When Civil Party Lay Chan was asked what he did when he was thirsty, but dared not ask for water, Lay responded, “I cannot respond to the question” and broke down before completing another sentence. The Trial Chamber president asked Lay to “try to collect [him]self” and asked if he needed time to re-compose. Lay paused before recounting that he had to drink his own urine.⁴⁶⁶ Civil party lawyers argued on a number of occasions for the Court to provide more time for their clients to cope with the emotional difficulty of the experience and to compose themselves. The judges explained that they would endeavor to do so within the time limitations.⁴⁶⁷

The judges in the *Duch* trial also had to manage the desire of some witnesses and Civil Parties to speak broadly about their families’ suffering during the Pol Pot era. In a few cases, Civil Parties provided eulogies for their lost loved ones,⁴⁶⁸ departing from facts specifically related to S-21.⁴⁶⁹ For example, Civil Party Touch Monin was cutoff by the defense because he recounted a long story of his family’s evacuation from Phnom Penh instead of events related to the accused and the harm he suffered as a result.⁴⁷⁰ These digressions were not necessarily caused by trauma, but awareness that most testifying survivors had experienced trauma likely made it more difficult for judges and attorneys to impose limits without appearing callous. Indeed, efforts by the judges to explain the parameters of the proceedings, perhaps inevitably, sounded cold and mechanistic.⁴⁷¹

Striking the right balance can be difficult. If judges interview witnesses in draconian fashion or allow lawyers to do so, they risk re-traumatizing survivors and compromising the public legitimacy needed to make any transitional justice mechanism successful. If judges are too *laissez faire*, they run the danger of presiding over a process that loses credibility for another reason—it appears to privilege the emotional accounts of survivors over the hard facts needed to establish the defendants’ culpability.

The challenge of managing emotional testimony or digressions will likely be even greater in Case 002. The *Duch* trial involved a defendant who essentially entered a guilty plea, but still took nine months, including six months of in-court proceedings. Much of that time was spent on the twenty-four witnesses and twenty-two Civil Parties interviewed—before they testified, during their courtroom appearances, and in subsequent review of their testimony. In Case 002, the joint trial of four senior Khmer Rouge leaders who deny guilt, many more witnesses and Civil Parties will take part. All of the defendants are elderly and in ill health, and the trial will have to be managed efficiently if a judgment is to be rendered while they are still able to stand trial. Justice will likely be in tension with the desire to enable each witness to tell his or her story in detail.

CONCLUSIONS & RECOMMENDATIONS

The experience of the ECCC to date suggests a number of important lessons related to trauma in the courtroom. It has reinforced what many other trials have demonstrated: in the aftermath of mass atrocities, victim participation in legal proceedings is an emotionally difficult process. Some degree of retraumatization is inevitable, and courts need to put measures in place to deal with its effects on both victims and the course of the proceedings. The *Duch* trial also showed that retraumatization is by no means limited to children or women who suffered sexual violence. Advocates for women's and children's rights have been pioneers in demanding that internationalized courts take due account of trauma. The resulting legal innovations, however, have tended to draw too sharp a distinction between the types of people who merit protection and those who do not. Courts should be cognizant of the special vulnerability of some groups of victims, but should also have the authority (and indeed the obligation) to put in place protections for other victims when special circumstances dictate.

At the same time, the *Duch* trial provided regular reminders that the needs of victims do not exist in isolation. They sometimes clash with other compelling interests, such as the prosecution's quest to build a focused and consistent narrative and the defendant's right to a fair and speedy trial. As this chapter has shown, international criminal courts have generally considered victims' rights when ruling on the credibility of witnesses and their requests for special courtroom protections. This likely reflects both the normative dispositions of the judges and the pressure applied by victims' advocacy groups. Courts have been explicit, however, about the balancing act they must undertake and have often denied requests for anonymous testimony and other measures that could unduly bias proceedings against the defense.

In the *Duch* trial, the ECCC did not confront the need to offer in-court protective measures—partly due to the lapse of time and diminution of the Khmer Rouge threat—or the need to substantially restrict the time allowed for victim testimony. It, however, will face greater

challenges in balancing victim protection against the rights of the accused in Case 002. In particular, the sheer number of Civil Parties and victim witnesses in that case and the advanced age of the defendants will add to the urgency of the proceedings, making time of the essence.⁴⁷² Judges will need to strike a difficult balance between the desire of victims to tell their stories and the need to focus on the criminal charges at hand. The prosecution's successful effort to charge the four defendants as part of a “joint criminal enterprise” may alleviate that tension to some degree, because it permits the prosecutors to paint a picture of broad and systemic abuse. The ECCC Trial Chamber will still need to be more demanding of witnesses and Civil Parties than it was in the *Duch* trial. As a consequence, training for judges and lawyers on trauma-related issues and psycho-social support for witnesses and Civil Parties will be that much more essential.

The Importance of Training Judges and Lawyers

The difficulty of managing trauma effectively in the courtroom underscores the need for judicial sensitivity to the issue. Training of judges and lawyers working on mass crimes cases is a key part of the answer. Numerous national and international development agencies are now engaged in judicial training, sometimes assisting special criminal courts like the Special Iraqi Tribunal.⁴⁷³ ECCC judges attended a number of legal training sessions organized by the UN Development Program before they took up their roles on the bench.⁴⁷⁴ They, however, have rejected offers for psycho-social training.⁴⁷⁵ Judicial training is not easy in courts like the ECCC, because the background of judges varies widely. Some require relatively basic instruction. Others require more, and trainers usually have limited time to devote to complex and nuanced issues such as how to optimize the goals of victims' rights and the conduct of a fair trial.

Nevertheless, the experience of the *Duch* trial shows that even a modest amount of exposure and learning can make a significant difference. Initially, President Nil Nonn of the ECCC Trial Chamber was criticized for appearing insensitive to the suffering of testifying Civil Parties. He and the other trial judges, however, quickly, if a bit gruffly, made an effort to handle such episodes more adroitly. For example, the President was criticized for repeatedly admonishing Chum Mey to compose himself (e.g., “Uncle Mey, please recompose yourself. This is the time we are conducting our trial.”)⁴⁷⁶ Afterward, he apparently sought advice about how to handle such situations more appropriately in the future.⁴⁷⁷ The next day when Bou Meng became overwhelmed, instead of merely hurrying him along, Nil Nonn made a lengthy speech in which he acknowledged Bou Meng's suffering and told him to be strong and “grab the opportunity” to share his story.⁴⁷⁸ Nil Nonn's adaptation is to be commended, but going forward the judges should accept training before encountering traumatized witnesses in the courtroom. Indeed, due to its potential for reducing retraumatization of victims and for ensuring a fair trial for the accused, such training should be automatically provided to the judges and staff at mass-crimes tribunals.

Support for Traumatized Courtroom Participants

Finally, the ECCC proceedings have underscored the fact that courts need to be equipped with the staff and resources to administer meaningful psychological support for victims. This is relevant to the protection of victims and has the potential to help manage the courtroom proceedings, because victims who are well supported are more likely to be able to offer composed and consistent testimony.

Advocates for women's rights have been influential in advancing measures to provide such services, especially in the context of violent sex offenses.⁴⁷⁹ The ICTR Witness Support and Protection Programme and ICTY Victims and Witnesses Section provide psychological counseling to witnesses, focusing on trauma survivors.⁴⁸⁰ The SCSL Rules of Procedure and Evidence provide that its Witnesses and Victims Section be staffed by experts in trauma related to sexual violence.⁴⁸¹

The architects of the ICC likewise provided for a Victims and Witnesses Unit (VWU), which has staff members who specialize in trauma, psychological counseling, and crisis intervention.⁴⁸² In addition to out-of-court counseling, the VWU has the authority to assign staffers to support children through all stages of the proceedings, “in particular traumatized children.”⁴⁸³ It is tasked with familiarizing witnesses with the courtroom environment to dampen anxiety and with accompanying them during testimony if required.⁴⁸⁴

The ECCC also set up a Witness and Experts Support Unit (WESU) and a Victims' Support Section (VSS). WESU assists all persons who testify in court proceedings and, like the VSS, consults with the Co-Investigating Judges and Chambers about the appropriateness of protective measures.⁴⁸⁵ The VSS, however, is the primary intermediary between Civil Parties or their representatives and the Court. Among its other responsibilities, the VSS is tasked with supporting the attendance of Civil Parties in court proceedings.⁴⁸⁶ Although no ECCC provisions mention psychosocial support,⁴⁸⁷ the ECCC website states that the VSS is responsible for its provision.⁴⁸⁸ In practice, this work is undertaken entirely by the Transcultural Psychosocial Organization, which signed a memorandum of understanding with the Court in 2007.⁴⁸⁹ TPO services for the Court include training ECCC staff and provision of “psychological briefing prior to the proceedings, monitoring participants' mental health condition, offering emotional support during the trial[,] and debriefing after the proceedings.”⁴⁹⁰

For example, a representative from TPO was asked to sit beside Chum Neou, a Civil Party who survived S-24, while she testified at the Trial Chamber. She said:

It is extremely difficult. It's indescribable. I can recall one event after another[,] and

this is the first time after 32 years that I start talking. And every time now when I think of that event, my tears keep flowing.⁴⁹¹

A TPO representative also sat beside Civil Party Nam Mon when she testified. Her lawyers cautioned that Nam Mon had never told her story before relating it to her lawyers shortly before the trial and that she was therefore “very excited, discomposed and nervous.”⁴⁹²

The task of ensuring that Civil Parties are not traumatized by their experiences at the Court also inevitably falls heavily on the Civil Party legal teams, again highlighting the importance of providing lawyers with adequate training and information on how to refer troubled clients to trained medical professionals.⁴⁹³ It is their responsibility to explain the proceedings and prepare their clients for the often mystifying and at times disappointing moments of a legal process. For example, before the *Duch* verdict was read, Civil Party Team I met with their clients to make clear that the Trial Chamber would likely reject some of their applications in the final judgment. They also met with their clients afterward to explain why some of them had in fact been rejected. This basic, but fundamental, task apparently helped soothe at least a few of those rejected, who told the team that they understood and accepted that the decision was based on a lack of documentation and not a belief that they had not suffered harm.⁴⁹⁴

Courts are not naturally equipped to deal with victims' psychological challenges, and in many post-conflict environments (including Cambodia), there are relatively few professionals who specialize in trauma and can communicate with victims in their native tongues. Developing that capacity needs to be a major priority for the Cambodian ministries of health and education and for donors interested in helping survivors cope with the legacy of conflict and abuse. Moreover, in the budgetary tug-of-war that determines resource allocation for internationalized courts, psychological support units have tended to get short shrift. Measures for victims are generally popular among donor countries, but concerns about the overall cost and length of proceedings abound, imposing broad constraints on courts' capacities to provide the support that traumatized victims require.

Ultimately, the jury is still out on whether victims inevitably benefit from participation in mass crimes trials, or if the gap between their desire to speak and find the truth and the strictures of the legal process is too wide to overcome the potential for retraumatization. Regardless of the answer, it seems clear that victims will continue to seek opportunities to participate in trial proceedings. For many survivors, the impulse to seek justice and tell one's story is powerful. One victim of crimes in the former Yugoslavia found that although testifying at the ICTY “did nothing to calm his nightmares” he would absolutely do it again: “It is in the interest of us all who survived the tortures to tell the truth, to tell the world what it was like.”⁴⁹⁵ To a considerable extent, this is why internationalized courts like

the ECCC were created. Further innovations and adaptations will be required to ensure that witnesses and Civil Parties in the ECCC's second case and other internationalized proceedings are able to share their stories with minimum harm to themselves and minimum disruption to a fair and speedy trial.

END NOTES

378 The authors would like to recognize the indispensable assistance of Della Sentilles in conducting research for this chapter, as well as the valued contributions of David Sukenik and George Tam.

379 As discussed below, twenty-four of these applicants were found not to meet the criteria for Civil Parties at judgment. See *Prosecutor v. Kaing Guek Eav alias Duch*, Case File No. 001/18-07-2007/ECCC/TC, Judgment, ¶¶ 647-49 (Trial Chamber 26 July 2010).

380 See, e.g., David Mendeloff, *Trauma and Vengeance: Assessing the Psychological and Emotional Effects of Post-Conflict Justice*, 31 HUM. RTS. Q. 592, 601-15 (2009); Marie-Bénédicte Dembour & Emily Haslam, *Silencing Hearings? Victim-Witnesses at War Crimes Trials*, 15 EUR. J. INT'L L. 151 (2004); Jamie O'Connell, *Gambling with the Psyche: Does Prosecuting Human Rights Violators Console Their Victims?* 46 HARV. INT'L L.J. 295, 319 (2005) (finding that "therapists writing about the effects of impunity do not describe actual instances of prosecutions helping victims psychologically. The large number of ways trials may positively or negatively affect victims...suggests that predictions of trials' effects based on victims' condition in their absence may be highly uncertain.").

381 See, e.g., VICTIMS' RIGHTS WORKING GROUP, VICTIM'S RIGHTS IN THE INTERNATIONAL CRIMINAL COURT 4 (2000); Yael Danieli, *Victims: Essential Voices at the Court*, VRWG BULL., at 1 (SEPT. 2004), available at <http://www.vrwg.org/smartweb/bulletins/past-issues>; WOMEN'S CAUCUS FOR GENDER JUSTICE, RECOMMENDATIONS AND COMMENTARY FOR AUGUST 1997 PREP COM ON THE ESTABLISHMENT OF AN INTERNATIONAL CRIMINAL COURT 33 (1997) (arguing that participation is important for "advancing the process of healing from trauma and degradation").

382 See Emily Haslam, *Victim Participation at the International Criminal Court: A Triumph of Hope Over Experience*, in THE PERMANENT INTERNATIONAL CRIMINAL COURT: LEGAL AND POLICY ISSUES 315 (Dominic McGoldrick et al. eds., 2004); Susana SáCouto & Katherine Cleary, *Victims' Participation in the Investigations of the International Criminal Court*, 17 TRANSNAT'L L. & CONTEMP. PROBS. 73, 76-78 (2008). But see Charles P. Trumbull IV, *The Victims of Victim Participation in International Proceedings*, 29 MICH. J. INT'L L. 777, 804-19 (2008) (arguing that the benefits of victim participation in domestic proceedings do not apply to mass crimes cases at international criminal tribunals because the large number of participants reduces their agency in and value to the proceedings, as well as the likelihood that they will receive meaningful reparations).

383 Criminal tribunals built on the Nuremberg model, including the tribunals for the former Yugoslavia and Rwanda, gave modest roles to survivors as witnesses. Victims' advocates, however, argued that they missed an opportunity to help victims heal by denying them a more central role in the proceedings. See, e.g., Yael Danieli, *Reappraising the Nuremberg Trials and their Legacy: The Role of Victims in International Law*, 27 CARDOZO L. REV. 1633, 1641-43 (2005-06); Int'l Fed'n for Hum. Rts. (FIDH), *Victims in the Balance: Challenges Ahead for the ICTR*, at 6 (2002), available at <http://www.iccnw.org/documents/FIDHrwVictimsBalanceNov2003.pdf>. In response to those critiques, the Rome Statute included provisions enabling victims to participate more directly at the ICC. David Donat-Cattin, *Article 68 Protection of the Victims and Witnesses and Their Participation in the Proceedings*, in COMMENTARY ON THE ROME STATUTE OF THE INTERNATIONAL COURT 869, 871 (Otto Triffterer ed., 1999). If a victim's application to the ICC Registrar is approved, he or she may select or be assigned a representative, and that representative may participate by filing written submissions, joining courtroom proceedings (if the judges approve), and requesting reparations. Int'l Crim. Ct. (ICC), Rules of Procedure and Evidence, r. 89-93, ICC-ASP/1/3 (Sept. 3-10, 2002) [hereinafter ICC Rules of Procedure and Evidence]; ICC, Rome Statute of the International Criminal Court, arts. 68(3) & 75, U.N. Doc. A/CONF.183/9 (1998) [hereinafter Rome Statute].

384 Survivors may be selected to become witnesses based on complaints that they register with the ECCC pursuant to Internal Rule 50, or other information indicating that they have relevant information. Survivors may become Civil Parties pursuant to Internal Rule 23bis(1) if they can demonstrate injury suffered as the direct

result of one of the crimes alleged against a charged person. See Extraordinary Chambers in the Courts of Cambodia (ECCC), Internal Rules of the Extraordinary Chambers in the Courts of Cambodia (revised Feb. 23, 2011) [hereinafter ECCC Internal Rules]; *Kaing Guek Eav*, *supra* note 2, ¶¶ 639-43 (explaining the criteria for Civil Party status pursuant to an earlier version of the rules).

385 Nevertheless, most Civil Parties were unable to attend early trial proceedings due to a lack of financial support. See Michelle Staggs Kelsall et al., *Lessons Learned from the Duch Trial*, at 31 (Dec. 2009), available at http://socrates.berkeley.edu/~warcrim/documents/Lessons%20Learned%20from%20the%20Duch%20Trial_MRSK_FINAL.pdf. This problem will be compounded in Case 002, which will include over 2000 Civil Parties, as the Court lacks the resources to fund their regular attendance.

386 ECCC Internal Rules, *supra* note 7, r. 23^{quinqüies}(1). In the Case 001 judgment, however, the ECCC Trial Chamber found that Duch was indigent and that most Civil Party requests either fell outside the Court's jurisdiction or lacked sufficient specificity. They therefore awarded only token reparations. *Kaing Guek Eav*, *supra* note 2, ¶¶ 664-75. In September 2010, the judges amended the rule, giving the chamber power to recognize specific projects designed in cooperation with the Victim Support Section that have secured sufficient external funding. ECCC Internal Rules, *supra* note 7, r. 23^{quinqüies}(3)(b). It is unclear if this change will enable the Court to award meaningful reparations in Case 002.

For information about the Cambodian public's reaction to the Case 001 reparation decision, see DOCUMENTATION CTR. OF CAMBODIA, DUCH VERDICT: A DC-CAM REPORT FROM THE VILLAGES (Sirik Savina & Richard Kilpatrick eds., 2010), available at http://www.dccam.org/Projects/Living_Doc/pdf/The_Duch_Verdict-A_DC-Cam_Report_from_the_Villages.pdf, and in particular, Dacil Keo, *Disarray and Disappointment after Duch Verdict*, in DUCH VERDICT: A DC-CAM REPORT FROM THE VILLAGES 95-96, available at http://www.dccam.org/Projects/Living_Doc/pdf/The_Duch_Verdict-A_DC-Cam_Report_from_the_Villages.pdf. See also BERLIN CTR. FOR THE TREATMENT OF TORTURE VICTIMS, THE SURVIVORS' VOICES: ATTITUDES ON THE ECCC, THE FORMER KHMER ROUGE AND EXPERIENCES WITH CIVIL PARTY PARTICIPATION 66 (Dec. 2010), available at http://www.bzfo.de/images/stories/pdf/bzfo_cambodia_report_2010.pdf (finding evidence that the *Duch* trial "was observed on a broad basis, but only a small group of respondents showed a deeper understanding of the proceedings").

387 In February 2010, the Internal Rules were amended to make the trial process more efficient for Case 002. Among the changes, a new rule gives two new Court-funded Civil Party Lead Co-Lawyers "[u]ltimate responsibility to the court for the overall advocacy, strategy[,] and in-court presentation of the interests of the consolidated group of Civil Parties during the trial stage and beyond." ECCC Internal Rules, *supra* note 7, r. 12^{ter}(5)(b). This rule change appears to sever the Civil Party attorney-client relationship, as Civil Party lawyers are now unable to represent their clients interests in court, such as by making oral or written submissions, without agreement from the Civil Party Lead Co-Lawyers, whose obligation is only to "seek the views of Civil Party lawyers and endeavour to reach consensus in order to coordinate representation of Civil Parties at trial." *Id.* r. 12^{ter}(3). Concomitantly, Civil Parties are unable to hire or fire the Lead Co-Lawyers, to determine the objectives of their legal representation, or to participate in deciding the means of carrying out those objectives, and the Lead Co-Lawyers have no clear responsibility to represent the interests of individual Civil Parties, in contrast to their obligations to the group as a whole. These changes are likely necessary and appropriate, as over 2,000 Civil Parties have been accepted in Case 002. The changes, however, reduce the robustness of the mechanism and thus the ability of victims to actively participate in the process, making the victims role look less like one of a "party," and more like one of a "participant," as at the ICC.

388 A 2001 study by international experts found a 28% prevalence of PTSD among over 600 Cambodians randomly surveyed in different parts of the country. Joop T.V.M. de Jong et al., *Lifetime Events and Posttraumatic Stress Disorder in 4 Postconflict Settings*, 286 JAMA 555 (2001). A more recent study found an incidence of roughly 11% overall. Within this group around 40% suffered from associated mental or physical disabilities. Jeffrey Sonis et al., *Probable Posttraumatic Stress Disorder and Disability in Cambodia: Associations With Perceived Justice, Desire for Revenge, and*

Attitudes Toward the Khmer Rouge Trials, 302 JAMA 527 (2009). See also Press Release, Nat'l Inst. of Mental Health, PTSD, Depression Epidemic among Cambodian Immigrants (Aug. 2, 2005), <http://www.nimh.nih.gov/science-news/2005/ptsd-depression-epidemic-among-cambodian-immigrants.shtml> (finding that among Cambodian refugees in the United States, "[s]ixty-two percent suffered from [PTSD] and 51 percent from depression in the past year—six-to-seventeen times the national average for adults"); Lauren Wagner, *Cambodian Women Confront Epidemic of Domestic Violence*, 43(15) PSYCHIATRIC NEWS 19 (Aug. 1, 2008), available at www.cwcc.org.kh/wp-content/uploads/2010/11/psych.pdf (noting the legacy of mental illness, depression and sexual abuse in Cambodia). Relatively few survivors have been able to benefit from professional counseling due to the dearth of mental health care providers in the country—a topic addressed elsewhere in this volume.

389 ECCC, Transcript of Trial Proceedings—Kaing Guek Eav "Duch," Case File No. 001/18-07-2007-ECCC/TC, at 70-71 (July 6, 2009) [hereinafter Ly Hor transcript].

390 ECCC, Transcript of Trial Proceedings—Kaing Guek Eav "Duch," Case File No. 001/18-07-2007-ECCC/TC, at 64 (Aug. 17, 2009) [hereinafter Ouk Neary transcript].

391 ECCC, Transcript of Trial Proceedings—Kaing Guek Eav "Duch," Case File No. 001/18-07-2007-ECCC/TC, at 20-21 (Aug. 20, 2009) [hereinafter 20 Aug. 2009 transcript].

392 *Id.* at 20.

393 See, e.g., *id.* at 59 & 64 (Civil Party Ou Savrith); Ouk Neary transcript, *supra* note 13, at 66.

394 See, e.g., Jamie O'Connell, *supra* note 3, at 317-29; Richard J. Goldstone, *Justice as a Tool for Peace-Making: Truth Commissions and International Criminal Tribunals*, 28 N.Y.U. J. INT'L L. & POL'Y 485, 489 (1995-96) (arguing that justice and official acknowledgment are "usually the first step in [victims'] healing process").

395 See, e.g., Jamie O'Connell, *supra* note 3, at 328-31 & 337-38; Yael Danieli, *Victims: Essential Voices at the Court*, *supra* note 4, at 6 (arguing that "[o]n an individual level, acknowledgement at least begins to heal psychic wounds . . . in that it vindicates the victim by, *inter alia*, signifying the transfer of the responsibility to the wrongdoers."). See also Ervin Staub, *Genocide and Mass Killing: Origins, Prevention, Healing, and Reconciliation*, 21 POL. PSYCHOLOGY 367, 376 (2002) (summarizing research that suggests revisiting past experience in a safe environment, sharing empathy, and receiving acknowledgment all contribute to victims' healing).

396 Yael Danieli, *Victims: Essential Voices at the Court*, *supra* note 4.

397 ECCC, Transcript of Trial Proceedings—Kaing Guek Eav "Duch," Case File No. 001/18-07-2007-ECCC/TC, at 48-49 (July 13, 2009) [hereinafter 13 July 2009 transcript].

398 ECCC, Transcript of Trial Proceedings—Kaing Guek Eav "Duch," Case File No. 001/18-07-2007-ECCC/TC, at 26 (Aug. 12, 2009) [hereinafter 12 Aug. 2009 transcript].

399 ECCC, Transcript of Trial Proceedings—Kaing Guek Eav "Duch," Case File No. 001/18-07-2007-ECCC/TC, at 35 (June 30, 2009) [hereinafter Chum Mey transcript].

400 20 Aug. 2009 transcript, *supra* note 14, at 64.

401 Chum Mey transcript, *supra* note 22, at 67.

402 Ouk Neary transcript, *supra* note 13, at 69-70.

403 ECCC, Transcript of Trial Proceedings—Kaing Guek Eav "Duch," Case File No. 001/18-07-2007-ECCC/TC, at 74 (July 1, 2009) [hereinafter Bou Meng transcript].

404 *Id.* at 85.

405 Arthur J. Lurigio & Patricia A. Resick, *Healing the Psychological Wounds of Criminal Victimization: Predicting Postcrime Distress and Recovery*, in VICTIMS OF CRIME: PROBLEMS, POLICIES AND PROGRAMS 60 (Arthur J. Lurigio et al. eds., 1990); Karen Bronéus, *Truth-Telling as Talking Cure? Insecurity and Retraumatization in the Rwandan Gacaca Courts*, 39 SECURITY DIALOGUE 55 (2008); Jamie O'Connell, *supra* note 3, at 331-36.

406 13 July 2009 transcript, *supra* note 20, at 61-62. The Civil Party explained one younger brother was in fact

a god-brother. *Id.* at 62. Victim witnesses also may feel attacked when they are asked multiple repetitive questions, particularly about sexual violence. *See, e.g.,* Binaifer Nowrojee, *Your Justice Is Too Slow*, U.N. Research Institute for Social Development, at 23 (Nov. 2005); FIDH, *Victims in the Balance: Challenges Ahead for the International Criminal Tribunal for Rwanda*, at 8-9 (Nov. 2002) (describing distress caused by repetitive questioning). This is a major concern in joint trials with multiple defense teams, as will be the situation in ECCC Case 002.

407 Marie-Bénédicte Dembour & Emily Haslam, *supra* note 3, at 159 (pointing out that “judicial ‘effectiveness’ may mean for [witnesses] that significant events and emotions are glossed over”).

408 Chum Mey transcript, *supra* note 22, at 35-36. Chum called himself *chbkout*, a Khmer term that best translates as “crazy” but that is used in lieu of more technical terms to describe a wide range of mental infirmities. *Chbkout* is not necessarily considered derogatory.

409 ECCC, Transcript of Trial Proceedings—Kaing Guek Eav “Duch,” Case File No. 001/18-07-2007-ECCC/TC, at 93-94 (July 9, 2009) [hereinafter 9 July 2009 transcript].

410 ESCOR, Guidelines for Justice in Matters Involving Child Victims and Witnesses of Crime, ¶¶ 10-19, 29-34, & 38-46, Res. No. 2005/20 (July 22, 2005) (promoting the rights of children victims and witnesses to be treated with dignity and compassion, to be protected from discrimination, to be informed, to be heard and to express views and concerns, to affective assistance, to privacy, to protection from hardship during the justice process, to safety, to reparation, and to special preventative measures; as well as the corresponding need to make training, education, and information available to professionals who work with such children).

411 Report of the Special Rapporteur on Violence Against Women, Mission to Sierra Leone, ¶¶ 76 & 127, UN Doc. E/CN.4/2002/83/Add.2 (2002).

412 Report of the High Commissioner for Human Rights, pursuant to Human Rights Council Resolution 9/11, ¶¶ 60-61, UN Doc. A/HRC/12/19 (Aug. 21, 2009).

413 Prosecutor v. Nsabimana, ICTR-97-29A-T, Decision of the Defense Motion Seeking a Separate Trial for the Accused Sylvain Nsabimana, ¶42 (Sept. 8, 2000).

414 Such requests have met with limited success. In the ICTR *Ntahobali* case, the prosecutor argued that questioning of two inconsistent witnesses on recall “should be very limited to avoid any further trauma.” Without explicitly mentioning trauma, the Trial Chamber agreed to a limited inquiry on recall. Prosecutor v. Ntahobali, ICTR-97-21-T, Decision on Ntahobali’s Motion for Exclusion of Evidence or for Recall of Prosecution Witnesses QY, SJ, and Others, ¶15 (Trial Chamber II Dec. 3, 2008). In the *Bagosora* case, the ICTY Trial Chamber denied the request of one witness to provide videoconference testimony partly on the basis of her past trauma. Prosecutor v. Bagosora, ICTR-98-41-T, Decision on Ntabakuze Motion to Allow Witness SK52 to Give Testimony by Video-Conference, ¶¶2 & 5 (Trial Chamber I Feb. 22, 2005).

415 Prosecutor v. Lubanga, Case No. ICC-01/04-01/06-1119, Decision on Victims’ Participation, ¶ 127, (Trial Chamber I Jan. 18, 2008).

416 *Id.* ¶ 129.

417 Rome Statute, *supra* note 6, art. 68(2). Such measures may include “conduct[ing] any part of the proceedings in camera or allow[ing] the presentation of evidence by electronic or other special means.” ICC Rules of Procedure and Evidence, *supra* note 6, r. 88(1); Colin T. McLaughlin, *Victim and Witness Measures of the International Criminal Court: A Comparative Analysis*, in *THE LAW AND PRACTICE OF INTERNATIONAL COURTS AND TRIBUNALS* 6, at 208-09.

418 This differs from the *ad hoc* tribunals, at which there is no presumption in favor of special protective measures, and the prosecution must apply and bear the burden of proof. Sam Garkawe, *Victims and the International Criminal Court: Three Major Issues*, 3 INT’L CRIM. L. REV. 352 (2003); ANNE MARIE DE BROUWER, SUPRANATIONAL CRIMINAL PROSECUTION OF SEXUAL VIOLENCE 243 (2005).

419 Prosecutor v. Lubanga, *supra* note 38, ¶¶ 130-32.

420 ICC Rules of Procedure and Evidence, *supra* note 6, r. 88(5).

421 Prosecutor v. Delalic, Case No. IT-96-21, Decisions on the Motions by the Prosecution for Protective Measures for the Prosecution Witnesses Pseudonymed “B” through to “M” (Int’l Crim. Trib. for the Former Yugoslavia Apr. 29, 1997).

422 Prosecutor v. Sesay, Case No. SCSL-2004-15-T, Decision on Prosecution Motion for Modification of Protective Measures for Witnesses (Trial Chamber July 5, 2004); Rules of Procedure and Evidence for the Special Court for Sierra Leone, r. 75 (2003) [hereinafter SCSL Rules of Procedure and Evidence].

423 Prosecutor v. Norman, Case No. SCSL-2004-14-T, Decision on Prosecution Motion for Modification of Protective Measures for Witnesses (Trial Chamber June 8, 2004).

424 ECCC, Transcript of Trial Proceedings—Kaing Guek Eav “Duch,” Case File No. 001/18-07-2007-ECCC/TC, at 49 (Aug. 18, 2009) [hereinafter 18 Aug. 2009 transcript].

425 *See, e.g.,* Michelle Staggs Kelsall et al., *supra* note 8, at 36 (noting that some witnesses appeared intimidated by Duch’s active role in the proceedings).

426 12 Aug. 2009 transcript, *supra* note 21, at 46-47.

427 *Id.* at 46-50.

428 ECCC, Transcript of Trial Proceedings—Kaing Guek Eav “Duch,” Case File No. 001/18-07-2007-ECCC/TC, at 20 (Aug. 19, 2009).

429 *Id.* at 22.

430 For example, some advocates for women’s rights have lauded the ICTR for being more explicit than previous tribunals in detailing cases of rape. *See* Lori A. Nessel, *Rape and Recovery in Rwanda: The Viability of Local Justice Initiatives and the Availability of Surrogate State Protection for Women That Flee*, 15 MICH. ST. J. INT’L L. 101, 113-14 (2007).

431 This was done at the ECCC, but only after Civil Party Im Sunthy broke down after viewing graphic evidence.

432 Jamie O’Connell, *supra* note 3, at 334 (citations omitted).

433 ECCC, Transcript of Trial Proceedings—Kaing Guek Eav “Duch,” Case File No. 001/18-07-2007-ECCC/TC, at 32 (July 7, 2009) [hereinafter Lay Chan transcript].

434 Lay Chan’s Civil Party application was rejected at judgment. The Trial Chamber highlighted the fact that “no evidence was provided to show that [the undoubted severe harm he suffered from detention, interrogation, and torture] occurred at S-21.” *Kaing Guek Eav*, *supra* note 2, ¶ 647.

435 Lay Chan transcript, *supra* note 57, at 48. *But see* 13 July 2009 transcript, *supra* note 20, at 62-63 (instructing defense co-lawyer Kar Savuth, at the request of a Civil Party lawyer, to “use a lower voice projection and make your speech gentle so that she can respond to your questions fully”).

436 ECCC, Transcript of Trial Proceedings—Kaing Guek Eav “Duch,” Case File No. 001/18-07-2007-ECCC/TC, at 87 (July 2, 2009).

437 ECCC, Transcript of Trial Proceedings—Kaing Guek Eav “Duch,” Case File No. 001/18-07-2007-ECCC/TC, at 4 (July 8, 2009) [8 July 2009 transcript]. Duch then offered his apology, “[T]hrough this Court I would like to seek forgiveness from Mr. Norng Chanphal because [before] I did not have the document and I would not accept it, but now I would accept it entirely.” *Id.* at 5.

438 *Kaing Guek Eav*, *supra* note 2, ¶ 647.

439 *Id.* at ¶¶ 648-649. Of the twenty-four Civil Party applicants rejected at the end of trial, eighteen were excluded at least in part due to a lack of documentation.

440 Transcultural Psychosocial Organization [TPO], Report on TPO’s After-Verdict Intervention with Case 001 Civil Parties, 27 July 2010, § 2.

441 *Id.*

442 *Id.* See also Charles P. Trumbull IV, *supra* note 5, at 810 n.224 (2008) (highlighting the unintended negative consequences on victims of having their participation applications rejected on technical grounds, such as a perception that they are being accused of untruthfulness or lack of injury).

443 See Julia A. Golier, Rachel Yehuda, & Steven Southwick, *Memory and Posttraumatic Stress Disorder*, in *TRAUMA AND MEMORY: CLINICAL AND LEGAL CONTROVERSIES* 225-42 (Paul S. Applebaum, Lisa A. Uyehara, & Mark R. Elin, eds., 1999).

444 Bessel A. van der Kolk, *Trauma and Memory*, 52 *PSYCHIATRY AND CLINICAL NEUROSCIENCES* S97 (1998).

445 Kathy Glassborow, *Lawyers Divided Over ICC Witness Preparation*, ACR (Mar. 9, 2009), available at <http://iwpr.net/report-news/lawyers-divided-over-icc-witness-preparation>.

446 *Id.* The ICC does not allow parties to engage witnesses in “discussion on the topics to be dealt with in court” due to the potential for the session to become “a rehearsal of in-court testimony.” See *Prosecutor v. Lubanga*, ICC-01/04-01/06, Decision Regarding the Practices Used to Prepare and Familiarize Witnesses for Giving Testimony at Trial, ¶ 51 (Trial Chamber Nov. 30, 2007). The ICC does, however, allow its Victims and Witnesses Unit to familiarize witnesses with court procedures and provide them the opportunity to read over their prior statements in order to refresh their memory prior to testifying. *Id.* ¶¶ 53 & 55. In contrast, the ICTY and ICTR allow parties to prepare their witnesses in advance by, for example, comparing prior witness statements and highlighting potential inconsistencies. See generally *Prosecutor v. Karemera et al.*, ICTR-98-44-AR73.8, Decision on Interlocutory Appeal Regarding Witness Proofing (Appeals Chamber May 11, 2007).

At the ECCC, which is governed largely by civil law procedures, the Witness and Expert Support Unit (WESU) takes time to familiarize all witnesses with logistical and process information before they testify; parties, however, are not supposed to prepare witnesses to the extent that lawyers do in an adversarial common-law trial. No ECCC provisions describe the parameters of witness preparation. In practice, due to the fact that “all witnesses are called by the Court and not by the parties, there is no possibility that they can be proofed by the parties.” E-mail from Anees Ahmed, former ECCC Assistant Prosecutor (March 10, 2011) (on file with author). Although it is theoretically possible that Civil Parties who are called by the Court to provide substantive information may be prepared by their attorneys, as they are not considered simple witnesses but interested parties, this was not the practice of at least one Case 001 Civil Party team due to the rules’ lack of clarity. Email from Alain Werner, Civil Party Lawyer Team I, Case 001 (March 23, 2011) (on file with author) (noting that the CPI team’s only client called to provide substantive information, Ly Hor, was not prepared in advance due to concerns underscored by the prosecution that it was an inappropriate practice in a civil law jurisdiction). See also ECCC Internal Rules, *supra* note 7, r. 23(4). As a result, a judge complained that the team’s lawyers had not sufficiently prepared their client to testify after he became confused. See *infra* n. 74-76 and accompanying text. See also Michelle Staggs Kelsall et al., *supra* note 8 (noting that ECCC parties’ inability to prepare witnesses likely prevented undue influence but also left some witnesses “ill prepared to take the stand”).

447 *Prosecutor v. Furundžija*, Case No. IT-95-17/I-T, Judgment, ¶¶ 90-107 (Trial Chamber Dec. 10, 1998).

448 *Prosecutor v. Aloys Simba*, ICTR-01-76-I, Decision on the Defence Motion to Exclude the Testimony of Witness KSM, ¶ 2 (Oct. 4, 2004).

449 See *Furundžija*, *supra* note 70, ¶¶ 108-09.

450 *Prosecutor v. Kunarac*, Case No. IT-96-23-t & IT-96-23/I-T, Judgment, ¶ 564 (Trial Chamber Feb. 22, 2001).

451 Ly Hor transcript, *supra* note 12, at 55.

452 Interview with Terith Chy, Team Leader Victim Participation Project, Documentation Center of Cambodia (Nov. 04, 2010) (on file with author).

453 *Kaing Guek Eav*, *supra* note 2, ¶ 647.

454 8 July 2009 transcript, *supra* note 60, at 93-94.

455 *Id.* at 40-47.

456 *Kaing Guek Eav*, *supra* note 2, ¶ 645.

457 Sam Garakwe, *Victims and the International Criminal Court: Three Major Issues*, 3 INT’L CRIM. L. REV. 345, 357 (2003); Gioia Greco, *Victims’ Rights Overview Under the ICC Legal Framework: A Jurisprudential Analysis*, 7 INT’L CRIM. L. REV. 531, 546 (2007).

458 See Marie-Bénédicte Dembour & Emily Haslam, *supra* note 3, at 168-69 (arguing that victim testimony in war crimes trials, which often relates only indirectly to the defendant, has the effect of shocking the public conscience and seems to serve “not so much to decide the guilt of the accused but to contribute to ‘a national saga that would echo through the generations’”) (quoting TOM SEGEV, *THE SEVENTH MILLION: THE ISRAELIS AND THE HOLOCAUST* 336 (1993)). But see also Mark J. Osiel, *Ever Again: Legal Remembrance of Administrative Massacre*, 144 PENN. L. REV. 463, 505-20 (1995) (acknowledging tension between liberal norms of culpability and the interest of conveying a broader historical narrative but arguing that “the orchestration of criminal trials for pedagogic purposes—such as the transformation of a society’s collective memory—is not inherently misguided or morally indefensible”).

459 Chum Mey transcript, *supra* note 22, at 12.

460 Ouk Neary transcript, *supra* note 13, at 104-05.

461 *Id.* at 107.

462 18 Aug. 2009 transcript, *supra* note 47, at 108.

463 20 Aug. 2009 transcript, *supra* note 14, at 26.

464 *Id.* at 26-27.

465 Bou Meng transcript, *supra* note 26, at 14.

466 Lay Chan transcript, *supra* note 57, at 37-38.

467 See, e.g., Bou Meng transcript, *supra* note 26, at I-3.

468 See, e.g., ECCC, Transcript of Trial Proceedings—Kaing Guek Eav “Duch,” Case File No. 001/18-07-2007-ECCC/TC, at 28-29 (Aug. 19, 2009) (in which Phung Guth details the character of her father).

469 See, e.g., 20 Aug. 2009 transcript, *supra* note 14, at 60-66.

470 ECCC, Transcript of Trial Proceedings—Kaing Guek Eav “Duch,” Case File No. 001/18-07-2007-ECCC/TC, at 93-96 (Aug. 24, 2009) [hereinafter 24 Aug. 2009 transcript].

471 *Id.* at 97 (accepting a defense objection, President Nil stated, “I myself made it clear of the 11 facts alleged on the accused that you received as a result of the establishment and operation of S-21 from the 17th April ’75 to the 6th of January ’79, which leads you to being joined as a Civil Party in this case. . . . So Mr. Civil Party, please only focus on the relevant part in relation to the facts and the accused”).

472 In recognition of the added efficiency challenges in Case 002, the Internal Rules have been amended to limit victim participation. See discussion *supra* note 10.

473 See, e.g., Michael P. Scharf & Ahran Kang, *Errors and Missteps: Key Lessons the Iraqi Special Tribunal Can Learn from the ICTY, ICTR, and SCSL*, 38 CORNELL INT’L L.J. 911, 912-13 (2005).

474 Suzannah Linton, *Safeguarding the Independence and Impartiality of the Cambodian Extraordinary Chambers*, 4 J. INT’L CRIM. JUST. 327 (2006).

475 Interview with Judith Strasser, TPO Clinical Psychologist Consultant & Supervisor (March 9, 2011) (noting that an offer by TPO and team of experts from the University of Zurich to provide training on psychological issues in the courtroom was rejected by the judges, but accepted by the Civil Party Lawyers in Case 002).

476 Chum Mey transcript, *supra* note 22, at 68. Although this repetition is not reflected in the transcript, it is discussed in trial monitor reports. See, e.g., Laura MacDonald, *Traumatized Survivor Painted Pol Pot Amidst Screams for Help*, CTM

BLOG (July 1, 2009), http://cambodiatribunal.org/images/CTM/ctm_blog_7-1-2009.pdf.

477 Bou Meng transcript, *supra* note 26, at 4-5 (noting the emotional testimony of Chum Mey the day before, Nil Nonn said, “after having examined how we could control the witness when he or she is very emotional...we also checked to see whether there are doctors or psychiatrists on standby, then the Court would seek their assistance to help that witness before we proceed further”).

478 *See supra* note 88 and accompanying text.

479 Patricia M. Wald, *Dealing with Witnesses in War Crime Trials: Lessons from the Yugoslav Tribunal*, 5 YALE H.R. & DEV. L.J. 217 (2002). For an early argument that special protective measures should be put in place when taking testimony from victims of sexual offenses in the Balkans, see Diane Ortenlicher, *No Justice, No Peace: Accountability for Rape and Gender-Based Violence in the Former Yugoslavia*, 5 HASTINGS WOMEN’S L.J. 89, 111-16 (1994).

480 Michael Bachrach, *The Protection and Rights of Victims Under International Criminal Law*, 34 INT’L L. 7, 12-13 (2000).

481 SCSL Rules of Procedure and Evidence, *supra* note 45, r. 34(B).

482 ICC Rules of Evidence and Procedure, *supra* note 6, rules 17(2)(iii)-(iv) & 19(d)-(j).

483 *Id.* r. 19(f).

484 HUMAN RIGHTS WATCH, *COURTING HISTORY: THE LANDMARK INTERNATIONAL CRIMINAL COURT’S FIRST YEARS* 156-58 (2008); Prosecutor v. Lubanga, Case No. ICC-01/04-01/06, Victims and Witnesses Unit Recommendations on Psycho-social In-court Assistance (Jan. 31, 2008).

485 ECCC Internal Rules, *supra* note 7, r. 29(3).

486 *Id.* r. 12bis(g).

487 This is all the more surprising since the ICC, which was created shortly beforehand, includes two provisions in its core document, the Rome Statute, authorizing it to take measures necessary to protect the psychological well-being of witnesses. *See* Rome Statute, *supra* note 6, arts. 68(1) & 87(4).

488 According to the ECCC website, “VSS ensures the safety and well-being of Victims who participate in the proceedings. This involves ensuring that Victims properly understand the risks sometimes inherent in such participation, as well as providing them with protective measures and other assistance, like psychosocial support.” ECCC, Victims Support Section, www.eccc.gov.kh/en/victims-support/victims-support-section.

489 It was renewed on July 22, 2010. *See* Cambodian Hum. Rts. & Dev. Ass’n et al., *Joint Cambodian NGO Report on Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment in the Kingdom of Cambodia, Presented to the UN Committee Against Torture*, ¶ 37 (Oct. 2010), www2.ohchr.org/english/bodies/cat/docs/ngos/Joint_Cambodian_NGO_Report_Cambodia45.pdf [hereinafter Joint Cambodian NGO Report on Torture].

490 TPO, Justice and Healing in Times of the Khmer Rouge Tribunal, http://www.tpocambodia.org/index.php?option=com_content&view=article&id=48:krt&catid=14:programs&Itemid=60. *See also* Joint Cambodian NGO Report on Torture, *supra* note 112, ¶ 37. TPO speaks to witnesses about possible psychological reactions they may experience and offers suggestions for stress management prior to their testimony. A representative is also available outside of the courtroom during breaks or should a witness need a rest. Upon a witness’s request, a TPO representative may also sit with them during their testimony. After testimony is completed, a representative is on hand; moreover, in Case 001 TPO followed up with all Civil Party and fact witnesses by phone every three weeks until the end of 2010. In follow-up interviews with Civil Party witnesses, they identified the presence of a TPO representative in the courtroom as the most valuable trial assistance they received. Interview with Judith Strasser, *supra* note 98.

491 24 Aug. 2009 transcript, *supra* note 93, at 10.

492 9 July 2009 transcript, *supra* note 32, at 50. Judge Cartwright replied that the ECCC had done an emotional assessment of the victims and had training in how to handle episodes of emotional distress. *Id.* at 53.

493 Lawyers also need to be aware of available psychosocial services and make appropriate referrals to mental health professionals.

494 Interview with Terith Chy, DC-Cam Victim Participation Project Team Leader (Nov. 4, 2010).

495 Diane F. Orentlicher, *The Impact of the ICTY in Bosnia*, Open Soc’y Just. Initiative, at 87 (2010).



7 JUSTICE AND HEALING AT THE KHMER ROUGE TRIBUNAL: THE PSYCHOLOGICAL IMPACT OF CIVIL PARTY PARTICIPATION

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My feeling, after I received the summons to appear before this Chamber, was so exciting, so happy. I was so clear in my mind that I would testify to shed light before this Chamber, to tell the truth. I felt so relieved. If I were not able to come before this Court to testify before your Honors and Mr. Lawyer, my mind was so disturbed, so bothering, and I wanted to get it out of my chest.⁴⁹⁶

It was very painful for me to recall my past... felt so hopeless and lonely during that regime. It seems like opening an old wound and I feel pain over and over.⁴⁹⁷

Psychosocial and human rights activists have long discussed the value of launching judicial proceedings against perpetrators of mass crimes and human rights violations. Proponents reason that such proceedings fulfill a number of purposes, including achieving justice, preventing future crimes, building the rule of law, creating a record of past abuses, and

promoting reconciliation. Despite little research and empirical evidence, some authors also argue that judicial proceedings dealing with legacies of violence may reduce trauma symptoms and associated impairment.⁴⁹⁸

Experiences from past international tribunals present a mixed picture on the assumed long-term relief of psychological distress through national truth-telling and accountability mechanisms.⁴⁹⁹ Mendeloff, for instance, summarizes: “Both trials and truth commissions, it seems, are equally as likely to dash victims’ hopes and aggravate their psychological wounds, as they are to provide a sense of justice and salve their psychic pain.”⁵⁰⁰

The Internal Rules of the Extraordinary Chambers in the Courts of Cambodia (ECCC) give victims a larger role than any previous international criminal tribunal. Victim participation rights permit victims to play an active role in the legal proceedings, as Civil Parties with full procedural rights.⁵⁰¹ In the tribunal’s Case 001 against Duch, ninety victims were provisionally accepted as Civil Parties (at the verdict, sixty-six were recognized, and those excluded have lodged an appeal). Currently, 2123 out of about 4000 applicants have been recognized as Civil Parties for Case 002 against the regime leaders.

The Civil Party mechanism has been praised as a significant advance in the field of international justice. It has, however, also provoked debate about whether and to what extent the active participation of victims can contribute to healing. In particular, some studies seem to suggest that participation in trials may also re-traumatize victims.⁵⁰² It is, therefore, all the more critical to monitor and analyze the impact of the tribunal on those who participate as Civil Parties in the proceedings.

What are specific challenges or benefits when participating in the juridical proceedings? What are particularly beneficial or harmful factors that influence Civil Parties’ responses? The authors addressed these questions while working at or in close cooperation with the Transcultural Psychosocial Organization Cambodia (TPO).

In 2007, TPO set up a special support scheme for Civil Parties and witnesses of the ECCC when the tribunal started operating.⁵⁰³ The program offers comprehensive psychological and psychiatric services and implements psychosocial outreach activities in cooperation with the Witness and Expert Support Unit (WESU) and the Victims Support Section (VSS) of the ECCC. In collaboration with international research institutes, TPO has been conducting studies to assess the mental health of Civil Parties and to explore the effects of their participation in Cambodia’s justice process. The authors combined and analyzed firsthand accounts of ECCC Civil Parties and Cambodian mental health professionals and analyzed the transcripts of the tribunal’s first trial. Quantitative and qualitative interviews with Civil Parties of Case 001 constituted an additional source to explore the effects of prosecutorial

justice on victims.

This Chapter aims to provide the reader with a typology of psychological dynamics by which the ECCC’s judicial process may affect Civil Parties. As exemplified in the two above-quoted citations, we found a wide spectrum of experiences by Khmer Rouge survivors who participated as Civil Parties in the tribunal’s first trial. Some psychological dynamics are beneficial, while others carry the risk of increasing the victims’ suffering.

VICTIMS MOTIVATIONS FOR PARTICIPATING AS CIVIL PARTIES IN THE ECCC

Before exploring the potential psychological effects of prosecutorial justice on Khmer Rouge survivors, we would like to draw attention to Civil Parties’ motives for participating in the legal proceedings. When asked why they personally decided to participate as Civil Parties to the ECCC, the majority of Case 001 Civil Parties interviewed in a study by the University of California at Berkeley (UC Berkeley) and TPO responded that they were seeking justice. For some, their participation was associated with the opportunity to request reparations. Others perceived their participation as a moral duty to their murdered relatives. An equal number hoped that the participation would help them in coping with their traumatic histories. Moreover, many Civil Parties expressed the hope that their participation would contribute to truth-telling as demonstrated by statements by Case 001 Civil Parties: “I want to share my past experiences and suffering with others. I want to tell what the Khmer Rouge did to me while I was imprisoned.”⁵⁰⁴ “I want to tell the truth about what happened. That’s what motivated me to join and talk to the ECCC as well as to other people.”⁵⁰⁵

Another motive repeatedly described by Civil Parties of Case 001 is the educative and preventive nature of their participation: “For our own dignity and for our own society, I don’t want that these terrible events happen again, to our children, to the next generation. We have to document this part of the Cambodian history.”⁵⁰⁶ This motive appears to mirror the general view of Cambodian survivors: in a random survey of 1000 Cambodians throughout Cambodia’s sixteen provinces, nearly 80% believed that it is important and necessary to know the truth and that national reconciliation is not possible without a better understanding of what happened under the Khmer Rouge regime.⁵⁰⁷

EXPERIENCES FROM THE KHMER ROUGE TRIBUNAL: POTENTIAL NEGATIVE EFFECTS ON THE MENTAL WELL-BEING OF CIVIL PARTIES

As we know from other international tribunals, victims’ participation in criminal proceedings has the potential to either reduce and/or aggravate victims’ suffering. The situation, however, might be different in Cambodia, as the ECCC is one of the first international tribunals to implement a comprehensive participation scheme that allows for the participation of victims as Civil Parties in the overall proceedings. Some argue that this mechanism is even

more likely to harm victims' well-being, especially as the ECCC experiments with various participation schemes and encounters tremendous challenges in making participation meaningful. Thus, before discussing the psychological benefits of victim participation at the ECCC, it is important to analyse the Civil Party mechanism's potentially harmful effects on Civil Parties, especially on their mental well-being. In particular, the following sections will discuss challenges related to: 1) the identification and legal representation of Civil Parties; 2) the admissibility of Civil Party applicants; 3) the logistical and financial support for Civil Parties; 4) expectations with regard to reparations and redress; 5) perceived risks of retaliation; 6) gender-related issues at the ECCC; 7) the attendance of survivors in the criminal proceedings; and 8) psychological strains in providing testimony.

Identification and Legal Representation of Civil Parties

Although the tribunal's internal rules state that Civil Parties have the right to legal representation, the ECCC did not have sufficient funds or resources for its Victims Support Section (VSS)—the ECCC's unit responsible for outreach to and support services for Civil Parties—to identify, update, and inform Civil Parties about the proceedings. Outreach was not prioritized in the beginning of the ECCC, and the VSS was not established until late 2007.⁵⁰⁸ Moreover, no funding was allocated for Civil Parties to be provided with lawyers in Case 001. As a result, local human rights organizations have carried the main burden of the tribunal's legal support and information activities.

Although independent and without funding from the ECCC, local nongovernmental organizations (NGOs) conducted a multiplicity of activities from 2006 to 2011 so as to inform Cambodians in rural areas about the ECCC, to inform the public of the court's objectives, to identify Civil Party applicants and complainants, and to provide them with legal support and information. Their work is widely seen as the major factor in making the ECCC's purpose and mandate known to the rural population and in making Civil Party participation at the tribunal possible.

Before and throughout the first trial, the Cambodian Human Rights and Development Association (ADHOC), the Khmer Institute for Democracy (KID), the Documentation Centre of Cambodia (DC-Cam), and the Centre for Social Development (CSD) implemented community-based information sessions aimed at informing Cambodians about the Court's objectives. The forums also worked to identify Civil Parties and complainants for their participatory engagement in the tribunal.

The Cambodian Defenders Project (CDP) has specifically sought out victims of gender-based violence by conducting awareness raising activities and engaging survivors in the tribunal process. DC-Cam provides special support services primarily for Civil Parties of the Cham minority, whereas the Khmer Kampuchea Krom Human Rights Organization

(KKKHRO) addresses Khmer Krom and Vietnamese minorities.

The influence of the Cambodian Human Rights Action Committee (CHRAC) and its networks has been of particular importance for securing meaningful victim participation.⁵⁰⁹ Its member organizations collected forty-seven of ninety-four Civil Party applications in Case 001. All ninety Case 001 Civil Parties accepted to the trial received legal support services. In Case 002, from 8,202 applications submitted to the ECCC Victims Support Section (VSS), 6,881 (about 84%) were submitted by local NGOs.

Despite concerted efforts by civil society organizations and their international partners (most prominently the Civil Peace Service of the German Agency for International Cooperation (GIZ)⁵¹⁰), the lack of funding by the ECCC led to budget constraints resulting in a lack of follow-up and legal support services for many Civil Parties. Thus, many Civil Parties were not fully informed about the Court's scope of investigation, the potential limitations of their participation, and the proceedings in their cases. In addition, the Court did not provide proper guidelines in regard to the admissibility of Civil Party applicants, so NGOs and Civil Party lawyers had problems focusing and directing their efforts.

In addition, the application to become a Civil Party or complainant requested victims to confront their past under narrow time constraints and with a strong focus on the legal requirements and usability of information. Most outreach activities were not accompanied by mental health professionals and many legal staff had only limited awareness of trauma and its after-effects. Instead, legal staff occasionally encountered survivors' emotional reactions and accounts, which lead to feelings of helplessness on both sides.⁵¹¹

Trauma literature shows that individuals who are subjected to prolonged trauma can develop psychological and emotional defence mechanisms, such as denial, dissociation, and psychic numbing.⁵¹² Further, traumatic memories are often difficult to recollect as coherent verbal narratives.⁵¹³ When dealing with traumatized victims, therefore, it is imperative to provide ample time and space and a certain level of knowledge on trauma symptoms to collect usable information and to avoid psychological harm. As a consequence of the above-mentioned shortcomings, the documentation of survivors' histories was sometimes incomplete and lacked evidence that would have allowed them to be accepted as Civil Parties by the Court.

Finally, given the unexpectedly high number of Civil Parties, civil society organizations had to narrow most of their services to those victims who were actually accepted as Civil Parties by the ECCC. This led to frustration on the part of those who were rejected, but still expected some kind of follow-up information as well as legal and psychosocial support. As one such individual noted: "I need psychological support and I need meetings with other

Civil Parties to exchange ideas and help each other to deal with these issues.”⁵¹⁴ Likewise, another rejected Civil Party applicant stated: “I suggest that the lawyer keeps me informed and advises me on legal measures in this situation.”⁵¹⁵

Admissibility and Impact of Rejection as Civil Party Applicants

There are three things that I will remember all my life: I witnessed how my family was slaughtered in front of me; I never had a proper marriage ceremony in my life; and I was not recognized by the ECCC for the trial against Duch.⁵¹⁶

When I learnt about my rejection, I felt stuck, I felt like in the middle of nowhere.⁵¹⁷

Perhaps the most distressing issue for many Civil Parties in Case 00I was the uncertainty about the status of their application until the verdict. When Civil Parties’ admissibility was challenged by the defense at the end of the substantial hearings of the Case 00I trial, the Trial Chamber decided that it would decide on the defense’s challenges to Civil Party applications at the time of the final verdict. As a result, twenty-four Civil Party applicants were finally informed, on the day of Duch’s judgment, that their applications had not been accepted.

Despite their lawyers’ attempts to explain to their clients the reasons for the non-admissibility determination,⁵¹⁸ many survivors did not fully understand or did not want to accept the legal arguments. Furthermore, some Civil Parties were confused as to why the information they provided was either not sufficient or not included in the court filing. A rejected Civil Party applicant stated:

I feel sad about my rejection, because the information I put in my complaint form is good enough. I complained because the [Khmer Rouge] arrested me with the intention to kill me. The Khmer Rouge military group I served collapsed and some of us including me were deported to Kampong Chhnang airport. This information was not included in my complaint file.⁵¹⁹

In addition, the decision by the Trial Chamber was often perceived as arbitrary. For example, although two applicants had photos of killed relatives displayed in the genocide museum S-21—implying that both relatives had been detained in the prison—one Civil Party applicant was accepted and the other Civil Party applicant was rejected. This seemingly arbitrary distinction caused anger and confusion. During a group discussion on the day after Duch’s verdict, both the rejected and accepted applicants reacted with intense emotional distress and expressed strong feelings of anger, sadness, and helplessness.⁵²⁰ The well-being

of two Civil Parties whose applications were denied in Case 00I deteriorated substantially in the months following their denial.

Some survivors attributed their rejection to personal failures rather than legal restrictions or shortcomings by their lawyers or the trial chamber: “I did not name my father in my complaint form, that’s why I missed a chance.”⁵²¹ Another survivor stated: “I feel so exhausted. I feel pain in my head and in my chest. I am here to find justice for my mother, who was killed at S21, but I did not succeed.”⁵²²

For many, the rejection was also associated with a failure in fulfilling their moral and spiritual duty, resulting in feelings of worthlessness, shame, and guilt: “I felt so tense when I heard about my rejection. It affects my relation[ship] to the spirits of the dead, because I could not fulfill my obligations towards my killed relatives.”⁵²³ This statement reflects the importance in Cambodia’s culture of spiritual bonds to deceased family members to help people deal with and to make sense of personal losses.⁵²⁴

Finally, some Civil Parties indicated a loss of face, status, and honour by not living up to the expectations of relatives, community members, and colleagues: “I testified at the Court. Many Cambodians saw me on TV. My colleagues saw me participating actively. And then I was rejected. They may think badly about me. . . . If I tell my family members about the rejection, they may tell this to others. I would feel even more ashamed.”⁵²⁵

In Case 002, when the Co-Investigating Judges determined which of the 4000 applications would be accepted, many applicants were not informed in a timely fashion. In addition, some applicants were informed earlier than others, leading to confusion and feelings of injustice.⁵²⁶

Lack of Logistic and Financial Support

Neither the ECCC Law nor the Internal Rules explicitly specify the Court’s obligation to finance Civil Parties’ attendance. Civil society and the GIZ’s Civil Peace Service stepped in to fill this gap. They did not have the funds or resources, however, to provide logistic support to all Civil Parties in the trial. This created barriers to participation in the Case 00I proceedings for the many Civil Parties who did not have the financial means to travel to Phnom Penh nor could they afford to leave work. Not surprisingly, a group of researchers and trial monitors observed, “During the first three months of the trial, only three of the ten seats in the Courtroom were regularly filled. . . . NGOs noted that many Civil Parties were disappointed by the fact that they were unable to attend the proceedings, because they could not afford to attend.”⁵²⁷

In response, the Court has recently adopted new measures to ensure greater access for Civil

Parties to the tribunal. For instance, the VSS disbursed transportation and accommodation costs to all Case 001 Civil Parties who wanted to participate in the release of Duch's verdict on 26 July 2010. Given its general lack of funding, however, it is foreseeable that VSS will not be able to finance and facilitate ample Civil Party attendance in the upcoming Case 002.

Reparations and Expectation Management

Perhaps one of the most contentious issues that may affect the psycho-social well-being of Civil Parties is the issue of reparations. The Internal Rules of the ECCC only allow for "collective and moral reparations." Survey data, however, suggest that survivors and their families prioritize basic needs over moral and symbolic forms of reparations. This is demonstrated by a preliminary analysis of complaint forms submitted to the VSS in Case 002, in which 18% of about 4000 ECCC Civil Party applicants requested medical services, 16% expressed that infrastructure should be improved, 16% asked for the construction of schools, 12% for individual reparations, and 13% for religious ceremonies.⁵²⁸

The Trial Chamber, however, rejected most of such claims for reparations in Case 001 on the basis that it had no capacity to enforce such claims against an indigent Accused.⁵²⁹ Thus, Civil Parties in Case 001 went through a painful learning process to adjust their reparations requests to the Court's internal rules. Many Civil Parties, however, still have expectations beyond what is foreseen by the Court. For instance, Civil Party lawyers continue to submit reparation requests of a "collective and moral" nature, such as asking for psychological care, memorializing and genocide education programs, publication, and dissemination of information, etc.⁵³⁰

Risks of Retaliation

Civil Parties who participated in the proceedings frequently expressed fear for their safety as exemplified in the following statement:

One day after my testimony at the Court, I was afraid of moving in the public, because once, when I went to the market, I heard people whispered to each other and they recognized me as the woman who testified at the ECCC. That made me feel afraid about my security.⁵³¹

Although no actual threats towards Civil Parties and witnesses were reported, Civil Parties' statements reflect that victims subjectively feel threatened: "I felt scared and concerned about my personal security. I wondered if Duch's relatives or even his son would take revenge."⁵³²

Attending the Criminal Proceedings

The unknown surroundings of the capital and the tribunal presented a physical and psychological challenge for many Civil Parties who joined the proceedings in Case 001.

Traveling by car or bus, eating unfamiliar food, and sleeping in a hotel room without family members led many to experience sleeping problems, headaches, and nausea. As a result, Civil Parties frequently asked for medical assistance.⁵³³ Security measures at the Court and the obvious differences between internationals as well as urban and rural Cambodians in clothing and behavior made some Civil Parties feel uncomfortable and insecure. Moreover, long hearings, language barriers, and translation made it difficult to follow the complicated legal procedures.

Being confronted with Duch face-to-face and being exposed to the precise reconstruction of torture and repetitive accounts of highly traumatic events were certainly among the most stressful factors for Civil Parties and survivors who participated in the proceedings. "I felt very bad, especially when facing Duch," one Civil Party stated.⁵³⁴ Several who did not yet know details about the torture inflicted on prisoners in the S-21 and S-24 prisons or about the executions in the Killing Fields, now had to listen to detailed accounts of the accused and witnesses. This forced some survivors to imagine the terrible pain that their relatives possibly had suffered. Other Civil Parties mentioned that they could hardly tolerate seeing the photos of their killed loved ones that were displayed during the trial: "When I saw the photo of my brother on the screen, this was the most stressful event for me."⁵³⁵

Providing Testimony and Psychological Strains

Recounting Traumatic Events

Giving testimony is often cited as stressful and may potentially cause retraumatization in human rights trials.⁵³⁶ During the trial of Case 001, twenty-two Civil Parties and/or Civil Party applicants provided testimony before the ECCC. Some of them had been waiting for decades for this opportunity. Nearly all Civil Parties expressed hope that their testimony would help to establish the truth and to achieve justice for their dead relatives and all victims of the regime. Unsurprisingly, they also experienced high levels of distress prior to their testimonies: "When it was my turn [to take the stand], I felt very much afraid. I felt as if something hit my stomach, I was nervous, and I got cold hands and feet."⁵³⁷ Several victims were afraid that they might not be able to answer accurately when questioned by judges and lawyers. One stated, "I felt afraid that I would make a mistake in my talk that they might notice or note. Seeing so many lawyers, nationals and internationals, I was worrying that I would do something wrong."⁵³⁸

The majority of Civil Parties who testified in Case 001 reported that remembering and recounting the atrocities committed against themselves and their family members was extremely difficult and painful: "It was so hard to recall my past experience when being asked by the Judge. Being an orphan in such a horrible regime was so painful...It was too painful for me to speak it out when they questioned me about my experiences."⁵³⁹ When asked about the consequences of his traumatic experience, Mr. Chum Mey, one of the most

prominent figures among Civil Parties, shed tears as he explained that “the recollection and articulation of his experiences systematically trigger[ed] memories of his five family members who perished during the reign of the Khmer Rouge.”⁵⁴⁰

In the beginning of Case 001, there was no mental health professional available in the Courtroom, because TPO staff was only permitted to be present during the testimony of witnesses. In response, the then-VSS Head, Dr. Helen Jarvis, promised that the Section would look into how psychological support can be ensured for those Civil Parties who are in the courtroom.⁵⁴¹ Later on in the proceedings, TPO staff were asked to sit next to the Civil Parties in the courtroom.

Testifying and Cross-Examination

Another stressful factor for some Civil Parties who took the stand was being questioned by the defense about the credibility of their accounts. Credibility was generally changed because of discrepancies between prior statements and their testimony in Court. When their credibility and status as a Civil Party was publicly called into question, Civil Parties were highly disturbed. One of the affected parties stated, “My heart was beating heavily, and I was trembling, especially on the first day, because there was so much public, and lawyers asked me questions back and forward, and that made me afraid. I was nervous and I felt like I was going to faint.”⁵⁴² As a result of the interrogations, some of the affected survivors perceived their testimony as irrelevant for the tribunal and the Case. As noted by one commentator, “This may lead to the unfortunate consequence that a Civil Party may feel, at best, dissatisfaction and, at worst, re-traumatization after testifying to his or her experiences.”⁵⁴³

The Chamber’s Response to the Expression of Pain, Anger, and Retributive Feelings

On several occasions, the Court restricted the public display of emotions and repeatedly urged Civil Parties to “recompose” themselves to avoid hindering the progress of the proceedings. These Court admonishments are exemplified in the following excerpts from the testimony of S-21 survivor, Mr. Chum Mey:⁵⁴⁴

Q. Mr. Chum Mey, you stated that for the 12 days that you were interrogated and tortured that you were placed in this cell for that period of time. What was the feeling—what was the feeling you had when you were placed in the cell, day in and day out, after being tortured for 12 days?

A. Mr. Co-Prosecutor, when I entered that my cell I could not expect to survive. At that time I only lie down waiting to be killed. It was the first time that I lied down on the floor, the first time in my life, and it was also the first time in my life that I was hosed with water. Even if you raise a pig you have to give food to the

pig, but I only got a spoonful of very thin gruel.

MR. PRESIDENT: Mr. Co-Prosecutor, your time runs out. Uncle Mey, please recompose yourself. This is the time that we are conducting our trial.

A. I will never forget the suffering that I endured at S-21, until the day I die. Once the justice will be done by Your Honors, then I will feel better.

Q. Thank you. From since you left S-21 until today, whenever you hear the name Tuol Sleng Prison, how do you feel?

A. Mr. Lawyer. Whenever the word Tuol Sleng prison comes to my mind I cannot hold my tears. They drop automatically. Every single day, when I hear about S-21, about Tuol Sleng, about torture, then my tears just keep flowing. I do not know what’s going to happen to me in the future, as I cannot control my tears when I hear such words.

Q. Uncle, please recompose yourself to answer my questions. I do not have much time left.

Based on court transcripts, it appears that the tribunal did not support the establishment of “emotional truth,” an understanding of truth that highlights the crucial, but sometimes ambivalent, role of our emotions in grounding and reasoning. Rather than using victims’ emotional expressions as a legitimate and important source of evidence to better understand the magnitude of individual and collective pain and suffering, the Trial Chamber required the presentation of victims’ experiences in a rather dry and factual way. This is exemplified by one occasion in which the Chamber’s President asked two survivors to publicly demonstrate their physical injuries resulting from the torture they endured in S-21, a request that was withdrawn after the survivors’ lawyer intervened.⁵⁴⁵ The Trial Chambers’ response to victims’ emotional distress raised critiques among Civil Party lawyers, tribunal monitoring staff, and Civil Parties alike. For instance, Civil Party lawyer Ms. Studzinsky, proposed that witnesses who are emotionally overwhelmed when recalling painful experiences, should be allowed a break and time “to cope with [their] emotions.”⁵⁴⁶

Not only the expression of pain, but also Civil Parties’ anger and retributive feelings towards the Accused were treated restrictively. When Civil Parties used “strong language to give vent to their emotions, particularly their feelings about the Accused, the President warned Civil Parties that the Chamber would not tolerate verbal abuse and ‘unethical’ comments directed at the Accused.”⁵⁴⁷ Trauma experts, however, emphasize that feelings of anger and the desire

for revenge can constitute important coping mechanisms. Indeed, TPO staff observed that victims who were able to feel and express their emotions, including their wish for revenge, were generally more empowered and less vulnerable. In the words of Aldana:

To be sure, many victims of violent crimes experience deep emotions of anger and hatred and the desire for revenge. It is mistaken, however, to dismiss these emotions as wholly invalid, irrational, or evil. It is not only natural for victims to hate those who wronged them and to seek revenge against those who victimized them, but it can also be good for them to despise passionately what they have experienced.⁵⁴⁸

Moreover, the expression of retributive feelings can provide important evidence to the understanding of the case as well as demonstrate commitment. As emphasized by Murphy, “True allegiance to morality and law is not merely intellectual but also must be revealed in passionate commitment; and indignation and resentment...represent such commitment.”⁵⁴⁹ One Civil Party stated, “I had so much anger and pain, so I decided that I want to seek justice because my husband and my little son died. To respond to the feelings I have, I wanted to show how people used people and I wanted to share my experiences.”⁵⁵⁰

Requests for Forgiveness

The defendant’s “permissive or rehabilitative orientation”⁵⁵¹ and request for forgiveness imposed additional psychological pressure on some of the Civil Parties. In Case 001, Duch frequently asked forgiveness from his victims or victims’ relatives.⁵⁵² It is well known, however, that calling for forgiveness is not necessarily psychologically beneficial and can even harm survivors.

Many Civil Parties emphasized that truth and justice must be rendered before they can think about forgiveness. They argued that forgiveness could only take place if Duch sincerely confessed his crimes and provided the full truth to victims. For example, many felt frustrated when the Accused would not reveal information on the fate of their loved ones. One party, who attended every day of the trial, expressed her deep disappointment because she did not receive answers to the question where and how her father, a S-21 prisoner and former teacher of the Accused, had been killed. Because the Accused is known for his precise documentation of the prisons’ inmates, she expected him to tell the full truth.⁵⁵³ Duch, however, insisted that he did not know about the presence of her father in S-21. This and other statements by the Accused substantiated Civil Parties’ perception, that Duch was not committed to telling the truth and that he was not genuine in his expression of remorse. Consequently, some requested that Duch abstain from apologizing gestures when facing them in the courtroom.

Aldana emphasizes, “To forgive is not always appropriate or virtuous. It must be consistent

with the dignity and self-respect of victims, and respond to their allegiance to the moral order.”⁵⁵⁴ Murphy further points out, “Forgiveness, as I understand it, is essentially an internal matter of the heart—a change in how one comes to feel about the person by whom one has been wronged. As such, forgiveness can only be stowed by the victim of wrongdoing and not by the legal mechanism of the state.”⁵⁵⁵ In the words of one Civil Party:

Forgiveness is a process and so first there is a need to find the people who did this. Then a judgment has to come in and depending on the punishment—and then there is reparation...This is a process perhaps thirty years from now—perhaps, it will take that long to be able to forgive; the same amount of time that we had to take in order to come to the truth.⁵⁵⁶

EXPERIENCES FROM THE KHMER ROUGE TRIBUNAL: PSYCHOLOGICAL BENEFITS OF VICTIM PARTICIPATION

Despite the challenging issues outlined above, experiences arising from Case 001 mostly underline the psychological benefits of a mechanism that allows for survivors’ close engagement in Cambodia’s justice process. Indeed, most Civil Parties in Case 001 stated that they were satisfied or very satisfied with their overall experience and would do it again if given the opportunity. This is reinforced by the fact that most Case 001 Civil Parties applied to be Civil Parties in Case 002. In the following section, we highlight factors that may have contributed to Civil Parties’ overall positive experience with the Civil Party mechanism. For now, it appears that the beneficial effects of participation on survivors outweigh its harmful effects.

Empowerment Through a Joint Struggle for Justice and Memorialization

In Case 001, survivors of the Khmer Rouge regime from different locations and with various backgrounds came together as Civil Parties. Regular meetings—for instance those organized by ADHOC in and outside Phnom Penh involving Case 001 Civil Parties, lawyers, and TPO’s mental health professionals—ensured that almost all Civil Parties supported by organizations in the CHRAC network obtained a certain level of information and access to psychological support. Over the full course of the trial, these meetings played a key role in empowering Civil Parties. For many, the meetings provided the main opportunity to understand the Court’s function and the scope of their own participation, to create new contacts, and to find meaning for their personal suffering. Learning that others suffered similar violations and losses, and experiencing mutual support created a strong sense of solidarity among victims. As one Civil Party described:

I think [the Civil Party experience] was positive. Before, I did not dare to talk about my past to others. Now I feel confident about myself. At the beginning, I felt lonely as I felt like the only one who filed a complaint...and I didn’t know any other Civil Party. Later, I found myself supported as many Civil Parties came together

and shared their experiences.⁵⁵⁷

The Civil Party mechanism further contributed to the empowerment of Civil Parties by allowing Civil Parties to play an important role in other innovative transitional justice activities implemented by Civil Society organizations, such as Youth for Peace, International Center for Conciliation (ICfC), TPO, KID, CDP, and DC-Cam. In addition, Civil Parties had the opportunity to articulate their experiences in various contexts, such as in local and international film productions,⁵⁵⁸ and during interviews with media representatives and researchers.

Given the many prominent figures that emerged out of the Civil Party group, the Civil Party mechanism seems to contribute to the empowerment of survivors. This is also exemplified by the foundation of the Ksem Ksan Victims Association as well as the following statement of one of its founding members: “We, the victims, have consensually established an association to monitor the very activities of the Court regarding proceedings and reparations, and to unite us throughout the country and advocate for justice.”⁵⁵⁹

Psychological Benefits of Acknowledgment and Condemnation

O’Connell states that criminal proceedings that “signify state acknowledgment of victims’ experiences and dignity, and condemnation of those responsible, might alleviate several of the traumatic effects of human rights violations.”⁵⁶⁰ Indeed, it appears that the ECCC’s acknowledgement of what victims lost and went through was psychologically significant for many Civil Parties.⁵⁶¹ For instance, one Civil Party pointed out:

I was happy because when the verdict was handed out, every name was announced according to the [judgment] book and also reasons were given. That was the point when I felt that the Court has acknowledged us officially. They trusted us, and they recorded this history for the next generations.⁵⁶²

Another Civil Party stated, “I think, this kind of means justice to me, because the perpetrator was prosecuted, punished and put in jail. I also got justice for my brother who died during the Khmer Rouge regime.”⁵⁶³ It appears that for some the tribunal expressed the state’s disapproval of the Khmer Rouges’ acts and helped victims to regain some confidence in the power of judicial proceedings.

Moreover, the situation in Court signified for many a reversal of power. In contrast to their experiences of immense helplessness in situations of victimization in the past, Civil Parties now had the chance to confront their perpetrators: “Of course there is pain in my heart when I attend the trial... However, I attend the trial every day so that the judges and Duch can look directly into my eyes.”⁵⁶⁴

The sense of power experienced by Civil Parties through their active participation appears all the more important because, within the Cambodian cultural context, responses to trauma are characterized by feelings of generalized helplessness, disempowerment, and low self-esteem as described in the work of Chhim Sothea.⁵⁶⁵

Finally, for many Civil Parties, the trials helped to embed their individual trauma in a larger political context and discourse around the Khmer Rouge past. As noted by Aldana, “Coming to know that one’s suffering is not solely a private experience best forgotten but instead an indictment of a social cataclysm can permit individuals to move beyond trauma, hopelessness, numbness, and preoccupation with loss and injury.”⁵⁶⁶

Psychological Benefits of Providing Testimony

I felt positive about my testimony, because my case was accepted by the Court, and moreover, the Accused also acknowledged that [my relative] was killed at S-21.⁵⁶⁷

Despite shortcomings in the process, the overall experience appears to confirm that most Civil Parties perceive their testimony at the ECCC as positive and essential for their personal healing process: “I have no more concern in my mind or heart, I feel clear and bright now.”⁵⁶⁸ Another Civil Party stated that her participation “was more positive than negative ...because [she] could open up what [she had] hidden inside [herself]...[She] disclosed the story that [she] tried to hide for years, since 1977.”⁵⁶⁹ Some Civil Parties mentioned that they felt as if a big burden has been taken from them. Others stated that providing testimony enabled them to fulfill their duty towards their murdered relatives: “I feel happy about [the testimony]. I thought of my father, and there was something valuable that I’ve done for him, something to dedicate to his death.”⁵⁷⁰

Moreover, many Civil Parties expressed their satisfaction with the opportunity to transfer their knowledge and experiences to a wider public and to the next generation. Civil Parties contributed to the production of a collective memory and were empowered to take on new roles: “I had the chance to get involved in a peace-building process for Cambodians, especially for the new generation so they can learn and prevent that such a bad regime happens again in Cambodia.”⁵⁷¹ Another Civil Party noted, “This Court is as a model that promotes the rule of law in Cambodia, and I’m happy to have the chance to participate and share this [with] others, both Cambodians and internationals.”⁵⁷²

Psychological Benefits of Psychological Support Services

I want to participate in the Court until its end. Despite all the suffering we went through during the Khmer regime, given the support from organizations such as TPO, we can now tell the truth.⁵⁷³

Civil Parties, who participated in the ECCC's first trial, frequently mention the importance of emotional and moral support by civil society organizations, lawyers, and ECCC staff. As exemplified in the following statement, almost all Civil Parties emphasized that this support as well as psychological services provided by TPO helped them enormously to deal with challenges when participating in the proceedings: "I was very much encouraged by many people: my lawyer, VSS staff, and TPO."⁵⁷⁴ Describing her experiences, another Civil Party stated, "Before [the testimony], I was very much afraid, but then, TPO assisted me and made me feel more confident."⁵⁷⁵

TPO staff was permanently present at the Court, providing psychological briefings and debriefings to attending Civil Parties prior to, during, and after the proceedings. The presence of a TPO counselor in the Courtroom, sitting next to the Civil Parties during their testimonies, appeared to be of particular importance: "When the Judge started to ask me questions, I started to cry. TPO staff helped me to release my feelings by holding my hands with empathy."⁵⁷⁶

TPO was often perceived as a reliable constant, because it did not have a legal agenda. Moreover, TPO's support program was specifically designed to allow Civil Parties time and space beyond the proceedings to share their traumatic experiences in a safe and respectful setting and to address fears related to their participation. Here, Civil Parties were also encouraged to articulate their needs beyond legal and psychological services and to explore coping strategies outside the ECCC.

In addition, one of TPO's main tasks was to assist victims in managing their expectations of the tribunal. In doing so, it was particularly important to make clear that victim participation would be painful, while simultaneously pointing out that their participation also had the potential to contribute to a more accurate view and to come, to some degree, to terms with the past.

TPO's telephone hotline was particularly effective to keep contact with and to provide follow-up to Civil Parties, many of whom were from remote areas of Cambodia. Regular phone contact allowed Civil Parties to process stressful experiences associated with their participation in the ECCC and to keep themselves updated on the tribunal's work. Bridging the gaps between their visits to the Court or NGO-initiated meetings, this long-term contact between Civil Parties and psychological counsellors created trustworthy and reliable relationships.

In summary, it appears that psychological services by TPO were of utmost importance in helping Civil Parties to deal with stressful and controversial situations typical in a criminal proceeding. In the words of one of TPO's clients, "Doing counselling with TPO staff made

me slowly feel better. I can manage my feelings now. Before, whenever I was thinking about the past, I always cried right away."⁵⁷⁷

CONCLUSION

The ECCC Civil Party mechanism is an important approach to make tribunals more accessible to victims. It appears to be successful in the empowerment of victims by providing a framework in which Civil Parties can play a more active role, express their views, and gain some acknowledgment for their suffering and pain. For now, the Civil Party mechanism seems to offer significant additional value for the mental well-being of survivors in international tribunals. It is too early, however, to make a final conclusion on the long-term mental health benefits of this important participatory mechanism in the ECCC.

The shortcomings discussed above, however, need to be addressed to allow for the best possible psychological outcome. First and foremost, the judicial process needs to be adjusted more effectively to victims' psychological needs. All participants in the judicial process should consider how they can reduce the psychological burden of Civil Party participation without compromising the legal procedures or fairness to the Accused.

In particular, the tribunal should undertake action to reduce stress during the testimony of victims. Lawyers in collaboration with mental health professionals should do their best to evaluate and respond to potential psychological risks in providing testimony. Lawyers must also effectively prepare their clients prior to their testimony and debrief their clients after they testify.

Further, the Court could ensure that survivors are afforded sufficient time to cope with the emotions invoked by recalling painful experiences. Moreover, judges and other legal staff could express more empathy toward victims without prejudicing defendants. By listening carefully and providing space for emotional expression, Court staff can support victims' understanding of what happened and help to repair victims' confidence in their own judgment.

In addition, the Court could increase gender sensitivity among investigators and other Court staff, and ensure gender-sensitive procedural protection mechanisms for victims of gender-based violence. Gender mainstreaming, the provision of female investigators and interpreters, and basic training on psychological principles could be important contributions to progress in this matter.

Secondly, additional efforts, strategies, and funding for information and legal support services are needed to prevent unnecessary rejection of applications, to counteract stress caused by delay, and to avoid frustration due to a lack of follow-up and legal support. The

provision of logistical and financial support to Civil Parties needs to be ensured to secure the attendance of Civil Parties in the proceedings, and information and legal support services for Civil Parties need to be sustained over the full length of the trial. In addition, legal and psychosocial support services could be expanded to include rejected Civil Parties and complainants. In particular, it is important to manage Civil Parties' expectations and to provide legal and psychological services to respond to the post-verdict, emotional reactions.

Third, it is imperative to offer structured and long-term psychosocial support services for Civil Parties prior, during, and following the proceedings. This is particularly important when the retelling of experiences has evoked long-suppressed emotions and for those who may be more vulnerable due to social isolation. Psychological expertise during outreach work and mental health training of legal staff could substantially help to identify potential Civil Parties with severe mental health problems and to avoid psychologically harmful practices. Further, additional funding is needed to ensure the provision of mental health services for Civil Parties, not only at the ECCC and through TPO's trauma treatment center, but in particular at the provincial/community level. Community-based and -enabled services are known to be particularly suited to addressing mental health care needs in developing countries.

Finally, for justice to be achieved, the question of reparations must be comprehensively addressed. With its new mandate to provide non-judicial forms of reparations, the ECCC has a unique opportunity to respond in a more integrated manner to the legal, psychological, and economic needs of Civil Parties. Particular attention should be given to decentralized and community-based mental health services and the establishment of informal support structures, such as self-help and advocacy groups, which are more likely to meet the psychological needs of survivors.

Notwithstanding these ways in which the ECCC can improve the experience of Civil Parties, we must not forget about the majority of survivors who were not able to participate in the tribunal. Those seeking to support survivors should therefore look far beyond the tribunal. Thus, an emphasis on a more comprehensive national transitional justice strategy is vital not only to foster individual healing but as part of a larger social scheme to foster reconciliation and healing.

As emphasized by many survivors, responses to major life stresses depend on a variety of factors including the availability of personal, cultural, political, and socio-economic resources. For instance, most Khmer Rouge survivors never received financial compensation, and many still live under precarious socio-economic conditions. In addition, one can hardly expect survivors to confront their victimization in a political and religious climate unsupportive of recalling the past. Thus, as a first step, greater attention should be given to

a holistic approach on the issue of reparations and measures in the areas of truth seeking, remembrance, and mourning.

Whereas the state must play an important role regarding the question of reparations, grass-root mobilization appears to be the key to further transitional justice developments in the area of memorialization. Given its mandate to design and implement non-judicial measures to address the broader interests of victims, the ECCC has the unique opportunity to contribute toward this endeavour in unprecedented ways. The ECCC can initiate and serve as a model for Cambodia's future transitional justice process, which is one important step toward securing the tribunal's legacy.

END NOTES

496 See Extraordinary Chambers in the Courts of Cambodia [ECCC], Transcript of Trial Proceedings—Kaing Guek Eav “Duch,” Case File No. 001/18-07-2007-ECCC/TC, at 36 (June 30, 2009) (Civil Party Chum Mey testimony).

497 Interview with Case 001 Civil Party (Dec. 6, 2010) [hereinafter 6 Dec. 2010 Interview] (on file with author).

498 See J. Sonis et al., *Probable Posttraumatic Stress Disorder and Disability in Cambodia Associations With Perceived Justice, Desire for Revenge, and Attitudes Toward the Khmer Rouge Trials*, 302(5) JAMA 527 (2009).

499 D. Mendeloff, *Trauma and Vengeance. Assessing the Psychological and Emotional Effects of Truth-telling in Post-Conflict*, 31 HUMAN RTS. Q. 592 (2009).

500 *Id.* at 616.

501 ECCC, Victim’s Unit, www.eccc.gov.kh/english/victims_unit.aspx.

502 U. Orth & A. Maercker, *Do trials of perpetrators retraumatize crime victims?*, 19(2) J. INTERPERSONAL VIOLENCE 212 (2004).

503 In 2007, TPO signed an official Memorandum of Understanding with the ECCC outlining its responsibilities.

504 Interview with Civil Party of Case 001 (Dec. 2, 2010) [hereinafter 2 Dec. 2010 Interview] (on file with author).

505 Interview with Civil Party of Case 001 (Nov. 26, 2010) [hereinafter 26 Nov. 2010 Interview] (on file with author). See P.N. Pham, et al., *So We Will Never Forget: A Population-Based Survey on Attitudes about Social Reconstruction and the Extraordinary Chambers in the Courts of Cambodia*, Human Rights Center, University of California, Berkeley (Jan. 2009), available at <http://hrc.berkeley.edu/>

506 *Id.*

507 P.N. Pham, et al., *After the First Trial: A Population-Based Survey on the Knowledge and Perception of Justice and the Extraordinary Chambers in the Courts of Cambodia*, Human Rights Center, University of California, Berkeley (June 2011) (surveys conducted in 2008 and 2010 by UC Berkeley).

508 As in other international tribunals, outreach by the ECCC is important to inform the Cambodian population about the tribunal’s work as well as to inform victims of their rights to participate. At the ECCC, outreach services also aim to identify Civil Party applicants and complainants and to provide them with legal support and information services.

509 See M. Raab & J. Poluda, *Evaluation Report: Justice for the Survivors and for Future Generations*, ADHOC (2010), www.adhoc-chra.org/article.php?language=english&art_id=155¤tpage=1.

510 At the time, the Civil Peace Service program was overseen by the German Development Service (DED). In 2011, DED and other German development agencies were merged into the Deutsche Gesellschaft fuer Internationale Zusammenarbeit (GIZ).

511 Transcultural Psychosocial Organization [TPO], *Assessment on the Impact of NGO Outreach Activities in Stung Treng Province* (Feb. 22, 2008).

512 See B.A. van der Kolk & R. Fisler, *Dissociation and the Fragmentary Nature of Traumatic Memories: Overview and Exploratory Study*, 8 J. TRAUMATIC STRESS 505-25 (1995).

513 See C.L. WHITFIELD, *MEMORY AND ABUSE: REMEMBERING AND HEALING THE EFFECTS OF TRAUMA* (1995).

514 *Id.*

515 *Id.*

516 Interview with Case 001 Civil Party Applicant (Dec. 5, 2010) (on file with author).

517 Case 001 Civil Party Applicant, Remarks in a meeting at TPO (Oct. 29, 2010) [hereinafter Civil Party Applicant Remarks] (on file with author).

518 Victims must prove that they and/or close relatives were victims of the security centre, S-21.

519 Civil Party Applicant Remarks, *supra* note 22.

520 As reported by TPO staff and Civil Party lawyers.

521 Civil Party Applicant Remarks, *supra* note 22.

522 *Id.*

523 *Id.*

524 See A.C.M. Van de Put & M. Eisenbruch, *The Cambodian Experience*, in TRAUMA, WAR AND VIOLENCE (J. de Jong ed., 2002).

525 Civil Party Applicant Remarks, *supra* note 22

526 As reported by TPO staff.

527 KRT TRIAL MONITORING GROUP, ASIAN INT’L JUST. INITIATIVE, LESSONS LEARNT FROM THE ‘DUCH’ TRIAL 31 (Dec. 2010).

528 ECCC Victims Support Section [VSS], Data Presented at a Roundtable Discussion with Civil Society Organizations, Phnom Penh, (Sep. 2010) (data on file with authors) (based on preliminary data analysis).

529 ECCC, Internal Rules of the Extraordinary Chambers in the Courts of Cambodia, r. 23^{quinqies} (revised Feb. 23, 2011), available at www.eccc.gov.kh/english/internal_rules.aspx.

530 See Prosecutors v. Kaing, Case No. 001/18-07-2007-ECCC/TC, Civil Parties’ Co-Lawyers’ Joint Submission on Reparations, ¶ 46 (Sep. 14, 2009).

531 Interview with Case 001 Civil Party (Nov. 2, 2010) [hereinafter 2 Nov. 2010 Interview] (on file with author).

532 Interview with Case 001 Civil Party (Dec. 8, 2010) (on file with author).

533 As reported by VSS staff.

534 26 Nov. 2010 Interview, *supra* note 10.

535 *Id.*

536 *Id.*

537 *Id.*

538 *Id.*

539 Interview with Case 001 Civil Party (Nov. 30, 2010) [hereinafter 30 Nov. 2010 Interview] (on file with author).

540 KRT Trial Monitor, Report Issue No. 11, at Annexure A (July 5, 2009) (on file at U.C. Berkeley War Crimes Studies Center/East-West Center, Berkeley, California).

541 *Id.*

542 30 Nov. 2010 Interview, *supra* note 44.

543 KRT Trial Monitor, Report Issue No. 12, at 8 (July 9, 2009) (on file at U.C. Berkeley War Crimes Studies Center/East-West Center, Berkeley, California).

544 *Id.* at 64.

545 See Report Issue No. 11, *supra* note 45, at 6.

546 KRT Trial Monitor, Report Issue No. 5, at 5 (May 2, 2009) (on file at U.C. Berkeley War Crimes Studies Center/East-West Center, Berkeley, California).

547 KRT Trial Monitor, Report Issue No. 18, at 4 (Aug. 23, 2009) (on file at U.C. Berkeley War Crimes

Studies Center/East-West Center, Berkeley, California).

548 R. Aldana, *A Victim-Centered Reflection on Truth Commissions and Prosecutions as a Response to Mass Atrocities*, 5(1) J. HUM. RTS. 116 (2006).

549 F.G. Murphy, *Christianity and Criminal Punishment*, 5(3) PUNISHMENT & SOC'Y 269 (2003).

550 2 Nov. 2010 Interview, *supra* note 36.

551 J. Herman, *Justice From A Victim's Perspective*, 11(5) VIOLENCE AGAINST WOMEN 578 (2005).

552 See ECCC, Transcript of Trial Proceedings—Kaing Guek Eav “Duch,” Case File No. 001/18-07-2007-ECCC/TC, at 42 (Aug. 17, 2009) [hereinafter 17 Aug. 2009 Transcript]. In her testimony, Martine Lefevre mentioned that she is not able to forgive the accused at this point. *Id.* Duch nonetheless asked for her forgiveness.

553 See Cambodian Tribunal Monitor, Families Still Searching for Answers (Aug. 2009), www.cambodiatribunal.org/blog/2009/08/families-still-searching-for-answers.html.

554 R. Aldana, *supra* note 53, at 117.

555 F.G. Murphy, *supra* note 54, at 267.

556 17 Aug. 2009 Transcript, *supra* note 57, at 42.

557 6 Dec. 2010 Interview, *supra* note 2.

558 For instance, a film on individual and collective coping mechanisms called, “We want (U) to know!” has been written, filmed, and directed by Khmer Rouge survivors’ and their descendants, available at www.we-want-u-to-know.com. It was produced by the Khmer Institute for Democracy (KID) and ICfC, facilitated by TPO, and financed by the Civil Peace Service of GIZ.

559 2 Nov. 2010 Interview, *supra* note 36.

560 J. O’Connell, *Gambling with the Psyche: Does Prosecuting Human Rights Violators Console Their Victims?*, 46 HARVARD INT’L L.J. 295, 319 (2005).

561 See C. Byrne, *Benefit or Burden: Victims’ Reflections on TRC Participation*, 10(3) J. PEACE PSYCHOL. 237 (2004).

562 2 Nov. 2010 Interview, *supra* note 36.

563 26 Nov. 2010 Interview, *supra* note 10.

564 Cambodia Tribunal Monitor, Interview with Case 001 Civil Party Chum Mey, available at <http://www.cambodiatribunal.org/blog/labels/Civil%20Parties.html>.

565 In a conference organized by TPO and the Berlin Treatment Centre for Victims of Torture (BFZO) in Phnom Penh on 17 December 2010.

566 R. Aldana, *supra* note 53, at 113.

567 30 Nov. 2010 Interview, *supra* note 44.

568 26 Nov. 2010 Interview, *supra* note 10.

569 2 Nov. 2010 Interview, *supra* note 36.

570 30 Nov. 2010 Interview, *supra* note 44.

571 *Id.*

572 2 Dec. 2010 Interview, *supra* note 9.

573 30 Nov. 2010 Interview, *supra* note 44.

574 2 Dec. 2010 Interview, *supra* note 9.

575 *Id.*

576 2 Nov. 2010 Interview, *supra* note 36.

577 *Id.*



8 PARTICIPATION AS REPARATIONS: THE ECCC AND HEALING IN CAMBODIA

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In the final days of the trial of Kaing Guek Eav (Duch), a Civil Party attorney, Mr. Canonne, proposed that for his clients “the most valuable reparation [was] probably their very presence [in the Court].”⁵⁷⁹ This Chapter explores the notion of whether victim participation in international criminal trials should be considered a form of reparation. Though the definition of reparations under international law is quite broad, it is not clear whether participation in trials of those responsible for mass crimes falls within its scope. Many studies of victim participation in international criminal tribunals have been critical of the psychological impact of testifying before these courts.⁵⁸⁰ These authors argue that participation runs counter to rehabilitative goals of reparations.⁵⁸¹

Using the first prosecution before the Extraordinary Chambers in the Courts of Cambodia (ECCC) as a case study, we explore in detail the various mechanisms for victim participation in international criminal trials.⁵⁸² We agree that contemporary participation mechanisms risk significant harm to victims, but suggest that a carefully structured participation process may offer an effective mechanism for providing collective symbolic reparations.⁵⁸³ We argue that reconceptualization of participation as reparation is in order and that international criminal tribunals should aim to maximize the rehabilitative potential of victim participation throughout the trial process.⁵⁸⁴

DEFINING REPARATIONS

While the right to reparation is widely acknowledged under international law, the definition of reparation is so broad that it can be difficult to determine its scope in practice.⁵⁸⁵ In this Chapter, we focus on three definitional axes: goals, types, and mechanisms.⁵⁸⁶ Reparations are generally aimed at compensation, rehabilitation, reconciliation, satisfaction, or any

combination of these goals.⁵⁸⁷ The types of reparations encompass financial, spiritual or moral, rights-restoring, and society-reconstructing. Reparations may be implemented through individual or collective mechanisms.⁵⁸⁸

Given this volume’s focus on mental health and trauma, this Chapter takes up rehabilitation as a central goal of reparations. As in many countries recovering from mass violence, resources in Cambodia are extremely limited and donor fatigue is high. As a result, we focus on moral and society-reconstructing reparations, leaving aside the more costly financial and rights-restoring reparations. Collective reparation mechanisms are appropriate in the Cambodian context because they offer a response to collective harms that affected the vast majority of the population. It would be nearly impossible to separate out a class of individual victims whose claims to reparations should be prioritized over others.⁵⁸⁹ We view such reparations as a component of national development.

This focus on moral and rights-restoring reparations also fits within the relatively narrow scope of reparations permitted under the ECCC’s statute and rules. The Court may award only collective and moral reparations to Civil Parties before the Court; these reparations are to be funded by perpetrators or through external donations.⁵⁹⁰ In contrast, the Rome Statute of the International Criminal Court (ICC) authorizes that court to provide for a broad range of reparations that are limited only by the principles of restitution, compensation, and rehabilitation.⁵⁹¹ The Trust Fund for Victims created under the Rome Statute provides funds to victims of crimes within the jurisdiction of the ICC and their families—a category of persons that could be interpreted much more broadly to include even those who have not participated in court proceedings.⁵⁹² Under the constraints of its narrower mandate, the ECCC has been particularly miserly and unimaginative with its reparation awards. In Case 00I, the only case to have been decided so far, the ECCC awarded only the publication of the names of the Civil Parties in the final judgment and the compilation and publication of all statements of apology made by the accused, Duch, over the course of the trial.⁵⁹³

THE CASE OF CAMBODIA

In this section, we next investigate the role of the ECCC in repairing trauma caused by the Khmer Rouge. In particular, we explore the concept of reparation as victim participation in international criminal trials by asking whether and how the Court’s Civil Party function during the trial of Case 00I has worked to rehabilitate individuals harmed by the Khmer Rouge.

After examining the level of involvement of victims in each type of participation enabled by the ECCC prosecutorial process, we posit that increasing active victim involvement is more likely to result in victim healing.⁵⁹⁴

There are four avenues available to Cambodians who wish to participate: giving testimony during the trials, becoming a Civil Party or filing a victim's complaint, observing the trials, and taking part in community dialogues about the proceedings. Although individual victims may engage in multiple forms of participation, community dialogues hold the most promise for rehabilitating Cambodians.

Testifying before the ECCC

Testifying before an international criminal tribunal offers victims the greatest opportunity for interaction with the court. Throughout the seventy-two trial days in Case 00I, the ECCC's Trial Chamber heard testimony from twenty-four witnesses, twenty-two Civil Parties, and nine experts.

To its credit, the Trial Chamber was concerned about the rehabilitative impact of the trial. Its focus, however, was on the impact on Cambodian society rather than the individual victims testifying. On the sixty-fourth day of trial, the Chamber called Dr. Chhim Sotheara, a psychological expert. Dr. Sotheara was asked:

For those victims that have joined the civil party action and for civil society as a whole, what is the importance of their participation to the trial, in public, in front of the nation? Can the other victims identify with this approach of the victims? Can it play the role of a cathartic outcome for Cambodian society without, of course, being a miracle remedy?

Sotheara's response focused on the impact of the trials on individuals:

For those who have the opportunity to participate as civil part[ies] and to provide a statement or testimony, [the trial] is a forum for them to express the feeling, the emotions, that have been hidden for many years; to express them to the public... The study of the genocidal regime was not included in the state curriculum, and people avoid talking about this issue. There seems to be a conspiracy of avoidance or conspiracy of silence that they seem together [to] not wish to express their feelings, to ignore the issues...[T]herefore... participation, the making of statements or...testimony...would help them.⁵⁹⁵

The survivors, likewise, seemed to also hold an expectation that reparative healing would spring from the act of testifying. On August 20, 2009, for example, Mr. Ou Savrith testified before the Trial Chamber, expressing his expectation that through testimony "a certain form of reparation begins."⁵⁹⁶

At least two factors, however, rendered testimony before the Tribunal in Case 00I insufficient for providing reparative justice for Cambodians, collectively and individually. First, the Trial Chamber used its rules of conduct⁵⁹⁷ to discipline witnesses whose testimony strayed beyond the limited scope of the Chamber's evidentiary needs. These disciplinary measures likely deprived this testimony of any reparative healing it may otherwise have provided and may in fact have alienated the witnesses. Second, the ECCC was inaccessible to many of the witnesses both because of the rigidity of its technical rules regarding testimony and its intimidating and alien appearance.

Enforcing Courtroom Decorum & Efficiency

The Court's inquiries in Case 00I were restricted to its evidentiary needs—needs that did not always match the interests of victims. On numerous occasions, judges asked witnesses to emotionally restrain themselves and to restrict their testimony to only those facts that the judges considered to be useful to the investigation. For example, when Chum Mey testified about his experience as a prisoner of the notorious S-2I detention center, Mey used harsh language toward the accused, stating that Duch would not have seen the light of day had Duch beaten Mey personally.⁵⁹⁸ President Nil Nonn reprimanded Mey, asking him to be "well-behaved" and to avoid attacking individuals because the process was "more about the legal proceedings." Mey responded with a reminder to the Court that he spoke out of honesty and that he felt obligated to recount his experience in a way that gives the Court a complete picture of the events that took place.

The Court similarly limited the scope of the testimony of Civil Party Chum Sirath.⁵⁹⁹ During his testimony, Sirath criticized the accused and questioned the accused's credibility. Duch's counsel objected to this portion of the testimony, arguing to the Chamber that the Civil Party should not incite any reaction from Duch or other victims present in the Chamber. Sirath's counsel defended his client's testimony, pointing out to the Chamber that Sirath's testimony is "part of the process of coping with the suffering and of course is part of the story that he wants to tell." The Chamber ultimately sided with the accused, reminding the Civil Party that testifying before the Court was not "the opportunity to make revenge or to affront anybody." The Chamber also reminded Sirath that the time allotted for his testimony was running out.

The Court refused to hear the emotional component of the testimony of Bou Meng, another S-2I survivor.⁶⁰⁰ After testifying about being tortured and losing his wife at S-2I, Meng become overwhelmed with emotion and was asked by the President Nil Nonn to "recompose" himself. The President urged, "Do not let your emotion overwhelm you. So try to grab the opportunity to tell your accounts to the Chamber as well as to the public." Although the President acted compassionately toward the witness, reminding Meng of the importance of his story for Cambodians and the international community, his testimony

was nonetheless restricted. Whereas the evidentiary details of Meng's testimony received high priority, the Court flatly rejected expressions of his emotional reaction toward the accused and the murderous regime.

The Court treated witness Chhin Navy similarly. After she recounted the experience of losing her husband under the Khmer Rouge, the Court instructed Navy to focus her testimony on the links between her husband's torture and S-21, and to "please [not] stray far away from that matter."⁶⁰¹ To be fair, the Tribunal judges are not the only culprits—lawyers also encumbered the process by asking repetitive and sometimes irrelevant questions of the witnesses.⁶⁰²

The Court has also limited its impact by being insensitive to gender issues.⁶⁰³ The ECCC's failure to accommodate female victims to date has been apparent not only in the Court's proceedings, but also in the scope of the Court's inquiry. With respect to the latter point, the co-prosecutors omitted rape charges in their final submissions to the Court in Case 001, despite Duch's admission of rape and the inclusion of rape in the indictment.⁶⁰⁴ A Civil Party attorney, Kong Pisey, noted this omission and reminded the Court of its responsibility to set an example for Cambodia's domestic legal system, in which court officials do not classify the rape of a non-virgin as rape.⁶⁰⁵ The indictment filed in Case 002 includes forced marriage as a rape charge, but it remains to be seen whether prosecutors pursue these gender crimes.⁶⁰⁶

The experience of witness Nam Mon is telling in this regard. It was only after Mon observed the testimony of another witness that she felt empowered to inform her attorney that she had been raped. The Chamber rejected this new information because it was not presented during Mon's testimony and also because of time constraints.⁶⁰⁷ The Court's disregard for Mon's emotional difficulty in disclosing her rape cost Mon the opportunity to convey her experience. This may serve as a deterrent for future witnesses who might wish to share a similar experience.

A Civil Party attorney, Silke Studzinsky, highlighted these problems in her final words to the Trial Chamber on November 23, 2009.⁶⁰⁸ Studzinsky noted that although providing testimony was cathartic for some victims, many of the testifying parties did not feel comfortable in the Trial Chamber because the Chamber did not appear receptive to their suffering. Studzinsky drew the Judges' attention to the fact that not a single Civil Party was thanked for his or her testimony. Moreover, those persons who testified in August 2009 received virtually no questions from the Chamber, leading the individuals to believe that the Chamber was uninterested in hearing about their experiences. According to Studzinsky, these victims felt that they were "mere fill-ins" and "standby witnesses." Studzinsky also revealed that many Civil Parties feared crying during testimony after they witnessed the

Chamber scolding other Civil Parties for expressing their emotions.

Inaccessibility of the ECCC & Its Procedures

The second problem is that the ECCC is inaccessible to many witnesses and Civil Parties as a result of the Court's technical rules of evidence and its very appearance. Because the Court's procedural rules are so technical and unfamiliar, witnesses are often preoccupied with rule compliance rather than the substance of their testimony. In this respect, the technicalities of the Court's proceedings may strip testimony of its potential reparative benefits. An example of this arose during the testimony of Sek Dan, a child medic at S-21.⁶⁰⁹ The Chamber took extended measures to warn Dan of his right against self-incrimination and his obligation to testify truthfully to the Court. During testimony, Dan refused to respond to a number of seemingly innocuous questions posed by the Chamber. Finally, after an extended exchange, Dan's attorney reassured the Court that Dan did not intend to be difficult; Dan was refusing to answer questions that appeared complicated. Not only did Dan misunderstand his right against self-incrimination, it appears that he did not even understand the questions being asked of him. Civil Party attorney Studzinsky also took note of this apparent intimidation, noting that many of those who testified were so nervous that they were unable to remember some of the facts that they wished to share with the Chamber.

The physical structure and technologies of the Court are similarly alien to many Cambodians so that testifying could be an intimidating and emotionally difficult experience. Initially, this critique may appear superficial, but a physical examination of the Tribunal lends credence. The Court's enormous and ornate edifice and technological features stand in stark contrast to the everyday lives of Cambodians, many of whom scarcely interact with electricity. In addition, testimony of countless witnesses and Civil Parties was regularly interrupted by the misuse or failure of technology. Most often, persons testifying had difficulty waiting for the lighted signal indicating when they were to speak.⁶¹⁰ This often frustrated the Chamber, which sternly reminded witnesses of the technological needs of the Court.

Virtually all international criminal proceedings, which are designed to be rigid and formal in structure, have been criticized for resulting in invasive or insensitive questioning of witnesses.⁶¹¹ Although ostensibly allowing the most participation in the ECCC's prosecutorial process, Cambodians who testified as witnesses against the accused were subjected to disciplinary reprimand, alienation, and in some cases exclusion from the proceedings. These anecdotes reveal that the ECCC's limited scope, rigid rules of composure, technical procedural rules, and unfamiliar physical structure and technologies rendered testimony before the Court inadequate as a form of reparation in Case 001.

Participating as a Civil Party or Filing a Victim's Complaint

Participation as a Civil Party or as a victim-complainant presents the second most intensive mode of involvement with the Court. A victim-complainant provides the Tribunal with evidence and the Court determines whether to pursue the allegations made by that victim. In contrast, a Civil Party participates in the proceedings by filing documents and presenting arguments before the Court.⁶¹² As witnesses, no procedural rights accrue to victim-complainants. Because Civil Parties participate in the trial, however, they are accorded some of the same due process rights as the accused.⁶¹³ For example, a Civil Party generally has the right to not be questioned in the absence of her attorney.⁶¹⁴ Civil Parties are also eligible for reparations unlike other participants in the proceedings.⁶¹⁵

The Victims Unit of the Tribunal was established to collect and organize Civil Party claims and to facilitate Civil Party participation in to the Court.⁶¹⁶ Nonetheless, participation as either a Civil Party or victim-complainant before the ECCC has thus far been inadequate as a reparation-providing measure. First, the ECCC Internal Rules are exclusive, necessarily precluding some Cambodians from participating as Civil Parties to the proceedings. Second, the low number of Civil Party petitions and victim-complainants suggests fear of the proceedings or a lack of awareness, interest, or capacity on the part of victims. Third, the legitimacy of the Victims Unit was damaged by the appointment, as the first head of the Unit, of a non-Cambodian with strong ties to the Cambodian government. Fourth, Internal Rule 23 substantially limits reparations.⁶¹⁷ Reparations may be provided only by, and thus are limited to the financial capacity of, the accused or external funders; the form is limited to collective and moral reparations; and receipt can be had only by Civil Parties.⁶¹⁸

Civil Party participation has not performed a reparative function for all Cambodians because only a select few are eligible to be Civil Parties.⁶¹⁹ In Case 001, the Trial Chamber dismissed the claims of some Civil Parties for failure to prove a close bond of affection with or dependency on one of Duch's victims.⁶²⁰ Survivors whose claims are beyond the immediate scope of the Prosecutor's investigation are also not qualified to be Civil Parties. In Case 002, the Pre-Trial Chamber interpreted the Internal Rules as barring a group of Khmer Krom survivors from participating as Civil Parties because the provinces in which the victims suffered were not included in the Prosecutor's initial submissions.⁶²¹ These are only two examples of how the Court's rules of procedure may limit access to the Court and prevent many Cambodians from participating as Civil Parties.

The Tribunal has also limited the extent of participation for those selected as Civil Parties.⁶²² For example, Civil Parties are not permitted to ask questions pertaining to the accused's character or personality.⁶²³ This limitation prompted a boycott of the Tribunal by two-dozen victims during Case 001.⁶²⁴ This restrictive approach has thus far rendered the Civil Party process inadequate for providing reparative healing to all Cambodians.

The second weakness of Civil Party and victim-complainant involvement has been apparent in the low rate of participation. Of the more than 12,000 victims of S-21, only ninety-four victims and family members of victims applied to be Civil Parties in Case 001.⁶²⁵ As of May 2010, the Victims Unit had received a mere 8,202 victim participation petitions for both Case 001 and Case 002, the latter of which involves nationwide crimes.⁶²⁶ This lack of participation can be explained by a number of factors, including a lack of awareness of or interest in the process, a perceived lack of ability to participate, or even fear of the proceedings. Even those survivors and their families knowledgeable about the existence of the ECCC may not have been sufficiently informed of their right to participate. Others who know of the Court may find it irrelevant to their lives, or may be faced with other pressing demands that make participation nearly impossible. In addition, some survivors and their families may fear the repercussions of participation in the ECCC. The lack of participation in the Civil Party process and Victims Unit suggests that these modes have thus far been unsuccessful in achieving reparations for Cambodians.

The third weakness centers on the staffing of the Victims Unit, specifically the appointment in 2009 of Helen Jarvis as its first head. Jarvis, an Australian national, is neither Cambodian-born nor a Khmer Rouge survivor. Khmer Rouge survivors were vociferous in their dissatisfaction with Jarvis.⁶²⁷ Many survivors viewed Jarvis as unfit to represent them on at least three counts: her inexperience with the Khmer Rouge, her connection to the Cambodian government, and her Marxist political leanings. Indeed, many Cambodians believe that the Victims Unit should be headed by a Khmer Rouge survivor, or at minimum, an ethnic Cambodian.⁶²⁸

The transparency of Jarvis' appointment was called into question, due to her status as a former Court employee and long-time adviser to the Cambodian government.⁶²⁹ Adding to the skepticism of her competence, the Cambodian Center for Human Rights speculated that Jarvis' appointment was designed to strengthen the Cambodian government's control over the Tribunal.⁶³⁰ This concern was shared by at least some of the Court's personnel. Andrew Ianuzzi, a legal consultant for the Nuon Chea defense team, stated that he and his colleagues "would welcome the addition of personnel who [were] not so close to the current government."⁶³¹

Jarvis' Marxist political background was also unsettling for Khmer Rouge survivors. Jarvis is a former member of Australia's Leninist Party Faction (LPF), a Marxist party.⁶³² Jarvis (along with her husband) is credited with writing: "We, too, are Marxists and believe that 'the ends justify the means.'...In time of revolution and civil war, the most extreme measures will sometimes become necessary and justified."⁶³³ In an open letter to Jarvis, a Khmer Rouge survivor wrote, "[I]t is both absurd and insulting to have a Marxist advocate representing the victims of a Marxist regime, which was being tried by the court of law."⁶³⁴

Jarvis stepped down from her position as head the Victims Unit in June 2010.⁶³⁵ Despite this shift, those victims represented by her throughout the Duch case may still be dissatisfied and feel distrustful of the ECCC. Without the survivors' trust in the Victims Unit and the Court, participation in legal proceedings cannot reasonably be considered reparative.

The final critique of the reparative potential of victim complaints and Civil Party membership is the limited source of reparations. The ECCC Internal Rules stipulate that reparations are either limited to the financial means of the accused or must be paid through external funding.⁶³⁶ Survivors have proposed a range of collective reparations ranging from the construction of memorials to learning centers.⁶³⁷ In Case 001, however, Duch responded to an inquiry regarding reparations by stating that he does not "have any ability to assist anybody at this stage."⁶³⁸ Therefore, faced with a defendant without financial resources and no external funding, the ECCC was unable to award any concrete reparations in Case 001.

Despite receiving numerous and diverse suggestions for moral reparations in Case 001, the Court determined that it was able to grant only two: inclusion of the names of Civil Parties and their relatives who died at S-21 in the judgment and compiling and publishing all statements of apology made by Duch during the trial.⁶³⁹ Though this effort is to be lauded, it falls short of meeting the reparative needs of Cambodians whose family members perished at Tuol Sleng.

Attending the Tribunal Proceedings

The Tribunal has opened its doors to Cambodians and to the international community to observe its trials. This form of victim participation is the least interactive because it entails the victim passively observing the trials without engaging with the Court or a framework for understanding the proceedings. In Case 001, attendance at the trial has failed to provide significant reparative relief for at least three reasons.

First, attendance at trial has re-traumatized some survivors. Chhim Sothea, a psychological expert, testified in Case 001 that although some of his clients reported they had healed since the Khmer Rouge violence, many felt re-traumatized after attending the Tribunal's hearings.⁶⁴⁰ Thus, even for those able to attend, without adequate psychosocial support, viewing the trial may have been anti-reparative.

Second, the Internal Rules of the Tribunal limit observers' emotional expression during the trials. For example, the Court barred observers from wearing t-shirts marked "Case 002" while in the courtroom gallery.⁶⁴¹ These shirts may have been worn to encourage the Court to pursue its second case, against the surviving senior members of the Khmer Rouge, quickly and fully.⁶⁴² The Court's enforcement of its regulation prohibiting such expression deprives the experience of observing the tribunal of any potential interactive reparative effect.

The final, and most obvious, shortcoming of observation is its inaccessibility. Many Cambodians, particularly those who reside outside Phnom Penh, are unable to spend the time and money required to observe the trials. Televised viewing is also unavailable to the majority of the population who does not have access to a television set. Without significant support for attendance, observation cannot offer a comprehensive reparation mechanism. Various elements of civil society did their best to enable court attendance, but these efforts reached only a small fraction of potential observers. Thus far, attendance at trial has not constituted a meaningful form of collective reparations.

Community Dialogues

Community dialogues around the trial constitute the final form of involvement in Case 001. While most participants in community dialogues do not interact directly with the ECCC, this mechanism offers perhaps the highest level of individual engagement with the issues raised by the trials. Community dialogue efforts around Case 001 have been organized and funded by non-governmental organizations. The Documentation Center of Cambodia's "Living Documents" project is an example of such efforts.⁶⁴³

To date, this project has enabled over fifteen thousand representatives of communes throughout Cambodia to tour the ECCC.⁶⁴⁴ These participants attend legal training sessions at the Documentation Center of Cambodia (DC-Cam) to learn more about the ECCC's jurisdiction and procedures and to study the biographies of defendants before the Court. The participants then attend ECCC hearings and discuss their experience at the Court with other participants through a facilitator. When they return home to their villages, the participants lead group discussions about the trials. DC-Cam staff and other experts often attend these meetings to field technical questions, help moderate discussions, and film the proceedings. These village forums are also publicized in neighboring villages that do not have a representative at the trials. The project aims to encourage public dialogue about the losses suffered at the hands of the Khmer Rouge, enabling community members to share their experiences with each other and begin the process of community-wide healing.⁶⁴⁵

The community dialogues also play an important role for the surviving Khmer Rouge cadres. The fear of revenge by survivors continues to haunt these lower-level troops. For example, Kong Leour, a village leader under the Khmer Rouge, told the DC-Cam team that he has "tried to be nice" to the survivors, but he continues to fear for his life because many former cadres have been killed by the villagers.⁶⁴⁶ Similarly, another villager, Som Chhoam of the Kraing Leav commune, noted that the forums are particularly important for communities that are home to former cadres because the dialogues can foster understanding among community members and opportunities for forgiveness.⁶⁴⁷ For the former cadres themselves, the dialogues also help to dispel any fears or misunderstandings they may have about the Tribunal's jurisdiction and the possibility of being prosecuted.⁶⁴⁸

The community dialogues present an opportunity for Cambodians themselves to structure a healing process that is most relevant and beneficial to their unique suffering. The forums allow Cambodians to play a central role in the reconciliation process in a way that is currently unavailable through the Tribunal's proceedings. These discussion groups continue after the DC-Cam outreach teams leave the communities, which may lead to an enduring impact on the community.⁶⁴⁹ It appears that these community dialogues may have created the most significant and lasting reparative impact around Case 001.

CONCLUSIONS & RECOMMENDATIONS

Though the experience of victims participating in Case 001 to date can hardly be categorized as reparative, a more carefully structured process could offer rehabilitative promise. We started our analysis with the example of testimony at a truth commission, which has been conceived of as symbolic individual reparations. Similar to victims who speak before a truth commission, victims who testify at international criminal trials should be provided with the opportunity to tell their stories, to obtain official recognition of harms perpetrated against them, and to participate in establishing the historical record.⁶⁵⁰ If these goals are met, victim participation can be conceived of as moral reparations that rehabilitate victims of mass violence. Efforts to make the ECCC more accessible by carefully educating witnesses about the procedural rules and technical requirements might help in this regard, though it may be too late to make the Court's structure less intimidating. It is less clear whether the Court's evidentiary rules could be modified to better align with the emotional interests of survivor witnesses.

Participation in truth-telling processes can also be seen as a form of societal reparation. Professor Ruth Rubio-Marin notes that the act of contesting oppression and exclusion through testimony can help to establish the legitimacy of a rights-respecting political order in a transitional state.⁶⁵¹ From a substantive perspective, this testimony serves to recognize the inherent equality and dignity of the victim, to describe past responsibility for rights violations, and to express the moral code of the new political order.⁶⁵² Moreover, from a procedural perspective, victim testimony can contribute to a more inclusive deliberative process.⁶⁵³ This process and dialogue are key to societal rehabilitation, also known as transformative justice.⁶⁵⁴

From a transformative justice perspective, our central critique of the Civil Party approach to participation in Case 001 is its exclusionary nature. This mode of participation limits the beneficiaries of reparations and draws potentially divisive distinctions. By necessity, some individuals will be accepted as Civil Parties and others will not.⁶⁵⁵ This critique applies equally to other post-conflict justice mechanisms in which the particular violations charged and the testifying victims accounted for represent a small portion of all the harms committed.⁶⁵⁶ Even among those accepted as Civil Parties, a court might treat different

groups of Civil Parties differently, leading to perceptions of injustice.⁶⁵⁷

Those designing reparation mechanisms must make choices about whom to compensate, for which harms, and to what degree. Such schemes may result in the perceived denial of the suffering of those not included.⁶⁵⁸ Of greater concern, distinctions inherent in any system mask structural and systemic patterns of injustice that may be at the root of the mass violence that the international criminal trial seeks to address.⁶⁵⁹ Moreover, the victim-perpetrator dichotomy may further entrench post-conflict social divisions.⁶⁶⁰ We advocate for a more comprehensive approach to participation in truth-telling as a way to make Civil Party involvement more effective in rehabilitating Cambodians and their society and in bridging the culpability gap.⁶⁶¹

In defining effective rehabilitation, we turn to the psychological literature around reparations, which reminds us that individual psychological repair from political violence has a moral dimension.⁶⁶² Because moral components of mass crimes must be addressed, "psychosocial work within reparations processes must be integrated and enacted within specific historical, cultural, and socio-political contexts, with singular individuals and their particular communities."⁶⁶³ These communities are the sites in which the individual and the collective are co-constructed and thus must be a part of effective rehabilitation processes.⁶⁶⁴ We, therefore, recommend that Civil Party involvement be complemented by community dialogues that enable truth-telling, dialogue between victims and perpetrators, and opportunities for acts of contrition and apology on the part of perpetrators and acceptance by victims, as well as the involvement of the whole community in this hearing process.⁶⁶⁵

END NOTES

578 Toni Holness was a summer intern at the Documentation Center of Cambodia in 2009. Jaya Ramji-Nogales has been a Legal Advisor to the Documentation Center of Cambodia since 1997. Many thanks to Elena Baylis, Margaret deGuzman, Jean Galbraith, Milan Markovic, Craig Martin, Beth Van Schaack, and David Zaring for their helpful comments.

579 Extraordinary Chambers in the Courts of Cambodia [ECCC], Transcript of Trial Proceedings – Kaing Guek Eav “Duch”, Case File No. 001/18-07-2007-ECCC/TC, at 80 (Nov. 23, 2009).

580 *See, e.g.*, Laurel E. Fletcher & Harvey M. Weinstein, *Violence and Social Repair: Rethinking the Contribution of Justice to Reconciliation*, 24 HUM. RTS. Q. 573, 593 (2002); David Mendeloff, *Trauma and Vengeance: Assessing the Psychological and Emotional Effects of Post-Conflict Justice*, 31 HUM. RTS. Q. 592, 599-600 (2009) (listing, at n. 13, studies warning of the harm to victims from truth-telling); Jamie O’Connell, *Gambling with the Psyche: Does Prosecuting Human Rights Violators Console Their Victims?*, 46 HARV. INT’L L.J. 295, 331-35 (2005); ERIC STOVER, THE WITNESSES: WAR CRIMES AND THE PROMISE OF JUSTICE IN THE HAGUE 32, 72-76, & 81-91 (2005) (“One can hardly expect victims and witnesses to come to a state of ‘psychological healing’ after recounting a highly traumatic experience in a public setting that in and of itself would be threatening...This is wh...war crimes tribunals...should not be viewed as vehicles for individual psychological healing...n the aftermath of genocide and ethnic cleansing.”).

581 Rama Mani, *Reparation as a Component of Transitional Justice: Pursuing “Reparative Justice” in the Aftermath of Violent Conflict*, in OUT OF THE ASHES: REPARATION FOR VICTIMS OF GROSS AND SYSTEMATIC HUMAN RIGHTS VIOLATIONS 53, 66-67 (K. De Feyter et al., eds. 2005).

582 The trial of Kaing Guek Eav, a.k.a. Duch, also referred to as Case 001. *See* Prosecutor v. Kaing Guek Eav *alias* Duch, Case File No. 001/18-07-2007/ECCC/TC, Case Information Sheet, (Feb. 17, 2009), *available at* www.eccc.gov.kh/english/caseInfo001.aspx.

583 *See also* Mani, *supra* note 4, at 53, 62 (“Potentially, this right to reparation could have been fulfilled indirectly through the functioning of trials or truth commissions rather than through a separate and distinct third mechanisms for reparations. However, neither trials nor truth commissions as instituted thus far within transitional justice have significantly fulfilled victims’ right to reparations.”); Brandon Hamber, *The Dilemmas of Reparations: In Search of a Process-Driven Approach*, in OUT OF THE ASHES: REPARATION FOR VICTIMS OF GROSS AND SYSTEMATIC HUMAN RIGHTS VIOLATIONS 135, 141-42, *supra* note 4 (describing the importance of the process of awarding reparations in acknowledging harms, establishing social belonging by recipients, and increasing civic trust).

584 Brandon Hamber, *supra* note 6, at 135 (arguing that the social and psychological ramifications of reparations should be prioritized more and the legal and technical dimensions less). *See also* Jamie O’Connell, *supra* note 3.

585 Dinah Shelton, *The UN Principles and Guidelines on Reparations: Context and Contents*, in OUT OF THE ASHES: REPARATION FOR VICTIMS OF GROSS AND SYSTEMATIC HUMAN RIGHTS VIOLATIONS, *supra* note 4, at 11, 31-33; Heidy Rombouts et al., *The Right to Reparation for Victims of Gross and Systemic Violations of Human Rights*, in OUT OF THE ASHES: REPARATION FOR VICTIMS OF GROSS AND SYSTEMATIC HUMAN RIGHTS VIOLATIONS, *supra* note 4, at 345, 451; U.N. GAOR, Basic Principles and Guidelines on the Right to a Remedy and Reparation for Victims of Gross Violations of International Human Rights Law and Serious Violations of International Humanitarian Law, U.N. Doc. No. A/RES/60/147 (Mar. 21, 2006). *But see* Christian Tomuschat, *Individual Reparation Claims in Instances of Grave Human Rights Violations: The Position under General International Law*, in STATE RESPONSIBILITY AND THE INDIVIDUAL: REPARATION IN INSTANCES OF GRAVE VIOLATIONS OF HUMAN RIGHTS I, 25 (Albrecht Randelzhofer & Christian Tomuschat eds., 1999) (“Our provisional conclusion is that there is much room for individual reparation claims within the framework of specific treaty regimes...[However, u]nder general international law...it would be unwise to suggest that the traditional system of State responsibility should be replaced by a system where the holder of

the new rights deriving from an internationally wrongful act would be, as a rule, the individual having directly sustained the damage in issue.”).

586 Jaya Ramji, *A Collective Response to Mass Violence: Reparations and Healing in Cambodia*, in BRINGING THE KHMER ROUGE TO JUSTICE: PROSECUTING MASS VIOLENCE BEFORE THE CAMBODIAN COURTS 359, 360 (Jaya Ramji & Beth Van Schaack eds., 2005).

587 *See, e.g.*, Comm. on Hum. Rts., Subcomm. on Prevention of Discrimination and Protection of Minorities, Special Rapporteur, *Study Concerning the right to restitution, compensation, and rehabilitation for victims of gross violations of human rights and fundamental freedoms*, ¶ 137, sub-¶¶ 8-II, U.N. Doc. E/CN.4/Sub.2/1998/8 (July 2, 1993) (by Theo Van Boven) (listing restitution, compensation, rehabilitation, and satisfaction and guarantees of non-repetition). Reparations may, of course, have other goals, but we focus here on those most relevant to the context of mass human rights abuses.

588 David Gray, *Book Reviews*, 4 INT’L J. TRANSINT’L JUST. 296 (2010).

589 Jaya Ramji, *supra* note 9, at 366 & 368. *See also* Heidy Rombouts et al., *supra* note 8, at 460.

590 Law on the Establishment of Extraordinary Chambers in the Courts of Cambodia for the Prosecution of Crimes Committed during the Period of Democratic Kampuchea, art. 39, NS/RKM/1004/006, Oct. 27, 2004 [hereinafter ECCC Statute]; ECCC, Internal Rules of the Extraordinary Chambers in the Courts of Cambodia, r. 23^{quinquies} [hereinafter ECCC Internal Rules]; David Boyle, *The Rights of Victims*, 4 J. INT’L CRIM. JUST. 307, 312 (2006) (noting that the right to claim reparation is a primary reason for becoming a Civil Party at the ECCC).

591 Int’l Crim. Ct. (ICC), Rome Statute of the International Criminal Court, art. 75, U.N. Doc. A/CONF.183/9 (1998).

592 Rome Statute, *supra* note 14, art. 79; Pablo de Greiff & Marieke Wierda, *The Trust Fund for Victims of the International Criminal Court*, in OUT OF THE ASHES: REPARATION FOR VICTIMS OF GROSS AND SYSTEMATIC HUMAN RIGHTS VIOLATIONS, *supra* note 4, at 225.

593 Prosecutors v. Kaing, Case No. 001/18-07-2007-ECCC/TC, at 240-41 (July 26, 2010); Patrick Falby, *Cambodia KRouge court leaves victims disappointed*, AFP (Sept. 13, 2010).

594 Brandon Hamber, *supra* note 6, at 149.

595 ECCC, Transcript of Trial Proceedings—Kaing Guek Eav “Duch,” Case File No. 001/18-07-2007-ECCC/TC, at 26 (Aug. 25, 2009) [hereinafter 25 Aug. 2009 transcript].

596 ECCC, Transcript of Trial Proceedings—Kaing Guek Eav “Duch,” Case File No. 001/18-07-2007-ECCC/TC, at 64 (Aug. 20, 2009) [hereinafter 20 Aug. 2009 transcript].

597 ECCC Internal Rules, *supra* note 13, r. 85(1) (“The President may exclude any proceedings that unnecessarily delay the trial, and are not conducive to ascertaining the truth.”).

598 ECCC, Transcript of Trial Proceedings—Kaing Guek Eav “Duch,” Case File No. 001/18-07-2007-ECCC/TC, at 13 (June 30, 2009).

599 20 Aug. 2009 transcript, *supra* note 19, at 28-29.

600 ECCC, Transcript of Trial Proceedings—Kaing Guek Eav “Duch,” Case File No. 001/18-07-2007-ECCC/TC, at 14 (July 1, 2009).

601 ECCC, Transcript of Trial Proceedings—Kaing Guek Eav “Duch,” Case File No. 001/18-07-2007-ECCC/TC, at 71 (Aug. 24, 2009).

602 Patrick Falby, *supra* note 16.

603 Dinah Shelton, *The Gender of Reparations*, 32 HUM. RTS. Q. 447 (2010) (noting that tribunals often fail to consider gender issues when designing reparations).

604 ECCC, Transcript of Trial Proceedings—Kaing Guek Eav “Duch,” Case File No. 001/18-07-2007-

ECCC/TC (Nov. 23, 2009) [hereinafter 23 Nov. 2009 transcript].

605 *Id.*

606 ECCC, Office of the Co-Investigating Judges, Case File No. 002/19-09-2007-ECCC-OCIJ (Closing Order Sept. 15, 2010), available at www.eccc.gov.kh/en/documents/court/closing-order. See also Beth Van Schaack, *Forced Marriage and the Khmer Rouge*, IntLawGrrls (Oct. 7, 2010), <http://intlawgrrls.blogspot.com/2010/10/forced-marriage-and-khmer-rouge.html>.

607 23 Nov. 2009 transcript, *supra* note 27.

608 *Id.* at 50.

609 ECCC, Transcript of Trial Proceedings—Kaing Guek Eav “Duch,” Case File No. 001/18-07-2007-ECCC/TC (Aug. 3, 2009) [hereinafter 3 Aug. 2009 transcript].

610 See, e.g., *id.* (During day 52 of trial, the President issued at least four reminders to a witness, Mr. Sek Dan, to wait for the lighted signal before speaking. Mr. Lach Mean, who testified after Mr. Dan was also reminded of this technicality).

611 Jaya Ramji-Nogales, *Designing Bespoke Transitional Justice: A Pluralist Process Approach*, 32 MICH. J. INT’L L. 1 (2010); Charles P. Trumbull IV, *The Victims of Victim Participation in International Criminal Proceedings*, 29 MICH. J. INT’L L. 777, 806 (2008).

612 ECCC Internal Rules, *supra* note 13, r. 23(1).

613 *Id.* r. 23(4). See also James P. Bair, *From the Numbers who Died to those who Survived: Victim Participation in the Extraordinary Chambers in the Courts of Cambodia*, 31 U. HAW. L. REV. 507, 520-530 (Summer 2009) (discussing the difference between victims and Civil Parties to the ECCC).

614 *Id.* r. 59(2).

615 *Id.* r. 23(1)(b).

616 *Id.* r. 12.

617 *Id.* r. 23 *quinquies* (Civil Party Claim:

1. Subject to Article 39 of the ECCC Law, the Chambers may award only collective and moral reparations to Civil Parties. These shall be awarded against, and be borne by convicted persons.

2. Such awards may take the following forms:

- a. An order to publish the judgment in any appropriate news or other media at the convicted person’s expense;
- b. An order to fund any non-profit activity or service that is intended for the benefit of Victims; or
- c. Other appropriate and comparable forms of reparation.

618 Unless paid by external funding. See *id.*

619 See ECCC Internal Rules, *supra* note 13, r. 23 *bis* §1(b) (requiring that a Civil Party must “demonstrate as a direct consequence of at least one of the crimes alleged against the Charged Person, that he or she has in fact suffered physical, material or psychological injury upon which a claim of collective and moral reparation might be based.”).

620 ECCC, Transcript of Trial Proceedings—Kaing Guek Eav “Duch,” Case File No. 001/18-07-2007-ECCC/TC, at 27 (July 26, 2010) [hereinafter 26 July 2010 transcript].

621 Prosecutors v. Nuon, Ieng, Ieng, Khieu, Kaing, Case No. 002/19-09-2007/ECCC-OCIJ, Combined Order on Co-Prosecutors’ Two Requests for Investigative Action Regarding Khmer Krom and Mass Executions in Bakan District (Pursat) and the Civil Parties Request for Supplementary Investigations Regarding Genocide of the Khmer Krom & the Vietnamese (Jan. 13, 2010).

622 See Sarah Thomas, *Civil Party Participation at the ECCC*, IntLawGrrls (July 15, 2008), <http://intlawgrrls.blogspot.com/2008/07/civil-party-participation-at-eccc.html> (discussing the reasons for the ECCC’s change in attitude, from welcoming to exclusionary, toward Civil Parties).

623 Patrick Falby, *supra* note 16.

624 *Id.*

625 23 Nov. 2009 transcript, *supra* note 27. In Case 001, the defense team attempted to dismiss twenty-four of the ninety-three Civil Parties. Patrick Falby, *supra* note 16.

626 ECCC website, www.eccc.gov.kh/english/default.aspx.

627 See, e.g., *UN Supports Victims Unit Chief, Despite Criticism of Many*, CAMBODIA DAILY, at 27 (June 11, 2009).

628 Robbie Corey-Boulet, *Nationality and the Jarvis debate*, PHNOM PENH POST (June 12, 2009).

629 James O’Toole, *Victims Support Head to Retire*, PHNOM PENH POST (May 6, 2010).

630 UN *Supports Victims Unit Chief*, *supra* note 50, at 27. See also Press Release, Cambodian Ctr. for Hum. Rts. (June 10, 2009), http://cchrcambodia.org/index.php?url=project_page/project_page.php&p=press_detail.php&prid=71&id=3.

631 James O’Toole, *supra* note 52.

632 Patrick Falby, *supra* note 16.

633 Calum MacLeod, *History cannot be hidden as Khmer Rouge leaders tried*, USA TODAY (Sep. 15, 2010).

634 Chanda Chhay, *Open Letter to Dr. Helen Jarvis, Appointed Head of the Victims Unit at the Extraordinary Chamber in the Court of Cambodia* (June 20, 2009), <http://ki-media.blogspot.com/2009/06/open-letter-to-dr-helen-jarvis.html>.

635 James O’Toole, *supra* note 52.

636 ECCC Internal Rules, *supra* note 13, r. 22 *quinquies*.

637 26 July 2010 transcript, *supra* note 43, at ¶¶ 652, 654, 656-57 (July 26, 2010). See also A Conversation with Theary Seng, MUJESTIC, www.mujustic.com/theary_seng_case_002.

638 ECCC, Transcript of Trial Proceedings—Kaing Guek Eav “Duch,” Case File No. 001/18-07-2007-ECCC/TC, at 115 (Aug. 17, 2009).

639 26 July 2010 transcript, *supra* note 43, at ¶¶ 667-68.

640 25 Aug. 2009 transcript, *supra* note 18, at 28.

641 Keo Dacil et al., *Searching for the Truth*, Documentation Center of Cambodia’s Outreach Team, DC-CAM MAGAZINE (July 2010). The Court took this disciplinary measure pursuant to its internal regulations requiring that participants’ clothing “may not display slogans” or “indicate their support to a party of the proceedings.” ECCC, Internal Regulations Governing the Courtroom on Hearing Days, r. 2, available at www.eccc.gov.kh/sites/default/files/documents/courtroom/Internal_Regulation_Governing_the_Courtroom_EN.pdf.

642 See Prosecutors v. Nuong, Case No. 002/19-09-2007/ECCC-PTC, Case Information Sheet, available at www.eccc.gov.kh/english/case002.aspx.

643 *Living Documents*, DOCUMENTATION CTR. OF CAMBODIA, www.dccam.org/Projects/Living_Doc/Living_Documents.htm.

644 DOCUMENTATION CTR. OF CAMBODIA, DC CAM ANNUAL REPORT 2010 21 (2010), www.dccam.org/Abouts/Annual/pdf/DC-Cam_2010_Annual_Report.pdf.

645 The DC-Cam has also instituted separate outreach projects targeted specifically at students and minorities in order to further discussion of and knowledge about the Khmer Rouge regime. *Id.* at 27-28.

646 Savina Sirik, *The Duch Verdict: A DC-Cam Report from the Villages*, DOCUMENTATION CTR. OF CAMBODIA, at 17 (July 26, 2010).

647 Savina Sirik, *Village Meeting: Fear Reduced Among Khmer Rouge Lower Level Cadres*, DOCUMENTATION CTR. OF

CAMBODIA (Mar. 23, 2010).

648 DC-CAM ANNUAL REPORT 2010, *supra* note 67, at 25.

649 *See, e.g.*, Savina Sirik, *The Duch Verdict: A DC-Cam Report from the Villages*, *supra* note 69, at 12 (noting that in Banteay Meanchey, conversations continued after the team left).

650 David Gray, *An Excuse-Centered Approach to Transitional Justice*, 74 *FORDHAM L. REV.* 2621 (2006) (noting the problems with participation as reparations, such as the incomplete, abstract, and essentializing nature of testimony and the feeling that harms have not been fully compensated).

651 Ruth Rubio-Marin, *Gender and Collective Reparations in the Aftermath of Conflict and Political Repression*, in *THE GENDER OF REPARATIONS* 381, 399 (2009); Ruth Rubio-Marin, *Introduction*, in *WHAT HAPPENED TO THE WOMEN?* 25 (2006).

652 Rubio-Marin, *Introduction*, *supra* note 74.

653 Rubio-Marin, *Gender and Collective Reparations in the Aftermath of Conflict and Political Repression*, *supra* note 74, at 400.

654 David Gray, *supra* note 73. Rama Mani, *supra* note 4, at 78-80.

655 *Id.* at 68.

656 *Id.* at 68.

657 Ruben Carranza, *Practical, Feasible and Meaningful: How the Khmer Rouge Tribunal Can Fulfill its Reparations Mandate*, *INT'L CTR. TRANSITIONAL JUST.* (Nov. 10, 2009).

658 David Gray, *supra* note 73.

659 Rama Mani, *supra* note 4, at 68.

660 *Id.* at 67.

661 David Gray, *Book Reviews*, 4 *INT'L J. TRANSITIONAL JUST.* 296, 297 (2010).

662 M. Brinton Lykes & Marcie Mersky, *Reparations and Mental Health: Psychosocial Interventions Towards Healing, Human Agency, and Retheorizing Social Realities*, in *THE HANDBOOK OF REPARATIONS* 589, 592-93 (Pablo de Greiff, ed., 2006). *See also* Rama Mani, *supra* note 4, at 71-72.

663 M. Brinton Lykes & Marcie Mersky, *supra* note 85, at 600.

664 *Id.* at 601.

665 Naomi Roht-Arriaza, *Reparations: Decisions and Dilemmas*, 27 *HASTINGS INT'L & COMP. L. REV.* 157, 192-93, 197 (2003) (noting that local-level community reconciliation programs might prove effective where there are many low-level perpetrators, where victims and perpetrators must co-exist, where power disparities between victims and perpetrators are relatively small, and where neither the state nor the perpetrators has the resources to pay monetary compensation).



PART III TRAUMA AND THE FUTURE OF MENTAL HEALTH IN CAMBODIA

9 CAMBODIAN PERSPECTIVES ON THE RESOURCES FOR TRAUMA-RELATED MENTAL HEALTH

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Cambodia's mental health system has many strengths and weaknesses. It also has an incredible task ahead of it, given the huge expectations, overwhelming demands, and very limited resources. The system's ability to deal with the heavy burden of trauma mental health problems has become the topic of scrutiny given proceedings before the Extraordinary Chambers in the Courts of Cambodia (ECCC), which have brought trauma psychology back to the forefront of national and international attention.

Critiques and analyses of the mental health system suggest a number of areas for improvement. Without the *insiders'* understanding of the challenges, complexities, and needs within the system, however, the realities of the story cannot be known. The opinions and thoughts of the dedicated mental health professionals working in Cambodia must be included to complete any discussion of forward progress for the Mental Health System.

This Chapter is a collection of the concerned opinions of some of the providers and administrators working within the web of agencies that interface with trauma-related mental health disorders. Their opinions are presented as quotes in the context of answers to survey questions about the challenges and the future of mental health in Cambodia.

METHODS

This Chapter on Cambodian perspectives about existing and needed resources for mental health attempts to capture the views of those working in the field. The editors of this volume created a survey utilizing open-ended questions to identify the nature of Cambodian

trauma, the concomitant mental health problems experienced by the populace, the systemic challenges inherent to dealing with these problems, and solutions for improving the system as a whole. The survey questions were reviewed and edited by several mental health professionals with familiarity with the situation in Cambodia.

The survey questions were as follows:

1) How does the problem of violence/trauma from the past impact the overall mental health of Cambodians today? How does the trauma of the Khmer Rouge era impact today's Cambodian youth?

១ - តើអំពើហិង្សាពីអតីតកាលដ៏អាក្រក់ ដែលសុទ្ធតាមរយៈវិទ្យុសាស្ត្រប្រជាជនកម្ពុជា ដោយរបៀបណាខ្លះនាំឲ្យមានបញ្ហាបច្ចុប្បន្ន?

.....
- តើអំពើហិង្សារបស់របបខ្មែរក្រហម ដ៏អាក្រក់យ៉ាងដូចម្តេចខ្លះដែលយុវជនកម្ពុជា នាំឲ្យមានបញ្ហាបច្ចុប្បន្ន?

2) What are the major challenges/barriers to treating trauma mental health in Cambodia today?

២ - តើអ្វីខ្លះជាឧបសគ្គក្នុងការព្យាបាលជំងឺផ្លូវចិត្ត ដែលបង្កឡើងដោយរបបខ្មែរក្រហម?

3) In addition to the lack of resources allocated directly to this issue, what other obstacles exist within Cambodian society or within the system of resource provision that might make it difficult to implement interventions?

៣ - បន្ថែមទៅលើការខ្វះខាតធនធាន សំរាប់ការព្យាបាលជំងឺផ្លូវចិត្ត តើមានឧបសគ្គផ្សេងទៀតណាខ្លះនៅក្នុងសង្គមកម្ពុជា និងក្នុងប្រព័ន្ធផ្តល់ធនធាន?

4) What are the best solutions for improving the treatment of trauma-related mental health problems in Cambodia?

៤ - តើអ្វីជាដំណោះស្រាយល្អបំផុត សំរាប់ជំរុញការព្យាបាលជំងឺផ្លូវចិត្ត បង្កឡើងដោយរបបខ្មែរក្រហម កាន់តែមានប្រសិទ្ធភាព?

5) If the government decided to make mental health a priority, how would you like to see these resources utilized? How could the existing institutions within Cambodia be recruited to assist with improving trauma mental health and other issues related to it?

៦ - តើស្ថាប័នដែលមានស្រាប់ នៅក្នុងប្រទេសកម្ពុជា ត្រូវរៀបចំឲ្យមានការព្យាបាលជំងឺផ្លូវចិត្ត ដែលបង្កឡើងដោយរបបខ្មែរក្រហម យ៉ាងដូចម្តេចខ្លះ?

The survey was distributed by the Documentation Center of Cambodia (DC-Cam) in English and in Khmer to identified providers and administrators in health care, mental health, and in parallel social service and education fields that collaborate with the mental health system. DC-Cam collected responses and translated them into English (if necessary). The collection of responses was analyzed, edited, and prepared for presentation. To highlight the direct opinions of the Khmer professionals in the field, minimum commentary was added.

RESULTS

Question I:

How does the problem of violence/trauma from the past impact the overall mental health of Cambodians today? How does the trauma of the Khmer Rouge era impact today's Cambodian youth?

Most practitioners agree that the traumatic experiences of the Khmer Rouge years had a profound effect not only on the psychology of the survivors, but also on their daily behaviors. Generally, this has caused maladaptive patterns that contribute to multiple social problems for the survivors and their families. Poverty and alcoholism are correlated to the psychological effects of trauma.

Violence from the past seriously impacts the mental health of Cambodians. It contributed to terror, PTSD [Post-Traumatic Stress Disorder], revenge, uncontrolled brutality, and sometimes depression and feelings of hopelessness due to the loss of their entire family.

— Dr. Sa Samanry (Phnom Penh Referral Hospital)

It makes people aggressive, intolerant, and irresponsible. Cambodian youth dare not express ideas, and are generally scared. Khmer Rouge violence also causes some people to be cruel and thoughtless; to act however they want without fearing the law or adhering to customs; and to fail to respect older people.

— Dr. Chhuong Sok Heng (Daem Tkov Mrket Referral Hospital)

The problem of violence/trauma has caused mental problems, such as depression and anxiety, which can be sometimes crippling. It impacts most of those families that lost an influential member. It also causes people to drink alcohol, to act in uncivilized ways, to steal donations aimed at helping poor people, to be competitive even in traveling, to change their religion, to be unkind to younger or older people, and to lose trust in the society.

— Dr. Sok Sedbaboth (*Touol Svay Prey Clinic*)

Physical, mental, sexual, and economic violence can affect mental health, and it can especially lead to PTSD. The violence of the Khmer Rouge era can affect youths' mental health, especially when they hear from relatives about violence, brutal torture, rape, forced labor, and starvation under that regime.

— Dr. Doeun Nan (*Chief of the Mental Health Department, Oudong Hospital*)

Overall, it appears as if those who lived through the Khmer Rouge era certainly face a high level of mental disorders related to surviving this time. In addition, there are a myriad of adjustment problems that may not be as severe, but still cause considerable difficulties in the day-to-day life of the individual. Almost inseparable from this is the 'collective effect' that those experiences had on society: a greater lack of trust, higher incidences of violence, emotional repression, a lack of reconciliation as the historical/personal narratives are still not openly shared or taught, and a distrust or fear of government, among others.

— Joe Stewart, MPH (*Institute of Migration*)

The Khmer Rouge era engendered a generalized mistrust and fear, low compassion, and feelings of disempowerment. [This phenomenon gave rise to the] concept of *baksbat* as described by Dr. Sotheara Chhim: a Cambodian response to trauma characterized by low self-esteem, low trust in self-efficacy, a submissive attitude, dependency, easily becoming fearful, etc. Poverty, as a result of the civil war and mental health problems, and alcoholism are mutually dependent.

— Dr. Muny Sothara (*Transcultural Psychosocial Organization*)

It is true that violence from the past impacts all people's health without any exception. For Cambodian people—including farmers, workers, employers, and government officers who have been educated to be kind and polite in their families—the impact on their mental health was harsh. This can be shown through their manners, social communication, and ways of thinking. It is not easy to heal these scars. For children, it unavoidably prevents them from fully expressing their intelligence and capacity.

— Dr. Leng Cheng Ang (*Oudong Meditation Center*)

Our participants also expressed the general concern that these changes created problematic parenting styles and created psychological symptoms and behavioral problems in the next generation.

Our youth may learn of bad experiences from their family members who have endured the Khmer Rouge regime. These stories may influence Cambodian youths by making them malicious, violent, inhuman, etc. Some children and youths are orphaned, so their psychological growth is different from that of people who are living with their family.

— Dr. Yim Botra (*Sunrise Mental Health Clinic*)

[There is a] role reversal in families (whereby children care for the psychological needs of parents) and an over-protectiveness in parents (e.g., children are not allowed to get politically engaged). Distrust in parents' accounts may lead to resistance and withdrawal. Poor identification with parents' suffering/silence may cause identity problems in children. Low education and knowledge among parents prevents them from communicating with their children about past experiences; this may lead to disrespect on the side of the children.

— Dr. Muny Sothara (*Transcultural Psychosocial Organization*)

[The Khmer Rouge had] no direct impact on them, but children inherit psychological problems from older people—their self-pity, neglect, and limited capacity to work. These things limit the opportunities of youths. Some parents provide excess freedom to their children, allow them to take risks, join unhealthy groups, abandon good habits, reject the advice of older people, ignore their ancestors, and dislike their own history.

— Dr. Sok Sedbaboth (*Touol Svay Prey Clinic*)

This is very difficult to answer...It has been more than 25 years since the Khmer Rouge era (1975-78). As all the Cambodian youth (15-24 years) were born after this period, we cannot say that the KR era has a direct impact on the youth today. But the question is: can there be indirect effects (vicarious trauma) on young people inter-generationally transmitted by their parents?

— Dr. Bhoonikumar Jegannathan (*Program Director and Consultant Child Psychiatrist, Chey Chumnas Hospital*)

With regard to Cambodia's youth, many have said that the parents have either 'over-parented' or 'under-parented,' which has resulted in some challenging developmental issues for Cambodia's youth. At an individual level, a parent who struggles with mental health problems may not be as available to nurture their

children. Perhaps the children will inherit/learn this manner of behavior as they grow up, which could be maladaptive. Socially, being raised in a culture still coming to terms with this time may bring with it certain challenges.

— Joe Stewart, MPH (*Institute of Migration*)

Question 2:

What are the major challenges/barriers to treating trauma mental health in Cambodia today?

Many problems are identified as challenges and barriers for treating trauma mental health today in Cambodia. Poverty of the potential client and lack of financial resources for providers were both cited as common issues.

Poverty. No support from family (due to the loss of them). Limited education and illiteracy. Limited knowledge. Fragile psychologies due to the Khmer Rouge regime.

— Dr. Sa Samanry (*Phnom Penh Referral Hospital*)

Poor living conditions prevent patients from regularly receiving treatment.

— Dr. Doeun Nan (*Chief of the Mental Health Department, Oudong Hospital*)

Poor living conditions. For instance, high expenses for families, lack of working capacity, and illiteracy due to poverty. Scarce government officers and civil servants, and retired people have poor living conditions.

— Prak Kimly (*Chief of Nuns, Oudong Meditation Center*)

Funding cycles from private money donors create a competitive and sometimes non-cooperative spirit among providers that can get in the way of service provision. It seems that agencies cannot see beyond the needs of their own program as a result of poor funding pools and competition for those resources.

— Sotheara Chhim (*Transcultural Psychosocial Organization*)

Other commonly identified challenges include lack of organization and lack of adequate human resources in the area of mental health and limitations in the skill level of qualified treating professionals.

An inadequate [number of] trained mental health professionals. (Cambodia has about twenty psychiatrists and forty psychiatric nurses for a population of 14.5 million!)

— Dr. Bhoomikumar Jegannathan (*Program Director and Consultant Child Psychiatrist, Chey Chumnas Hospital*)

Lack of human resources (no specialists), lack of budget, [and] insufficient medicines.

— Dr. Doeun Nan (*Chief of Mental Health Department, Oudong Hospital*)

Lack of human resources or special techniques to treat only PTSD. No specific medicine. Only Tricyclic Antidepressants have been used. The developed countries now use Lesotonine, Selective [Serotonin] Reuptake Inhibitors (SSRI's), etc. Members of the community do not really understand PTSD. Mental problems have not been prioritized.

— Dr. Yim Botra (*Sunrise Mental Health Clinic*)

We do not have enough human resources and services to treat all Cambodian people who have mental problems. We're trained in limited techniques to cure mental problems. [We work with poor] equipment to measure and evaluate the problem. There is no suitable center to cure mental problems.

— Ang Sody (*Transcultural Psychosocial Organization*)

The low priority given to mental health within the public health care system is noted as a recurring issue. Lack of financial resources for providers emerges as a limitation for developing the infrastructure to handle the issue adequately. These observations call for improved integration of mental health services within the public health system, as well as public health campaigns to eliminate the stigma associated with mental health.

Mental health care is low priority in Cambodia. Most health officers do not really understand mental health problems. The mental health system's budget is low. In general, healthcare providers focus on physical problems rather than mental health problems. Mental health policy is ineffective, and does not match the real needs of the populace.

— Prof. Ka Sunbonat (*Director, National Program for Mental Health*)

Mental health issues are not integrated at the primary care level, and there is a lack of institutional commitment, leadership, and political will.

— Dr. Bhoomikumar Jegannathan (*Program Director and Consultant Child Psychiatrist, Chey Chumnas Hospital*)

Stigma is also one of the obstacles. There are limited services.

— Dr. Yim Botra (*Sunrise Mental Health Clinic*)

A primary obstacle is the lack of an effective-working plan. Who is going to do that?

— Dr. Leng Cheng Ang (*Oudong Meditation Center*)

These challenges are synthesized in the following remark:

There are many challenges and barriers to treating trauma mental health...The general awareness of mental health is low; this also applies to trauma-specific mental health issues. Many people spend lots of time and money on ineffective (and sometimes harmful) treatments as a result. As such, even for those that know that they are suffering from a trauma-related mental health problem, there is a great lack of available, effective services.

Additionally, the services that do exist are not often all encompassing in that they don't combine social work, psychology, and psychiatry. That problem is caused by lack of human and financial resources in Cambodia with regards to mental health.

Within the human resources that exist, the knowledge/training level is low, especially with regard to trauma mental health. Given the complexity and severity of trauma-related mental disorders, much training and experience is needed to provide quality care. As of yet, the treatment modalities are not particularly culturally sensitive, as they borrow mainly from Western paradigms. The lack of human and financial resources can be attributed to poor leadership (caused by ongoing conflicts) within the mental health sector of the Cambodian Health System. This lack of leadership also impedes their work with non-governmental organizations (NGOs) and international organizations.

Finally, there are a number of stakeholders who are not in favor of putting too much focus on the 'trauma' aspect of mental health in Cambodia, given that there exists a great burden of other mental health problems. By this view, the entire mental health system ought to be developed more before too much focus is placed on developing specialized services.

— Joe Stewart, MPH (*Institute of Migration*)

Question 3:

In addition to the lack of resources allocated directly to this issue, what other obstacles exist within Cambodian society or within the system of resource provision that might make it difficult to implement interventions?

Poverty as an obstacle to obtaining mental health treatment emerged as a recurrent theme. Free treatment was suggested, which would require government or outside funders for financial support.

Provide sufficient medicines and financial encouragement. The Ministry of Health should use all their capacity to treat patients injured by the Khmer Rouge regime. . . . Mental health problems have not been introduced broadly to the authorities and community. [There must be] money to encourage service providers. [The services must be] provided free of charge for the patients.

— Dr. Doeun Nan (*Chief of Mental Health Department, Oudong Hospital*)

Also, stigma about mental illness and a lack of public awareness about psychiatry and treatment approaches are frequently highlighted as problems.

Broaden the broadcast system to teach people about mental health and mental problems. Continue healing people who have problems. Search for people who are not aware of their problems in the community and provide them a suitable treatment. Provide support and encourage patients to come and receive treatment. Establish self-help groups in the community.

— Dr. Kaet Chhunly (*Russia Hospital*)

The overwhelming beliefs, selfishness, family biases, lack of solidarity and knowledge relating to psychology, and limited resources donated from outside the country.

— Dr. Sok Sedhaboth (*Touol Svay Prey Clinic*)

Lack of awareness about mental health. Social stigma: Patients may perceive themselves as weak if they have mental health problems. The perception of patients that the only effective treatment available is medication. Limited personnel and financial resources allocated in the field of mental health. Poverty: Patients cannot afford the cost and time to travel and seek treatment.

— Dr. Muny Sothara (*Transcultural Psychosocial Organization*)

Question 4:

What are the best solutions for improving the treatment of trauma-related mental health problems in Cambodia?

Improving the profile of mental health in the public health system was a salient theme for improving matters. Respondents also cited the need for greater

integration of, and collaboration by, services that deal with trauma-related mental health issues directly and/or indirectly.

A couple of solutions: we need a comprehensive mental health program that is integrated in the primary (MPA—minimum package of activities) and secondary (CPA—complementary package of activities) levels of the health care system.

— *Dr. Bhoomikumar Jegannathan (Program Director and Consultant Child Psychiatrist, Chey Chumnas Hospital)*

Strengthen treatment and mental health care services, provide sufficient treatment and care services, set up a place to help crippled people who have been treated, disseminate more information about mental health treatments, facilitate the ability of patients to receive treatment, and create a good network and trust among providers and the community.

— *Dr. Sa Samanry (Phnom Penh Referral Hospital)*

Many responders commented that any treatment approach must be culturally-specific.

We must create mental health services that meet the needs within Cambodia's specific culture and situation, and avoid copying [intervention models] completely from other countries. We must increase the understanding of mental health and strengthen mental health programs at a community level. To do this, an understanding of psychology of Khmer individuals and Khmer society is necessary.

— *Prof. Ka Sunbonat (Director, National Program for Mental Health)*

Understanding the psychological aspect of trauma is only one part of a complicated cycle. The Transcultural Psychosocial Organization (TPO) put special emphasis on the holistic approach to strengthen communities.

The most important interventions are at the community level. The most successful programs are those that work toward strengthening community resources. Psychological/psychiatric interventions alone are not enough. We have to improve the social system.

— *Dr. Sotheara Chhim (Transcultural Psychosocial Organization)*

An integrated approach to trauma-related mental health problems by combining psychological, social, and economic interventions, and by fostering social cohesion. Integrating mental health as cross-cutting issue in rural development and livelihood programs.

We need to combine community-based interventions with specialized services. Community-based support structures (such as self-help groups) are most effective in preventing and dealing with mental health and psychosocial problems. Severe cases should be referred to specialized treatment centers.

— *Dr. Muny Sothara (Transcultural Psychosocial Organization)*

The TPO also recommends improvement of measurement methods, of which interventions are the most useful for understanding best practices for programs and systems.

There is poor critical analysis of outcomes [of treatment interventions]. There are no great studies. We have evaluations of programs, but no systemic, controlled trials of outcomes.

— *Dr. Sotheara Chhim (Transcultural Psychosocial Organization)*

Question 5:

If the government decided to make mental health a priority, how would you like to see these resources utilized? How could the existing institutions within Cambodia be recruited to assist with improving trauma mental health and other issues related to it?

Most respondents agree that more serious government attention and resources will be a key factor. Greater training in the specialized area of trauma mental health emerged as a recurring theme in our responses. This suggests a role and responsibility for the government to coordinate and ensure ongoing training in trauma mental health.

Strengthen and respect the existing work.

— *Prof. Ka Sunbonat (Director, National Program for Mental Health)*

Training of the existing service providers to provide effective and efficient medicines and broaden the mental health community. Private service could also partner with the government to help the patients.

— *Dr. Yim Botra (Sunrise Mental Health Clinic)*

Train more specialists and disseminate more information regarding mental health via the media.

— *Dr. Kim Sopheap (Oudong Referral Hospital)*

Better education for existing human resources. Increase services that serve mental patients in referral hospitals and health centers. Educate people living in the community about mental health problems. Do more research and provide the results to the Ministry of Health.

— *Ang Sody (Transcultural Psychosocial Organization)*

Broaden and strengthen mental health treatment services in the whole country from the national level to the community level. Broaden the broadcast system to teach people about mental health and mental problems. Train prominent people in the community, such as traditional healers whom residents first approach for help, on mental health and mental problems.

— *Dr. Kaet Chhunly (Russia Hospital)*

Provide more consultations with patients, including adequate medicine, and offer more support by strengthening capacity.

— *Dr. Chhuong Sok Heng (Daem Tkov Market Referral Hospital)*

There are existing institutions like the Ministry of Religious Affairs and the Ministry of Education in Cambodia that can be mobilized. These two Ministries are obligated to educate people and to find work for all people in accordance with their capacities.

— *Dr. Sok Sedboth (Touol Svay Prey Clinic)*

Educate and train more doctors and consultants and connect them to the relevant institutions. Introduce the governmental organizations to the impact [of mental health] and [to the] difficulties of people who have mental health problems.

— *Ang Sody (Transcultural Psychosocial Organization)*

More collaboration between agencies that focus on mental health and/or social problems with a mental health component will be an essential part of the solution with cross-training as a focus. Also, more cross collaboration between agencies that may not usually treat mental health issues, like primary care medicine, was recommended.

Strengthen the existing service and broaden it to the base area, increase core doctors, create direct community ties, consultations and follow up by groups or individual psychiatrists, and spend some resources on medicine. Research, cooperate with information providers, directly travel to villages and communities that have numerous trauma patients, try to increase the capacity and trust of those who try to hide themselves from the health system, and try to explain to patients the impact

of the past.

— *Prak Kimly (Chief of Nuns, Oudong Meditation Center)*

Comprehensive mental health promotion programs that are integrated into the educational, social, and economic sectors. Perhaps it is time to move away from the ‘trauma-related mental health model’ to a more comprehensive mental health development and promotional model.

— *Dr. Bhoomikumar Jegannathan (Program Director and Consultant Child Psychiatrist, Chey Chumnas Hospital)*

The government should focus on using all its knowledge to create a plan. [The government] should implement [the plan] transparently and announce it publicly in order to encourage participation from the people.

— *Dr. Leng Cheng Ang (Oudong Meditation Center)*

There needs to be more focus on building infrastructure and encouraging joint projects/programming within the governments and NGOs, which would probably involve investing more energy in improving the capacity for leadership and advocacy.

— *Joe Stewart, MPH (Institute of Migration)*

Many of these themes are summarized in the following statement:

Increase number and capacities of mental health professionals. Integrate specialized services in general hospitals. Support psychotherapeutic approaches by allocating resources: time, space, and incentives for clients and doctors. Specific services for survivors of Khmer Rouge-related trauma. In hospitals/public sector: increase capacities for identifying trauma cases and offering primary care and refer—if necessary—to specialized centers.

TPO should be promoted to become a specialized centre for trauma treatment, as the organization has long-term expertise in trauma treatment combining psychiatric and psychological interventions, as well as Western and indigenous approaches. Foster/establish referral networks and inter-organizational exchange. Establish/promote cooperation between trauma treatment centers and other agencies such as: organizations providing vocational training, legal aid, DC-Cam, research institutes, etc. Improve research capacities of Cambodian psychiatrists and psychologists and implement research on the effectiveness of trauma treatment in Cambodia.

— *Dr. Muny Sothara (Transcultural Psychosocial Organization)*

CONCLUSION

There is some consensus among Cambodian providers and administrators about areas of strength and weakness in the system for treatment of trauma-related mental health. Current mental health limitations include limited financial resources, few professional training programs, and few opportunities for continuing education. Also, a lack of coordination of resources and personnel seems to be a consistent concern. Within programs, there is concern about low sustainability and about barriers to access to care (especially given the low financial resources of most afflicted individuals).

Strengths include great dedication among current mental health leaders and providers, and enthusiasm among providers for enhanced collaboration and coordination. There is a great desire among providers for continuing education and for increased mental health awareness within the general public.

END NOTES

666 Contributors to this Chapter: Dr. Leng Cheng Ang (Oudong Meditation Center), Dr. Yim Botra (Sunrise Mental Health Clinic), Dr. Sotheara Chhim (Transcultural Psychosocial Organization), Dr. Kaet Chhunly (Russia Hospital), Dr. Chhuong Sok Heng (Daem Tkov Mrket Referral Hospital), Dr. Bhoomikumar Jegannathan (Program Director and Consultant Child Psychiatrist, Chey Chumnas Hospital), Prak Kimly (Chief of Nuns, Oudong Meditation Center), Dr. Doeun Nan (Chief of the Mental Health Department, Oudong Hospital), Dr. Sa Samanry (Phnom Penh Referral Hospital), Dr. Sok Sedhaboth (Touol Svay Prey Clinic), Ang Sody (Transcultural Psychosocial Organization), Dr. Kim Sopheap (Oudong Referral Hospital), Dr. Muny Sothara (Transcultural Psychosocial Organization), Joe Stewart, MPH (Institute of Migration), and Prof. Ka Sunbonat (Director, National Program for Mental Health).



10

ANALYSIS OF TRAUMA-RELATED MENTAL HEALTH RESOURCES IN CAMBODIA: CONSENSUS IDEAS FOR AN IMPROVED METHOD

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Joe Stewart (M.A.) worked as an intern with the International Organization for Migration in Cambodia.

This Chapter will examine the issue of trauma-related mental health in the context of the current Cambodian system for interventions and treatments. It provides an external perspective of the problems and solutions within the system for trauma-related mental health issues, based on the reports of providers and administrators within the system of care. The intent is to provide an objective report of the current strengths and weaknesses by synthesizing inputs from the people most familiar with the current system.

SPECIAL ISSUE OF TREATING TRAUMA PSYCHOLOGY

Cambodia has a history of tremendous violence and many of its citizens have had great exposure to severe traumatic experience, which has been highlighted and detailed throughout Part I of this volume. Based on empirical studies of trauma, and Cambodia's history of violence, it is predicted that the psychological consequences of trauma will have a strong impact on many systems including, but not limited to, the mental health system.

Trauma-related mental health issues are complicated because the consequences of trauma on psychology have manifestations in multiple spheres of human experience. The psychological outcomes of trauma are well known to mental health professionals, but associated behaviors have far reaching consequences outside the realm of psychiatry and

psychology. While resources for trauma-related mental health issues are often assumed to be only connected with a mental health system, the effects will be seen across systems of health care, social services, and an array of other fields.

Trauma-induced anxiety disorders (e.g., posttraumatic stress disorder) and their comorbidities, or psychiatric and behavioral problems that often occur simultaneously (e.g., major depressive disorder and alcoholism) are viewed by mental health professionals as primary examples of trauma-related mental health problems. It is clear from the perspective of mental health professionals that these disorders should be treated within a system of mental health. For individuals experiencing symptoms of these conditions, however, the mental health system is not necessarily the first place to turn for care.

Symptoms and behaviors related to anxiety and depression will often be experienced and/or interpreted in a variety of ways. In Cambodia, for example, anxiety symptoms may be experienced as physical symptoms (heart pounding, upset stomach, headache) or as a spiritual problem (bad luck, bad karma, being haunted). Additionally, the individual suffering from these difficulties may present to different entry points (like the temple rather than a mental health clinic) for care and enter treatment. Some Cambodians may turn to the mental health system for care, but more likely they will go to a family elder, a monk, a primary medical provider, or a traditional healer. Some may not seek an intervention of any kind. Nevertheless, the behaviors may result in interactions with social service agencies or the criminal justice system, as when they leading to other problems like domestic violence or substance abuse.

Trauma-related mental health symptoms are so varied that they may be understood differently by different people, and therefore, a person may enter treatment through a wide array of possible resources. Furthermore, there may not be a common understanding of the underlying problem. Monks, *Kruu* (Cambodian traditional healers), psychologists, and police may have very different interpretations of the symptoms and behaviors of persons with trauma-related mental health problems, and each of these professions may interact with these symptoms and behaviors in different contexts. For this reason, a wide net must be cast to best understand the real resources for trauma-related mental health in Cambodia. In addition, a broad social perspective must be considered to understand the ripple effects of trauma-related mental health throughout contemporary Cambodian society.

METHOD OF DATA COLLECTION FOR THIS PROJECT

Two separate studies were recently performed that analyze the resources for trauma-related mental health disorders interventions. In the summer of 2010, Joe Stewart performed a qualitative study of Cambodia's mental health system for the International Organization for Migration.⁶⁶⁷ The overall purpose of Mr. Stewart's research study was to evaluate the current

mental health situation in Cambodia, to understand cultural contexts of mental health in Cambodia, and to generate recommendations for the future direction of the field. Based on a background literature review and informational interviews with mental health professionals, the research design and interview questions were developed. After ethics approval was obtained in both Cambodia and in the United States, the evaluation was conducted using qualitative, semi-structured interviews with 15 key stakeholders in Cambodia who were nominated by peers. Critical themes were identified in each transcript, and from those, overarching core concepts were developed. Mr. Stewart's study was not focused specifically on trauma-related mental health, but more generally on the overall delivery of mental health services.

An independent study was performed in the fall of 2010 through the Documentation Center of Cambodia by psychiatrists Jim Boehnlein and Daryn Reicherter to examine resources specifically designed for the treatment of trauma-related mental health issues.⁶⁶⁸ The purpose was to identify the resources for survivors of trauma within the mental health system or in the parallel social services. While the focus of Drs. Boehnlein and Reicherter's interviews remained in mental health, it was clear that opinions from other disciplines were necessary to understand how Cambodians interface with other systems in their attempts to get help for problems related to trauma. The researchers' data points, therefore, included interviews with prominent persons from an interdisciplinary system of services that included mental health, primary health care, social work, religious institutions, nongovernmental organizations (NGOs), education, and government programs.

Each study was completed independently, without knowledge of the other study. It was only later that the independent researchers came together to discuss results and collaborate for the production of this Chapter. The two studies included many overlapping data points and obtained similar results and conclusions. Thus, the results presented in this Chapter are as a consensus of multiple opinions summarized by the researchers.

MAJOR STRENGTHS IN RESOURCES FOR TRAUMA-RELATED MENTAL HEALTH ISSUES

Cambodia has many areas of strength with regard to resources for trauma-related mental health. Cambodia has an intact, functioning system for the treatment of mental health and substance abuse disorders. There is a government-supported, national program in place that has some resources and is committed to the treatment of mental illness. That system understands trauma-related mental health issues as an important topic within the spectrum of disorders that they treat. Many post-conflict societies do not have a functioning mental health system at all, or may have an entirely non-functioning system that exists in name only, without any real capacity or efficacy. Though it may have challenges with regard to financial and human resources, Cambodia has the framework for an effective mental health system.

The mental health system has a commitment to deliver a decentralized, community-based program. It also exists as part of a larger government-supported medical health program: the Ministry of Health. The government system is interested in cooperating with other brokers of services for mental health, such as NGOs and private providers. The NGOs and the government program already share some ideas and cross training.

There is a strong focus on trauma-related mental health among NGOs in Cambodia, with several agencies addressing trauma-related mental health as their primary mission. Many of these agencies are well established and have been providing quality services for long periods of time. This has led to creative approaches and improved conceptualization of the problem. Sotheara Chhim, the clinical director of the Transcultural Psychosocial Organization (TPO), has run a program for many years that specifically targets trauma-related mental health as its primary mission. The TPO has become a model for treating traumatized Cambodian survivors. In addition, there is a network of social service NGOs that deal with issues indirectly related to trauma-related mental health. This general sense of willingness for greater cooperation and collaboration within the NGO network and between government agencies has led to a growing general understanding of the importance of psychological factors affecting those served by these agencies.

Another area of great strength is the professional and intellectual quality of individuals working in the field. There are dedicated and wise individuals throughout the system with long track records of personal devotion to serving others. There also seems to be reasonable attempts to obtain advice from professionals outside of Cambodia, as well as the drive to take seriously the collaborations and recommendations from experts in the field of trauma psychology. For instance, Sek Sisokhom, chair of the master's program in clinical and counseling psychology at the Royal University of Phnom Penh, sponsors courses taught by foreign experts in psychology. In addition, TPO hires foreign experts as advisers for program development and research. Many creative and thoughtful approaches have been explored that mix culturally specific Khmer concepts with Western psychology theories.

The special application of psychological interventions in a cultural context is not a new concept for providers of mental health in Cambodia. For example, promising synergies of crossing Western psychological concepts with Khmer Buddhism have been explored, studied, and applied. Professor Ka Sunbaunat of the National Mental Health Program has collaborated with Buddhist monks to integrate spirituality into a comprehensive approach to trauma-related mental health for Cambodians. He believes that the mindfulness meditation approach of the monks can complement the cognitive behavioral therapy of Western psychology. There are also the beginnings of cross-training between other health care and social service disciplines on the topic of trauma-related mental health.

Another significant strength is that there is a growing awareness and understanding about mental health issues in Cambodia. While the stigma associated with mental illness and the general lack of public awareness will be discussed later in this Chapter as a challenge, the direction toward growth is positive. Chhit Sophal, the Deputy Director of the National Program on Mental Health, reported that there is a trend toward improvement in the general public's understanding of mental health issues. Furthermore, there is a definite sense among providers that mental health awareness is growing across the health care, government, and education sectors.

The combination of these strengths inspires the hope that improvement in the resources for, and delivery of, trauma-related mental health services is possible. This statement is not made lightly. There are many systems of health care in other countries in the world with fewer strengths and less hope for real improvement. Cambodia's system, however, seems to have fundamental strengths that set it apart. It is the consensus opinion from the contributors within the system and from the authors of this Chapter that there is great potential for real growth and improvement in this area for Cambodia.

MAJOR THEMES OF CHALLENGES

As in many developing countries around the world, adequate and consistent funding of mental health services remains a challenge in Cambodia. There is a great deal of competition among all sectors of health care for scant government funding of health services, and less than one percent of available health care dollars is allocated towards mental health care. Trauma-related mental health was only recently identified as an area requiring specific services.

Factors within the public health and international development sectors of Cambodia also create challenges. For example, funding streams are unpredictable, which affects both the creation and maintenance of mental health service programs and projects. A lack of consistency and sustainability not only affects the availability of treatment services, and therefore the patients' mental health, but it also influences the recruitment and retention of talented mental health professionals. Dr. Chhim, from TPO, exemplified his concern by describing the closure of a project due to the end of funding cycles, forcing the elimination of some services and the loss of a number of jobs. Unstable funding also may contribute to negative competition among agencies and organizations instead of creative collaborations that would enhance the synergy of mental health program development and maintenance. This competition contributes to poor communication within the various sectors, including governments and NGOs, responsible for funding and creating mental health programs. In turn, poor communication can perpetuate discontinuity of program development and the long-term stability of successful education or clinical programs.

The limited financial capital is reflected in the scarcity of trained human resources in the mental health professions. There are only forty-six psychiatrists throughout the country and most work in the area around Phnom Penh. There is only one child psychiatrist for the entire country, Dr. Bhoomikumar Jegannathan. The doctor expressed his concern for the overwhelming burden revealed by these statistics.

Within the past few years, graduate programs have been created to train more professionals in other mental health professions. At the Royal University of Phnom Penh, the masters program in clinical and counseling psychology began in 2008-2009, with the first class graduation in late 2010. Likewise, the bachelors and masters level programs in social work have existed for only a few years. Because these are new programs, there are not yet any defined roles for these professionals that allow either the professionals themselves or the programs to optimally utilize the graduates' talents and abilities in service delivery.

In the existing culture of Cambodian mental health professionals, there exists little supervision or continuing education beyond the years of formal schooling and training. This can be attributed to many factors: the lack of structure or tradition for continuing education once the training years are completed, insufficiently experienced supervisors to provide ongoing supervision, and limited funding for continuing education. As a result, the further development of treatment skills stagnates and treatment providers do not have a means to collaborate in a meaningful professional network.

Cambodia also lacks a tradition of collaboration among the various mental health professions in the areas of education and clinical service. Since there has been only a very brief history of psychology and social work in Cambodia, opportunities to create and sustain collaborative patient care models have been limited. Additionally, little incentive and focus is placed on building administrative and policy-level skills within the various sectors and at the policy and administrative levels within the various sectors. Talented young professionals may be discouraged by the lack of opportunities for creative careers or by the lack of stability in funding that would allow successful programs to continue. Providing incentives for performance, creativity, and collaboration among administrators and program directors can be vitally important in improving the mental health system.

Perhaps the most pertinent challenge that arises from the lack of financial and human resources is the poor access to mental health care across Cambodia. There are significant logistical challenges in providing a national system of care, complicated by geographical and financial limitations. Particularly in rural areas, villagers described practical issues that limited their ability to access general and mental health care. For example, rural villagers and those in small towns have traditionally had limited transportation access to district health centers and hospitals; a trip back and forth to a provincial clinic often would take all day.

Because of the length of the trip, they needed to ask a friend or family member to come to their farm to feed their animals while they were away. For middle aged and elderly villagers who had children living in Phnom Penh this was often not possible because their children were working full-time jobs or had responsibilities for their own children. In addition, the cost of transportation limited access, and the trip over rugged roads was difficult for elderly people who had additional medical problems. Only in recent years have there been improvements in the national highway network that would allow for easier access to health care facilities. Finally, among those mental health services that exist, some are provided by NGOs with target beneficiaries, such as women and children, and are not available to other demographics.

Serving as an additional barrier to care access is the traditional stigma of psychological and emotional illness. This is, of course, not unique to Cambodia and is apparent in many countries throughout the world. The fact that this stigma exists, however, has been an important factor impeding the awareness of mental distress and mental health needs, as well as impeding the creation of programs for training mental health professionals and the funding ongoing services. Partially because of this stigma, there has not been adequate awareness of how psychological and emotional distress impact physical illness, and how this distress impacts family cohesion, and the ability to adequately function in school, at work, or in other sectors of the community.

Moreover, the presence of stigma and the lack of awareness with regard to the influence of trauma on the development of associated conditions, such as addiction or destructive behaviors contributing to domestic or sexual violence, can impede the development of health and legal services that would address personal and social consequences of emotional disorders. Ellen Minotti of Social Services of Cambodia stated her view that the social problems in Cambodia overwhelmingly interact and overlap with mental health issues. These aspects can be best addressed if social workers have a good understanding of the mental health issues underlying the dysfunction. It is important to note that the stigma towards mental health is also perpetuated within the health care system itself through the fragmentation of care, lack of efficiency, and poor coordination of services.

CONCLUSIONS & RECOMMENDATIONS: CONSENSUS IDEAS FOR DESIRED CHANGES FROM PROVIDERS AND AGENCIES

Serving as a reflection of the great need for widespread improvement, ideas for change are extensive and all-encompassing. Generally, feedback from mental health providers and agencies identified a number of broad areas of focus that impact all levels of mental health within Cambodia, including trauma-related mental health services. This feedback also addresses the dynamics within and across the various levels of mental health, from treatment providers to policy makers, in terms of collaboration and coordination towards advancing

mental health within Cambodia. Although it is difficult to create a comprehensive summary of feedback from providers and agencies given their varied backgrounds, the following recommendations seek to elucidate the context in which desired changes can be made.

As is the case in any relatively young mental health system like Cambodia, much focus on the future is placed on further development of resources and expansion of services, as well as increasing awareness and advocacy. These goals are balanced by the realities of development in a developing country context: shortage of financial and human resources, minimal prioritization, poor integration and cooperation, and insufficient education and training, among others. Because the mental health sector at large is still growing, specialized services, such as treatments for trauma, are still under-developed. As such, developing all mental health services will advance the continued development of the trauma-related mental health sector.

A major key to further development of mental health services is increased financial and human resources, a need that exists at all levels, from the treatment provider to the governmental and policy levels. International organizations (IOs), NGOs, and governmental entities are unable to design and implement programs without adequate funding. In addition, treatment providers garner low wages, and employment within organizations remains inconsistent and dependent on funding streams. As a result, there is little incentive to attract additional human resources, which therefore makes expansion of treatment coverage difficult. Feedback cited the importance of attracting greater funding streams from the international donor aid community through designing innovative funding proposals that address cross-cutting issues (i.e. gender equity), of seeking to incorporate multiple mental health stakeholders in organizational programming, and of focusing on long-term infrastructure building within government and NGO entities. Specifically, the government programs, whose leadership role in coordinating countrywide programs is relatively weak, require additional resources to further direct both the National Program for Mental Health and Bureau of Mental Health, as well as improve long-term sustainability of the government as a coordinating agency for mental health. At the provider level, increased financial resources would attract additional human resources to work in mental health, promote education, and expand service coverage to provide treatment to people and areas in great need.

In order to build greater human resources in mental health, more education and training are needed to begin meeting the considerable demand for mental health services. The provision of additional funding, through internal governmental funding or external aid, can direct and enhance education from the policy level to the university education systems and NGO training levels. At the professional level, this can be achieved through promoting and improving existing formal education programs at the University of Health Sciences for psychiatry, the social work and psychology programs at the Royal University of Phnom

Penh, as well as further expansion of mental health professional training into other universities and professional disciplines. Increasing general mental health knowledge and skills in other professional disciplines, such as general medicine and social welfare, promotes basic levels of treatment-seeking and awareness in broader levels of society.

Given the complexity of trauma theories and the significant amount of knowledge required to implement treatments, additional specific training in trauma-related mental health is essential to ensure positive therapeutic outcomes. At the clinical level, there is an identified need to encourage supervision and reformat training methods. In addition, educators and providers suggested the development and implementation of clinical guidelines to address disagreement among providers regarding appropriate clinical methods. Generally, this would include a culturally sensitive, client-centered paradigm involving family-oriented support and drawing on existing community resources. Furthermore, group and individual clinical supervision ought to be encouraged to continue building clinical and problem solving skills, as well as to promote individual awareness through discussion and support. At present, organizational training is often focused on short-term, specific skill building for treatment of specific target populations. Professionals supported encouraging longer-term, sustainable training methods, including education and training focused on building knowledge of all mental health concepts, on the development of general clinical skills, and on intensive training in trauma-related mental health treatment.

As a means of attracting more attention and support, repeated calls have been made for the government and international organizations to recognize mental health as a higher priority within their agendas. Although the World Health Organization (WHO) and other international organizations have advocated for increased attention on mental health, the progress continues to be slow. Indeed, greater priority is often given to issues outlined specifically in the United Nations' Millennium Development Goals—a global action plan to achieve poverty reduction goals.⁶⁶⁹ At present, there exists a small number of committed NGOs, minimal involvement of IOs, and a recognized, but poorly supported, mental health department within the Ministry of Health. At the systems level, there is a severe lack of coordination, with significant conflict in some instances, among the various entities addressing mental health. The conflict is most notable between governmental departments and the NGO and IO communities. Increased involvement of a neutral, international organization—to serve as facilitator and mediator between and within governmental and smaller NGO entities—would greatly enhance cooperation by providing a stable, leadership role. The WHO was specifically identified as being an ideal candidate, given its existing role as technical advisor to the governmental entities and its considerable support at the international level. Graham Shaw from the WHO echoed this idea, suggesting that the WHO may be an appropriate agent for this role. He went on to suggest that the WHO might be an ideal organization to advocate for increased funding and to suggest financial

allocation recommendations for donors.

Furthermore, regular coordination meetings, such as a technical working group on mental health, could help mental health organizations collaborate and plan initiatives. Such efforts may allow these organizations to address more efficiently gaps in systems and services on a larger scale. These meetings could also help organize greater lobbying efforts to attract resources and expand awareness of mental health issues.

The stakeholders involved in these coordination meetings would also have input in the development of the National Plan for Mental Health, an important document that legitimizes this issue within the Ministry of Health and serves as a major platform from which mental health initiatives are allocated resources and implemented. At present, NGOs and educational institutions have been minimally consulted on the development of this document. This absence has resulted in an incomplete picture of the present status of mental health in Cambodia and an inadequate plan for improvement. Greater incorporation of and participation by all stakeholders is necessary in designing the mental health plan. The acceptance and implementation of a national mental health policy would generate additional support for the National Mental Health Program, Bureau of Mental Health, and other mental health stakeholders throughout Cambodia.

Greater integration across the various trauma-related mental health disciplines is also needed. These disciplines include social workers, primary care physicians, psychiatrists, counselors, monks, and traditional healers. Whether on policy or treatment, these studies showed that the various professions rarely overlap or consult with one another. For instance, Buddhist monks from the Vipassana Dhura Buddhist Meditation Center reported that they are very often the first line of recognition for trauma-related mental illness, but have no overlap with the mental health system or formal training in mental health. While the lack of human resources in many areas may be largely to blame, promoting teamwork within the disciplines would make treatment more efficient and effective given the minimal resources. Increased cohesiveness between the various professions may be achieved through training that incorporates all disciplines—to encourage collaborative approaches—and through designing programming with all aspects of mental health in mind. In addition, it would be helpful for each professional discipline to spend time at each other's clinical sites to develop greater working knowledge of the variety of theoretical and clinical perspectives, and to provide opportunities for collaboration and the exchange of ideas.

In addition to more coordination within the mental health sector, greater collaboration with outside entities was suggested to promote mental health in cross-cutting issues, such as health, social welfare, and gender issues. As mentioned earlier, this collaboration could ensure that more developmental entities working together to enhance the scope and quality

of service planning and program implementation. This could be achieved by inviting stakeholders to provide input and to collaborate on programming, while also seeking out opportunities to provide mental health feedback in other areas.

Finally, the participants advocated for increasing education for the public on mental health and available treatment services, and for promoting positive mental health behaviors. Borrowing from the success of the HIV public awareness campaigns, mental health could employ similar methods to broaden awareness of what mental health is and what can be done to manage it. For example, a public media campaign, utilizing television and radio and focused on reducing the stigma associated with seeking mental health treatment, could greatly reduce barriers to receiving treatment and increase general quality of mental health. Ideally, such a campaign would involve patients and prominent Cambodians as advocates. Targeting the younger generations of Cambodia, through informative and entertaining programming inside and outside of school, could increase understanding of mental health issues. Furthermore, many suggested using World Mental Health Day on October 11 as an opportunity to hold events, forums, discussions, and provide information on mental health and treatment options within Cambodia.

In summary, current mental health limitations in Cambodia include meager financial resources, few professional training programs or opportunities for continuing education, lack of coordination of resources and personnel, low sustainability of programs, and barriers to access to care. Strengths include great dedication among current mental health leaders and providers, creativity among those building education programs, enthusiasm among providers for enhanced continuing education, and increased mental health awareness among the general public. In addition, an exceedingly important strength is the large youth population in Cambodia, who will produce the next generation of creative leaders and providers of health and mental health services. Finally, we want to emphasize the extraordinary comparability of comments and perspectives that we received across the spectrum of administrators, clinicians, and educators with whom we spoke. Despite the tragic history that these professionals had experienced and witnessed during and after the Khmer Rouge era, their dedication and optimism are additional signs of hope for the future of Cambodia and for its general and mental health care systems.

END NOTES

667 See Int'l Org. for Migration—Cambodia, *Mental Health in Cambodia: A Qualitative Evaluation* (forthcoming).

668 This study was not conducted for research purposes, but with the intent of generating the information for this Chapter.

669 B. Saraceno et al., *Barriers To Improvement Of Mental Health Services In Low-Income and Middle-Income Countries*, LANCET 76-86 (2007).





Son Sem is the eldest daughter of Sek Say. She is twenty two years old. She has been working for a garment factory in Phnom Penh since she was 17 years old. At first, without a proper education, Son Sem could only earn 30 USD per month. Today, with more experience, she earns 80 to 90 USD per month at King Fashion factory. But that amount alone can only cover her daily commute to and from her home which is about 30 km from the factory in Kampong Speu province. She spends around 12 USD per month for transportation. Many of her friends rent small rooms for 20 USD per month near the factory. Son Sem works hard and she likes her job. She gets up at 5 am each day to wait for a small truck serving factor workers around Phnom Penh to arrive to take her to work and arrives home at 7 pm each night. She works overtime a few times a month to earn extra income. All her income is used to support her family. Her parents sell watermelons and they donot earn much doing this. Her younger children help farmers to transplant rice for a few thousand riel per day. The photograph pictured was taken at her factory.



Sek Say is 44 years old and is the eldest daughter of Chan Kim Srun (the S-21 prisoner). The baby in the hands of Chan Kim Srun in the photograph was 30 days old at the time. Sek Say has five children. At the time of their parents' arrest in May 1978, Sek Say was eleven and her younger sister, Chreb, was only nine. While the newborn son was imprisoned with Sek Sat and Chan Kim Srun, the girls and their aunt were jailed in a low-security prison in Koh Thom district. Chreb & Sek Say escaped with the aid of the Vietnamese in late 1978, but Chreb died of disease before reaching safety. Sek Say survived and moved to Kampong Speu where she remains today in Kong Pisey district.



Phan Srey Leak is a very bright and brave 5 year old girl. She likes to work in the rice field at the back of her house. She and her younger sister, Phan Srey Lai (4) could not help her parents yet. So they are two members of the family who are carefree and have the village as their playground.



At nine years old, Phan Srey Leab is a quiet and docile girl with piercing eyes. She is the granddaughter of Chan Kim Srun and Sek Sat. Phan Srey Leab is the third child of Sek Say. Srey Leab likes to play in the kitchen when she can find a spot of her own. After school, she helps her mother cook, do household chores, and look after her younger sisters. Srey Leab only manages to achieve an average performance at school. Srey Leab has heard her mother blame their poverty on being orphaned at a young age. The young girl asked once about her grandparents and what had happened to them. Srey Leab listened to their story, but—quiet as she is—she has never again talked about it. At this time of year, July, she helps farmers transplanting rice and earns a few thousand riels for her mother.



Phan Teng is the single son of the family. He is 12. Like his immediate sister, Phan Srey Leab, Phan Teng works in nearby rice fields to transplant rice. He earns a few thousand riels a day for his family. When his parents are away on business trip to Takeo province to sell watermelon, he cooks rice and takes care of his younger siblings



This is Mrs. Sim, mother of Sek Say's first husband Samreth Pum. She still visits Sek Say and her family often even though Sek Say remarried 13 years ago. She said that her son died a long time ago and she decided to allow Sek Say to remarry. She lives in a house in the same village.



Chan Kim Srun



MENTAL HEALTH REFORM: TOWARD A NATIONAL PROGRAM FOR TRAUMA-RELATED MENTAL HEALTH

Daryn Reicherter, Beth Van Schaack & Youk Cbbang

The Extraordinary Chambers in the Courts of Cambodia (ECCC) has brought the issue of trauma mental health to the forefront of attention in multiple arenas. Cambodia's history of violence has left a legacy shrouded in the psychological consequences of traumatic experience. The trauma psychology is connected with so many factors of contemporary Cambodian experience that it crosses over into multiple disciplines of social study. It is also intrinsically connected to the history, the documentation, and the prosecution of crimes from the Khmer Rouge era. In addition, the effects of trauma have been transmitted to subsequent generations and permeate contemporary social and economic relations, limiting the advancement of the developing country.

The grand size of the problem has led to critical review of resources for the people affected by trauma psychology and to the notion that new and progressive resources are required. The prosecution of crimes from the past has highlighted the hidden scars that have been well known for decades.

The Documentation Center of Cambodia recommends that the ECCC mandate mental health resources for victims as reparations for the crimes of the past. To achieve anything approaching a comprehensive notion of justice in the context of prosecuting crimes as heinous as those examined in the ECCC requires that the insults of the past must not only be recognized and documented—their consequences also must be addressed and treated.

What follows is an outline of consensus ideas for changes that the ECCC should recommend as a form of collective reparations to address the state of mental health of Cambodia. This summary will be presented to the ECCC and to the Cambodian Government for consideration and as an introduction to deeper and more specific recommendations. The court and the government must take note and act, if there is to be any healing of the hidden scars on the psyche of Cambodia.

SUMMARY OF OBSERVATIONS

The People of Cambodia have suffered extremes of trauma. According to a number of studies, as much as one-third of the population meet the DSM criterion for the Western diagnosis of posttraumatic stress disorder (PTSD). Even more people have mental health pathology related to trauma and its effects. This mental health pathology causes a huge burden of suffering and, when untreated, personal and social dysfunction.

The current life conditions of most of the people with mental health problems in Cambodia are not conducive to psychological recovery. Most of the people continue to live in poverty. Complications of trauma-like domestic violence and substance abuse continue to be factors in people's day-to-day lives. The primary mental health problems are usually unidentified and untreated.

Many Cambodians were traumatized during the Pol Pot years; yet, many more Cambodians are young and did not personally experience the Khmer Rouge era. The consequences of trauma, however, have had a profound effect on the younger generation both directly (via other forms of trauma) or indirectly (through second-generation effects of trauma). Cambodian youth have known only a post-genocide and post-conflict society. Trauma-related mental health problems cause personal and societal dysfunction and contribute to economic stagnation and even decline.

Despite the high burden of mental health problems, there is little recognition of mental illness among the general Cambodian public. Accordingly, there is very little public knowledge about the destructive outcomes of trauma on peoples' health and mental health. In addition, there is an overwhelming stigma about mental illness. As a result of these phenomena, persons suffering with trauma-related mental health problems generally do not seek appropriate treatments.

Given the lack of public understanding around mental health, most Cambodians may not interpret their own mental health symptoms as medical problems in need of treatment. Most people suffering with trauma-related mental health issues will not seek help, despite symptoms that cause daily dysfunction. To the extent people do seek help, they are more likely to go to a non-mental health professional, such as a primary care doctor, a monk, or a *Kruu Khmer* (traditional healer).

Most alternative healers and spiritual figures are not educated in Western concepts of mental health. Most have an entirely different explanation and solution for each patient. The reality is that even most Western primary care doctors are not well trained in mental health. There is limited cross-cultural and cross-discipline sharing of ideas for treating mental health conditions.

A Western mental health treatment model may have limited applicability to address the public health problem of trauma in Cambodia because of cultural differences and resource limitations. Psychiatric medication alone will not ameliorate trauma-related mental health conditions. Even if psychotropic medication were a reasonable solution, twenty-six psychiatrists cannot realistically treat fourteen million people. Even if the number of psychiatrists were increased tenfold, the need for assessment, prescription, and regular monitoring could not be met. Furthermore, the country's formulary (i.e. list of available medications) consists of a limited number of older medications. Often, the use of these medications has been discontinued as a result of intolerable side effects. In addition, there are limited financial resources both within the populace and in government coffers.

Psychotherapy is a Western idea that may or may not have adequate impact in Cambodia. Psychotherapists require rigorous training before therapy can appropriately be introduced. In addition, effective therapy may require long-term contact. Even then, the effectiveness of therapy provided by well-trained therapists can be variable for PTSD.

From the perspective of national policy, trauma and mental health are not seen as major priorities for the Cambodian government's health care plan. In general, there is limited resource allocation to mental health programs, and the issue of trauma-related mental health is given very little priority even under that rubric. This has resulted in very little government funding for trauma-related mental health.

The National Mental Health Program (NMHP), together with several mental health NGOs, is the leading broker of mental health services and education around mental health in Cambodia. Many NGOs deal with trauma-related mental illness directly or indirectly; they may not understand, however, the extent to which mental health problems among the populace are impacting their own work. These groups are over-burdened and under-resourced. There is often poor coordination between these groups and with the NMHP. In fact, they are often pitted against each other in competition for very limited funding opportunities.

Collectively, these observations all suggest that some hybridization of Western and Khmer approaches to treatment would be most likely to be accepted and effective.

IDEAS FOR IMPROVEMENT

Financial Resources

In order for serious attention to be given to the overwhelming issue of trauma-related mental health, financial resources must be adjusted to provide mental health providers with reasonable budgets to address the issues of Cambodia. The other serious obstacles, such as human resources, coordination of efforts, and training, cannot be addressed without

increased funding.

The Government Health Budget should allocate a realistic percentage of the overall budget to mental health. At present, the budget is so restricted that basic mental health services cannot be provided and only some of the most serious psychiatric disorders (e.g. schizophrenia) fall within the provisions of government spending. Under this system, trauma psychopathology is not well addressed. Changes in government funding patterns are recommended to ensure a permanent shift in the budget allocated to mental health and, thus, to allow trauma-related mental health issues to be brokered seriously into the National Mental Health Plan.

In addition, the government can encourage International Donor Funding to be directed toward trauma-related mental health by acknowledging this issue as a prime objective for the Kingdom of Cambodia.

Increase Awareness to the Issues

The government should promote a nationwide public health campaign geared toward raising awareness and de-stigmatizing mental health problems associated with trauma. Such a campaign would likely involve partnering with international health-interest organizations, such as the World Health Organization (WHO), and with local NGOs, such as the Transcultural Psychosocial Organization (TPO) and the Documentation Center of Cambodia (DC-Cam). This public education project should be seen as similar to the advocacy campaigns that were successfully pioneered for the education and prevention/treatment of HIV.

Within the government, awareness and concern should be promoted. Given the traumatic past history and current judicial processes going forward in the Extraordinary Chambers in the Courts of Cambodia (ECCC), the government must acknowledge the consequences that trauma has had on its people and the areas of dysfunction this has created.

Within health care, the government should consider the creation of awareness campaigns. Health care providers in all disciplines are likely to deal with the consequences of psychological problems from trauma given its overwhelming prevalence. Awareness of the issue and training in its management are important for providers to increase their efficiency.

Coordination of Efforts

The appropriate conceptualization of trauma-related mental health expands beyond health care and carries over into other social service areas. Therefore, brokers of social services that deal with the consequences of trauma-related mental health pathology must be involved in the coordination of efforts. Some of this coordination and collaboration has developed spontaneously, but because these efforts have not been formally organized, they tend to be

non-inclusive.

We recommend an interdisciplinary coordination of services by a non-biased consulting group (e.g. WHO). This concept seems welcome by most providers, including administrators in the government programs. This inclusive steering committee, directed by an objective organization, could define the overall mission and coordinate efforts to maximize efficiency and reduce redundancy of services. Such coordination could also improve communication among agencies, as well as increase opportunities for advancing training and knowledge on the relevant issues for providers and administrators across disciplines.

Coordination of the flow of financial and human resources could improve the maximal yield by expanding cooperation and reducing energy dissipated in bitter competition for limited funding. Coordination could also lead to consensus ideas for best practices and for the creation of appropriate outcomes measures to evaluate what is working and what is not working.

Sustainability

The above general recommendations are only useful with sustainable resources. For each recommendation, the government should consider a way to maintain continuation and accountability. We recommend a paradigm shift in attention and resources to trauma-related mental health, rather than a symbolic or singular injection of one-time, potentially unsustainable, resources. For example, new legislation that demands a greater percentage of the overall health budget go toward mental health generally, and trauma-related mental health specifically, will have a broader and more long-term effect than a one-time infusion of financial resources into mental health programs. We strongly suggest policy changes toward sustainable solutions that will support our above recommendations and the long-term mental health and well-being of the people of Cambodia through the creation of robust trauma-related mental health systems in Cambodia.



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Prof. Van Schaack joined the law faculty from private practice at Morrison & Foerster LLP. As a Senior Associate at “MoFo”, Prof. Van Schaack practiced in the areas of commercial law, intellectual property, international law, and human rights. In particular, she was trial counsel for *Romagoza v. Garcia*, a human rights case on behalf of three Salvadoran refugees that resulted in a plaintiffs’ award of \$54.6 million. She was also on the criminal defense team for John Walker Lindh, the “American Taliban.”

Prior to entering private practice, Prof. Van Schaack was Acting Executive Director and Staff Attorney with The Center for Justice & Accountability, a non-profit law firm in San Francisco dedicated to the representation of victims of torture and other grave human rights abuses. She was also a law clerk with the Office of the Prosecutor of the International Criminal Tribunal for the Former Yugoslavia.

Since 1995, she has served as a legal advisor to the Documentation Center of Cambodia, an organization dedicated to staging a legal accounting for the crimes committed during the Khmer Rouge era in Cambodia. In 2006, she served as Prosecutor for the International Citizen’s Tribunal for Sudan, presided over by Nobel Laureate Wole Soyinka, which presented the case under international criminal law against President Omar Al-Bashir of Sudan.

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YOUK CHHANG is the Chairman of the Sleuk Rith Institute, Director of the Documentation Center of Cambodia (DC-Cam), and a survivor of the Khmer Rouge's "killing fields." DC-Cam grew out of Yale University's Cambodian Genocide Program and became an independent Cambodian NGO in 1997 under Mr. Chhang's leadership. Mr. Chhang received the Truman-Reagan Freedom Award from the Victims of Communism Memorial Foundation in Washington, DC in 2000. He was named one of *Time*

magazine's "60 Asian heroes" in 2006 and one of the "Time 100" most influential people in the world in 2007 for his stand against impunity in Cambodia and elsewhere.





Cambodia's Hidden Scars: The Khmer Rouge Standing Committee aimed to ensure compliance and eliminate dissent by oppressing the people through psychological dominance. The defilement of Khmer religion, Khmer art, Khmer familiar relations, and the Khmer social class structure undermined deeply-held societal assumptions. The Khmer Rouge also destabilized the mass psychology that was secure in those realities. Cambodia's psychology was thus altered in damaging and enduring ways. In societies that experience war and genocide, trauma significantly impacts the people's psychology. The ripple effects of this damage are often incalculable. There are well-established statistics demonstrating a higher prevalence of trauma-related mental health disorders in post-conflict societies. This book considers the mental health implications of the Khmer Rouge era among the Cambodia populace. Specialists in trauma mental health discuss the increased rates of post-traumatic stress disorder (PTSD) and major depression, among other major mental health disorders, in the country. They also discuss the staggering burden of such a high prevalence of societal mental illness on a post-conflict society. Legal experts discuss the way in which the Extraordinary Chambers in the Courts of Cambodia can better accommodate victims and witnesses who are traumatized to avoid re-traumatization and to ensure a meaningful experience with justice. The text also offers a set of recommendations for addressing the widespread mental health issues within the society.

Cover Photos: Phan Srey Leab Holds a Photo of Family Members Imprisoned by the Khmer Rouge regime

At nine years old, Phan Srey Leab is a quiet and docile girl with piercing eyes. She is a granddaughter of Chan Kim Srun and Sek Sat. As a member of the military, Sek Sat rose quickly through the ranks, first commanding the 18th Company of Region 33 and then the 12th Regiment in 1973. By 1977, Sek Sat was a secretary of Koh Thom district and, by 1978, a secretary of Region 25.

On May 13, 1978, the Khmer Rouge arrested Sek Sat, his wife, and their newborn baby boy. They arrived at Tuol Sleng Prison (S-21) the next day. Forty days later, Sek Sat wrote a sixty-seven-page confession, in which he admitted to traitorous activities dating back to 1965 when he joined the United States Central Intelligence Agency. According to the confession, his main goals were to oppose the monarchy and communism, and to "hide in the revolution to build force."

Documents from Tuol Sleng prison do not indicate whether Chan Kim Srun wrote a confession before she died. The only prison document directly concerning Chan Kim Srun is a short biography and a portrait, taken upon her arrival at S-21, of her carrying her sleeping baby. Her brief biography, obtained by the Documentation Center of Cambodia (DC-Cam), indicates that she managed a handicrafts workshop in Region 25 where her husband was chief. This portrait of Chan Kim Srun and her son graces the cover of our book. In the original photo, which is on display at Tuol Sleng Museum, it is possible to see tears dropping from Chan Kim Srun's eyes.

Chan Kim Srun and Sek Sat had three children. At the time of their parents' arrest, Sek Say was eleven and her younger sister, Chreb, was only nine. While the newborn son was imprisoned with Sek Sat and Chan Kim Srun, both of the girls and their aunt were jailed in a low-security prison in Koh Thom district. Chreb & Sek Say escaped with the aid of the Vietnamese in late 1978, but Chreb died of disease before reaching safety. Sek Say survived and moved to Kampong Speu where she remains today in Kong Pisey district.

Sek Say resembles her mother. She has five children, of which Phan Srey Leab is the third. Srey Leab likes to play in the kitchen when she can find a spot of her own. She only manages an average performance at school, but after school, she helps her mother cook, do household chores, and look after her younger sisters. Srey Leab has heard her mother blame their poverty on being orphaned at a young age. The young girl asked once about her grandparents and what had happened to them. Srey Leab listened to their story, but—quiet as she is—she has never again talked about it.

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