

CAMBODIA'S HIDDEN SCARS: TRAUMA PSYCHOLOGY AND THE EXTRAORDINARY CHAMBERS IN THE COURTS OF CAMBODIA

SECOND EDITION



EDITED BY:

BETH VAN SCHAACK • DARYN REICHERTER

MANAGING EDITOR:

GILLIAN REIERSON

DOCUMENTATION SERIES NO. 22 — DOCUMENTATION CENTER OF CAMBODIA

CAMBODIA'S HIDDEN SCARS:

TRAUMA PSYCHOLOGY AND THE EXTRAORDINARY CHAMBERS IN THE COURTS OF CAMBODIA

SECOND EDITION



EDITED BY:

BETH VAN SCHAACK • DARYN REICHERTER

MANAGING EDITOR:

GILLIAN REIERSON

ស្វែងរកការពិតដើម្បីការបដិសេធនិងយុត្តិធម៌

Searching for the Truth: Memory & Justice

មជ្ឈមណ្ឌលឯកសារកម្ពុជា

MEMORY & JUSTICE

“...a society cannot know itself if it does not have an accurate memory of its own history.”

DOCUMENTATION CENTER OF CAMBODIA (DC-Cam)
66 Preah Sihanouk Blvd., P.O. Box 1110, Phnom Penh, Cambodia
Tel: +855 23 211 875, +855 12 90 55 95 e: dccam@online.com.kh

With the future of the Khmer Rouge Tribunal limited to a small number of high profile leaders, and a modern Cambodian population of which some 70% of the population was born after the worst of the Khmer Rouge genocide, Cambodia is facing a turning point. On the one hand, Cambodians run a real risk of losing a firm grip on understanding, memorializing and ultimately accepting a difficult past. On the other hand, a rapidly globalizing Cambodia must take on new challenges of sustainable growth, democratic integrity and human rights.

Affiliations:
The Cambodia Tribunal Monitor (CTM) www.cambodiatribunal.org
The Sleuk Rith Institute (SRI) www.cambodiasri.org
Zaha Hadid Architects (ZHA) www.zaha-hadid.com

Cambodia's hidden scars: trauma psychology and the extraordinary chambers in the courts of Cambodia (ECCC)
Second Edition

V. Schaack Beth
Reicherter Daryn

Cambodia—Law—Human Rights—Psychology
Cambodia—Politics and Government—1975-1979
Cambodia—History—1975-1979

Funding for this project was generously provided by the individuals with core support from U.S. Agency for International Development (USAID).



The views expressed in this book are the points of view of the author only.

Copyright © 2016 by the Documentation Center of Cambodia—Documentation Series No. 22.

Thanks go to Alina Petra Utrata and Britni Olina Chau for their excellent editorial assistance.

All rights reserved. No part of this book may be reproduced or utilized in any form or by any means, electronic or mechanical, including photocopying, recording, or any information storage and retrieval system, without permission in writing from the publisher.

Cover and book concept: Youk Chhang
Photo Credit: All photographs and the cover photograph of the Kraing Ta Chan memorial site WERE taken in 2014 by artist Makara Ouch, the Film Director at the Documentation Center of Cambodia (DC-Cam). Before joining DC-Cam, Ouch was with Khmer Mekong Films from 2006-2013; his work has been screened at the Cambodian International Film Festival and elsewhere. See <http://makaraouch/weebly.com>.

ISBN-13:978-99963-900-5-0
Printed in Cambodia

Dedicated to all the Civil Parties who appeared before the Extraordinary Chambers in the Courts of Cambodia to provide their own testimony and also to bear witness on behalf of the millions of other Khmer who did not survive the Khmer Rouge regime or who could not appear before the ECCC.

“When I despair, I remember that all through history the way of truth and love have always won. There have been tyrants and murderers, and for a time, they can seem invincible; but in the end, they always fall. Think of it—always.”

~ Mahatma Gandhi

TABLE OF CONTENTS

Preface to the New Edition	6	Part III: Trauma, the Khmer Rouge Tribunal & The Future of Mental Health in Cambodia	
<i>By Beth Van Schaack</i>			
Introduction	16	12. Interview with the Supreme Monk	277
<i>By Daryn Reicherter</i>		<i>By Youk Chhang</i>	
Part I: The Experience of Trauma in Cambodia		13. Cambodian Perspectives on the Resources for Trauma-Related Mental Health	283
1. The Impact of War and Genocide on Psychiatry and Social Psychology	26	<i>By Daryn Reicherter & Kok-Thay Eng</i>	
<i>By Daryn Reicherter & Alexandra Aylward</i>		14. Analysis of Trauma-Related Mental Health Resources in Cambodia: Consensus Ideas for an Improved Method	302
2. The Effect of the Khmer Rouge on the Mental Health of Cambodia and Cambodians	44	<i>By Daryn Reicherter, James Boehnlein & Joe Stewart</i>	
<i>By James K. Boehnlein & J. David Kinzie</i>		Appendix A: Letter to the Kingdom Of Cambodia and Head of the Victim Support Section of the ECCC	316
3. PTSD Severity and Key Idioms of Distress among Rural Cambodians: The Results of a Needs Assessment	57	<i>By Youk Chhang</i>	
<i>By Devon Hinton, Alexander Hinton, Youk Chhang, Kok-Thay Eng & Sophearith Choung</i>		Appendix B: Response from the Kingdom of Cambodia	321
4. Transcultural Psychiatry	81	<i>By Youk Chhang</i>	
<i>By Inger Agger</i>		Appendix C: The Mental Health Outcomes Resulting from Crimes Committed by the Khmer Rouge Regime Before the Extraordinary Chambers in the Courts of Cambodia in Case 002/2	323
5. Intergenerational Transmission of Trauma Stemming from the Khmer Rouge Regime: An Attachment Perspective	100	<i>By The Stanford University Human Rights in Trauma Mental Health Laboratory</i>	
<i>By Nigel P. Field</i>			
Part II: Trauma and the Khmer Rouge Tribunal Process			
6. The Effects of Traumatic Memory and Secondary Trauma at the Extraordinary Chambers in the Courts of Cambodia	121		
<i>By S. Megan Berthold & Gerald Gray</i>			
7. Trauma in the Courtroom	159		
<i>By John D. Ciorciari & Anne Heindel</i>			
8. Justice and Healing at the Khmer Rouge Tribunal: The Psychological Impact of Civil Party Participation	190		
<i>By Judith Strasser, Julian Poluda, Chhim Sotheara & Phuong Pham</i>			
9. Participation as Reparations: The ECCC and Healing in Cambodia	213		
<i>By Toni Holness & Jaya Ramji-Nogales</i>			
10. The Importance of Mass Trauma Evidence in Accountability Before the ECCC	235		
<i>By Nushin Sarkarati & Kathy Roberts</i>			
11. Creating Lab Reports on Psychological Outcomes of Political Violence in Human Rights Criminal Cases: The Human Rights in Trauma Mental Health Laboratory at Stanford University	268		
<i>By Daryn Reicherter, David Reed, Rachel Williamson & Ryan Matlow</i>			

PREFACE TO THE SECOND EDITION

Beth Van Schaack (B.A., J.D.) is the Leah Kaplan Visiting Professor of Human Rights at Stanford Law School and a Legal Advisor to the Documentation Center of Cambodia. She is a co-founder and co-director of the Human Rights in Trauma Mental Health Laboratory at Stanford University.

This volume was originally published in 2011 just as proceedings before the Extraordinary Chambers in the Courts of Cambodia (ECCC) were finally underway after a long and winding process marked by intense negotiations and dogged brinksmanship.¹ The establishment of the ECCC followed decades of impunity inaugurated by the 1979 ouster of the Khmer Rouge after their four murderous years in power. But in 1997, by way of a letter to the U.N. Secretary-General, Cambodia finally asked the international community to stand up an international tribunal to prosecute surviving members of the Khmer Rouge.² The Secretary-General commissioned an expert report, which originally recommended the creation of an international tribunal to be located somewhere in Southeast Asia given concerns about the competency and independence of the Cambodian judiciary.³ Meanwhile, the Government of Cambodia produced a competing proposal (for a court almost entirely domestic in nature) and generated enabling legislation.⁴

Protracted negotiations ensued. Cambodian intransigence on certain points led Secretary-General Kofi Annan to withdraw from the process—he had long insisted that the United Nations could remain involved only if there was a majority of international judges, an independent international prosecutor, and certain guarantees that the local authorities would actually arrest indictees. After the General Assembly urged him to resume talks,⁵ an agreement was reached on June

¹ See Helen Horsington, *The Cambodian Khmer Rouge Trials: The Promise of a Hybrid Tribunal*, 5 MELBOURNE J. OF INT'L L. 462 (2004) (recounting detailed history of the ECCC).

² U.N. Legal Counsel Hans Corell, Statement at Press Briefing at U.N. Headquarters in New York (Feb. 8, 2002), www.un.org/news/dh/infocus/cambodia/corell-brief.htm.

³ U.N. G.A. Rep. of the Group of Experts for Cambodia established pursuant to General Assembly Resolution 52/135, U.N. Doc. A/53/850 (Feb. 18, 1999), www1.umn.edu/humanrts/cambodia-1999.html.

⁴ See Peter J. Hammer & Tara Urs, *The Elusive Face of Cambodian Justice*, in BRINGING THE KHMER ROUGE TO JUSTICE: PROSECUTING MASS VIOLENCE BEFORE THE CAMBODIAN COURTS 27-29 (Jaya Ramji & Beth Van Schaack eds., 2005) (discussing of the many twists and turns of these negotiations)

⁵ G.A. Res. 57/228 B (May 22, 2003).

6, 2003, that offered several key concessions to the Cambodian side.⁶ This agreement—which regulates cooperation between the Government and the United Nations but also contains a number of substantive building blocks—was later ratified in 2004.⁷ The relevant domestic legislation was then amended to reflect elements of the agreement, but some key points of divergence remain.⁸ In 2005-6, the ECCC were finally staffed and provided the first of what would be many incomplete tranches of funding. The ECCC bear the distinction of being the only U.N.-originated tribunal created by domestic legislation. Although a domestic court,⁹ its activities are entirely “self-contained,” from investigation through appeals, with no overlap with the ordinary Cambodian court system. International elements include the incorporation of international criminal law and human rights protections and the provision of technical assistance and staff through the United Nations Assistance to the Khmer Rouge Trial (“UNAKRT”).

The ECCC are exceptional among hybrid institutions in that they, like the International Criminal Court and the Special Tribunal for Lebanon, allow victims to constitute themselves as Civil Parties and therefore enjoy certain procedural rights. For example, Civil Parties can be independently represented by Civil Party Representatives, introduce their own evidence, and cross-examine witnesses.¹⁰ In most other international and hybrid tribunals, victims have participated in legal proceedings primarily as witnesses called by the Prosecution.¹¹ The ECCC’s interpretation of “victim” has been contested, however, and the overwhelming number of Civil Party interventions in Case 001 led to rulings and rules’ amendments that significantly limited the direct involvement of Civil Parties over

6 Agreement Between the United Nations and the Royal Government of Cambodia Concerning the Prosecution Under Cambodian Law of Crimes Committed During the Period of Democratic Kampuchea, Cambodia-UN, June 6, 2003, 2329 U.N.T.S. 117; see also G.A. Res. 57/228, *supra* note 187 (approving the establishment of the ECCC).

7 Instrument of Ratification on the Agreement between the United Nations and the Royal Government of Cambodia Concerning the Prosecution under Cambodian Law of Crimes Committed during the Period of Democratic Kampuchea, Oct. 19, 2004, www.eccc.gov.kh/sites/default/files/legal-documents/Instrument_of_Ratification_of_Agreement.pdf.

8 Law on the Establishment of the Extraordinary Chambers in the Courts of Cambodia for the Prosecution of Crimes Committed During the Period of Democratic Kampuchea, with the inclusion of amendments as promulgated on 27 October 2004 (NS/RKM/1004/006), Oct. 27, 2004, www.eccc.gov.kh/sites/default/files/legal-documents/KR_Law_as_amended_27_Oct_2004_Eng.pdf [hereinafter ECCC Statute].

9 See *Prosecutor v. Kaing Guek Eav alias Duch*, Case No. 001/18-07-2007-ECCC/OCIJ (PTC01), Decision on Appeal Against Provisional Detention Order of Kaing Guek Eav Alias “Duch,” ¶¶ 18-19 (Extraordinary Chambers in the Ct. of Cambodia Dec. 3, 2007), www.eccc.gov.kh/sites/default/files/documents/courtdoc/PTC_decision_appeal_duch_C5-45_EN_0_0.pdf (ruling that while the ECCC was “distinct from other Cambodian Courts in a number of respects,” it nevertheless operates as “an independent entity within the Cambodian court structure”).

10 Melanie Vianney-Liaud, *Emerging Voices: Victim Participation in ICC and ECCC’s Proceedings*, OPINIOJURIS, Aug. 20, 2015, <http://opiniojuris.org/2015/08/20/emerging-voices-victim-participation-in-icc-and-eccc-proceedings/>.

11 John Ciorciari & Anne Heindel, *Victim Testimony in International and Hybrid Criminal Courts: Narrative Opportunities, Challenges, and Fair Trial Demands*, 56(2) VA. J. INT’L L 8 (2016).

time.¹² Most importantly, victims appearing before the ECCC must now be represented by Lead Co-Lawyers designated by the Court, similar to the appointment of class counsel in U.S. mass claims litigation. Nonetheless, victims continue to enjoy participation rights before the ECCC that are unparalleled internationally.

In another innovation, victims before the ECCC can also pursue civil remedies in the form of collective and moral reparations.¹³ Although the ECCC will not order individualized cash payments to particular victims, it will look for ways to advance the rehabilitation of victims and contribute to the restoration of their dignity. Originally, it was envisaged that the convicted defendant would satisfy any reparations award, because the ECCC cannot impose obligations on the Cambodian state or parties not appearing before it. However, the standard for such individualized reparations awards was set quite high (there must be a clear specification of the nature of the relief, its link to the harm caused by the accused, and the amount due to give effect to the remedy). In addition, the accused have all successfully pled indigence (somewhat unconvincingly). In these ways, the ECCC differ from human rights courts, which exercise jurisdiction over states and can order responsible states to make reparations to victims of human rights violations.

In the end, Case 001 did not generate any meaningful reparations for victims, in part because the defendant was deemed indigent and in part because the requests were considered to be outside of the ECCC legal framework. Bitter disappointment among victims ensued. In response, the judges of the ECCC amended the Rules in 2010 to allow reparations to be funded by external sources (e.g., from donor countries, private entities, etc.). These reparations are to be implemented through the ECCC’s Victims Support Section (VSS) with assistance from the Civil Party lawyers and in cooperation with relevant governments and non-governmental organizations. Per Internal Rule 23*quinqies*(2), the Civil Parties must submit a single claim for reparations through the Lead Co-Lawyers setting forth reasoned arguments for how the proposed reparations will address the harm suffered as well as the modes of implementation. In a pre-verdict ruling,

12 Michelle Stagg et al., *Lessons Learned from the Duch Trial: A Comprehensive Review of the First Case before the ECCC*, ASIAN INT’L JUST. INITIATIVE’S KRT TRIAL MONITORING GROUP 28 (2009), http://wccsc.berkeley.edu/wp-content/uploads/documents/Lessons%20Learned%20from%20the%20Duch%20Trial_MRSK_FINAL.pdf. See *Prosecutor v. Duch*, Case No. 001/18-07-2007/ECCC/TC, Decision on Motion for a Ruling on the Standing of Civil Party Lawyers to Make Submissions on Sentencing and Directions concerning the Questioning of the Accused, Experts and Witnesses Testifying on Character (Extraordinary Chambers in the Ct. of Cambodia Oct. 8, 2009).

13 *Prosecutor v. Duch*, Case No. 001/18-07-2007-ECCC/SC, Appeal Judgment, ¶¶ 643, 659 (Extraordinary Chambers in the Ct. of Cambodia Feb. 3, 2012). Rule 23(11) of the ECCC’s Internal Rules departs from ordinary Cambodian criminal procedure and provides that such collective and moral reparations can only be ordered against convicted persons. The ICC has a similar system of victim participation at Article 75.



A man is setting up his cast net to catch fish in a creek in Preah Sihanouk Province in September 2014 under the light rain. A cast net is a typical instrument used to catch fish that is widely used in rural Cambodia. Fresh-water fish is a staple food and a main source of protein for Cambodians, many of whom consume fish more than any other meat. As a Cambodian proverb says "wherever there is water, there is fish." Photo by Ouch Makara/Documentation Center of Cambodia Archive

the ECCC made clear that it could only endorse reparations measures upon a showing that they were fully funded and would enjoy the consent and cooperation of any necessary third party.¹⁴

These new rules governed Case 002/1, which was brought against the surviving members of the Khmer Rouge Standing Committee whose plea of indigence went (remarkably) unchallenged. The charges involved the forced evacuation of Phnom Penh as well as executions at Tuol Po Chrey of members of the former Lon Nol regime. All told, almost 4,000 Civil Party applications were deemed admissible in Case 002 following an appeal, and 31 Civil Parties gave oral testimony. Additional written accounts were also submitted into the record.

The first edition of this volume was originally produced in parallel with the ECCC process with an eye toward compiling the current research on the enduring mental health *sequelae* of the Khmer Rouge's crimes—including intergenerational harm. We also presented concrete recommendations to the Royal Government of Cambodia to address the mental health needs of the Cambodian populace. In the context of Case 002/1, however, the ECCC accepted the entire book into evidence. Furthermore, the VSS and the Civil Party lawyers were able to secure funding commitments from various states (e.g., Australia, Germany, Switzerland) to enable the ECCC to render a more meaningful reparations order than it had done in Case 001.

In this regard, the Co-Lead Civil Party Representatives proposed 13 discrete and innovative reparation projects to the Trial Chamber, several of which addressed mental health issues and reflected recommendations contained in the first edition of this text. Of these proposals, eleven were endorsed by the Trial Chamber. Most relevant to this volume, the Trial Chamber approved a program of Testimonial Therapy—i.e., the recording of testimonies of traumatic experiences by mental health workers and their distribution during ceremonies throughout Cambodia—and the facilitation of Self-Help Groups to provide a course of therapy developed by the Transcultural Psychosocial Organization (TPO). Funding for training of personnel and other costs in connection with the implementation of these two projects in Phnom Penh was secured from the Australian, German, and Swiss governments. Additional funding is being sought to extend these two projects outside of the capital. In endorsing these projects, the Trial Chamber noted that they are “likely to promote public awareness of the harm suffered by the victims of Khmer Rouge era crimes and thereby may

contribute to national reconciliation.”¹⁵

In addition, the Trial Chamber recommended the establishment of a National Remembrance Day on May 20, which enjoyed the assent of the Royal Government of Cambodia. No funding was required. The Trial Chamber agreed that:

an official national holiday amounts to a nationwide and official acknowledgement of the harm suffered by the victims. Public memorials may further assist to restore the dignity of victims, provide public acknowledgement of the crimes committed and harm suffered, and assist in healing the wounds of all victims by diffusing their effects far beyond the individuals who were admitted as Civil Parties.¹⁶

The ECCC blessed three memorialization projects: a memorial within Phnom Penh to acknowledge the victims of forced evacuation (with funding from the French Embassy and other French funders); a Permanent Exhibition in five provinces focused on the ECCC proceedings and the participation of the Civil Parties (German funding); and a Mobile Exhibition and Education Project on Transitional Justice, also with German funding. A proposed memorial to Cambodian victims living in France (with the support of the City Hall of Paris and several French NGOs) failed because fundraising was still ongoing. Another Public Memorial Initiative would have established five public, accessible, educational, and sustainable memorial sites throughout Cambodia. Although this project enjoyed the support of the government and the NGOs that were slated to implement it, no funding had been secured at the time of the judgment. Nor had details been provided as to the proposed locations or other supplementary information. Accordingly, the Trial Chamber did not endorse this initiative.

On the education front, the Chamber supported adaptations to school curricula and the teaching manual produced by the Documentation Center of Cambodia (DC-Cam) to discuss forced population movements and executions with the understanding that any edits would indicate that certain facts had not been fully adjudicated since the judgment is open to appeal. The Germans also agreed to fund a booklet on facts adjudicated in Case 002/01 and Civil Party Participation/Statements. Construction will also proceed on a Peace Learning Center in Battambang Province with Swiss funding. Finally, two editions of the verdict were

¹⁴ ECCC, Internal Rules (revision 9 Adopted on 9 February 2009 and amended on 17 September 2010), Rule 23quinquies(3).

¹⁵ See Prosecutor v. Nuon Chea and Khieu Samphan, Case No. 002/19-09-2007/ECCC/TC, Trial Judgment, Section 19.5.1 Assessment of all awards sought by the Lead Co-Lawyers, ¶ 1154. (Extraordinary Chambers in the Ct. of Cambodia Aug. 7, 2014).

¹⁶ See *id.* at ¶ 1152.

published and distributed, and the VSS and Public Affairs Section of the ECCC included Civil Party names on the ECCC website by way of acknowledgement of their suffering. The Trial Chamber noted that these documentation and education projects are collective and moral in nature and will advance the goals of acknowledgement, remembrance, and awareness.

In the meantime, and building on the research produced in the first edition of this volume, the two primary editors of this volume formed the Human Rights in Trauma Mental Health Laboratory (“Lab”) in the Department of Psychiatry and Behavioral Sciences of the Stanford University School of Medicine.¹⁷ The Lab is committed to advancing and applying research on the psychiatric *sequelae* exhibited by survivors of human rights abuses with an eye towards informing transitional justice and judicial processes and advocating for mental health reforms and reparations for victims. The Lab focuses on the science behind the psychological damage, neurological changes, and mental health pathologies caused by human rights trauma on individuals, their families, and their communities, over time and between generations. Lab affiliates include faculty from the Schools of Medicine and Law as well as members of the WSD HANDA Center for Human Rights & International Justice and Palo Alto University’s graduate program in Psychology. Lab affiliates and colleagues analyze and build upon the rich data in the interdisciplinary scientific literature and in specific conflict situations to identify the impact on human psychology of various forms of mass trauma, including genocide, crimes against humanity, rape, and torture. This analysis is deployed to advocate for survivors’ human rights and mental health in a whole range of settings, including criminal trials, civil suits for money damages, humanitarian parole hearings, and asylum proceedings. Most recently, the Lab collaborated with the Office of the Prosecutor of the ICC to provide testimony and an expert report in the case against Jean-Pierre Bemba, which resulted in an 18-year sentence for war crimes and crimes against humanity (specifically, mass rape and pillage).¹⁸

Given the obvious utility of the first edition of this text to the ECCC proceedings, the editors decided to update the volume with new research and scholarship. The second edition thus includes updated chapters by a number of the original authors covering the impact of international crimes on psychiatry and social psychology in general and on Cambodian survivors of the Khmer Rouge in

particular. The second edition contains an entirely new chapter on transcultural psychiatry by Inger Agger. Revised and new chapters on the impact of trauma on the courtroom include a close analysis and a critique of the proceedings before the ECCC in Cases 001 and 002/1 and the resulting judgments. Finally, Part III includes updated recommendations, although these have not changed appreciably given the lack of progress toward building a more robust and accessible mental health system in Cambodia since the publication of the first edition of this text. All told, it is hoped that this new edition will continue to inform legal proceedings before the ECCC and other national and international tribunals as well as a process of mental health reform at the national level.

¹⁷ See <http://med.stanford.edu/psychiatry/research/HumanRightsTraumaMH.html>.

¹⁸ See *Prosecutor v. Jean-Pierre Bemba Gombo*, Case ICC-01/05-01/08, Trial Judgment (International Criminal Court March 21, 2016). The Bemba brief is available here: <https://ilg2.org/2016/11/09/expert-report-on-trauma-mental-health-and-mass-rape-prosecutor-v-bemba/>.

INTRODUCTION

Daryn Reicherter (M.D.) is a Clinical Associate Professor in the Department of Psychiatry and Behavioral Sciences of Stanford University's School of Medicine. He is a co-founder and co-director of the Human Rights in Trauma Mental Health Laboratory at Stanford University.

On April 17th, 1975, school teacher Sophany Bay was with her three children in her home when the Khmer Rouge invaded Phnom Penh and Pol Pot declared “year zero” in a massive reorganization of Khmer society. 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 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 eventually 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 had the honor of testifying as Civil Party 1 in Case 002/1 before the Extraordinary Chambers in the Courts of Cambodia against the regime leaders.

She can still 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, although at the time, Cambodia under the Khmer Rouge was largely closed to the outside world and only glimpses and stories of Pol Pot's horrible vision were known beyond Cambodia's borders. For those living under his rule, however, oppression was ever-present.

“To keep you is no benefit, to destroy you is no loss” became the popular



Muslim religious leaders and citizens attending the inauguration ceremony of an exhibition on "Forced Transfer during the Khmer Rouge regime" at Preah Sihanouk Provincial Museum in September 2014. The exhibition displays the experiences of survivors of forced transfer committed by the Khmer Rouge, who moved massive entire populations from the eastern and southern parts of the country to the west and northwest via train. The Khmer Rouge tribunal considered this transfer to be a crime against humanity. The exhibition has been on display at Preah Sihanouk and other provincial museums. Photo by Ouch Makara/Documentation Center of Cambodia Archive

slogan of the Khmer Rouge toward their victims. Hundreds of thousands of 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 almost four 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 purges and massive deportations 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. Although the violence of the regime finally came to an end, the trauma produced by that era remains unforgettable.

Human Psychology as a Target of Terror under the Khmer Rouge

The Khmer Rouge violence was characterized by physical savagery. At the same time, the brutal terror also had a deliberate psychological component. The Khmer Rouge mission to obliterate Khmer culture and start anew made the mass psychology of the Khmer people a calculated target for the regime. This nefarious goal was implemented through the destruction of deeply-rooted principles of Khmer culture and society.

Those who would implement a reign of terror have the goal of dominating the victim into powerlessness. The very purpose of oppression is to undermine the populace's psychological will and to shock an entire populace into submission. The Khmer Rouge under Pol Pot went a step farther with a broad-based and specific attack against important cultural and religious icons with particular symbolic relevance among the people. The defilement of Khmer religion, Khmer art, Khmer familiar relations, and the Khmer social class structure undermined deeply-held societal assumptions and values. 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 a similar pattern.

There is well-established research demonstrating a higher prevalence of trauma-related mental health disorders in post-conflict societies throughout the world. Cambodia offers 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.

Population-based research examining the psychology of people in post-conflict societies can reveal the existence of specific mental health disorders. 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 our standard diagnostic techniques fully measure the psychological impact on future generations.

The 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 invisible. The Court cannot help but find itself immersed in the psychology of trauma. The survivors' needs must be addressed.

In documenting the history and the crimes of the Khmer Rouge, the Documentation Center of Cambodia (DC-Cam) soon realized that trauma-related mental health problems were ubiquitous in post-genocide Cambodia. After countless interviews with survivors, the same patterns of psychological trauma presented again and again. As people began to describe what they had experienced, these hidden scars would open to reveal a profound suffering that is

known well to the field of psychology. These scars were deemed so intrinsic to the documentation of genocide and other crimes against humanity that DC-Cam decided to include trauma-related mental suffering as a research category in their documentation efforts. It became clear that documenting crimes against humanity must go beyond chronicling the wicked deeds of perpetrators and interring the bones of the victims. Rather, documenting international crimes must include an examination of the psychology of the survivors who endure and lament for those who did not. In Cambodia and beyond, documenting the psychological scars in the wake of such a history is essential to the telling of a fuller story of abuses. And, once the ECCC were established, the need to address this societal suffering emerged as a major area of concern for the legacy of Cambodia.

This volume attempts to bridge interdisciplinary inquiries into Cambodia's destructive history under the Khmer Rouge, the launching of an international court of justice, and efforts to alleviate the mental suffering of a nation. To this end, Part I considers trauma's effects on human psychology generally and in Cambodia in particular. It offers a statistical and theoretical overview of the mental health consequences of mass violence at the individual and societal levels. It also 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. This part also examines more broadly how the concept of justice relates to trauma psychology. It also offers a critique of the Court's reaction to the psychological state of the survivors.

Part III raises questions about the presentation of mental health outcomes in transitional justice mechanisms when it comes to prosecutions, survivor advocacy, and the documentation of international crimes. It discusses reparations aimed at enhancing the mental health of survivors as a form of accountability and the way in which transitional justice programs can and should advocate for improved access to psychological services for survivors.

Part IV examines the resources available to address 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 advance the idea that trauma-related psychological problems must be anticipated 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 victims of such atrocities. It is part of the living history of violence that should not be forgotten or neglected.

This volume is also intended to advocate for respect for the survivors' psychology in the justice process. Tribunals traditionally sift 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. 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 merely an afterthought. Although there is room for improvement, the ECCC has shown some progress in this area relative to other international tribunals, particularly when it comes the handling of evidence of mental suffering in court and in the decisions it has rendered.

This volume is also 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.

The first edition of this text, "Cambodia's Hidden Scars: Trauma Psychology in the Wake of the Khmer Rouge" was accepted as evidence by the ECCC. The research contained in the book was cited in the testimony of expert witnesses on mental health. Sophany Bay, the survivor whose experience is highlighted above, testified about her personal story of victimization and survival. She also testified about the mental health consequences of the Khmer Rouge era that she has seen in her diaspora Cambodian community. She had her day in court and was able to

elucidate the mental health data through her experience as a survivor and as a professional.

The ECCC in Case 002/1 rendered a guilty verdict with life sentences. The judgment in Case 002/1 reflected the fact that the judges had internalized the key message of this book:

The chamber finds that as a consequence of the crimes of which the accused have been convicted, the Civil Parties and a very large number of additional victims have suffered immeasurable harm, including physical suffering, *loss of dignity*, *psychological trauma*, and grief arising from the loss of family members and close relations.



Sophany Bay stands outside the ECCC while testifying.

Throughout its judgment, the Chamber referred specifically to the psychological effects of trauma. Furthermore, the Chamber acknowledged and endorsed the provision of reparations for mental health access for survivors, recommending major funding for two treatment programs.

The editors of and contributors intend to for this new and updated volume to continue the advocacy for the provision of better mental health services for survivors of the Khmer Rouge, and for survivors of international crimes generally, through the full range of transitional justice processes.

PART 1: THE EXPERIENCE OF TRAUMA IN CAMBODIA

THE IMPACT OF WAR AND GENOCIDE ON PSYCHIATRY AND SOCIAL PSYCHOLOGY

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

Alexandra Aylward (B.A.) is a former research coordinator in the Department of Psychiatry and Behavioral Sciences at Stanford University. She is currently pursuing a doctoral degree in Sociology of Education at New York University.

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, the number of people disabled, or 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, these impacts 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. Theoretically, this gap may be partially bridged by understanding the mental health consequences for individuals and the subsequent risks of pathological behaviors. These 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 further multiplied through the multi-generational 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. However, in recent decades 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. Organizations such as 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.¹⁹

For example, the resolution of the WHO Executive Board in January 2005 urged support for "implementation of programmes to repair the psychological damage of war, conflict[,] and natural disasters."²⁰ The WHO reports that conflicts, wars, and civil strife are associated with higher rates of mental health problems.²¹ 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.²²

Clearly, international health organizations have recognized the consequences of mental health disorders for human health and social function as a major,

¹⁹ Inter-Agency Standing Committee, *IASC Guidelines on Mental Health and Psychosocial Support in Emergency Settings* (June 20, 2007), www.unhcr.org/refworld/docid/46c0312d2.html.

²⁰ World Health Organization, *Resolution on health action in crises and disasters*, A58/6 (Apr. 15, 2005), available at http://apps.who.int/gb/ebwha/pdf_files/WHAS8/A58_6-en.pdf.

²¹ World Health Organization, *The World Health Report 2001—Mental Health: New Understanding*, New Hope (2001), www.who.int/whr/2001/en/.

²² World Health Organization, *The Invisible Wounds: The Mental Health Crisis in Afghanistan* (2001), www.who.int/disasters/repo/7399.pdf.

worldwide problem.

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 examining the prevalence of mental health disorders as defined by the Diagnostic Statistical Manual of Psychiatry (DSM-IV)²³ or by the International Classification of Diseases, 9th Revision (ICD-9)²⁴ 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 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 mental health disorder very commonly associated with war trauma is PTSD. PTSD is defined in the DSM-5 and described in detail in chapter 6 of this volume (“Post-Traumatic Stress Reactions and Secondary Trauma Effects in Tribunals”). PTSD was also previously defined in the DSM-IV in essentially the same way as it is defined in DSM-5. Most of the studies referred to in this chapter (and throughout the volume) are based on DSM IV criteria and associated rating scales. PTSD is not the only mental health disorder expected to increase in a population affected by war. Other trauma-related mental health disorders, like anxiety and severe mood disorders, are also seen at higher frequencies. In addition, somatoform disorders—in which the patient experiences physical pain as a result of psychological stress—are more prevalent in post-conflict settings.

Furthermore, psychiatric disorders often occur simultaneously, as one disorder can create a heightened risk of developing another. For instance, PTSD and depression can occur together in the same individual. Similarly, a disorder like PTSD may increase the likelihood of alcohol use, so an individual with PTSD may also develop alcohol dependence. Indeed, alcohol and other substance-use disorders are extremely common among persons with PTSD.²⁵ For example, as many as 75% of combat veterans with lifetime PTSD also met the criteria for alcohol abuse or dependence.²⁶ Researchers have identified PTSD as a mediating

23 AM. PSYCHIATRIC ASSOCIATION, *DIAGNOSTIC AND STATISTICAL MANUAL OF MENTAL DISORDERS* (4th ed. 1994).

24 World Health Organization, *MANUAL OF THE INTERNATIONAL STATISTICAL CLASSIFICATION OF DISEASES, INJURIES AND CAUSES OF DEATH* (9th rev. 1977).

25 L.K. Jacobsen, S.M. Southwick, & T.R. Kosten, *Substance Use Disorders in Patients With Posttraumatic Stress Disorder: A Review of the Literature*, 158(8) AM. J. PSYCHIATRY 1184 (2001).

26 R.A. Kulka et al., *Trauma and the Vietnam War Generation: Report of Findings from the National Vietnam Veterans Readjustment Study* (1990).

factor in the relationship between veterans’ combat experience and its negative effects on veterans’ families. To some extent, veterans’ anger is associated with troubled family relationships and secondary traumatization among family members.²⁷ Destructive social phenomena like domestic violence increase after war²⁸ 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, for example.²⁹ Additionally, veterans who have comorbid trauma disorders in addition to PTSD are more susceptible to using violence against their intimate partners.³⁰ The perpetration of violence is a common occurrence for persons affected by violence and by PTSD. While there is not always 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

One obvious at-risk population is soldiers experiencing and participating 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 diagnosed with PTSD.³¹ In a different American study on Gulf War veterans, the prevalence of PTSD among a population-based sample of 11,441 veterans was 12.1%. The estimated overall prevalence of PTSD among the Gulf War veteran population is 10.1%.³²

Civilians

Civilian populations often suffer significantly during war, both as a result of

27 T. Galovski & J. Lyons, *Psychological Sequelae of Combat Violence: A Review of the Impact of PTSD on the Veteran’s Family and Possible Interventions*, 9 AGGRESSION & VIOLENT BEHAVIOR 477 (2004).

28 D.M. Glenn et al., *Violence and Hostility among Families of Vietnam Veterans with Combat-related Posttraumatic Stress Disorder*, 17 VIOLENCE & VICTIMS 473 (2002).

29 C. Catani, E. Schauer, & F. Neuner, *Beyond Individual War Trauma: Domestic Violence Against Children in Afghanistan and Sri Lanka*, 34(2) J. MARITAL & FAM. THERAPY 165 (2008).

30 M.D. Sherman et al., *Domestic Violence in Veterans with Posttraumatic Stress Disorder who Seek Couples Therapy*, 32(4) J. MARITAL & FAM. THERAPY 479 (2006).

31 R.A. Kulka et al., *Trauma and the Vietnam War Generation*, *supra* note 26.

32 H.K. Kang et al., *Post-Traumatic Stress Disorder and Chronic Fatigue Syndrome-like Illness among Gulf War Veterans: A Population-based Survey of 30,000 Veterans*, 157(2) AM. J. EPIDEMIOLOGY 141 (2003).

systemic violence directed against civilian populations in conflict and due to other spillover effects that harm the civilian population. The use of tactics such as ethnic cleansing, sexual violence, torture, and genocide as weapons of war place 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, the destruction of the civilian infrastructure, and exposure to disease—all result in staggering numbers of civilian deaths. For example, from 1998 to 2003, an estimated 5.4 million people died in the war in the Congo. Most were civilians, and most died from starvation and disease.³³ The exposure to violence greatly increases the risk of developing mental health problems.

Victims of Sexual Violence

The use of sexual and gender-based violence (SGBV) and specifically mass rape as a weapon of war and a tactic of genocide has also gained more attention in recent years. Such violence had previously been considered an unfortunate consequence of war, but is now being recognized as a prosecutable war crime and crime against humanity. Indeed, in 2008, the U.N. Security Council passed a resolution condemning sexual violence as a war crime, a crime against humanity, a form of torture, and a constituent act of genocide.³⁴

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.³⁵

In all of these conflicts, perpetration of rape and other forms of sexual violence

as weapons of war has had devastating effects on the social fabric of societies and the mental health of the victims, men and women. Such violence is deployed as a method for humiliating the victim, their families, and their communities. The consequences—including unwanted pregnancies and children, sexually-transmitted diseases, social stigmatization, and familial rejection—frequently may result in a near complete breakdown of family structure.

Children

Children, like other victims of war, are often injured or killed during conflict. Additionally, vulnerable children are often recruited to serve as child soldiers or sex slaves, particularly in places like Africa and Asia. Even if not the subject of violence directly, children are also impacted by the loss of a parent or guardian. 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. These conditions are highly correlated with childhood trauma and subsequent serious mental health pathology.³⁶

Lasting and Intergenerational Effects of War and Genocide

The psychological effects of war trauma last much longer than the war itself, impacting both survivors and their children by affecting parenting styles and perpetuating maladaptive behaviors in the next generation. Much of the data on this topic comes from studies of survivors of the Jewish Holocaust of World War II. During the Holocaust, approximately six million European Jews were killed of the nine million Jews who resided in Europe before the Holocaust. They left behind about two million survivors.³⁷ These survivors were and are at risk for emotional disorders and adjustment problems, including emotional distress, depression, anxiety,³⁸ posttraumatic stress disorder,³⁹ and chronic pain.⁴⁰ Moreover, Holocaust survivors with PTSD reported more depressive symptoms than those

33 Craig Timberg, *Report: Congo's War and Aftermath Have Killed 5.4 Million*, Wash. Post (Jan. 23, 2008).

34 The United Nations Department of Public Information, *Security Council Demands Immediate and Complete Halt to Acts of Sexual Violence Against Civilians in Conflict Zones, Unanimously Adopting Resolution 1820, SC/9364* (June 19, 2008), www.un.org/press/en/2008/sc9364.doc.htm.

35 *The United Nations, Report on the situation of human rights in Rwanda submitted by Mr. Rene Degni-Segui, Special Rapporteur of the Commission on Human Rights*, UN Resolution S-3/1, (May 25, 1994); Bunch, Charlotte and Reilly, Niamh, *The Global Campaign and Vienna Tribunal for Women's Human Rights*, Center for Women's Global Leadership and the United Nations Development Fund for Women (1994), www.cwgl.rutgers.edu/docman/coalition-building-publications/283-demand-accountability/file; Amber Peterman, Tia Palermo, and Caryn Bredenkamp, *Estimates and Determinants of Sexual Violence Against Women in the Democratic Republic of Congo*. 101(6) *American Journal of Public Health* (June 2011); Physicians for Human Rights, *War-Related Sexual Violence in Sierra Leone: A Population-Based Assessment* (2002), https://s3.amazonaws.com/PHR_Reports/sierra-leone-sexual-violence-2002.pdf.

36 Schauer, Elizabeth and Elbert, Thomas, *The Psychological Impact of Child Soldiering*, chapter in *TRAUMA REHABILITATION AFTER WAR AND CONFLICT*, edited by Martz, E. (2010).

37 D. Newyck & F. Nicosia, *THE COLUMBIA GUIDE TO THE HOLOCAUST* (2000).
38 W.G. Niederland, *The Problem of the Survivor: The Psychiatric Evaluations of Emotional Problems in Survivors of Nazi Persecution*, in *MASSIVE PSYCHIC TRAUMA* 8-22 (H. Krystal ed., 1968); A. Sharon et al., *Psychiatric Disorders and Other Health Dimensions among Holocaust Survivors 6 Decades Later*, 195(4) *BRIT. J. PSYCHIATRY* 331 (2009).

39 E. Barel et al., *Surviving the Holocaust: A Meta-analysis of the Long-term Sequelae of a Genocide*, 136(5) *PSYCHOL. BULL.* 677 (2010); K. Kuch & B. Cox, *Symptoms of PTSD in 124 Survivors of the Holocaust*, 149(3) *AM. J. PSYCHIATRY* 337 (1992).

40 A. Yaari et al., *Chronic Pain in Holocaust Survivors*, 17(3) *J. PAIN & SYMPTOM MGMT.* 181 (1999).

without PTSD.⁴¹ 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.⁴²

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.⁴³ 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.⁴⁴ 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.⁴⁵ 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.⁴⁶ According to Danieli, the effects of trauma may become intergenerational when they affect families and succeeding generations.⁴⁷ 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.⁴⁸

Yehuda and colleagues observed a higher prevalence of lifetime PTSD, mood disorders, and anxiety disorders in offspring of Holocaust survivors than in

41 R. Yehuda et al., *Depressive Features in Holocaust Survivors with Post-traumatic Stress Disorder*, 7(4) J. TRAUMATIC STRESS 699 (1994).

42 J. Brodsky et al., *Holocaust Survivors in Israel: Population Estimates, Demographic, Health and Social Characteristics, and Needs*, Center for Research on Aging, Myers-JDC-Brookdale Institute, (2010).

43 E. Barel et al., *Surviving the Holocaust*, *supra* note 39.

44 *Id.*

45 B. Trappler, C.I. Cohen, & R. Tulloo, *Impact of Early Lifetime Trauma in Later Life: Depression Among Holocaust Survivors 60 Years After the Liberation of Auschwitz*, 15(1) AM. J. GERIATRIC PSYCHIATRY 79 (2007).

46 H. Keilson, *SEQUENTIAL TRAUMATIZATION IN CHILDREN* (1992).

47 Y. Danieli, *Assessing Trauma Across Cultures from a Multigenerational Perspective*, in *CROSS-CULTURAL ASSESSMENT OF PSYCHOLOGICAL TRAUMA AND PTSD* 65-89 (J. Wilson & C. Tang eds., 2007); *INTERNATIONAL HANDBOOK OF MULTIGENERATIONAL LEGACIES OF TRAUMA* (Y. Danieli ed., 1998)

48 R. Dekel & H. Goldblatt, *Is There Intergenerational Transmission of Trauma? The Case of Combat Veterans' Children*. 78(3) AM. J. ORTHOPSYCHIATRY 281, 284 (2008).

controls.⁴⁹ 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.⁵⁰ This was true in both community and clinical subjects.

Two meta-analyses have investigated second (children of survivors) and third (grandchildren of survivors) generation traumatization in Holocaust survivor families. Van IJzendoorn and colleagues found evidence of intergenerational 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.⁵¹ Additionally, Sagi-Schwartz, Van IJzendoorn, and Bakermans-Kranenburg did not find evidence for third-generation traumatization in Holocaust families and interpreted these findings as a sign of resilience, even when the Holocaust survivors were profoundly traumatized personally.⁵²

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

Measured Mental Health Consequences of Current and Recent Conflicts

There has been a large accumulation of data 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 as compared to more peaceful societies. Unsurprisingly, global data show that trauma-related mental health disorders are far more prevalent in post-conflict countries than in peaceful

49 R. Yehuda et al., *Maternal, Not Paternal, PTSD is Related to Increased Risk for PTSD in Offspring of Holocaust Survivors*, 42(13) J. PSYCHIATRIC RES. 1104 (2008).

50 R. Yehuda et al., *Vulnerability to Posttraumatic Stress Disorder in Adult Offspring of Holocaust Survivors*, 155(9) AM. J. PSYCHIATRY 1163, 1163-71 (1998).

51 M.H. van IJzendoorn, M.J. Bakermans-Kranenburg, & A. Sagi-Schwartz, *Are Children of Holocaust Survivors Less Well-adapted? A Meta-analytic Investigation of Secondary Traumatization*, 16(5) J. TRAUMATIC STRESS 459 (2003).

52 A. Sagi-Schwartz et al., *Attachment and Traumatic Stress in Female Holocaust Child Survivors and Their Daughters*, 160(6) AM. J. PSYCHIATRY 1086 (2003).

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.⁵³

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%.⁵⁴ 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%.⁵⁵

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.⁵⁶ Violence and a bloody civil conflict ensued, causing an estimated 150,000 to 200,000 deaths and approximately 15,000 forcibly disappearances.⁵⁷ FIS and other armed terrorist groups also massacred civilians to punish communities and warn them against withdrawing their support.⁵⁸ In 2007, Algeria suffered an upsurge in violence, including suicide bombings that targeted government and foreign interests.⁵⁹

53 In addition to the presented case studies, the Ministry of Health Iraq (in collaboration with the WHO) estimates that 29% of adolescents in Iraq and 33% of adolescents in occupied Palestinian territories had PTSD. Ministry of Health Iraq & WHO, *Mental Health in Iraq* (2006). The prevalence rate of assessed PTSD was 17.8% in Gaza. J.T. de Jong et al., *Lifetime Events and Posttraumatic Stress Disorder in 4 Postconflict Settings*, 286(5) *JAMA* 555 (2001).

54 B.L. Cardozo et al., *Mental Health, Social Functioning, and Disability in Postwar Afghanistan*, 292(5) *JAMA* 575 (2004).

55 W.F. Scholte et al., *Mental Health Symptoms Following War and Repression in Eastern Afghanistan*, 292(5) *JAMA* 585 (2004).

56 M. Turshen, *Militarism and Islamism in Algeria*, 39(1-2) *J. ASIAN & AFR. STUD.* 119 (2004).

57 Y. Ryan, *Uncovering Algeria's Civil War*, *AL JAZEERA*, Nov. 18, 2010, <http://english.aljazeera.net/indepth/2010/11/2010118122224407570.html>.

58 M. Sidhoum et al., *Terrorism, Traumatic Events and Mental Health in Algeria*, in *TRAUMA, WAR, AND VIOLENCE: PUBLIC MENTAL HEALTH IN SOCIO-CULTURAL CONTEXT* 367-404 (J. de Jong ed., 2002).

59 'Dozens killed' in Algeria blasts, *BBC NEWS*, Dec. 11, 2007, <http://news.bbc.co.uk/2/hi/7137997.stm>; The Associated Press, *Algeria: Suicide Bombing Kills* 9, *New York Times*, June 11, 2010, www.nytimes.com/2010/06/12/world/africa/12briefs-SUICIDEBOMBI_BRF.html.

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.⁶⁰ De Jong and colleagues found a 37.4% prevalence rate of assessed PTSD.⁶¹ Women manifested more PTSD symptoms than men.⁶² 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, a measurement of an individual's severity of illness.⁶³ 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 the secession of 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 flared in Kosovo from 1998 to 1999.⁶⁴ 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.⁶⁵

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

60 M. Sidhoum et al., *supra* note 58.

61 J.T. de Jong et al., *Lifetime Events*, *supra* note 53.

62 *Id.*

63 M. Sidhoum et al., *supra* note 58. A GSI score above 1 is considered high. The GSI is designed to measure overall psychological distress. The GSI is obtained from the Symptom Checklist-90-R (SCL-90-R) instrument, which helps to evaluate a broad range of psychological problems and symptoms of psychopathology. The instrument is also useful in measuring patient progress or treatment outcomes.

64 Int'l Ctr. for Transitional Just. [ICTJ], *Transitional Justice in the Former Yugoslavia*, Jan. 2009, www.ictj.org/sites/default/files/ICTJ-FormerYugoslavia-Justice-Facts-2009-English.pdf.

65 *Id.*

initial assessment, and 16% had developed PTSD, depression, or both.⁶⁶ 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.⁶⁷ 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.⁶⁸ 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.⁶⁹

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.⁷⁰ 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.⁷¹

In a random survey of 2091 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 1.43.⁷² 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 2074 respondents with data on exposure to trauma, 1563 (75.4%) were forced to flee their homes, 1526 (73.0%) had a close member of their family killed, and 1472 (70.9%) had property destroyed or lost.⁷³ 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

66 R.F. Mollica et al., *Longitudinal Study of Psychiatric Symptoms, Disability, Mortality, and Emigration among Bosnian Refugees*, 286(5) JAMA 546 (2001).

67 B.L. Cardozo, *Mental Health, Social Functioning, and Attitudes of Kosovar Albanians Following the War in Kosovo*, 284(5) JAMA 569 (2000).

68 *Id.*

69 P. Smith et al., *War Exposure Among Children from Bosnia-Herzegovina: Psychological Adjustment in a Community Sample*, 15(2) J. TRAUMATIC STRESS 147 (2002).

70 *Rwanda: How the genocide happened*, BBC NEWS, Dec. 18, 2008, <http://news.bbc.co.uk/2/hi/1288230.stm>.

71 A. DES FORGES, *LEAVE NONE TO TELL THE STORY: GENOCIDE IN RWANDA*, (1999).

72 Adjusted Odds Ratios (OR) refers to ORs for all significant variables that are adjusted for the effects of other significant predictors in a model.

73 P.N. Pham, H.M. Weinstein, & T. Longman, *Trauma and PTSD Symptoms in Rwanda*, 292(5) JAMA 602, 602-12 (2004).

future, which suggest that societal interventions should consider the effects of trauma if reconciliation is to be realized.⁷⁴

Sri Lanka

The conflict between the majority Sinhala and minority Tamil population lasted for nearly thirty years.⁷⁵ 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%).⁷⁶

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.⁷⁷ A UNICEF Study found evidence of psychological effects of the prolonged conflict situation in a high proportion of a sample of 10,000 children.⁷⁸ 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.⁷⁹

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 loomed in the background of systemic

74 *Id.*

75 R.S. Murthy & R. Lakshminarayana, *Mental Health Consequences of War: A Brief Review of Research Findings*, 5(1) WORLD PSYCHIATRY 25 (2006).

76 D. Somasundaram & C.S. Jamunanantha, *Psychosocial Consequences of War*, in *TRAUMA, WAR, AND VIOLENCE: PUBLIC MENTAL HEALTH IN SOCIO-CULTURAL CONTEXT* 205-58 (J. de Jong ed., 2002).

77 M. Odenwald et al., *Use of Khat and Posttraumatic Stress Disorder as Risk Factors for Psychotic Symptoms: A Study of Somali Combatants*, 69(7) SOC. SCI. & MED. 1040 (2009).

78 U.N. CHILDREN'S FUND [UNICEF], *FROM PERCEPTION TO REALITY—A STUDY OF CHILD PROTECTION IN SOMALIA* (2004).

79 R.S. Murthy & R. Lakshminarayana, *supra* note 75.

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.⁸⁰

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.⁸¹ 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).⁸² 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.⁸³ 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.⁸⁴

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.⁸⁵ 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%.⁸⁶ Probable PTSD was significantly associated with mental disability (40.2% versus 7.9%) and physical disability (39.6% versus 20.1%).⁸⁷

Respondents with high levels of perceived justice⁸⁸ for violations perpetrated by the Khmer Rouge were less likely to have probable PTSD than those with low levels (7.4% versus 12.7%).⁸⁹

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.⁹⁰

In a study of the 586 Cambodian refugees between thirty-five and seventy-five years old who had lived in Cambodia during the Khmer Rouge reign and relocated to Long Beach, California—the largest Cambodian community in the United States—all participants had been exposed to trauma before immigration to the United States. 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.⁹¹

Adolescent Cambodian refugees, who were child-survivors, have high levels of stress exposure and trauma symptoms.⁹² Starvation and exposure to 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

80 J.T. de Jong et al., *Lifetime Events and Posttraumatic Stress Disorder*, *supra* note 53.

81 V. Dubois et al., *Household Survey of Psychiatric Morbidity in Cambodia*, 50(2) INT'L J. SOC. PSYCHIATRY 174 (2004).

82 *Id.*

83 *Id.*

84 *Id.*

85 J. Sonis et al., *Probable Posttraumatic Stress Disorder and Disability in Cambodia*, 302(5) JAMA 527 (2009).

86 *Id.*

87 *Id.*

88 Perceived justice is measured on a scale that assesses satisfaction with punishment of perpetrators, apologies by perpetrators, and financial restitution for suffering.

89 *Id.*

90 R.F. Mollica et al., *The Effect of Trauma and Confinement on Functional Health and Mental Health Status of Cambodians Living in Thailand-Cambodia Border Camps*, 270(5) JAMA 581 (1993).

91 G.N. Marshall et al., *Mental Health of Cambodian Refugees 2 Decades after Resettlement in the United States*, 294(5) JAMA 571 (2005).

92 G.M. Realmuto et al., *Adolescent Survivors of Massive Childhood Trauma in Cambodia: Life Events and Current Symptoms*, 5(4) J. TRAUMATIC STRESS 589 (1992).

PTSD. Age was strongly related to reporting higher trauma exposure.⁹³ Likewise, in a sample of Cambodian refugees attending a psychiatric clinic in the United States, 56% met DSM-IV criteria for PTSD.⁹⁴

Beyond the individual statistics for mental health disorders, Cambodia endured traumatic extremes on a societal level. Forced marriages, the separation of families and kinship groups, and relocation of children away from their parents were implemented and enforced during the Khmer Rouge period. In fact, the Khmer Rouge made every attempt to ban family life and deconstruct familial bonds. In addition, in a majority Buddhist nation, the Khmer Rouge attempted to eliminate religion by executing countless Buddhist monks and destroying Buddhist temples and shrines. Indeed, most cultural constructs became a target of destruction for 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 Pedersen 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.⁹⁵

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

⁹³ *Id.*

⁹⁴ D.E. Hinton et al., *Assessment of Posttraumatic Stress Disorder in Cambodian Refugees Using the Clinician-Administered PTSD Scale: Psychometric Properties and Symptom Severity*, 19(3) J. TRAUMATIC STRESS 405 (2006).

⁹⁵ D. Pedersen, *Political Violence, Ethnic Conflict, and Contemporary Wars: Broad Implications for Health and Social Well-being*, 75 Soc. Sci. & Med. 175 (2002).

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. Pedersen 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.⁹⁶

Often mental health problems present as other medical issues, like headaches, pain, or stomach aches, and the psychological component remains undetected, even though it is the primary cause. 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 still 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 forms of anguish that will influence social functioning. 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.

⁹⁶ *Id.*

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.⁹⁷

Psychological dysfunction can become 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.⁹⁸

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 these 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.

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.

⁹⁷ SOCIAL SUFFERING (A. Kleinman, V. Das, & M. Lock eds., 1997).

⁹⁸ *Id.*

2

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

James K. Boehnlein (M.D., M.Sc.) is Professor of Psychiatry, Oregon Health and Science University, and Associate Director for Education, Veterans Administration Northwest Network Mental Illness Research, Education, and Clinical Center (MIRECC).

J. David Kinzie (M.D.) is Professor of Psychiatry, Oregon Health and Science University.

The Khmer Rouge regime of 1975 to 1979 is one of the most brutal recorded in the twentieth century, responsible for the deaths of over two million Cambodians from an initial population of about eight million. The sparse survivors of execution, starvation, and disease among millions murdered were left with multiple and long-standing psychiatric disorders. Our chapter focuses on the mental health of Cambodians around the globe. 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, and specially emphasizing the treatment of Cambodian refugees in our Intercultural Psychiatric Program at the Oregon Health and Science University (OHSU).

Epidemiology and Syndromes Associated with Psychological Trauma among Cambodian Survivors

Our group published the first report of posttraumatic stress disorder (PTSD) among survivors of Cambodian concentration camps in 1984.⁹⁹ 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.¹⁰⁰ Of the thirteen refugees we evaluated, all met the criteria for PTSD by showing symptoms of hyperactivity, numbness, intrusive

thoughts, nightmares, and avoidant symptoms. Since that time, there have been multiple reports and studies throughout the world speaking to the prevalence 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% had clinical depression.¹⁰¹ A rare exception to this trend was a study that found a PTSD rate of 12.1% among 223 refugees in New Zealand.¹⁰² In a study of 1,000 households in Thai refugee camps at Site 2 on the Thai/Cambodian border, a high rate 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.¹⁰³ A later study of 1,017 Cambodians in Cambodia found a current PTSD rate of 11.2% overall, 7.9% among younger people and 14.2% among older people.¹⁰⁴ Probable PTSD was significantly associated with mental disability.

For many years, the validity of applying the PTSD diagnosis cross-culturally was questioned.¹⁰⁵ However, researchers have found that the trauma symptoms noted from Cambodian refugees are nearly ubiquitous with those of trauma victims around the globe.¹⁰⁶ In addition, a report on Khmer adolescents noted that PTSD surmounts variants of language and culture.¹⁰⁷ 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 PTSD by finding four correlated factors—re-experiencing, avoidance, emotional numbing, and hyperarousal.¹⁰⁸

Among Cambodian refugees, there are other psychiatric conditions that co-

101 E.B. Carlson & R. Rosser-Hogan, *Trauma Experiences, Posttraumatic Stress, Dissociation, and Depression in Cambodian Refugees*, 148(11) AM. J. PSYCHIATRY 1548 (1991).

102 P. Cheung, *Post-traumatic Stress Disorder among Cambodian Refugees in New Zealand*, 40(1) INT'L J. SOC. PSYCHIATRY 17 (1994).

103 R.F. 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).

104 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).

105 See, e.g., M. Eisenbruch, *From Posttraumatic Stress Disorder to Cultural Bereavement: Diagnosis of Southeast Asian Refugees*, 33(6) SOC. SCI. & MED. 673 (1991).

106 E.B. Carlson & R. Rosser-Hogan, *Mental Health Status of Cambodian Refugees Ten Years After Leaving Their Homes*, 63(2) AM. J. ORTHOPSYCHIATRY 223 (1993); E.B. Carlson & R. Rosser-Hogan, *Cross-cultural Response to Trauma: A Study of Traumatic Experiences and Posttraumatic Symptoms in Cambodian Refugees*, 7(1) J. TRAUMATIC STRESS 43 (1994).

107 W.H. Sack et al., *Does PTSD Transcend Cultural Barriers? A Study from the Khmer Adolescent Refugee Project*, 36(1) J. AM. ACAD. CHILD & ADOLESCENT PSYCHIATRY 49 (1997).

108 P.A. Palmieri et al., *Confirmatory Factor Analysis of Posttraumatic Stress Symptoms in Cambodian Refugees*, 20(2) J. TRAUMATIC STRESS 207 (2007). Hyperarousal refers to a state of heightened internal, nervous system stimulation. Hyperarousal trauma symptoms may include difficulties falling and staying asleep, night terrors, and an exaggerated startle response.

99 J.D. Kinzie et al., *Posttraumatic Stress Disorder among Survivors of Cambodian Concentration Camps*, 141(5) AM. J. PSYCHIATRY 645 (1984).

100 AM. PSYCHIATRIC ASS'N, DIAGNOSTIC AND STATISTICAL MANUAL OF MENTAL DISORDERS (1980)

exist with PTSD. We reported on posttraumatic psychosis among Cambodian refugees in our Intercultural Program.¹⁰⁹ 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 individuals. A study in Thai refugee camps found that traumatic brain injury was strongly associated with depression and had a weaker association with PTSD.¹¹⁰ Brain injury represented 4% of the total traumatic events and contributed to 20% of the total symptom score for depression and 8% of the total symptom score for PTSD.¹¹¹ 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.¹¹²

Somatization—the manifestation of physical symptoms with no identifiable physical origin—is often the presenting complaint among Cambodians with depression and PTSD.¹¹³ 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.¹¹⁴ 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.¹¹⁵ The 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 high-volume stress caused by the phenomenon. The authors' ongoing research studying key idioms of distress and somatic complaints among Cambodian refugees has continued to show the links between trauma and certain

109 J.D. Kinzie & J. K. Boehnlein, *Post-traumatic Psychosis among Cambodian Refugees*, 2(2) J. TRAUMATIC STRESS 185 (1989).

110 R.F. Mollica et al., *Psychiatric Effects of Traumatic Brain Injury Events in Cambodian Survivors of Mass Violence*, 181 BRIT. J. PSYCHIATRY 339 (2002).

111 *Id.*

112 D.E. Hinton et al., *Anger-associated Panic Attacks in Cambodian Refugees with PTSD: A Multiple Baseline Examination of Clinical Data*, 41(6) BEHAV. RES. & THERAPY 647 (2003).

113 P. Cheung, *Somatization as a Presentation in Depression and Post-traumatic Stress Disorder among Cambodian Refugees*, 27(3) AUSTL. & N.Z. J. PSYCHIATRY 422 (1993).

114 D.E. Hinton et al., *The Panic Attack-posttraumatic Stress Disorder Model: Applicability to Orthostatic Panic Among Cambodian Refugees*, 37(2) COGNITIVE BEHAV. THERAPY 101 (2008).

115 D.E. Hinton et al., *Sleep Paralysis among Cambodian Refugees: Association with PTSD Diagnosis and Severity*, 22(2) DEPRESSION & ANXIETY 47 (2005). Sleep paralysis occurs when a person remains aware while the body is asleep; the condition can cause panic symptoms or be accompanied by hallucinations.

somatic symptoms such as dizziness and weakness, and psychological symptoms such as “thinking a lot.”¹¹⁶

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.¹¹⁷ In addition, refugees who endured a high number of resettlement stresses in the previous year experienced increased risk of both PTSD and depression, and those who endured financial stress experienced increased 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.¹¹⁸ Overall, the least acculturated were found to have the highest rate of psychiatric morbidity.¹¹⁹

Addiction, however, is less common than was predicted. 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.¹²⁰ The breadth of trauma exposure and marital status were significant predictors of disordered gambling. Problem-drinking was also found among Cambodian refugees, but in a study by D'Amico, Schell, Marshall et al., the rate of consumption and alcohol use problems were low.¹²¹ In the thirty days prior to the interview, only 26% reported any alcohol consumption and only 2% reported heavy drinking.¹²² Recent alcohol consumption was not related to the degree of trauma exposure or psychiatric distress.¹²³

Reactivation

Among the more predominant aspects of PTSD, especially among refugees, is

116 D.E. HINTON ET AL., *KHYAL ATTACKS: A KEY IDIOM OF DISTRESS AMONG TRAUMATIZED CAMBODIAN REFUGEES*, 34(2) CULT MED PSYCH 244 (2010); D.E. Hinton et al., *PTSD and Key Somatic Complaints and Cultural Syndromes Among Rural Cambodians: The Results of a Needs Assessment Survey*, 26(3) MED ANTHRO QUARTERLY 383 (2012); D.E. Hinton et al., *The Relationship of PTSD to Key Somatic Complaints and Cultural Syndromes Among Cambodian Refugees Attending a Psychiatric Clinic: The Cambodian Somatic Symptom and Syndrome Inventory (CSSI)*, 50(3) TRANSCULT. PSYCHIATRY 347 (2013)

117 R.G. Blair, *Risk Factors Associated with PTSD and Major Depression Among Cambodian Refugees in Utah*, 25(1) HEALTH & SOC. WORK 23 (2000).

118 P. Cheung, *Acculturation and Psychiatric Morbidity among Cambodian Refugees in New Zealand*, 41(2) INT'L J. SOC. PSYCHIATRY 108 (1995).

119 *Id.*

120 G.N. Marshall et al., *Prevalence and Correlates of Lifetime Disordered Gambling in Cambodian Refugees Residing in Long Beach, CA*, 11(1) J. IMMIGRANT & MINORITY HEALTH 35 (2009).

121 E.J. D'Amico et al., *Problem Drinking among Cambodian Refugees in the United States: How Big of a Problem Is It?* 68(1) J. STUD. ALCOHOL & DRUGS 11 (2007).

122 *Id.*

123 *Id.*

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 many refugees were reactivated when the attacks on the United States' World Trade Center in 2001 occurred. This reactivation of symptoms occurred among our refugees from Southeast Asia, Bosnia, and Somalia, partly related to the widely televised images of this event. PTSD patients reacted most intensely, with increased hyperarousal symptoms, including nightmares about their original traumas. Generally, symptoms remitted two to three months after perceived threats receded.¹²⁴

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 responses tended to occur while watching all scenes, not just scenes specific to Cambodian trauma, indicating a general non-specific arousal. Interestingly, the Vietnam veterans had few reactions, while a control group was intermediate in their physiological responses.¹²⁵ From our clinical experience, symptoms are exacerbated during the initial psychiatric evaluation when patients discuss their history, but these 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 nor is discussing trauma the sole goal of treatment.¹²⁶

In summary, victims and survivors of the Khmer Rouge 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 of the two conditions are very similar to those found in Western cultures. A few patients had severe psychosis and a smaller number had traumatic brain injuries. Additionally, patients have described anger, panic attacks, and sleep paralysis. Disordered gambling is a problem but not as predominant as feared, and alcohol consumption is relatively low among Cambodian refugees, which may be due to the influence of Buddhism. Resettlement stress increases symptoms, and low acculturation probably increases psychiatric morbidity. One of the most significant

124 J.D. Kinzie et al., *The Effects of September 11 on Traumatized Refugees: Reactivation of Posttraumatic Stress Disorder*, 190:7 J. NERVOUS & MENTAL DISEASE 437 (2002).

125 J.D. Kinzie et al., *A Cross-cultural Study of Posttraumatic Stress Disorder Symptoms: American and Cambodian Psychophysiological Response to Viewing Traumatic Video Scenes*, 186(11) J. NERVOUS & MENTAL DISEASE 670 (1998).

126 D. Silove et al., *Impact of Recounting Trauma Stories on the Emotional State of Cambodian Refugees*, 46(12) PSYCHIATRIC SERVICES 1287 (1995).

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, as well as 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.¹²⁷ Others reported that infectious diseases were seen in 75% of those initially screened and examined, as well as significant effects of chronic under-nutrition and vitamin deficiency.¹²⁸ The original rate of malnutrition among children, which was 15% in 1979, was reduced to 1% a year later.¹²⁹ Public health measures were very important in reducing the course of communicable diseases. In a 1999 study of a Cambodian refugee community in California, chronic illness and prolonged depression were more prevalent than the infectious diseases and other health problems Cambodian refugees initially suffered from when they first settled in the United States.¹³⁰ In a community survey of 381 Cambodians in Massachusetts, 44% reported fair or poor health.¹³¹ The demographic most likely to report fair or poor health were older female Cambodians who were unable to work due to a disability, had spent a smaller portion of their life in the United States, and had been unable to see a doctor.¹³² 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.¹³³ Particularly, the odds ratio¹³⁴ for hypertension, or high blood pressure, was 1.49 for Cambodian girls to black and white children.¹³⁵

The high prevalence of diabetes and hypertension among our refugee psychiatric patients is striking. In our study of refugees from Vietnam, Cambodia,

127 B. Feldstein & R. Weiss, *Cambodian Disaster Relief: Refugee Camp Medical Care*, 72(6) AM. J. PUB. HEALTH, 589 (1982).

128 B.S. Levy, *Special Report: Working in a Camp for Cambodian Refugees*, 304(23) NEW ENG. J. MED. 1440 (1981).

129 *Id.*

130 S.M. Pickwell, *Health of Cambodian Refugees*, 1(1) J. IMMIGRANT HEALTH 49 (1999).

131 S. Koch-Weser et al., *Self-reported Health among Cambodians in Lowell, Massachusetts*, 17(2) Supp. J. HEALTH CARE POOR & UNDERSERVED 133 (2006).

132 *Id.*

133 R.G. Munger et al., *Elevated Blood Pressure among Southeast Asian Refugee Children in Minnesota*, 133(12) AM. J. EPIDEMIOLOGY 1257 (1991).

134 The odds ratio compares the probability of a certain event occurring in two separate groups. For example, an odds ratio of 1 suggests that the event is equally likely in both populations, whereas an odds ratio greater than 1 suggests that the event is more likely to occur in the first group than the second.

135 *Id.*

Somalia, and Bosnia, the prevalence of hypertension was 42%; diabetes, 15.5%. This was significantly greater than U.S. norms, especially for groups younger than 65 years of age. Body Mass Index (BMI) was related positively to diabetes, and BMI and age were related positively to hypertension.¹³⁶ Clinically we found that the prevalence of dementia in the United States' Cambodian population is increasing as they age. Studies of United States veterans with PTSD indicate a higher prevalence and incidence of dementia in older veterans with PTSD.¹³⁷ Given this, a higher incidence of dementia in older Cambodian refugees is quite likely.

Children and Families

The events of the Khmer Rouge period have left a depression in the structure of Cambodian society and families both 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 familial authority was usurped by Angkor, the obscure, all-powerful, and 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 align with the state and to reject or even betray their families. Age and experience, which once placed elders in roles of authority, were no longer determinants of clout.

After the fall of the Khmer Rouge regime, the country was required to rebuild from the remains of a shattered social foundation. The Khmer Rouge specifically targeted figures that deviated from an agrarian-model society, such as leaders in politics, law, medicine, education, religion, and military. As a result, there were few people who were qualified or 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.¹³⁸ 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.

For children and families who immigrated to the United States, France, and Australia, the pressure of acculturation has further challenged traditional

Cambodian values that had been the foundation of family life. For example, after migration, elderly refugees 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 cultural broker between the family and the majority society. This role reversal has been shown to be a mechanism for second generation effects of trauma.¹³⁹

Furthermore, the norm of children moving away from the family home as young adults presents additional challenges for refugee families. Because of the extensive loss of life during the Khmer Rouge era, Cambodian refugee families may feel more averse to the Western world's routine practices that call for early separation in families, such as moving away to college or to another part of the country after marriage. Chronic depression and PTSD can adversely affect the stability and nurturance of family relationships, and symptoms can be exacerbated at times of significant and unaccustomed family life cycle transitions.

Studies of depression and PTSD in Cambodian families have shown to be extensively co-morbid (i.e., they occurred together),¹⁴⁰ but each condition follows a different chronological course. Depression is related to acculturative pressures that lessen over time whereas PTSD is more chronic, as it is related to war-time stressors.¹⁴¹ When Cambodian-American children and adolescents have been studied in community settings over time, they generally function quite well despite a continually high prevalence of PTSD.¹⁴² For Cambodian adolescents living in North America, an adverse connection between symptomatology and scholastic achievement¹⁴³ or social adjustment¹⁴⁴ has been largely undermined. In

139 N.P. Field et al., *Parental Styles in the Intergenerational Transmission of Trauma Stemming From the Khmer Rouge Regime in Cambodia*, 83(4) AM J ORTHOPSYCHIATRY 483 (2013).

140 J.D. Kinzie et al., *A Three-year Follow-up of Cambodian Young People Traumatized as Children*, 28(4) J. AM. ACAD. CHILD & ADOLESCENT PSYCHIATRY 501 (1989); W.H. Sack et al., *The Khmer Adolescent Project I: Epidemiologic Findings in Two Generations of Cambodian Refugees*, 182(7) J. NERVOUS & MENTAL DISEASE 387 (1994).

141 W.H. Sack et al., *Posttraumatic Stress Disorder Across Two Generations of Cambodian Refugees*, 34(9) J. AM. ACAD. CHILD & ADOLESCENT PSYCHIATRY 1160 (1995); D. Savin, *The Khmer Adolescent Project III: A Study of Trauma from Thailand's Site II Refugee Camp*, 35(3) J. AM. ACAD. CHILD & ADOLESCENT PSYCHIATRY 384 (1996).

142 See Kinzie et al., *A Three-year Follow-up of Cambodian Young People Traumatized as Children*, *supra* note 119; W.H. Sack et al., *The Khmer Adolescent Project II: Functional Capacities in Two Generations of Cambodian Refugees*, 183(3) J. NERVOUS & MENTAL DISEASE 177 (1995); W.H. Sack et al., *A 6-Year Follow-up Study of Cambodian Refugee Adolescents Traumatized as Children*, 32(2) J. AM. ACAD. CHILD & ADOLESCENT PSYCHIATRY, 431 (1993).

143 C. Rousseau & A. Drapeau, *Scholastic Achievement of Adolescent Refugees from Cambodia and Central America*, 35(138) ADOLESCENCE 243 (2000).

144 C. Rousseau et al., *The Complexity of Trauma Response: A 4-year Follow-up of Adolescent Cambodian Refugees*, 27(11) CHILD ABUSE & NEGLECT 1277 (2003).

136 J.D. Kinzie et al., *High Prevalence Rates of Diabetes and Hypertension among Refugee Psychiatric Patients*, 196(2) J. NERVOUS & MENTAL DISEASE 108 (2008).

137 S.U. Qureshi et al., *Greater Prevalence and Incidence of Dementia in Older Veterans with Posttraumatic Stress Disorder*, 58(9) J. AM. GERIATRIC SOC'Y 1627 (2010).

138 J.K. Boehnlein, *Clinical Relevance of Grief and Mourning among Cambodian Refugees*, 25(7) SOC. SCI. & MED. 765 (1987).

fact, the maintenance of core values amid implicit family duty to succeed may foster resilience among these adolescents with an intergenerational legacy of trauma.¹⁴⁵

It is important to emphasize that, regardless of the ultimate effects of the Khmer Rouge trauma experience on Cambodian individuals and families, the intensity and length of the persecution experienced by Cambodians has few parallels in the twentieth century. Based on research related to a large number of traumatized populations throughout the world over the last several decades, it would be expected that Cambodians, both those who have emigrated and those who have not, would experience vast 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 on 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 in response 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.¹⁴⁶ Differences in who improves and who does not are not always or easily explainable by conventional risk factors such as the degree of violence exposure, current stresses, physical health, or the extent of social support.¹⁴⁷ 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 United States—PTSD and major depression were highly co-morbid,¹⁴⁸ and were associated with older age, poor English language proficiency, unemployment, retirement or disability, and poverty.¹⁴⁹ In Cambodia, a national probability sample found that PTSD was significantly associated with

145 C. Rousseau et al., *Family Trauma and Its Association with Emotional and Behavioral Problems and Social Adjustment in Adolescent Cambodian Refugees*, 23(12) CHILD ABUSE & NEGLECT 1263 (1999).

146 J.K. Boehnlein et al., *One Year Follow-up Study of Posttraumatic Stress Disorder Among Survivors of Cambodian Concentration Camps*, 142(8) AM. J. PSYCHIATRY 956 (1985); J.D. Kinzie et al., *The Effects of September 11 on Traumatized Refugees: Reactivation of Posttraumatic Stress Disorder*, *supra* note 124.

147 J.K. Boehnlein et al., *A Ten-year Treatment Outcome Study of Traumatized Cambodian Refugees*, 192(10) J. NERVOUS & MENTAL DISEASE 658 (2004).

148 Comorbid describes the presence of two or more simultaneous, but independent medical conditions or diseases.

149 G.N. Marshall et al., *Mental Health of Cambodian Refugees 2 Decades after Resettlement in the United States*, 294(5) JAMA 571 (2005).

both mental and physical disability.¹⁵⁰

A recent study among Cambodians living in Cambodia and Thailand—the first population-based study comparing conflict vs. non-conflict affected communities from the same ethnic background—found that significantly more respondents met the clinical threshold for depression, PTSD, and physical disability in the conflict vs. non-conflict affected communities, with a dose effect of lifetime traumatic experience for depression and PTSD.¹⁵¹ This study clearly shows that the Pol Pot era trauma continues to have an adverse mental and physical health impact on survivors for decades after the genocidal events. A recent community study among Cambodian refugees in the United States¹⁵² also showed that, decades after the Khmer Rouge era, comorbid depression and PTSD put survivors at risk for physical health problems.

Treatment

A variety of approaches for the treatment of depression and PTSD exist among traumatized populations, specifically Cambodians. The range of approaches 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 prazosin¹⁵³ and clonidine.¹⁵⁴ Antidepressants, both tricyclics and SSRI's, 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.

150 Sonis, *supra* note 104.

151 R.F. Mollica et al., *The Enduring Mental Health Impact of Mass Violence: A Community Comparison Study of Cambodian Civilians Living in Cambodia and Thailand*, 60(1) INT J SOC PSYCHIATRY 6 (2014).

152 S.M. Berthold et al., *Comorbid Mental and Physical Health and Health Access in Cambodian Refugees in the US*, Mar 21 Epub ahead of print, J COMMUNITY HEALTH (2014).

153 M.A. Raskind et al., *A Parallel Group Placebo Controlled Study of Prazosin for Trauma Nightmares and Sleep Disturbance in Combat Veterans with Post-traumatic Stress Disorder*, 61(8) BIOLOGICAL PSYCHIATRY 928 (2007); M.A. Raskind et al., *Reduction of Nightmares and Other PTSD Symptoms in Combat Veterans by Prazosin: A Placebo-Controlled Study*, 160(2) AM. J. PSYCHIATRY 371 (2003); J.K. Boehnlein & J.D. Kinzie, *Pharmacologic Reduction of CNS Noradrenergic Activity in PTSD: The Case for Clonidine and Prazosin*, 13(2) J. PSYCHIATRIC PRAC. 72 (2007); R.N. Aurora et al., *Best Practice Guide for the Treatment of Nightmare Disorder in Adults*, 6(4) J. CLINICAL SLEEP MED. 389 (2010); M.A. Raskind et al., *A Trial of Prazosin for Combat Trauma PTSD with Nightmares in Active-Duty Soldiers Returned from Iraq and Afghanistan*, 170(9) AM J PSYCHIATRY 1003 (2013).

154 J.D. Kinzie & P. Leung, *Clonidine in Cambodian Patients with Posttraumatic Stress Disorder*, 177(9) J. NERVOUS & MENTAL DISEASE 546 (1989); J.D. Kinzie et al., *The Polysomnographic Effects of Clonidine on Sleep Disorders in Posttraumatic Stress Disorder: A Pilot Study with Cambodian Patients*, 182(10) J. NERVOUS & MENTAL DISEASE 585 (1994).

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.¹⁵⁵ Meaning in any society will be influenced by a person's culture, social and secular values, and by religious traditions.

Success in treatment is dependent upon medical providers' ability to bridge 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.¹⁵⁶ For example, a representative sample drawn from Long Beach's Cambodian community exhibited 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.¹⁵⁷

Two of the most common CAM treatments used by Cambodians are coining and cupping. Coining and cupping are commonly used by family members and traditional healers to diminish somatic symptoms that are 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.¹⁵⁸ Modifying exposure-based cognitive behavioral therapy (CBT) by using metaphors and a culturally relevant process can be effective and acceptable to Cambodian patients.¹⁵⁹ 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.¹⁶⁰ 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 resolved in a social context. The effects of the violence of the Khmer Rouge era have been pervasive and 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.¹⁶¹ In this context the role of a healer is to aid in reestablishing equilibrium between the survivor and his or her environment.

For any treatment approach to be 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.¹⁶² 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.¹⁶³ Among Cambodian refugees in the United States, parent-child

158 P. Morris et al., *Variations in Therapeutic Interventions for Cambodian and Chilean Refugee Survivors of Torture and Trauma: A Pilot Study*, 27(3) AUSTL. & N.Z. J. PSYCHIATRY 429 (1993).

159 M.W. Otto & D.E. Hinton DE, *Modifying Exposure-based CBT for Cambodian Refugees with Posttraumatic Stress Disorder*, 13(4) COGNITIVE & BEHAV. PRAC. 261 (2006).

160 D.E. Hinton et al., *Mechanisms of Efficacy of CBT for Cambodian Refugees with PTSD: Improvement in Emotion Regulation and Orthostatic Blood Pressure Response*, 15(3) CNS NEUROSCIENCE & THERAPEUTICS 255 (2009).

161 R. Hinton Desjarlais et al., *WORLD MENTAL HEALTH* (1995); D. Summerfield, *War and Mental Health: A Brief Overview*, 321 BRIT. MED. J. 232 (2000).

162 J.K. Boehnlein et al., *Cambodian American Families*, in *WORKING WITH ASIAN AMERICANS: A GUIDE FOR CLINICIANS* (E. Lee ed., 1997).

163 J.K. Boehnlein et al., *A Comparative Study of Family Functioning Among Vietnamese and Cambodian Refugees*, 183(12) J. NERVOUS & MENTAL DISEASE 768 (1995).

155 J.D. Kinzie, *Combined Psychosocial and Pharmacological Treatment of Traumatized Refugees*, in *CROSS-CULTURAL ASSESSMENT OF PSYCHOLOGICAL TRAUMA AND PTSD* 359-69 (J.P. Wilson & C.S. Tang eds., 2007).

156 T.C. Daley, *Beliefs about Treatment of Mental Health Problems among Cambodian American Children and Parents*, 61(11) SOC. SCI. & MED. 2384 (2005).

157 S.M. Berthold et al., *U.S. Cambodian Refugees' Use of Complementary and Alternative Medicine for Mental Health Problems*, 58(9) PSYCHIATRIC SERVICES 1212 (2007).

conflict¹⁶⁴ and child abuse and neglect in lieu of parental substance abuse and mental illness,¹⁶⁵ make it imperative that family and social factors be addressed in treatment programs. Family therapy can help parents and children navigate the process of cultural change and enhance the family's ability to negotiate between the cultural worlds of the home and the host countries.¹⁶⁶

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.

3

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

Devon Hinton (M.D., Ph.D.) is an Associate Professor of Psychiatry at Harvard Medical School and Massachusetts General Hospital.

Alexander Hinton (Ph.D.) is Professor of Anthropology and Director of the Center for the Study of Genocide, Conflict Resolution, and Human Rights, Rutgers University.

Youk Chhang (M.A.) is the founder and Executive Director of the Documentation Center of Cambodia.

Kok-Thay Eng (M.A., M.S.) was deputy director of the Documentation Center of Cambodia and is currently pursuing a Doctor of Philosophy on Global Affairs at Rutgers University.

Sophearith Choung (LL.B) is a witness assistant for the Witness and Expert Support Unit (WESU) at the Extraordinary Chambers in the Courts of Cambodia (ECCC).

164 Y. Choi et al., *Intergenerational Cultural Dissonance, Parent-child Conflict and Bonding, and Youth Problem Behaviors among Vietnamese and Cambodian Immigrant Families*, 37(1) J. YOUTH & ADOLESCENCE 85 (2008); D.E. Hinton et al., *Anger, PTSD, and the Nuclear Family: A Study of Cambodian Refugees*, 69(9) SOC. SCI. & MED. 1387 (2009).

165 J. Chang et al., *Child Abuse and Neglect in Cambodian Refugee Families: Characteristics and Implications for Practice*, 87(1) CHILD WELFARE 141 (2008).

166 For more, see the following sources: C. Rousseau et al., *Family Environment and Emotional and Behavioural Symptoms in Adolescent Cambodian Refugees: Influence of Time, Gender, and Acculturation*, 20(2) MED. CONFLICT & SURVIVAL 151 (2004); D.E. Hinton et al., *Khyal Attacks: A Key Idiom of Distress Among Traumatized Cambodian Refugees*, 34(2) CULT MED PSYCH 244 (2010); D.E. Hinton et al., *PTSD and Key Somatic Complaints and Cultural Syndromes Among Rural Cambodians: The Results of a Needs Assessment Survey*, 26(3) MED ANTHRO QUARTERLY 383 (2012); D.E. Hinton et al., *The Relationship of PTSD to Key Somatic Complaints and Cultural Syndromes Among Cambodian Refugees Attending a Psychiatric Clinic: The Cambodian Somatic Symptom and Syndrome Inventory (CSSI)*, 50(3) TRANSCULT PSYCHIATRY 347 (2013); N.P. Field et al., *Parental Styles in the Intergenerational Transmission of Trauma Stemming From the Khmer Rouge Regime in Cambodia*, 83(4) AM J ORTHOPSYCHIATRY 483 (2013); R.F. Mollica et al., *The Enduring Mental Health Impact of Mass Violence: A Community Comparison Study of Cambodian Civilians Living in Cambodia and Thailand*, 60(1) INT J SOC PSYCHIATRY 6 (2014); S.M. Berthold et al., *Comorbid Mental and Physical Health and Health Access in Cambodian Refugees in the US*, Mar 21 Epub ahead of print, J COMMUNITY HEALTH (2014); M.A. Raskind et al., *A Trial of Prazosin for Combat Trauma PTSD with Nightmares in Active-Duty Soldiers Returned from Iraq and Afghanistan*, 170(9) Am J Psychiatry 1003 (2013).

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 then-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 to indicate who among them was known to have psychological problems or difficulties due to the hardship and suffering they experienced during the Pol Pot period. If, after an interview and assessment, it was determined that the identified 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 capital or in Phnom Penh) and to purchase any prescribed medications.

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 Questionnaire¹⁶⁷ and the Hopkins Checklist.¹⁶⁸ 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.¹⁶⁹ After discussing these issues, the authors agreed to include a newly created Cambodian Symptom and Syndrome Inventory (C-SSI), devised by Devon Hinton 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 1), 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 long endured prolonged conflict and trauma. After a brutal civil war in which nearly 500,000 Cambodians died and many more were injured, displaced, or impoverished by fighting, the Khmer Rouge took power. From April 17, 1975, to January 6, 1979, this 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.¹⁷⁰ 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, from 1979-1993. 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

¹⁶⁷ The Harvard Trauma Questionnaire provides a list of trauma events and trauma symptoms, such as PTSD symptoms, that apply to all cultural groups.

¹⁶⁸ The Harvard Trauma Questionnaire and the Hopkins Checklist instruments assess anxiety and depression severity and do not assess culturally specific symptoms.

¹⁶⁹ These instruments assess general traumas and symptoms that may be related to trauma rather than delineating traumas and symptoms specific to the Cambodian population.

¹⁷⁰ 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 11 CALIFORNIA SERIES IN PUBLIC ANTHROPOLOGY (2005).

some smaller resistance groups.¹⁷¹ 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, ensued.

Even after a peace deal was brokered and the refugees repatriated as part of the 1993 UN-sponsored elections, the new Royal Government of Cambodia continued to battle the Khmer Rouge, who had 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. Still, 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. Other refugees, who had been resettled in the United States, France, or other countries, had to deal with not just adapting to an entirely new socio-cultural milieu, but 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 had fled abroad, and the country was subject to international sanctions until the 1993 peace agreement. Refugees who fled to the border and/or were later resettled abroad were often treated by mental health systems unequipped to deal with Cambodians and other refugee groups due to cultural differences in understanding and addressing trauma. Eventually, attempts were made to create more culturally sensitive diagnostic instruments for Cambodian refugees, such as Richard Mollica's Harvard Trauma Questionnaire.¹⁷² That instrument, however, simply combines an assessment of the 16 DSM-III-r criteria¹⁷³ 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 (C-SSI) 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 (Hinton), who is fluent in the Khmer language and is 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.¹⁷⁴ The components of the SSI and their meaning in the Cambodian culture, including the relationship to PTSD severity, have been documented in multiple articles.¹⁷⁵ Ultimately, the C-SSI was added to the suite of measures that the Documentation Center of Cambodia was using in its Victims of 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.¹⁷⁶ The 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

The C-SSI consists of two main parts: culturally-emphasized somatic complaints and key cultural syndromes (see Table 1).

Somatic Complaints Assessed in the C-SSI

The C-SSI assesses the twelve somatic symptoms listed in Table 1. Each of

171 WILLIAM SHAWCROSS, *THE QUALITY OF MERCY: CAMBODIA, HOLOCAUST, AND MODERN CONSCIENCE* (1984); FIONA TERRY, *CONDEMNED TO REPEAT? THE PARADOX OF HUMANITARIAN ACTION* (2002).

172 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).

173 The DSM-III-r has almost the same PTSD criteria as the DSM-IV-r.

174 Lowell is home to the second largest Cambodian population in the United States.

175 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).

176 For a review, see D.E. Hinton & R. Lewis-Fernández, *The Cross-cultural Validity of Posttraumatic Stress Disorder: Implications for DSM-5*, *DEPRESSION & ANXIETY* (2011).

Table 1. The Cambodian Symptom and Syndrome Inventory (C-SSI).
The Somatic Symptoms and Cultural Syndromes Subscales

Somatic Symptoms	Cultural Syndromes
Dizziness	Khyâl attacks ¹⁷⁰
Standing up and feeling dizzy	Standing up and feeling poorly to the point you feared fainting, khyâl overload, or heart attack
Blurry vision	Neck soreness to the point you feared your neck vessels would burst
Tinnitus	“Heart weakness”
Headache	Khyâl arising from your stomach, making you fear you might die of asphyxia
Neck soreness	“Thinking too much”
Palpitations	“Ghost pushing you down” (sleep paralysis)
Shortness of breath	
Cold hands and feet	
Sore arms and legs	
Weakeness	
Poor appetite	

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

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); ethnophysiology¹⁷⁷/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 1, 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. Below, we examine how these four processes or dimensions apply to the C-SSI somatic symptoms and result in those somatic symptoms being salient in the Cambodian cultural context.¹⁷⁸

The Biology of Trauma

Cambodians experienced extreme and prolonged trauma during the Pol Pot period. This type of trauma 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 multiple causes. These causes range from sounds, so-called “startle,” to emotions. For example, a trauma victim worrying about a problem, such as a child acting out 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

¹⁷⁷ Ethnophysiology refers to a cultural group's conceptualization of the workings of bodily physiology.

¹⁷⁸ 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).

example of a noise-caused startle or response to trauma reminders, two of the DSM-IV PTSD symptoms.¹⁷⁹ By bringing about this combination of arousal and arousability, the psychobiology of trauma may cause 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 have the salience they do: trauma may have biological effects that increase motion sickness and dizziness upon standing.¹⁸⁰ Indeed, certain Asian populations, such as Cambodian refugees, appear to be particularly predisposed to both of these symptoms.¹⁸¹

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 symptoms 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.”¹⁸² 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.¹⁸³ 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 khueu 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 Cambodians think about a current problem, it may bring about dizziness and neck soreness, or 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.¹⁸⁴

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

179 D.E. Hinton et al., *Worry and its Relationship to PTSD among Traumatized Cambodian Refugees: A Path Analysis*, SOC. SCI. & MED. (forthcoming).

180 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).

181 See *id.*; D.E. Hinton & B.J. Good, *A Medical Anthropology of Panic Sensations*, *supra* note 178.

182 D.E. Hinton et al., *Khyâl Attacks: A Key Idiom of Distress among Traumatized Cambodia Refugees*, 34(2) CULTURE, MED., & PSYCHIATRY 244 (2010).

183 D.E. Hinton et al., *A Unique Panic-disorder Presentation among Khmer Refugees: The Sore-neck Syndrome*, 25(3) CULTURE, MED., & PSYCHIATRY 297 (2001).

184 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 179. 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 175.

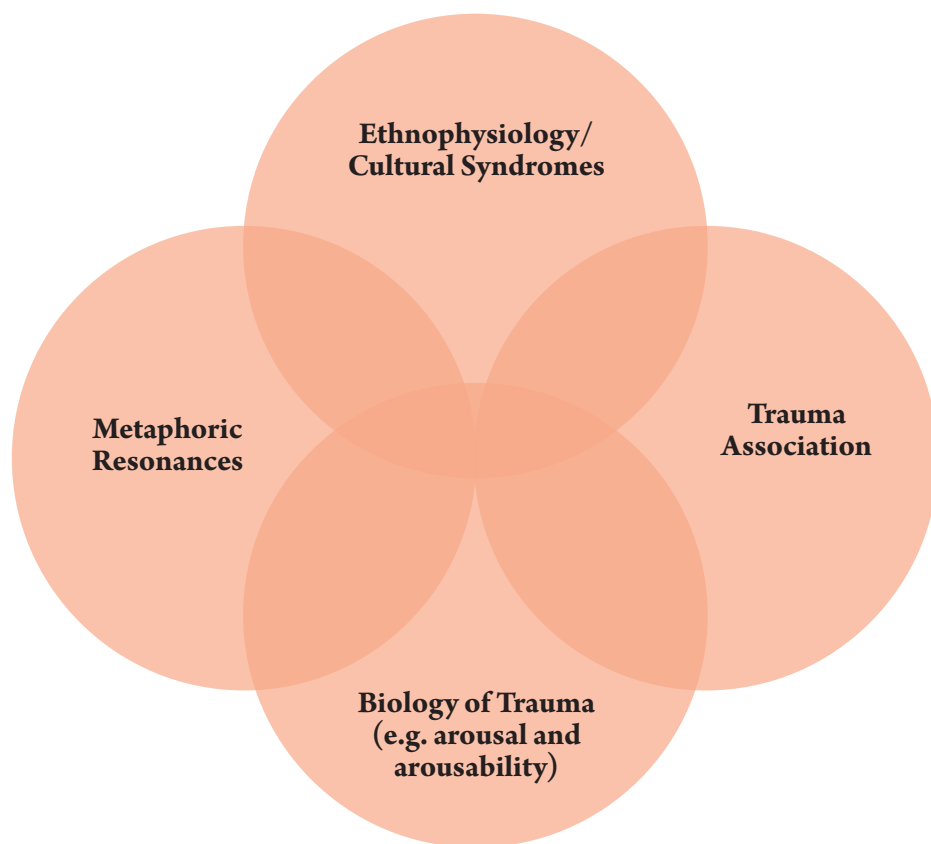


Figure 1. Dizziness and the Four Symptom Dimensions in the Cambodian Context.

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.

forced to do slave labor while starving, which caused dizziness and, not uncommonly, syncope (fainting). 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.¹⁸⁵

If Cambodians experience one of those symptoms (e.g., dizziness) for any reason, this 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.¹⁸⁶

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 C-SSI, the person is asked seven questions about how much he or she has been bothered by the seven cultural syndromes listed in Table 1.¹⁸⁷ Of note, in Cambodia, the concept of PTSD is usually not familiar to laypersons and so the term itself is used infrequently to explain their symptoms.

¹⁸⁵ D.E. Hinton et al., *Cultural Anthropology and Anxiety Diagnoses*, in *CURRENT PERSPECTIVES ON THE ANXIETY DISORDERS: IMPLICATIONS FOR DSM-5 AND BEYOND* 245-274 (D. McKay et al. eds., 2009).

¹⁸⁶ D.E. Hinton, *The ‘Multiplex Model’ of Somatic Symptoms*, *supra* note 178.

¹⁸⁷ 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.

As described above (see Figure 2 and Table 2), Cambodians greatly fear *khyâl* attacks. Most Cambodians consider *khyâl* to be a potentially pathogenic element.¹⁸⁸ 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 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).¹⁸⁹

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* 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 cold extremities and *khyâl* attacks. Heart weakness is thought to have a number of causes, including poor sleep, poor appetite, and excessive worry. If Cambodians note in themselves 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

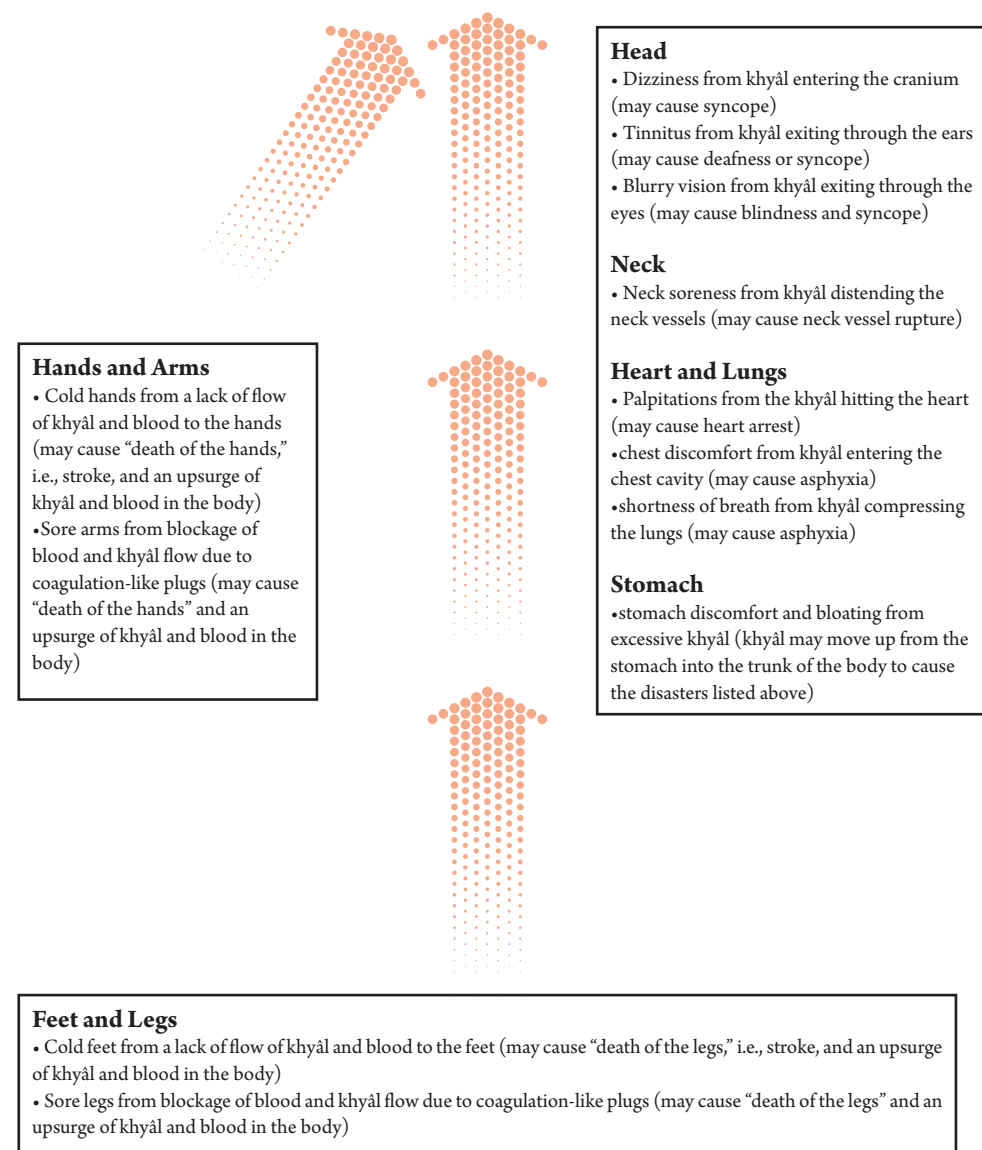


Figure 2. A *khyâl* attack: Ethnophysiology, symptoms, and associated disasters.

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.

188 D.E. Hinton et al., *Khyâl Attacks: A Key Idiom of Distress*, *supra* note 182.

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

see *id.*

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

Symptoms	Correlated Physiological State	Feared Consequence
Dizziness	A surge of khyâl and blood into the cranium	Syncope, “khyâl attack,” and “khyâl overload” (khyâl koeu)
Tinnitus	A pressure-like escape of khyâl from the ears, with tinnitus being called “khyâl exits from the ears,” or khyâl ceuny taam treujieu	A pressure-like escape of khyâl from the ears, with tinnitus being called “khyâl exits from the ears,” or khyâl ceuny taam treujieu
Blurry vision	Syncope, “khyâl attack,” and “khyâl overload” (khyâl koeu)	Blindness, khyâl attack, and syncope
Headache	A rush of khyâl and blood into the head and its vessels	Syncope, blindness, and khyâl overload
Neck Soreness	A surge of khyâl and blood into the neck vessels	Bursting of the neck vessels, the occurrence of khyâl attack or khyâl overload
Palpitations	Khyâl 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 khyâl 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 khyâl and blood upward in the body
Shortness of Breath	Khyâl surges upward from the limbs or stomach to press on the lungs and cause shortness of breath	Asphyxia, the occurrence of khyâl attack or khyâl overload
Soreness in the legs or arms	Blockage of the flow of khyâl and blood at the joints, with sore joints being called “plugged vessels” (cok sosai) or “blocked khyâl” (sla khyâl)	“Death” of the limbs from a lack of outward flow along the limbs, a surge of khyâl 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 khyâl and blood in the limbs	“Death” of the limbs from a lack of outward flow along the limbs, a surge of khyâl and blood upward in the body to cause the various disasters listed above
Poor Appetite	A direct effect of excessive bodily khyâl	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 khyâl attacks.
Out of Energy	Serious depletion of the bodily energy supplies, a direct effect of excessive bodily khyâl	The body is depleted, which may cause a weakened heart, possibly resulting in heart arrest and in khyâl attacks. This is because the weakened heart does not adequately pump and circulate the khyâl and blood, resulting in plugs in the limbs that then bring about an upward surge of khyâl and blood into the trunk.

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.¹⁹⁰ 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

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

(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 (using the 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).¹⁹¹ In the current study, we used a conservative cut-off score of 34 for assessing probable PTSD.¹⁹²

191 D.E. Hinton et al., *Anger, PTSD, and the Nuclear Family: A Study of Cambodian Refugees*, 69 Soc. Sci. & Med. 1387 (2009).

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

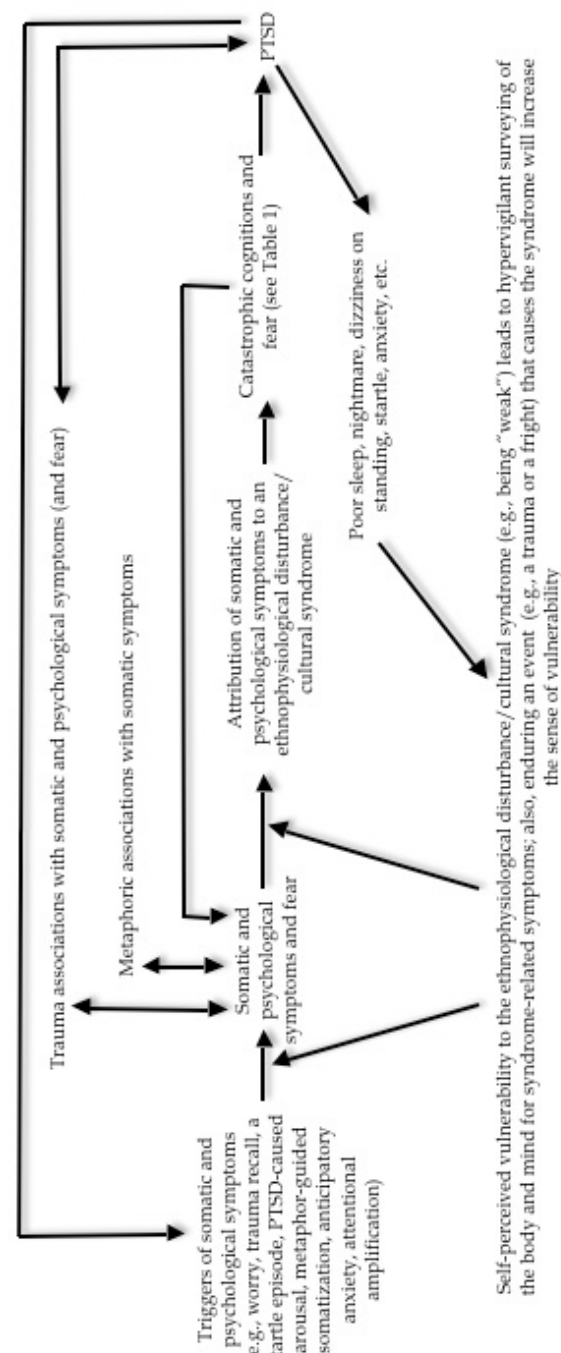


Figure 3. The Multiplex Model of the Cultural Syndrome-PTSD interaction among patients with PTSD.

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.

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 also 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 1, 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,¹⁹³ 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.¹⁹⁴ 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 physical 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.¹⁹⁵ One item used assesses self-perceived general health. The remaining two assess self-perceived impairment in

physical functioning with questions such as: (1) Does your health limit you in your ability to do activities such as moving a table or carrying groceries?, and (2) 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.¹⁹⁶

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

193 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).

194 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).

195 *Id.*

196 $F(2, 63) = 8.1, p < .001$.

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.

C-SSI Item	Mild PTSD Mean (SD)	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.

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 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 C-SSI and that the severity of the C-SSI items increased significantly across each of the three levels of PTSD severity. This illustrates that Cambodians with significant PTSD not only have PTSD symptoms, but also several other culturally-salient somatic symptoms and 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.¹⁹⁷ Kleinman and Kleinman¹⁹⁸ 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.¹⁹⁹

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.²⁰⁰ 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 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.²⁰¹ 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' key symptoms are also PTSD. 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.²⁰² 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.²⁰³ 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,

197 D.E. Hinton & B.J. Good, *A Medical Anthropology of Panic Sensations*, *supra* note 178.

198 A. Kleinman & J. Kleinman, *How Bodies Remember*, *supra* note 178.

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

200 D.E. Hinton, *The Khmer “Weak Heart” Syndrome*, *supra* note 187; D.E. Hinton, *The SF-36 among Cambodian and Vietnamese Refugees*, *supra* note 194.

201 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).

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

203 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).

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.

Finally, 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. 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.

4

TRANSCULTURAL PSYCHIATRY

Inger Agger (Ph.D.) is a licensed psychologist, NIAS Associate, and Senior Expert, Nordic Institute of Asian Studies.²⁰⁴ This article was previously published at: Agger I (2015). *Calming the mind: Healing after mass atrocity in Cambodia*. *Transcult. Psychiatry*. 52(4):543-60. doi: 10.1177/1363461514568336. Epub 2015 Feb 4.

During the Khmer Rouge regime (1975–1979), Cambodia endured systematic human rights violations that included torture, executions, slave labor, and starvation. Nearly one fifth of the population is reported to have died during this period.²⁰⁵ Although thirty-five years have now passed since these tragic events, Cambodians are still struggling to understand how this tragedy could have happened and how to cope with its painful legacy. While more than 90% of the population claim to be Theravada Buddhists, during the brutal moral chaos of the Khmer Rouge regime, Buddhism was systematically, and in most cases brutally, dismantled. Over the last 20 years Buddhism has gradually reemerged, and many Cambodians pin their hopes on Buddhism helping them to cope with the past and restore “moral order.” Buddhist rituals and techniques of meditation may enhance feelings of security and wellbeing and thus help survivors cope with residual distress.²⁰⁶

Unlike many countries in the West, Cambodia lacks a developed mental healthcare system. However, there exists a range of indigenous practices that Cambodians can call upon to help calm the distressed mind and, indeed, elements of these practices, particularly meditation and mindfulness, have helped inform

²⁰⁴ This research was supported by a grant from the Danish Council for Independent Research in Culture and Communication (FKK) from 2010–2012. An earlier version of this paper was presented at the workshop: “Mindfulness in Cultural Context,” organized by the Division of Social and Transcultural Psychiatry, McGill University, Advanced Study Institute, Montreal, June 4–5, 2013. Inger Agger’s research in Cambodia was carried out in cooperation with the Transcultural Psychosocial Organization – Cambodia (TPO) with the assistance of Taing, Sopheap. She wishes to thank the survivors, civil society organizations, venerables at the Buddhist pagodas, and staff of the Extraordinary Chambers in the Courts of Cambodia (ECCC) who generously shared their experiences with her. Inger Agger is also very thankful for comments and suggestions to earlier versions of this article by Alexandra Kent. She is furthermore grateful for the support provided by Dignity – Danish Institute Against Torture, Copenhagen where her research project was based.

²⁰⁵ Chandler, D. *A history of Cambodia* (4th ed., 2008), Chiang Mai, Thailand: Silksworm

²⁰⁶ Kent, A. *Reconfiguring security: Buddhism and moral legitimacy in Cambodia*, *SECURITY DIALOGUE*, 37(3), 343–361, (2006).

Western psychological practice.²⁰⁷ In this article, the point of departure is recent work in the field of transcultural psychology and psychiatry on survivors of the Khmer Rouge regime that argues for greater cultural sensitivity in approaches to improving mental health. It is critical of “the Euro-Western universalized semiotics of suffering,”²⁰⁸ and emphasizes the importance of understanding the cultural meaning of symptoms.²⁰⁹ Langford argues for the importance of understanding the Khmer cultural significance of ancestor veneration and the “social existence of the dead.”²¹⁰ This literature suggests that the mental effects of trauma may be experienced and expressed in markedly different ways in different cultural contexts and that much may be learnt by also exploring what cultural tools may be available to address posttraumatic distress.²¹¹

The concept of mindfulness is central to the Theravada Buddhist tradition.

Khmer Buddhism, an amalgam of preexisting animist and Hindu traditions onto which Buddhism was later grafted, also offers numerous approaches to healing, including medicinal herbs, spirit possession, and various “magical” practices. In particular, approaches to calming the mind—through meditation, knowledge, and understanding—are particularly well-developed within Buddhist tradition.

The primary aim of this study was to explore the ways in which Cambodians appeal to this element of Buddhism in their efforts to calm their minds, and also to situate this in the context of broader Khmer Buddhist practices and understandings. Considerable space is given to Cambodians’ own voices and formulations as well as observations of their practices. The objective is to enable the reader to engage closely with the culturally-shaped experiences and ideas of Cambodians who are trying to alleviate their posttraumatic suffering. By suspending some of our own preconceptions about suffering and mental health, and learning what we can about reality as it is experienced by our informants, we

207 Mollica, R. F., Brooks, R., Tor, S., Lopez-Cardozo, B., & Silove, D., *The enduring mental health impact of mass violence: A community comparison study of Cambodian civilians living in Cambodia and Thailand*, 60(1), INTERNATIONAL JOURNAL OF SOCIAL PSYCHIATRY, 6–20, (2014).

208 Kidron, C. A., *Alterity and the particular limits of universalism: Comparing Jewish-Israeli Holocaust and Canadian-Cambodian genocide legacies*, 53(6), CURRENT ANTHROPOLOGY, 723–754, (2012).

209 Stevens, C. A., *Perspectives on the meaning of symptoms among Cambodian refugees*, 37(1), JOURNAL OF SOCIOLOGY, 81–98, (2001).

210 Langford, J. M., *Gifts intercepted: Biopolitics and spirit debt*, 24(4), CULTURAL ANTHROPOLOGY, 681–711, (2009).

211 Hinton, D. E., Hinton, A., Eng, K.-T., & Choung, S., *PTSD severity and key idioms of distress among rural Cambodians: The results of a needs assessment survey*. In B. van Schaack, D. Reicherter, & Y. Chhang (Eds) CAMBODIA'S HIDDEN SCARS: TRAUMA PSYCHOLOGY IN THE WAKE OF THE KHMER ROUGE, Phnom Penh, Cambodia: Documentation Center of Cambodia (2011); Hinton, D. E., Kredlow, M. A., Pich, V., Bui, E., & Hofmann, S. G., *The relationship of PTSD to key somatic complaints and cultural syndromes among Cambodian refugees attending a psychiatric clinic: The Cambodian Somatic Symptom and Syndrome Inventory (CSSI)*, 50(3), TRANSCULTURAL PSYCHIATRY, 347–370, (2013).

may gain insights that can help us critically evaluate and enrich our own models of wellness.

Discourses of suffering

Using Western psychiatric diagnostic frameworks, a large percentage of the Cambodian population has been diagnosed with posttraumatic stress disorder (PTSD), depression, and/or anxiety due to the mass atrocities that occurred before, during, and after the Khmer Rouge regime.²¹² However, Eisenbruch has noted the limitations of simply transposing Western diagnostic categories to characterize the distress experienced by Cambodian refugees.²¹³ He points to the importance of including people’s own ways of formulating their experience: what the trauma meant to them, their cultural recipes for signaling their distress, and the coping strategies they adopt. He suggests that some of those who were diagnosed with PTSD according to the criteria of the Diagnostic and Statistical Manual-III can be better understood as undergoing a process of “cultural bereavement” and that their responses may include constructive elements that help them heal after traumatic experiences.²¹⁴

Chhim also questions whether the PTSD diagnosis can adequately capture the symptoms of distress as they are experienced by many Cambodian survivors of the Khmer Rouge regime and suggests that the cultural idiom of distress known as *Baksbat*²¹⁵ (broken courage) should be recognized by mental health professionals in order to “provide appropriate support for traumatized Cambodians.”²¹⁶ He

212 For instance, in a randomly selected sample of 613 Cambodians, 28.4% met the criteria for PTSD. In a randomly selected household survey of 1,320 Cambodians, 7% met the criteria for PTSD, 42% for depression, and 53% for anxiety. And in a national, longitudinal study that covered a randomly selected sample of 813 Cambodians, 14% met the criteria for PTSD. In a comparative community survey, Mollica et al. found that the Cambodian population continues to suffer “psychiatric morbidity and poor health” 25 years after the Khmer Rouge regime. See De Jong, J. T. V. M., Komproe, I. H., van Ommeren, M., El Masri, M., Araya, M., Khaled, N., Somasundaram, D., *Lifetime events and posttraumatic stress disorder in 4 post-conflict settings*, 286(5), THE JOURNAL OF THE AMERICAN MEDICAL ASSOCIATION, 555–562, (2001); Dubois, V., Tonglet, R., Hoyois, P., Sunbaunat, K., Roussaux, J.-P., & Hauff, E., *Household survey of psychiatric morbidity in Cambodia*, 50(2), INTERNATIONAL JOURNAL OF SOCIAL PSYCHIATRY, 174–185, (2004); Sonis, J., Gibson, J. L., de Jong, J. T. V. M., Field, N. P., Hearn, S., & Komproe, I., *Probable posttraumatic stress disorder and disability in Cambodia*, 302(5), THE JOURNAL OF THE AMERICAN MEDICAL ASSOCIATION, 527–536, (2009); Mollica, R. F., Brooks, R., Tor, S., Lopez-Cardozo, B., & Silove, D., *The enduring mental health impact of mass violence: A community comparison study of Cambodian civilians living in Cambodia and Thailand*, 60(1), INTERNATIONAL JOURNAL OF SOCIAL PSYCHIATRY, 6–20, (2014).

213 Eisenbruch, M., *From post-traumatic stress disorder to cultural bereavement: Diagnosis of southeast Asian refugees*, 33(6), SOCIAL SCIENCE AND MEDICINE, 673–680, (1991).

214 American Psychiatric Association, DSM-III, (1980).

215 For transliteration of Khmer words the author has used a phonetic system or, when referring to the work of other authors, has adopted that used in those original works.

216 Chhim, S., *Baksbat (broken courage): The development and validation of the inventory to measure Baksbat, a Cambodian trauma-based cultural syndrome*, 36(4), CULTURE, MEDICINE AND PSYCHIATRY, 640–659, (2012); Chhim, S., *Baksbat (broken courage): A trauma-based cultural syndrome in Cambodia*, 32(2), MEDICAL ANTHROPOLOGY, 160–173, (2013).

describes the symptoms of *Baksbat* as a lack of trust in others, submissiveness, feeling fearful, and being “mute and deaf” (Khmer: *dam doeum kor*).

Hinton and colleagues also found that the questionnaires used in many studies of the psychological health of Cambodians were not culturally-sensitive and did not consider the ways in which Cambodians themselves experience, understand, and cope with their distress.²¹⁷ Hinton's team therefore developed the Cambodian Somatic Symptom and Syndrome Inventory (C-SSI) which includes indigenous symptoms and causal explanations such as: “wind attack,” “thinking too much,” “sleep paralysis,” and “weak heart.” They found that “thinking too much” was a key indicator of distress and those who scored highly for symptoms of PTSD according to the DSM-IV also had high C-SSI scores.²¹⁸ The interviewees themselves, however, expressed more concern about the somatic and culturally-familiar syndromes captured by the C-SSI than they did about the psychological problems identified using foreign norms.

One of the most prominent and commonly occurring problems found by van de Put, Eisenbruch, Hinton and colleagues was “thinking too much” (Khmer: *kut caraeun*).²¹⁹ This includes thinking about upsetting topics, past traumatic events, and death of loved ones. *Kut caraeun* may lead to headaches, dizziness, “wind attacks,” depletion of bodily energy, heart weakness, and even “overheating of the brain” (memory loss, insanity). Hinton, Nickerson, and Bryant found that “thinking too much,” often called “worry,” was common among Cambodian refugees in the United States, exacerbated their PTSD symptoms, and provided a key target for intervention.²²⁰

In interviews with Cambodians undertaken for the study, “thinking too much” was frequently identified by the interviewees as a problem that could give rise not only to personal distress but also anger, which, if not controlled, might be

217 Hinton, D. E., Hinton, A., Eng, K.-T., & Choung, S., *PTSD severity and key idioms of distress among rural Cambodians: The results of a needs assessment survey*, in B. van Schaack, D. Reicherter, & Y. Chhang (Eds) *CAMBODIA'S HIDDEN SCARS: TRAUMA PSYCHOLOGY IN THE WAKE OF THE KHMER ROUGE*, Phnom Penh, Cambodia: Documentation Center of Cambodia (2011); Hinton, D. E., Kredlow, M. A., Pich, V., Bui, E., & Hofmann, S. G., *The relationship of PTSD to key somatic complaints and cultural syndromes among Cambodian refugees attending a psychiatric clinic: The Cambodian Somatic Symptom and Syndrome Inventory (C-SSI)*, 50(3), *TRANSCULTURAL PSYCHIATRY*, 347–370 (2013).

218 American Psychiatric Association, DSM-IV, (2000).

219 Van de Put, W. A. C. M., & Eisenbruch, M., *The Cambodian experience*, in J. de Jong (Ed.) *TRAUMA, WAR, AND VIOLENCE*, (2002), New York, NY: Plenum; Van der Kolk, B., *Yoga and post-traumatic stress disorder: An interview with Bessel van der Kolk*, *Integral Yoga Magazine*, (2009, Summer); Hinton, D. E., Hinton, A. L., Eng, K.-T., & Choung, S., *PTSD and key somatic complaints and cultural syndromes among rural Cambodians: The results of a needs assessment survey*, 26(3), *MEDICAL ANTHROPOLOGY QUARTERLY*, 383–407, (2012); Hinton, D. E., Kredlow, M. A., Pich, V., Bui, E., & Hofmann, S. G., *The relationship of PTSD to key somatic complaints and cultural syndromes among Cambodian refugees attending a psychiatric clinic: The Cambodian Somatic Symptom and Syndrome Inventory (C-SSI)*, 50(3), *TRANSCULTURAL PSYCHIATRY*, 347–370, (2013).

220 Hinton, D. E., Nickerson, A., & Bryant, R. A., *Worry, worry attacks, and PTSD among Cambodian refugees: A path analysis investigation*, 72, *SOCIAL SCIENCE AND MEDICINE*, 1817–1825, (2011).

expressed through violent and antisocial behavior. Similarly, Nickerson and Hinton noted that anger reactions are a common problem among Cambodians who have resettled in the United States.²²¹ Nickerson and Hinton also state that many turn to Buddhist monks for advice about managing their feelings and that all of the monks they interviewed cited mindfulness and meditation as key methods for regulating anger.²²²

A second significant mental health problem among Cambodian survivors of the Khmer Rouge period is that of recurrent, disturbing dreams about loved ones who died untimely or violent deaths during the regime. In Cambodia, it is widely believed that the spirits of those who die a violent death may be unable to find peace. For example, the spirits of women who have died in childbirth are known in Khmer as *bray* and are thought to be maleficent unless they are tamed within the confines of the pagoda, where they become transformed into beneficent *parami* spirits.²²³ According to proper Buddhist custom the problem of restless and hungry ghosts is exacerbated when funeral rites are not performed, which is something that was impossible under the Khmer Rouge, who banned Buddhist practices.

It is against this cultural and historical background that Cambodians' dreams about the disconsolate ghosts of their dead can be understood as symptoms not simply of individual mental disturbance but also as a spiritual disruption of the relationship between the living and the dead. Psychological diagnostic and therapeutic methods that fail to appreciate the cultural significance of these dreams may result in a form of “category fallacy” and thereby fail to offer appropriate support to sufferers.²²⁴ Better diagnostic assessment and treatment interventions depend on paying closer attention to what Cambodians themselves have to say about the explanatory models and coping strategies they find intelligible and helpful.

Method

221 Hinton, D. E., Nickerson, A., & Bryant, R. A., *Worry, worry attacks, and PTSD among Cambodian refugees: A path analysis investigation*, 72, *SOCIAL SCIENCE AND MEDICINE*, 1817–1825, (2011); Hinton, D. E., Kredlow, M. A., Pich, V., Bui, E., & Hofmann, S. G., *The relationship of PTSD to key somatic complaints and cultural syndromes among Cambodian refugees attending a psychiatric clinic: The Cambodian Somatic Symptom and Syndrome Inventory (C-SSI)*, 50(3), *TRANSCULTURAL PSYCHIATRY*, 347–370, (2013).

222 Hinton, D. E., Nickerson, A., & Bryant, R. A., *Worry, worry attacks, and PTSD among Cambodian refugees: A path analysis investigation*, 72, *SOCIAL SCIENCE AND MEDICINE*, 1817–1825, (2011).

223 The term *parami* is a Buddhist technical term meaning literally one of the 10 perfections of the Buddha. However, in common parlance in Cambodia, it is used to refer to a sacred force or energy.

224 Hinton, D. E., Peou, S., Joshi, S., Nickerson, A., & Simon, N., *Normal grief and complicated bereavement among traumatized Cambodian refugees: Cultural context and the central role of dreams of the deceased*, 37 *CULTURE, MEDICINE, AND PSYCHIATRY*, 427–464, (2013).

The project followed the principles of the World Medical Association Declaration of Helsinki and was reviewed and approved by the Danish Council for Independent Research in Culture and Communication. The findings presented here derive primarily from a study conducted by the author on local approaches to healing trauma. The study included 7 months of fieldwork in Cambodia from 2011 to 2012. The author cooperated closely with a local organization, Transcultural Psychosocial Organization (TPO), to make contact with and interview 27 survivors (18 male and 9 female) of the Khmer Rouge regime who had received psychosocial support from TPO. Each interview took about 1 to 2 hours to complete and all interviews were audiotaped. At the beginning of each interview, signed informed consent was obtained. The author explained to participants that the objective of the interview was to understand how survivors had experienced their life during and after the Khmer Rouge, which kind of mental support they had received (if any), and, if so, how they had experienced it, with the objective of developing better methods for assisting survivors, if needed. The author, furthermore, explained that the intention was to publish the results but that names of participants would not be mentioned, and their identities disguised. Each participant received a US \$5.00 gift voucher as a token of appreciation. All interviews were carried out in the village homes of the survivors.

The author also interviewed nine members of victim associations—seven from the “Ksem San Association” and two from the “Association of Khmer Rouge Victims in Cambodia.” Staff members of five nongovernmental organizations who provide psychosocial assistance to survivors were also interviewed, as well as six staff members of the Extraordinary Chambers in the Courts of Cambodia. Additionally the author was present as an observer at the trials.²²⁵

An important part of the study was learning about Buddhist healing practices.

To this end the author interviewed 10 Buddhist monks, four Buddhist nuns (*donchee*), and six traditional healers (*kruh*). The author attained these interviewees by asking for volunteers in local villages. She also had the opportunity to observe a number of religious ceremonies and rituals.

A Cambodian psychologist acted as interpreter and all interviews were tape-

²²⁵ The tribunal was established in 2006 after more than 10 years of negotiations between United Nations and the Kingdom of Cambodia in order “to bring to trial senior leaders and those most responsible for crimes committed during Democratic Kampuchea, known as the Khmer Rouge regime, from 17 April 1975 to 6 January 1979.” In the ongoing Case 002, four (now two) former Khmer Rouge leaders have been accused of “genocide, crimes against humanity, grave breaches of the 1949 Geneva conventions and murder, torture, and religious persecution under Cambodian law.” See ECCC, *An introduction to the Khmer Rouge trials* (2004, 4th ed.), Phnom Penh, Cambodia: Public Affairs Section, Extraordinary Chambers in the Courts of Cambodia; ECCC, *Background information on Extraordinary Chambers in the Courts of Cambodia*, (2011), Phnom Penh, Cambodia; ECCC, *Overview of Civil Party reparation requests in Case 002/01*, (2014), www.eccc.gov.kh/en/articles/wide-ranging-support-secured-reparations-victims-khmer-rouge.

recorded and later transcribed and translated once more into English. The interviews were open-ended and qualitative. In the interviews with survivors, the emphasis was on exploring how they had coped with their experiences and memories from the Khmer Rouge period. With monks, nuns, and traditional healers, the emphasis was on their approaches to the suffering of survivors who consulted them for support. The results presented are based on analysis of the interview transcripts, field notes, and a review of relevant documents and literature. Thematic analysis of these materials focused on local cultural techniques for coping with trauma and its aftermath.

Results

Cambodian Methods for Calming the Mind

Meditation. Various forms of meditation are practiced in Cambodia, but the two most commonly mentioned during the fieldwork were *Samadhi*, the practice of stilling the mind through mental concentration, and *vipassana*, the practice of acquiring self-knowledge and insight into the true nature of reality. In interviews, people who had experienced Khmer Rouge atrocities sometimes described how they used meditation as a coping strategy. For instance, a middle-aged male survivor in Pursat Province described how he practiced *Samadhi*:

[T]o calm my feelings and to cool my body. I noticed that if I was thinking too much I felt so hot in my head. Now it is released, even though there are still some family problems which make me feel a little bit of headache, but I can solve this.

A male teacher at a meditation center in Siem Reap province explained how meditation can help survivors:

They do meditation or relaxation with breathing exercises until their breath becomes normal again. They come here to calm their feeling, so it can lead them to gain more energy inside and to push their nervous system to run more smoothly.

As was the case among the Khmer refugees whom Nickerson and Hinton studied in the United States, most of the informants turned to monks for advice

about how to deal with mental suffering.²²⁶ A monk from a village pagoda in Kampot Province explained how he assists members of his congregation in calming their minds and gaining insight when they feel upset by their memories about the Khmer Rouge period:

They come here because they want to forget their problems, to observe morality and perform religious concentration . . . they want to calm down their feelings. . . . They cross their legs and fold their arms; they close their eyes to control their self-possession, because people who have mental problems, their feelings are very stuck. So they select one object for mental concentration, for example a *Tevada* [angel]. They keep on quietly reciting this word, *Tevada*, in order not to be overwhelmed by feelings about the past. . . *Tevada* is a Pali word.

By concentrating on a word in the Pali language, such as *Tevada*, one can recall the goodness of the Buddha. The very fact that something was expressed in Pali meant it had a protective power (*monakum*). The monks used Pali chanting from an old palm leaf manuscript to enact healing rituals, although they often did not know how to translate the Pali into Khmer. They also had Pali stanzas tattooed as a form of protection.

While meditation may help reduce distress, Buddhism also recognizes that suffering (Pali: *dukkha*, literally “unsatisfactoriness”) is an intrinsic feature of the human condition. The objective of meditation is therefore not to abolish suffering but to transcend it. As the same monk explained,

This [meditation] can help reduce their suffering, but not a hundred percent. All people are born with suffering. *Tevada* means that we recall the goodness of the Buddha. If the person understands the Buddha’s teachings about the life cycle we all must go through of birth, ageing, illness, and death, then the person can live. When the person has meditated on the Buddha’s teaching, she will feel fresh. She no longer suffers.

Cambodians hold that meditating helps cultivate a calm “mind” (Khmer: *chet*

sngap).²²⁷ However, the Khmer word *chet* is derived from the Pali *citta* and refers both to the mind and the heart, the intellect and the passions. Wellbeing (Khmer: *sok*) in Cambodia depends upon training the mind/heart (Khmer: *sok phluw chet*) according to the dictates of the Buddhist canon, the *dhamma*. Meditation and mindfulness not only alleviate the suffering caused by “thinking too much” but also lead to moral behavior in line with the Buddha’s teachings. It follows also that when an individual pursues the Noble Eightfold Path of Buddhism,²²⁸ they reduce not only their own suffering but also the chances of causing suffering for others by performing wrong actions. Ultimately, then, this helps heal relationships and build trust within the community.²²⁹

The Khmer term generally used for wellbeing or peace of mind is *sekkadai sok*. The word *sok* is derived from the Pali term *sukkhā*, which means pleasure or bliss. It is the opposite of *dukkha*, which results from craving (Pali: *tanha*) and which can be vanquished not by succumbing to or gratifying the craving, but by understanding the Buddhist principles of impermanence and practicing its virtues of self-control.²³⁰

An elderly monk from a rural pagoda in Kampot province explained how he approached the suffering of the Khmer Rouge survivors as follows:

Buddha is the only way that can help them release the tension in their minds. I ask them to do meditation. I explain the natural law of human beings: we are born, get old, get sick, and die. Every family experiences separation and the past is already gone, so you should calm your feeling, so as not to suffer any more. If you did not die during the Khmer Rouge times, you will die later. I explain to them that life is unstable, about the suffering of human beings, we all have suffering, so if we want to release our suffering we have to consider other families who face the same problems as we do. So the victims can find a way to deal with their unstable minds.

Making Merit for the Deceased. The notion of merit (Khmer: *bon*) is fundamental to an understanding of Khmer Buddhist practice. When individuals visit the pagoda, make offerings to the monks, and observe the Buddhist precepts and meditate, they accumulate stores of *bon*, which will benefit their own karmic

²²⁷ Kent, A., *Reconfiguring security: Buddhism and moral legitimacy in Cambodia*, (2006).

²²⁸ Right view, right intentions, right speech, right action, right livelihood, right effort, right concentration, and right mindfulness.

²²⁹ Kent, A., *Reconfiguring security: Buddhism and moral legitimacy in Cambodia*, (2006).

²³⁰ *Id.*, pp. 351-352.

²²⁶ Hinton, D. E., Peou, S., Joshi, S., Nickerson, A., & Simon, N., *Normal grief and complicated bereavement among traumatized Cambodian refugees: Cultural context and the central role of dreams of the deceased*, 37, *CULTURE, MEDICINE, AND PSYCHIATRY*, 427-464, (2013).

progress and help ensure that they will be reborn into a better next life.

Khmer Buddhism is an amalgam of pre-Buddhist Hindu and animist practices onto which Theravada Buddhism was later grafted. Buddhist meditation practices therefore exist in Cambodia within a broader cultural framework of ancestor and spirit worship. While Western notions of healthy grieving are rooted in Abrahamic religious ideas of life terminating upon death, Hindu and Buddhist traditions see death as a transition into the next life. Indeed, even in the West, the idea that healthy grieving requires reaching a sense of “closure” and the acceptance of the ending of a relationship has begun to be problematized by Western scholars.²³¹ In Cambodia, it is recognized that healthy grieving involves maintaining a good relationship with the dead and perhaps assisting the dead towards rebirth. The spirits of those who died a violent death or whose bodies were not ritually handled by monks may continue to experience distress and unfulfilled needs even after death and they may continue to disturb their surviving relatives. Therefore, efforts to “calm the mind” may need to be directed not simply to the living individual but also to their relationship with the dead.

This means that the dead are treated as an extension of the moral community of the living and attending to their wellbeing and tranquility is integral to the wellbeing of the living as well. The “currency” by which this is achieved is that of *bon*. After performing meditation, it is common practice for Cambodians to pour a cup of water onto the earth while thinking of their dead. This symbolically enacts the transfer of the merit accumulated through meditation to the spirits of the dead, thus enhancing their karmic status and aiding their passage along the chain of being.

As a middle-aged female survivor of the Khmer Rouge regime from a village in Takeo Province explained,

They died and there were many victims killed during the Khmer Rouge regime. (So we are here at the pagoda) to let them know that the survivors care for them, to help their souls calm down and to assist them to find a place and be reborn. So we pray for them and make offerings to them.

Similarly, a middle-aged man from the same village said,

Because we are Khmer Rouge victims and thinking too much

²³¹ For example, see Berns, N., *Closure: The rush to end grief and what it costs us*, (2011), Philadelphia, PA: Temple University Press.

about the past, about family members who were killed, they have rituals to make us feel calm and relief from pain and relief from grief. This is also to calm the spirit of the dead.

Another male survivor from the village elaborated,

I think the dead are still here, because I often dream of them and maybe we have not offered enough for them to be reborn. They were killed, they are still out there, but if they had died naturally they could have been reborn. They are still calling for us, because we think of them and dream of them. Sometimes we sleep well, and sometimes we dream that they come to see us. Those who were killed, their souls are still out there and cannot find a place to be reborn.

Dreams of the deceased and concerns about their spiritual status play an important role in the grieving process in Cambodia. These dreams are often upsetting.²³² A female survivor in the village explained how she handled the dream visit of her husband,

I had a dream about my husband. He came to see me as a shadow, because he is a ghost now. I just saw his shadow, but he would not say anything. I felt better after I had conducted a ceremony for him. I have never dreamed about him again.

The fact that the deaths of the Khmer Rouge victims were not ritually attended to by monks was also alluded to by many informants. A middle-aged male survivor from a village in Pursat Province explained,

The purpose of the monks' praying and chanting is to make all the dead people and the victims calm down their feelings. It helps us to feel relief to offer to the dead, relief from grief, because our relatives were killed during the Khmer Rouge regime, because the dead people died without the monks chanting for them. They

²³² Hinton, D. E., Hinton, A. L., Pich, V., Loeum, J. R., & Pollack, M. H., *Nightmares among Cambodian refugees: The breaching of concentric ontological security*, 33, *CULTURE, MEDICINE, AND PSYCHIATRY*, 219–265, (2009); Hinton, D. E., Field, N. P., Nickerson, A., Bryant, R., & Simon, N., *Dreams of the dead among Cambodian refugees: Frequency, phenomenology, and relationship to complicated grief and PTSD*, 37, *Death Studies*, 750–767, (2013); Hinton, D. E., Peou, S., Joshi, S., Nickerson, A., & Simon, N., *Normal grief and complicated bereavement among traumatized Cambodian refugees: Cultural context and the central role of dreams of the deceased*, 37, *CULTURE, MEDICINE, AND PSYCHIATRY*, 427–464, (2013).

were just abducted and killed.

Another male survivor from the same village concurred,

We do rituals to calm the spirits of the dead, and I think that the ceremony can also calm down my feeling, so that I am not furiously mad at the cruel behaviour of the Khmer Rouge. I think only Buddha can make me feel stable like this.

According to Hinton et al., Cambodians are particularly afraid that those who died under the regime of Khmer Rouge may become “dream visitors,” or malevolent ghosts who try to harm the dreamer, indicating that the deceased have not moved on to reincarnation or that they have not been ritually buried.²³³

Of particular interest regarding traumatic memory and commemorative practices for the Khmer Rouge dead is the ritual performance known in Pali as the *pansukula* (*bangsoekool* in Khmer), the “gift-bestowal ritual,”²³⁴ which forms part of the funeral rites in Cambodia and elsewhere in Theravada Buddhist Southeast Asia.²³⁵ The term *pansukula* refers specifically to a white cloth that is used to cover the corpse and that represents asceticism,²³⁶ but also refers more generally to the ritual process that includes a particular form of rhythmic chanting by the monks: “the chant of death.”²³⁷ This chanting follows the rhythm of the breath and is held by many Cambodians to have a powerful, calming effect on the audience—

233 Hinton, D. E., Field, N. P., Nickerson, A., Bryant, R., & Simon, N., *Dreams of the dead among Cambodian refugees: Frequency, phenomenology, and relationship to complicated grief and PTSD*, 37, *DEATH STUDIES*, 750–767, (2013); Hinton, D. E., Peou, S., Joshi, S., Nickerson, A., & Simon, N., *Normal grief and complicated bereavement among traumatized Cambodian refugees: Cultural context and the central role of dreams of the deceased*, 37, *CULTURE, MEDICINE, AND PSYCHIATRY*, 427–464, (2013).

234 Hinton, D. E., Peou, S., Joshi, S., Nickerson, A., & Simon, N., *Normal grief and complicated bereavement among traumatized Cambodian refugees: Cultural context and the central role of dreams of the deceased*, 37, *CULTURE, MEDICINE, AND PSYCHIATRY*, 427–464, (2013).

235 Davis, E. W., *Treasures of Buddha: Imagining death and life in contemporary Cambodia*, (Unpublished doctoral dissertation, 2009), University of Chicago, IL; Phra Khru Anusarasanakiarta, & Keyes C. F., *Funerary rites and the Buddhist meaning of death: An interpretative text from Northern Thailand*, 68(1), *JOURNAL OF THE SIAM SOCIETY*, 1–28, (1980).

236 The Pali term *pansukula* originally meant “dusty rags” and referred to rags that were used to wrap the corpse for taking it to the cremation grounds. Today, lay people donate a clean white cloth to the monks at a funeral ceremony instead. Translation by David Wharton, personal communication (February 15, 2013). For example, Professor Ka Sunbaunat of the National Mental Health Programme has collaborated with Buddhist monks to integrate spirituality into a comprehensive approach to trauma-related mental health for Cambodians. Reicherter, D., Boehnlein, J., & Stewart, J., *Analysis of trauma-related mental health resources in Cambodia: Consensus ideas for an improved method*, in B. van Schaack, D. Reicherter, & Y. Chhang (Eds) *CAMBODIA'S HIDDEN SCARS: TRAUMA PSYCHOLOGY IN THE WAKE OF THE KHMER ROUGE*, (2011), Phnom Penh, Cambodia: Documentation Centre of Cambodia (DC-Cam).

237 Davis, E. W., *Treasures of Buddha: Imagining death and life in contemporary Cambodia*, (Unpublished doctoral dissertation, 2009), University of Chicago, IL

especially if it is followed by a special type of mourning songs (*smot*) that are performed by lay persons. The *pansukula* chant is one of the many means by which the Cambodian clergy ritually enables the laity to transfer merit to their dead relatives, thus assisting their progress through the cycle of death and rebirth. This is done to placate both the minds of the living and the spirits of the dead.²³⁸ A translation of the main section of the text from this chant shows how it promotes reflection upon the impermanence of life:

All conditioned things are impermanent
With the nature to arise and to pass away
Having arisen they cease
And in their passing is the highest happiness.²³⁹

Few Cambodian lay people understand Pali, but interviewees nevertheless claimed that simply listening to the rhythm and melody of the chanting gave them a feeling of inner peace.

Festival of the Dead. The most spectacular instance of social healing that involves the dead is the annual festival of the dead, *p'chum ben*, during which ritual merit-making for the restless souls of the dead continues for a full two weeks.²⁴⁰ This is also an important opportunity to perform rituals that may alleviate complicated grief among Khmer Rouge survivors.²⁴¹ *P'chum ben* is celebrated in pagodas throughout the country, with local variations, and takes place in accordance with the lunar calendar in September–October, beginning on the full moon of the month of *photrobot* and continuing throughout the moon's wane. During this festival, the gates of the underworld are opened and the hungry ghosts are given a fortnight's release. These insatiate spirits are thus able to commune with the living and beseech their living relatives to feed them through the mediation of Buddhist monks.²⁴²

The festival enables the living to ease the suffering of those who have died with stores of bad *kamma* by transferring merit to them in the form of the specially

238 Hinton, D. E., Field, N. P., Nickerson, A., Bryant, R., & Simon, N., *Dreams of the dead among Cambodian refugees: Frequency, phenomenology, and relationship to complicated grief and PTSD*, 37, *DEATH STUDIES*, 750–767, (2013)

239 Translation by David Wharton, personal communication (February 15, 2013).

240 Holt, J. C., *Caring for the dead ritually in Cambodia*, 1(1), *SOUTHEAST ASIAN STUDIES*, 3–75, (2012).

241 Hinton, D. E., Peou, S., Joshi, S., Nickerson, A., & Simon, N., *Normal grief and complicated bereavement among traumatized Cambodian refugees: Cultural context and the central role of dreams of the deceased*, 37, *CULTURE, MEDICINE, AND PSYCHIATRY*, 427–464, (2013).

242 Kent, A., *Purchasing power and pagodas: The sima monastic boundary and the culture of consumption in Cambodia*, 38(2), *JOURNAL OF SOUTHEAST ASIAN STUDIES*, 335–354, (2007); Ladwig, P., *Feeding the ghosts: Materiality and merit in a Lao Buddhist festival for the deceased*, in P. William, & P. Ladwig (Eds) *BUDDHIST FUNERAL CULTURES OF SOUTHEAST ASIA AND CHINA* (2012), Cambridge, UK: Cambridge University Press.

prepared rice balls. On the final day of the fortnight, people gather at the temple to distribute the rice to the spirits by throwing it over the *sima* (ritual boundary) of the *vihara* (ordination hall), out into the surrounding area where the spirits are said to gather. This is conducted as day breaks and afterwards the families return home to prepare offerings of food on a straw mat with which they ask their ancestors for protection. The festival ends with the return of the ghosts to their infernal home, often by floating their symbolic representations on a hollowed banana tree stem along the river, back to the underworld. The gates of hell then close upon them once again. The rapid revival of *p'chum ben* since the end of the war may be understood partly as an attempt to ritually reinstate the distinction between the realms of the dead and of the living, and thus to bring both social order and peace of mind to those who experienced the country's traumatic history.²⁴³

Healing the Wider Community. Since Cambodia's past has deeply affected many survivors, collective rituals that take place in symbolic locations, where spiritual power is managed to heal and reinstate order, play an important role. These include the erection of state-sponsored memorials, as well as village rituals that take place at symbolic locations such as mass burial sites. Guillou has investigated informal peasant healing practices related to mass bereavement and the cult of tutelary spirits (Khmer: *neak ta*) and has shown how, over the years, villagers have made use of their popular religious system to heal social suffering; this involves alternately forgetting and remembering the Khmer Rouge atrocities and ritually transforming the spirits of the dead into tutelary spirits who protect the community.²⁴⁴ By meditating and participating in the various memorial events and ceremonies, victims (and perpetrators) can engage with traumatic memory involving the dead, build shared memory, and make sense of tragedy within the framework of cultural recovery.

Survivor associations

Cambodian civil society organizations, including survivor associations and religious institutions have initiated a wide variety of culturally relevant psychosocial and spiritual activities, in parallel with the ongoing justice process at the Extraordinary Chambers in the Courts of Cambodia. The tribunal process itself is viewed by some as an attempt to encourage a collective healing process at the national level, a "ritual of purification," during which the Khmers can obtain

²⁴³ Kent, A., *Purchasing power and pagodas: The sima monastic boundary and the culture of consumption in Cambodia*, 38(2), JOURNAL OF SOUTHEAST ASIAN STUDIES, 335–354, (2007).

²⁴⁴ Guillou, A., *An alternative memory of the Khmer Rouge genocide: The dead of the mass graves and the land guardian spirits (neak ta)*, 20(2), SOUTH EAST ASIA RESEARCH, 207–226, (2012).

"justice" for the living and the deceased.

Mr. Chum Mey is one of the twelve known survivors of "S-21," the Khmer Rouge torture and interrogation facility at *Tuol Sleng* in which 16,000 people were killed, and is now head of one of the associations of Khmer Rouge survivors, which was started during the first trial at the tribunal (of Duch, the former chief of office for S-21). The goal of the Ksem Ksan Association is to "seek justice in the trials by setting up strong voices of the victims."²⁴⁵ Mr. Chum Mey related in an interview,

We held a Buddhist ceremony in S-21, and the idea of having a ceremony there was to dedicate to those who died in S-21. We would like the dead people to know that we are going to seek justice for them.

An elderly male member of the association from Pursat Province explained,

In 1979–1980, I really wanted to take revenge, I felt very angry because they arrested me and tortured me, but now I think about the dharma of the Buddha, and then I don't want to take revenge because Buddha says malice can be pacified by not taking revenge on each other.

Some leading members of the association also provide psychological support to members. One of the key women members explained,

I teach them to do meditation . . . we do it once a week. We also do relaxation exercises and wake up every morning to exercise. . . It helps them to calm down their feelings, because some people have had a nervous disease since the Pol Pot regime. They cannot sleep and they hurt their muscles. I also tell them not to keep the suffering in their bodies, but to speak it out so that they will not feel tension. . . some people cry while sharing their suffering experiences and I tell them to keep crying if they want to, because that will make them feel better.

Theary Seng, the head of another survivor association, the Association of Khmer Rouge Victims in Cambodia, explained how the associations help people

²⁴⁵ C. Mey, personal communication, October 25, 2011

feel that they are not alone and that they can learn what it means to be a citizen with rights and responsibilities.²⁴⁶ One of the members of her association explained how the association supports survivors:

They come to us and talk about their past, we can share it among us, and I discovered that they felt relief by doing that.

A monk from Phnom Penh explained that the trial at the tribunal could help survivors feel released especially if they combined testifying at the court with a visit to the pagoda:

For people who know how to use the court, the court could be divine medicine for them. Buddhism is just to console them and to calm their feeling. The people who also go to court get better more quickly.

Discussion

This Cambodian material shows that the semantics of Buddhist mindfulness are interwoven into a broader cultural fabric that extends well beyond the calming of the individual's emotions and includes enhancing the karmic status of others, including the dead. In the Khmer context, practicing mindfulness is inextricably linked to other cultural notions—particularly that of merit-making—and its objectives are both to bring psychological benefit to individuals and to support cultural regeneration.

The data presented here build on a brief survey administered with the help of a translator and are based on a small sample. The Buddhist-informed practices mentioned in this preliminary ethnography need further investigation and should be examined in more detail in future studies. It would also be relevant to explore in more depth how Western notions of psychological health and methods for achieving it are being transposed into the Asian context, possibly giving rise to innovative, hybrid discourses and therapeutic methods. For instance, some Cambodian mental health professionals have been inspired by the Western “third wave” cognitive approaches, which they combine with indigenous traditions in

collaboration with Buddhist monks.²⁴⁷

At the same time, Western “third wave” cognitive methods have been inspired by Buddhist practices and combine elements of meditation and mindfulness with cognitive-behavioral therapy (CBT).²⁴⁸ “Third wave” methods include a heterogeneous group of approaches such as acceptance and commitment therapy (ACT),²⁴⁹ dialectical behavior therapy (DBT),²⁵⁰ compassion-focused therapy (CFT),²⁵¹ mindfulness-based stress reduction (MBSR),²⁵² mindfulness-based cognitive therapy (MBCT),²⁵³ and culturally adapted cognitive-behavioral therapy (CA-CBT).²⁵⁴ This might indicate that Western psychological methods are becoming more readily transposable onto work with Buddhist trauma sufferers such as the Cambodians discussed here. Cambodians' efforts to “cool their body” and stop “thinking too much”²⁵⁵ correspond well with Western notions of core “emotion regulation and distress tolerance skills,”²⁵⁶ how to “restore self-

247 In an action research project with different Asian nongovernmental organisations including TPO-Cambodia, the author has developed a culturally adapted version of “Testimonial Therapy (TT)” that involves a Buddhist “testimony ceremony” as a significant element of its practice in Cambodia, creating a sense of closure and transformation and linking the trauma with a positive memory state. Testimonial therapy has also been adopted by the Khmer Rouge Tribunal as one of the reparations made available to 200 Civil Parties from Case 002/01 (see ECCC, 2014). Agger, I., Igreja, V., Kiehle, R., & Polatin, P., *Testimony ceremonies in Asia: Integrating spirituality in testimonial therapy for torture survivors in India, Sri Lanka, Cambodia, and the Philippines*, 49(3–4), *TRANSCULTURAL PSYCHIATRY*, 568–589, (2012); Hinton, D. E., Rivera, E., Hofmann, S. G., Barlow, D. H., & Otto, M. W., *Adapting CBT for traumatized refugees and ethnic minority patients: Examples from culturally adapted CBT (CA-CBT)*, 49, *TRANSCULTURAL PSYCHIATRY*, 340–365, (2012); ECCC, *Overview of Civil Party reparation requests in Case 002/01* (2014), <http://www.eccc.gov.kh/en/articles/wide-ranging-support-secured-reparations-victims-khmer-rouge>.

248 Kahl, K. G., Winter, L., & Schweiger, U., 25(6), *The third wave of cognitive behavioural therapies: What is new and what is effective?*, *CURRENT OPINION IN PSYCHIATRY*, 522–528, (2012).

249 Fung, K., *Acceptance and commitment therapy: Western adoption of Buddhist tenets?*, 52(4), *Transcultural Psychiatry*, 561–576, (2015); Walsler, R. D., & Westrup, D., *Acceptance & commitment therapy for the treatment of post-traumatic stress disorder & trauma-related problems*, (2007), Oakland: New Harbinger.

250 Linehan, M. M., *Cognitive-behavioral treatment for borderline personality disorder*, (1993), New York, NY: Guilford Press.

251 Gilbert, P., *The compassionate mind: A new approach to life's challenges*, (2009), London, UK: Constable & Robinson.

252 Kabat-Zinn, J., *Full catastrophe living: Using wisdom of your body and mind to face stress pain, and illness*, (1990), New York, NY: Bantam Dell.

253 Segal, Z. V., Williams, J. M. G., & Teasdale, J. D., *Mindfulness-based cognitive therapy for depression: A new approach to preventing relapse*, (2002), New York, NY: Guilford Press.

254 Hinton, D. E., Rivera, E., Hofmann, S. G., Barlow, D. H., & Otto, M. W., *Adapting CBT for traumatized refugees and ethnic minority patients: Examples from culturally adapted CBT (CA-CBT)*, 49, *TRANSCULTURAL PSYCHIATRY*, 340–365, (2012); Hinton, D. E., Pich, V., Hofmann, S. G., & Otto, M. W., *Mindfulness and acceptance techniques as applied to refugee and ethnic minority populations: Examples from culturally adapted CBT (CA-CBT)*, 20, *COGNITIVE AND BEHAVIORAL PRACTICE*, 33–46, (2013).

255 Nickerson, A., & Hinton, D. E., *Anger regulation in traumatized Cambodian refugees: The perspectives of Buddhist monks*, 35, *CULTURE, MEDICINE, AND PSYCHIATRY*, 396–416, (2011).

256 McKay, M., Wood, J. C., & Brantley, J., *The dialectical behaviour therapy skills workbook: Practical DBT exercises for learning mindfulness, interpersonal effectiveness, emotion regulation & distress tolerance*, (2007), Oakland, CA: New Harbinger.

246 T. Seng, personal communication, February 20, 2011.

regulation,”²⁵⁷ and “how to tolerate feelings and sensations by increasing the capacity for interception.”²⁵⁸ However, as the data show, Khmer Buddhism is a syncretic cosmological system in which practices such as meditation and mindfulness derive particular meanings.

Western practitioners of psychological support for survivors of mass human rights abuses still have much to learn by paying close attention to the way in which survivors themselves formulate and seek to address their distress. Others, such as Hinton and his colleagues have begun to do pioneering work using culturally sensitive methods of assessment and treatment of distress among Cambodian refugees.²⁵⁹ However, further studies of local therapeutic processes of healing are needed.²⁶⁰

The use of the ethnographic methods allowed the informants to speak for themselves about their reality. The voices of the Cambodians cited here tell us much about the relationship between indigenous understandings of wellbeing and their complex cultural and historical context. The Cambodians in this study describe an approach to wellbeing that extends beyond the individualistic focus of Western approaches to include the relationship between the living and the dead and between the individual and his or her karmic position in the great chain of being.

In much of the Western use of meditation/mindfulness techniques, if Buddhism is mentioned at all, it tends to be portrayed as a psychology closely akin to cognitive psychology.²⁶¹ Western cognitive therapists and users of mindfulness perhaps seek legitimacy by stressing the “scientific” and evidence-based nature of their methods and distancing themselves from religion. Some suggest that incorporating Buddhist practice in a more wholesale manner into Western contexts could be rejected as an affront to Christianity.²⁶² However, the scientific community would benefit from taking religious worldviews seriously and using what they learn of these to reflect upon the limitations of the scientific episteme. Straightforward transposition of therapeutic models developed within the

scientific paradigm onto survivors of mass atrocity, for whom religion often plays a consequential role in wellbeing, may result in the kind of “category truncation” to which Hinton, Peou, et al. allude.²⁶³ Furthermore, because of the high status awarded to Western positivist science as yielding modern “knowledge,” non-western and folk medical systems are regarded as systems of “belief” and subtly discounted.²⁶⁴ This may mean that when Western psychological “knowledge” is introduced in countries like Cambodia, it is interpreted by locals as superior to their own knowledge even though it may be quite dissonant with their experience.

Conclusion

In conclusion, although elements of Eastern traditions, such as meditation and mindfulness techniques, are becoming incorporated into the Western psychological paradigm, it is important to understand such elements as part of the broader cultural and historical totality that shapes people’s lives and experience. The reflections of the participants in this study illustrate some of the ways in which individual suffering is experienced as relating to the Cambodian nation’s shared history of grief and traumatization and its shared cultural universe. Moreover, they underscore the fact that the Western and Eastern uses of mindfulness are framed by significantly different systems of meaning that must be considered in the cultural adaptation or transposition of interventions.

²⁵⁷ Levine, P., *In an unspoken voice: How the body releases trauma and restores goodness*, (2010), Berkeley, CA: North Atlantic Books.

²⁵⁸ Van der Kolk, B., *Yoga and post-traumatic stress disorder: An interview with Bessel van der Kolk*, *Integral Yoga Magazine*, 12–13, (2009, Summer); Van der Kolk, B., *The body keeps the score: Brain, mind, and body in the healing of trauma*, (2014), New York: Viking.

²⁵⁹ Hinton, D. E., Rivera, E., Hofmann, S. G., Barlow, D. H., & Otto, M. W., *Adapting CBT for traumatized refugees and ethnic minority patients: Examples from culturally adapted CBT (CA-CBT)*, 49, *TRANSNATIONAL PSYCHIATRY*, 340–365, (2012).

²⁶⁰ Hinton, D. E., & Kirmayer, L. J., *Local responses to trauma: Symptom, affect, and healing*, 50(5), *TRANSNATIONAL PSYCHIATRY*, 607–621, (2013).

²⁶¹ Kirmayer, L. J., *Mindfulness in cultural context*, 52(4), *TRANSNATIONAL PSYCHIATRY*, 447–469, (2015).

²⁶² Crosby, K., *Theravada Buddhism: Continuity, diversity, identity*, (2013), Chichester, UK: Wiley-Blackwell.

²⁶³ Hinton, D. E., Peou, S., Joshi, S., Nickerson, A., & Simon, N., *Normal grief and complicated bereavement among traumatized Cambodian refugees: Cultural context and the central role of dreams of the deceased*, 37, *CULTURE, MEDICINE, AND PSYCHIATRY*, (2013).

²⁶⁴ Good, B. J., *Medicine, rationality, and experience: An anthropological perspective*, (1994), Cambridge, UK: Cambridge University Press.

5

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

Nigel P. Field was a core faculty member in the PhD Program in Clinical Psychology at Palo Alto University's Pacific Graduate School of Psychology. He specialized 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 work also included a focus on human perpetrated trauma with special emphasis on genocide and intergenerational psychological effects of such trauma in a Cambodian context. Due to Dr. Fields's untimely death in 2013, this chapter has not been substantively revised.

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.²⁶⁵ In a separate survey study, 11.5% of Cambodians met the criteria for major depression,²⁶⁶ while 40% had an anxiety disorder.²⁶⁷ 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%.²⁶⁸ 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 was born after the end

265 J. de Jong et al., *PTSD and Disability in Cambodia: Associations with Desire for Revenge, Perceived Justice and Attitudes toward the Khmer Rouge Trials*, 302 JAMA 527 (2009) (conclusions based on a national probability sample).

266 A psychiatric disorder characterized by low self-esteem, an inability to experience pleasure in normal activities, poor concentration, and poor appetite, as well as general behavioral withdrawal. Major depression has a disabling effect on general functioning, which may negatively impact relationships and the ability to work.

267 M. Eisenbruch & W. Van de Put, *The Cambodian Experience*, in *TRAUMA, WAR, AND VIOLENCE: PUBLIC MENTAL HEALTH IN SOCIO-CULTURAL CONTEXT* 93-155 (J. de Jong ed., 2002).

268 S.M. Berthold et al., *Mental Health of Cambodian Refugees 2 Decades after Resettlement in the United States*, 294 JAMA 571 (2005) (conclusions based on a representative sample).

of Khmer Rouge.²⁶⁹ 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 was never directly exposed to the hostilities of the Khmer Rouge and its aftermath.²⁷⁰ 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 observations²⁷¹ of children's emotional response to separation from their parents.²⁷² Bowlby sought to explain these effects by positing the existence of a built-in tendency in the child to organize

269 B. Munyas, *Genocide in the Minds of Cambodian Youth: Transmitting Histories of Genocide to Second and Third Generations in Cambodia*, 10 J. GENOCIDE RES. 413 (2008).

270 G. Miles & G. Thomas, 'Don't Grind an Egg Against a Stone'—*Children's Rights and Violence in Cambodian History and Culture*, 16 CHILD ABUSE REV. 383 (2007).

271 Naturalistic observation is a research technique that allows observation of subjects in their natural environment without intervention by the observer.

272 R. KAREN, *BECOMING ATTACHED: UNFOLDING THE MYSTERY OF THE INFANT-MOTHER BOND AND ITS IMPACT ON LATER LIFE* (1994).

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.²⁷³

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.²⁷⁴ Internal and external stressors, including illness, fatigue, unfamiliar settings, and separation from the attachment figure, serve to activate the attachment system.²⁷⁵ 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.²⁷⁶

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.²⁷⁷

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.²⁷⁸ 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.²⁷⁹

One of the most robust findings in the attachment research literature is the concordance between the parent and child's attachment.²⁸⁰ 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.²⁸¹ Attachment theory also identifies different variants of insecure attachment as an outgrowth of sub-optimal parenting.²⁸² 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.²⁸³ 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.²⁸⁴ 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

278 See M.D.S. AINSWORTH ET AL., PATTERNS OF ATTACHMENT: A PSYCHOLOGICAL STUDY OF THE STRANGE SITUATION (1978).

279 M. MIKULINER & P.R. SHAVER, ATTACHMENT IN ADULTHOOD: STRUCTURE, DYNAMICS, AND CHANGE (2007).

280 M.H. van Ijzendoorn, *Adult Attachment Representations, Parental Responsiveness, and Infant Attachment: A Meta-analysis on the Predictive Validity of the Adult Attachment Interview*, 117 PSYCHOL. BULL. 387 (1995).

281 M.D.S. AINSWORTH ET AL., *supra* note 278.

282 M. MIKULINER & P.R. SHAVER, *supra* note 279.

283 M.D.S. AINSWORTH ET AL., *supra* note 278.

284 M. Main & J. Solomon, *Procedures for Identifying Infants as Disorganized/Disoriented during the Ainsworth Strange Situation*, in ATTACHMENT IN THE PRESCHOOL YEARS: THEORY, RESEARCH, AND INTERVENTION 121-60 (M. T. Greenberg et al. eds., 1990).

273 *Id.*

274 J. BOWLBY, 2 ATTACHMENT AND LOSS—SEPARATION: ANXIETY AND ANGER (1973).

275 *Id.*

276 J. Solomon & C. George, *The Place of Disorganization in Attachment Theory: Linking Classic Observations with Contemporary Findings*, in ATTACHMENT DISORGANIZATION 3-32 (J. Solomon & C. George eds., 1999).

277 C. George & J. Solomon, *Attachment and Caregiving: The Caregiving Behavioral System*, in HANDBOOK OF ATTACHMENT: THEORY, RESEARCH, AND CLINICAL APPLICATIONS 833-56 (J. Cassidy & P. R. Shaver eds., 2d ed. 2008).

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.²⁸⁵ 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.²⁸⁶ In addition, maternal psychopathology—such as depression and psychotic disorder—increased the likelihood for the child having disorganized attachment.²⁸⁷

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.²⁸⁸ 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.²⁸⁹

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.²⁹⁰ 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.²⁹¹ Although defensively warded off under normal conditions, these segregated mental representations may intrude into awareness. Such intrusions may take the form of dysregulated²⁹² attachment-related thoughts, feelings, and behavior under conditions of perceived threat that serve to activate the attachment system.²⁹³ 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.²⁹⁴ 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.²⁹⁵ 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 six²⁹⁶ and later dissociative symptoms in adolescence and early adulthood.²⁹⁷ 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-

285 For more detail, see E. Hesse et al., *Unresolved States Regarding Loss or Abuse can have "Second-generation" Effects: Disorganization, Role inversion, and Frightening Ideation in the Offspring of Traumatized, Non-maltreating Parents, in HEALING TRAUMA: ATTACHMENT, MIND, BODY, AND BRAIN 57-106* (M. Solomon & D. Siegel eds., 2003).

286 J. Solomon & C. George, *The Place of Disorganization in Attachment Theory*, *supra* note 276.

287 *Id.* See also K. Lyons-Ruth & D. Jacobvitz, *Attachment Disorganization: Genetic Factors, Parenting Contexts, and Developmental Transformation from Infancy to Adulthood, in HANDBOOK OF ATTACHMENT: THEORY, RESEARCH, AND CLINICAL APPLICATIONS 666-97* (J. Cassidy & P. R. Shaver eds., 2d ed. 2008); J. Green & M.W. Wan, *The Impact of Maternal Psychopathology on Child-mother Attachment*, 12 *ARCHIVES WOMEN'S MENTAL HEALTH* 123 (2010).

288 C. George & J. Solomon, *Attachment and Caregiving: The Caregiving Behavioral System*, *supra* note 277; K. Lyons-Ruth & D. Jacobvitz, *supra* note 287.

289 G. Atwood et al., *Expanding the Concept of Unresolved Mental States: Hostile/Helpless States of Mind in the Adult Attachment Interview are Associated with Disrupted Infant-Mother Communication and Infant Disorganization*, 17 *DEV. & PSYCHOPATHOLOGY* 1 (2005).

290 G. Liotti, *Trauma, Dissociation, and Disorganized Attachment: Three Strands of a Single Braid*, 41 *PSYCHOTHERAPY: THEORY, RESEARCH, PRACTICE, TRAINING* 472 (2004).

291 J. BOWLBY, 3 *ATTACHMENT AND LOSS—LOSS: SADNESS AND DEPRESSION* (1980). Representational systems are neuro-linguistic models for describing the ways in which the human mind processes information. The brain uses the representational systems, which correspond to the five senses, to perceive the world and subjectively characterize experiences.

292 Dysregulated refers to inability to effectively regulate emotional responses.

293 J. Solomon & C. George, *The Place of Disorganization in Attachment Theory*, *supra* note 276.

294 P. Fearson & W. Mansell, *Cognitive Perspectives on Unresolved Loss: Insights for the Study of PTSD*, 65 *BULL. MENNINGER CLINIC* 380 (2001).

295 For a review, see K. Lyons-Ruth & D. Jacobvitz, *supra* note 287.

296 *Id.*

297 F.A. Carlson, *A Prospective Longitudinal Study of Disorganized/Disorientated Attachment*, 69 *CHILD DEV.* 1107 (1998); Lissa Dutra et al., *The Relational Context of Dissociative Phenomena, in DISSOCIATION AND THE DISSOCIATIVE DISORDERS: DSM-5 AND BEYOND 83-92* (Paul F. Dell et al. eds., 2009).

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.²⁹⁸ 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.²⁹⁹ 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 parentified³⁰⁰ type of controlling stance toward the parent, which was characterized by helpfulness or attempts to improve the mother's mood.³⁰¹ 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.³⁰²

298 C. George & J. Solomon, *Intergenerational Transmission of Dysregulated Maternal Caregiving: Mothers Describe their Upbringing and Childrearing*, in PARENTING REPRESENTATIONS: THEORY, RESEARCH, AND CLINICAL IMPLICATIONS 265-95 (O. Maysless et al. eds., 2002).

299 C. George & J. Solomon, *Attachment and Caregiving: The Caregiving Behavioral System*, *supra* note 277.

300 Parentification is defined by a role-reversal between parent and child. The child's emotional and/or physical needs are sacrificed in favor the parent's needs. When the child takes on the parent's role, he becomes *parentified*.

301 C. George & J. Solomon, *Attachment and Caregiving: The Caregiving Behavioral System*, *supra* note 277.

302 *Id.* See also K. Lyons-Ruth & D. Jacobvitz, *supra* note 287.

It is noteworthy that, in a doll-play method for assessing attachment,³⁰³ 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.³⁰⁴

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.³⁰⁵ 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.³⁰⁶

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.³⁰⁷ 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.³⁰⁸ A parent who is under threat of being physically abused will also be compromised in her role as a caregiver

303 In the doll-play projective method for assessing attachment, the child is presented with various scenarios relevant to attachment, such as a child who falls and whose knee has been hurt. The child is instructed to compose a story using doll figures as adjuncts. These stories are assumed to reveal the child's underlying attachment, as expressed at the symbolic or mental representational level rather than at the overt behavioral level. This is the case in the Strange Situation.

304 According to Bowlby, early experiences with attachment figures become internalized in the form of mental representations akin to a generalized memory or schema gradually built up from such experiences. The content of these mental representations are based on early experiences with parents and include beliefs regarding the emotional availability of attachment figures and the ability to elicit care and protection from them. The quality of attachment at the mental representational level is reflected in the child's responses to projective stimuli such as pictures or story stems. See *supra* note 292.

305 C. George & J. Solomon, *Intergenerational Transmission of Dysregulated Maternal Caregiving: Mothers Describe their Upbringing and Childrearing*, *supra* note 298.

306 C. George & J. Solomon, *Attachment and Caregiving: The Caregiving Behavioral System*, *supra* note 277.

307 B.C. Feeney & M. Van Vleet, *Growing Through Attachment: The Interplay of Attachment and Exploration in Adulthood*, 27 J. SOC. & PERSONAL RELATIONSHIPS 226 (2010).

308 C. George & M. West, *Abuse and Violence in Intimate Adult Relationships: New Perspectives for Attachment Theory*, 1 ATTACHMENT & HUMAN DEV. 137 (1999).

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.³⁰⁹

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.³¹⁰ Witnessing torture, execution, and starvation, and the ongoing threat of personal harm further added to the sense of vulnerability, horror, and loss.³¹¹ 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.³¹² 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.³¹³

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.³¹⁴ 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.³¹⁵

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.³¹⁶ 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.³¹⁷ 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.³¹⁸

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.³¹⁹ 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.³²⁰

314 C. Courtois & J. Ford, *Defining and Understanding Complex Trauma and Complex Traumatic Stress Disorders*, in *TREATING COMPLEX TRAUMATIC STRESS DISORDERS: AN EVIDENCE-BASED GUIDE* 13-30 (C. Courtois & J. Ford eds., 2009).

315 L. SROUFE ET AL., *THE DEVELOPMENT OF THE PERSON: THE MINNESOTA STUDY OF RISK AND ADAPTATION FROM BIRTH TO ADULTHOOD* (2005).

316 B. KIERNAN, *supra* note 310.

317 *Id.*

318 G. Miles & G. Thomas, *supra* note 270.

319 S. Dicklitch & A. Malik, *Justice, Human Rights, and Reconciliation in Postconflict Cambodia*, 11(4) *HUM. RTS. REV.* 515 (Dec. 2010).

320 J. de Jong et al., *supra* note 307. See also M. Eisenbruch & W. Van de Put, *The Cambodian Experience, in TRAUMA, WAR, AND VIOLENCE: PUBLIC MENTAL HEALTH IN SOCIO-CULTURAL CONTEXT* 93-155 (J. de Jong ed., 2002).

309 C. George & J. Solomon, *Attachment and Caregiving: The Caregiving Behavioral System*, *supra* note 277.

310 B. KIERNAN, *THE POL POT REGIME: RACE, POWER, AND GENOCIDE IN CAMBODIA UNDER THE KHMER ROUGE* 1975-79 (2d ed. 2002).

311 *Id.*

312 K. Almquist & A.G. Broberg, *Young Children Traumatized by Organized Violence Together with Their Mothers—The Critical Effects of Damaged Internal Representations*, 5 *ATTACHMENT & HUMAN DEV.* 367 (2010).

313 *Id.*

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.³²¹

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.³²² 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.³²³ 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.³²⁴ 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

321 C. Chemtob et al., *Impact of Maternal Posttraumatic Stress Disorder and Depression Following Exposure to the September 11 Attacks on Preschool Children's Behavior*, 81 CHILD DEV. 1129 (2010).

322 G. Miles & G. Thomas, *supra* note 270.

323 R. Surtees, *Negotiating Violence and Non-violence in Cambodian Marriages*, 11(2) GENDER & DEV. 30 (2003).

324 *Id.*

light, thus increasing the likelihood for violence.³²⁵

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.³²⁶ There is evidence of longstanding effects of exposure to the Nazi regime on unresolved trauma and PTSD symptoms among Holocaust survivors.³²⁷ Moreover, maladaptive parenting styles have been identified in the Holocaust literature with implications for the psychological health of the offspring.³²⁸

Role-reversal parenting is one type of maladaptive parenting identified in the Holocaust literature.³²⁹ In role-reversal, a parent turns to a child to meet his or her unmet childhood needs.³³⁰ 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.³³¹ 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.³³² 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

325 C. George & M. West, *supra* note 308.

326 Y. DANIELI, *INTERNATIONAL HANDBOOK OF MULTIGENERATIONAL LEGACIES OF TRAUMA* (1998).

327 S. Alkalay et al., *Attachment and Traumatic Stress in Female Holocaust Survivors and their Daughters*, 160 AM. J. PSYCHIATRY 1086 (2003).

328 D. Bar-On et al., *Multigenerational Perspectives on Coping with the Holocaust Experience: An Attachment Perspective for Understanding the Developmental Sequelae of Trauma Across Generations*, 22 INT'L J. BEHAV. DEV. 3 (1998).

329 *Id.*

330 N.D. Chase, *Parentification: An Overview of Theory, Research and Societal Issues*, in BURDENED CHILDREN: THEORY, RESEARCH, AND TREATMENT OF PARENTIFICATION 3-33 (N.D. Chase ed., 1999).

331 C. George & J. Solomon, *Intergenerational Transmission of Dysregulated Maternal Caregiving: Mothers Describe their Upbringing and Childrearing*, *supra* note 298.

332 D. Bar-On et al., *supra* note 328.

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.³³³ 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.³³⁴ The role-reversal served to foster a parentified orientation in their offspring.³³⁵

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.³³⁶ 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.³³⁷ 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.³³⁸

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

333 D. Brom et al., *A Controlled Double-blind Study on Children of Holocaust Survivors*, 38 ISRAELI J. PSYCHIATRY & RELATED SCI. 47 (2001).

334 L. Baider & M. Sarell, *Coping Among Holocaust Survivors in Israel: An Exploratory Study*, 10 J. HUM. STRESS 121 (1984).

335 *Id.*

336 D. Bar-On et al., *supra* note 328.

337 *Id.*

338 D. Brom et al., *supra* note 333.

severity.³³⁹ 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 caregiving 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.³⁴⁰

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

339 R. Grossman et al., *Childhood Trauma and Risk for PTSD: Relationship to Intergenerational Effects of Trauma, Parental PTSD, and Cortisol Excretion*, 13 DEV. & PSYCHOPATHOLOGY 733 (2001).

340 S. Alkalay et al., *supra* note 327.

Rouge) from three high schools in Phnom Penh.³⁴¹ 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.³⁴² 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").³⁴³

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.³⁴⁴ 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 hyperarousal³⁴⁵ 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.³⁴⁶ 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.³⁴⁷ 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-

344 N.P. Field & S. Vannavuth, *Second Generation Effects of Trauma Stemming from the Khmer Rouge Regime, paper presented at Mental Health of Khmer Rouge Survivors and their Descendants* (2009) (sponsored by German Development Foundation for Cambodia (DED)).

345 Hyperarousal refers to a state of heightened internal, nervous system stimulation. Hyperarousal trauma symptoms may include difficulties falling and staying asleep, irritability, and an exaggerated startle response.

346 N.P. Field & S. Muong, *Parent-child Transmission of Trauma Stemming from the Khmer Rouge, paper presented at International Society for Traumatic Stress Studies* (2009).

347 K. Del Ben et al., *Psychometric Properties of the PTSD Checklist – Civilian Version*, 16 J. TRAUMATIC STRESS 495 (2003).

341 N.P. Field et al., *Intergenerational Transmission of Trauma: Second Generation Effects of the Khmer Rouge Regime, paper session at International Society for Traumatic Stress Studies* (2007).

342 See P.C. Alexander, *Parent-child Role Reversal: Development of a Measure and Test of an Attachment Theory Model*, 22(2) J. SYSTEMIC THERAPIES 31 (2003).

343 See L.B. Brown et al., *A Parental Bonding Instrument*, 52 BRIT. J. MED. PSYCHOLOGY 1 (1979).

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.³⁴⁸ Many rank-and-file members of the Khmer Rouge are known to have had limited privileged status and were themselves exposed to considerable trauma.³⁴⁹ 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.³⁵⁰

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

348 N.P. Field, *Intergenerational Effects in Collective Blame Assignment Linked to Khmer Rouge Regime: Attitudes Among Second Generation Cambodians*, paper presented at Transcultural Psychosocial Organization (TPO) (2008).

349 M. Ea & S. Sim, *Victims and Perpetrators: Testimony of Young Khmer Rouge Comrades*, Documentation Center of Cambodia, Doc. Series No. 1 (2001).

350 Field et al., *Intergenerational Transmission of Trauma*, *supra* note 341.

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.³⁵¹ 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,

351 Y. DANIELI, *supra* note 326.

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.³⁵² 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.³⁵³

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.³⁵⁴ 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.

352 C. George & J. Solomon, *Attachment and Caregiving: The Caregiving Behavioral System*, *supra* note 277.

353 Z. Solomon & E. Prager, *Elderly Israeli Holocaust Survivors During the Persian-Gulf-War—A Study of Psychological Distress*, 149 AM. J. PSYCHIATRY 1707 (1992).

354 Z. Solomon et al., *Combat-related Posttraumatic Stress Disorder among 2nd-Generation Holocaust Survivors—Preliminary Findings*, 145 AM. J. PSYCHIATRY 865 (1988).

6

THE EFFECTS OF TRAUMATIC MEMORY AND SECONDARY TRAUMA IN THE EXTRAORDINARY CHAMBERS IN THE COURTS OF CAMBODIA

S. Megan Berthold (Ph.D., LCSW) is a trauma specialist and Assistant Professor at the University of Connecticut's School of Social Work whose career has focused on work with survivors of torture and related traumas. She has worked as a clinician and researcher with Cambodian refugees in the United States and displaced Cambodians on the Thai-Cambodian border since 1987.

Gerald Gray (LCSW, MPH) is co-director of The Institute for Redress & Recovery at Santa Clara University School of Law. He has initiated the founding of several torture treatment centers and the creation of legal organizations that track torturers and bring them to justice for their actions, where he has served variously as psychotherapist, administrator, or board president.³⁵⁵

PART II: TRAUMA AND THE KHMER ROUGE TRIBUNAL PROCESS

Cambodians who lived through the Khmer Rouge era have endured and survived some of the worst human rights atrocities known to humankind. Now, more than three decades after the Vietnamese invaded Cambodia and ended the Khmer Rouge reign in early 1979, the Extraordinary Chambers in the Courts of Cambodia (ECCC) have started to prosecute a small number of the Khmer Rouge leaders who are still alive. Dozens of Cambodian survivors have provided 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 Cambodian survivors. We will discuss how trauma and other posttraumatic sequelae³⁵⁶ might impact a survivor-witness's memory and ability to testify in court and offer some suggestions for addressing these concerns. We will also highlight the potential risk for re-traumatization or secondary traumatization of legal representatives, adjudicators, interpreters, and other staff of the ECCC. Finally, we will present implications and recommendations for the well-being of the ECCC staff and court proceedings.

³⁵⁵ The authors wish to thank Drs. Yael Fischman and John Briere for their contributions in the development of this chapter.

³⁵⁶ Sequelae are pathological conditions that result from some prior trauma or illness.

At the time of the writing of this second edition of this manuscript, the ECCC have completed Case 001, which primarily addressed crimes committed at Tuol Sleng prison (Security Prison S-21), and the trial phase of Case 002/01, which covered crimes against humanity committed between 17 April 1975 and December 1977 in relation to the forced movement of the civilian population (phases one and two) and executions of former Khmer Republic officials at Tuol Po Chrey. In Case 002/01, Nuon Chea and Khieu Samphan, two of the senior leaders of the Khmer Rouge, were convicted of crimes against humanity in the Trial Chamber of the ECCC in August 2014 and sentenced to life imprisonment. The first edition of *Cambodia's Hidden Scars* was entered into evidence, and testimony regarding the psychological impact of trauma experienced during the Khmer Rouge regime was included at trial. The ECCC discussed mental health issues covered by this and other chapters in the decision emerging from Case 002/01 in relation to damages and reparations for Civil Parties. Nuon Chea and Khieu Samphan are currently standing trial again before the ECCC (Case 002/02) for charges of genocide against Cham and Vietnamese civilians, crimes against humanity, and grave breaches of the Geneva Conventions of 1949.

The updated version of this chapter includes an expanded discussion of the importance of mental health in the ECCC and other human rights tribunal processes; it also advocates for enhanced mental health services in Cambodia. In so doing, this chapter draws from multiple sources: the clinical and scholarly literature on primary and secondary trauma, including among Cambodian survivors; the authors' clinical experience with Cambodian survivors in the United States and on the Thai-Cambodian border; the authors' experience with Cambodian and other survivors appearing before U.S. federal courts in immigration and other proceedings; the second author's experience on two occasions with interpreters at the International Criminal Court in The Hague; and transcripts from and the ECCC Trial Chamber's Judgment in Case 002/01.³⁵⁷ This chapter aims to: (1) provide an understanding of the effects of human-induced trauma, so that courts—such as the ECCC—can adequately undertake their work without doing disservice to traumatized witnesses or staff; and (2) provide information related to the mental health of survivors and their communities following the commission of genocide and crimes against humanity that will be useful for the judges of the ECCC and other human rights tribunals as they deliberate and issue their judgments.

³⁵⁷ ECCC, *Trial Chamber Case 002/01 Judgment*, Case File/Dossier No. 002/19-09-2007/ECCC/TC. Retrieved from www.eccc.gov.kh/en/document/court/case-00201-Judgment.

Psychological Consequences of Trauma

Our world is rife with examples of traumatic events accompanied by devastating consequences to human psychology, 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 determining the extent and type of symptoms a survivor experiences include variables specific to the survivor and stressor characteristics. In addition, the nature and extent of support, resources, and social responses received by the survivor will shape a survivor's response to trauma.³⁵⁸ 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 the military or police in repressive regimes, because such a reaction inhibits the political organization of a viable opposition. A situation of state terror can also inhibit efforts to seek justice. 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. Courts must recognize this distinction 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 PTSD first appeared in the American Psychiatric Association's *Diagnostic and Statistical Manual (DSM)*, Third Edition.³⁵⁹ The diagnosis of PTSD was largely developed from the need to categorize the persistent suffering experienced by Vietnam War combat veterans. Previously, persistent symptoms of psychological distress following a trauma were considered to be influenced by the person's character. With the advent of the diagnostic category of PTSD, posttraumatic distress was now viewed primarily as a consequence of the traumatic stressor. The diagnostic criteria and understanding of the construct of PTSD has evolved during the intervening years, but the basic

³⁵⁸ J. BRIERE & C. SCOTT, *PRINCIPLES OF TRAUMA THERAPY: A GUIDE TO SYMPTOMS, EVALUATION, AND TREATMENT* (2006).

³⁵⁹ AM. PSYCHIATRIC ASS'N, *DIAGNOSTIC AND STATISTICAL MANUAL OF MENTAL DISORDERS: DSM-III* (1980).

phenomenon has retained its currency in the field.³⁶⁰

Many survivors of trauma—but not all—develop full-blown PTSD and/or clinical depression. Many others experience at least some of the distressing symptoms associated with these conditions, which can negatively affect their daily functioning and sense of well-being. PTSD has four clusters of symptoms: intrusion, avoidance, negative alterations in cognitions and mood, and marked alterations in arousal and reactivity associated with the traumatic event(s). All eight of the DSM-5³⁶¹ diagnostic criteria must be met for a person to be diagnosed with PTSD (see the Box 1 for the criteria).

Populations that have been exposed to high levels of violence and war—such as combat veterans, refugees, and torture survivor populations—have a higher estimated prevalence of PTSD than other groups. For example, 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.³⁶²

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 bereavement³⁶³ 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 as a 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.³⁶⁴ Great attention has been focused in recent years on the cross-cultural assessment of the impact of psychological trauma and its consequences.³⁶⁵ 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 typically found in survivors from some cultures, and failing to include somatic and dissociative symptoms often found in non-North American populations.³⁶⁶ At the same time, a recent review found considerable evidence of the cross-cultural validity of PTSD.³⁶⁷ 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 also develop within a specific cultural context in response to trauma. Some traumatized Cambodian refugees have been found to suffer from *weak heart syndrome (khsaoy beh doung)*³⁶⁸ that can cause calamitous cognitions and somatic symptoms and is believed may lead to various dangerous physiological problems such as a *wind attack (khyâl 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.³⁶⁹ 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 Aaruupey* (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).³⁷⁰

Major Depressive Disorder

Persistent depression has been found in many studies of those who have been chronically traumatized.³⁷¹ Major Depressive Disorder is one of the primary psychiatric outcomes of trauma, regardless of the type of trauma. In some

360 J. BRIERE, PSYCHOLOGICAL ASSESSMENT OF ADULT POSTTRAUMATIC STATES: PHENOMENOLOGY, DIAGNOSIS, AND MEASUREMENT (2d ed. 2004).

361 AM. PSYCHIATRIC ASS'N, DIAGNOSTIC AND STATISTICAL MANUAL OF MENTAL DISORDERS (5TH EDITION): DSM-5 (2013).

362 J.T. de Jong et al., *Lifetime Events and Posttraumatic Stress Disorder in Four Postconflict Settings*, 286 JAMA 555 (2001).

363 M. Eisenbruch, *Toward a Culturally Sensitive DSM: Cultural Bereavement in Cambodian Refugees and the Traditional Healer as Taxonomist*, 180(1) J. NERVOUS & MENTAL DISEASE 8 (1992).

364 J. BRIERE & C. SCOTT, *supra* note 358.

365 M. Eisenbruch, J.T. de Jong & W. van de Put, *Bringing Order Out of Chaos: A Culturally Competent Approach to Managing the Problems of Refugees and Victims of Organized Violence*, 17(2) J. TRAUMATIC STRESS 123 (2004); AM. PSYCHOL. ASS'N, ETHNOCULTURAL ASPECTS OF POSTTRAUMATIC STRESS DISORDER: ISSUES, RESEARCH, AND CLINICAL APPLICATIONS (A. J. Marsella et al. eds., 1996); CROSS-CULTURAL ASSESSMENT OF TRAUMA AND PTSD (J. P. Wilson & C. H. Tang eds., 2007).

366 AM. PSYCHOL. ASS'N, ETHNOCULTURAL ASPECTS OF POSTTRAUMATIC STRESS DISORDER, *supra* note 360.

367 D.E. Hinton & R. Lewis-Fernandez, *The Cross-cultural Validity of Posttraumatic Stress Disorder: Implications for DSM-5*, DEPRESSION & ANXIETY 1 (2010). This text also provides suggestions for revision to the construct as well as areas for future research.

368 D.E. Hinton & M.W. Otto, *Symptom Presentation and Symptom Meaning Among Traumatized Cambodian Refugees: Relevance to a Somatically Focused Cognitive-Behavior Therapy*, 13(4) COGNITIVE & BEHAV. PRAC. 249 (2006).

369 D.E. Hinton et al., *Khyâl Attacks: A key Idiom of Distress among Traumatized Cambodia Refugees*, 34(2) CULTURAL MED. PSYCHIATRY 244 (2010).

370 D.C. Henderson et al., *Building Primary Care Practitioners' Attitudes and Confidence in Mental Health Skills in a Post-conflict Society: A Cambodian Example*, 193(8) J. NERVOUS & MENTAL DISEASE 551 (2005); HARVARD GUIDE TO KHMER MENTAL HEALTH: A PROJECT OF THE HARVARD PROGRAM IN REFUGEE TRAUMA (J. Lavelle et al. eds., 1996).

371 J.L. HERMAN, TRAUMA AND RECOVERY: THE AFTERMATH OF VIOLENCE—FROM DOMESTIC ABUSE TO POLITICAL TERROR (1992).

populations, depression is more prevalent than PTSD.³⁷² 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., PTSD combined with depression).³⁷³

Other Posttraumatic Outcomes

The symptoms of distress that are found in the DSM-IV-TR³⁷⁴ and earlier versions of the 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,³⁷⁵ guilt/shame symptoms, dissociative symptoms, aggressive/externalizing symptoms, and negative appraisals about the world and oneself.³⁷⁶ The new version of the DSM (the DSM-5) includes a dissociative sub-type for the first time.

Often, neither depression nor PTSD captures the full range of distress of trauma survivors. Survivors often have complex presentations,³⁷⁷ 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.³⁷⁸

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 behaviors³⁷⁹ 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

372 D. Silove & J.D. Kinzie, *Survivors of War Trauma, Mass Violence, and Civilian Terror*, in *THE MENTAL HEALTH CONSEQUENCES OF TORTURE* 159 (E. Gerrity, T.M. Keane, & F. Tuma eds., 2001).

373 J. BRIERE, *PSYCHOLOGICAL ASSESSMENT*, *supra* note 360.

374 AM. PSYCHIATRIC ASS'N, *DIAGNOSTIC AND STATISTICAL MANUAL OF MENTAL DISORDERS: DSM-IV-TR* (2000).

375 Anhedonia is a psychological condition characterized by the inability to experience pleasure in situations or acts that would normally produce pleasure. Dysphoria is a state of feeling unwell or unhappy.

376 M.J. Friedman, *PTSD Revisions Proposed for DSM-5, with Input from Array of Experts*, 45(10) *PSYCHIATRIC NEWS* 8 (2010).

377 J. BRIERE & C. SCOTT, *supra* note 358.

378 *Id.*

379 J. Briere, *Treating Adult Survivors of Severe Childhood Abuse and Neglect: Further Development of an Integrative Mode*, in *THE APSAC HANDBOOK ON CHILD MALTREATMENT* 175 (J.E.B. Meyers et al. eds., 2d ed. 2002).

or forms of externalizing anxiety reduction strategies), psychosis, dissociation, sexual problems, somatic symptoms, cognitive distortions, and self-blame, guilt, and/or low self-esteem.³⁸⁰ 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.³⁸¹ 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.³⁸² The relationship, however, is complex.³⁸³ Episodes of dissociation during and after a trauma are often conceptualized as a psychological defense mechanism,³⁸⁴ 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,³⁸⁵ and the survivor may experience symptoms of depersonalization, amnesia, derealization, and/or fugue³⁸⁶. 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

380 J. BRIERE & C. SCOTT, *supra* note 360.

381 J. Briere, M. Hodges & N. Godbout, *Traumatic Stress, Affect Dysregulation, and Dysfunctional Avoidance: A Structural Equation Model*, 23(6) *J. TRAUMATIC STRESS* 767 (2010).

382 F.W. PUTNAM, *DISSOCIATION IN CHILDREN AND ADOLESCENTS: A DEVELOPMENTAL PERSPECTIVE* (1997); *DISSOCIATIVE DISORDERS: A CLINICAL REVIEW* (D. Spiegel ed., 1993).

383 J. BRIERE & C. SCOTT, *supra* note 360.

384 D. Spiegel, *Dissociation and Trauma*, in *10 AMERICAN PSYCHIATRIC PRESS REVIEW OF PSYCHIATRY* 261 (A. Tasman & S.M. Goldfinger eds., 1991).

385 J. Briere, C. Scott & F. Weathers, *Peritraumatic and Persistent Dissociation in the Presumed Etiology of PTSD*, 162 *AM. J. PSYCHIATRY* 2295 (2005).

386 E. Cardena et al., *Dissociative Disorders*, in *DSM-IV SOURCEBOOK* 261 (J.A. Widiger et al. eds., 1996).

exposure are many, and include chronic physical and mental health conditions and health-related diminutions in quality of life.³⁸⁷ 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.³⁸⁸ 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).³⁸⁹

The rate found in refugees and torture survivors is considerably higher.³⁹⁰ 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 among whom they are residing.³⁹¹ 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.³⁹² 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,³⁹³ especially in those with PTSD. In one review, 40% of refugees with PTSD made suicide attempts.³⁹⁴ A more recent 2010 review found a prevalence of suicidal behavior ranging from 3.4% to 34% in refugees.³⁹⁵ In another study, the primary cause of premature death in Australian detention centers was suicide.³⁹⁶

387 G.N. Marshall, et al. *Diabetes and cardiovascular disease risk in Cambodian refugees*, 18(1) JOURNAL OF IMMIGRANT AND MINORITY HEALTH 110-117 (2016); M. Bogic, et al., *Long-term mental health of war-refugees: a systematic literature review*, 15 BMC INT HEALTH HUM RIGHTS 29 (2015); P.S. Corso et al., *Health related quality of life among adults who experienced maltreatment during childhood*, 98(6) AM. J. PUBLIC HEALTH 1094 (2008).

388 B.H. Stamm, *Measuring Compassion Satisfaction as well as Fatigue: Developmental History of the Compassion Satisfaction and Fatigue Test*, in TREATING COMPASSION FATIGUE 107 (C.R. Figley ed., 2002).

389 R.C. Kessler et al., *Prevalence, Severity, and Comorbidity of 12-month DSM-IV disorders in the National Comorbidity Survey Replication*, 62 ARCHIVES GEN. PSYCHIATRY 617 (2005).

390 J.K. Boehnlein & J.D. Kinzie, *Refugee Trauma*, 32 TRANSCULTURAL PSYCHIATRY 223 (1995); Z. Steel et al., *Association of Torture and Other Potentially Traumatic Events with Mental Health Outcomes Among Populations Exposed to Mass Conflict and Displacement: A Systematic Review and Meta-analysis*, 302 JAMA 537 (2009).

391 M. Fazel, J. Wheeler & J. Danesh, *Prevalence of Serious Mental Disorder in 7000 Refugees Resettled in Western Countries: A Systematic Review*, 365(9467) LANCET 1309 (2005).

392 J.D. Kinzie, J.M. Jaranson & G.V. Kroupin, *Diagnosis and Treatment of Mental Illness*, in IMMIGRANT MEDICINE 639 (P.F. Walker & E.D. Barnett eds., 2007).

393 L. Vijayakumar, *Suicide among refugees – a mockery of humanity*, 37(1) CRISIS 1 (2016).

394 M. Ferrada-Noli et al., *Suicidal Behavior after Severe Trauma. Part 1: PTSD Diagnoses, Psychiatric Comorbidity, and Assessments of Suicidal Behavior*, 11(1) J. TRAUMATIC STRESS 103 (1998).

395 L. Vijayakumar & A.T. Jotheeswaran, *Suicide in refugees and asylum seekers in mental health of refugees and asylum seekers*, in D. Bhugra, T. Craig, & K. Bhui (eds.), MENTAL HEALTH OF REFUGES AND ASYLUM SEEKERS 195 (2010).

396 N. G. Procter, *Suicide and self-harm prevention for people in immigration detention*, 199(11) MEDICAL JOURNAL OF AUSTRALIA 730 (2013).

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; rather other life experiences and factors also play a central role. Some survivors are resilient, possessing strengths that have enabled them to endure and survive their experiences, as well as persevere and thrive in their lives.³⁹⁷ Indeed, trauma treatment can facilitate resiliency in some survivors.

Posttraumatic Sequelae in Cambodia and in Cambodian Survivors and 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.³⁹⁸ 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 (expansively defined to include the ingestion of rodents or other creatures they captured in the fields) when they were starving. Many individuals lost family members who were killed for such infractions. The “New People” (the previously urban Cambodians who were 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 *Angkor* (the organization or the ruling body of the Khmer Rouge) were taken away to be killed—offences could include having worked for the former government or simply breaking a tool. Survivors sometimes saw dead bodies and encountered or heard about mass graves.

Cambodians were forcibly separated from family members. 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 illnesses associated with the conditions imposed by the Khmer Rouge. In some cases, survivors lost dozens of extended family members, leaving them without any living 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

397 S.M. Berthold, *Survivors of torture*, in A. Gitterman (ed.), HANDBOOK OF SOCIAL WORK PRACTICE WITH VULNERABLE AND RESILIENT POPULATIONS 484-508 (3rd ed. 2014).

398 R.J. RUMMEL, DEATH BY GOVERNMENT (1994).

Box 1: DSM-5 diagnostic criteria for PTSD (APA, 2013)

Note: The following criteria apply to adults, adolescents, and children older than 6 years. For children 6 years and younger, see corresponding criteria in the DSM-5.

A. Exposure to actual or threatened death, serious injury, or sexual violence in one (or more) of the following ways:

1. Directly experiencing the traumatic event(s).
2. Witnessing, in person, the event(s) as it occurred to others.
3. Learning that the traumatic event(s) occurred to a close family member or close friend. In cases of actual or threatened death of a family member or friend, the event(s) must have been violent or accidental.
4. Experiencing repeated or extreme exposure to aversive details of the traumatic event(s) (e.g., first responders collecting human remains; police officers repeatedly exposed to details of child abuse). Note: Criterion A4 does not apply to exposure through electronic media, television, movies, or pictures, unless this exposure is work related.

B. Presence of one (or more) of the following intrusion symptoms associated with the traumatic event(s), beginning after the traumatic event(s) occurred:

1. Recurrent, involuntary, and intrusive distressing memories of the traumatic event(s). Note: In children older than 6 years, repetitive play may occur in which themes or aspects of the traumatic event(s) are expressed.
2. Recurrent distressing dreams in which the content and/or affect of the dream are related to the traumatic event(s). Note: In children, there may be frightening dreams without recognizable content.
3. Dissociative reactions (e.g., flashbacks) in which the individual feels or acts as if the traumatic event(s) were recurring. (Such reactions may occur on a continuum, with the most extreme expression being a complete loss of awareness of present surroundings.) Note: In children, trauma-specific reenactment may occur in play.
4. Intense or prolonged psychological distress at exposure to internal or external cues that symbolize or resemble an aspect of the traumatic event(s).
5. Marked physiological reactions to internal or external cues that symbolize or resemble an aspect of the traumatic event(s).

C. Persistent avoidance of stimuli associated with the traumatic event(s), beginning after the traumatic event(s) occurred, as evidenced by one or both of the following:

1. Avoidance of or efforts to avoid distressing memories, thoughts, or feelings about or closely associated with the traumatic event(s).
2. Avoidance of or efforts to avoid external reminders (people, places, conversations, activities, objects, situations) that arouse distressing memories, thoughts, or feelings about or closely associated with the traumatic event(s).

D. Negative alterations in cognitions and mood associated with the traumatic event(s), beginning or worsening after the traumatic event(s) occurred, as evidenced by two (or more) of the following:

1. Inability to remember an important aspect of the traumatic event(s) (typically due to dissociative amnesia and not to other factors such as head injury, alcohol, or drugs).
2. Persistent and exaggerated negative beliefs or expectations about oneself, others, or the world (e.g., "I am bad," "No one can be trusted," "The world is completely dangerous," "My whole nervous system is permanently ruined").

3. Persistent, distorted cognitions about the cause or consequences of the traumatic event(s) that lead the individual to blame himself/herself or others.
4. Persistent negative emotional state (e.g., fear, horror, anger, guilt, or shame).
5. Markedly diminished interest or participation in significant activities.
6. Feelings of detachment or estrangement from others.
7. Persistent inability to experience positive emotions (e.g., inability to experience happiness, satisfaction, or loving feelings).

E. Marked alterations in arousal and reactivity associated with the traumatic event(s), beginning or worsening after the traumatic event(s) occurred, as evidenced by two (or more) of the following:

1. Irritable behavior and angry outbursts (with little or no provocation) typically expressed as verbal or physical aggression toward people or objects.
2. Reckless or self-destructive behavior.
3. Hypervigilance.
4. Exaggerated startle response.
5. Problems with concentration.
6. Sleep disturbance (e.g., difficulty falling or staying asleep or restless sleep).

F. Duration of the disturbance (Criteria B, C, D, and E) is more than 1 month.**G. The disturbance causes clinically significant distress or impairment in social, occupational, or other important areas of functioning.****H. The disturbance is not attributable to the physiological effects of a substance (e.g., medication, alcohol) or another medical condition.**

Specify whether: With dissociative symptoms: The individual's symptoms meet the criteria for posttraumatic stress disorder, and in addition, in response to the stressor, the individual experiences persistent or recurrent symptoms of either of the following:

1. Depersonalization: Persistent or recurrent experiences of feeling detached from, and as if one were an outside observer of, one's mental processes or body (e.g., feeling as though one were in a dream; feeling a sense of unreality of self or body or of time moving slowly).
2. Derealization: Persistent or recurrent experiences of unreality of surroundings (e.g., the world around the individual is experienced as unreal, dreamlike, distant, or distorted).

Note: To use this subtype, the dissociative symptoms must not be attributable to the physiological effects of a substance (e.g., blackouts, behavior during alcohol intoxication) or another medical condition (e.g., complex partial seizures).

Specify if: With delayed expression: If the full diagnostic criteria are not met until at least 6 months after the event (although the onset and expression of some symptoms may be immediate).

Box 2: DSM-5 criteria for Major Depressive Disorder (APA, 2013)

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: Do not include symptoms that are clearly attributable to another medical condition.

1. Depressed mood most of the day, nearly every day, as indicated by either subjective report (e.g., feels sad, empty, hopeless) 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).
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 gain.)
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 cause clinically-significant distress or impairment in social, occupational, or other important areas of functioning.

C. The episode is not attributable to the physiological effects of a substance or to another medical condition.

Note: Criteria A–C represent a major depressive episode.

Note: Responses to a significant loss (e.g., bereavement, financial ruin, losses from a natural disaster, a serious medical illness or disability) may include the feelings of intense sadness, rumination about the loss, insomnia, poor appetite, and weight loss noted in Criterion A, which may resemble a depressive episode. Although such symptoms may be understandable or considered appropriate to the loss, the presence of a major depressive episode in addition to the normal response to a significant loss should also be carefully considered. This decision inevitably requires the exercise of clinical judgment based on the individual's history and the cultural norms for the expression of distress in the context of loss.

In distinguishing grief from a major depressive episode (MDE), it is useful to consider that in grief the predominant affect is feelings of emptiness and loss, while in MDE it is persistent depressed mood and the inability to anticipate happiness or pleasure. The dysphoria in grief is likely to decrease in intensity over days to weeks and occurs in waves, the so-called pangs of grief. These waves tend to be associated with thoughts or reminders of the deceased. The depressed mood of MDE is more persistent and not tied to specific thoughts or preoccupations. The pain of grief may be accompanied by positive emotions and humor that are uncharacteristic of the pervasive unhappiness and misery characteristic of MDE. The thought content

associated with grief generally features a preoccupation with thoughts and memories of the deceased, rather than the self-critical or pessimistic ruminations seen in MDE. In grief, self-esteem is generally preserved, whereas in MDE feelings of worthlessness and self-loathing are common. If self-derogatory ideation is present in grief, it typically involves perceived failings vis-à-vis the deceased (e.g., not visiting frequently enough, not telling the deceased how much he or she was loved). If a bereaved individual thinks about death and dying, such thoughts are generally focused on the deceased and possibly about “joining” the deceased, whereas in MDE such thoughts are focused on ending one's own life because of feeling worthless, undeserving of life, or unable to cope with the pain of depression.

D. The occurrence of the major depressive episode is not better explained by schizoaffective disorder, schizophrenia, schizophreniform disorder, delusional disorder, or other specified and unspecified schizophrenia spectrum and other psychotic disorders.

E. There has never been a manic episode or a hypomanic episode.

Note: This exclusion does not apply if all of the manic-like or hypomanic-like episodes are substance-induced or are attributable to the physiological effects of another medical condition.

Coding and Recording Procedures

- The diagnostic code for major depressive disorder is based on whether this is a single or recurrent episode, current severity, presence of psychotic features, and remission status. Current severity and psychotic features are only indicated if full criteria are currently met for a major depressive episode. Remission specifiers are only indicated if the full criteria are not currently met for a major depressive episode.
- In recording the name of a diagnosis, terms should be listed in the following order: major depressive disorder, single or recurrent episode, severity/psychotic/remission specifiers, followed by as many of the following specifiers without codes that apply to the current episode.

Specify:

- **With anxious distress**
- **With mixed features**
- **With melancholic features**
- **With atypical features**
- **With mood-congruent psychotic features**
- **With mood-incongruent psychotic features**
- **With catatonia. Coding note: Use additional code 293.89 (F06.1).**
- **With peripartum onset**
- **With seasonal pattern (recurrent episode only)**

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. These are just some of the many types of persecution that Cambodian survivor-witnesses at the ECCC have experienced.

Cambodians who survived and remained in Cambodia, and those who fled as refugees, have experienced extremely high levels of trauma.³⁹⁹ Not unexpectedly, therefore, they have a high prevalence of psychiatric disorders. In a study of displaced Cambodians on the Thai-Cambodian border using multistage area probability sampling,⁴⁰⁰ 15% were found to suffer from PTSD, 55% suffered from depression, and 20% reported health impairments.⁴⁰¹ Mollica, Poole, and Tor⁴⁰² found symptoms of depression in two thirds of the Cambodian participants in another study on the border and PTSD in one third. In addition, high rates of cumulative trauma and a positive dose-effect association between exposure to trauma and symptoms were found.⁴⁰³

Similarly, 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.⁴⁰⁴ 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.⁴⁰⁵

399 J.T. de Jong et al., *Lifetime Events*, supra note 363; G.N. Marshall et al., *Mental Health of Cambodian Refugees Two Decades after Resettlement in the United States*, 294 JAMA 571 (2005); R.F. Mollica, *The Effect of Trauma and Confinement on Functional Health and Mental Health Status of Cambodians Living in Thailand-Cambodian Border Camps*, 270 JAMA 581 (1993).

400 Multistage area probability sampling was employed using the following steps: (1) researchers started with a grid map of the displaced persons camp where the study was conducted along with data on the number of households in each of the five regions in the camp; (2) 100 primary sampling units were selected and distributed among the five regions of the camp proportionate to the number of households in each of these regions; (3) interviewers were given a randomly assigned starting point and proceeded along a specified route to ten households in each of the primary sampling units; and (4) the interviewer selected an adult at random from each household to participate in the study from a roster the researchers developed of all household members living in the household during the study period.

401 R.F. Mollica, *The Effect of Trauma and Confinement on Functional Health*, supra note 399.

402 R.F. Mollica, C. Poole & S. Tor, *Symptoms, Functioning, and Health Problems in Massively Traumatized Populations: The Legacy of Cambodian Tragedy*, in ADVERSITY, STRESS, AND PSYCHOPATHOLOGY 34 (B.P. Dohrenwend ed., 1998).

403 *Id.*

404 G.N. Marshall et al., *Mental Health of Cambodian Refugees*, supra note 399.

405 J.K. Boehnlein et al., *A Ten-year Treatment Outcome Study of Traumatized Cambodian Refugees*, 192 J. NERVOUS & MENTAL DISEASE 658 (2004).

The lifetime PTSD rate among the population in Cambodia has been estimated to be over twenty percent.⁴⁰⁶ 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.⁴⁰⁷ 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.

It is common for traumatized individuals to experience fluctuating symptoms, with periods of exacerbations and remissions in response to traumatic triggers.⁴⁰⁸ 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.⁴⁰⁹ Among Cambodian refugees treated at psychiatric clinics in the United States, similarly high rates of psychopathology have been found (92% PTSD,⁴¹⁰ 56% PTSD,⁴¹¹ and 60% panic disorder⁴¹²). In one treatment study in the United States, 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.⁴¹³ 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) and traumatic head injury (THI) are known to be common experiences 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.

406 W. van de Put & M. Eisenbruch, *The Cambodian Experience*, in TRAUMA, WAR, AND VIOLENCE: PUBLIC MENTAL HEALTH IN SOCIO-CULTURAL CONTEXT 93 (J.T. de Jong ed., 2002).

407 J.T. de Jong, D.H. Komproe & M. Van Ommeren, *Common Mental Disorders in Postconflict Settings*, 361(9375) LANCET 2128 (2003).

408 J.D. Kinzie, *Guidelines for Psychiatric Care of Torture Survivors*, 21(1) TORTURE 18 (2011).

409 J.D. Kinzie et al., *The Effects of September 11 on Traumatized Refugees: Reactivation of Posttraumatic Stress Disorder*, 190(7) J. NERVOUS & MENTAL DISEASE 437 (2002).

410 J.D. Kinzie et al., *The Prevalence of Posttraumatic Stress Disorder and its Clinical Significance Among Southeast Asian Refugees*, 147 AM. J. PSYCHIATRY 913 (1990).

411 D.E. Hinton et al., *Assessment of Posttraumatic Stress Disorder in Cambodian Refugees Using the Clinician-Administered PTSD Scale: Psychometric Properties and Symptom Severity*, 19(3) J. TRAUMA STRESS 405 (2006).

412 D. Hinton et al., *Panic Disorder Among Cambodian Refugees Attending a Psychiatric Clinic: Prevalence and Subtypes*, 22(6) GEN. HOSP. PSYCHIATRY 437 (2000).

413 R.F. Mollica, G. Wyshak & J. Lavelle, *The Psychosocial Impact of War Trauma and Torture on Southeast Asian Refugees*, 144 AM. J. PSYCHIATRY 1567 (1987).

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.⁴¹⁴

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 as compared to the general U.S. population and other Asian immigrants.⁴¹⁵ This is true even when matched on demographic indicators often found to be associated with poor health.⁴¹⁶ 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.⁴¹⁷ 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).⁴¹⁸ The literature in Cambodian and other populations on the relationship between trauma, PTSD, and chronic physical health problems is growing⁴¹⁹ and attests to the fact that this mind-body association warrants further investigation.

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

414 R.F. Mollica et al., *Brain Structural Abnormalities and Mental Health Sequelae in South Vietnamese Ex-political Detainees who Survived Traumatic Head Injury and Torture*, 66(11) ARCHIVES GEN. PSYCHIATRY 1 (2009); R.F. Mollica, et al., *The Mental Health Sequelae of Traumatic Head Injury in South Vietnamese Ex-Political Detainees Who Survived Torture*, 55(7) COMPREHENSIVE PSYCHIATRY 1626 (2014).

415 G.N. Marshall, et al. *Diabetes and cardiovascular disease risk in Cambodian refugees*, 18(1) JOURNAL OF IMMIGRANT AND MINORITY HEALTH 110 (2016).

416 J.D. Kinzie et al., *High Prevalence Rates of Diabetes and Hypertension Among Refugee Psychiatric Patients*, 196(2) J. NERVOUS & MENTAL DISEASE 108 (2008); National Cambodian Town Hall Meeting, National Cambodian American Diabetes Project of Khmer Health Advocates (April 17, 2006), available at www.khmerhealthadvocates.org/ncadp.asp?m=5 (funded by Cambodian Document Center; teleconference meeting about the Cambodian health crisis with Cambodian communities and experts in five states in the U.S.); E.C. Wong et al., *The Unusually Poor Physical Health Status of Cambodian Refugees Two Decades After Resettlement*, J. IMMIGRANT MINORITY HEALTH (Sept. 29, 2010) (available by internet search for document object identifier (DOI): 10.1007/s10903-010-9392-y).

417 J.D. Kinzie et al., *High Prevalence Rates of Diabetes and Hypertension*, *supra* note 416.

418 H. King et al., *Diabetes and Associated Disorders in Cambodia: Two Epidemiological Surveys*, 366 LANCET 1633 (2005); Berthold, S. M., Kong, S., Mollica, R. F., Kuoch, T., Scully, M. & Franke, T. (2014). Comorbid mental and physical health and health access in Cambodian refugees in the US. J COMMUNITY HEALTH. DOI 10.1007/s10900-014-9861-7; Wagner, J., Burke, G., Kuoch, T., Scully, M., Armeli, S., & Rajan, T. V. (2013). Trauma, healthcare access, and health outcomes among Southeast Asian refugees in Connecticut. J IMMIGR MINOR HEALTH, 15(6), 1065-1072. doi: 10.1007/s10903-012-9715-2.

419 J.D. Kinzie et al., *High Prevalence Rates of Diabetes and Hypertension*, *supra* note 417; J. Wagner, et al. *m Diabetes among refugee populations: What newly arriving refugees can learn from resettled Cambodian Americans*, 15(8) CURRENT DIABETES REPORTS 56 (advance online publication, doi:10.1007/s11892-015-0618-1); S.M. Berthold, et al., *Comorbid mental and physical health and health access in Cambodian refugees in the US* 39(6) JOURNAL OF COMMUNITY HEALTH 1045 (2014).

painful.⁴²⁰ Many parts of Cambodia remain without adequate (or any) service providers for those struggling with the symptoms of posttraumatic stress. Moreover, there is little to no tradition of seeking mental health services in Cambodia, and the stigmatizing connotation of the Khmer word for mental health (i.e., “*ckuot*” which describes 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. Many Cambodians will not seek treatment unless they are in crisis, and their efforts to cope with their symptoms have not been successful. Even if victims desire treatment, 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.

A few bright spots exist. The Transcultural Psychosocial Organization (TPO) in Cambodia has established innovative community-based and culturally-sensitive psychosocial services. 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.⁴²¹ Their services include: psychological support to survivor witnesses and Civil Parties before, during and after the ECCC proceedings; trauma treatment; community-based memorialization and truth-telling projects; and efforts to raise community awareness of trauma and mental health. Importantly, TPO’s services focus on capacity-building and sustainability. The TPO also builds on culturally-mediated, protective factors and the indigenous coping strategies of the people. 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).⁴²² Mollica and his colleagues have conducted training for primary care physicians in Cambodia to enable these physicians to appropriately assess and treat various mental health problems.⁴²³

420 R.F. MOLLICA, HEALING INVISIBLE WOUNDS: PATHS TO HOPE AND RECOVERY IN A VIOLENT WORLD (2008).

421 M. Eisenbruch, J.T. de Jong & W. van de Put, *Bringing Order Out of Chaos*, *supra* note 10; W. van de Put & M. Eisenbruch, *Internally Displaced Cambodians: Healing Trauma in Communities*, in THE MENTAL HEALTH OF REFUGEES: ECOLOGICAL APPROACHES TO HEALING AND ADAPTATION 133 (K. Miller & L. Rasco eds., 2004).

422 M. Eisenbruch, J.T. de Jong & W. van de Put, *Bringing Order Out of Chaos*, *supra* note 421.

423 R.F. Mollica, *Harvard Training and Certification of Primary Care Physicians in Cambodia*, Khmer Newsletter of the Harvard Program in Refugee Trauma, Dec. 1996 (available in English and Khmer).

The Impact of Trauma on the Ability of Survivor-Witnesses to Participate in Legal Processes

Impact of Trauma on Appearing as a Witness

Although individual differences exist in the extent of distress and the ability of survivors to tolerate their distress and function, there are many ways that posttraumatic symptoms have manifested themselves in asylum court settings in the United States and in other legal proceedings, including before the ECCC.⁴²⁴ In particular, the sequelae of trauma can have a profound effect on the ability of survivors to testify in legal 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, including the nature of the traumas they endured and the symptoms experienced by those who suffer from PTSD and/or depression. This inability to testify effectively is made worse by the fact that victim-witnesses 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 as they receive the testimony of victims and witnesses.

Although the experiences of Cambodian survivors vary, all of these impediments to victim-witnesses providing effective testimony before the ECCC exist in Cambodian survivors. Although the witness's age and region of residence during the Khmer Rouge reign may give rise to differences in an ability to testify, there were some commonalities experienced by many victim-witnesses that are particularly salient in helping 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,⁴²⁵ researchers on the mental health consequences of the Cambodian killing fields,⁴²⁶ reports provided to the authors during the course of clinical work with Cambodian survivors in the

424 U. Jacobs & S.L. Lustig, *Psychological and Psychiatric Opinions in Asylum Applications: Ten Frequently Asked Questions by Fact Finders*, 15(15) BENDER'S IMMIGR. BULL. 1066 (2010).

425 D.P. CHANDLER, *A HISTORY OF CAMBODIA* (2d ed. 1992); B. KIERNAN, *THE POL POT REGIME: RACE, POWER AND GENOCIDE IN CAMBODIA UNDER THE KHMER ROUGE, 1975-1979* (2d ed. 2002).

426 G.N. Marshall et al., *Mental Health of Cambodian Refugees*, *supra* note 38; R.F. Mollica, G. Wyshak & J. Lavelle, *The Psychosocial Impact of War Trauma*, *supra* note 46; 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 J. NERVOUS & MENTAL DISEASE 111 (1992).

United States and on the Thai-Cambodian border, and insights gleaned during trainings in Cambodia.

One common symptom of PTSD and Major Depressive Disorder (disorders with high rates of incidence among Cambodian survivors) 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 another hallmark of PTSD for many survivors. Many Cambodian survivors, like numerous other survivors, have learned over time to avoid thinking and talking about their traumatic experiences. The pervasive desire among many Cambodian survivors to avoid revisiting these traumas⁴²⁷ and provoking the associated distress may challenge their ability to recall and recount relevant aspects of their experience under the Khmer Rouge and compromise their ability or willingness to provide adequate information or details that are relevant in a court of law.⁴²⁸ This is a self-protective mechanism that enables victim-witnesses 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. It is a survival strategy that enables them to function more effectively in their daily lives—one that must be suppressed if they are to testify in court about their trauma.⁴²⁹

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 victimization or the concomitant trauma.⁴³⁰ This can be compounded by their mental health status⁴³¹ and the understandable mistrust that some survivors harbor towards government officials and authorities. Survivors' abilities to remember or recount details of their traumatic experiences that may be deemed to be important in court can be further hindered 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

427 R.F. MOLLIKA, *HEALING INVISIBLE WOUNDS*, *supra* note 420.

428 Much of the material in the next several paragraphs is drawn from the clinical work of one of the authors (Berthold) with hundreds of Cambodian survivors in the U.S. and on the Thai-Cambodian border and from her experiences with Cambodian asylum applicants in the U.S.

429 R.F. MOLLIKA, *HEALING INVISIBLE WOUNDS*, *supra* note 420.

430 *Id.*

431 R.F. Mollica, *The Trauma Story: A Phenomenological Approach to the Traumatic Life Experiences of Refugee Survivors*, 64(1) PSYCHIATRY 60 (2001).

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.⁴³²

Additionally, 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 other witnesses or perpetrators in court can likewise provoke these flashbacks. Such 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 properly understood by a court as evidence of the witness's symptoms of posttraumatic distress (see Ciorciari & Heindel in this volume).

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. Head trauma can have a negative impact on cognitive functioning. Finally, although it is beyond the scope of this chapter, threats to victims and witnesses are not unknown before or after testimony, and this surely will affect their willingness to make court appearances. If a threatened person does end up testifying, the nature of his or her testimony may be affected by the threats (e.g., withholding some facts).

Impact of Trauma on 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 memories and the ways in which trauma can affect memory formation. Such an understanding will be invaluable in understanding how survivor-

witnesses present themselves and their testimony in court. It may also provide explanations for inconsistencies and memory deficits in witnesses who may otherwise be found to be credible.

The psychological mechanisms involved in forming normal autobiographical memories versus traumatic memories are significantly different in ways that are relevant to one's ability to testify. Autobiographical memories involve the recall of events from one's personal history, generally about normal everyday events. 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. 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.⁴³³

High levels of emotion have been found to result in impaired memory of even non-traumatic events.⁴³⁴ The formation of traumatic memories is even more disruptive of this normal process. Traumatic memories are re-experienced in the moment of recall, not as a narrative of events from the past. Unlike normal memories, traumatic memories are typically unintentionally evoked. They 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 compose 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 by external stimuli, 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

433 J. Herlihy & S. Turner, *Should Discrepant Accounts Given by Asylum Seekers Be Taken as Proof of Deceit?*, 16(2) TORTURE 81 (2006).

434 J. Herlihy & S. Turner, *Asylum Claims and Memory of Trauma: Sharing our Knowledge*, 191 BRIT. J. PSYCHIATRY 3 (2007).

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 the Giving of Testimony

The prospects of testifying in court is stressful for virtually everyone. 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. In addition to the stress inherent in testifying in court, 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.

The first involves a disconnect between what the lawyers need for their cases and the way in which survivor-witnesses recall their own lived experience, often in a way that includes the expression of strong emotions connected to these experiences. Sometimes survivor-witnesses are asked about aspects of their experiences that are less important to them than the events about which they want to testify or consider most important or than the related emotional impact. In response, they may try to offer testimony about parts of their traumatic experiences that the lawyers or court deem irrelevant given the legal matters at hand. As a result, survivor-witnesses may be redirected or interrupted in order to “keep them on track.” While this may be done in an effort to foster efficiency and promote focus on legally pertinent testimony, this can be frustrating for the survivor-witness. At times (e.g., during the testimony of Ms. Sophany Bay in Case 002/01), efforts were made by the Court to restrict emotional displays by genocide survivors (see detailed discussion in Ciorciari & Heindel chapter in this volume). Such efforts may trigger reminders in survivors of when they were ordered by Khmer Rouge cadre not to express any emotion such as pain or grief. Victims learned that it was essential to suppress their feelings in order to survive during the genocide. Through lack of understanding of some of the realities experienced by survivor witnesses (e.g., of their trauma, history, culture, and/or countertransference reactions), court personnel can derail valuable testimony. Testifying can also be confusing for these witnesses when they are asked to speak about certain details of their experiences out of context or not in chronological order.

With traumatic memories, the person experiencing the trauma tends to focus on 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, precise dates). 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 salience.

These reactions to testifying have been confirmed in research on memory and recall. In a study of 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.⁴³⁵ Herlihy and Turner 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 different interviews, even in cases in which the interviews are conducted only weeks apart.⁴³⁶ 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 or hiding something while in reality they may be dissociating or simply avoiding talking about painful aspects of their trauma.

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.⁴³⁷ Testifying about one’s traumatic experiences is a time of high arousal that tends to invoke defensive strategies in the witness, particularly

⁴³⁵ J. Herlihy, P. Scragg & S. Turner, *Discrepancies in Autobiographical Memories—Implications for the Assessment of Asylum Seekers: Repeated Interviews Study*, 324 *BMJ* 324 (2002).

⁴³⁶ *Id.*

⁴³⁷ J. BRIERE, *PSYCHOLOGICAL ASSESSMENT*, *supra* note 360; F.W. Putnam, *Dissociative Phenomenon, in DISSOCIATIVE DISORDERS: A CLINICAL REVIEW* (D. Spiegel ed., 1993).

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).

For example, Kaing Guek Eav (alias Duch), the former Chairman of the Khmer Rouge S-21 Security Center in Phnom Penh, was the defendant in Case 001 at the ECCC. During the Duch trial the defense counsel (and at times Duch himself) challenged the credibility of the 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 state, the survivor-witness may not be able to remember or recount some, or all, of the trauma, including aspects of his or her experience under the Khmer Rouge 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. Chapters 7 and 8 in this volume provide extensive examples and excerpts from ECCC transcripts of victims' challenges with cross-examination or the reverse (i.e., difficulties experienced by defense lawyers and the judges in questioning victim witnesses). All of 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.

Impact of Trauma on the 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, as might be expected. 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 or is being melodramatic. Either way, the judge may conclude that the person is not a credible witness.

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 immigration courts, 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 experiences of violence.

Many Cambodians, 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. In this regard, some survivors have spoken of becoming the "walking dead," a phrase used by a number of the author's 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, human rights courts should make resources available to adequately prepare and support these witnesses. In the case of the ECCC, the TPO has worked closely with the Court's Victims Support Services (VSS) and the Witness and Expert Support Unit (WESU) to provide extensive psychosocial support and counseling to Khmer Rouge survivor witnesses and Civil Parties during the ECCC proceedings. TPO also launched a psychosocial "Justice and Relief for Survivors of the Khmer Rouge" program.⁴³⁸

Ideally, all survivors appearing in court would receive official clinical support.⁴³⁹ Specifically, psychological preparation is strongly recommended to facilitate the witness's 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. Preparation regarding how to manage the stress associated with court participation, as well as anticipating and managing any symptoms of posttraumatic distress triggered by 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. In addition, 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. As will be described later in this chapter, such training was provided to legal monitors and ECCC lawyers by the UK-based Centre for the Study of Emotion and Law.

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 support⁴⁴⁰ (see Strasser et al. in this volume). Many will not have the resources to access the care that they need. Institutional support

⁴³⁸ For more information about this program visit TPO's website: <http://tpocambodia.org/justice-and-relief-for-survivors-of-the-khmer-rouge/>.

⁴³⁹ The United Nations has recognized the problems trauma symptoms cause for work in other areas and has proposed steps similar to ours for those workers, though not for secondary trauma. See Y. Danieli, ed., *SHARING THE FRONT LINE AND THE BACK HILLS: PEACEKEEPERS, HUMANITARIAN AID WORKERS AND THE MEDIA IN THE MIDST OF CRISIS* (2002).

⁴⁴⁰ J. Strasser, et al., *Engaging Communities - Easing the Pain: Outreach and Psychosocial Interventions in the Context of the Khmer Rouge Tribunal*, in K. Lauritsch and F. Kernjak (eds), *WE NEED THE TRUTH. ENFORCED DISAPPEARANCES IN ASIA* 146 (2011).

from the Court is recommended to ensure that essential services are available when the witnesses return home. In a welcome development, amendments were made to the participation of Civil Parties for the ECCC proceedings that responded more fully to the needs of victims and included Victims Support Services involvement in developing alternative forms of reparations (discussed later).⁴⁴¹

The Importance of Psychological Factors in Judgments of the ECCC and in Reparations

Testimony by Civil Party Mrs. Sophany Bay and mental health expert witness Dr. Chhim Sotheara in Case 002/01 included coverage of the psychological impact of trauma experienced by victims. Dr. Chhim Sotheara, for example, testified about the psychological effects of forced relocation, hunger, witnessing traumatic events, and losing loved ones. Mrs. Bay's testimony included description of her symptoms of psychological distress such as nightmares and wanting to die after the death of her children during the reign of the Khmer Rouge. In the Judgment of Case 002/01, the justices emphasized that the harm experienced by genocide survivors included psychological trauma: "The Trial Chamber found that the Civil Parties and additional victims have suffered immeasurable harm, including physical suffering, economic deficiency, loss of dignity, psychological trauma and grief arising from the loss of relatives."⁴⁴² It has been noted (including in other chapters of this volume) that there is room for improvement in the way mental health has been addressed in expert witness proceedings at the ECCC, including further use of relevant scientific research, changes to the nature and scope of questions posed to experts, and further training of court personnel in order to best utilize the expertise of mental health professionals as witnesses.⁴⁴³

Some of the reparations projects endorsed by the ECCC in Case 002/01 reflected attention to psychological issues. For example, the Court deemed the proposed National Day of Remembrance (Project 1) as an important means of recognizing the psychological harms inflicted by the Khmer Rouge and of restoring the dignity of victims. Projects 5 (Testimonial Therapy) and 6 (Self-Help Groups) would provide opportunities for those affected to process their traumatic experiences. TPO is already implementing testimonial therapy and self-help

⁴⁴¹ Extraordinary Chambers in the Courts of Cambodia, Internal Rules, (Rev 8) (adopted 3 August 2011)

⁴⁴² ECCC, *Nuon Chea and Khieu Samphan sentenced to life imprisonment for crimes against humanity*, 76, The Court Report, 2, (2014, August), www.eccc.gov.kh/en/publication/court-report-august-2014

⁴⁴³ Kim, Y-H, *Reflection on mental health in ECCC Case 002: Testimony of Civil Party Sophany Bay and mental health expert Dr. Chhim Sotheara*, Cambodia Tribunal Monitor, (2013, July 11). Retrieved from www.cambodiatribunal.org/2013/07/11/reflection-on-mental-health-in-eccc-case-002-testimony-of-civil-party-sophany-bay-and-mental-health-expert-dr-chhim-sotheara/

groups. The Court noted in its Judgment in Case 002/01 that Testimonial Therapy was also intended to assist in documenting violations of human rights, restore the dignity of victims, and afford opportunities for victims to advocate for their interests and needs in the context of the ongoing reconciliation and transitional justice process in Cambodia.⁴⁴⁴ It is possible that the desire of Civil Parties to the ECCC proceedings to have their participation formally documented (in part by including their names on the ECCC website as part of reparations Project 13) reflects the psychological benefit of agency that some survivors experience when they publically speak out against human rights abuses (see Strasser et al. chapter in this volume).

In this regard, some human rights activists and others have described that testifying in court proceedings or truth commissions can facilitate the healing process of victims,⁴⁴⁵ a view not held by all mental health professionals and trauma specialists. As the next chapter describes, public testimony is not universally beneficial and can have some unintended negative consequences,⁴⁴⁶ including in such cases in which perpetrators are not undergoing prosecution. Sierra Leonean survivors experienced additional psychological distress associated with their testimony in truth commissions.⁴⁴⁷ In the case of the ECCC, re-experiencing of trauma and the loss of faith in the system of justice in some victims appeared to result from a number of factors, including: failure of the tribunal to meet victims' expectations (e.g., regarding obtaining reparations, those who expected testify but who were not called for testimony), victim concerns about retaliation, pain experienced by victims when testifying and being cross-examined about their traumas, and the Court's efforts to limit emotional displays and documentation of the emotional impact of the Khmer Rouge genocide during testimony.⁴⁴⁸

Secondary or Vicarious Trauma

It is essential to attend to the psychosocial impact of testimony on survivor-witnesses; at the same time it is equally as important to be aware of and address

⁴⁴⁴ ECCC, *supra* note 441.

⁴⁴⁵ See Fletcher, L. E., & Weinstein, H. M., *Violence and social repair: Rethinking the contribution of justice to reconciliation*, 24(3) HUMAN RIGHTS QUARTERLY 573 (2002); D. Mendeloff, *Trauma and Vengeance: Assessing the Psychological and Emotional Effects of Post-Conflict Justice*, 31 HUMAN RIGHTS QUARTERLY 592 (2009).

⁴⁴⁶ See also E. Stover, et al., *Confronting Duch: Civil Party participation in Case 001 at the Extraordinary Chambers in the Courts of Cambodia*, 93(882) INTERNATIONAL REVIEW OF THE RED CROSS 503 (2011).

⁴⁴⁷ J. Cilliers, et al. *Reconciling after civil conflict increases social capital but decreases individual well-being*, 352(6287) SCIENCE 787 (2016).

⁴⁴⁸ J. D. Ciorciari, & A. Heindel, *Experiments in International Criminal Justice: Lessons from the Khmer Rouge Tribunal*, 35(2) MICHIGAN JOURNAL OF INTERNATIONAL LAW, 369-442 (2014); Stover, E., Balthazard, M., & Koenig, K. A. (2011). *Confronting Duch: Civil Party participation in Case 001 at the Extraordinary Chambers in the Courts of Cambodia*. *International Review of the Red Cross*, 93(882), 503-546; Agger, I., & Chhim, S. (2013). Psychological aspects of victim participation in Cambodia's Extraordinary Chambers. *VRWG Bulletin*, 22, p. 7.

the possibility of retraumatization or secondary/vicarious trauma in the staff of the ECCC.⁴⁴⁹ The staff at war crime tribunals and in other human rights settings are frequently exposed to, even 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 themselves 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 a sense of empathy 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 psychotherapists,⁴⁵⁰ somewhat in lawyers⁴⁵¹ and judges,⁴⁵² and least of all in interpreters.⁴⁵³

Secondary Traumatic Stress Defined

Secondary trauma has been defined as follows:

[T]he psychological signs and symptoms that result from ongoing interaction with traumatized individuals. In human

⁴⁴⁹ Readers interested in additional relevant literature on secondary trauma in the legal profession are directed to visit <http://law.scu.edu/redress/bibliography.cfm> for a relevant bibliography developed at Santa Clara University School of Law.

⁴⁵⁰ Y. Fischman, *Interacting with Trauma: Clinicians' Responses to Treating Psychological Aftereffects of Political Repression*, 61(2) AM. J. ORTHOPSYCHIATRY 179 (1991); B.H. Stamm, *Comprehensive Bibliography of the Effect of Caring for Those Who Have Experienced Extremely Stressful Events and Suffering*, Professional Quality of Life Elements Theory and Measurements (ProQOL), 2010, available at www.proqol.org/Bibliography.html.

⁴⁵¹ A.P. Levin & S. Greisberg, *Vicarious Trauma in Attorneys*, 24 PACE L. REV. 245, 246 (2003); L. Piwowarczyk et al., *Secondary Trauma in Asylum Lawyers*, 3 BENDER'S IMMIGR. BULL. 263 (2009).

⁴⁵² S.L. Lustig et al., *Burnout and Stress Among United States Immigration Judges*, 13 BENDER'S IMMIGR. BULL. 22 (2008); S.L. Lustig et al., *Inside the Judges' Chambers: Narrative Responses from the National Association of Immigration Judges Stress and Burnout Survey*, 23(1) GEO. IMMIGR. L.J. 57 (2009).

⁴⁵³ D.W. Engstrom, T. Roth & J. Hollis, *The Use of Interpreters by Torture Treatment Providers*, 19(1) J. ETHNIC & CULTURAL DIVERSITY IN SOC. WORK 54 (2010); H. Holmgren, H. Sondergaard & A. Elklit, *Stress and Coping in Traumatized Interpreters: A Pilot Study of Refugee Interpreters Working for a Humanitarian Organization*, 1(3) INTERVENTION 22 (2003).

rights, work with trauma involves contact with experiences of intense pain and suffering, extreme fear, humiliation, and loss of self. [Survivors recount 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.⁴⁵⁴

As this definition suggests, 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 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 challenging. In a 2012 report for the ECCC, de Langis (2012) noted that there was no office for staff welfare, a concern given observations of signs of vicarious trauma in court staff. Some briefing sessions for staff had been held to address vicarious trauma, but this was not standard policy at that time.⁴⁵⁵

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.⁴⁵⁶

These symptoms may also appear in court personnel who work in settings in which violations of human rights are adjudicated.⁴⁵⁷ 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 traumatic material and may find it challenging to maintain effective and appropriate boundaries between their personal and professional lives.⁴⁵⁸ 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 even avoid the witnesses themselves in court by withdrawing.

It is important to note that not all vicariously traumatized professionals will develop PTSD or depression.⁴⁵⁹ 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,⁴⁶⁰ 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.⁴⁶¹ Some seasoned professionals, however, protect themselves by leaving the work because of their unattended secondary trauma.

The exposure to the suffering of others and the emergence of secondary trauma changes the professional deeply in harmful ways, particular when it comes to the cumulative effect of this exposure on their memories, feelings, cognitive schemas, self-esteem, and sense of safety.⁴⁶² 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 person 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

456 I. McCann & L. Pearlman, *Vicarious Traumatization: A Framework for Understanding the Psychological Effects of Working with Victims*, 3(1) J. TRAUMATIC STRESS 131 (1990).

457 Y. Fischman, *Secondary Trauma in the Legal Professionals, a Clinical Perspective*, 18(2) *Torture* 107 (2008).

458 B.H. Stamm, *The Concise ProQOL Manual, 2nd ed.*, ProQOL, Nov. 2010), available at www.proqol.org/ProQOL_Test_manuals.html

459 *Id.*

460 K.W. SAAKVITNE ET AL., *TRANSFORMING THE PAIN: A WORKBOOK ON VICARIOUS TRAUMATIZATION* (1996).

461 Y. Fischman, *Secondary Trauma in the Legal Professionals*, *supra* note 457. This has also been the experience of the authors.

462 K.W. SAAKVITNE ET AL., *TRANSFORMING THE PAIN*, *supra* note 460.

454 Yael Fischman, personal communication (on file with authors).

455 T. de Langis, *Final results for ECCC baseline study: ECCC baseline study on gender sensitivity in transitional justice processes in Cambodia* (March 2012), available at <http://gbvkr.org/wp-content/uploads/2013/01/Results-of-the-ECCC-Baseline-on-Gender-Sensitivity-in-Transitional-Justice-Processes-in-Cambodia-20121.pdf>.

orderly, predictable, or easily comprehended. They may become fearful and begin to view themselves as powerless against such forces.⁴⁶³

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 may be survivors themselves who have developed posttraumatic reactions from their own traumas. As such, they may be more at risk of being re-traumatized by their work or of 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 vicarious experiences. 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. In this context, the accumulation is generally due to exposure to multiple cases of extreme human rights abuse. 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.⁴⁶⁴ 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.⁴⁶⁵

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.⁴⁶⁶ High workloads, the professional isolation experienced by many judges, and the perceived disconnect between the judicial culture and what judges see as ideal prevention and coping strategies in the face of exposure to traumatic material, have likewise been identified as some of the risk factors for the development of vicarious trauma in judges.⁴⁶⁷ 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.⁴⁶⁸ 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.

⁴⁶⁴ T. Sagy, *Even Heroes Need to Talk: Psycho-Legal Soft Spots in the Field of Asylum Lawyering*, Bepress Legal Series, Mar. 1, 2006, working paper 1014, available at <http://law.bepress.com/expresso/eps/1014>.

⁴⁶⁵ A.P. Levin & S. Greisberg, *supra* note 451, at 246.

⁴⁶⁶ S.L. Lustig et al., *Inside the Judges' Chambers: Narrative Responses from the National Association of Immigration Judges Stress and Burnout Survey*, 23(1) GEO. IMMIGR. L.J. 57 (2009).

⁴⁶⁷ P.G. Jaffee, et al. *Vicarious trauma in judges: the personal challenge of dispensing justice*, 54(4) JUVENILE AND FAMILY COURT JOURNAL 1 (2003).

⁴⁶⁸ H. Holmgren, H. Sondergaard & A. Elklit, *Stress and Coping in Traumatized Interpreters*, *supra* note 453.

⁴⁶³ R. JANOFF-BULMAN, *SHATTERED ASSUMPTIONS: TOWARDS A NEW PSYCHOLOGY OF TRAUMA* (1992).

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. In particular, secondary trauma can change the professional by altering or interfering 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, including their ability to make informed decisions on behalf of their clients.⁴⁶⁹ The result can damage the attorney-client relationship if clients feel that their attorney is insensitive to their experiences and pain.⁴⁷⁰ The effects 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.⁴⁷¹ Interpreters may fear being perceived as emotionally weak and unable to deal with certain cases and therefore dismissed if they show emotions in the context of their work.

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

Thankfully, it is not necessary to suffer the effects of secondary trauma forever; it is possible to recover. 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.⁴⁷² Among the many recommendations proffered, 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.⁴⁷³

These recommendations are relevant and valuable in other judicial settings, including human rights tribunals such as the ECCC. It is essential for courts entertaining human rights cases or claims to build systemic support for all of its staff (i.e., judges, attorneys, interpreters, clerks, security, victims services and other staff) to prevent and address the negative effects of secondary traumatic stress. Adequate training about secondary trauma, self-awareness, support, and an effectively implemented plan are needed. Mentoring and supervision that routinely addresses secondary trauma can be valuable as well.⁴⁷⁴

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. Accordingly, Sagy recommends including training for attorneys 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.⁴⁷⁵

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. 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. 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.⁴⁷⁶ Our experience, however, shows that lack of funding may prevent these services from being offered. In addition, the problem of secondary

473 Additional recommendations made by Lustig and his colleagues related to the stressful work of U.S. immigration judges, including providing immigration judges with additional resources to allow them greater flexibility to issue written decisions as necessary; the suspension of case-completion goals until adequate resources are available; judges must have control over their docket; accountability for judges' performance should be handled through the appeals process rather than employee performance appraisal systems; and making a much needed structural change in the Immigration Court system. *Id.*

474 H. Holmgren, H. Sondergaard & A. Elklit, *Stress and Coping in Traumatized Interpreters*, *supra* note 79; Y. Fischman, *Secondary Trauma*, *supra* note 457; Berthold, S. M., & Fischman, Y. (2014). Social work with trauma survivors: Collaboration with interpreters. *Social Work*, 59(2), 103-110. doi: 10.1093/sw/swu011

475 T. Sagy, *Even Heroes Need to Talk*, *supra* note 464.

476 The Center for Justice and Accountability does supply its plaintiffs with clinical support during trial through arrangements with various U.S. torture treatment centers.

469 Y. Fischman, *Secondary Trauma*, *supra* note 457.

470 T. Sagy, *Even Heroes Need to Talk*, *supra* note 464.

471 Y. Fischman, *Secondary Trauma*, *supra* note 457; A.P. Levin & S. Greisberg, *Vicarious Trauma in Attorneys*, *supra* note 77; T. Sagy, *Even Heroes Need to Talk*, *supra* note 464.

472 S.L. Lustig et al., *Inside the Judges' Chambers*, *supra* note 466.

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.⁴⁷⁷ 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),⁴⁷⁸ 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),⁴⁷⁹ 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 (in keeping with the three symptom clusters found in the PTSD diagnostic criteria in the DSM-IV).

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.⁴⁸⁰ 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.⁴⁸¹ 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. The Institute for the Study of Psychosocial Trauma's (ISPT)⁴⁸² secondary trauma training model⁴⁸³ addresses professionals' personal motivations for working with traumatized populations and connects it to larger issues of

477 Space does not permit a full exploration of secondary trauma prevention and self-care strategies here. A good source for a comprehensive bibliography on this topic can be found online at B.H. Stamm, *Comprehensive Bibliography of the Effect of Caring*, *supra* note 450.

478 B.H. Stamm, *The Professional Quality of Life Scale*, ProQOL, 2009, available at www.proQOL.org.

479 B.E. Bride et al., *Development and Validation of the Secondary Traumatic Stress Scale*, 14(1) RES. SOC. WORK PRAC. 27 (2004).

480 This self-care worksheet was developed by K.W. SAAKVITNE ET AL., *TRANSFORMING THE PAIN*, *supra* note 460.

481 *Id.*

482 Y. Fischman, *Secondary Trauma*, *supra* note 457.

483 Information about the ISPT can be found on the Institute for Redress and Recovery's website at <http://law.scu.edu/redress/>.

purpose and meaning.⁴⁸⁴

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. Work related stressors that may be experienced by ECCC staff should also be assessed and addressed, as such stressors have been identified as potential contributors to burnout in other settings.⁴⁸⁵

In January 2012, shortly after publication of the first edition of Cambodia's Invisible Scars, Jane Herlihy from the Centre for the Study of Emotion and Law in the United Kingdom and Pennie Blackburn conducted training in Cambodia for ECCC legal monitors from the War Crimes Studies Center of the University of California (Berkeley) and, separately, for ECCC lawyers and their assistants.⁴⁸⁶ The second training was hosted by the TPO and covered such topics as the relevance of psychology to legal decision-making, psychological responses to trauma, and self-care for those who work with traumatized individuals. These trainings were well received and helpful in educating lawyers about how trauma can affect the quality of evidence in testimony and also affect their own well-being.⁴⁸⁷ More is needed, however, than a one-time training to ensure robust attention and supports are available for court personnel and survivor/witnesses alike moving forward with subsequent ECCC trials and other human rights tribunals.

Conclusions

Information related to mental health following the commission of genocide and crimes against humanity is valuable for justices of the ECCC and other human rights tribunals as they deliberate, issue their judgments, and consider appropriate reparations. Cambodian and other survivors of gross human rights violations are frequently re-traumatized by participating in international tribunals such as the

484 Y. Fischman, *Secondary Trauma*, *supra* note 457.

485 C. Maslach, et al., *Job Burnout*, 52 ANNUAL REVIEW OF PSYCHOLOGY 397 (2001).

486 Herlihy, J. (2012, January 5). *Improving psychological understanding in international human rights trials*. Blogspot. Retrieved from <http://cselblog.blogspot.com/2012/01/improving-psychological-understanding.html>; Langdon-Down, G. (2012, February 16). *Beyond the Killing Fields – Unlocking witness testimony*. *The Times*. Retrieved from www.thetimes.co.uk/tto/law/article3321378.ece

487 L. Marschner, *Implications of trauma on testimonial evidence in international criminal trials*, in P. Alston & S. Knuckey (eds.) *THE TRANSFORMATION OF HUMAN RIGHTS FACT-FINDING* 213-230 (2016).

ECCC. These courts must understand the impact of trauma on these survivors and ensure that adequately supported mental health services are available and accessible in post-conflict societies. 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, human rights 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. Strong psychological support must be in place to safeguard witnesses and their families.

7 TRAUMA IN THE COURTROOM

John D. Ciorciari (J.D., D.Phil.) *is an associate professor at the University of Michigan's Gerald R. Ford School of Public Policy and a senior legal advisor to the Documentation Center of Cambodia.*

Anne Heindel (J.D., LL.M) *has served as a legal advisor for the Documentation Center of Cambodia and as assistant director of the War Crimes Research Office at Washington College of Law, American University.*⁴⁸⁸

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 re-traumatization, especially 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.

In this chapter, we focus on the ECCC's first two trials. The first person tried by the ECCC was 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. Duch admitted responsibility for many crimes. That proceeding, known as "Case 001," involved the active courtroom participation of numerous survivors, including a handful of witnesses and some of the ninety Civil Party applicants⁴⁸⁹—individuals who joined the criminal proceedings to allege injuries as a result of Duch's criminal conduct. The second trial, known as "Case 002/01," was the first of at least two

⁴⁸⁸ 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.

⁴⁸⁹ Four legal teams represented distinct groups of Civil Parties, 22 of whom testified during the trial, and selected Civil Parties were able to sit at the courtroom during each hearing. As discussed below, twenty-four of the applicants were found not to meet the criteria for Civil Parties at judgment. See *Prosecutor v. Kaing Guek Eav "Duch," Case No. 001/18-07-2007/ECCC/TC*, Judgment, ¶¶ 647-49 (Trial Chamber, 26 July 2010).

mini-trials against former senior Khmer Rouge leaders Nuon Chea and Khieu Samphan,⁴⁹⁰ who have denied all criminal responsibility. This trial also featured extensive testimony by survivors acting as witnesses or Civil Parties, though Civil Party participation rights were scaled back in the interests of efficiency and equality of arms.⁴⁹¹ Many victims who testified at these proceedings described suffering from trauma related to abuse they suffered during the Pol Pot years.

We examine some of the apparent immediate effects of courtroom participation on those trauma survivors and analyze the ECCC's efforts to balance their needs against other goals of the criminal process, including the interests of pursuing the truth, conducting efficient trials, and upholding rights of the accused. The ECCC's approach was largely informal and mostly improvised, evolving as the Court sought to respond to these challenges during its first two trials. The Court worked, often by trial and error, to address the needs of many witnesses and Civil Parties who suffer from trauma but are neither children nor victims of sexual violence—the categories of victims typically provided special protection against re-traumatization in other mass crimes courts. In particular, the Court sought to develop appropriate norms and practices related to questioning victims, seeking to balance victims' desire to tell their stories against defense rights to interject with questions and challenge their testimony.

Thus far, the ECCC proceedings suggest that while courtroom testimony does have some therapeutic potential, those benefits are highly uncertain and exist beside real risks of re-traumatization. Cases 001 and 002/01 showed the need to move beyond the legal innovations developed by women's and children's rights advocates regarding re-traumatization and consider the protections required for any traumatized witnesses and Civil Parties. Moreover, the proceedings underscored that mass crimes courts must be equipped with the staff and resources to administer meaningful psychological support for victims.

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

⁴⁹⁰ Case 002 initially involved four charged persons who occupied senior positions in Democratic Kampuchea (DK): former Deputy Secretary of the Communist Party of Kampuchea Nuon Chea, former president of the DK state presidium Khieu Samphan, former DK Deputy Prime Minister Ieng Sary, and former DK Social Affairs Minister Ieng Thirith. Ieng Thirith was severed from the case in 2011 due to dementia, and Ieng Sary passed away in 2013. The case was split into a series of mini-trials, each of which adjudicates a distinct set of alleged crimes. See generally JOHN D. CIORCIARI & ANNE HEINDEL, *HYBRID JUSTICE: THE EXTRAORDINARY CHAMBERS IN THE COURTS OF CAMBODIA*, Ch. 5 (2014). "Case 002/01," dealt with the evacuation of Phnom Penh in 1975, other forced population movement, and related crimes.

⁴⁹¹ Faced with approximately 4,000 applicants for Civil Party status in its second trial, the ECCC appointed a pair of Lead Co-Lawyers to represent Civil Party interests in court and limiting opportunities for Civil Parties to participate directly at trial. CIORCIARI & HEINDEL, *supra* note 490, at 216-30.

available evidence is mixed, and the debate will be difficult to resolve without many more detailed empirical studies.⁴⁹² Nevertheless, key victims' rights groups have argued that survivor participation has therapeutic potential.⁴⁹³ That argument has gained considerable currency among proponents of transitional justice,⁴⁹⁴ 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.⁴⁹⁵

The ECCC took the ICC model one step further by enabling trauma survivors to participate in the pre-trial and trial process as Civil Parties, though the mechanism was later revised in ways that make Civil Party roles more comparable

⁴⁹² 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) (reviewing the available evidence and finding a "paltry empirical record that offers little support for claims of either salutary or harmful effects of post-conflict justice"); 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.").

⁴⁹³ 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 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").

⁴⁹⁴ 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).

⁴⁹⁵ 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 www.iccnw.org/documents/FIDHrvtVictimsBalanceNov2003.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].

to those of victim participants at the ICC.⁴⁹⁶ Unlike witnesses, Civil Parties have formal legal representatives who appear in the courtroom sessions beside the prosecutors. The Court also reserves seats for selected Civil Parties at each hearing.⁴⁹⁷ 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.”⁴⁹⁸ The ECCC Civil Party mechanism—particularly in the *Duch* case, where there were fewer Civil Parties with stronger individual participatory rights—thus offers certain victims a particularly deep and extended opportunity for direct participation in the courtroom process.

Relatively little is known about the effects of testifying on trauma survivors,

⁴⁹⁶ 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.” Internal Rules of the ECCC r. 12ter(5)(b) (revised Feb. 23, 2011) [hereinafter ECCC Internal Rules]. 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. 12ter(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 nearly 4,000 Civil Parties were 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.

⁴⁹⁷ Nevertheless, most Civil Parties were unable to attend 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/~warcrime/documents/Lessons%20Learned%20from%20the%20Duch%20Trial_MRSK_FINAL.pdf (discussing this in the context of the first trial). This problem was compounded in Case 002, which includes nearly 4000 Civil Parties, as the Court lacks the resources to fund their regular attendance.

⁴⁹⁸ ECCC Internal Rules, *supra* note 496, r. 23quinquies(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. It therefore awarded only token reparations. *Kaing Guek Eav, supra* note 489, ¶¶ 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 496, r. 23quinquies(3)(b). In the Case 002/01 Judgment the Trial Chamber endorsed “11 projects concerning remembrance of the victims and memorialization of the suffering endured, therapy and psychological assistance to the victims, and documentation and education.” *Prosecutor v. Nuon Chea et al., Case No. 002/19-09-2007-ECCC/TC, Case 002/01 Judgment*, at 622 (Trial Chamber, Aug. 7, 2014). See also *id.* ¶¶ 1126-40.

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 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 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 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”). For Cambodian villagers’ reactions to the Case 002/01 verdict, see DOCUMENTATION CTR. OF CAMBODIA, *VILLAGERS REACT TO VERDICT IN CASE 002/01* (Aug. 7, 2014), at www.dccam.org/Projects/Living_Doc/pdf/Villagers_React_to_Verdict_in_Case_002-01.pdf.

and claims about the therapeutic payoff of courtroom participation remain more articles of faith than conclusions rooted in robust empirical observation or research.⁴⁹⁹ The ECCC’s first two trials did present some evidence of the potential therapeutic benefits of testimony, but those effects were far from uniform across victims, had uncertain depth and duration, and exist beside considerable risks of anti-therapeutic effects.⁵⁰⁰

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.⁵⁰¹

Many Civil Parties who appeared before the ECCC during its first two cases complained of suffering acute emotional distress from trauma that they experienced during the Democratic Kampuchea period. Yos Phal, testifying in Case 002/01, said: “[r]egarding my psychological status [...] even at the moment, whenever I think of the events that happened [...] my body becomes trembling. I feel heavy in my chest.”⁵⁰² In Case 001, Civil Party Ly Hor described being “scared of other people” and “mentally ill” as a result of his severe beatings during the

⁴⁹⁹ See Jonathan Doak, *The Therapeutic Dimension of Transitional Justice: Emotional Repair and Victim Satisfaction in International Trials and Truth Commissions*, 11 INT’L CRIM. L. REV. 263 (2011) (noting that “[b]oth popular and academic literature are prone to making claims concerning the healing potential of post-conflict justice but such accounts are often impressionistic or anecdotal in nature, and all too often they lack hard empirical evidence to support their assertions”).

⁵⁰⁰ This has been true in other courts as well. See JONATHAN DOAK, *VICTIMS’ RIGHTS, HUMAN RIGHTS AND CRIMINAL JUSTICE: RECONCEIVING THE ROLE OF THIRD PARTIES* ch. 2 (2008) (noting the anti-therapeutic effects of cross-examination in particular).

⁵⁰¹ 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), 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.

⁵⁰² ECCC, Transcript of Trial Proceedings—Nuon Chea et al., Case No. 002/19-09-2007-ECCC/TC, at 78 (May 27, 2013) [hereinafter 27 May 2013 transcript].

Khmer Rouge regime and said that he lived with “anger and traumatization.”⁵⁰³ Ouk Neary, who was four years old when her father was detained and killed at Tuol Sleng, 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.⁵⁰⁴

Civil Party Chum Sirath, who lost two brothers and a sister-in-law in S-21, 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?⁵⁰⁵

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.”⁵⁰⁶ 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.⁵⁰⁷

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

⁵⁰³ ECCC, Transcript of Trial Proceedings—Kaing Guek Eav “Duch,” Case No. 001/18-07-2007-ECCC/TC, at 70-71 (July 6, 2009).

⁵⁰⁴ ECCC, Transcript of Trial Proceedings—Kaing Guek Eav “Duch,” Case No. 001/18-07-2007-ECCC/TC, at 64 (Aug. 17, 2009) [hereinafter Ouk Neary transcript].

⁵⁰⁵ ECCC, Transcript of Trial Proceedings—Kaing Guek Eav “Duch,” Case No. 001/18-07-2007-ECCC/TC, at 20-21 (Aug. 20, 2009) [hereinafter 20 Aug. 2009 transcript].

⁵⁰⁶ *Id.* at 20.

⁵⁰⁷ *See, e.g., id.* at 59 & 64 (Civil Party Ou Savrith); Ouk Neary transcript, *supra* note 504, at 66.

psychological injuries. Some analysts argue that seeing justice done can help victims heal after they have suffered serious rights violations.⁵⁰⁸ 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.⁵⁰⁹ 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.”⁵¹⁰

Some survivors appearing in the ECCC’s first two trials observed that being able to testify had required strength. 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.”⁵¹¹ 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.”⁵¹² Asked about 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.”⁵¹³

One refrain in the Case 001 proceedings was the momentousness of victims’ opportunity to express themselves directly to Duch, the day-to-day manager of the prisons where they or a loved one were detained, often to reject his pleas for forgiveness. For example, Ou Kamela, the daughter of an S-21 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.”⁵¹⁴ A similar opportunity to confront an immediate perpetrator was not possible in Case 002, as the high-level Khmer Rouge officials on trial were further removed

⁵⁰⁸ *See, e.g., O’Connell, supra* note 492, 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”).

⁵⁰⁹ *See, e.g., O’Connell, supra* note 492, at 328-31 & 337-38; Yael Danieli, *Victims: Essential Voices at the Court, supra* note 495, 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).

⁵¹⁰ Danieli, *Victims, supra* note 495.

⁵¹¹ ECCC, Transcript of Trial Proceedings—Kaing Guek Eav “Duch,” Case No. 001/18-07-2007-ECCC/TC, at 48-49 (July 13, 2009) [hereinafter 13 July 2009 transcript].

⁵¹² ECCC, Transcript of Trial Proceedings—Kaing Guek Eav “Duch,” Case No. 001/18-07-2007-ECCC/TC, at 26 (Aug. 12, 2009) [hereinafter 12 Aug. 2009 transcript].

⁵¹³ ECCC, Transcript of Trial Proceedings—Kaing Guek Eav “Duch,” Case No. 001/18-07-2007-ECCC/TC, at 35 (June 30, 2009) [hereinafter Chum Mey transcript].

⁵¹⁴ 20 Aug. 2009 transcript, *supra* note 505, at 64.

from the physical atrocities. In that case most survivors described their desire to testify as part of a search for justice against the Khmer Rouge regime rather than a chance to confront the individual defendants.⁵¹⁵ For example, Civil Party So Sotheavy said:

The testimony is really important for me. I have been waiting for more than 30 years now. Today, I am willing to be here taking the stand to find justice, hoping that my message today will also — my cause today will also help tell younger generation that the regime of the Khmer Rouge would not be followed again; and I would like to tell everyone about the great suffering we have had.⁵¹⁶

In both trials, survivors expressed optimism that participation in ECCC proceedings could help them heal from trauma, by enabling them to engage in truth-telling and relieve their psychological burdens. 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.⁵¹⁷

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.”⁵¹⁸ When asked why it was so important for him to testify about his suffering Civil Party Yos Phal said similarly:

I bore the suffering and the burden of pain with me for more

⁵¹⁵ One exception was Civil Party Chau Ny, who asserted that Khieu Samphan knew Chau's late uncle. Chau used his allotted time for a “statement of suffering” to ask Khieu Samphan about his uncle's fate. ECCC, Transcript of Trial Proceedings—Nuon Chea et al., Case No. 002/19-09-2007-ECCC/TC, at 95-97 (Nov. 23, 2012).

⁵¹⁶ 27 May 2013 transcript, *supra* note 502, at 20.

⁵¹⁷ Chum Mey transcript, *supra* note 415, at 67.

⁵¹⁸ Ouk Neary transcript, *supra* note 504, at 69-70.

than 30 years. And I do not know where I can reveal the truth and the suffering, and this is the only chance for me to do so.⁵¹⁹

S-21 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.”⁵²⁰ 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.”⁵²¹

In Case 002/01, a number of Civil Parties expressed particular gratitude for being able to present “statements of suffering” at the conclusion of their testimony. Those statements enabled Civil Parties to express the harms they suffered during the Khmer Rouge period in uninterrupted narrative form. The Trial Chamber began allowing statements of suffering in Case 002/01 in response to a request by Civil Party lawyers, who argued *inter alia* that Civil Parties' harm was “both physical and psychological,” and that “a complete statement... would make [the testifying] Civil Party feel better”⁵²² and was “part of how to make their grief be healed.”⁵²³ The court assented, and many Civil Parties expressed their gratitude for the opportunity to testify in this freer narrative form. For example, Civil Party Lay Bony said:

[T]his is the best opportunity after 30 years I have been living with all the suffering. And because of the Court, I am here to express my sufferings [...] I have kept this suffering in my heart for a very long period of time, and I would like to thank you, the Chamber, very much for giving me this opportunity to speak it out.⁵²⁴

Although some trauma survivors report psychological benefits of appearing in the courtroom during or shortly after their testimony, the therapeutic payoffs of

⁵¹⁹ 27 May 2013 transcript, *supra* note 502, at 80.

⁵²⁰ ECCC, Transcript of Trial Proceedings—Kaing Guek Eav “Duch,” Case No. 001/18-07-2007-ECCC/TC, at 74 (July 1, 2009) [hereinafter Bou Meng transcript].

⁵²¹ *Id.* at 85.

⁵²² ECCC, Transcript of Trial Proceedings—Case 002, Case File No. 002/19-09-2007-ECCC/TC, at 4 (22 Oct. 2012) [hereinafter 22 Oct. 2012 transcript] (quoting Civil Party Lead Co-Lawyer Pich Ang). *See also id.* at 5-6 (in which his international co-counsel Elisabeth Simmoneau-Fort added that Civil Parties “have mental trauma” as a result of events connected to the case and arguing that “we should allow them to express their suffering globally”).

⁵²³ *Id.* at 15-16 (quoting Pich Ang).

⁵²⁴ ECCC, Transcript of Trial Proceedings—Case 002, Case File No. 002/19-09-2007-ECCC/TC, at 59 (Oct. 24, 2012) [hereinafter 24 Oct. 2012 transcript].

courtroom participation are far from certain and may be modest and fleeting even when they appear. The most extensive study of the effects of testifying at the ECCC was a 2011 study by Eric Stover et al. of 21 of the 22 Civil Parties who testified in the *Duch* trial. Most characterized their experiences as positive, though sometimes difficult and frustrating.⁵²⁵ In a similar survey of 87 victims and witnesses who testified at the International Criminal Tribunal for the former Yugoslavia (ICTY), Stover found that most “valued the opportunity to tell their story to the wider world,” and some relatives of deceased persons expressed “relief that they could exercise what was perceived to be a moral duty in testifying.”⁵²⁶ Although some also reported a sense of catharsis, that feeling tended to dissipate when they returned home.⁵²⁷

Risks of Re-traumatization

While the cathartic effects of testimony have been difficult to assess, there is ample evidence of the potential of courtroom engagement to re-traumatize victims.⁵²⁸ 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, at least for a time.⁵²⁹ Stover argues that “[i]f we were ever prompted to design a system for provoking intrusive post-traumatic symptoms in victims of war crimes, we could not do better than a court of law.”⁵³⁰ 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.⁵³¹ 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, as described below. 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.⁵³²

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.”⁵³³ 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.”⁵³⁴ Civil Party Denise Affonço spoke about her son’s inability to testify due to the trauma of beatings by Khmer Rouge cadres after scavenging for wood to help his family:

He was so traumatized that even today he doesn’t want to even talk about this period. I can’t bring him to testify, I can’t ask him to help me testify because once, when I found his body covered with the marks where he had been beaten, and he can’t even see scenes of people being beaten on TV without suffering.⁵³⁵

⁵²⁵ Eric Stover et al. *Confronting Duch: Civil Party participation in Case 001 at the Extraordinary Chambers in the Courts of Cambodia*, 93 INT’L REV. OF THE RED CROSS 503, 541 (2011).

⁵²⁶ ERIC STOVER, *THE WITNESSES: WAR CRIMES AND THE PROMISE OF JUSTICE IN THE HAGUE* 76 (2005).

⁵²⁷ *Id.* at 107.

⁵²⁸ See, e.g., Gabriela Mischkowski & Gorana Mlinarević, *Medica Mondiale, The Trouble with The Trouble with Rape Trials – Views of Witnesses, Prosecutors and Judges on Prosecuting Sexualised Violence during the War in the former Yugoslavia* (2009) at 56 (finding that 65% of women interviewees who testified about rape before the ICTY or hybrid War Crimes Chamber (WCC) in Bosnia and Herzegovina reported the experience as traumatic); Michelle Staggs Kelsall & Shanee Stepakoff, “When we wanted to talk about rape”: *Silencing Sexual Violence at the Social Court for Sierra Leone*, INT’L J. TRANS. JUST. 355 (2007) (finding that rape victims at the SCSL often reported the experience of testifying as difficult and emotionally painful). See also generally STOVER, *supra* note 526.

⁵²⁹ 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 Re-traumatization in the Rwandan Gacaca Courts*, 39 SECURITY DIALOGUE 55 (2008); Jamie O’Connell, *supra* note 592, at 331-36.

⁵³⁰ STOVER, *supra* note 526, at 81.

⁵³¹ 13 July 2009 transcript, *supra* note 511, 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.

⁵³² Marie-Bénédicte Dembour & Emily Haslam, *Silencing Hearings? Victim-Witnesses at War Crimes Trials*, 15 EUR. J. INT’L L. 151, 159 (2004) (pointing out that “judicial ‘effectiveness’ may mean for [witnesses] that significant events and emotions are glossed over”).

⁵³³ Chum Mey transcript, *supra* note 513, at 35-36. Chum called himself *chhkout*, 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. *Chhkout* is not necessarily considered derogatory.

⁵³⁴ ECCC, Transcript of Trial Proceedings—Kaing Guek Eav “Duch,” Case No. 001/18-07-2007-ECCC/TC, at 93-94 (July 9, 2009) [hereinafter 9 July 2009 transcript].

⁵³⁵ ECCC, Transcript of Trial Proceedings—Nuon Chea et al., Case No. 002/19-09-2007-ECCC/TC/12/12/2012, at 93 (Dec. 12, 2012) [hereinafter 12 Dec. 2012 transcript].

A number of international authorities have emphasized the need for sensitivity toward trauma victims in the courtroom. The UN Economic and Social Council has issued guidelines on protections for child victims and witnesses,⁵³⁶ 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,⁵³⁷ and the UN High Commissioner for Human Rights has endorsed both positions.⁵³⁸

Other internationalized criminal tribunals have acknowledged the possibility of re-traumatization 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."⁵³⁹ Prosecutors and defense attorneys have also invoked the risk of re-traumatization to justify motions to make special arrangements for certain witnesses or keep them from being recalled.⁵⁴⁰

The ICC has been more explicit and forward-leaning than the *ad hoc* ICTR and ICTY. 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 that Chambers may order "special measures to facilitate [their] testimony."⁵⁴¹ The Chamber also held that "protective measures are not

536 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).

537 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).

538 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).

539 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).

540 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 SKS2 to Give Testimony by Video-Conference, ¶¶ 2 & 5 (Trial Chamber I, Feb. 22, 2005).

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

favours but instead are the rights of victims."⁵⁴² 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.⁵⁴³ Thus, at the ICC, the defense bears the burden of showing that such protective measures should not apply.⁵⁴⁴ 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.⁵⁴⁵

Given the time elapsed since the demise of the Democratic Kampuchea regime, none of the witnesses or Civil Parties in the *Duch* trial was underage at the time of the proceedings. Relatively few have alleged sexual violence, in part because the first two trials did not feature prosecution for rape and other forms of sexual violence. No survivor has alleged suffering rape or other physical violence perpetrated by an accused person present in the courtroom. 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 ECCC trials have exposed a blind spot in the existing normative regime for in-court victim protection.

Facing the Accused

Confrontations between survivors and the defendant present special risks of re-traumatization, 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.⁵⁴⁶ 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

542 *Id.* ¶ 129.

543 Rome Statute, *supra* note 495, 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 495, 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.

544 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).

545 Prosecutor v. *Lubanga*, *supra* note 541, ¶¶ 130-32.

546 ICC Rules of Procedure and Evidence, *supra* note 495, r. 88(5).

used in the *Delalić* case.⁵⁴⁷ The Special Court of Sierra Leone (SCSL) also enabled witnesses to testify behind screens or from outside of the courtroom for similar reasons, and the SCSL used that measure when hearing testimony from child witnesses in the *Sesay* trial.⁵⁴⁸ 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.⁵⁴⁹

Survivors appearing at the ECCC have not been granted special forms of protection such as video testimony, partitions, or *in camera* hearings.⁵⁵⁰ Nevertheless, the trial of Duch, a direct perpetrator well known to his victims, provided further evidence of the difficulty that some survivors have facing an accused. In at least one instance a potential Civil Party refrained from joining the proceedings out of fear of re-traumatization. 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.”⁵⁵¹

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.⁵⁵² 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.⁵⁵³ 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.⁵⁵⁴ 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.

In Case 002/01, confrontation between the accused and the testifying

⁵⁴⁷ Prosecutor v. Delalić, Case No. IT-96-21, Decisions on the Motions by the Prosecution for Protective Measures for the Prosecution Witnesses Pseudonymed “B” through to “M” (Trial Chamber, Apr. 29, 1997).

⁵⁴⁸ 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].

⁵⁴⁹ 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).

⁵⁵⁰ The Trial Chamber allowed one Civil Party, Denise Affonço, to testify via video-link, but its rationale was that requiring her to travel from France was unnecessary given video availability. Prosecutor v. Nuon Chea et al., Case No., Case No. 002/19-09-2007-ECCC/TC, Order for Video-Link Testimony of Civil Party TCCP-13 (Trial Chamber, May 22, 2013).

⁵⁵¹ ECCC, Transcript of Trial Proceedings—Kaing Guek Eav “Duch,” Case No. 001/18-07-2007-ECCC/TC, at 49 (Aug. 18, 2009) [hereinafter 18 Aug. 2009 transcript].

⁵⁵² See, e.g., Michelle Staggs Kelsall et al., *supra* note 497, at 36 (noting that some witnesses appeared intimidated by Duch's active role in the proceedings).

⁵⁵³ 12 Aug. 2009 transcript, *supra* note 512, at 46-47.

⁵⁵⁴ *Id.* at 46-50.

survivors does not appear to have been a major cause of re-traumatization. The Case 002 defendants set the policies leading to mass atrocities but were not intimately involved in the physical acts of violence committed against the witnesses and Civil Parties appearing. Nonetheless, some survivors did find the experience unsettling, showing that the psychological challenges of testifying are present even when a trauma survivor's tormentor does not sit across the courtroom.

Hearing Graphic Details of Crimes

Graphic courtroom depiction of crimes can also heighten the risk of re-traumatization. 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.”⁵⁵⁵ 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.⁵⁵⁶

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.⁵⁵⁷ 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.⁵⁵⁸

⁵⁵⁵ ECCC, Transcript of Trial Proceedings—Kaing Guek Eav “Duch,” Case No. 001/18-07-2007-ECCC/TC, at 20 (Aug. 19, 2009).

⁵⁵⁶ *Id.* at 22.

⁵⁵⁷ 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).

⁵⁵⁸ This was done at the ECCC, but only after Civil Party Im Sunthy broke down after viewing graphic evidence.

Having Veracity Questioned

Re-traumatization 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."⁵⁵⁹ Some studies also suggest that repetitive questioning can lead to inaccurate testimony by disconcerting or exhausting a trauma survivor.⁵⁶⁰ In at least one instance, this prompted an ECCC defense lawyer to object to repetitive questions from the prosecution on the basis that "we're not learning anything new and we're just re-traumatizing a traumatized witness."⁵⁶¹

At the ECCC, defense lawyers frequently have challenged victims' accounts based on a lack of corroborating documentary evidence. During the Khmer Rouge period, as often happens in times of upheaval, many people's family records and photos were lost or destroyed, making formal legal proof of relationships or events difficult. 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."⁵⁶² 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-21.⁵⁶³ 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."⁵⁶⁴

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 . . ."⁵⁶⁵ 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."⁵⁶⁶

When the verdict against Duch 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 had been detained and tortured at S-21 were rejected due in large part to a lack of corroborating documentary evidence.⁵⁶⁷ Several Civil Parties who claimed to have lost relatives at S-21 were likewise denied recognition on this basis.⁵⁶⁸

According to research conducted by the Transcultural Psychosocial Organization (TPO), 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."⁵⁶⁹ 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."⁵⁷⁰ 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."⁵⁷¹

⁵⁵⁹ ECCC, Transcript of Trial Proceedings—Kaing Guek Eav "Duch," Case No. 001/18-07-2007-ECCC/TC, at 87 (July 2, 2009).

⁵⁶⁰ ECCC, Transcript of Trial Proceedings—Kaing Guek Eav "Duch," Case 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.

⁵⁶¹ *Kaing Guek Eav*, *supra* note 488, ¶ 647.

⁵⁶² *Id.*, ¶¶ 648-49. 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.

⁵⁶³ Transcultural Psychosocial Organization [TPO], Report on TPO's After-Verdict Intervention with Case 001 Civil Parties, 27 July 2010, § 2.

⁵⁶⁴ *Id.*

⁵⁶⁵ *Id.* See also Charles P. Trumbull IV, *supra* note 493, 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).

⁵⁵⁹ Jamie O'Connell, *supra* note 517, at 334 (citations omitted).

⁵⁶⁰ See, e.g., Annie Cossins, *Cross-Examination in Child Sexual Assault Trials: Evidentiary Safeguard or an Opportunity to Confuse?* 33 MELBOURNE L. REV. 68 (2009).

⁵⁶¹ 12 Dec. 2012 transcript, *supra* note 535 at 113.

⁵⁶² ECCC, Transcript of Trial Proceedings—Kaing Guek Eav "Duch," Case No. 001/18-07-2007-ECCC/TC, at 32 (July 7, 2009) [hereinafter Lay Chan transcript].

⁵⁶³ 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 488, ¶ 647.

⁵⁶⁴ Lay Chan transcript, *supra* note 562, at 48. *But see* 13 July 2009 transcript, *supra* note 485, 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").

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. Scientific research has shown that victims of trauma often experience significant memory impairment after suffering severe emotional distress.⁵⁷² Some experts say this results in a higher than normal level of inconsistent and unreliable recall: "[T]he more trauma, the worse the memory."⁵⁷³ 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.⁵⁷⁴ At the ECCC, Civil Party Chin Met suggested as much when 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."⁵⁷⁵

However, other experts say that traumatized witnesses retain the capacity to recall information "in clear order, completeness and chronology"; instead, the more traumatized they are, the more painful and difficult they find it to offer a

⁵⁷² 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).

⁵⁷³ Prosecutor v. Furundžija, Case No. IT-95-17/1-T, Judgment, ¶¶ 102-03 (Trial Chamber, Dec. 10, 1998) (recounting the testimony of experts for the defense).

⁵⁷⁴ Bessel A. van der Kolk, *Trauma and Memory*, 52 *PSYCHIATRY AND CLINICAL NEUROSCIENCES* 597 (1998).

⁵⁷⁵ 8 July 2009 transcript, *supra* note 566 at 93-94.

detailed account of their traumatic experiences.⁵⁷⁶ According to ICC expert witness Elisabeth Schauer, post-traumatic stress disorder involves the "intrusion of memory involuntarily" so that if you recall one piece of a memory "the rest also comes." This doesn't mean "that it's not true[,] ... it's just maybe hard to put into words in a proper order and structure as is needed [in court]."⁵⁷⁷ 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 impact of trauma on the accuracy of witness's testimony has been raised at all mass crimes tribunals. None of these courts presupposes that the testimony of traumatized victims will be any less valuable than that of other witnesses. For example, an ICTR Trial Chamber has ruled that "being a victim of the events that occurred in Rwanda in 1994 cannot automatically discredit a witness's evidence in such a way as to exclude it. The Chamber recalls that many victims have already contributed to the search for truth in judicial proceedings ... before this Tribunal."⁵⁷⁸ Whether or not trauma does affect recall per se, many judges and prosecutors view it as "an obstacle for 'getting the facts.'"⁵⁷⁹ This is particularly true with regard to rape and torture survivors, who are perceived as "the most vulnerable" categories of witnesses.⁵⁸⁰

Factual inconsistencies often arise between pre-trial and trial statements or

⁵⁷⁶ See Elisabeth Schauer, *The Psychological Impact of Child Soldiering*, Vivo International, at 35, 37, ICC-01/04/01/06-1729-Anx1 (Feb. 25, 2009); ICC, Transcript of Trial Proceedings—*Lubanga Dyilo*, Case No. ICC-01/04-01/06-T-166ENG, at 56 (April 7, 2009) [hereinafter *Lubanga Apr. 7, 2009 Transcript*] (testimony of Dr. Elisabeth Schauer discussing traumatized witnesses and specifically former child soldiers).

⁵⁷⁷ *Lubanga Apr. 7, 2009 Transcript*, *supra* note 576, at 58 (testimony of Dr. Elisabeth Schauer). Cf. van der Kolk, *supra* note 573, at 597 (noting that victims sometimes experience vivid flashbacks but also have difficulty articulating what they are thinking and feeling); ECCC, Transcript of Trial Proceedings—*Nuon Chea et al.*, Case No. 002/19-09-2007-ECCC-TC, at 70 (June 5, 2013) (testimony of Chhim Sothea, an expert on trauma and Khmer Rouge survivors, saying that one PTSD symptoms include that "the victim would recall the events that happened to them and ... it seems that the event is taking place vividly in front of their eyes, either during the daytime or at night time through a nightmare"; and that "they do not want to talk about any events that would trigger the events that happened to them in the past"); ECCC, Transcript of Trial Proceedings—*Nuon Chea et al.*, Case No. 002/19-09-2007-ECCC-TC, at 28 (Dec. 6, 2012) (testimony of Civil Party Kim Vandy saying, "Every time I think of [the suffering and deaths in his family under the Khmer Rouge], it seems so vivid, living in front of my eyes and it makes me so angry").

⁵⁷⁸ Prosecutor v. Gacumbtsi, Case No. ICTR-2001-64-T, Judgment, ¶ 220 (Trial Chamber III, June 17, 2004). See also Prosecutor v. Kunarac et al, Case No IT-96-23/1-A, Judgment, ¶ 324 (Appeals Chamber, June 12, 2002) (stating that "there is no recognized rule of evidence that traumatic circumstances necessarily render a witness's evidence unreliable").

⁵⁷⁹ Mischkowski & Mlinarevic, *supra* note 8, at 66.

⁵⁸⁰ *Id.* at 65, 68.

between witness accounts. Noting these discrepancies, international courts consider not only witness trauma, but also factors including the passage of time; cultural, educational and other barriers to identifying precise dates, measuring distances, and estimating the duration of events; variations in how questions are asked; and translation problems.⁵⁸¹ In weighing the evidence, they carefully scrutinize victim-witness testimony with the potential impact of trauma in mind,⁵⁸² and generally find victim-witness accounts reliable despite discrepancies deemed “immaterial” or “insubstantial.”⁵⁸³ For example, although defense lawyers pointed out discrepancies between Chin Met’s testimony and written statement,⁵⁸⁴ her Civil Party status was nevertheless recognized in the judgment.⁵⁸⁵ 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.

Nevertheless, in some cases, factual discrepancies are so major that a witness who is obviously traumatized is found to lack credibility. The first witness in the Lubanga case at the ICC was questioned about his claims that he was recruited as a child soldier into Lubanga’s Congolese militia, and soon recanted his testimony, saying it was coached.⁵⁸⁶ When recalled, he recounted his story in a thorough and persuasive manner.⁵⁸⁷ However, due to significant “contradictions and inconsistencies” between his testimony and that of other witnesses, and the fact that he “never explained” why he claimed to have received payment to lie under oath, the Trial Chamber found that his honesty was uncertain.⁵⁸⁸

⁵⁸¹ See, e.g., Prosecutor v. Vasiljevic, Case No. IT-98-32-T, Judgment, ¶ 21 (Trial Chamber II, Nov. 29, 2002) (noting that “a witness may be asked questions at the trial not asked previously or may through questioning remember details previously forgotten”).

⁵⁸² See, e.g., Prosecutor v. Kupreškić, Case No. IT-95-16-A, Appeal Judgment, ¶ 31 (Appeals Chamber, Oct. 23, 2001); Prosecutor v. Kunarac et al., Case No. IT-96-23/1-A, Judgment, ¶ 324 (Appeals Chamber, June 12, 2002) (stating that a trial chamber “must be especially rigorous in assessing identification evidence” provided by traumatized witnesses); Prosecutor v. Akayesu, Case No. ICTR-96-40-T, Judgment, ¶¶ 142-43 (Trial Chamber I, Sept. 2, 1998); Prosecutor v. Brima et al., Case No. SCSL-04-16-T, Judgment, ¶ 111 (Trial Chamber, June 20, 2007) (considering “the possibility that any observations made by the witnesses at the relevant time may have been affected by terror or stress” and weighing the evidence provided “with particular scrutiny”).

⁵⁸³ See, e.g., Akayesu Judgment, *supra* note 582, ¶¶ 456 (finding inconsequential discrepancies including a difference of a few days about when the witness went somewhere, and whether women were stripped on the way to or upon arrival at a location); Kunarac et al. Appeals Judgment, *supra* note 607 ¶ 309 (stating that “the absence of such natural discrepancies [between prior statements and trial testimony] could form the basis for suspicion as to the credibility of a testimony”).

⁵⁸⁴ 8 July 2009 transcript, *supra* note 575, at 40-47.

⁵⁸⁵ *Kaing Guek Eav*, *supra* note 488, ¶ 645.

⁵⁸⁶ ICC, Transcript of Trial Proceedings—*Lubanga Dyilo*, Case No. ICC-01/04-01/06-T-166ENG, at 40 (Jan. 28, 2009).

⁵⁸⁷ *Id.* at 22 (quoting the presiding judge telling the witness: “[Y]ou’ve done very well. I wish I could speak as well as you have”).

⁵⁸⁸ Prosecutor v. Lubanga Dyilo, Case No. ICC-01/04-01/06, Judgment Pursuant to Article 74 of the Statute, ¶¶ 436-41 (Trial Chamber I, Mar. 14, 2012) (noting inconsistencies including whether his mother was dead, if he had finished school, his age, and if and when he was recruited).

Similarly, in ECCC Case 001, a Civil Party testified at trial that she had been a medic at the S-21 security center, and later a prisoner, and that her entire family had been killed there.⁵⁸⁹ However, there were significant inconsistencies between her Civil Party application, her in-court testimony, and subsequent filings, and her descriptions of the detention center and its regimen did not match those of other victims or experts. The Trial Chamber acknowledged the “tremendous” physical and psychological harm she had undoubtedly suffered under the Khmer Rouge regime, but found her account not credible “[e]ven allowing for the impact of trauma and the passage of time[.]”⁵⁹⁰

The testimony of Civil Party Ly Hor was also confused. A confession transcript from S-21 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. Afterward, Ly Hor said he did not know what happened during trial; he had become confused and could not think clearly.⁵⁹¹ Although there were documents submitted attesting that someone named “Ear Hor”—the name Ly Hor allegedly went by at the time—was detained at S-21, in its judgment the Trial Chamber expressed doubt that they were one and the same person, and his Civil Party application was rejected in the trial judgment.⁵⁹² All these episodes precipitated debates on the extent to which vulnerable victims should be prepared for the courtroom environment.⁵⁹³

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

⁵⁸⁹ See 9 July 2009 transcript, *supra* note 534 at 59-60, 64 (testimony of Nam Mon).

⁵⁹⁰ *Kaing Guek Eav*, *supra* note 488, ¶ 647.

⁵⁹¹ Interview with Terith Chy, Team Leader Victim Participation Project, Documentation Center of Cambodia (Nov. 04, 2010) (on file with author).

⁵⁹² *Kaing Guek Eav*, *supra* note 488, ¶ 647. His lawyers submitted additional identification evidence to the Supreme Court Chamber, which was satisfied that he had been an S-21 detainee. Prosecutor v. Kaing Guek Eav “Duch,” Case No. 001/18-07-2007-ECCC/SC, Appeal Judgment, ¶ 540 (Supreme Court Chamber, Feb. 3, 2012) (overturning the trial chamber and accepting his Civil Party application). Although he reacted stoically to the trial chamber’s rejection, his recognition by the Supreme Court Chamber was clearly a relief: “I have now been accepted as a Civil Party in Case 001, which means that my suffering has been acknowledged by the court. ... I feel proud.” Ly Hor, Banteay Meanchey Province, unpublished interview by staff of the Documentation Center of Cambodia (2011) (on file with authors).

⁵⁹³ See 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>; ECCC, Transcript of Trial Proceedings—*Kaing Guek Eav “Duch,”* Case No. 001/18-07-2007-ECCC/TC, at 55 (July 6, 2009) (Judge Silvia Cartwright lamenting, “This Civil Party has been very poorly prepared for this morning’s experience.”).

against the defendant's right to a fair and speedy trial.⁵⁹⁴ 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.⁵⁹⁵

One risk of emotional testimony is that it may bias the proceedings against the accused. 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."⁵⁹⁶ 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 feces, 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.⁵⁹⁷

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

⁵⁹⁴ 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).

⁵⁹⁵ See Marie-Bénédicte Dembour & Emily Haslam, *supra* note 532, 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").

⁵⁹⁶ Chum Mey transcript, *supra* note 513, at 12.

⁵⁹⁷ Ouk Neary transcript, *supra* note 504, at 104-05.

courtroom was not the appropriate venue "for any revenge or abusive words."⁵⁹⁸ He asked Neth Phally to "avoid using this venue as the place where you seek vengeance."⁵⁹⁹ 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 . . ."⁶⁰⁰ 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.⁶⁰¹

In Case 002, direct attacks on the senior-level accused were the exception, likely due to their physical removal from the scenes of the crimes being discussed and their denial of responsibility. Nevertheless, similar concerns arose. For example, when a Civil Party called the accused senior leaders "immoral," defense counsel emphasized that "such a wording is very inappropriate and of course it has an impact on the status of the accused."⁶⁰²

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

⁵⁹⁸ *Id.* at 107.

⁵⁹⁹ 18 Aug. 2009 transcript, *supra* note 551, at 108.

⁶⁰⁰ 20 Aug. 2009 transcript, *supra* note 505, at 26.

⁶⁰¹ *Id.* at 26-27.

⁶⁰² ECCC, Transcript of Trial Proceedings—Nuon Chea et al., Case No. 002/19-09-2007-ECCC-TC, at 25 (Oct. 22, 2012).

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?⁶⁰³

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.⁶⁰⁴ 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.⁶⁰⁵

Judges and lawyers also try to keep proceedings moving by curtailing longwinded or legally extraneous discussions. For example, at the ECCC, a lawyer interrupted a Civil Party’s detailed chronological account of what he experienced on the day Phnom Penh was forcibly evacuated by the Khmer Rouge, the subject matter of the Case 002/01 charges: “I apologize for interrupting your speech. Due to time constraints, I would like to ask you to please describe your general activities and the events of the evacuation of the 17th of April, but please be brief on this.” The Civil Party responded, “Actually ... I had already been very brief.”⁶⁰⁶

Witnesses bristle against time restrictions, seeking to convey a full account of the harm they have suffered. The judges in Case 001, the topic of which was the S-21 security center, had to manage the desire of some witnesses and Civil Parties to speak broadly about their families’ suffering during the entire Pol Pot era. In a few instances, Civil Parties called to testify provided eulogies for their lost loved

ones,⁶⁰⁷ departing from facts specifically related to the charges.⁶⁰⁸ For example, Civil Party Touch Monin was cut off by the defense because he recounted a long story of his family’s evacuation from Phnom Penh instead of events related to the accused.⁶⁰⁹ 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.⁶¹⁰

In Case 002/01, additional issues arose in connection with Civil Party “statements of suffering,” during which the Trial Chamber allowed Civil Parties to testify broadly to their experiences during the Khmer Rouge period, even when certain of the harms they suffered went well beyond the specific offenses being adjudicated. Defense lawyers said that allowing such uninterrupted statements would make a “joke” of the trial by allowing Civil Parties to narrate about facts unrelated to the case.⁶¹¹ Although the Court later agreed to allow defense lawyers to question Civil Parties about new facts or allegations introduced in their statements of suffering, defense lawyers continued to worry about bias. Most notably, Case 002/01 Civil Party Chau Ny introduced a new allegation against Khieu Samphan in his statement of suffering.⁶¹² The Trial Chamber later said that such statements would not be prejudicial, because the judges distinguished between Civil Parties’ factual testimony (which can be used as evidence like other witness testimony) and statements of suffering, but defense lawyers were not convinced.⁶¹³

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

⁶⁰⁷ See, e.g., ECCC, Transcript of Trial Proceedings—Kaing Guek Eav “Duch,” Case No. 001/18-07-2007-ECCC/TC, at 28-29 (Aug. 19, 2009) (in which Phung Guth details the character of her father).

⁶⁰⁸ See, e.g., 20 Aug. 2009 transcript, *supra* note 505, at 60-66.

⁶⁰⁹ ECCC, Transcript of Trial Proceedings—Kaing Guek Eav “Duch,” Case No. 001/18-07-2007-ECCC/TC, at 93-96 (Aug. 24, 2009) [hereinafter 24 Aug. 2009 transcript].

⁶¹⁰ *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”).

⁶¹¹ 22 Oct. 2012 transcript, *supra* note 522, at 12 (quoting Khieu Samphan’s Cambodian co-counsel Kong Sam Onn).

⁶¹² ECCC, Transcript of Trial Proceedings—Case 002, Case File No. 002/19-09-2007-ECCC/TC, at 95-97 (Nov. 23, 2012) (in which Chau alleged that Khieu Samphan had sent a letter in 1975 recalling Chau’s uncle, who later disappeared).

⁶¹³ See ECCC, Transcript of Trial Proceedings—Case 002, Case File No. 002/19-09-2007-ECCC/TC, at 6, 14 (May 23, 2013) (in which Khieu Samphan’s lawyers advanced similar arguments).

⁶⁰³ Bou Meng transcript, *supra* note 520, at 14.

⁶⁰⁴ Lay Chan transcript, *supra* note 562, at 37-38.

⁶⁰⁵ See, e.g., Bou Meng transcript, *supra* note 520, at 1-3.

⁶⁰⁶ ECCC, Transcript of Trial Proceedings—Nuon Chea et al., Case No. 002/19-09-2007-ECCC-TC, at 17 (Feb. 7, 2013). See also *id.* at 31 (reminding the same witness to “please listen to the questions carefully and limit your response to the questions only. And please do not make additional comments further from what is being asked of you. Thank you.”).

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 relevant hard facts needed to establish the defendants' culpability.

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 re-traumatization 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 ECCC trials have shown that re-traumatization 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, both trials have 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 to increase support for trauma witnesses, including by offering sensitivity training to staff and judges, and providing in-court psychological support to victims. Nonetheless, there is room for improvement in future justice processes.

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 such as the Iraqi Special Tribunal.⁶¹⁴ ECCC judges attended a number of legal training sessions organized by the UN Development Program before they took up their roles on the bench.⁶¹⁵ They, however, have rejected offers for psycho-social training.⁶¹⁶ 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. It is unfortunate that the ECCC has not taken advantage of offers to provide psychosocial training to judges and staff, and we strongly encourage other courts to do so.

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.")⁶¹⁷ Afterward, he apparently sought advice about how to handle such situations more appropriately in the future.⁶¹⁸ 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.⁶¹⁹ Nil Nonn's adaptation, which became standard practice in Case 002, is to be commended, but going forward international court judges should accept training before encountering traumatized witnesses in the courtroom. Indeed, due to its potential for reducing re-traumatization of victims and for ensuring a fair trial for the accused, such training should be automatically provided to the judges and staff at

⁶¹⁴ 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).

⁶¹⁵ Suzannah Linton, *Safeguarding the Independence and Impartiality of the Cambodian Extraordinary Chambers*, 4 J. INT'L CRIM. JUST. 327 (2006).

⁶¹⁶ 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).

⁶¹⁷ *Chum Mey transcript*, *supra* note 513, 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.

⁶¹⁸ Bou Meng transcript, *supra* note 519, 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").

⁶¹⁹ See *supra* note 602 and accompanying text.

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.⁶²⁰ The ICTR Witness Support and Protection Programme and ICTY Victims and Witnesses Section provide psychological counseling to witnesses, focusing on trauma survivors.⁶²¹ The SCSL Rules of Procedure and Evidence provided that its Witnesses and Victims Section be staffed by experts in trauma related to sexual violence.⁶²²

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.⁶²³ 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."⁶²⁴ It is tasked with familiarizing witnesses with the courtroom environment to dampen anxiety and with accompanying them during testimony if required.⁶²⁵

The ECCC also established a Witness and Experts Support Unit (WESU) and a Victims' Support Section (VSS). WESU is responsible for services required to provide "a safe and supportive environment" for witnesses and Civil Parties who testify at the court.⁶²⁶ Although no ECCC provision mentions psychosocial

support,⁶²⁷ the ECCC website states that the VSS is responsible for its provision for victims who participate as Civil Parties.⁶²⁸ In practice, all psychological assistance is provided by the Transcultural Psychosocial Organization (TPO), which signed a memorandum of understanding with the Court to provide support for witnesses and Civil Parties. TPO services for the Court include trainings for ECCC staff about "stress management, secondary trauma and self-care strategies"; outpatient treatment; a phone hotline; and on-site psychological support.⁶²⁹ The latter includes "reducing anticipatory anxiety through psychological briefing prior to the proceedings, monitoring participants' mental health condition, offering emotional support during the trial and debriefing after the proceedings."⁶³⁰ Researchers reported that in the ECCC's first case:

[M]any [Civil Parties] were concerned about how they would perform in the courtroom, especially when relating traumatic events and feelings, and, ultimately, how the judges and audience would perceive their testimonies. Respondents described a range of physical and emotional symptoms, including a perceived rise in blood pressure, sweaty palms and feet, trembling hands, and alternate feelings of terror and lightness immediately before entering the courtroom.⁶³¹

A TPO representative was asked to sit beside Chum Neou, a Civil Party who survived the S-24 detention camp, 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."⁶³² A TPO representative also sat beside Civil Party Nam Mon after she broke down while testifying about the deaths of her family under the regime.⁶³³ Her lawyers cautioned that Nam Mon had never told her story before relating it to her lawyers shortly before the trial

620 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 Orentlicher, *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).

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

622 SCSL Rules of Procedure and Evidence, *supra* note 593, r. 34(B).

623 ICC Rules of Evidence and Procedure, *supra* note 495, rules 17(2)(iii)-(iv) & 19(d)-(j).

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

625 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).

626 ECCC, *Court Management Section*, www.eccc.gov.kh/en/office-of-administration/court-management-section (visited Nov. 15, 2014).

627 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 495, arts. 68(1) & 87(4).

628 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*, <http://www.eccc.gov.kh/en/victims-support/victims-support-section> (last visited Nov. 16, 2014).

629 Transcultural Psychosocial Organization, Khmer Rouge Tribunal Project Information Sheet, at http://tpocambodia.org/uploads/media/Khmer_Rouge_Tribunal_Project_Information_English.pdf

630 Stover et al. *supra* note 525, at 525.

631 *Id.*

632 24 Aug. 2009 transcript, *supra* note 609 at 10.

633 13 July 2009 transcript, *supra* note 485 at 27 (continuing testimony of Nam Mon).

and that she was therefore “very excited, discomposed and nervous.”⁶³⁴

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.⁶³⁵ 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 1 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.⁶³⁶

Comparatively, in Case 002, approximately 200 Civil Parties organized a protest after the verdict, arguing that the “collective and moral” reparations projects granted in the judgment did not address the needs of Civil Parties directly and demanding compensation.⁶³⁷ Civil Party Chim Sim said:

[Without compensation] it means nothing to proceed to the next trial because the verdict will be the same. We will get nothing except becoming traumatized—psychological and emotional hurt deep inside our bodies.⁶³⁸

It is not known how much information their lawyers provided these Civil Parties about what reparations to expect, but it is clear that after two years of trial they retained unrealistic expectations that may have been a source of re-traumatization.

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

⁶³⁴ 9 July 2009 transcript, *supra* note 534 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.

⁶³⁵ Lawyers also need to be aware of available psychosocial services and make appropriate referrals to mental health professionals.

⁶³⁶ Interview with Terith Chy, DC-Cam Victim Participation Project Team Leader (Nov. 4, 2010).

⁶³⁷ See, e.g., Griff Tapper & Chanrasmeay, *Anger Toward Khmer Rouge Tribunal*, PHNOM PENH POST, Oct. 18, 2014.

⁶³⁸ Kuch Naren & Holly Robertson, *Victims Call from Money from ECCC*, CAMBODIA DAILY, Oct. 17, 2014.

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 re-traumatization. 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.”⁶³⁹ To a considerable extent, this is why courts like the ECCC were created. Further innovations and adaptations will be required to ensure that witnesses and Civil Parties in other internationalized proceedings are able to share their stories with minimum harm to themselves and minimum disruption to a fair and speedy trial.

⁶³⁹ Diane F. Orentlicher, *The Impact of the ICTY in Bosnia*, Open Soc’y Just. Initiative, at 87 (2010).

8

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

Judith Strasser (M.A.) was a senior advisor at the Civil Peace Service of the Deutsche Gesellschaft für Internationale Zusammenarbeit (GIZ) and was associated with the Transcultural Psychosocial Organization Cambodia (TPO).

Julian Poluda (M.D., DTMPH, M.Sc.) is a freelance consultant specializing in the areas of Conflict Transformation, Mental Health, and Psychosocial Interventions.

Chhim Sotheara (M.D., MPH) is Executive Director of the Transcultural Psychosocial Organization Cambodia (TPO).

Phuong Pham (Ph.D., MPH) was Director of Research, Human Rights Center, University of California, Berkeley.

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.⁶⁴⁰

It was very painful for me to recall my past . . . I felt so hopeless and lonely during that regime. It seems like opening an old wound and I feel pain over and over.⁶⁴¹

Psychosocial and human rights activists have long discussed the value of

⁶⁴⁰ 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). 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(S) JAMA 527 (2009).

⁶⁴¹ Interview with Case 001 Civil Party (Dec. 6, 2010) [hereinafter 6 Dec. 2010 Interview] (on file with author).

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. 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.⁶⁴² 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.”⁶⁴³

The Internal Rules of the Extraordinary Chambers in the Courts of Cambodia (ECCC) give victims a larger role in trial proceedings than any previous international criminal tribunal. Victim participation rights permit victims to play an active role in the legal proceedings, as Civil Parties with expansive procedural rights.⁶⁴⁴ 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 suggest that participation in trials may also re-traumatize victims.⁶⁴⁵ 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

⁶⁴² D. Mendeloff, *Trauma and Vengeance. Assessing the Psychological and Emotional Effects of Truth-telling in Post-Conflict*, 31 HUMAN RTS. Q. 592 (2009).

⁶⁴³ *Id.* at 616.

⁶⁴⁴ ECCC, Victim’s Unit, http://www.eccc.gov.kh/english/victims_unit.aspx.

⁶⁴⁵ U. Orth & A. Maercker, *Do Trials of Perpetrators Retraumatize Crime Victims?*, 19(2) J. INTERPERSONAL VIOLENCE 212 (2004).

of the ECCC when the tribunal started operating.⁶⁴⁶ 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,"⁶⁴⁷ or "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."⁶⁴⁸

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."⁶⁴⁹ 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.⁶⁵⁰

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.

⁶⁴⁶ In 2007, TPO signed an official Memorandum of Understanding with the ECCC outlining its responsibilities.

⁶⁴⁷ Interview with Civil Party of Case 001 (Dec. 2, 2010) [hereinafter 2 Dec. 2010 Interview] (on file with author).

⁶⁴⁸ 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/>

⁶⁴⁹ *Id.*

⁶⁵⁰ 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).

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 2007.⁶⁵¹ 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

⁶⁵¹ 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.

participation.⁶⁵² 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)⁶⁵³), 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. As a result, legal staff occasionally encountered survivors' emotional reactions and accounts, which lead to feelings of helplessness among both parties.⁶⁵⁴

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.⁶⁵⁵ Further, traumatic memories are often difficult to recollect as coherent verbal narratives.⁶⁵⁶ When dealing with traumatized victims, therefore, it is imperative to provide ample time and space and to have a certain level of knowledge about trauma symptoms in order 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

⁶⁵² 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.

⁶⁵³ 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).

⁶⁵⁴ Transcultural Psychosocial Organization [TPO], *Assessment on the Impact of NGO Outreach Activities in Stung Treng Province* (Feb. 22, 2008).

⁶⁵⁵ 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).

⁶⁵⁶ See C.L. WHITFIELD, *MEMORY AND ABUSE: REMEMBERING AND HEALING THE EFFECTS OF TRAUMA* (1995).

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 a form 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.”⁶⁵⁷ Likewise, another rejected Civil Party applicant stated: “I suggest that the lawyer keeps me informed and advises me on legal measures in this situation.”⁶⁵⁸

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.⁶⁵⁹

When I learnt about my rejection, I felt stuck, I felt like in the middle of nowhere.⁶⁶⁰

Perhaps the most distressing issue for many Civil Parties in Case 001 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 001 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,⁶⁶¹ 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 Chnang airport. This information was not included in my complaint file.⁶⁶²

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.⁶⁶³ The well-being of two Civil Parties whose applications were denied in Case 001 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.”⁶⁶⁴ 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.”⁶⁶⁵

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.”⁶⁶⁶ This statement reflects the importance in Cambodia's culture of spiritual bonds to deceased family members to help people cope with and make sense of personal losses.⁶⁶⁷

Finally, some Civil Parties indicated a loss of face, status, and honor 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 . . .

⁶⁵⁷ *Id.*

⁶⁵⁸ *Id.*

⁶⁵⁹ Interview with Case 001 Civil Party Applicant (Dec. 5, 2010) (on file with author).

⁶⁶⁰ Case 001 Civil Party Applicant, Remarks in a meeting at TPO (Oct. 29, 2010) [hereinafter Civil Party Applicant Remarks] (on file with author).

⁶⁶¹ Victims must prove that they and/or close relatives were victims of the security centre, S-21.

⁶⁶² Civil Party Applicant Remarks, *supra* note 660.

⁶⁶³ As reported by TPO staff and Civil Party lawyers.

⁶⁶⁴ Civil Party Applicant Remarks, *supra* note 660.

⁶⁶⁵ *Id.*

⁶⁶⁶ *Id.*

⁶⁶⁷ See A.C.M. Van de Put & M. Eisenbruch, *The Cambodian Experience*, in TRAUMA, WAR AND VIOLENCE (J. de Jong ed., 2002).

If I tell my family members about the rejection, they may tell this to others. I would feel even more ashamed.”⁶⁶⁸

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.⁶⁶⁹

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 001 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.”⁶⁷⁰

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 4,000 ECCC Civil Party applicants requested medical services, 16% expressed that infrastructure should be improved, 16% asked for the construction of schools,

⁶⁶⁸ Civil Party Applicant Remarks, *supra* note 660.

⁶⁶⁹ As reported by TPO staff.

⁶⁷⁰ KRT TRIAL MONITORING GROUP, ASIAN INT’L JUST. INITIATIVE, LESSONS LEARNT FROM THE ‘DUCH’ TRIAL 31 (Dec. 2010).

12% for individual reparations, and 13% for religious ceremonies.⁶⁷¹

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.⁶⁷² 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.⁶⁷³

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.⁶⁷⁴

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.”⁶⁷⁵

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,

⁶⁷¹ 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).

⁶⁷² ECCC, Internal Rules of the Extraordinary Chambers in the Courts of Cambodia, r. 23 *quinquies* (revised Feb. 23, 2011), available at http://www.eccc.gov.kh/english/internal_rules.aspx.

⁶⁷³ See Prosecutors v. Kaing, Case No. 001/18-07-2007-ECCC/TC, Civil Parties’ Co-Lawyers’ Joint Submission on Reparations, ¶ 46 (Sep. 14, 2009).

⁶⁷⁴ Interview with Case 001 Civil Party (Nov. 2, 2010) [hereinafter 2 Nov. 2010 Interview] (on file with author).

⁶⁷⁵ Interview with Case 001 Civil Party (Dec. 8, 2010) (on file with author).

headaches, and nausea. As a result, Civil Parties frequently asked for medical assistance.⁶⁷⁶ 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.⁶⁷⁷ 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.”⁶⁷⁸

Providing Testimony and Psychological Strains

Recounting Traumatic Events: Giving testimony is often cited as stressful and potentially re-traumatizing in human rights trials.⁶⁷⁹ 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.”⁶⁸⁰ 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.”⁶⁸¹

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.”⁶⁸² 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.”⁶⁸³

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 could be ensured for those Civil Parties who are in the courtroom.⁶⁸⁴ 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 questioned because of discrepancies between Civil Parties’ 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.”⁶⁸⁵ 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.”⁶⁸⁶

⁶⁸¹ *Id.*

⁶⁸² Interview with Case 001 Civil Party (Nov. 30, 2010) [hereinafter 30 Nov. 2010 Interview] (on file with author).

⁶⁸³ 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).

⁶⁸⁴ *Id.*

⁶⁸⁵ 30 Nov. 2010 Interview, *supra* note 682.

⁶⁸⁶ 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).

⁶⁷⁶ As reported by VSS staff.

⁶⁷⁷ 26 Nov. 2010 Interview, *supra* note 649.

⁶⁷⁸ *Id.*

⁶⁷⁹ *Id.*

⁶⁸⁰ *Id.*

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:⁶⁸⁷

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

⁶⁸⁷ *Id.* at 64.

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.⁶⁸⁸ 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.”⁶⁸⁹

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.”⁶⁹⁰ 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.⁶⁹¹

⁶⁸⁸ See Report Issue No. 11, *supra* note 683, at 6.

⁶⁸⁹ 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).

⁶⁹⁰ 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).

⁶⁹¹ R. Aldana, *A Victim-Centered Reflection on Truth Commissions and Prosecutions as a Response to Mass Atrocities*, 5(1) J. HUM. RTS. 116 (2006).

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.”⁶⁹² 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.”⁶⁹³

Requests for Forgiveness: The defendant’s “permissive or rehabilitative orientation”⁶⁹⁴ 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.⁶⁹⁵ 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.⁶⁹⁶ 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’ perceptions 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.”⁶⁹⁷ 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.”⁶⁹⁸ 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.⁶⁹⁹

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 of 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

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

693 2 Nov. 2010 Interview, *supra* note 674.

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

695 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 Lefeuve mentioned that she is not able to forgive the accused at this point. *Id.* Duch nonetheless asked for her forgiveness.

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

697 R. Aldana, *supra* note 691, at 117.

698 F.G. Murphy, *supra* note 692, at 267.

699 17 Aug. 2009 Transcript, *supra* note 695, at 42.

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.⁷⁰⁰

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,⁷⁰¹ 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."⁷⁰²

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."⁷⁰³ Indeed, it appears that the ECCC's acknowledgement of what victims lost and went through was psychologically significant for many Civil Parties.⁷⁰⁴ For instance, one Civil Party

⁷⁰⁰ 6 Dec. 2010 Interview, *supra* note 640.

⁷⁰¹ 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.

⁷⁰² 2 Nov. 2010 Interview, *supra* note 674.

⁷⁰³ J. O'Connell, *Gambling with the Psyche: Does Prosecuting Human Rights Violators Console Their Victims?*, 46 HARVARD INT'L L.J. 295, 319 (2005).

⁷⁰⁴ See C. Byrne, *Benefit or Burden: Victims' Reflections on TRC Participation*, 10(3) J. PEACE PSYCHOL. 237 (2004).

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.⁷⁰⁵

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."⁷⁰⁶ 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."⁷⁰⁷ 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 Sotheara.⁷⁰⁸

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."⁷⁰⁹

⁷⁰⁵ 2 Nov. 2010 Interview, *supra* note 674.

⁷⁰⁶ 26 Nov. 2010 Interview, *supra* note 648.

⁷⁰⁷ Cambodia Tribunal Monitor, Interview with Case 001 Civil Party Chum Mey, available at www.cambodiatribunal.org/blog/labels/Civil%20Parties.html.

⁷⁰⁸ In a conference organized by TPO and the Berlin Treatment Centre for Victims of Torture (BFZO) in Phnom Penh on 17 December 2010.

⁷⁰⁹ R. Aldana, *supra* note 691, at 113.

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-21.⁷¹⁰

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.”⁷¹¹ 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.”⁷¹² 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.”⁷¹³

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.”⁷¹⁴ 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.”⁷¹⁵

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.⁷¹⁶

Civil Parties, who participated in the ECCC’s first trial, frequently mention

710 30 Nov. 2010 Interview, *supra* note 682.

711 26 Nov. 2010 Interview, *supra* note 648.

712 2 Nov. 2010 Interview, *supra* note 674.

713 30 Nov. 2010 Interview, *supra* note 682.

714 *Id.*

715 2 Dec. 2010 Interview, *supra* note 672.

716 30 Nov. 2010 Interview, *supra* note 682.

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.”⁷¹⁷ 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.”⁷¹⁸

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.”⁷¹⁹

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

717 2 Dec. 2010 Interview, *supra* note 672.

718 *Id.*

719 2 Nov. 2010 Interview, *supra* note 674.

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."⁷²⁰

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.

Furthermore, 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.

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. 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 also 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 also as part of a larger social scheme to foster reconciliation and healing.

As emphasized by many survivors, responses to major life stresses depend on

⁷²⁰ *Id.*

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.

9

PARTICIPATION AS REPARATIONS: THE ECCC AND HEALING IN CAMBODIA

Toni Holness (J.D., M.A.) is Public Policy Counsel with the American Civil Liberties Union of Maryland.

Jaya Ramji-Nogales (J.D., LL.M) is the I. Herman Stern Professor of Law and Co-Director of the Institute for International Law and Public Policy at Temple University, Beasley School of Law.⁷²¹

In the final days of the trial of Kaing Guek Eav (Duch), Civil Party attorney Phillippe Canonne proposed that for his clients “the most valuable reparation [was] probably their very presence [in the Court].”⁷²² This chapter explores the question of whether victim participation in international criminal trials should be considered a form of reparation in and of itself. 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.⁷²³ The authors of these studies argue that participation runs counter to rehabilitative goals of reparations.⁷²⁴

Using the Extraordinary Chambers in the Courts of Cambodia (ECCC) as a

⁷²¹ 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 on an earlier version of this chapter. Thanks to Kunthy Seng for helpful research assistance.

⁷²² 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).

⁷²³ 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 why . . . war crimes tribunals . . . should not be viewed as vehicles for individual psychological healing . . . in the aftermath of genocide and ethnic cleansing.”).

⁷²⁴ 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).

case study, we explore in detail the various mechanisms for victim participation in these international criminal trials.⁷²⁵ The ECCC has been lauded for its groundbreaking approach to victim participation.⁷²⁶ This innovation is meaningful only to the extent that it has a positive impact on victims and Cambodian society more broadly. 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.⁷²⁷ In particular, community-based dialogues have offered some benefits for Cambodians—benefits unavailable through the current ECCC structure. We therefore argue that reconceptualization of participation as reparations is in order and that international criminal tribunals should aim to maximize the rehabilitative potential of victim participation throughout the trial process.⁷²⁸

Reparations at the ECCC

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.⁷²⁹ In this chapter, we focus on three definitional axes: goals,

⁷²⁵ 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 <http://www.eccc.gov.kh/english/caseInfo001.aspx>.

⁷²⁶ See, e.g., ECCC, *Germany Pledges More Financial Support to Maximise Victims' Participation in KR Trials* (June 17, 2010).

⁷²⁷ See also Mani, *supra* note 724, 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 (2005) (describing the importance of the process of awarding reparations in acknowledging harms, establishing social belonging by recipients, and increasing civic trust).

⁷²⁸ Brandon Hamber, *supra*, at 727 (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 723.

⁷²⁹ 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* 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 749, 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* 1, 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.”).

types, and mechanisms.⁷³⁰ Reparations are generally aimed at compensation, rehabilitation, reconciliation, satisfaction, or any combination of these goals.⁷³¹ Reparations can also be divided into several types: financial, spiritual or moral, rights-restoring, and society-reconstructing. Reparations may be implemented through individual or collective mechanisms.⁷³²

The ECCC may award only collective and moral reparations to Civil Parties before the Court; its Internal Rules explicitly proscribe the award of monetary payments to Civil Parties.⁷³³ Moreover, reparations are to be funded by perpetrators or through external donations.⁷³⁴ The limitation on the type of reparations and the mechanism through which they are implemented has become increasingly controversial.⁷³⁵ As more Cambodians expressed a preference for individual financial reparations, Civil Party lawyers asked the Court to create a reparations fund, either by obtaining financing from the Cambodian government or by establishing a voluntary trust fund through the Court’s Victims Unit.⁷³⁶ Faced with limited resources and high donor fatigue, the ECCC has repeatedly refused to establish these more costly types of reparations.

The ECCC’s limits on types of reparations and recipients stand in contrast to the Rome Statute of the International Criminal Court (ICC), which authorizes that court to provide for a broad range of reparations pursuant to the principles of

⁷³⁰ 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).

⁷³¹ 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-¶¶ 8-11, 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). These reparations may, of course, have other goals, but we focus here on those most relevant to the context of mass human rights abuses.

⁷³² David Gray, *Book Reviews*, 4 *INT’L J. TRANSIT’L JUST.* 296 (2010).

⁷³³ Extraordinary Chambers in the Courts of Cambodia, Internal Rules, (Rev 8) (adopted 3 August 2011) r. 23 *quinquies* [hereinafter ECCC Internal Rules]:

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:

An order to publish the judgment in any appropriate news or other media at the convicted person’s expense;

An order to fund any non-profit activity or service that is intended for the benefit of Victims; or other appropriate and comparable forms of reparation.

⁷³⁴ 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]; 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).

⁷³⁵ See, e.g., Kuch Naren and Holly Robertson, *Victims Call for Money from ECCC*, *CAMBODIA DAILY* (Oct. 17, 2014), available at www.cambodiadaily.com/news/victims-call-for-compensation-from-eccc-70135/.

⁷³⁶ Civil Parties’ Co-Lawyers’ Joint Submission on Reparations, Case No. 001/18-7/2007-ECCC/TC (Sept. 14, 2009).

restitution, compensation, and rehabilitation.⁷³⁷ 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.⁷³⁸

The ECCC's funding requirements have substantially restricted its ability to provide reparations. Even taking these constraints as a given, the ECCC was particularly miserly and unimaginative in its reparations awards for Case 001. Because Duch was indigent, the Civil Party teams suggested low-cost reparations (such as requiring Duch to write letters to the Government requesting a state apology) and avenues to raise funds for reparations (from the entrance fees for S-21 and the Choeung Ek killing fields). They also proposed innovative reparations projects that might have been made possible through such funding (such as psychological services to Civil Parties and the dedication of public buildings to named victims).⁷³⁹ Yet 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.⁷⁴⁰

The limited scope of reparations awarded in Case 001 gave rise to an amendment in the Court's internal rules to empower the Victims Support Section (Victims Unit) to “develop and implement non-judicial measures in the form of projects to address the broader interests of victims.”⁷⁴¹ As a result, in Case 002/01, the ECCC demonstrated greater creativity in its award of reparations, blessing the establishment of thirteen reparations projects, all of which were proposed by the victims' lawyers. We return to a more detailed discussion of these reparations in the section below on Civil Parties after a discussion of victim participation at the ECCC more broadly.

Victim Participation at the ECCC

In this section, we investigate the role of the ECCC in repairing trauma caused

⁷³⁷ Int'l Crim. Ct. (ICC), Rome Statute of the International Criminal Court, art. 75, U.N. Doc. A/CONF.183/9 (1998).

⁷³⁸ Rome Statute, *supra* note 737, 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*, at 225.

⁷³⁹ Appeal Against Judgment on Reparations by Co-Lawyers for Civil Parties-Group 2 (SCC, Nov. 2, 2010); Appeal of the Co-Lawyers for the Group 3 Civil Parties against the Judgment of 26 July 2010 (Oct. 25, 2010).

⁷⁴⁰ Prosecutors v. Kaing, Case No. 001/18-07-2007-ECCC/TC, at 240-41 (July 26, 2010); Patrick Falby, *Cambodia Khmer Rouge court leaves victims disappointed*, AFP (Sept. 13, 2010). For an excellent analysis of the political dimensions of this ruling, see John D. Ciorciari and Anne Heindel, *HYBRID JUSTICE: THE EXTRAORDINARY CHAMBERS IN THE COURTS OF CAMBODIA* 128-30 (2014).

⁷⁴¹ ECCC Internal Rules, r 12(3); see also Ciorciari and Heindel, *supra* note 740 at 226.

by the Khmer Rouge. In particular, we explore the concept of reparation as victim participation in international criminal trials by asking whether and how participation in the Court processes 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.⁷⁴²

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 001, the ECCC's Trial Chamber heard testimony from twenty-four witnesses, twenty-two Civil Parties, and nine experts. In the first trial of Case 002, the Trial Chamber sat for much longer—two hundred and twenty-two days, during which time it heard testimony from fifty eight witnesses, thirty-one Civil Parties, and three 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 offering testimony. On the sixty-fourth day of trial in Case 001, 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

⁷⁴² Brandon Hamber, *supra* note 727, at 149.

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.⁷⁴³

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.”⁷⁴⁴

At least two factors, however, rendered testimony before the Tribunal in Case 001 insufficient for providing reparative justice for Cambodians, collectively and individually. First, the Trial Chamber used its rules of conduct to discipline witnesses whose testimony strayed beyond the limited scope of the Chamber’s evidentiary needs.⁷⁴⁵ 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.


Courtroom Culture

The Court’s inquiries in Case 001 were restricted to its evidentiary needs—needs that did not always match the interests or preferences of victims. On numerous occasions, judges asked witnesses to restrain themselves emotionally 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-21 detention center, Mey used harsh language toward the accused, stating that Duch would not have seen the light of

⁷⁴³ 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].

⁷⁴⁴ 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].

⁷⁴⁵ ECCC Internal Rules, *supra* note 733, r. 85(1) (“The President may exclude any proceedings that unnecessarily delay the trial, and are not conducive to ascertaining the truth.”).



Villagers of Koh Nhek District, Monduliri Province, attending a village forum organized by the Documentation Center of Cambodia in July 2015 to raise awareness about the Khmer Rouge tribunal amongst villagers who do not have access to radio or television. The forums, usually organized in public places—such as commune office halls, village halls or Buddhist temples—are attended by villagers, students and local teachers. In these forums, survivors of the Khmer Rouge regime shared their life experiences with students who have no memory of the regime in order to foster discussion teach the history of the survivors. Photo by Ouch Makara/Documentation Center of Cambodia Archive

day had Duch beaten Mey personally.⁷⁴⁶ 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 gave 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.⁷⁴⁷ During his testimony, Sirath criticized the accused and questioned his 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-21 survivor.⁷⁴⁸ After testifying about being tortured and losing his wife at S-21, Meng became 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, Meng’s 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.”⁷⁴⁹ To be fair, the Tribunal judges are not the only culprits—lawyers also encumbered the process by asking

⁷⁴⁶ ECCC, Transcript of Trial Proceedings—Kaing Guek Eav “Duch,” Case File No. 001/18-07-2007-ECCC/TC, at 13 (June 30, 2009).

⁷⁴⁷ 20 Aug. 2009 transcript, *supra* note 745, at 28-29.

⁷⁴⁸ ECCC, Transcript of Trial Proceedings—Kaing Guek Eav “Duch,” Case File No. 001/18-07-2007-ECCC/TC, at 14 (July 1, 2009).

⁷⁴⁹ ECCC, Transcript of Trial Proceedings—Kaing Guek Eav “Duch,” Case File No. 001/18-07-2007-ECCC/TC, at 71 (Aug. 24, 2009).

repetitive, aggressive, and sometimes irrelevant questions of the witnesses.⁷⁵⁰

The Court has also limited its impact to date by being insensitive to gender concerns.⁷⁵¹ The ECCC’s failure to accommodate female victims 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.⁷⁵² 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 forcible sexual intercourse with a non-virgin as rape.⁷⁵³ Though Case 002/02 includes charges of forced marriage and rape, the Court may not be well prepared to handle prosecutions of gender crimes in a way that respects the victims’ emotional needs.⁷⁵⁴

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.⁷⁵⁵ 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.

Former Civil Party attorney Silke Studzinsky highlighted these problems to the Trial Chamber on November 23, 2009.⁷⁵⁶ 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

⁷⁵⁰ Patrick Falby, *supra* note 740. See, e.g., www.eccc.gov.kh/sites/default/files/documents/court/doc/E1_25.1_TR002_20120111_Final_EN_Pub.pdf (example of aggressive questioning by defense attorney Son Arun)

⁷⁵¹ Dinah Shelton, *The Gender of Reparations*, 32 HUM. RTS. Q. 447 (2010) (noting that tribunals often fail to consider gender issues when designing reparations).

⁷⁵² 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].

⁷⁵³ *Id.*

⁷⁵⁴ 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), available at <http://intlawgrrls.blogspot.com/2010/10/forced-marriage-and-khmer-rouge.html>. See also Sopenh Cheang, *Cambodia Khmer Rouge Genocide Tribunal Begins*, Huffington Post (Oct. 16, 2014), available at www.huffingtonpost.com/2014/10/16/cambodia-khmer-rouge-geno_n_6000958.html

⁷⁵⁵ 23 Nov. 2009 transcript, *supra* note 753.

⁷⁵⁶ *Id.* at 50.

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.

Inaccessible Structures

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 in Case 001 during the testimony of Sek Dan, a child medic at S-21.⁷⁵⁷ 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.⁷⁵⁸

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. First, 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. Second, the positioning of witnesses directly facing the judges has been criticized as being distracting and uncomfortable for Cambodians. Youk Chhang, the Executive Director of the Documentation Center of Cambodia explained, “Face to face is a Western way—it is not our culture.”⁷⁵⁹

In addition, the testimony of countless witnesses and Civil Parties was

⁷⁵⁷ 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].

⁷⁵⁸ 23 Nov. 2009 transcript, *supra* note 753.

⁷⁵⁹ Taing Kimlong, *Architecture of justice: Sketches of a historic day*, PHNOM PENH POST (Aug. 9, 2014), available at <http://phnompenhpost.com/post-weekend/architecture-justice-sketches-historic-day>.

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.⁷⁶⁰ This often frustrated the Chamber, which sternly reminded witnesses of the Court’s technological needs.

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.⁷⁶¹ 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, together with its physical structure and technologies rendered testimony before the Court inadequate as a form of reparation.

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.⁷⁶² 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.⁷⁶³ For example, a Civil Party generally has the right to not be questioned in the absence of his or her attorney.⁷⁶⁴ Civil Parties are also eligible for reparations unlike other participants in the proceedings.⁷⁶⁵

Participation as either a Civil Party or victim-complainant before the ECCC has thus far been inadequate as a reparation-providing measure for several reasons. Many Cambodians who suffered under the Khmer Rouge were unable to participate as Civil Parties because of the nature of criminal trials generally and

⁷⁶⁰ *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).

⁷⁶¹ 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).

⁷⁶² ECCC Internal Rules, *supra* note 735, r. 23(1).

⁷⁶³ *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).

⁷⁶⁴ *Id.* r. 59(2).

⁷⁶⁵ *Id.* r. 23(1)(b).

limitations in the ECCC's Internal Rules specifically. For those Cambodians able to engage directly with the Court as Civil Parties or victim-complainants, this Western-style criminal trial was difficult to understand and therefore failed to meet many of their expectations. Though the Court established a Victims Unit to collect and organize Civil Party claims and to facilitate Civil Party participation in the Court's proceedings, this branch was severely underfunded.⁷⁶⁶ It was unable to perform sufficient outreach to victims or even to process the complaints it received.⁷⁶⁷ Finally, as noted above, Internal Rule 23 substantially limits reparations.⁷⁶⁸ In particular, reparations hinge on the financial capacity of the accused or external funders; their form is limited to collective and moral reparations; and receipt can be had only by individuals designated as Civil Parties.⁷⁶⁹

Civil Party participation has not performed a reparative function for many Cambodians because only a select few are eligible to be Civil Parties.⁷⁷⁰ This is in part due to the limited scope of criminal trials, and in part due to limitations specific to the Court. The ECCC's Internal Rules require that Civil Parties establish suffering "as a direct consequence of at least one of the crimes alleged" in the relevant case.⁷⁷¹ Though these limits are reasonable from a criminal justice perspective, they are mystifying for many survivors. Even worse, the requirements were not made clear at the beginning of Case 001, leading the Trial Chamber to dismiss the claims of some applicants for Civil Party status for failure to prove a close bond of affection with or dependency on one of Duch's victims.⁷⁷² According to a survey of all Civil Party applicants resident in Cambodia, those denied Civil Party status felt helpless and worthless, and thought the rejection was "an injustice" not only to them, but also to their "dead relatives."⁷⁷³ Even the Civil Parties who were accepted stated, "If there is one Civil Party rejected, we are all feeling the pain."⁷⁷⁴

In Case 002, the Court took the opposite tack. Of the 3,988 Civil Parties

seeking to participate in Case 002, the Court declared 3,850 admissible.⁷⁷⁵ The Pre-Trial Chamber interpreted the Internal Rules more broadly than in Case 001, enabling Civil Parties to show simply a link between the injury and "one of the crimes alleged."⁷⁷⁶ This meant that applicants did not have to establish a connection with a specific list of crime sites but rather could rely upon their suffering from the implementation of the criminal policies charged, even if such crimes occurred in different locations. Yet only 32 of these Civil Parties were able to testify in Case 002/01. In August 2011, the ECCC amended its Internal Rules to require that Civil Parties be part of a single consolidated group represented by the Lead Co-Lawyers at trial.⁷⁷⁷ While this approach improves efficiency, it means that the needs of Civil Parties are not addressed individually, likely minimizing the rehabilitative effect of participation.⁷⁷⁸

Over 2,125 Civil Party applications have been filed in Cases 003 and 004.⁷⁷⁹ The Co-Investigating Judges interpreted the Internal Rules extremely stringently in Case 003, rejecting applicants who had been accepted as Civil Parties in previous cases. Though these inconsistent decisions have been discredited by the Pre-Trial Chamber, at least some of the harm to the applicants from these rejections remains.⁷⁸⁰

Despite being more engaged with the Court than most Cambodians, Civil Parties at Duch's trial had little understanding of the trial and mixed perceptions of the adequacy of the process. Only one-third of the Civil Parties reported that they understood what was happening during the trial, and more than a quarter stated that they had little or no understanding of the trial. One in three Civil Parties from the Duch trial said the hearings failed to meet their expectations. Most believed that the Court gave Duch too much time to explain himself, while giving victims insufficient time to tell their stories. Of greater concern, Civil Parties who reported greater understanding of and attendance at court proceedings viewed the trial less positively than those who were less knowledgeable and less

⁷⁶⁶ *Id.* r. 12.

⁷⁶⁷ Ciorciari and Heindel, *supra* note 740 at 205-07.

⁷⁶⁸ ECCC Internal Rules, *supra* note 733, r. 23 *quinquies*.

⁷⁶⁹ Unless paid by external funding. *See id.*

⁷⁷⁰ *See* ECCC Internal Rules, *supra* note 733, 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.").

⁷⁷¹ Internal Rules of the ECCC (rev. 5), *rev'd* Feb. 9, 2010, r. 23.

⁷⁷² 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].

⁷⁷³ Phuong N. Pham, Patrick Vinck, Mychelle Balthazard, Judith Strasser, and Chariya Om, *Victim Participation and the Trial of Duch at the Extraordinary Chambers in the Courts of Cambodia*, 3(3) J. HUM. RTS. PRACTICE 264, 274 (2011).

⁷⁷⁴ *Id.*

⁷⁷⁵ ECCC, *Pre-Trial Chamber overturns previous rejection of 98% of appealing Civil Party applicants in Case 002* (June 24, 2011), available at www.eccc.gov.kh/en/articles/pre-trial-chamber-overturns-previous-rejection-98-appealing-civil-party-applicants-case-002

⁷⁷⁶ Decision on Appeals Against Orders of the Co-Investigating Judges on the Admissibility of Civil Party Applications, Case No. 002/19-9-2007-ECCC/OCIJ (June 24, 2011).

⁷⁷⁷ Internal Rules of the ECCC, *rev'd* Aug. 3, 2011, r. 12.

⁷⁷⁸ *See* Ciorciari and Heindel, *supra* note 740, at 221-25 for a detailed discussion of the consolidated representation approach.

⁷⁷⁹ The Court Report—The Extraordinary Chambers in the Courts of Cambodia, October 2014, Issue 78, available at www.cambodiatribunal.org/wp-content/uploads/2014/11/ECCC_CourtReport78_20141030.pdf.

⁷⁸⁰ Ciorciari and Heindel, *supra* n. 740, at 215.

involved.⁷⁸¹ In terms of reparations as rehabilitation, none of the Cambodian Civil Parties at the Duch trial described a healing effect.⁷⁸²

Over time, the Tribunal has also limited the extent of participation for those selected as Civil Parties.⁷⁸³ Under the Court's Internal Rules, the consolidation of Civil Parties' representation in Case 002 means that all rights must be exercised through these lawyers.⁷⁸⁴ Given that the Civil Parties in Case 001 who testified found it empowering to address Duch directly, this limitation on the rights of Civil Parties to speak in person, though understandable from an efficiency perspective, has minimized the rehabilitative effect of victim participation.⁷⁸⁵

The chronic underfunding of the Victims' Unit has led to very low rates of victim participation, either as Civil Parties and victim complainants. 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 001.⁷⁸⁶ As of April 2015, the Victims Unit served a mere 3,867 Civil Parties in Case 002.⁷⁸⁷ This low level 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 who are knowledgeable about the existence of the ECCC may not have been sufficiently informed of their right to participate. Others who are familiar with the Court may find it irrelevant to their lives, or may be faced with other pressing daily 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 final critique of the reparative potential of victim complaints and Civil Party membership is the capacity of the Court to order reparations. As noted above, the ECCC Internal Rules stipulate that reparations are limited either to the financial means of the accused or must be paid through external funding.⁷⁸⁸ Survivors have proposed a range of collective reparations ranging from the

781 Phuon N. Pham, Patrick Vinck, Mychelle Balthazard, Judith Strasser, and Chariya Om, *Victim Participation and the Trial of Duch at the Extraordinary Chambers in the Courts of Cambodia*, 3(3) J. HUM. RTS. PRACTICE 264, 277 (2011).

782 Pham et al., *supra* n. 782 at 284.

783 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).

784 Ciorciari and Heindel, *supra* n. 740 at 219.

785 *Id.*

786 23 Nov. 2009 transcript, *supra* note 753. In Case 001, the defense team attempted to dismiss twenty-four of the ninety-three Civil Parties. Patrick Falby, *supra* note 752.

787 ECCC website, <http://www.eccc.gov.kh/english/default.aspx>.

788 ECCC Internal Rules, *supra* note 733, r. 22 *quinquies*.

construction of memorials to learning centers.⁷⁸⁹ 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."⁷⁹⁰ Therefore, faced with a defendant without financial resources and no external funding, the ECCC was unable to award any concrete reparations in Case 001. The defendants in Case 002/01 have also been declared indigent.⁷⁹¹

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.⁷⁹² This falls far short of meeting the reparative needs of Cambodians whose family members perished at Tuol Sleng.

In Case 002/01, Khmer Rouge survivors made a number of creative suggestions for reparations.⁷⁹³ Victims' lawyers proposed thirteen projects, eleven of which were approved by the Court.⁷⁹⁴ The Victim's Unit secured over US \$770,000 to fund these projects.⁷⁹⁵ The approved projects include sculptures, a national day of remembrance, self-help groups for rehabilitation, and educational materials.⁷⁹⁶ Despite the Court's approval of these projects, many Civil Parties have since denounced the projects' adequacy in providing meaningful reparations. A group of 200 Civil Parties issued a statement criticizing the projects as "worthless for victims and the Civil Parties."⁷⁹⁷ Civil Party Pen Soeun also denounced the projects for failing to reflect the desires of the victims. He believed the projects served the interests of NGOs that were exploiting Khmer Rouge survivors for the

789 26 July 2010 transcript, *supra* note 773, at ¶¶ 652, 654, 656-57 (July 26, 2010). See also A Conversation with Theary Seng, MUJESTIC, http://www.mujustic.com/theary_seng_case_002.

790 ECCC, Transcript of Trial Proceedings—Kaing Guek Eav "Duch," Case File No. 001/18-07-2007-ECCC/TC, at 115 (Aug. 17, 2009).

791 Khmer Rouge survivors protest at war crimes trial restart, World Bulletin, Oct. 17, 2014. Available at www.worldbulletin.net/world/146436/khmer-rouge-survivors-protest-at-war-crimes-trial-restart

792 26 July 2010 transcript, *supra* note 773, at ¶¶ 667-68.

793 George Wright, KR Victims Want Mass Grave for Regime Leaders, Cambodia Daily, Oct. 7, 2014, available at www.cambodiadaily.com/news/kr-victims-want-mass-grave-for-regime-leaders-69233/

794 *Supra* note 734. The Court endorsed the following 11 (out of the 13 proposed) reparations projects: a National Remembrance Day project; the construction of a memorial in Phnom Penh to honor victims of forced evacuations; a testimonial therapy project; self-help groups; a permanent exhibition; a mobile exhibition and education project; the inclusion of a chapter on forced population movement and executions at Tuol Po Chrey within the Cambodian school curriculum; the construction of a peace learning center; a booklet on adjudicated facts and Civil Party participation at the ECCC; two editions of the verdict in Case 002/01; and the inclusion of Civil Party names on the ECCC website. See also http://d.dccam.org/Projects/Living_Doc/pdf/Villagers_React_to_Verdict_in_Case_002-01.pdf p. 4-5

795 *Most ECCC Reparations Projects Secure Funding*, CAMBODIA DAILY (Apr. 22, 2014), available at www.cambodiadaily.com/archives/most-eccc-reparations-projects-securefunding-56910/.

796 www.eccc.gov.kh/en/articles/meaningful-reparation-khmer-rouge-victims

797 *Supra* note 734.

NGOs' own interests.⁷⁹⁸ He said, "They took the money, and I don't see anything helpful for us."⁷⁹⁹ Some of the protesters called for individual monetary reparations of \$13,500 for each family member who died during the reign of the Khmer Rouge. Bou Meng, a survivor of Tuol Sleng, proposed that the money was needed to hold Buddhist ceremonies in memory of those lost during the regime.⁸⁰⁰ This call for individual financial reparations is not unanimous—one survivor suggested, "If we give money to individuals, they will spend it all, but collective reparation can last for generations."⁸⁰¹ These concerns may speak to the challenges of satisfying a diverse group of survivors, but also raise the importance of ensuring that the perspectives of various victim groups are represented in reparations awards.

The Court's Internal Rules specifically proscribe the award of individual monetary payments.⁸⁰² Chim Sim, a Civil Party who was a victim of forced marriage under the regime, demanded that the verdict in Case 002/02 be postponed until the Court's rules are amended to allow compensation. He said, "[Without compensation,] it means nothing to proceed to the next trial because the verdict will be the same."⁸⁰³ Such an amendment to the rule has not yet been proposed to the Court.⁸⁰⁴

The experience of Civil Parties in Case 002/01 demonstrates that although undeniably well intentioned, Civil Party engagement in the design of reparations projects comes up short. The eleven thoughtful and diverse mechanisms for providing reparations to survivors approved by the Court can hardly be considered reparative when the Civil Parties—who themselves proposed the projects—deem the projects inadequate, insulting, even "worthless." To briefly conclude this section, the reparations awarded in both Case 001 and Case 002/01 failed to provide Civil Parties meaningful reparations.

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 being engaged by the Court or provided with a framework for understanding the proceedings. In Case 001 and 002, attendance at the trial failed to provide significant reparative relief for at least four reasons.

⁷⁹⁸ *Id.*

⁷⁹⁹ www.phnompenhpost.com/post-weekend/khmer-rouge-accused-pledge-boycott-trial

⁸⁰⁰ www.cambodiadaily.com/news/kr-victims-stage-protest-outside-tribunal-over-reparations-70257/

⁸⁰¹ http://d.dccam.org/Projects/Living_Doc/pdf/Villagers_React_to_Verdict_in_Case_002-01.pdf p. 34

⁸⁰² ECCC Internal Rules, r. 23(1);

⁸⁰³ *Supra* note 802.

⁸⁰⁴ *Id.*

First, attendance at trial re-traumatized some survivors. Chhim Sotheara, 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.⁸⁰⁵ Thus, even for those able to attend, viewing the trial may have been anti-reparative in the absence of adequate psychosocial support.

Second, the Internal Rules of the Tribunal limit observers' emotional expression during the trials. For example, during Case 001, the Court barred observers from wearing t-shirts marked "Case 002" while in the courtroom gallery.⁸⁰⁶ 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.⁸⁰⁷ The Court's enforcement of its regulation prohibiting such expression deprives the experience of observing the tribunal of any potential interactive reparative effect.

Third, the glass partition separating the audience from those participating in the Court creates a superficial barrier, which may interfere with the natural human connection that would otherwise occur. Youk Chhang stated, "The glass blocks the connection between people."⁸⁰⁸

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. While most participants in community dialogues do not interact directly with the

⁸⁰⁵ 25 Aug. 2009 transcript, *supra* note 742, at 28.

⁸⁰⁶ 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.

⁸⁰⁷ See Prosecutors v. Nuong, Case No. 002/19-09-2007/ECCC-PTC, Case Information Sheet, available at <http://www.eccc.gov.kh/english/case002.aspx>.

⁸⁰⁸ <http://phnompenhpost.com/post-weekend/architecture-justice-sketches-historic-day>

ECCC, this mechanism offers perhaps the highest level of individual engagement with the issues raised by the trials. Community dialogue efforts around Case 001 and 002 were organized and funded by non-governmental organizations. The Documentation Center of Cambodia's "Living Documents" project is an example of such efforts.⁸⁰⁹

To date, this project has enabled over seven thousand representatives of communes throughout Cambodia to tour the ECCC.⁸¹⁰ 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.⁸¹¹

The value of these dialogues cannot be overstated. After participating in a dialogue about Case 002/01, one participant stated that the screening of the Court's proceedings was helpful to her because her community was remote with no electricity and therefore unable to follow the Court's proceedings closely.⁸¹² In dialogues around Case 002/01, many participants stated that the dialogues provided them with not only critical information about the regime, but also clarification on the Court's proceedings.⁸¹³

These community dialogues are particularly important for communities that were targeted based on demographic characteristics. Case 002/01 centered on the Khmer Rouge's targeting of ethnic Cham Muslims and ethnic Vietnamese. The case also addressed gender-based crimes, including rape and forced marriage.⁸¹⁴ An estimated half a million Cham were murdered during the regime.⁸¹⁵ According

to Vann Math, head of the Cambodia Islamic Association, the Khmer Rouge ruthlessly targeted Chams and destroyed mosques. As a result, many Cham Muslims avidly followed the Court's proceedings.⁸¹⁶ Ethnic Vietnamese were also singled out and targeted by the Khmer Rouge—an estimated 20,000 Vietnamese were killed under the Khmer Rouge.⁸¹⁷ Hundreds of thousands of ethnic Vietnamese were forced to flee to Vietnam and almost all those who remained were executed.⁸¹⁸ Case 002/01 also finally gave due acknowledgment to the suffering experienced by women during the Khmer Rouge. The sensitive, even taboo, nature of forced marriage and allegations of rape necessitated a personal and intimate mechanism for addressing the suffering of women during the regime. For the Cham Muslims, ethnic Vietnamese, and women, the shared experience of persecution based on their demographic characteristics enhances the value of community dialogue.

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 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.⁸¹⁹ Similarly, another villager, Som Chhoam of the Kraing Leave 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.⁸²⁰ 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.⁸²¹

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.⁸²² It

809 *Living Documents*, DOCUMENTATION CTR. OF CAMBODIA, www.dccam.org/Projects/Living_Doc/Living_Documents.htm.

810 DOCUMENTATION CTR. OF CAMBODIA, DC CAM ANNUAL REPORT 2010 21 (2010), www.dccam.org/About/Annual/pdf/DC-Cam_2010_Annual_Report.pdf.

811 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.

812 http://d.dccam.org/Projects/Living_Doc/pdf/Villagers_React_to_Verdict_in_Case_002-01.pdf p. 25

813 http://d.dccam.org/Projects/Living_Doc/pdf/Villagers_React_to_Verdict_in_Case_002-01.pdf p. 6

814 www.cambodiadaily.com/news/second-trial-against-kr-leaders-begins-70275/

815 <http://online.wsj.com/articles/khmer-rouge-genocide-trial-resumes-in-cambodia-1413509448>

816 www.huffingtonpost.com/2014/10/16/cambodia-khmer-rouge-geno_n_6000958.html

817 <http://online.wsj.com/articles/khmer-rouge-genocide-trial-resumes-in-cambodia-1413509448>

818 Ruth Rubio-Marin, *Gender and Collective Reparations in the Aftermath of Conflict and Political Repression*, in *THE GENDER OF REPARATIONS* 381, 399 (2009).

819 Savina Sirik, *The Duch Verdict: A DC-Cam Report from the Villages*, DOCUMENTATION CTR. OF CAMBODIA, at 17 (July 26, 2010).

820 Savina Sirik, *Village Meeting: Fear Reduced Among Khmer Rouge Lower Level Cadres*, DOCUMENTATION CTR. OF CAMBODIA (Mar. 23, 2010).

821 DC-CAM ANNUAL REPORT 2010, *supra* note 813, at 25.

822 *See, e.g.*, Savina Sirik, *The Duch Verdict: A DC-Cam Report from the Villages*, *supra* note 816, at 12 (noting that in Banteay Meanchey, conversations continued after the team left).

appears that these community dialogues may have created the most significant and lasting reparative impact around the Court's two cases.

Conclusions & Recommendations

Though the experience of victims participating in Case 001 and Case 002/01 to date can hardly be categorized as reparative, a more carefully structured process could offer rehabilitative promise. 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.⁸²³ 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 this 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.⁸²⁴ 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.⁸²⁵ Moreover, from a procedural perspective, victim testimony can contribute to a more inclusive deliberative process.⁸²⁶ This process and dialogue are key to societal rehabilitation, also known as transformative justice.⁸²⁷

From a transformative justice perspective, our central critique of the ECCC's Civil Party approach to participation 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.⁸²⁸ This critique applies equally to other post-conflict justice mechanisms in which the particular violations charged and the testifying victims represent a small portion of all the harms committed.⁸²⁹ Even among those accepted as Civil Parties, a court might treat different groups of Civil Parties differently, leading to perceptions of injustice.⁸³⁰

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.⁸³¹ 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.⁸³² Moreover, the victim-perpetrator dichotomy may further entrench post-conflict social divisions.⁸³³ 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.⁸³⁴ For example, USAID recently funded the Transcultural Psychosocial Organization Cambodia (TPO) to provide mental health services for communities in 15 provinces who suffered harm during the Khmer Rouge.⁸³⁵

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.⁸³⁶ 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."⁸³⁷ 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.⁸³⁸ We, therefore, recommend that Civil Party involvement be complemented by community dialogues that enable truth-telling, dialogue between victims and

⁸²⁸ *Id.* at 68.

⁸²⁹ *Id.* at 68.

⁸³⁰ Ruben Carranza, *Practical, Feasible and Meaningful: How the Khmer Rouge Tribunal Can Fulfill its Reparations Mandate*, INT'L CTR. TRANSITIONAL JUST. (Nov. 10, 2009).

⁸³¹ David Gray, *supra* note 825.

⁸³² Rama Mani, *supra* note 725, at 68.

⁸³³ *Id.* at 67.

⁸³⁴ David Gray, *Book Reviews*, 4 INT'L J. TRANSITIONAL JUST. 296, 297 (2010).

⁸³⁵ USAID Announced Project to Promote Healing and Reconciliation for Victims of Torture of the Khmer Rouge. US Embassy in Cambodia. 16 August 2016.

⁸³⁶ M. Brinton Lykes & Marcie Mersky, *Reparations and Mental Health: Psychosocial Interventions Towards Healing, Human Agency, and Rethreading Social Realities*, in THE HANDBOOK OF REPARATIONS 589, 592-93 (Pablo de Greiff, ed., 2006). See also Rama Mani, *supra* note 725, at 71-72.

⁸³⁷ M. Brinton Lykes & Marcie Mersky, *supra* note 837, at 600.

⁸³⁸ *Id.* at 601.

⁸²³ 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).

⁸²⁴ 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).

⁸²⁵ Rubio-Marin, *Introduction*, *supra* note 821.

⁸²⁶ Rubio-Marin, *Gender and Collective Reparations in the Aftermath of Conflict and Political Repression*, *supra* note 821, at 400.

⁸²⁷ David Gray, *supra* note 826. Rama Mani, *supra* note 726, at 78-80.

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.⁸³⁹

10

THE IMPORTANCE OF MASS TRAUMA EVIDENCE IN ACCOUNTABILITY BEFORE THE ECCC

Nushin Sarkarati (J.D.) is a Staff Attorney at the Center for Justice and Accountability.

Kathy Roberts (J.D., Ph.D.) is CJA's Legal Director.

Mass atrocity crimes inflict profound and widespread psychological injury on victim populations. The trauma that results is not a discrete injury limited to direct victims, but one that passes through families, communities and generations. If unaddressed, it inhibits entire populations from making the transition from periods of conflict to sustained peace. Despite the proliferation of mass trauma research and studies linking psycho-social harm to various traumatic events within periods of conflict, the causal relationship between atrocity crimes and mass trauma has not been well developed by international criminal courts and tribunals. As a result, findings on the broad psychological impact of atrocity crimes on victim communities have not—at least until recently—been a significant part of the trial judgments issued against the perpetrators of these crimes. The Extraordinary Chambers in the Courts of Cambodia (“ECCC”) reversed this trend in its second case, Case 002/1, when it demonstrated that the mental trauma experienced by victims and their families can play a significant role in mass atrocity trials in a number of ways. Indeed, evidence developed on this psychological impact during the ECCC’s Victim Impact Hearing formed a key part of the Court’s understanding of the gravity of the crimes and led to a sentence of life imprisonment for the two senior leaders on trial in Case 002/1.⁸⁴⁰

In a week-long hearing at the close of Case 002/1, the ECCC’s Trial Chamber heard statements by Civil Parties on the extent of their continued suffering and expert testimony from Dr. Chhim Sotheara, a leading Cambodian expert on mental trauma related to Khmer Rouge atrocities. The impact hearing was widely publicized and broadcast throughout Cambodia, providing an opportunity for much needed

⁸³⁹ 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).

⁸⁴⁰ See *Co-Prosecutors v. Nuon Chea & Khieu Samphan*, Case File No. 002/19-09-2007-ECCC/TC, Case 002/1 Judgment [hereinafter “Case 002/1 Judgment”], at 1073-78, 1105-07, 1141-50, (Aug. 7, 2014), available at www.eccc.gov.kh/en/document/court/case-00201-Judgment.

education about the ongoing and often unaddressed mental harm that continues to impact Cambodians today. Although psychological harm evidence has been utilized by other international tribunals in a few cases, the ECCC's development of such evidence in the Victim Impact Hearing provides a compelling example of its effectiveness and importance for sentencing and reparation purposes, and will likely inspire such evidence to be broadly developed by other courts as well as in future proceedings before the ECCC.

Path-breaking though it was, an examination of the Victim Impact Hearing reveals some shortcomings in exposing the link between mass atrocities and the ongoing suffering of the victims of these crimes. Specifically, in spite of the high volume of scientific studies conducted on the psychiatric outcomes from trauma among Cambodian survivors, few of these findings were presented before the ECCC, with Civil Party lawyers instead choosing to focus their questions on anecdotal evidence or individual statements of traumatic events. Although understandable, this approach drew justified challenges to relevance and methodology and deprived the Court of the opportunity to render more significant judicial findings on the issue of mental trauma.

The second trial against senior leaders in Case 002/2 provides an opportunity to make more effective use of evidence relating to psychological harm across victim populations and to prove the link between crimes of the Khmer Rouge and the ongoing suffering of millions of Cambodians. This chapter will provide an overview of the innovative method of presenting psychological trauma evidence developed in Case 002/1 before the ECCC and compare it with that used in other courts, with particular attention to the trial of Congolese warlord Thomas Lubanga Dyilo before the International Criminal Court ("ICC"). It will then offer suggestions for structuring such evidence for future proceedings. Specifically, the authors recommend the development of written and oral expert testimony in future trials that will establish the link between atrocity crimes and mass trauma by use of population-based studies, expertise with the victim population, the international body of psychological research on the impact of the specific crimes, and ideally, epidemiological studies. It is hoped that these ideas will inform future efforts to present evidence of the psychological impact on victims in order to prove the gravity of the crimes for sentencing and determine the appropriate remedy or reparations in criminal proceedings.

Background on Case 002 and Victim Participation before the ECCC

Case 002 was initially brought against four senior leaders of the Khmer Rouge regime for a wide range of offences, including genocide, crimes against humanity,

grave breaches of the Geneva Conventions and offences under Cambodian domestic law committed from April 17, 1975 until the fall of the regime in January 1979.⁸⁴¹ Due to the broad scope of the crimes charged, as well as increased public awareness and outreach to victims, over 4,000 victims applied to be Civil Parties and 3,867 victims were admitted to participate in the trial and seek reparations.⁸⁴² From the beginning, Case 002 was anticipated to be one of the largest, most complex international criminal trials conducted to date, with parties seeking to call 1,054 witnesses, experts, and Civil Parties at trial and to tender over 7,600 documents and other materials as evidence.⁸⁴³ However, given the immensity of the trial and the advanced age and physical frailty of the surviving accused, the Court severed Case 002 into two smaller trials, covering discrete claims and crime bases.⁸⁴⁴

The first trial, known as Case 002/1, reached judgment on August 7, 2014. The Trial Chamber found Nuon Chea and Khieu Samphan guilty of crimes against humanity committed during the forced evacuation of Phnom Penh, the subsequent forced transfer of the population, and the executions of members of the Lon Nol regime at Tuol Po Chrey in Pursat. The accused were sentenced to life imprisonment.⁸⁴⁵ The trial included twenty months of evidentiary hearings and concluded with a Victim Impact Hearing during which the Chamber received evidence on the physical, psychological, and material harm experienced by victims of the specific crimes in Case 002/1. The second case against the two senior leaders, known as Case 002/2, began on 17 October 2014 and includes the remaining crimes charged in the original Closing Order, which apply to a broader

⁸⁴¹ Co-Prosecutors v. Nuon Chea, et al., Case File No. 002/19-09-2007-ECCC-OCIJ, Closing Order, 331-390 (15 September 2010), available at www.eccc.gov.kh/sites/default/files/documents/courtdoc/D427Eng.pdf.

⁸⁴² See *ECCC at a Glance*, ECCC (April 2014), www.eccc.gov.kh/sites/default/files/ECCC%20at%20a%20Glance%20-%20EN%20-%20April%202014_FINAL.pdf (providing figures on victim participation and figures on the Court's outreach initiatives).

⁸⁴³ Co-Prosecutors v. Nuon Chea & Khieu Samphan, Case File No. 002/19-09-2007/ECCC/TC, Trial Chamber Decision on Severance following Supreme Court Chamber Decision of 8 February 2014, ¶ 5 (26 April 2013), available at http://www.eccc.gov.kh/sites/default/files/documents/courtdoc/2013-04-26%2016:43/E284_EN.PDF.

⁸⁴⁴ Co-Prosecutors v. Nuon Chea & Khieu Samphan, Case File No. 002/19-09-2007-ECCC/TC, Severance Order Pursuant to Internal Rule 89ter, ¶ 8 (Sept. 22, 2011), available at www.eccc.gov.kh/en/document/court/severance-order-pursuant-internal-rule-89ter.

⁸⁴⁵ See Case 002/1 Judgment, *supra* note 841, at 622.

class of victims.⁸⁴⁶

The ability of victims to participate directly in criminal trials as Civil Parties and to request reparations are key components of the ECCC's adjudicatory process. To be admitted as a Civil Party before the ECCC, a victim 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."⁸⁴⁷ In Case 002, 3,867 victims were admitted as Civil Parties, with rights to seek reparations before the Court. The ECCC's reparation system is designed to "a) acknowledge the harm suffered by Civil Parties as a result of the commission of the crimes for which an Accused is convicted and b) provide benefits to the Civil Parties which address this harm."⁸⁴⁸ The Court's reparations are limited to collective or moral awards, benefiting a large number of victims and seeking to repair moral rather than material harms, such as harm resulting from physical suffering, loss of dignity, psychological trauma, harm to private and family life, harm to reputation, harm to traditions and culture, loss of freedom or liberty, loss of future life prospects, and loss of enjoyment of life.⁸⁴⁹ Due to the large volume of victims, individual Civil Parties are organized as part of a consolidated group made up of all victims participating in Case 002 and the request for reparations is submitted as a single request on behalf of this consolidated group.⁸⁵⁰

⁸⁴⁶ The crime sites and factual allegations in Case 002/2 were restricted from the number of crime sites and factual allegations that originally formed the basis of Case 002. These include: Genocide against the Cham and the Vietnamese (excluding crimes committed by the Revolutionary Army of Kampuchea on Vietnamese territory); Forced marriages and rape (nationwide); Internal purges; S-21 Security Centre; Kraing Ta Chan Security Centre, Au Kanseng Security Centre and Phnom Kraol Security Centre; 1st January Dam Worksite; Kampong Chhnang Airport Construction site, Trapeang Thma Dam Worksite; Tram Kok Cooperatives; Treatment of Buddhists (limited to Tram Kok Cooperatives); and targeting of former Khmer Republic Officials (implementation limited to Tram Kok Cooperatives, 1st January Dam Worksite, S-21 Security Centre and Kraing Ta Chan Security Centre). See Co-Prosecutors v. Nuon Chea & Khieu Samphan, Case File No. 002/19-09-2007-ECCC/TC, Decision on Additional Severance of Case 002/02 and Scope of Case 002/02 (April 4, 2014) available at www.eccc.gov.kh/en/document/court/decision-additional-severance-case-00202-and-scope-case-00202.

⁸⁴⁷ Internal Rules of the Extraordinary Chambers in the Courts of Cambodia (rev. Jan. 16, 2015) [hereinafter "ECCC Internal Rules"], r. 23bis(1)(b).

⁸⁴⁸ *Id.* at r. 23quinquies(1).

⁸⁴⁹ See ECCC Civil Party Lead Co-Lawyers Section, Guidebook on Judicial Reparations in Case 002/02 before the ECCC, at 2 (Nov. 13, 2014), available at www.eccc.gov.kh/en/document/court/annex-2-guidebook-judicial-reparations-case-00202-eccc; Prosecutor v. Kaing Guek Eav alias Duch, Case File No. 001/18-07-2007-ECCC/SC, Appeal Judgment, ¶658 (Feb. 3, 2012), available at www.eccc.gov.kh/en/document/court/case-001-appeal-judgment.

⁸⁵⁰ ECCC Internal Rules, *supra* note 848, r. 23(3) ("At the pre-trial stage, Civil Parties participate individually. Civil Parties at the trial stage and beyond shall comprise a single, consolidated group, whose interests are represented by the Civil Party Lead Co-Lawyers as described in IR 12 ter. The Civil Party Lead Co-Lawyers are supported by the Civil Party Lawyers described in IR 12 ter (3). Civil Party Lead Co-Lawyers shall file a single claim for collective and moral reparations.").

Victim Impact Hearings Before the ECCC in Case 002/1

For judicial reparations, lawyers representing Civil Parties must work to establish a nexus between the harm suffered by the consolidated group of Civil Parties and the crimes upon which the accused is convicted.⁸⁵¹ Before a decision on reparations can be made, Civil Party Lawyers must first present evidence of the harm suffered by the Civil Parties and the relationship between this harm and the crimes alleged at trial. A request for reparations is then made that addresses these harms.⁸⁵² The Victim Impact Hearing is designed to provide the evidence necessary to establish this nexus. Moreover, evidence of the lasting impact of these crimes on the Cambodian people is a relevant factor in determining the gravity of the crime for the purpose of sentencing the accused as well as the issuance of appropriate reparations.⁸⁵³ In a week-long hearing open to the public, fifteen representative Civil Parties were selected to recount the physical, psychological, and material harm they suffered under the Khmer Rouge regime, followed by the expert testimony of Dr. Chhim Sotheara, who discussed the connection between the traumatic events under the Khmer Rouge and the immediate and ongoing psychological harm of the victims.⁸⁵⁴

In a statement issued by then Lead Civil Party Lawyers, Pich Ang and Elisabeth Simonneau Fort, the purpose of the Victim Impact Hearing in Case 002/1 was primarily

... to provide the Trial Chamber with detailed, concrete and compelling evidence on the impact (suffering) experienced by Civil Parties as a consequence of the crimes alleged to have taken place in Democratic Kampuchea, particularly that evidence on impact (suffering) which relates to the crimes being tried in Case 002/01: forced transfer phases 1 and 2 and the executions at Tuol Po Chrey. This evidence will assist the Trial Chamber in assessing the gravity of the crimes, placing them in their proper context, and determining the appropriateness of the reparations claimed

⁸⁵¹ The ECCC also offers non-judicial measures, which are projects to benefit victims of the Khmer Rouge regime, administered by the Victim Support Section of the Court. These measures are not linked to the conviction of a crime, nor are they limited to Civil Parties. See *Victim Support Section (VSS) Structure*, ECCC, www.eccc.gov.kh/en/victims-support/vss-structure (last visited May 1, 2016).

⁸⁵² ECCC Internal Rules, *supra* note 850, r. 23quinquies(2) (The reparations request is made as a single submission to the Court, on behalf of the consolidated group of victims, in a submission that states "a) a description of the awards sought; b) reasoned argument as to how they addresses the harm suffered and specify, where applicable, the Civil Party group within the consolidated group to which they pertains; and c) in relation to each award, the single, specific mode of implementation described in Rule 23quinquies(3)(a)-(b) sought.").

⁸⁵³ Case 002/1 Judgment, *supra* note 841, at ¶1073.

⁸⁵⁴ See Case 002/1 Judgment, *supra* note 841, at ¶1142.



People of Banteay Ampril District, Oddar Meanchey Province, watching a live screening verdict of Case 002/01 in August 2014 organized by the Documentation Center of Cambodia (DC-Cam). During the announcement of the verdict, DC-Cam staff travelled to every corner of the country to set up live screenings of the verdict for people who could not otherwise hear the verdict. The verdict sentenced Khieu Samphan and Nuon Chea to life imprisonment for crimes against humanity. Photo by Ouch Makara/Documentation Center of Cambodia Archive

to remedy these harms. Accordingly, the Hearings on Impact are an essential mechanism for bringing the human toll of these crimes into the proceedings.⁸⁵⁵

Through the course of the hearing, the Civil Parties described a wide array of traumatic events, detailing their material, psychological, and physical harm over the course of the hearing.⁸⁵⁶ With respect to crimes committed during the evacuation of Phnom Penh, the Civil Parties testified to the trauma of being forced to abandon their homes, under threat of violence, and to leave behind most of their material possessions, including items of sentimental value that made up part of their personal identity.⁸⁵⁷ Victims described the evacuation as grueling, forcing them to travel out of the city on foot in journeys that lasted up to one month, with few supplies to aid them. Most described being forced to walk long distances under the heat of the sun with no shelter while experiencing severe pain from hunger, thirst, and exhaustion.⁸⁵⁸ Some Civil Parties described how their family members fell ill during the journey, and one described being forced to bury her youngest child, a nine-month old baby, who died during the evacuation.⁸⁵⁹ The victims described being “terrified and shocked” at the sight of seeing corpses⁸⁶⁰

⁸⁵⁵ *The Purpose of Hearing Victims' Suffering*, ECCC Public Affairs Section (June 7, 2013), www.eccc.gov.kh/en/blog/2013/06/07/purpose-hearing-victims-suffering.

⁸⁵⁶ See, e.g., ECCC, Transcript of Trial Proceedings - Nuon Chea & Khieu Samphan Case File No. 002/19-09-2007-ECCC/TC [hereinafter “Case 002/1 Trial Transcript”], at 105-106 (Nov. 14, 2012) (Testimony of Civil Party Mr. MEAS Saran) (all Case 002 Transcripts are available at www.eccc.gov.kh/en/Case002-Transcripts/en); Case 002/1 Trial Transcript, at 11 (May 27, 2013) (Testimony of Civil Party Ms. SOU Sotheavy); Case 002/1 Trial Transcript, at 93 (May 29, 2013) (Testimony of Civil Party Ms. CHHENG Eng Ly); Case 002/1 Trial Transcript, at 71 (May 29, 2013) (Testimony of Civil Party Ms. HUO Chantha); Case 002/1 Trial Transcript, at 45 (May 30, 2013) (Testimony of Civil Party Ms. SOPHAN Sovany); Case 002/1 Trial Transcript, at 96 (30 May 2013) (Testimony of Civil Party Ms. PO Dina). See also Case 002/1 Judgment, *supra* note 841, ¶ 466 (Section 10: Movement of the Population (Phase One), ¶ 1144 (Section 19.4 Harm Suffered by the Civil Parties)).

⁸⁵⁷ See, e.g., Case 002/1 Trial Transcript, at 19-20, (June 4, 2013) (Testimony of Civil Party Ms. BAY Sophany); Case 002/1 Trial Transcript, at 11 (May 30, 2013) (Testimony of Civil Party NOU Hoan); see also Case 002/1 Judgment, *supra* note 876, ¶ 1144.

⁸⁵⁸ See, e.g., Case 002/1 Trial Transcript, at 87, 92 (Oct. 23, 2012) (Testimony of Civil Party Ms. LAY Bony); Case 002/1 Trial Transcript, at 6-7 (May 30, 2013) (Testimony of Civil Party Mr. NOU Hoan); Case 002/1 Trial Transcript, at 9 (June 4, 2013) (Testimony of Civil Party Ms. BAY Sophany); Case 002/1 Trial Transcript, at 100 (Nov. 2, 2012) (Testimony of Civil Party Ms. OR Ry); Case 002/1 Trial Transcript, at 24 (Dec. 5, 2012) (Testimony of Civil Party Ms. PECH Srey Phal); Case 002/1 Trial Transcript, at 100 (Dec. 5, 2012) (Testimony of Civil Party Mr. KIM Vandy); Case 002/1 Trial Transcript, at 16 (May 27, 2013) (Testimony of Civil Party MS. SOU Sotheavy); Case 002/1 Trial Transcript, at 77 (May 27, 2013) (Testimony of Civil Party Mr. YOS Phal); Case 002/1 Trial Transcript, at 34 (May 27, 2013) (Testimony of Civil Party Mr. AUN Phally); Case 002/1 Trial Transcript, at 88 (May 30, 2013) (Testimony of Civil Party Mr. YIM Roumdoul); Case 002/1 Trial Transcript, at 96, 98 (May 30, 2013) (Testimony of Civil Party Ms. PO Dina); Case 002/1 Trial Transcript, at 97 (June 4, 2013) (Testimony of Civil Party Ms. SENG Sivutha); see also Case 002/1 Judgment, *supra* note 841, ¶¶ 491, 1145.

⁸⁵⁹ Case 002/1 Trial Transcript, at 12 (June 4, 2013) (Testimony of Civil Party Ms. BAY Sophany).

⁸⁶⁰ Case 002/1 Trial Transcript, at 82 (Oct. 19, 2012) (Testimony of Civil Party Ms. YIM Sovann); Case 002/1 Trial Transcript, at 92 (Oct. 23, 2012) (Testimony of Civil Party Ms. LAY Bony).

and experiencing ongoing nightmares and recurring memories of the traumatic events.⁸⁶¹

The Trial Chamber permitted Civil Parties to express general statements of suffering, describing the overall harm suffered as a result of their experience under the Khmer Rouge regime, without differentiating the harm they suffered as a consequence of any specific crime within the scope of the proceedings.⁸⁶² Not only did the testimony help the Court to evaluate the magnitude of harm experienced by the victims, but the statements also contributed to a greater understanding and recognition of victim harm amongst Cambodian survivors in country and in the diaspora. In fact, the Civil Party lawyers acknowledged that such education and awareness was another significant impact of the hearing:

[T]hough not the *raison d'être* for these hearings, another undeniably important aspect of these hearings is the opportunity they provide for at least a limited number of Civil Parties to tell their stories in an official, judicial setting with the presence of (and sometimes exchange with) one or more of the Accused. Under the right circumstances, this can be a meaningful, empowering and healing experience for Civil Parties wherein the process itself provides a reparative benefit—in the broader meaning of the term.⁸⁶³

The reparative benefits of such hearings are further discussed in chapter eight in this volume.

The Expert Testimony of Dr. Chhim Sotheara

The Victim Impact Hearing concluded with the expert testimony of Dr. Chhim Sotheara, the director of the Transcultural Psychosocial Organization (“TPO”), Cambodia’s leading NGO in the field of mental health care and psychosocial support, and one of the few Cambodian experts on trauma relating to Khmer Rouge atrocities. As a clinical psychologist and academic, Dr. Sotheara

⁸⁶¹ Case 002/1 Trial Transcript, at 106 (Dec. 13, 2012) (Testimony of Civil Party Ms. Denise AFFONÇO); Case 002/1 Trial Transcript, at 21 (June 4, 2013) (Testimony of Civil Party Ms. BAY Sophany).

⁸⁶² See, e.g., Case 002/1 Trial Transcript, at 87-88 (Jan. 11, 2012) (Testimony of Civil Party Mr. KLAN Fit) (indicating that the Chamber granted an opportunity to Klan Fit, “as a Civil Party, to express [his] suffering and harms [he has] incurred during the Democratic Kampuchea period”); see also Case 002/1 Trial Transcript, at 27-28 (Aug. 29, 2012) (Testimony of Civil Party Mr. EM Oeun) (The Chamber permitted the Civil Party to voice sufferings and grievance during the period of Democratic Kampuchea from the 17th of April 1975 through the 6th of January 1979); see also Case 002/1 Trial Transcript, at 74 (Oct. 19, 2012) (Testimony of Civil Party Ms. YIM Sovann) (same).

⁸⁶³ *The Purpose of Hearing Victims' Suffering*, ECCC Public Affairs Section (June 7, 2013), www.eccc.gov.kh/en/blog/2013/06/07/purpose-hearing-victims-suffering.

was uniquely positioned to provide expertise based on his work directly with survivors of the Khmer Rouge regime, as well as provide information on the relevant research conducted on the victims of the regime in general. Moreover, TPO serves a large number of Civil Parties participating in the first and second trial before the ECCC (Case 001 and Case 002). Dr. Sotheara's testimony was used to support findings of fact and law throughout the Final Judgment against the two accused. Significantly, the Court cited Dr. Sotheara's statements in its determination of the effect of the evacuation of Phnom Penh on victims, the seriousness of the acts committed by the accused, the gravity of the crimes, and the ongoing impact or harm of victims for the purpose of reparations.⁸⁶⁴

Dr. Sotheara's testimony began with a broad overview of the trauma-related symptoms he recognized amongst Cambodian survivors in his practice. These symptoms included nightmares, symptoms of depression or anxiety, paranoia, vivid recollections of the events experienced and other indicators of trauma and post-traumatic stress disorder (PTSD).⁸⁶⁵ Specifically, he described the continued anxiety experienced amongst survivors and the feelings of hopelessness from the tremendous loss endured during the regime, such as the loss of relatives and destruction of homes and property.⁸⁶⁶ In addition, he testified that some survivors experience symptoms of paranoia resulting from the fact that they were accused of being spies and tortured as a result of these accusations.⁸⁶⁷ Dr. Sotheara explained the psychological impact of discrimination experienced by victims during the resettlement of Cambodians from cities into the countryside; such individuals were labeled as "New People" and were subject to additional surveillance, torture, and threats to security. As a result, they "had the sense of losing their identity" which amounted to a "severe, traumatic experience."⁸⁶⁸ The expert also described the continued social impact of the crimes on Cambodian society—such as the loss of community and identity and their desire to avoid discussing Khmer Rouge history with family members.⁸⁶⁹ The regime's oppression of religion and destruction of temples also contributed to the loss of community and eliminated a common source of assistance amongst the victims.⁸⁷⁰ In addition, Dr. Sotheara explained the Cambodia-specific terminology for trauma such as *baksbat*, or the feeling of having a "broken spirit" that broadly describes the suffering of survivors of the

regime.⁸⁷¹

Importantly, Dr. Sotheara's testimony explained that without treatment, these harms remain ongoing; thus, the crimes charged continue to impact many Cambodians to the present day. Cultural differences in Cambodia that inhibit communication or discussion of trauma can aggravate symptoms by preventing survivors from seeking treatment.⁸⁷² Feelings of paranoia stemming from the Khmer Rouge regime cause people to fear that they are being still monitored or followed and create mistrust amongst the community.⁸⁷³ The avoidance of communicating about Khmer history can also lead to long-term suffering.⁸⁷⁴

Dr. Sotheara concluded that being forcibly uprooted and deceived by the Khmer Rouge government resulted in widespread PTSD and other psychological consequences of prolonged exposure to trauma, finding that "the PTSD experienced by the people under the Khmer Rouge regime and the constant relocation from one place to another; compounded with hard labor and insufficient food, led them to a complete PTSD . . . of course, they suffered more than the ordinary PTSD as defined by the Western experts."⁸⁷⁵ To address these harms, the expert provided several recommendations for victim redress, such as medical treatment, psychological counseling, legal support, restoration of livelihood through programs designed to reintegrate survivors into the mainstream, as well as other social needs such as harmony, justice, truth, respect for their identity and culture, and financial assistance required for victim redress.⁸⁷⁶

Objections and Difficulties Present in the Victim Impact Hearing

Throughout the Victim Impact Hearing, several problems arose related to the relevance of the testimony, the psychological methodology, and the comprehension of the science. In their questioning of the expert, lawyers for the victims and prosecution heavily emphasized Dr. Sotheara's clinical background and personal experience working with victims rather than providing him with an opportunity to discuss mental health findings from peer-reviewed studies or other professional sources. The discussion of population-wide trauma was limited and often objected to or undermined by the defense. As a result, only a partial picture was developed on the disorders affecting the consolidated group of Civil Parties and the victim population as a whole.

⁸⁶⁴ See Case 002/1 Judgment, *supra* note 841, at 522 – 24, 582, 1142, 1150.

⁸⁶⁵ ECCC, Transcript of Trial Proceedings - Nuon Chea & Khieu Samphan Case File No. 002/19-09-2007-ECCC/TC, at 69 (June 5, 2013) [hereinafter "Transcript of Dr. CHHIM Sotheara (June 5, 2013)"].

⁸⁶⁶ *Id.* at 71.

⁸⁶⁷ *Id.* at 72.

⁸⁶⁸ *Id.* at 84.

⁸⁶⁹ *Id.* at 71-72.

⁸⁷⁰ *Id.* at 104.

⁸⁷¹ *Id.* at 85-86.

⁸⁷² *Id.* at 71.

⁸⁷³ *Id.* at 72.

⁸⁷⁴ *Id.* at 86-87.

⁸⁷⁵ ECCC, Transcript of Trial Proceedings - Nuon Chea & Khieu Samphan Case File No. 002/19-09-2007-ECCC/TC, at 80 (June 6, 2013) [hereinafter "Transcript of Dr. CHHIM Sotheara (June 6, 2013)"].

⁸⁷⁶ Transcript of Dr. CHHIM Sotheara (June 5, 2013), *supra* note 866, at 73, 105.

An academic as well as a clinician, Dr. Sotheara was well qualified to discuss the numerous studies conducted on Cambodian survivors, which have identified a broad range of relevant symptoms. For example, several population-based studies on Cambodian survivors of the Khmer Rouge regime indicate high rates of psychiatric disorders associated with trauma amongst survivors—including high rates of anxiety, major depression, and PTSD—as well as continued negative social impacts on the community.⁸⁷⁷ Such damage is widespread, impacts future generations, and can result in severe mental disorders and even new pathologies unique to the crimes.⁸⁷⁸ Testimony from Dr. Sotheara about these sources of information, including population studies and scientific peer-reviewed articles, would have addressed any concerns about his methodology and strengthened confidence in his conclusions.

Throughout the hearing, the majority of questions posed to the expert sought conclusions based on the expert's professional practice and victim statements made to the expert directly. For example, in one exchange, the lawyers for Civil Parties asked: “Could you please tell the Court, based on your professional experience in your work with victims, elaborate for us the impact of having left their homes, of the victims having left everything they knew and owned; can you please tell us what the victims told you about the impact on them as a result of

⁸⁷⁷ See, e.g., Inger Ager, *Calming the mind: healing after mass atrocity in Cambodia*, 52 *TRANSCULTURAL PSYCHIATRY* 543 (2015) (citing Joop T. V. M. de Jong et al., *Lifetime events and posttraumatic stress disorder in 4 post-conflict settings*, 286 *JAMA* 555 (2001) (In a random sample study of 613 Cambodians, 28.4% met the criteria for PTSD); Vincent Dubois et al., *Household Survey of Psychiatric Morbidity in Cambodia*, 50 *Int J Soc Psychiatry* 174 (2004) (citing survey of 1,320 Cambodians, 7% of whom met the criteria for PTSD, 42% for depression, and 53% for anxiety); Jeffrey Sonis et al., *Probable posttraumatic stress disorder and disability in Cambodia*, 302 *JAMA* 527 (2009) (citing a national, longitudinal study that covered a randomly selected sample of 813 Cambodians, 14% of whom met the criteria for PTSD); Richard Mollica et al., *The enduring mental health impact of mass violence: A community comparison study of Cambodian civilians living in Cambodia and Thailand*, 60 *INT J SOC PSYCHIATRY* 6 (2014) (describing comparative community survey in which researchers found that the Cambodian population continues to suffer “psychiatric morbidity and poor health” 25 years after the Khmer Rouge regime). A study of Cambodian refugees conducted two decades after resettlement in the United States indicated that 62% of the refugee population suffered from PTSD and 51% suffered from major depression, which is much greater than the rates among the general population in the U.S. (PTSD= 3.5%; major depression = 6.7%). Grant N. Marshall et al., *Mental Health of Cambodian Refugees Two Decades After Resettlement in the United States*, 294 *JAMA* 571 (2005); Ronald C. Kessler, et al., *Prevalence, Severity, and Comorbidity of 12-month DSM-IV disorders in the National Comorbidity Survey Replication*, 62 *Arch Gen Psychiatry* 617 (2005).

⁸⁷⁸ For example, Dr. Chhim Sotheara has conducted extensive research on the Cambodian syndrome of *baksbat* or “broken courage”, which is now recognized as a formal trauma syndrome unique to Cambodia. See Chhim S., *Baksbat (broken courage): a trauma-based cultural syndrome in Cambodia*, 32(2) *MEDICAL ANTHROPOLOGY* 160-173 (2013). Similarly, the International Criminal Tribunal for the Former Yugoslavia heard evidence of a new pathology category called the “Srebrenica Syndrome”, a unique impediment to the recovery of survivors from the Srebrenica massacre, which involved the mass killing of more than 8,000 Muslim men and boys by Bosnian Serb forces in the town of Srebrenica during the Bosnian War. See *Prosecutor v. Radislav Krstić*, Trial Judgment, Case No. IT-98-33-T, ¶93 (Int'l Crim. Trib. for the Former Yugoslavia Aug. 2, 2001).

leaving their homes...”⁸⁷⁹ Another example: “Q. Did you, yourself, have the possibility to identify perhaps not in precise percentages, but at least have an idea of the number of Cambodians living abroad ... who are the Khmer Rouge victims and who are now afflicted with some form of a psychological or mental disorder?”⁸⁸⁰ By contrast, when the expert was asked broadly what psychological consequences occurred from certain traumatic experiences—without limiting the information to statements directly observed by victims—the expert was free to cite multiple data sources. In an exchange with the prosecutor, for example, Dr. Sotheara was asked “What are the psychological risks and consequences for Civil Parties, victims in general, of the denial of responsibility on the part of the leaders of Democratic Kampuchea?” In response, the expert cited a study conducted by TPO on Civil Parties participating in Case 001, as well as a population-based study by Dr. Jeffrey Sonis of the Department of Social Medicine at the University of North Carolina at Chapel Hill on the impact of achieving a sense of justice when it comes to alleviating trauma symptoms and the import on victim recovery.⁸⁸¹

This line of questioning elicited objections and concerns about the foundation of the evidence and the methodology underlying the expert's conclusions.⁸⁸² For example, in one exchange, lawyers for Civil Parties asked if the expert had ever encountered a victim who had suffered from hunger or famine and what the

⁸⁷⁹ Transcript of Dr. CHHIM Sotheara (June 5, 2013), *supra* note 866, at 93 (emphasis added); see also *id.* at 98 (“Did you ever hear of any victims talk about their hunger and their famine?”); *id.* at 99 (Q. “...Did you hear from victims who...described to you how difficult it was for them to see their parents change and deteriorate before their eyes?”); *id.* at 104 (Q. “based on your experience with victims of the Khmer Rouge you met, based on the grievances that they expressed, can you tell us what the psychological needs are today?”); *id.* at 88 (“[D]id you meet persons who told you how they met the perpetrators of acts of violence and how they did not want to meet those persons who committed those acts of violence?”).

⁸⁸⁰ Transcript of Dr. CHHIM Sotheara (June 5, 2013), *supra* note 866, at 102.

⁸⁸¹ *Id.* at 110 (making reference to J. Sonis et al., *Probable Posttraumatic Stress Disorder and Disability in Cambodia*, 302(S) *JAMA* 527 (2009)). In another exchange, the Prosecutor asked, “Regarding persons who lost close relatives during the Khmer Rouge regime, can they feel guilty vis-à-vis those who survived. ... Do they feel guilty because ... they did not endure the fate of those died during that period?” In concluding that there is a symptom of guilt amongst survivors, Dr. Sotheara explained that the symptom was observed amongst patients at TPO, as well as a study in Phnom Penh conducted by an anti-torture institute in Berlin. *Id.* at 109.

⁸⁸² For example, Defense Counsel for Nuon Chea asked “how many patients did he speak to, how many patients does he have, how did he establish whether the patients that he spoke to were, in fact, representative of victims; many questions as concerns methodology of the answers that he's been giving.” Transcript of Dr. CHHIM Sotheara (June 5, 2013), *supra* note 868, at 116. Another objection arose when PICH Ang posed the question of whether Civil Parties in Case 002 expressed similar traumatic experiences to other victims that Dr. Sotheara had interviewed over the course of his work. An objection to the question by counsel for Nuon Chea was sustained on the ground that the attorney had not established whether the expert knows the specific trauma or symptoms of trauma that the Civil Parties had described in court. In fact, Dr. Sotheara was not given an opportunity to review the testimony of the Civil Parties that preceded him in the impact hearing and thus was not able to make the comparison. In an attempt to rephrase the question and pose specific trauma or symptoms, Pich Ang then recalled several statements of traumatic events made by Civil Parties and asked whether Dr. Sotheara had experiences with victims expressing similar harms. *Id.* at 76.

consequences were for that victim. By way of objection, the defense for Nuon Chea asked for further clarification on the foundation of this evidence: “Are we speaking about victims in general? Are we speaking about patients in his practice? Are we speaking about people who were subject [of] a questionnaire used in this article in the ‘Journal of Affective Disorders’? [We cannot] speak in general terms about victims. We have to be very specific.”⁸⁸³ Because much of the information presented was anecdotal, the defense repeatedly asked for clarification on the foundation for the statements made applying to the majority of Cambodian survivors.⁸⁸⁴

Because many of the questions put to Dr. Sotheara were limited to his clinical practice, the defense argued that the conclusions did not apply to the broader population, because the class of victims surveyed had been limited to those who were already being treated for symptoms of trauma by TPO.⁸⁸⁵ Dr. Sotheara admitted that the research he had done thus far had come from clients who had sought out counseling and treatment from TPO.⁸⁸⁶ Although such studies are relevant and important for the Court’s understanding of victim impact, the attorneys should have provided an opportunity for Dr. Sotheara to explain how such studies fit within findings based on the victim population as a whole.

The Importance of Psychological Evidence in the Case 002/1 Judgment

In spite of several sustained objections by the defense, the evidence of psychological impact played a significant role in three aspects of the judgment: the determination of the seriousness of the crimes, the gravity of the harm for the purpose of sentencing, and victim impact for the purpose of reparations.

In the final judgment against the two accused, the Court relied on expert testimony and victim impact statements in determining whether the inhumane acts of forced transfer of the population (phase one and phase two) and attacks against human dignity were serious enough to comprise crimes against humanity.⁸⁸⁷ “Other inhumane acts” are acts that cause “serious bodily or mental harm” that, if committed in the context of a widespread or systematic attack on a civilian population, can amount to a crime against humanity under the laws of the ECCC

and customary international law.⁸⁸⁸ The severity of the act must be of a nature and gravity similar to other enumerated crimes against humanity, with consideration given to such circumstances as the context in which the act occurred, the personal circumstances of the victim, and the *impact of the act upon the victim*.⁸⁸⁹ Although long-term psychological harm is not required as an element of proof, such evidence is useful in determining whether the crime is serious enough to merit the label of “crime against humanity.”⁸⁹⁰

The Trial Chamber cited both Civil Party statements on suffering as well as Dr. Sotheara’s testimony in determining the seriousness of the inhumane act of forced transfer as a crime against humanity, reaching the important conclusion that

[I]n addition to physical trauma endured during their exodus, many Cambodians continue to suffer from anxiety as a result of having experienced great loss. For people who lost loved ones, personal property and their homes, the trauma may have been compounded; such people are prone to loneliness and experience a loss of motivation in life.⁸⁹¹

The Judgment also cited Dr. Sotheara in determining the psychological effects of material loss that resulted from the transfer—for example, the diminished sense of spiritual and physical security that occurred from the loss of home and places of worship.⁸⁹² In addition, the Trial Chamber acknowledged that even witnessing or hearing traumatic events during the evacuation caused psychological disorders amongst surviving victims.⁸⁹³ Evidence of psychological impact was also cited in the evaluation of the seriousness of the second phase of forced transfer of victims. Notably, the Trial Chamber cited the disorientation experienced in the relocation, the aggravated trauma to children who lost their ability to see a future, the impact of children who lost their parents and the effect on the second generation of victims, as well as the loss of identity, stigma and discrimination endured by

⁸⁸⁸ *Id.* at ¶¶ 434-437 (citing Prosecutor v. Kaing Guek Eav alias Duch, Case No. 001/18-07-2007/ECCC/TC, Trial Judgment, ¶ 368 (July 26, 2010), and Prosecutor v. Dragomir Milošević, Case No. IT-98-29/1-A, Appeal Judgment, ¶108 (Int’l Crim. Trib. for the Former Yugoslavia Nov. 12, 2009)).

⁸⁸⁹ Case 002/1 Judgment, *supra* note 841, at ¶ 438 (citing Prosecutor v. Vasiljević, Case No. IT-98-32-A, Appeal Judgment, ¶ 165 (Int’l Crim. Trib. for the Former Yugoslavia Feb. 25, 2004), and Prosecutor v. Brima et al., Case No. SCSL-2004-16-A, Appeal Judgment, ¶ 184 (Special Ct. for Sierra Leone, Feb. 22, 2008)); *see also* Prosecutor v. Kaing Guek Eav alias Duch, Case File No. 001/18-07-2007/ECCC/TC, Trial Judgment, ¶ 369 (ECCC, July 26, 2010).

⁸⁹⁰ Case 002/1 Judgment, *supra* note 841, at ¶ 439 (citing Prosecutor v. Kaing Guek Eav alias Duch, Case File No. 001/18-07-2007/ECCC/TC, Trial Judgment, ¶369 (July 26, 2010), and Prosecutor v. Vasiljević, Case No. IT-98-32-A, Appeal Judgment, ¶165 (Int’l Crim. Trib. for the Former Yugoslavia Feb. 25, 2004).

⁸⁹¹ *Id.* at ¶ 522 (citing 5 June 2013 Transcript of Dr. CHHIM Sotheara, *supra* note 866, at 71, 83).

⁸⁹² *Id.* at ¶ 523 (citing 5 June 2013 Transcript of Dr. CHHIM Sotheara, *supra* note 866, at 80-82, 93-94).

⁸⁹³ *Id.* at ¶ 524 (citing 5 June 2013 Transcript of Dr. CHHIM Sotheara, *supra* note 866, at 95-96).

⁸⁸³ Transcript of Dr. CHHIM Sotheara (June 5, 2013), *supra* note 866, at 97.

⁸⁸⁴ Transcript of Dr. CHHIM Sotheara (June 6, 2013), *supra* note 878, at 98 (Defense Counsel Victor Koppe: “I’m just trying to get clarification on what exactly [Dr. Sotheara] means when he is speaking about the majority of the Cambodian people and what he is basing himself.”).

⁸⁸⁵ *Id.* at 100 (“if the majority of the victims that you have worked with suffer from PTSD or from depression, for instance, that that doesn’t say anything about the people who lived in the DK period as a whole. Is that correct?”).

⁸⁸⁶ *Id.* at 94.

⁸⁸⁷ *See* Case 002/1 Judgment, *supra* note 841, at ¶¶ 552, 565, 645.

victims identified as “New People.”⁸⁹⁴

Psychological trauma was also used to evaluate the gravity of the crimes for the purpose of sentencing. Citing international and Cambodian sentencing principles, the Trial Chamber found that the long-term impact of the crimes (including psychological impact), along with the large number of victims, the brutality of the crimes, and the role of the accused were all factors that demonstrated the gravity of the crimes in relation to determining the appropriate sentence for the accused.⁸⁹⁵ The expert testimony and statements of mental suffering by the victims played a strong role in the Court’s analysis:

The gravity of the crimes is further demonstrated by their serious and lasting impact upon the victims and their relatives and Cambodia in general. For the victims who died as a result of the crimes, the consequences were absolute. Many of those who survived suffered ongoing physical trauma, as well as mental and psychological disorders. The grave impact of these crimes on the victims and their relatives is both devastating and enduring.⁸⁹⁶

This, along with several aggravating factors and the lack of significant mitigating factors, resulted in a maximum sentence of life imprisonment against both Nuon Chea and Khieu Samphan.⁸⁹⁷

Lastly, the testimony played a significant role in the findings for Civil Party reparations. Internal Rule 23 *quinquies*(1) requires that reparations awarded by the Chamber acknowledge and address the harm suffered by Civil Parties as a result of the commission of these crimes.⁸⁹⁸ Citing several of the conclusions made by Dr. Sotheara in his testimony, the Court found that victims suffered from long-lasting trauma as a result of their experience under the Khmer Rouge. This trauma

⁸⁹⁴ *Id.* at ¶ 582 (citing 5 June 2013 Transcript of Dr. CHHIM Sotheara, *supra* note 866, at 80-84, 95).

⁸⁹⁵ *Id.* at ¶¶ 1068-69 (“The Supreme Court Chamber has identified the following factors as being relevant to an assessment of the gravity of a crime: the number and the vulnerability of victims; the impact of the crimes upon them and their relatives; the discriminatory intent of the convicted person when it is not already an element of the crime; the scale and the brutality of the offences; and the role played by the convicted person.”).

⁸⁹⁶ *Id.* at ¶ 1077.

⁸⁹⁷ *Id.* at ¶¶ 1105-07. In general, international courts have determined that the same fact cannot be used both to demonstrate the gravity of the crime and as an aggravating factor. *Id.* at ¶ 1069 (citing Prosecutor v. Kaing Guek Eav alias Duch, Case No. 001/18-07-2007/ECCC/TC, Trial Judgment, ¶ 583 (July 26, 2010), and Prosecutor v. Deronjić, Case No. IT-02-61-A, Judgment on Sentencing Appeal, ¶¶ 106-107 (Int’l Crim. Trib. for the Former Yugoslavia (July 20, 2005)).

⁸⁹⁸ ECCC Internal Rules, *supra* note 848, r. 23*quinquies*(1) (“If an Accused is convicted, the Chambers may award only collective and moral reparations to Civil Parties. Collective and moral reparations for the purpose of these Rules are measures that: a) acknowledge the harm suffered by Civil Parties as a result of the commission of the crimes for which an Accused is convicted and b) provide benefits to the Civil Parties which address this harm.”).

was made manifest, for example, by nightmares, post-traumatic stress disorder, depression, anxiety, and paranoia. As a result, the Court found that “[h]aving heard expert evidence, the Chamber is satisfied that the suffering inflicted on the Civil Parties as a result of the crimes committed by the accused has contributed to the symptoms of long-term psychological damage reported by a great number of them” and recognized that the Civil Parties and a broader class of victims suffered immeasurable harm as a consequence of the experience under the Khmer Rouge.⁸⁹⁹

The Use of Psychological Expert Testimony in the Lubanga and Bemba Trials

While the ECCC’s Case 002/1 Hearing on Victim Impact marks an important development in the presentation and use of evidence relating to mass trauma, the contrasting use of such evidence in the case of *The Prosecutor v. Thomas Lubanga Dyilo* before the International Criminal Court (“ICC”) is also illuminating. There, the Trial Chamber invited the testimony of Dr. Elizabeth Schauer, a clinical psychologist and the director of *vivo* international, an international NGO dedicated to research on, prevention of, and therapy for the consequences of traumatic stress on violence and conflict-affected individuals and communities.⁹⁰⁰ Although the expert’s written report and oral testimony were useful in aiding the Court’s determination of the gravity of the crimes, the Trial Chamber and the Appeals Chamber in the Lubanga case—in contrast to the ECCC—missed the opportunity to rely on such evidence in providing factual findings on victim harm resulting from the crimes. Such a finding could have been crucially important for, *inter alia*, reparations determinations.

Specifically, Dr. Schauer submitted written and oral testimony at trial about the psychological impact of child soldiering—the sole crime charged against Lubanga. Among other things, she testified that children are increasingly participating in armed conflicts, mostly as members of rebel forces, and that children are particularly vulnerable to being under the control of adults and cannot meaningfully “choose” to enlist in armed forces.⁹⁰¹ She further testified to the effects of repeated traumatic events on the psychology of children, increasing their likelihood of developing PTSD and other problems, which she further

⁸⁹⁹ Case 002/1 Judgment, *supra* note 841, at ¶ 1150 (emphasis added).

⁹⁰⁰ Prosecutor v. Thomas Lubanga Dyilo, Case No. ICC-01/04-01/06, Annex 1, EVD-CHM-00001, Curriculum Vitae of Dr. Elisabeth Schauer (April 22, 2009) (*available at* www.icc-cpi.int/iccdocs/doc/doc670786.PDF); *see also vivo* international Home Page, www.vivo.org/en/.

⁹⁰¹ Prosecutor v. Thomas Lubanga, Case No. 01/04-01/06, T-166-ENG Transcript of Trial Proceedings – Testimony of Trial Chamber Expert Dr. Elizabeth Schauer [hereinafter “Testimony of Trial Chamber Expert Dr. Elizabeth Schauer”], at 9-14 (April 7, 2009), *available at* www.icc-cpi.int/iccdocs/doc/doc804068.pdf); Prosecutor v. Thomas Lubanga Dyilo, Case No. 01/01-01/06, Annex 1, EVD-CHM-00001, *The Psychological Impact of Child Soldiering* [hereinafter “Dr. Schauer’s Expert Report”], at 1, 4-9 (Feb. 25, 2009), *available at* www.icc-cpi.int/iccdocs/doc/doc636752.pdf.

defined and elaborated.⁹⁰² Dr. Schauer highlighted transgenerational trauma, whereby traumatic memory can be passed to the children and even grandchildren of the victims.⁹⁰³ She also spoke to the effect of trauma on memory and to the difficulty that former child soldiers would likely have in presenting clear testimony.⁹⁰⁴ Finally, the expert explained what difficulties former child soldiers typically face in their re-integration into civilian society, especially for women and girls.⁹⁰⁵ She highlighted that “[k]ey gender-based experiences of both women and girls during armed conflicts is sexual violence, including torture, rape, mass rape, sexual slavery, enforced prostitution, forced sterilization, forced termination of pregnancies, giving birth without assistance and being mutilated.”⁹⁰⁶

On March 14, 2012, the Trial Chamber convicted Thomas Lubanga for the crimes of conscripting and enlisting children under the age of fifteen and using them to actively participate in hostilities.⁹⁰⁷ Mr. Lubanga was sentenced on July 10, 2012 to a total of 14 years of imprisonment,⁹⁰⁸ and, on December 1, 2014, the Appeals Chamber confirmed, by majority, the verdict declaring Mr. Lubanga guilty as well as the sentencing decision.⁹⁰⁹ In its judgment, the Trial Chamber relied on Dr. Schauer’s testimony as it weighed the credibility of traumatized witnesses, and also endorsed Dr. Schauer’s conclusion that children cannot give meaningfully informed consent to participate in hostilities. This undergirded the ruling that even informed or valid consent could not serve as a defense to

902 Testimony of Trial Chamber Expert Dr. Elizabeth Schauer, *supra* note 902, at 14-33; Dr. Schauer’s Expert report, *supra* note 902, at 10-34.

903 Testimony of Trial Chamber Expert Dr. Elizabeth Schauer, *supra* note 902, at 30-31; Dr. Schauer’s Expert Report, *supra* note 902, at 25-27.

904 Testimony of Trial Chamber Expert Dr. Elizabeth Schauer, *supra* note 902, at 56-57 (“It’s not that memory is affected or you cannot – you’ve lost the actual memory or the truth or something. It’s just that it might be painful or difficult to talk about it. And that depends on the way questions are asked. You can get every piece of information, anything, if you ask – if you ask in a chronologic context, forward-moving way. You probably have a hard time just wanting to know— jumping and wanting to know little details here and there. That’s difficult to do for somebody, because in a traumatised person the memory isn’t often correctly—well, how can I say?—isn’t awfully connected to time and place. It’s always there. You see, somebody who is living with post-traumatic stress disorder is -- hasn’t left the trauma. The person feels as if she or he is under a condition of danger right now.”). Some African children may feel threatened in addition “because a majority of children in sub-Saharan Africa also believe in the spiritual powers of their leaders.” *Id.* at 57.

905 Testimony of Trial Chamber Expert Dr. Elizabeth Schauer, *supra* note 929, at 76-77; Dr. Schauer’s Expert Report, *supra* note 902, at 27-29.

906 Dr. Schauer’s Expert Report, *supra* note 902, at 28.

907 Prosecutor v. Thomas Lubanga Dyilo, Case No. ICC-01/04-01/06, Judgment pursuant to Article 74 of the Statute [hereinafter “Lubanga Trial Judgment”] (March 14, 2012).

908 Prosecutor v. Thomas Lubanga Dyilo, Case No. ICC-01/04-01/06, Decision on Sentence pursuant to Article 76 of the Statute [hereinafter “Lubanga Sentencing Decision”] (July 10, 2012).

909 Prosecutor v. Lubanga, Case No. ICC-01/04-01/06 A, Judgment on the appeal of Mr Thomas Lubanga Dyilo against his conviction [hereinafter “Lubanga Appeal Judgment”] (Dec. 1, 2014).

enlistment.⁹¹⁰

At sentencing, the Trial Chamber leaned heavily on Dr. Schauer’s testimony for its findings related to the gravity of the crimes for which Mr. Lubanga was convicted, which were weighed against the “general background” of the harms associated with these crimes—something upon which Dr. Schauer had elaborated. Specifically, the Trial Chamber relied on Dr. Schauer’s testimony to find that

40. [A] significant number of [child soldiers] had developed the debilitating mental health condition known as post-traumatic stress disorder [following] their exposure to traumatic events whilst serving as child soldiers. Ms. Schauer described the core symptoms and she indicated that post-traumatic stress tends to persist, possibly for the remainder of the individual’s life. She suggested that “the response to war-related trauma by ex-combatants and child soldiers in countries directly affected by war and violence is complex and frequently leads to severe forms of multiple psychological disorders.”

41. A significant percentage of the former child soldiers who were the subject of [a study cited by Dr. Schauer] had abused drugs or alcohol; they suffered from depression and dissociation; and some demonstrated suicidal behaviour. According to the report, “research shows that former child soldiers have difficulties in controlling aggressive impulses and have little skills to handle life without violence. These children show ongoing aggressiveness within their families and communities even after relocation to their home villages.” Studies indicate that abduction and the consequent trauma have a negative impact on their education and cognitive abilities. It was stated in the report that “psychological exposure and suffering from trauma can cripple individuals and families even into the next generations.”

42. Ms. Schauer also pointed out that children who have been child soldiers for a significant period of time usually do not demonstrate “civilian life skills” as they have difficulties socialising,

910 Lubanga Trial Judgment, *supra* note 908, at ¶¶610, 613 (relying on Dr. Schauer to find that children “have limited understanding of the consequences of their choices; they do not control or fully comprehend the structures and forces they are dealing with; and they have inadequate knowledge and understanding of the short- and long-term consequences of their actions,” and thus are unable to give informed or valid consent to enlist in hostilities.)

they missed schooling, and as a result they are at a disadvantage, particularly as regards employment. This loss of the productivity of a large number of young people is described as a challenge in a poor country.

Unlike the testimony presented by Dr. Sotheara at the ECCC, Dr. Schauer's testimony at the ICC barely touched on statements from direct victims, focusing instead on studies that identified broad, overlapping, and sometimes diverging cross-sections of individual subjects suffering from the effects of trauma, including child soldiers and ex-combatants, children living in internally-displaced camps, or children simply living in a country in conflict.⁹¹¹ Her report and testimony relied on a number of studies that considered large samples; however, she had very little to say about the specific context of the Democratic Republic of the Congo (DRC), where the crimes occurred. In fact, only one study upon which she relied drew information from Congolese subjects.⁹¹² Rather than relying on Dr. Schauer's testimony for evidence relating to the trauma experienced by child soldiers in the DRC or more specifically in the case before it, the Trial Chamber relied on eyewitnesses and a non-psychologist expert for factual testimony and put this testimony into a context of trauma laid out by the principles Dr. Schauer articulated.⁹¹³ While Dr. Schauer's testimony had a substantial impact on sentencing, that impact may have been muted by the distance between her testimony about the general impact of war on children and the specific evidence of trauma within the DRC victim population presented to the Trial Chamber.

In contrast to the ECCC, the ICC did not rely on psychological expert testimony to establish victim harm for the purpose of reparations against Thomas Lubanga. In fact, Dr. Schauer's testimony was not directed to reparations at all. Nor did the Court order a victim impact or reparations hearing, as seen in the

ECCC.⁹¹⁴ The Trial Chamber's Decision establishing the principles and procedures to be applied for determining reparations made no findings of fact regarding the physical, psychological, or material harm suffered by the victims of Lubanga's crimes. Instead, the Court vested the power to both define and assess the harm of the victims in the Trust Fund for Victims ("TFV").⁹¹⁵ The TFV, a non-judicial entity also created by the Rome Statute that established the ICC, assists victims of crimes within the jurisdiction of the Court and supports programs that address the harms resulting from these crimes in ICC situation countries.⁹¹⁶ As such, "where appropriate," court-ordered reparations may be implemented through the TFV.⁹¹⁷

Thus, rather than evaluating the evidence of mass trauma presented by the expert and victim participants who testified before the Court, the Trial Chamber empowered the TFV to utilize "a team of interdisciplinary experts [to assess] the harm suffered by the victims in different localities, with the support of the Registry, the OPCV [Office of Public Counsel for Victims] and local partners."⁹¹⁸ In turn, the Court retained a monitoring role and oversight function for reparations "including considering the proposals for collective reparations that

914 See *Prosecutor v. Lubanga*, Case No. ICC-01/04-01/06-2844, Scheduling order concerning timetable for sentencing and reparations, ¶ 12 (March 14, 2012) (Wherein the Trial Chamber stated that, after receiving the requested reports and observations, it would "decide thereafter whether to hold a reparations hearing"). No reparations hearing was held, even though requesting such a hearing is well within the power of the Trial Chamber to determine the scope of victim harm. See *Prosecutor v. Lubanga*, Case No. ICC-01/04-01/06, Decision establishing the principles and procedures to be applied to reparations, ¶¶ 22, 176 (Aug. 7, 2012) (stating that Article 75(1) of the Rome Statute gives the Chamber a broad discretion to establish the principles that are to be applied to reparations for victims, including determining the scope and extent of any damage, loss and injury they experienced) (citing Registrar's observations on reparations issues, Doc. No. ICC-01/04-01/06-2865, ¶ 6 (April 18, 2012)); see also Rome Statute of the International Criminal Court, opened for signature July 17, 1998 [hereinafter "Rome Statute"], art. 75(1) (entered into force Jul. 1, 2002) ("The Court shall establish principles relating to reparations to, or in respect of, victims, including restitution, compensation and rehabilitation. On this basis, in its decision the Court may, either upon request or on its own motion in exceptional circumstances, determine the scope and extent of any damage, loss and injury to, or in respect of, victims and will state the principles on which it is acting"). Moreover, the Rules of Procedure and Evidence of the Court permit the Trial Chamber to appoint experts to assist in determining the scope or extent of the harm to victims and to "suggest various options concerning the appropriate types and modalities of reparations." Int'l Crim. Ct. (ICC), Rules of Procedure and Evidence, r. 97 (2) (Sept. 9, 2002).

915 *Prosecutor v. Lubanga*, Case No. ICC-01/04-01/06, Decision establishing the principles and procedures to be applied to reparations [hereinafter "Lubanga Trial Chamber Decision on Reparations"], ¶ 283 (Aug. 7, 2012) ("The Chamber agrees that the assessment of harm is to be carried out by the TFV during a consultative phase in different localities.").

916 Rome Statute, *supra* note 915, art. 79(1) ("A Trust Fund shall be established by decision of the Assembly of States Parties for the benefit of victims of crimes within the jurisdiction of the Court, and of the families of such victims"); *Mission Statement of Trust Fund for Victims*, TFV, www.trustfundforvictims.org/about-us.

917 Rome Statute, *supra* note 915, art. 75(2) ("The Court may make an order directly against a convicted person specifying appropriate reparations to, or in respect of, victims, including restitution, compensation and rehabilitation. Where appropriate, the Court may order that the award for reparations be made through the Trust Fund provided for in article 79.").

918 Lubanga Trial Chamber Decision on Reparations, *supra* note 915, at ¶ 285.

911 See *e.g.*, Testimony of Trial Chamber Expert Dr. Elizabeth Schauer, *supra* note 902, 23-26.

912 Dr. Schauer's Expert Report, *supra* note 902, at 10n.38.

913 See, *e.g.*, Lubanga Sentencing Decision, *supra* note 909, at ¶¶ 39-45; *Id.* at 45 - 48, ¶¶ 12-18 (Odio, J., dissenting).

are to be developed in each locality, which [would] be presented to the Chamber for its approval.”⁹¹⁹ As a result, the Trial Chamber’s initial order for reparations did not identify the harm suffered by direct and indirect victims of Lubanga’s crimes, did not utilize expert assistance in determining the scope of harm for reparations, and did not provide the victims with official acknowledgement by the Court. By contrast, the ECCC judgment in Case 002/1 provided each of these elements, which are crucial to victims.⁹²⁰

On appeal, the ICC Appeals Chamber recognized its shortfalls to some extent. While acknowledging that the TFV has a role in *assessing* victim harm, the Appeals Chamber found that the Trial Chamber erred by delegating its task of *defining* the victim harm to the TFV. Specifically, the Appeals Chamber held that the order for reparations must determine which kinds of victim harm could be considered as being the direct or indirect consequence of the crimes for which Lubanga was convicted.⁹²¹ Rather than remanding the reparations order, the Appeals Chamber amended the impugned decision and thus was limited to defining victim harm based on two sources: the Trial Chamber’s findings made in the context of the trial proceedings (such as decisions relevant to victim participation and findings in the record that relate to victim harm) and the Sentencing Decision, which includes an assessment of the gravity of the crime in regard to “the extent of the damage caused, in particular the harm caused to the victims and their families.”⁹²²

As detailed above, the Trial Chamber’s methodology and determination were primarily based on Dr. Schauer’s written and oral expert testimony.⁹²³ It bears recalling that Dr. Schauer’s testimony was directed to providing an overview of the impact of child soldiering in general and did not include information from local experts in the Democratic Republic of Congo nor an evaluation of statements made by direct victims of the crimes. Thus, although the Appeals Chamber was able to rely on the expert evidence of psychological harm that could result from the crimes for which Lubanga was convicted, it was only able to do so through the limited lens of the Trial Chamber’s findings.⁹²⁴ It bears further note that because the Trial Chamber did not attribute acts of sexual violence to Mr. Lubanga, the

Appeals Chamber held that he could not be required to pay reparations for such harm.⁹²⁵

Without the benefit of access to the full expert report or testimony—or, indeed, any evidence that could have been derived through a hearing on victim impact—the definition of victim harm in the amended order on reparations was predictably limited. The Amended Decision acknowledged evidence of psychological trauma that could be assessed for both direct and indirect victims, including “psychological trauma and the development of psychological disorders, such as, *inter alia*, suicidal tendencies, depression, and dissociative behavior” and psychological suffering experienced “as a result of the sudden loss of a family member” or “aggressiveness on the part of former child soldiers relocated to their families and communities.”⁹²⁶ The Amended Decision also identified harms to direct victims that could manifest as difficulty socializing within the victim’s family or community and difficulties in controlling aggressive impulses as well as the failure to develop civilian life skills that disadvantaged the victim, particularly in regard to employment.⁹²⁷

As this chapter was being drafted, the ICC also relied on expert testimony on gender crimes and mental harm in the judgment and sentencing of Jean-Pierre Bemba Gombo for crimes against humanity and war crimes committed in the Central African Republic.⁹²⁸ Dr. Adeyinka M. Akinsulure-Smith, an expert witness on gender crime and PTSD, spoke to the mental impact and ostracism of rape victims in the Central African Republic (CAR).⁹²⁹ Dr. André Tabo, a Central African psychiatrist who treated victims of sexual violence during the conflict, provided expert testimony on how rape was used as a tool of war to reward soldiers and punish or humiliate a particularly vulnerable victim population.⁹³⁰ Following Bemba’s conviction, the prosecutors called one additional psychological expert to support the prosecution argument that crimes of sexual violence exert a particularly grave impact on the victim population and serve to target particularly vulnerable victims with particular cruelty. Dr. Daryn Reicherter, an editor of this book and an expert on the “longitudinal and intergenerational impact of mass sexual violence,” described the way in which particularly serious crimes (such as

919 *Id.* at ¶ 289.

920 *See* Case 002/1 Judgment, *supra* note 841, at ¶¶ 597-620 (section of Judgment on Civil Party Reparations, including assessment of harm suffered by the Civil Parties).

921 Prosecutor v. Lubanga, Case No ICC-01/04-01/06-A, Judgment on the appeals against the “Decision establishing the principles and procedures to be applied to reparations” of 7 August 2012 with amended order for reparations [hereinafter “Lubanga Appeals Judgment on Reparations”], ¶ 184 (March 3, 2015).

922 *Id.* at ¶ 187 (quoting Lubanga Sentencing Decision, *supra* note 909, at ¶ 44).

923 *Id.* at ¶¶ 188-89.

924 *Id.* at ¶ 189.

925 *Id.* at ¶ 198. Such a finding does not prevent the TFV from providing appropriate assistance to such victims, however. *See id.* at ¶ 199.

926 *Id.* at ¶ 190.

927 *Id.*

928 Prosecutor v. Jean-Pierre Bemba Gombo, Case No. ICC-01/05-01/08-3399, Decision on Sentence pursuant to Article 76 of the Statute [hereinafter “Bemba Sentencing Decision”] (June 21, 2016).

929 Transcripts of Trial Proceedings in the case of The Prosecutor v. Jean-Pierre Bemba Gombo, Case File No. ICC-01/05-01/08 (Nov. 29 - 30, 2010).

930 Transcript of Trial Proceedings, Case File No. ICC-01/05-01/08 (Apr. 13, 2011).

rape, gang rape, and sexual violence committed in front of family members and against children as seen in the Central African Republic) result in a greater magnitude of “negative and permanent psychological issues.”⁹³¹ Portions of each of the testimony of each of the three experts were cited in the sentencing order against Jean-Pierre Bemba Gombo⁹³² and used to support the Trial Chamber’s findings of the seriousness of the crimes of murder, rape, and pillage committed by Bemba. The crime of rape in particular was identified as a crime of the “utmost, serious gravity” and, in the Central African Republic conflict, gave rise to two separate aggravating circumstances: namely that they were committed (i) against particularly defenseless victims, and (ii) with particular cruelty.⁹³³

This expert testimony on mental harm and ongoing psychological impact, in addition to statements of mental suffering by victims, were crucial to the Trial Chamber’s sentencing of Bemba to 18 years in prison. Although the reparations order against Bemba is still pending, the Trial Chamber’s particular attention to psychological damage and the ongoing mental impact on victims in the sentencing decision, and its classification of rape in the Central African Republic conflict as a crime of the utmost, serious gravity, indicates that the future reparations order will likely put significant emphasis on the immediate and ongoing mental harm of victims from the conflict.

In spite of the limitations in *Lubanga*, the ICC’s decisions on sentencing and reparations are in accordance with the ECCC’s reliance on psychological trauma evidence. In clarifying the duty of the Trial Chamber to identify victim harm resulting from the crimes in the judgment on reparations, future Trial Chambers will likely request victim impact hearings as well as assistance from experts on victim trauma to aid in their assessment both of the gravity of the crimes and the proper scope of reparations.

Other Relevant Judicial Decisions

Apart from the ECCC and the ICC, international criminal tribunals have largely missed the opportunity to consider expert testimony on the psychological effects of the crimes charged. Testimony by psychological experts and other evidence of mental harm have mostly been introduced in international criminal courts and tribunals to assess the competence of an alleged perpetrator (the “accused”) to stand trial; to determine the reliability or credibility of a witness (such as that of a witness suffering from PTSD or some degree of mental disorder);

or to prove the underlying element of a crime. For instance, like the Trial Chamber in the *Lubanga* case, the Special Court for Sierra Leone left the determination of victim harm to non-judicial bodies: the Truth and Reconciliation Commission for Sierra Leone (“TRC”) and its related project, the National Vision for Sierra Leone. Although a tremendous amount of psychological evidence and expert testimony was developed in support of these processes, litigants at the Special Court for Sierra Leone missed the opportunity to present expert testimony on mass trauma in any of the tribunal’s four trials.⁹³⁴ Perhaps because it was not originally envisioned that there would be both a TRC and Special Court, the two entities were not developed with an eye to their interaction. As a result, the TRC largely handled trauma evidence in relation to restorative justice and reconciliation while the Special Court heard evidence of individual trauma, particularly from the suffering of child soldiers and women, and staffed a unit devoted to supporting witnesses and victims. While experts testified about such issues as command structure, cultural anthropology, the scope of child soldier conscription, and the scope of gender-based violence, no experts testified as to the psychological impacts of trauma on the victims.⁹³⁵

The International Criminal Tribunal for Yugoslavia (“ICTY”) took advantage of the opportunity to develop evidence of victim impact in only a few instances. For example, in the judgment convicting Radoslav Krstić to 35 years in prison for complicity in genocide, the Trial Chamber of the ICTY relied on testimony from

⁹³⁴ See, e.g., WSD HANDA Center for Human Rights and International Justice, *Special Court Monitoring Program Update #44 - CDF Trial* (June 17, 2005), available at <https://handacenter.stanford.edu/report/special-court-monitoring-program-update-44>; WSD HANDA Center for Human Rights and International Justice, *Special Court Monitoring Program Update #83, Trial Chamber 1 – RUF Trial* (July 14, 2006), available at <https://handacenter.stanford.edu/report/special-court-monitoring-program-update-83a>; WSD HANDA Center for Human Rights and International Justice, *Special Court Monitoring Program Update #57, Trial Chamber 2 – AFRC Trial* (October 5, 2005), available at <https://handacenter.stanford.edu/report/special-court-monitoring-program-update-57>. For examples of testimony developed at the Truth and Reconciliation Commission of Sierra Leone, see Sierra Leone Truth and Reconciliation Commission, TRC Research Data, available at www.sierraleonetr.com/index.php/resources/trc-research-data; Benetech Human Rights Data Analysis Group, the Statistical Appendix to the Report of the Truth and Reconciliation Commission of Sierra Leone (Oct. 5, 2004), available at www.sierraleonetr.com/images/docs/statistical_report.pdf; Sierra Leone Truth and Reconciliation Commission, Volume Three B Files (Witness to Truth Reports), available at www.sierraleonetr.com/index.php/view-the-final-report/download-table-of-contents/volume-three-b; Sierra Leone Truth and Reconciliation Commission, Appendix 3: Transcripts of TRC Public Hearings (appendix containing transcripts of the TRC public hearings held in Freetown and the District Headquarter Towns), available at www.sierraleonetr.com/index.php/view-the-final-report/download-table-of-contents/appendices/item/appendix-3-transcripts-of-trc-public-hearings?category_id=15.

⁹³⁵ See, generally, WSD HANDA Center for Human Rights and International Justice, *Special Court Monitoring Program Update #44 - CDF Trial* (June 17, 2005), available at <https://handacenter.stanford.edu/report/special-court-monitoring-program-update-44>; WSD HANDA Center for Human Rights and International Justice, *Special Court Monitoring Program Update #83, Trial Chamber 1 – RUF Trial* (July 14, 2006), available at <https://handacenter.stanford.edu/report/special-court-monitoring-program-update-83a>; WSD HANDA Center for Human Rights and International Justice, *Special Court Monitoring Program Update #57, Trial Chamber 2 – AFRC Trial* (October 5, 2005), available at <https://handacenter.stanford.edu/report/special-court-monitoring-program-update-57>.

⁹³¹ Bemba Sentencing Decision, *supra* note 929, at ¶37; Transcript of Trial Proceedings Case File No. ICC-01/05-01/08, at 86, 98, 109 (May 16, 2016).

⁹³² Bemba Sentencing Decision, *supra* note 929, ¶¶ 36-37, 44.

⁹³³ Bemba Sentencing Decision, *supra* note 929, ¶¶ 40, 95.

Dr. Teufika Ibrahimfendić—a psychotherapist from Vive Žene, a women’s organization in the Balkans—to provide her expert opinion regarding common psychological impacts of the Srebrenica massacres in Bosnia and Herzegovina.⁹³⁶ Specifically, Dr. Ibrahimfendić described symptoms of trauma suffered by individuals who survived the takeover of Srebrenica (mostly women and children who were separated from Bosnian males at the time of the takeover) and how such trauma continues to the present day.⁹³⁷ She highlighted a new pathology called “the Srebrenica syndrome,” which encompasses the grief and deep pain of family members of victims of the genocide who were unable to identify and bury their loved ones and, as a result, continue to live their lives in a state of uncertainty and confusion.⁹³⁸ The new pathology, coupled with the social impact of the massacre on the community, were identified in the Trial Chamber judgment against Krstić, which concluded that “the impact of these events on the Bosnian Muslim community of Srebrenica has been catastrophic.”⁹³⁹ The factual finding pointed to Vive Žene’s findings of the social impact of the crimes—such as difficulty finding employment and returning to the home—and mental harm—such as the collective guilt experienced by women who survived the events—and the “exceptionally high” levels of trauma in the community.⁹⁴⁰ The expert’s testimony, along with several victim statements, constituted the foundation of the court’s factual findings on the impact of the crimes on the Bosnian Muslim community of Srebrenica.

Although the Srebrenica massacre itself and the impact on victims were not heavily contested by witnesses before the Trial Chamber, the court nevertheless explained that it was “imperative to document these ‘incredible events’ in detail.”⁹⁴¹ However, the findings were also key in determining the gravity of the crime and

the appropriate sentence. Following the conviction, Krstić became the first person to be convicted of genocide at the ICTY and was sentenced to 46 years’ imprisonment. The aggravated sentence reflected in part the “the obvious psychological suffering of the survivors” as a result of the crimes, including the new pathology known as Srebrenica Syndrome affecting the women and children survivors.⁹⁴²

In stark contrast, the International Tribunal for Rwanda (“ICTR”), even when it received evidence of victim trauma, failed to marshal that evidence in support of its legally-significant findings on the gravity of the crimes, its sentencing decisions, or the provision of reparations. The *ad hoc* tribunals have broad discretion in determining factors relevant to the gravity of an offence for sentencing, giving room for the introduction of evidence of psychological trauma of victims in this context, even where victim participation or reparations were not available.⁹⁴³ Thus, the ICTR missed the opportunity to solicit expert testimony on mental trauma to aid with sentencing decisions or in relation to determining the gravity of the genocide offences before the Trial Chamber.

Since the body of practice of admitting expert psychological testimony in international criminal proceedings is not large, courts and tribunals could also look to the jurisprudence developed, for example, at the Inter-American Court of Human Rights, which has routinely applied such evidence in the context of evaluating victim harm, or even to national court proceedings where psychological

⁹³⁶ Prosecutor v. Radislav Krstić, Case No. IT-98-33-T, Judgment, at 30-31 (Int’l Crim. Trib. for the Former Yugoslavia Aug. 2, 2001). Dr. Ibrahimfendić was also used as a prosecution expert in other trials before the ICTY and the national court of Bosnia and Herzegovina to help prove the crimes at issue have a lasting impact on those who survived. See Prosecutor v. Plavšić, Case No. IT-00-39 & 40/1, Transcript of Hearing with Dr. Ibrahimfendić (Int’l Crim. Trib. for the Former Yugoslavia Dec. 16, 2002), available at www.icty.org/x/cases/plavsic/trans/en/021216IT.htm; Prosecutor v. Tolimir, Case No. IT-05-88/2, Transcript of Hearing with Dr. Ibrahimfendić (Int’l Crim. Trib. for the Former Yugoslavia Feb. 17, 2011); Prosecutor v. Karadžić, Case No. IT-95-5/18, Transcript of Hearing with Dr. Ibrahimfendić (Int’l Crim. Trib. for the Former Yugoslavia Mar. 22, 2012), available at www.icty.org/x/cases/karadzic/trans/en/120322ED.htm; Prosecutor v. Ratko Mladić, Case No. IT-09-92-T, Transcript of Hearing with Dr. Ibrahimfendić (Int’l Crim. Trib. for the Former Yugoslavia July 18, 2013), available at www.icty.org/x/cases/mladic/trans/en/130718ED.htm; see also Prosecutor v. Milorad Trbić, Case No.: X-KR-07/386, at ¶ 848 (National Court of Bosnia and Herzegovina, Apr. 29, 2010).

⁹³⁷ Prosecutor v. Radislav Krstić, *supra* note 928, Judgment, at ¶¶ 91-94.

⁹³⁸ *Id.* at ¶ 93 (citing Prosecutor v. Radislav Krstić, Case No. IT-98-33-T, Transcript of Dr. Ibrahimfendić, at 5817-5818 (Int’l Crim. Trib. for the Former Yugoslavia July 27, 2000), available at www.icty.org/x/cases/krstic/trans/en/000727it.htm).

⁹³⁹ Prosecutor v. Radislav Krstić, *supra* note 937, Judgment, at ¶ 90.

⁹⁴⁰ *Id.* at ¶ 93.

⁹⁴¹ *Id.* at ¶ 95.

⁹⁴² *Id.* at ¶ 720.

⁹⁴³ The International Criminal Tribunal for Rwanda (“ICTR”) has broad discretion in considering factors relevant to determining gravity of the crimes or aggravating factors for sentencing. In *Prosecutor v. Kambanda*, the ICTR Trial Chamber held that “judges of the Chamber cannot limit themselves to the factors mentioned in the Statute and the Rules...their unfettered discretion to evaluate the facts and attendant circumstances should enable them to take into account any other factor that they deem pertinent.” *Prosecutor v. Jean Kambanda*, Case No. ICTR 97-23-S, Judgment and Sentence, ¶ 30 (Int’l Crim. Trib. for Rwanda Sept. 4, 1998). Judges from both *ad hoc* Tribunals have considered factors such as leadership position of the accused and abuse of power, terrorizing victims, sadism or enthusiasm, cruelty and humiliation, heinous means, and espousal of ethnic and religious discrimination as aggravating factors in sentencing. See Robert D. Sloane, *Sentencing for the ‘Crime of Crimes’: The Evolving ‘Common Law’ of Sentencing of the International Criminal Tribunal for Rwanda*, 5(3) J. INTL. CRIM. JUST. 713, 727-28 (2007); see also Int’l Crim. Trib. for the Former Yugoslavia, Statute of the Tribunal, art. 24 (2) (September 2009) (“(1) ...In determining the terms of imprisonment, the Trial Chambers shall have recourse to the general practice regarding prison sentences in the courts of the former Yugoslavia. (2) In imposing the sentences, the Trial Chambers should take into account such factors as the gravity of the offence and the individual circumstances of the convicted person.”) and Int’l Crim. Trib. for Rwanda, Statute of the Tribunal, art.23 (October 2006) (same); Andrew N. Keller, *Punishment for Violations of International Criminal Law: An Analysis of Sentencing at the ICTY and ICTR*, 12 IND. INT’L & COMP. L. REV. 53, 56 (2001-2002) (arguing that Trial Chambers have broad sentencing discretion under these guidelines and may consider “any aggravating circumstances” and give them “due weight” in sentencing)(citing Int’l Crim. Trib. for the former Yugoslavia, Rules of Procedure, r. 101 (Mar. 14, 1994), and Int’l Crim. Trib. for Rwanda, Rules of Procedure and Evidence, r.101 (July 5, 1995)).

evidence on victim impact has also been considered.⁹⁴⁴ For example, in the *Case of the "Las Dos Erres" Massacre v. Guatemala*, the Inter-American Court of Human Rights heard from two experts on the psychosocial impact of torture and disappearance; namely on the psychological impact on families (especially children) and the effects that the lack of justice and truth over the years has had on the surviving victims of the *Dos Erres* Massacre.⁹⁴⁵ The experts also identified the impact on the next of kin of those killed in the massacre and the intergenerational impact of the crimes, and provided recommendations for an adequate program for psychological counseling that Guatemala should adopt by means of reparations.⁹⁴⁶ The expert statements contributed to the Court's factual findings, linking the crimes to the grave damages to the mental integrity of the victims.⁹⁴⁷ Moreover, the testimony aided the Court's understanding of the re-traumatization that occurs with impunity, identifying the damage resulting from the uncertainty of what happened to the disappeared victims and the lack of investigation or recognition of the crime as "a new traumatic impact" related to the crimes.⁹⁴⁸ As a result, the Court found it necessary to order reparations that provide adequate attention to and counseling for the psychological issues and moral damages suffered by the victims. It also ordered reparations to memorialize and publicly acknowledge the responsibility of the state for the harm to victims of the massacre in *Dos Erres*.⁹⁴⁹

Guatemala's National Court also utilized expert testimony on psychological impact in the trial against former Guatemalan President Efraín Ríos Montt and former Chief of Military Intelligence Mauricio Rodríguez Sánchez for genocide, forced disappearances, torture, crimes against humanity, and state terrorism

944 See e.g., *Case of the Plan de Sánchez Massacre v. Guatemala, Reparations and Costs, Judgment*, Inter-Am. Ct. H.R. (ser. C.) No. 116, P 20-22 (Nov. 19, 2004); *Case of the Río Negro Massacre v. Guatemala, Preliminary Objections, Merits, Reparations and Costs, Judgment*, Inter-Am. Ct. H.R. (ser. C.) No. 250, P 98-99 (Sept. 4, 2012), *Case of the Massacres of El Mozote and Nearby Places v. El Salvador, Merits, Reparations, and Costs, Judgment*, Inter-Am. Ct. H.R. (ser. C.) No. 252, (Oct. 25, 2012); *Case of Tibi v. Ecuador, Preliminary Objections, Merits, Reparations and Costs, Judgment*, 2004 Inter-Am. Ct. H.R. (ser. C.) No. 114, ¶¶ 31-34 (Sept. 7, 2004). Courts and tribunals could also look to the use of expert psychological testimony in national courts pursuant to universal jurisdiction, including civil cases in the United States. See e.g., *Ahmed v. Magan*, No. 2:10-CV-00342, 2013 WL 4479077, at *5 (S.D. Ohio Aug. 20, 2013) report and recommendation adopted, No. 2:10-CV-00342, 2013 WL 5493032 (S.D. Ohio Oct. 2, 2013); *Doe v. Constant*, No. 04 Civ. 10108, at *2, 11-13 (S.D.N.Y. Oct. 24, 2006), available at www.cja.org/downloads/Constant_FOF_and_COL_71.pdf; and *Romagoza Arce v. Garcia*, No. 99-8364-CIV, Trial Testimony of Plaintiffs' Expert Glen Caddy, pages 1602-1646 (S.D. Florida July 10, 2002) (available at www.cja.org/downloads/Romagoza%20Trial%20Transcript,%20Volume%209,%20pages%201531-1691.pdf).

945 *Case of "Las Dos Erres" Massacre v. Guatemala, Preliminary Objection, Merits, Reparations, and Costs, Judgment*, Inter-Am. Ct. H.R. (ser. C.) No. 31, ¶ 56 (Nov. 24, 2009), available at www.corteidh.or.cr/docs/casos/articulos/serie_211_ing.pdf.

946 *Id.*

947 *Id.* at ¶ 139.

948 *Id.* at ¶¶ 211-213.

949 *Id.* at ¶¶ 257-64, 269-70.

primarily against the country's indigenous population.⁹⁵⁰ Psychologist Nieves Gómez testified as an expert witness about the psychological impacts of Guatemala's civil war and the "harm to the mental integrity" of individuals and the Maya Ixil community.⁹⁵¹ Gómez described this psychological damage as causing strong disorientation, feelings of loss of control, severe anxiety and post-traumatic stress among individual victims.⁹⁵² This mental harm caused destruction of culture, stigmatization of women who had been raped, and a rupture of the social fabric.⁹⁵³ The objective of this testimony was to determine the severe harm to mental, psychosocial, and psychological integrity caused by the massacres, displacement, and violent acts that occurred during Ríos Montt's rule.⁹⁵⁴ Portions of the expert and witness testimony regarding mental trauma were used to establish intent to harm the social fabric of the indigenous community and ultimately to prove the crime of genocide.⁹⁵⁵ And, evidence of the broader psychological impact of displacement, massacres, and sexual violence were considered to determine the intensity of harm caused to individual victims, as well as to society at large.⁹⁵⁶ Accordingly, portions of the expert evidence were used to prove the underlying crime and support the claims for reparations.⁹⁵⁷

Recommendations for Developing Testimony on the Outcomes of Mass Trauma on Survivor Psychology

To meet some of the challenges described above in presenting and evaluating expert psychological testimony and to support the more effective development of such testimony in future international criminal trials, we recommend that psychological experts, judges, and litigants adopt the following guidelines for the

950 *State v. Efraín Ríos Montt and Mauricio Rodríguez Sánchez*, Case No. C-01076-2011-00015 of. 2nd, Sentence and Judgment of National Courts of Guatemala, (May 17, 2013) (available at www.ijmonitor.org/2013/05/718-page-rios-montt-judgment-released-all-eyes-on-constitutional-court/) (Judgment overturned by Constitutional Court of Guatemala on May 20, 2013).

951 International Justice Monitor, *Prosecution Experts Testify on Psychological, Cultural, Statistical, and Gender Issues*, Open Society Foundation (Apr. 2013), available at www.ijmonitor.org/2013/04/prosecution-experts-testify-on-psychological-cultural-statistical-and-gender-issues/.

952 *Id.*

953 *Id.*

954 *State v. Efraín Ríos Montt and Mauricio Rodríguez Sánchez*, Case No. C-01076-2011-00015 of. 2nd, Sentence and Judgment of National Courts of Guatemala, 205 (May 17, 2013) available at www.ijmonitor.org/2013/05/718-page-rios-montt-judgment-released-all-eyes-on-constitutional-court/ (Judgment overturned by Constitutional Court of Guatemala on May 20, 2013).

955 *Genocide in Guatemala: Ríos Montt Found Guilty*, International Federation for Human Rights (FIDH), at 14, available at www.fidh.org/IMG/pdf/rapguatemala613uk2013.pdf (July 2013).

956 *State v. Efraín Ríos Montt and Mauricio Rodríguez Sánchez*, Case No. C-01076-2011-00015 of. 2nd, Sentence and Judgment of National Courts of Guatemala, 698, 707 (May 17, 2013), available at www.ijmonitor.org/2013/05/718-page-rios-montt-judgment-released-all-eyes-on-constitutional-court/.

957 *Id.* at 714-18.

development of expert psychological testimony relating to victim trauma.

As an initial matter, we submit that the aim of written and oral expert psychological testimony should be to place the specific experiences of victims of the crimes at issue within the context of the general psychiatric, psychological, and medical knowledge of the impact of such crimes. Therefore, the psychological expert's development of written reports entails a review of documentation of local and specific experiences, along with a broader review of the established literature. Presentation of the expert's oral testimony should take account of, and elicit testimony about, this prior preparation as a foundation to the expert's testimony. By providing experts the opportunity to provide the foundation of their testimony first, attorneys can avoid inviting objections to each question on methodology and foundation for an expert's statements. If necessary, follow-up questions can elicit the support behind an expert's conclusions and may include support from peer-reviewed articles, population studies, clinical studies, and other sources of data that similar experts would reasonably rely upon. Having established the basis of testimony, an expert will then be free to explain the connection between crimes committed and certain resulting psychological harm in a manner that applies to the broader victim population or a consolidated group of Civil Parties.

For example, in the Hearing on Victim Impact in Case 002/1, Dr. Sotheara could have been given an opportunity to explain the scientific methods used at TPO for conducting studies as well as the science and sources of information he relied upon to prepare his testimony. With such a foundation already laid, attorneys could dispense with the need to ask about the derivation of his testimony with each question. Indeed, had Dr. Sotheara been allowed to explain the science underlying his conclusions, questions directing him to his "professional practice" or direct experience with victims could have been avoided altogether. Instead, lawyers could have posed questions simply to elicit Dr. Sotheara's expert opinion, taken from the variety of sources established at the start.

We further suggest that a solid evidentiary foundation for psychological expert testimony should include documentation of experiences specific to the crimes at issue, specifically victim testimony and expert reports from authorized licensed practitioners who had direct interactions with victims. Such testimony would ideally include culturally-specific impacts or language used by victims to describe their experiences of trauma. In addition, testifying experts should review official reports from global health agencies and human rights organizations that provided assistance in response to the crimes. Wherever possible, published peer-reviewed manuscripts of studies involving the specific population of individuals affected by the current crime base should also be reviewed and incorporated into

reports and the presentation oral testimony.

Expert testimony on victim trauma should explain the generally-established knowledge regarding the impact of experiences similar to the crimes at issue in the case, for example by reference to the Diagnostic and Statistical Manual of Mental Disorders, 5th Edition (DSM-5), which is published by the American Psychiatric Association. DSM-5 offers the standard criteria for the classification of mental disorders and is used and accepted internationally by clinicians, researchers, health regulation agencies, legal systems, and policy makers. Diagnoses and specific symptom presentations of those impacted by the crimes at issue could be defined in a standardized way based on the DSM-5.

In addition, such expert testimony should incorporate a comprehensive literature review identifying empirically-validated research articles related to the topics addressed.⁹⁵⁸ In this review, experts should rely only on articles that are the products of a critical peer review process to confirm credibility; manuscripts should not be included if they were purely theoretical or were based on case- or single-studies that did not undergo rigorous peer review (e.g., an unpublished thesis or dissertation). Wherever possible, path-breaking articles by experts and leaders in their respective fields of study should be included and highlighted in reports and subsequent testimony.

Opinions of local experts should guide inclusion of previous research and supplement the massive amount of data that exist in the psychological and psychiatric literature. These opinions should be informed by considerable experience treating, representing, and working with victims of severe trauma and in communities impacted by massive human rights violations. Finally, judges and lawyers eliciting testimony from psychological experts should avoid overreliance either on anecdote or generalizations and instead take care that all of the scientific foundations are presented in a manner that allows the experts to explain how each of these steps contributes to their conclusions linking the commission of the crimes at issue to the impact on the victims, their family members, and their communities. We have included in Annex I to this article a brief outline of the major elements we recommend including in presenting written or oral expert testimony regarding victim trauma in cases involving mass atrocity crimes.

⁹⁵⁸ Electronic databases including PUBMED/MEDLINE and PsycINFO can be searched for key terms related to areas of study relevant to the current report (e.g., "trauma", "posttraumatic stress disorder"). The results may include single studies, meta-analyses (wherein multiple studies are statistically combined to determine the effect of a particular subject matter), and review articles (wherein multiple studies are combined in narrative form to draw conclusions on a specific subject matter).

Conclusion

Evidence of psychological harm suffered by the victims played a significant role in the Case 002/1 judgment, and this evidence was widely publicized by local media during the trial. Despite the success of the Victim Impact Hearing and accompanying expert testimony, more and better evidence on impact can be developed in similar hearings in the future. The Trial Chamber's reliance in its Judgment on mass trauma evidence indicates its importance for future trials. We hope this approach will inspire the use of such evidence not only in future trials before the ECCC but in mass atrocity trials across the globe. Introducing expert testimony based on general psychological knowledge, clinical experience, and empirically-validated research, especially research surveying the affected population of victims, will ensure the introduction of more and better evidence of the impact of the crimes on victim communities. This, in turn, will aid the Court's understanding of the gravity of the crimes at issue, provide recognition to victims who suffered direct or indirect harms as a result of the crimes, raise public awareness on the medical, psychological, and social needs of victims in post-conflict communities, and lay the groundwork for the establishment of comprehensive mental health services for victim populations.

Annex I

Information to Include in a Report or Outline for Testimony

1. **General Knowledge:** A comprehensive review of the known physical and psychological effects of trauma, including common outcomes and comorbid issues. Mental health outcomes of terror and trauma should not be limited to PTSD.

- a. Overview of conventions of syndromes well understood in medical sciences (Diagnostic and Statistical Manual of Mental Disorders (DSM), International Statistical Classification of Diseases and Related Health Problems (ICD), etc.).
- b. Description of validated tools for assessing mental health symptoms and disorders.
- c. Summary of evidence for how psychiatric changes produce suffering and impair functioning.

2. **Known Effects of Crimes at Issue:** A detailed summary of the known effects of mass trauma and human rights violations on populations, as well as

evidence relating to the specific case.

- a. Summary of findings related to the social and psychological outcomes for exposed populations, e.g., high prevalence of mental illness, impaired social functioning and academic achievement, increased substance use and medical issues.

- b. Presentation of evidence on the intergenerational effects of mass population-wide trauma. Findings are well documented in multiple populations, but may not yet be available for current case.

3. **Evaluating Effects in the Victim Population:** Review of the science of epidemiology and an overview of population-based studies on the exposed victim population.

- a. Description of methods, validity and outcomes of epidemiology studies. World Health Organization (WHO) statistics may be used as a model for accepted practices.

- b. Delineation of the scientific standards by which judges should evaluate these types of data.

- c. Summary of key findings from the analysis of the population-based studies.

4. **Making the Link:** Clear and specific argument for the importance of considering psychological trauma in the evaluation of the crimes at issue.

- a. Summary of evidence for psychological suffering caused by crimes at issue in the case.

- b. Demonstration of the direct link between crime and mental health outcomes of both the individual and population. It should be shown, if possible, that the perpetrators of such crimes are directly responsible for the psychiatric outcomes of victims in the same way that they are responsible for physical or property damage.

II

CREATING REPORTS ON PSYCHOLOGICAL OUTCOMES OF POLITICAL VIOLENCE IN HUMAN RIGHTS CRIMINAL CASES: THE HUMAN RIGHTS IN TRAUMA MENTAL HEALTH LABORATORY AT STANFORD UNIVERSITY

Daryn Reicherter (M.D.) is Clinical Associate Professor, Psychiatry and Behavioral Sciences and Director of the Human Rights in Trauma Mental Health Laboratory at Stanford University School of Medicine.

David Reed & Rachel Williamson are PhD students in Clinical Psychology at Palo Alto University.

Ryan Matlow (Ph.D.) is the Director of Research Programs for the Early Life Stress and Pediatric Anxiety Program at the Stanford University School of Medicine.

Introduction

Insults to human psychology are often a striking aspect of human rights cases. Indeed, in many ways, human psychology is the target of war crimes and human rights violations. The effects of trauma, both emotional and physical, on the human condition are a means to evoke the desired effect: terror on the part of the victim and his or her community. And yet, while the effects of trauma on mental health are evident throughout human rights proceedings, they are not always formally referenced or highlighted in court proceedings despite the quantified, well-documented, and impressive data on the etiology, epidemiology, and long-term consequences of trauma on mental health. Given that there is a field of science devoted to understanding and addressing these effects with standard, reliable, and valid forms of measurement, these data could be used in tribunals, courts, and truth commissions as evidence for the prosecution, at the time of sentencing, and/or when measuring damages owed to victims. It should also be a component of the documentation of crimes and highlighted throughout the process of prosecution and restitution.

Psychological Effects of War Crimes and Human Rights Violations: Science of Epidemiology

In many circumstances, human psychology is a target for the perpetrators of human rights violations. Regardless of the ultimate goals that may fuel human rights violations (political disputes, economic competition, etc.), psychological terror has been used as a tool against individuals and populations. Methods of terror are intended to create psychological reactions and outcomes, and have been well-designed to have a lasting psychological impact on individuals and populations exposed.⁹⁵⁹ Not surprisingly, there are serious negative psychological outcomes following the commission of human rights abuses at the individual, familial, and community levels.⁹⁶⁰

Psychiatrists and psychologists often work with individuals as single units within targeted populations, whereas sociologists and anthropologists work with groups and populations. Individual cases can be aggregated for research purposes, generating a substantial academic discourse around, and body of evidence of, the psychological effects of trauma. As a result, scientists in the fields of medicine and psychology have compiled a large body of data concerning common outcomes following human rights abuses.⁹⁶¹ In fact, compilations of data from many individuals (a subpopulation of the population of interest) has allowed specialists working in the fields of psychiatry and psychology to define common symptom patterns associated with trauma with great reliability (i.e., scientists can consistently provide accurate results) and validity (i.e., scientists can accurately understand, and differentiate between, one disorder compared to another). Within these conventions and through application of the scientific method, scientists are able to describe and explain that the observed psychological outcomes are a direct result of the trauma in human rights cases.⁹⁶²

Epidemiological science—the study of the patterns, causes, and effects of disease conditions on defined populations—is one of the basic tools of health care. Mental health epidemiology is no different from that of other medical

959 Reicherter D, Alyward A, Student A, Koopman C, *The Psychology of Denial in the Political Context: The Case of Torture*, in THE PSYCHOLOGY OF DENIAL, SK Ogden and AD Biebers (Eds.), Nova Science Publishers, Inc., Hauppauge, NY (2010).

960 Kinzie, J. D., Fredrickson, R. H., Ben, R., Fleck, J., Karls, W., *Posttraumatic Stress Disorder among Survivors of Cambodian Concentration Camps*, 141(5) JOURNAL OF AMERICAN PSYCHIATRY 645-650 (1984); Niederland, W. G., *The Problem of the Survivor: Part I, Some Remarks on the Psychiatric Evaluation of Emotional Disorders in Survivors of Nazi Persecution*, publisher not identified, (1961).

961 Murthy, R.S. & Lakshminarayana, R., *Mental Health Consequences of War: A Brief Review of Research Findings*, 5(1) WORLD PSYCHIATRY 25 (2006).

962 Murthy, R.S. & Lakshminarayana, R., *Mental Health Consequences of War: A Brief Review of Research Findings*, 5(1) World Psychiatry 25 (2006); Reicherter D, Sugarbaker R, *Mental Health Consequences of War and Political Conflict*, in THE INTERNATIONAL HANDBOOK OF PSYCHIATRY: A CONCISE GUIDE FOR MEDICAL STUDENTS, RESIDENTS, AND MEDICAL PRACTITIONERS, LW Roberts (Ed.), World Scientific Publishing, Hackensack, NJ, (2013).

professions (such as the science that has proven that tobacco use causes a range of medical diseases). It is no surprise that in populations exposed to human rights violations, epidemiologists often see a higher prevalence of the mental health pathologies associated with trauma. The link between traumatic experiences and negative mental health outcomes has now been proven beyond a reasonable doubt and is universally accepted.⁹⁶³ The epidemiology of trauma and its mental health outcomes is similarly well documented. Unsurprisingly, populations exposed to war crimes and other international crimes have a heightened prevalence of trauma-related mental health problems.⁹⁶⁴

With advances in neuroscience technology and research in recent decades, scientists are now able to identify, describe, and measure the neurobiological consequences that result from exposure to traumatic stress such as that which occurs during and following instances of serious human rights violations. We have the ability to describe the biological and neurological mechanisms that lead to negative physical and mental health outcomes. Neuroscience research also explains how these negative outcomes impact not only the individuals and groups directly victimized in human rights violations, but also the way in which this harm can be transmitted inter-generationally.⁹⁶⁵ Therefore, the neuroscience of traumatic stress provides a context for the epidemiological study of populations affected by human rights violations. Despite its accepted forensic merit, this science is usually not deployed in the investigation or prosecution of international crimes.

In response to this perceived gap, the Human Rights in Mental Health Trauma

963 For example, Kilpatrick, D.G., Edmunds, C., Seymour, A., *Rape in America: A report to the nation*, National Victim Center & the Crime Victims Research and Treatment Center, Medical University of South Carolina (1992); Kessler, R. C., Sonnega, A., Bromet, E., Hughes, M., & Nelson, C. B., *Posttraumatic stress disorder in the National Comorbidity Survey*, 52(12) ARCHIVES OF GENERAL PSYCHIATRY 1048-1060 (1995); Dunmore, E., Clark, D. M., & Ehlers, A., *Cognitive factors involved in the onset and maintenance of posttraumatic stress disorder (PTSD) after physical or sexual assault*, 37(9) BEHAVIOUR RESEARCH AND THERAPY 809-829 (1999); van der Kolk, B., Pynoos, R. S., Cicchetti, D., Cloitre, M., et al., *Proposal to include a developmental trauma disorder diagnosis for children and adolescents in DSM-5*, (2009) <http://www.traumacenter.org/announcements/DTD_papers_Oct_09.pdf>; Cloitre, M., Stolbach, B. C., Herman, J. L., van der Kolk, B., et al., *A developmental approach to complex PTSD: Childhood and adult cumulative trauma as predictors of symptoms complexity*, 22 JOURNAL OF TRAUMATIC STRESS 399-408 (2009); D'Andrea, W., Ford, J., Stolbach, B., Spinazzola, J., van der Kolk, B. A., *Understanding interpersonal trauma in children: Why we need a developmentally appropriate trauma diagnosis*, 82 AMERICAN JOURNAL OF ORTHOPSYCHIATRY 187-200 (2012); Morof, D. F., Sami, S., Mangeni, M., Blanton, C., Cardozo, B. L., & Tomczyk, B., *A cross-sectional survey on gender-based violence and mental health among female urban refugees and asylum seekers in Kampala, Uganda*, 127(2) INTERNATIONAL JOURNAL OF GYNECOLOGY & OBSTETRICS 138-143, (2014).

964 de Jong et al., *Lifetime Events and Posttraumatic Stress Disorder in 4 Postconflict Settings*, 286 JAMA 555 (2001).

965 Schore, A. N., *Dysregulation of the right brain: a fundamental mechanism of traumatic attachment and the psychopathogenesis of posttraumatic stress disorder*, 36(1) AUSTRALIAN & NEW ZEALAND JOURNAL OF PSYCHIATRY 9-30 (2002); Yehuda, R., Daskalakis, N.P., Bierer, L.M., Bader, H.N., Klengel, T., Holsboer, F., & Binder, E.B., *Holocaust exposure induced intergenerational effects on FKBP5 methylation*, BIOLOGICAL PSYCHIATRY, (2015, Aug 12) <<http://dx.doi.org/10.1016/j.biopsych.2015.08.005>>.

Laboratory at Stanford University (“Lab”) aims to integrate this research and science into legal processes. The Lab has developed a report writing methodology and has served as a consultant to several international and domestic courts considering the impacts of trauma on survivors in contemporary cases.⁹⁶⁶ The Lab is comprised of faculty from the Department of Psychiatry and Behavioral Sciences, the School of Law, and the University’s human rights program based at the WSD HANDA Center for Human Rights & International Justice. Graduate students may participate in the collection and review of data from the established literature. Faculty from other Stanford University departments have been called upon as needed. The lab also collaborates with international experts relevant to particular cases. Reports issued by the Lab reflect this broad interdisciplinary collaboration. Appendix C of this volume contains an expert report detailing the mental health impacts of crimes committed during the Khmer Rouge era and in particular the crimes being adjudicated in Case 002 before the Extraordinary Chambers in the Courts of Cambodia.

Using Epidemiology for Evidence in International Human Rights Cases

Information on the epidemiology of the mental health effects of trauma is regularly published in scientific journals. These journal articles are peer-reviewed and go through a rigorous screening process prior to publication. The reviewers are experts in the field, and they provide feedback and suggestions for revisions as part of the editorial process. Because of their technical nature, scientific journals can be difficult to understand to those who do not already have a base knowledge of the field. Judges recognize this and thus regularly rely on expert testimony to synthesize the current literature and present it in court. It is reasonable for both investigators and the courts to rely on such testimony from world leaders in mental health.

Expert testimony must be validated and admitted into evidence to be considered by the court. All court systems have their own vetting process for expert witnesses. It is up to the attorney of interest to provide the court with proper foundation for concluding that a potential witness is worthy of being certified as an expert pursuant to the prevailing evidentiary standards governing such testimony.

In terms of the substance of their testimony, an advantage of appearing as an expert witness is that the expert can present his or her opinions on the matters at issue in the litigation as well as information from multiple different kinds of

966 See Human Rights in Trauma Mental Health Laboratory, <<http://med.stanford.edu/psychiatry/research/HumanRightsinTraumaMH.html>>.

sources, so long as they constitute the kinds of materials on which experts in the particular field would normally rely. This can include peer-reviewed epidemiological research as well as the reports of civil society organizations (e.g., Human Rights Watch and Amnesty International). While many such advocacy organizations are well-established and generate trusted sources of information, any information found online should be properly analyzed by an expert not only for content, but also for reputability and, in particular, conflicts of interest. Expert witnesses may also review and comment upon relevant court testimony that can corroborate his or her testimony. In addition, expert witnesses have the ability to collaborate with other experts in the field and conduct their own research for a specific case. This may include field work in the victim population of interest and qualitative and/or quantitative analyses of data specific to the case. Testimony and/or data from medical/psychological examinations can corroborate the existing literature and provide evidence of the real-time effects of human rights crimes in the form of quantitative and/or qualitative data. By using the existing epidemiological literature, combined with witness-generated information, an expert witness has the ability to reasonably deduce what psychosocial and medical conditions might be endemic in the population of interest (i.e. the victims in the court proceedings).

Using Epidemiology for Reconciliation and Reparations in Other Transitional Justice Processes

Mental health epidemiology is relevant for other purposes outside of the courtroom. The consideration of mental health outcomes in victim populations may assist in advocacy for psychological care for those individuals who are directly involved with these cases (e.g., victims and witnesses). International criminal courts are becoming increasingly sophisticated about this notion and more regularly provide mental health support for victim-witnesses through specialized units. Mental health analysis from experts can also assist in identifying the long-term mental health needs of, and resources for, survivor populations. Expert testimony or a carefully-drafted report that examines the specific crimes and outcomes can educate courts on the effects of identified human rights violations for the purpose of designing appropriate interventions for the survivors during and after trial. Finally, mental health experts can assist with advocacy for the incorporation of mental health needs in the evaluation of reparations for survivor populations.

It is fairly straight-forward to assess damages when it comes to the destruction of physical property, expenditures for medical procedures, and anything else with

quantifiable monetary value. Outside of services sought as a direct result of the crimes committed against survivors, however, quantifying reparations for mental health outcomes can be difficult, subjective, and oblique, particularly given the lack of established guidelines. The first step in creating such guidelines for reparations—whether they be in the form of direct monetary redress, the establishment of community-based health systems, interventions that support healing (e.g., mental health training, outreach, and treatment facilities), or symbolic measures (e.g., memorials)—is to understand what harm needs to be repaired. Expert testimony and reports can facilitate this understanding by providing direct and indirect evidence of how crimes against humanity lead to negative psychological outcomes, which can cause additional impairments in social functioning and physical health.

Specific Methods for Developing Experts' Reports: Methods Employed by the Human Rights in Trauma Laboratory

Expert witnesses will generally be required to submit a report detailing their intended testimony, including their qualifications, methodology, general conclusions, and recommendations. The aim of such report writing in human rights cases is to place the specific experiences of victims of the international crimes at issue within the context of the general psychiatric, psychological, and medical knowledge of the impact of such crimes. The methodology for developing such reports thus entails a review of documentation of local and specific experiences, along with a broader review of the general established literature. The documentation of experiences related to the specific case in question can also include validated victim testimony and other expert reports or testimony from authorized licensed practitioners who had direct interactions with victims. In addition, official reports from global health agencies and human rights organizations that provided assistance in connection with the commission of such crimes can be included in the report. Wherever possible, published peer-reviewed manuscripts of studies involving the specific population of individuals affected by the current crime will be incorporated.

Most experts in the psycho-social harm of international crimes will begin by referring to the Diagnostic and Statistical Manual of Mental Disorders (DSM-5),⁹⁶⁷ published by the American Psychiatric Association, which offers the standard criteria for the classification of mental health disorders and is accepted internationally by clinicians, researchers, health regulation agencies, legal systems,

⁹⁶⁷ American Psychiatric Association, *Diagnostic and statistical manual of mental disorders* (5th ed., 2013), Washington, DC.

and policy makers. Diagnoses and specific symptom presentations of those impacted by the crime(s) in question can be defined in a standardized way based on the DSM-5. The report can rely upon the DSM-5 to connect specific diagnoses and symptom presentations with the various forms of functional impairment that are known to be associated with the relevant mental health disorders.

Reports generated by mental health specialists should also provide a comprehensive review of the known physical and psychological effects of trauma, including common outcomes and comorbidities drawn from the established academic and clinical literature. Given the confirmed links between traumatic stress exposure and increased prevalence and severity of a wide range of mental health disorders, mental health outcomes of terror and trauma should not be limited to prevalence of single mental health diagnoses (e.g., post-traumatic stress disorder, or PTSD). Rather, the expert should provide an overview of conventions of syndromes well-understood in medical sciences using, but not limited to, diagnostic codes found in well-established medical conventions (e.g., DSM-5 and the International Classification of Disorders [ICD]-10).⁹⁶⁸ Reports generated for any transitional justice mechanism should include a concise description of validated tools for assessing mental health symptoms and disorders as well as a summary of evidence for how psychiatric changes produce suffering and impair functioning. Such reports can focus on the outcomes of the specific case, but also reveal related aggregate data.

The aggregated data and the peer-reviewed studies mentioned above may come from multiple sources. In order to obtain these data, a comprehensive literature review is performed to identify empirically-validated research articles related to topics addressed in the report. Electronic databases including MEDLINE/PUBMED⁹⁶⁹ and PsycINFO⁹⁷⁰ are searched for key terms related to areas of study relevant to the current report (e.g., using such search terms as “trauma” and “posttraumatic stress disorder”). The results include single studies, meta-analyses (wherein multiple studies are statistically combined to determine the effect of a particular subject matter), and review articles (wherein multiple studies are combined in narrative form to draw conclusions on a specific subject matter). Research articles cited in the reports are the products of a critical peer review process to confirm credibility; in general, we do not make reference to manuscripts that were purely theoretical, were based on case- or single-studies, or

did not undergo peer review (e.g., a thesis or dissertation). Wherever possible, seminal articles by experts and leaders in their respective field of study are included and highlighted.

In addition to focusing on particular victims and witnesses, an expert report should also include a summary of findings related to the social and psychological outcomes for other exposed populations (e.g., a high prevalence of mental illness, impaired social functioning and academic achievement, increased substance use, and accompanying medical issues). There is a rich comparative literature to support this approach from a global perspective. In addition, expert reports can discuss the intergenerational effects of mass trauma. These findings are well-documented in multiple populations, but may or may not yet be detailed/studied in a particular population before a particular court. Accordingly, expert reports can include a review of the neuroscience of stress and trauma in order to provide a foundation for understanding the common mechanisms by which human rights violations and mass trauma lead to negative outcomes in all human populations, regardless of culture. The neurobiological consequences of trauma exposure are objectively and quantitatively measured; this science and literature can therefore strengthen the arguments that link human rights violations with negative outcomes in exposed populations.

Finally, the report authors should also include their expert opinions to supplement the massive amounts of data that exist in the psychological and psychiatric literature. These opinions should be informed by considerable experience treating, representing, and working with victims of severe trauma and in communities impacted by massive human rights violations.

The inclusion of a detailed summary of the known effects of mass trauma and human rights violations on populations, as well as evidence relating to the specific case, enables courts and other transitional justice mechanisms to better understand the negative outcomes for the purpose of elucidating damages, reparations, etc. This will also demonstrate that the perpetrators of such crimes are directly responsible for the psychiatric outcomes and functional impairment of victims in the same way that they are responsible for physical or property damage. This richer understanding should contribute to a fuller understanding of the court's responsibility to provide reparation in the area of mental health interventions for survivors suffering from mental illness as a result of proven international crimes.

Case Example: Population Psychiatry in The Extraordinary Chambers in the Courts of Cambodia

International courts are increasingly receiving expert testimony about mass

⁹⁶⁸ World Health Organization, *The ICD-10 classification of mental and behavioural disorders: Clinical descriptions and diagnostic guidelines*, World Health Organization (1992).

⁹⁶⁹ United States National Library of Medicine *Fact Sheet Medline*, www.nlm.nih.gov/pubs/factsheets/medline.html.

⁹⁷⁰ American Psychological Association, *PsychINFO*, (2016), www.apa.org/pubs/databases/psycinfo.

psychological trauma and mental health epidemiology in the wake of human rights abuses. Most importantly, the Extraordinary Chambers in the Courts of Cambodia (ECCC) established an important precedent when it heard testimony about and relied on the findings from “Cambodia’s Hidden Scars: Trauma Psychology in the Wake of the Khmer Rouge,” the prior edition of this book, which included chapters providing general information about mental health outcomes of massive human rights crimes in Cambodia and elsewhere, as well as specific outcomes manifested in the local survivor population.⁹⁷¹ Through the acceptance of the book as a piece of evidence and of expert testimony about its contents, the ECCC was informed about the grave psychiatric damages suffered by the Khmer people as a result of the specific charges against the defendants in Case 002/1. The testimony of mental health specialist and victim, Sophany Bay, and psychiatrist Sotheara Chhim elucidated the relevant mental health outcome data and impressed the judges as to the severity of the effects. In the final ruling in Case 002/1, the ECCC not only acknowledged the severity of these outcomes as damages in the judgment, but it also paved the way for the Court to recommend appropriate reparations from funding earmarked for the rehabilitation/treatment of the survivors with mental health sequela.⁹⁷²

Conclusion

Negative mental health outcomes are endemic in survivors of grave human rights abuses, yet they are not always formally addressed in transitional justice and other legal mechanisms. The Lab thus recommends that a sensitivity to victims’ mental health characterize multiple stages of such processes. Documenting human rights crimes should include the gathering of information about mental health outcomes resulting from these crimes. Investigators and prosecutors would benefit from considering the mental health outcomes as basic and predictable realities for the survivors. Reports on the mental health outcomes can be used at multiple stages in the progression from documentation and investigation to prosecution and reparation. Thus far, expert testimony and reports may be most applicable in the damages hearing stage of transitional justice processes. However, litigants and policymakers should explore other applications for these sources of information whenever societies are undertaking a process of transitional justice following the commission of human rights violations.

⁹⁷¹ Van Schaack B, Reicherter D, Chhang Y, CAMBODIA’S HIDDEN SCARS: TRAUMA PSYCHOLOGY IN THE WAKE OF THE KHMER ROUGE, Documentation Center of Cambodia, Phnom Penh, Cambodia (2011).

⁹⁷² ECCC judgment, www.eccc.gov.kh/en/document/court/case-00201-judgment.

12

INTERVIEW WITH THE SUPREME MONK SAMDECH PREAHMOHA AREYAVONG VENERABLE SAO CHANTHOL, PH.D.

Youk Chhang is the founder and Executive Director of the Documentation Center of Cambodia.

Samdech Preahmoha Areyavong, Dr. Sao Chanthol (Ph.D.) is the most prominent Buddhist Monk of the Theravada Buddhist Order in the Kingdom of Cambodia. He is the Cambodian Vice Inspectorate General of Buddhist Education, the Vice Rector of Preah Sihanouk Raja Buddhist University, and also the Chief Monk of the Lanka Preahkosomaram Monastery.

I would like to ask you, as a venerable priest, about the Khmer Rouge tribunal, which has been hotly debated since its inception. What is your attitude toward this process?

In my own view, establishing the Khmer Rouge Tribunal is in accordance with the will of Cambodians who are victims of the Khmer Rouge regime and national and international law. Though this process will end up with whatever outcome, it is also a crucial procedure in the history of Cambodia and the truth-seeking process in order to generate and preserve the historical record and lessons for Cambodians’ next generation. The organization and proceedings of this court have critical historical value for Cambodia and for all the world’s citizens.

From the Standpoint of the Dharma, is the tribunal appropriate?

According to *Karma* and *Sanchita* theory in Buddhism, one who does good deeds will receive happiness, while those who do bad things will suffer.⁹⁷³ This means where there is cause, there will be result. If so, why should there be the Khmer Rouge Tribunal? The Khmer Rouge Tribunal was established because there was the Khmer Rouge regime. The leaders of this regime led Cambodia into horrible destruction, i.e. the genocide, which took millions of lives. Thus, based on the above concept, the establishment of this Khmer Rouge Tribunal resulted

⁹⁷³ *Karma sanchita* “is one of the three kinds of karma. It is the sum of one’s past karmas—all actions (accumulated good and bad) from one’s past life follow through to the next life.” See *Three Kinds of Karma*, www.salagram.net/karma-three-kinds.html.

from the genocide. This is in accordance with cause-and-effect relation of the Dharma raised by the respectful Buddha.

Should there be reconciliation between former Khmer Rouge and other Cambodians?

I would briefly answer that there should be reconciliation. This is because reconciliation is the principle that ends the anger in the minds of the relevant individuals toward and from the Khmer Rouge regime. Reconciliation leads to peace among everyone in society and is a way of avoiding revenge. However, reconciliation is addressed to preserve social sustainability and must be acceptable to all conflicting parties.

Do you think that former Khmer Rouge leaders have suffered from what they did?

As mentioned in my second answer, the bad doer must accept the outcomes from their actions. This means what former Khmer Rouge currently receive is the result of their bad deeds in the past.

You have mentioned there is Karma and Sanchita. Did the Khmer Rouge victims from 1975 to 1979 do something wrong?

Talking about *Karma* and *Sanchita* Theory, it is hard to be properly understood. This is the discipline of Buddha and all priests; as such, it is not easy for ordinary people to understand. Still, if one improves his/her knowledge, one could, at least, understand some parts. Thus, I cannot reach a firm conclusion on whether what the victims suffered during Khmer Rouge regime (1975-1979) was their *Sanchita*. It is different from the outcome of the Khmer Rouge leaders, which is the current prosecution before the Khmer Rouge Tribunal; this is happening because of their past *Karma* (genocide). Yet, I would like to clarify again that everything happens based on a process of cause-and-effect. For some situations, people can see both the cause and the effect, while some issues can be seen only in its effect, not its cause. This depends on training, the level of intelligence, experience, etc. It also reflects intangible beliefs and other factors.

Did the Khmer Rouge leaders intentionally commit the crimes?

In response to this question, I have no comment. According to *Dharma*, no layman can see into an individual's mind. Based on legal principles and codes, however, this answer could be different.

Samdech Preahmoha Areyavong, Dr. Sao Chanthol (Ph.D.) is the most prominent Buddhist Monk of the Theravada Buddhist Order in the Kingdom of Cambodia. He is the Cambodian Vice Inspectorate General of Buddhist Education, the Vice Rector of Preah Sihanouk Raja Buddhist University, and also the Chief Monk of the Lanka Preahkosomaram Monastery.

Do you believe in “vindictiveness is ended by not being vindictive”?

Buddha claimed that vindictiveness is ended by not being vindictive; this establishes a strong foundation to avoid misdeeds resulting from anger. Not being vindictive will enable other vindictiveness to end. As a Buddhist, one should intelligently seek a better understanding of this principle in relation to cause and effect, since vindictiveness-related issues are very complicated and depend on the relation between the past, present, and future of each individual. Also, it is even more complicated when it comes to the point that vindictiveness and ending vindictiveness depends on each individual's view. Indeed, in my own view, as a Buddhist monk, I profoundly believe in this perception by referring to *Dharma*, not humankind theory.

Do you think that the study of the Khmer Rouge history may re-traumatize people?

The study of the Khmer Rouge history will surely re-traumatize the victims, for they would be reminded about their past suffering. Nevertheless, this study will also afford them a life lesson, i.e. learning about their experience. At least, they will be in a better position to remember their experiences and educate younger generations to avoid choosing this way. Or, the wise one can, at least, gain the eye of wisdom which can be used to understand that all living things have to face the eight types of *Dharma*: greed, loss, glory, humility, jealousy, praise, happiness, and suffering. Suffering is the beginning of ending the suffering. Consequently, learning about the suffering can help end the suffering.

According to current research, many Cambodians who survived the Khmer Rouge regime are still being traumatized by what happened. How is Buddhism contributing to healing the population?

I would like to impress upon your readers that, based on the supreme truth foundation, Buddha taught humankind to clearly understand suffering (which is a genuine occurrence in all living species' lives), the origins or root causes of suffering, the need to seek the abolition of all suffering, and the ways to end suffering. Furthermore, Buddhism educates people to know about uncertainty (all states normally change), suffering (all states involve the suffering of all living things), and dispossession (all things are not owned by living things). There are many more natural issues that Buddhism teaches. Thus, if all victims during the Khmer Rouge regime concentrate on learning *Dharma* and operate accordingly, they will gain greater intelligence; this will allow the suffering gradually to end. Buddhism can help them if they are willing to let Buddhism help. This means that

they have to seek understanding about *Dharma* and how to operate it. They will live happily because of *Dharma*.

What should the government do to help heal the population? And what can a monk do?

The establishment of the Khmer Rouge Tribunal at this point in time is considered to be an effort by the Royal Government of Cambodia (RGC) to contribute to the psychological healing of Cambodians who have suffered during Khmer Rouge regime. In addition, the RGC helps to heal Cambodian citizens' psychologically through providing education and promoting citizens' standard of living. By having a better life, people can at least partially release their anger.

In regard to Buddhist monks, they also are an important factor in healing citizens' mental problems. This is because monks educate the Buddha's disciples to have a clear understanding about life and the phenomena that happened in their lives. In other words, a monk educates the disciple to have honesty in their lives; later, this will lead to the removal of suffering and the emergence of happiness based on their enhanced knowledge. A monk not only provides educational preaching but also educates people to operate the *Dharma* wisely and introduces meditation that is highly efficient for dealing with psychological matters. Thus, a monk plays a vital role in this effort.

Do you think mental health issues are visible in Cambodia?

Usually, body and mind have a close relationship that cannot be separated. This is just like fire and light. If there is fire, there is light. Thus, are mental health issues visible and acceptable? I would say yes. It is visible through the actions of the people. Currently, if we look at the actual state of Cambodia, we can see that the mental health of Khmer Rouge victims seems better. The economy and society are developed, and Buddhism again can provide people with spiritual motivation after the collapse of Khmer Rouge regime. We can take a close look at people's smiles and the activity at tourist sites and during ceremonies; this reveals that their mental health is better, although their suffering and their memories during that time remain. At least, they can live happily rather than being sad. Based on *Dharma*, all lives have not succeeded to *Nirvana*. This means that they all live in suffering, yet their suffering has been lessened. We can call this happiness, but it is still considered suffering since lives outside *Nirvana* are considered uneducated lives.

13

CAMBODIAN PERSPECTIVES ON THE RESOURCES FOR TRAUMA-RELATED MENTAL HEALTH

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

Kok-Thay Eng (M.A., M.S.) is the former deputy director of the Documentation Center of Cambodia and is currently pursuing a Doctor of Philosophy on Global Affairs at Rutgers University.⁹⁷⁴

Cambodia's mental health system has many strengths and weaknesses. It also has an incredible task ahead of it, given the huge expectations among the populace, the overwhelming demands upon it, 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 presents 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.

⁹⁷⁴ 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 Market 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).

PART III: TRAUMA & THE FUTURE OF MENTAL HEALTH IN CAMBODIA

Methods

This chapter on Cambodian perspectives on 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 - តើអំពើហិង្សាពីអតីតកាលជន់ឥទ្ធិពល ដល់សុខភាពផ្លូវចិត្តរបស់ប្រជាជនកម្ពុជា ដោយរបៀបណាខ្លះនាពេលបច្ចុប្បន្ន? តើអំពើហិង្សារបស់របបខ្មែរក្រហម ជន់ឥទ្ធិពលយ៉ាងដូចម្តេចខ្លះដល់យុវជនកម្ពុជានាពេលបច្ចុប្បន្ន?

2. What are the major challenges/barriers to treating trauma mental health in Cambodia today?

២ - តើអ្វីខ្លះជាទប់ស្កាត់ការព្យាបាលជំងឺផ្លូវចិត្ត 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 សម្រាប់ការព្យាបាលជំងឺផ្លូវចិត្ត តើមានទប់ស្កាត់ផ្សេងទៀតណាខ្លះនៅក្នុងសង្គមកម្ពុជា និងក្នុងប្រព័ន្ធផ្តល់ធនធាន?

4. What are the best solutions for improving the treatment of trauma-related mental health problems in Cambodia?

៤ - តើអ្វីជាដំណោះស្រាយល្អបំផុត សម្រាប់ជំរុញការព្យាបាលជំងឺផ្លូវចិត្ត បង្កឡើងដោយរបបខ្មែរក្រហមកាន់តែមានប្រសិទ្ធភាព?

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 - តើស្ថាប័នដែលមានស្រាប់នៅក្នុងប្រទេសកម្ពុជា ត្រូវជួយក្នុងការបង្កើនការព្យាបាលជំងឺផ្លូវចិត្ត ដែលបង្កឡើងដោយរបបខ្មែរក្រហមយ៉ាងដូចម្តេចខ្លះ?

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 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?

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 Market 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 Sedhaboth (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' these experiences have 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 Sedhaboth (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. Bhoomikumar 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

People of Banteay Ampril District, Oddar Meanchey Province, watching a live screening OF THE verdict of Case 002/01 in August 2014 organized by the Documentation Center of Cambodia (DCCam). During the announcement of the verdict, DC-Cam staff travelled to every corner of the country to set up live screenings of the verdict for people who could not otherwise hear the verdict. The verdict sentenced Khieu Samphan and Nuon Chea to life imprisonment for crimes against humanity. Photo by Ouch Makara Documentation Center of Cambodia Archive.



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*)

A man is reading the textbook "History of Democratic Kampuchea" on his stilt house at Kampong Phluk fishing community, Siem Reap, in March 2015. Kampong Phluk is a floating village on the Tonle Sap Lake, where five to six months a year, the area is covered by water. Villagers earn a living by fishing, growing vegetables, and tourism, as Kampong Phluk has become a site to visit the Lake and flooding vegetation. Stilt houses are built to protect against the flooding, which lasts from May to December. Photo by Ouch Makara/Documentation Center of Cambodia Archive

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 Sedhaboth (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*)

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 the treatment of trauma-related mental health issues among the populace. 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 impediment. 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.

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.

ANALYSIS OF TRAUMA-RELATED MENTAL HEALTH RESOURCES IN CAMBODIA: CONSENSUS IDEAS FOR AN IMPROVED METHOD

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

James Boehnlein (M.D., M.Sc) is Professor of Psychiatry, Oregon Health and Science University, and Associate Director for Education, Veterans Administration Northwest Network Mental Illness Research, Education, and Clinical Center (MIRECC).

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 of 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 been exposed to severe traumatic experiences, which has been highlighted and detailed throughout Part 1 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 social and political systems including, but not limited to, the mental health system.

Trauma-related mental health issues are complicated because the consequences of trauma on psychology will manifest themselves 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 multiple health care systems, social services, and an array of other fields.

Trauma-induced anxiety disorders (e.g., posttraumatic stress disorder) and their co-morbidities (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 at different entry points (like the temple rather than a mental health clinic) for care and treatment. Some Cambodians may turn to the mental health system, but it is more likely that 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, their behaviors may result in interactions with social service agencies or the criminal justice system, as mental health issues often lead 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. 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 adopted 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 performed that analyze the resources for trauma-related mental health disorders and interventions. In the summer of 2010, Joe

Stewart performed a qualitative study of Cambodia's mental health system for the International Organization for Migration.⁹⁷⁵ The overall purpose of Mr. Stewart's research 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 conducted in the fall of 2010 through the Documentation Center of Cambodia by psychiatrists Jim Boehnlein and Daryn Reicherter in order to examine resources specifically designed for the treatment of trauma-related mental health issues.⁹⁷⁶ 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 within the mental health field, 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 includes 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 reflect the 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-

⁹⁷⁵ See Int'l Org. for Migration—Cambodia, *Mental Health in Cambodia: A Qualitative Evaluation* (forthcoming).

⁹⁷⁶ This study was not conducted for research purposes, but with the intent of generating the information for this chapter.

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 in place 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 indirectly deal with issues related to trauma-related mental health. This general willingness for greater cooperation and collaboration within the NGO network and between government agencies has led to a growing understanding of the importance of psychological factors affecting those served by these agencies.

Another area of great strength is the professionalism 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 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 of the professionals 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 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; 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 master's 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 phenomenon is 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 undermining the awareness of mental distress and mental health needs, impeding the creation of programs for training mental health professionals, and preventing funding ongoing services. Partially because of this stigma, there has not been adequate awareness of how psychological and emotional distress impact physical illness, 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's, much focus 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 the developing country context: the 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, expanding and improving all mental health services will advance the continued development of the trauma-related mental health sector.

The further development of mental health services depends on increased



A man wearing a Krama lying on his bed on the ground floor of his house in Battambang in March 2015. Taking a nap is a common practice for Cambodian farmers, who typically take a short break from work after lunch as the weather is too hot to go out in the field. In most cases, parents do not allow their small kids to play or climb up trees after lunch as they believe that ghosts roam around at noon. Villagers resume their work at around 2 p.m. when the weather cools. Photo by Ouch Makara Documentation Center of Cambodia Archive

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 unstable and dependent on inconsistent 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), seeking to incorporate multiple mental health stakeholders in organizational programming, and focusing on long-term infrastructure building within government and NGOs. 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 the 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 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, encourages those who are suffering to seek treatment and promotes an awareness of mental health issues 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 mental health concepts, the development of general clinical skills, and trauma-related mental health treatment.

As a means of attracting more attention and support, repeated calls have been made for the government and IOs 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 to mental health issues, 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.⁹⁷⁷ At present, there exists a small number of committed NGOs, the 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 NGOs—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 and 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

⁹⁷⁷ B. Saraceno et al., *Barriers To Improvement Of Mental Health Services In Low-Income and Middle-Income Countries*, LANCET 76-86 (2007).

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 can be funded 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, participants advocated for increasing education for the public on mental health issues and on available treatment services, and for promoting positive mental health behaviors. Borrowing from the success of the HIV public awareness campaigns, mental health professionals and advocates could employ similar methods to broaden awareness of what mental health is and what can be done to manage and improve 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.

LETTER TO THE KINGDOM OF CAMBODIA

July 15, 2011

Dear Excellency Prime Minister Hun Sen,

Based on the research of international expert consultants together with Cambodian mental health agencies and government mental health administrators, we have developed a plan for improving mental health services in Cambodia. We are proposing increased resource allocation to heighten the impact of the national mental health plan and augment access to services for trauma-related mental health problems throughout the country. As a core component, we are requesting that the government establish a National Center for Mental Health in Phnom Penh to provide a centralized location from which mental health policies can be implemented. We offer a synopsis of our proposal below for your consideration.

Detailed analysis of the current resources for trauma mental health is available in "Analysis of Trauma Mental Health Resources in Cambodia: Consensus Ideas for an Improved Method," a chapter in the forthcoming book from the Documentation Center of Cambodia: *CAMBODIA'S HIDDEN SCARS: TRAUMA MENTAL HEALTH IN THE WAKE OF THE KHMER ROUGE*. For your further information, an advance copy of this publication is included as an attachment to this letter.

Summary of Observations

The people of Cambodia have suffered extremes of trauma. According to studies, as much as one third of the population meets the DSM⁹⁷⁸ criterion for the Western diagnosis of Post-Traumatic Stress Disorder (PTSD). Even more people have mental health pathology related to trauma and its effects. Mental health pathology causes a huge burden of suffering and, when untreated, personal and social dysfunction.

The current 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 for their day-to-day life. And the primary mental health problems are usually unidentified and untreated.

Many Cambodians were traumatized during the Pol Pot years. Many more Cambodians are young and not survivors of Pol Pot. But the consequences of trauma have had a profound effect directly (via other trauma) or indirectly (2nd generation effects of trauma). They have known only a post-genocide, post-conflict society. Trauma related mental health problems cause personal and societal dysfunction and contribute to economic decline.

Despite the high burden of mental health problems, there is little recognition of mental illness in the public. There is a huge stigma against mental illness. There is very little public knowledge about the destructive outcomes of trauma on people's health and mental health. Persons suffering with trauma related mental health problems tend not to get appropriate treatment.

Given the lack of public understanding around mental health, most Cambodians may not

⁹⁷⁸ The Diagnostic and Statistical Manual of Mental Disorders (DSM) is published by the American Psychiatric Association and provides generally accepted criteria for the classification of mental disorders.

interpret their own mental health symptoms as such. Most people suffering with trauma related mental health issues would not seek help even though the symptoms cause dysfunction. If one were to seek help, it is likely that one would seek the help of a non-mental health professional (a primary care doctor, a monk, a kru Khmer, etc).

Most alternative healers and spiritual figures are not educated in (Western) mental health. Most would have an entirely different explanation and solution for the situation. Most Western doctors (primary care) are not well trained in mental health. There is limited sharing of ideas on how to connect concepts for treating.

A Western mental health treatment model may have limited applicability for the big picture of dealing with the public health problem of trauma in Cambodia because of cultural differences and because of resource limitations. Psychiatric medication alone will not ameliorate trauma related mental health conditions. Even if psychotropic medication were a reasonable solution, 26 psychiatrists cannot treat 14 million people. Even if the number of psychiatrists were increased tenfold, it would still not come close to meeting the need for assessment, prescription, and regular monitoring. Furthermore, the country's formulary (list of available medications) consists of a limited number of older medications. These medications are often discontinued as a result of intolerable side effects. And there are limited financial resources.

Psychotherapy is a Western idea that may or may not have adequate impact in Cambodia. Psychotherapists require rigorous and long training before therapy can appropriately be introduced. Effective therapy may require long-term contact. The effectiveness of therapy for PTSD is variable even in the West, by well-trained therapists. Some hybridization of Western and Khmer approaches to treatment would be most likely to be accepted and effective.

Trauma and mental health are not seen as major priorities for the government's health care plan. There is very little government funding for trauma related mental health. There is little resource allocation to "mental health" generally, and the issue of trauma related mental health is given very little priority even under that rubric.

The National Mental Health Program (NMHP), working together with several mental health NGOs, is the leading broker of mental health services and education around mental health. Many NGOs deal with trauma related mental illness indirectly and may or may not understand that that is what they are dealing with. These groups are overburdened and under-resourced. They are poorly coordinated with each other and with the NMHP. In fact they are often pitted against each other in competition for very limited funding opportunities.

Ideas for Improvement

Financial Resources

In order for any serious attention to be given to the overwhelming issue of trauma mental health, financial resources must be adjusted to provide mental health providers with reasonable budget to address the issues of Cambodia. The other serious obstacles (like human resources, coordination of efforts, training, etc.) cannot be addressed without increased funding.

The Government Health Budget should be adjusted to provide a realistic percentage of the overall budget for 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 (like schizophrenia) fall into the catchments for the provisions of government spending. Trauma psychopathology is not well addressed. Changes in government funding patterns are recommended to ensure a permanent shift in the percentage of the budget going to mental health so that trauma

related mental health issues can be seriously brokored into the National Mental Health Plan.

The government can encourage the direction of international donor funding to go toward trauma mental health. If the government acknowledges this issue as a prime objective for the Kingdom of Cambodia, they may influence the flow of funding into programs that deal with trauma mental health.

Increase Awareness to the Issues

The government should promote a public health campaign toward awareness and destigmatization of mental health problems associated with trauma. Such a campaign would likely involve partnership with international health interest organizations (like the World Health Organization) and with local NGOs (like Trans-cultural Psychosocial Organization and the Documentation Center of Cambodia). This public education project should be seen as similar to advocacy campaigns pioneered successfully for education and prevention/treatment of HIV.

Within the government, awareness and concern should be promoted. Given the traumatic past history and current reconciliation efforts of the ECCC, the government must acknowledge the consequences that trauma has on its people and the areas of dysfunction this has created.

Within health care, campaigns of awareness should be considered. 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 is important for providers to increase their efficiency.

Coordination of Efforts

The appropriate conceptualization of trauma mental health expands beyond what is usually thought about under "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 coordination of efforts and collaborations has developed spontaneously, but such efforts are not completely organized and they tend to be non-inclusive.

We recommend an interdisciplinary coordination of services by a non-biased consulting group (like the 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 the efforts that are executed to maximize efficiency and reduce redundancy of services. Also, such coordination could improve communication among agencies as well as 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.

Sustainability

The above general recommendations can only be made useful with sustainable resources. For each category recommended, the government may consider a way to maintain insurance of continuation and accountability. We are recommending a paradigm shift in attention and resources to trauma mental health rather than a symbolic or singular injection of one-time resources that are unsustainable. For instance a one-time infusion of financial resources into the mental health

system would be irrelevant relative to new legislation demanding a greater percentage of the overall health budget to go toward this issue. We strongly suggest policy change toward sustainable versions of solutions for the above recommendations.

Sincerely,

Youk Chhang
Director, Documentation Center of Cambodia

Enclosure

cc: H.E. Mr. Him Chhem, Minister of Culture and Fine Arts

A similar letter was sent to Rong Chhorng, Head of the Victims Support Section (VSS), Extraordinary Chambers in the Courts of Cambodia (ECCC) and cc: Mr. Tony Kranch, Acting Director of Administration. As detailed in chapter 10, the Extraordinary Chambers in the Courts of Cambodia integrated many of these recommendations into its second reparations award within the context of the ECCC framework.

APPENDIX B: RESPONSE FROM THE KINGDOM OF CAMBODIA

Nation Religion King

The Office of the Council of Ministers
N0: 1316 LS AV

Phnom Penh, August 18, 2011

Deputy Prime Minister, Minister in charge of the Office of the Council of Ministers Inform to
His Excellency Minister of the Ministry of Health

Objective: Research study and Recommendation from the Documentation Center of Cambodia.

Reference: Letter from the Documentation Center of Cambodia, dated July 15, 2011, sent to
Samdech Akka Moha Sena Padei Techo, the Prime Minister of the Kingdom of Cambodia.

Pursuant to above objective and reference, I would like to inform Your Excellency Minister
that the Documentation Center of Cambodia has requested the Royal Government to build a
mental health hospital to promote mental health service in Cambodia.

As above mentions, may Your Excellency Minister kindly study and advice over the
recommendation from the Documentation Center of Cambodia to enable the Office of the
Council of Ministers to have the foundation to present a recommendation to the Royal
Government for consideration and approval.

Please, Your Excellency Minister, accept the assurance of my utmost regard.

On behalf of Deputy Prime Minister, Minister in charge of
the Office of the Council of Ministers
Secretary of State
[Signed and Sealed]
Seng Limneou

Copied

- Cabinet of Samdech Akka Moha Sena Padei Techo, the Prime Minister
- Cabinet of His Excellency Deputy Prime Minister
- Documentation Center of Cambodia
- Chronological – Documentation

**APPENDIX C:
THE MENTAL HEALTH OUTCOMES
RESULTING FROM CRIMES COMMITTED
BY THE KHMER ROUGE REGIME
BEFORE THE EXTRAORDINARY CHAMBERS
IN THE COURTS OF CAMBODIA
IN CASE 002/2**

THE MENTAL HEALTH OUTCOMES RESULTING FROM CRIMES COMMITTED BY THE KHMER ROUGE REGIME

Produced by the Human Rights in Trauma Mental Health Laboratory, Stanford University Department of Psychiatry and Behavioral Sciences, Stanford University School of Medicine, on Mental Health Outcomes Related to Crimes Before the Extraordinary Chambers in the Courts of Cambodia in Case 002/2

I. Introduction

We represent the Human Rights in Trauma Mental Health Laboratory, an interdisciplinary program based at Stanford University and comprising members of the Department of Psychiatry and Behavioral Sciences and the Palo Alto University Clinical Psychology Ph.D. Program. Among our members are psychiatrists, professors of medicine, private treating psychotherapists and social workers, human rights lawyers, law professors, and graduate and undergraduate students. The members of this Lab have amassed considerable expertise in trauma mental health from a range of disciplinary perspectives that render us qualified to submit this Experts' Report ("Report"). In producing this Report, our lab has collaborated with professionals from the Kingdom of Cambodia and expert witnesses certified by the Extraordinary Chambers in the Courts of Cambodia (ECCC) specializing in Khmer mental health. By way of background, attached to this Report are the *curricula vitae* (Exhibit A) from the writers of the report. We did not receive any compensation in connection with our preparation of this Report.

This submission is based on our review of the evidence and trial record in the cases designated ECCC 001/1, 002/1, and 002/2 (including the reference material on mental health accepted as evidence, the testimony of Dr. Sotheara Chhim of the Transcultural Psychosocial Organization (TPO), and the testimony of Civil Parties), along with a comprehensive and comparative literature review on the psycho-social impact of war violence and other forms of extreme trauma on individuals, their families, and their communities. In this Report, we rely upon empirical research that links trauma exposure with damaging psychophysiological and neurobiological outcomes, thereby elucidating the mechanisms by which violence and other forms of extreme trauma give rise to the psychosocial outcomes documented in the record. This Report is also

informed by our long experience treating, representing, and working with victims of severe trauma in communities wracked by massive human rights violations, including more than ten years of work with Cambodian survivors abroad and in the Kingdom of Cambodia. Finally, we reviewed testimony from victim witnesses at trial in order to show a direct connection between the academic literature, the expert testimony, and the impact of actual events in Cambodia during the Khmer Rouge era. Direct quotations from Khmer Civil Party testimony are compared with medical/psychiatric literature from the Cambodian and other conflict situations throughout the Report.

This Report highlights that the crimes underlying the charges at issue in Case 002/2 are associated with poor mental health outcomes and long-term psychological harm in cross-cultural contexts. Victims of the Khmer Rouge experienced a range of chronic adverse conditions and continual threats to safety and well-being that, when left unaddressed, are associated with an increased prevalence, severity, and complexity of mental health disorders along with lasting changes in neurological, physiological, and psychological functioning. These disorders include Post-Traumatic Stress Disorder (PTSD), major depression and dysthymia (chronic but less severe depression), generalized anxiety disorder, and panic disorder; these combine with certain Cambodia-specific expressions of distress. Many of these disorders are comorbid, which is to say that they appear simultaneously in individuals. In addition to reviewing the research on the physiological and neurological consequences of trauma, this Report presents a number of Khmer-specific studies that show extremely elevated rates of traumatic stress symptoms and diagnoses in Khmer populations exposed to multiple traumas (even when compared to other victim populations). These studies corroborate the evidence adduced at trial. This research includes studies of children and adolescents that reveal the impact of trauma experienced directly by child victims as well as indirectly via intergenerational transmission from traumatized parents. Although many of the survivors in this case were victims of multiple international crimes, this Report attempts to discuss the impact of discrete harms and traumatic events—such as harms related to starvation, forced labor, sexual and gender-based violence, and genocide—on victim populations.

The Report closes with a discussion of the prospects for healing among this victim population. Although the experience of repeated and prolonged trauma places individuals at a high risk for severe and persistent physical, psychological, and social damage, it is possible for survivors to lead meaningful lives after trauma with appropriate medical, psychiatric, and psychological treatment. A reparations order focused on the provision of such assistance will go a long way toward

enabling the Civil Parties to achieve optimum physical and mental health, notwithstanding the level of trauma experienced under the Khmer Rouge.

II. Methodology

The Human Rights in Mental Health Trauma Laboratory at Stanford University has served as a source of expert testimony and as a consultant to several international and domestic courts considering the impacts of trauma on survivors. The aim of this Report is to place the specific experiences of victims of the current crime base within the context of the general psychiatric, psychological, and medical knowledge of the impact of such crimes on victims, their families, and their communities as captured in the academic, medical, and legal literature. Our methodology entails a survey of documentation of local and specific experiences of Cambodian survivors, along with a broader review of the established science literature from a cross-cultural perspective. Graduate and undergraduate students associated with the Lab participate in the collection and review of data from the general medical literature under faculty supervision. We consult with faculty from other Stanford University departments as needed and with trauma experts across academic institutions the world over and in Cambodia specifically.

When incorporating established knowledge regarding the impact of experiences similar to the crime(s) in question, we begin by referring to the most recent Diagnostic and Statistical Manual of Mental Disorders (DSM-5), which is regularly updated and published by the American Psychiatric Association (APA, 2013). Now in its fifth iteration, the DSM-5 offers the standard criteria for the classification of mental health disorders and is used and accepted internationally by clinicians, researchers, health regulation agencies, legal systems, and policy makers. Diagnoses and specific symptom presentations of those impacted by the crime(s) in question can be defined in a standardized way based on the DSM-5. (It should be noted that some studies in this Report make reference to the previous editions of the DSM if they were operative at the time). This Report connects specific diagnoses and symptom presentations with the various forms of functional impairment that are known to be associated with the experience of trauma in Cambodia and in other societies experiencing international crimes such as those at issue before the ECCC.

In addition to the DSM, we have performed a comprehensive literature review to identify empirically-validated research articles related to topics addressed in the report. We have searched within electronic databases, including MEDLINE/PUBMED (United States National Library of Medicine, 2016) and PsycINFO (APA, 2016), for key terms related to areas of study relevant to the current Report

(e.g., “trauma” and “posttraumatic stress disorder”). The results include single studies, meta-analyses (wherein multiple studies on a particular subject matter are statistically combined), and review articles (wherein multiple studies are combined in narrative form to draw conclusions on a specific subject matter). Research articles cited in the Report are the products of a critical peer review process to confirm credibility; manuscripts are not included if they were purely theoretical or were based on case- or single-studies that did not undergo peer review (e.g., a thesis or dissertation). Wherever possible, we highlight seminal articles by experts and leaders in their respective field of study and studies involving the specific population of Khmer affected by the crimes being prosecuted. Lab members have also reviewed and incorporated official reports from global health agencies and human rights organizations. In short, this Report synthesizes the massive amounts of data that exist in the psychological and psychiatric literature on the impact of human rights trauma on human psychology with special, comprehensive attention to the effects of the Khmer Rouge.

This literature review is then combined with an analysis of testimony from the record in the ECCC to highlight the mental health outcomes as discussed in expert testimony and to extract clear evidence of harm expressed by Civil Party Participants. Civil Party statements were analyzed and grouped (when possible) according to the type of harm discussed in the statement.

The expert opinions contained in this Report are also informed by previous research and considerable experience treating, representing, and working with victims of severe trauma and in communities impacted by massive human rights violations. In particular, several members of the lab have worked extensively in Cambodia on transitional justice issues and mental health. The leading text about the psychology of Khmer Rouge victims, “Cambodia’s Hidden Scars: Trauma Mental Health in the Wake of the Khmer Rouge” was compiled and edited by faculty from the Lab. Daryn Reicherter, the Director of the Human Rights in Trauma Mental Health Laboratory has extensive clinical and research experience with survivors of the Khmer Rouge through his long history of providing psychiatric service to Cambodian diaspora living in the United States and consultative service to the Documentation Center of Cambodia.

III. Psychological Consequences linked to Traumatic Events experienced under the Khmer Rouge Regime

The Khmer Rouge regime, led by Pol Pot, controlled Cambodia from 1975-1979. Nearly two million Cambodians died during this period as a result of the Khmer Rouge’s efforts to create an idealized rural, communist society. As the

historical literature and jurisprudence of the ECCC reveals, those who were not immediately executed were forced into labor camps, where they lived and worked in extreme conditions characterized by fifteen hour work days, insufficient food rations, and severe beatings (Blair, 2001). Cambodian civilians were exposed to armed conflict and crimes against humanity, including mass population movements, the destruction of personal and state property, starvation, forced labor, executions, torture, rape, imprisonment, enslavement, deportation, and persecution on religious, racial, ethnic, and political grounds. Surviving leaders of the Khmer Rouge have been charged with the specific crimes of torture, forced labor, starvation, willful killing, detention of civilians without charge, and gender based violence.

These crimes, often experienced simultaneously and for an extended duration, represent serious traumatic events that have lasting psychological effects on victims and their loved ones. The science of psychiatry informs us that traumatic experiences cause mental illness and other poor mental health outcomes; profound changes in human cognition, emotions, and behaviors; and even physiological changes in the human brain. What follows is an overview of the epidemiologic science on specific outcomes in Cambodia as a result of the trauma experienced under the Khmer Rouge regime, with reference to specific psychiatric diagnoses, neuropsychiatric changes, and major mass psychological changes in the population.

A. Common Mental Health Pathologies Associated with Extreme Trauma and their Prevalence amongst Khmer Rouge survivors

The crimes of the Khmer Rouge caused many poor mental health outcomes in the Cambodian populace. Specific mental health disorders are still seen at extremely high rates in the surviving population. One study by Dubois, Tonglet, Hoyois, Sunbaunat & Roussaux (2004) surveyed Cambodians in the Kampong Cham province over five years after the fall of the Khmer Rouge regime. Within this group, 42.4% met criteria for depression and 53% had high anxiety symptoms. Comorbid disorders were also common: 29.2% had depression and anxiety, 16.5% anxiety, 6.1% depression, and 7.1% had triple comorbidity (PTSD, depression, and anxiety). 25.3% reported being socially impaired, and those with comorbid symptoms had increased risk for social impairment. We will examine each of these mental health outcomes in this section.

Cambodian survivors of trauma also report a number of cultural idioms of distress to describe their experience (Hinton, Pich, Marques, Nickerson & Pollack, 2010; Hinton, Nickerson & Bryant, 2011). Among Cambodian survivors

of the Khmer Rouge regime, *Baksbat* (Broken Courage), *Khsaoy beh doung* (Weak Heart Syndrome), and *Khyal Cap* (Wind Attack) have been cited as negative consequences of the traumas experienced during the regime (Hinton, Hinton, Um, Chea & Sak, 2002). In trial, Dr. Chhim specifically described *Baksbat* as the psychological damage to an individual in the context of his broader testimony about the range of suffering experienced by the Cambodian people throughout the regime (Chhim Testimony, 2013).

Below we describe some of the common mental health disorders caused by the traumatic events experienced during the Khmer Rouge and present data on the prevalence of these disorders amongst survivors.

1. Cultural Idioms of Distress in Cambodia

Criterion-based mental health disorders delineated by the American Psychiatric Association in the DSM and by the International Statistical Classification of Diseases and Related Health Problems (ICD), a medical classification list by the World Health Organization, provide a generalized means of describing psychological distress for clinical purposes and measuring it for medical science. But within each culture and among individuals, there also exist numerous idiosyncratic expressions of psychological suffering that can be well established and valid (Hinton & Lewis-Fernández, 2010). These cultural idioms of distress run parallel to one another, as well as to the medical models used in the DSM and ICD, each using a relatable language to give shape to the human experience of psychological distress. The mental health impacts of the trauma and stress experienced under the Khmer Rouge regime are documented in the language of both Western medicine and Cambodian idioms (Hinton, Pich, Marques, Nickerson & Pollack, 2010; Hinton, Nickerson & Bryant, 2011). Specifically, *Baksbat* (Broken Courage) and *Khsaoy beh doung* (Weak Heart Syndrome) and *Khyal Cap* (Wind Attack) represent commonly cited negative consequences of the traumas experienced during the regime (Hinton, Hinton, Um, Chea & Sak, 2002).

Baksbat denotes the negative experiences following distressing or life-threatening events and has been conceptualized by Chhim (2012) using a three-factor model: psychological distress (e.g., trouble thinking, easily fearful, feeling flat or low emotionally, loss of self-confidence), broken courage (e.g., submits to others, remains mute, cannot be open as before, cannot rely on oneself), and erosion of self (e.g., avoids meeting others, loss of honesty, loss of relationships with others). Fifty three experts on the subject, all of whom had been exposed to the Khmer Rouge regime, provided a consensus on the concept of *baksbat* and

assisted in the initial *baksbat* description. *Baksbat* and PTSD were found to be highly correlated; however, *baksbat* encompasses additional symptoms within the “broken courage” and “erosion of self” factors that are not included in the PTSD diagnostic criteria (Chhim, 2012). In his testimony, Dr. Chhim discussed *baksbat* as encompassing the psychological damage to an individual as well as the suffering experienced by the entire Cambodian people (Chhim Testimony, 2013).

Khyal Cap, or “wind attack,” has many similarities to the experience of a panic attack, as understood through the DSM-5 criteria. Those experiencing “wind attack” typically report palpitations, shortness of breath, and fear of dying as the result of palpitations, which can be abruptly triggered by minor disturbances (Hinton & Lewis-Fernández, 2010). *Khyal* Attack is included in the American Psychiatric Association’s DSM-5 (APA, 2013). Within a sample of 100 Cambodian refugees attending an outpatient mental health clinic in Boston, 60% reported that they currently suffer “weak heart” and 90% of those individuals thought that palpitations might result in death (Hinton et al., 2002).

The Cambodian Symptoms and Syndrome Inventory (C-SSI; Hinton, Kredlow, Pich, Bui & Hofmann, 2013) was created to assess psychological distress in Cambodia in a more culturally-sensitive and –specific manner. The C-SSI is divided into somatic symptoms and cultural syndromes associated with traumatic experiences. Somatic symptoms include: dizziness, blurry vision, tinnitus, headache, neck soreness, palpitations, shortness of breath, chest tightness, rising sputum, stomach bloating/discomfort, cold hands and feet, numbness in the arms and legs, sore arms and legs, weakness, poor appetite, and feeling of lightness in the body. Cultural syndromes include: somatic-focused syndromes, that is, physical symptoms such as feeling out of energy to the point of fearing having a *khyal* attack or dying from depletion; agoraphobia/motion-sickness syndromes (e.g., the patient feels that they have been “poisoned by people”), emotion-focused syndromes (e.g., *kut caraeun* or “thinking too much”), cognitive-capacity syndrome (e.g., forgetful), and spiritual-type syndromes (e.g., *khmaoch sangot* or “Ghost pushing you down”, also known as sleep paralysis). The C-SSI was administered to Cambodians identified as suffering as a result of the Khmer Rouge regime. Respondents had very high scores on the C-SSI, which increased across levels of PTSD severity; however, the C-SSI was found to be a better indicator of the severity of past trauma events and self-perceived health than the PTSD Checklist (Hinton et al., 2013). That said, the PTSD Checklist is still a valid tool for diagnosis in the victim community.

2. Post-Traumatic Stress Disorder

Post-Traumatic Stress Disorder (PTSD), a chronic and debilitating mental illness, is common in individuals experiencing a traumatic event. The DSM-5 (APA, 2013) defines PTSD as a conglomerate of symptoms that results from experiencing, witnessing, or being exposed to traumatic events. Individuals experiencing a trauma that represents a serious threat to one’s social and psychological functioning often go on to develop a constellation of symptoms. These symptoms are divided into four different categories of symptomology:

1. intrusive thoughts pertaining to the event,
2. avoidance of stimuli related to the event,
3. negative changes in thoughts and/or mood regarding the event, and
4. hyper-arousal (APA, 2013).

Intrusive thoughts may include memories, dreams, dissociation/flashbacks, and psychological or physiological distress when triggered by reminders of the event (APA, 2013). Avoidance symptoms may include attempts to elude internal thoughts or emotions about the event or external people, places, and objects that are somehow related to the event (APA, 2013). The negative change in mood and/or cognitions includes an inability to remember events surrounding the trauma; negative views about the self, others, and the world; self-blame; negative moods such as shame, fear, or guilt; anhedonia (an inability to experience pleasure from normally pleasurable activities); a sense of detachment from people; and an inability to experience positive mood states (APA, 2013). Hyper-arousal symptoms may include irritability and/or anger, self-destructive behavior, hyper-vigilance (being on constant alert for external stimuli), an exaggerated startle response, decreased concentration, and sleep problems (APA, 2013). In order to meet the diagnosis of PTSD, individuals must have one symptom each from the intrusive and avoidance category, and two symptoms each from the categories of negative changes in thoughts and/or mood and hyper-arousal (APA, 2013).

Although trauma-related symptoms due to intense fear, terror, and arousal often fit within a PTSD diagnosis, the negative consequences of trauma extend beyond conditioned fear-responses and may alter fundamental aspects of one’s identity, worldview, and general ability to find meaning in one’s life. The vulnerability and terror experienced during a traumatic event significantly alters one’s orientation and perception of the self, others, and the world such that individuals exposed to trauma can and often see themselves as at fault for, or deserving of, their experience. They may also see others as out to “get” them or as

unable to protect them and see the world as being a dangerous and unjust place. These disturbances are reflected in the symptoms of PTSD defined by negative alterations in cognitions and mood (Newman, Riggs & Roth, 1997). PTSD rating scales in Khmer are valid and are used as a standard for assessment in Cambodia.

Although the DSM contains a clinical check-list, trauma experiences and the related symptom presentations can also be understood in more nuanced ways. This is particularly relevant to the types of trauma experienced during the Khmer Rouge regime. The experience of recurrent and compounded interpersonal traumas is associated with increased symptom severity and complexity, and tends to have more pervasive impact on both social and psychological functioning (Herman, 1992). These types of traumatic experiences make it especially difficult for survivors to find meaningful and adaptive perspectives about themselves and their environment (Newman et al., 1997), resulting in particular impairments in relationship functioning. Impaired self-esteem and sense of identity, inability to trust others and form healthy relationships, and emotional hyper-arousal and hypo-arousal (heightened or blunted stress responses) are just some of the possible consequences of extreme trauma. These symptoms can persist long after the traumatic event and serve as risk factors for re-victimization (e.g., Marx, Heidt & Gold, 2005).

Survivors of the Khmer Rouge have extremely high rates of PTSD, even when compared to other survivors of war crimes and other mass atrocities. Dr. Chhim testified in the ECCC that the majority of victims to whom the TPO provided psychological services were severely traumatized and exhibited symptoms of PTSD (Chhim Testimony, 2013). The most commonly reported PTSD symptoms were: re-experiencing (e.g., vivid imagination, nightmares of being chased, tortured, or killed, as well as about relatives who were killed), physical arousal (e.g., difficulty breathing, shaking, heightened startle response, and muscle tension), and avoidance (e.g., avoiding thinking and talking about the traumatic events). In addition, there is great resistance to talking about what happened within Khmer communities, because people were conditioned to keep silent during the Khmer Rouge regime (Stammel, Heeke, Bockers, Chhim, Taing, Wagner & Knaevelsrud, 2013).

3. Comorbid Symptoms and Disorders

Many other mental health diagnoses are related to trauma and are often seen as co-morbid (i.e., occurring simultaneously) with PTSD. In fact, the comorbidity of psychiatric disorders is thought to be the rule rather than the exception in cases of interpersonal trauma and abuse. Also, other mental health symptoms and/or

disorders may be present without the presence of a formal diagnosis of PTSD. Forty percent of children exposed to trauma are diagnosed with at least two psychiatric disorders (Copeland, Keeler, Angold & Costello, 2007). Major depression, dysthymia (chronic but less severe depression), bipolar disorder, generalized anxiety disorder, panic disorder, agoraphobia (fear of open places), social phobia, and obsessive-compulsive disorder have all been linked to PTSD (Creamer, Burgess & McFarlane, 2001). The 1995 National Comorbidity Study—a massive epidemiological study that surveyed 5,877 individuals in the United States—established an historical precedent for understanding PTSD and its comorbid disorders. PTSD was found to be comorbid in 47.9% of individuals with a history of major depression, 21.4% with dysthymia, 16.8% with generalized anxiety disorder, 31.4% with specific phobia, and 27.6% with social phobia (Kessler, Sonnega, Bromet, Hughes & Nelson, 1995). However, other disorders without the presence of PTSD have also been documented. The range of psychological disorders associated with PTSD is further discussed below.

4. Dissociative Disorders

Dissociative symptoms are another common response to trauma. Dissociative symptoms include an unawareness of one's present state, flashbacks, out-of-body experiences (also known as "depersonalization"), or feeling as if the world around one is surreal or artificial in some way (known as "derealization"). Previous research indicates that approximately half of individuals who develop PTSD also experience significant dissociative symptoms (Briere, Scott & Weathers, 2005) compared to only 4.4% of adults with no PTSD diagnosis. Carlson, Dalenberg and McDade-Montez (2012) concluded that dissociative symptoms are related to traumatic experiences and their severity; effects can be long lasting; and high dissociative symptoms increase the likelihood and severity levels of PTSD symptoms.

5. Anxiety Disorders

Anxiety symptoms and disorders have numerous debilitating effects and consequences for the individual. The experience of fear, avoidance, panic, and uncontrollable arousal are common symptoms of anxiety disorders that can lead to significant functional impairment (DSM-5). These symptoms not only affect the individual but also have repercussions for family and community. For example, children of mothers with panic disorder are 6.8 times more likely to develop the disorder, and children of mothers with phobic disorders are 3.1 times more likely to be diagnosed with the disorder at some point in their life (Merikangas & Pine,

2002). Cultures differ in regards to individual presentation and societal explanations for anxiety symptoms. Hinton et al. (2002; 2010) describe symptoms associated with culturally bound anxiety disorders in Cambodia, which we discuss in section (1) above on Cultural Idioms of Distress in Cambodia.

6. Depressive Disorders

Mood disorders, such as Major Depressive Disorder, are a common outcome for trauma survivors (O'Donnell, Creamer & Pattison, 2004). According to the DSM-5, symptoms of depression include depressed mood, suicidal thinking, loss of appetite, weight loss or gain, loss of interest, and hopelessness. Irritability and physical complaints may also be present (APA, 2013).

Many survivors of the Khmer Rouge regime suffered symptoms of anxiety and feelings of hopelessness due to the multiple losses experienced under the Khmer Rouge regime, including loss of home, community, family, and friends. Some individuals reported considering suicide because of these factors. Other survivors present with continued experiences of paranoia as a result of being tortured on the basis of spurious allegations that they were spies. Many of these individuals remain suspicious that they are still being monitored or followed. People also became distrustful of one another and made efforts to conceal their identity. This sense of mistrust is the result of the PTSD, and all these factors are related to the events that took place during the Khmer Rouge era (Chhim Testimony, 2013).

7. Suicidal Behavior

The term "suicidal behavior" is typically used to describe suicide-related thoughts and/or actions, such as suicide ideation, suicide planning, and suicide attempts, or completed suicide. Suicide is a leading cause of death worldwide, and according to World Health Organization (WHO) data, suicide rates are projected to increase dramatically over the next few decades (Nock et al., 2008). Established risk factors for suicidal behavior include psychiatric disorders, psychiatric comorbidity, hopelessness, impulsiveness, anhedonia (inability to experience pleasure), high emotional reactivity, stressful life events and persistent stress. While being female is a risk factor for suicidal behavior, being male is associated with a greater likelihood of suicide completion (Nock et al., 2008).

Suicidal behavior is pervasive in Cambodia. The results of a study conducted by the Royal University of Phnom Penh revealed completed suicide prevalence rates in individuals above the age of 21 to be 42.35 per 100,000 people. This number is significantly higher than the WHO's estimated country average of 16

per 100,000 people. Furthermore, the ratio of attempted to completed suicides in Cambodia was found to be more than double the WHO country average (Dara & Dene-Hern, 2012). Suicidal behavior is listed as a DSM-5 criteria of major depression. However, other psychiatric disorders (trauma-related mental health outcomes, etc.) contribute to suicidal tendencies as well (Nock et al., 2008).

8. Substance Use Disorders

Another common form of mental health comorbidity involves substance use disorders (Kessler et al., 1995). Alcohol and drug use are a common form of coping with significant distress and posttraumatic reactions. Thus, PTSD and substance use disorders are highly comorbid (Mills, Teesson, Ross & Peters, 2006). Kessler et al. (1995) found that among individuals with PTSD, 51.9% were diagnosed with alcohol use/dependence, and 34.5% were diagnosed with drug abuse/dependence. Consistent with the findings of Kessler et al. (1995), Mills et al. (2006) found alcohol to be the most commonly abused substance amongst individuals with comorbid substance use disorders and PTSD.

Illicit drug use in Cambodia continues to be a public health concern with the number of reported drug users increasing each year (Yi et al., 2011). In a sample of Cambodian adolescents, traumatic events such as family-violence, victimization, and community-violence witnessing were identified as significant risk factors for substance use (Yi et al., 2011). Jacobsen, Southwick, and Kosten (2001) described the relationship between PTSD and substance-use disorders as a reciprocal process and form of self-medication. Individuals with PTSD often begin using illicit and addictive substances in order to alleviate or reduce their symptoms. If dependence develops, withdrawal symptoms can exacerbate existing PTSD symptoms. This interaction makes individuals with PTSD especially vulnerable to developing and maintaining substance use disorders (Jacobsen et al., 2001).

9. Physiological and Neurological Consequences of Trauma in Human Biology

Mental health disorders caused by traumatic experience often result in biological changes in the human nervous system. The continued activation of the sympathetic nervous system—that part of the nervous system that responds to stressful events—in response to threatening or stressful experiences has detrimental effects on both one's physical health and one's ability to regulate psychological responses to the environment (McEwen, 1998). The physiological process of allostasis is particularly relevant to recurrent trauma. Allostasis refers to the body's attempts at maintaining stability through change. Allostatic load

describes the physiological costs and consequences of maintaining this stability over long periods of time. Traumatic stress, and its subsequent physiological consequences, occurs when an individual experiences a threat to safety and well-being during a specific event or through exposure to chronic adversity, leading to an allostatic load that becomes too burdensome over time. The allostatic load is thought to be cumulative; therefore, while one specific traumatic event may not immediately result in the trauma-related symptoms and disorders discussed above, each individual event brings the individual closer to the clinical threshold.

Traumatic stress exposure results in the activation of the sympathetic nervous system (which prepares the body for action), without the compensatory response of the parasympathetic nervous system (which prepares the body for resting activities). The flooding of stress hormones and general activation of the body suppresses the immune system and impairs adaptive functioning (McEwen, 1998). Traumatic stress occurs when this accumulation of stress reactions overwhelm one's capacity to effectively manage—both psychologically and/or physiologically—environmental challenges. In essence, the individual is continuously faced with what are perceived as insurmountable barriers, resulting in chronic feelings of fear, hopelessness, and distress. Traumatic stress and a burdensome allostatic load leads to lasting alterations in physiological and neurological systems (McEwen, 1998; Sapolsky, Romero & Muncket, 2000; McEwen & Wingfield, 2003; Boyce & Ellis, 2005; Herbert et al., 2006).

The age at which trauma occurs is of particularly importance when considering the physiological and neurobiological consequences of trauma, as traumatic stress exposure can alter developmental trajectories in children. The experience of trauma in childhood, and specifically prolonged exposure to stressful events, greatly impacts the neurochemistry and brain functioning of the developing child (Carrion & Kletter, 2012; Van der Kolk, 1998; Teicher & Samson, 2013, 2016). Research using neuroendocrinological and neuroimaging assessment of children and adolescents has provided important insight into the understanding and implications of early trauma. Neuroendocrinology is the study of human hormones' effect on the brain. Abnormal levels of arousal impair the development of cognitive coping abilities, the capacity to modulate varying arousal states, and the ability to respond to a changing environment in adaptive ways. The endocrine (i.e., hormonal) system is affected by the hypothalamic-pituitary-adrenal (HPA) axis that secretes cortisol, signaling to the rest of the body to prepare for action. Cortisol is a hormone that is increased in times of stress or over-excitement. Research has shown that prolonged stress can damage the HPA axis, which in turn causes impaired regulation of cortisol secretion. This dysregulation in cortisol

levels, which can be either dulled or heightened, is associated with PTSD too. Among adolescents, the temporal proximity of the trauma is a strong predictor of the abnormal cortisol level, i.e. proximal traumas predict elevated levels and distal (i.e., more distant) traumas predict low levels (Carrion & Kletter, 2012).

Neuroimaging studies have demonstrated correlations between PTSD and abnormalities and impairments in brain structure (De Bellis, et al., 2002). Neuroimaging is a medical tool for scientists to look at effects on brain tissue in living subjects. A recent review of the impact of child abuse on neurobiology by Teicher and Samson (2016) demonstrates alterations in multiple brain structures as a result of childhood maltreatment, including heightened amygdala activation in response to emotional triggers and decreased activation of reward-pathways (striatum) in response to expected rewards. In other words, physical brain structures connected to emotion are altered by traumatic experience. In addition to prompting fear responses, the amygdala plays an integral role in the processing and consolidation of emotional memories. Among both adults and adolescents, those with PTSD showed increased amygdala activation when presented with threatening facial expressions in comparison to controls (Carrion & Kletter, 2012).

In addition, traumatic memories are qualitatively different from normal memories (Van der Kolk, 1998). Avoidance of reminders of the trauma and dissociation from the trauma itself interfere with memory encoding, consolidation, and reconstruction (Van der Kolk, 1998). Pediatric neuroimaging has also found abnormalities of the prefrontal cortex among adolescents who have experienced abuse. The prefrontal cortex is the area of the brain that is involved with planning. This study showed that adolescents with PTSD tend to activate their prefrontal cortex less than healthy controls, instead relying on the more primitive and emotion-based brain structures, such as the limbic system, which regulates our emotions (De Bellis et al., 2002).

10. Comparative Research on PTSD and Khmer Rouge Survivors

The mental health consequences of civil conflict have been well-documented around the world (Murthy & Lakshminarayana, 2006). An epidemiological study by de Jong et al. (2001) conducted over two years (1997-1999) surveyed survivors of mass political violence from community samples in Algeria (n = 653), Cambodia (n = 610), Ethiopia (n = 1200), and Gaza (n = 585). (The designation "n" indicates the sample size). The prevalence rate of PTSD was high in all four countries: 37.4% in Algeria, 28.4% in Cambodia, 15.8% in Ethiopia, and 17.8% in Gaza. In addition, conflict-related trauma after age 12 years was a significant

predictor of PTSD across all four countries. However, additional risk factors varied between samples. For instance, torture was a risk factor in all but Cambodia; psychiatric history and current illness were risk factors in Cambodia and Ethiopia; and youth domestic stress, familial death or separation, and parental alcohol abuse were risk factors only in the Cambodia sample.

Studies assessing the prevalence of PTSD symptoms in Cambodian populations have provided general support for the validity of the PTSD criteria; however, the avoidance symptom cluster was found to be less applicable, while the addition of dissociative symptoms appeared to increase cultural sensitivity of the disorder (Mollica, McInnes & Pool, 1998). There remain some concerns about the use of PTSD as a universal diagnosis, especially as it applies to cultures that relate to collective harm, rather than individual harm (Bracken, Giller & Summerfield, 1995). Nevertheless, PTSD remains a valid international standard for examining traumatic response in humans across cultures. And it has been used reliably to gauge trauma responses in Cambodian survivors given that Western diagnostic criteria for PTSD capture symptoms experienced by many Cambodian people. Still, the definition may neglect important cultural idioms and interpretation of the experienced distress (which we will discuss in the next section). As a result, some argue convincingly for the inclusion of other cultural idioms of distress to describe the suffering states reported by Cambodian survivors (Eisenbruch, 1991) (Hinton, 2013).

B. Additional Research on the Widespread Psychological Consequences of Trauma Associated with the Khmer Rouge Regime

The impact of the Khmer Rouge regime spans generations and touches individuals who remained in Cambodia as well as refugees who have sought asylum or attained refugee status elsewhere. The unusual longevity of symptoms speaks to the complex and continuous nature of the trauma experienced. The majority of Cambodians lost a close family member, and even three decades after the Khmer Rouge regime, a significant number of individuals still suffer from prolonged grief (Stammel, Heeke, Bockers, Chhim, Taing, Wagner & Knaevelsrud, 2012). Following the invasion of Vietnamese forces in 1979 and throughout the following decade, a large number of Cambodian refugees continued to experience and witness violence, and live in harsh physical conditions with limited food, water, and access to health care (Mollica et al., 1993). These are the types of chronic adverse conditions and continual threats to safety and well-being that, when left unaddressed, are associated with increased prevalence, severity, and complexity of mental health disorders along with lasting changes in neurological,

physiological, and psychological functioning.

Below we discuss additional psychological impacts identified amongst Cambodian survivors—namely on children, adolescents, descendants of direct victims, as well as refugees—that indicate the widespread psychological consequences of trauma related to the Khmer Rouge regime.

1. Effects of Trauma on Children and Adolescents who Survived the Khmer Rouge regime

Cambodians of all ages were impacted by the actions of the Khmer Rouge regime and mental health effects have been well documented in children who survived the Khmer Rouge regime. Children at different levels of development witnessed and directly experienced extreme violence and the loss of both family and culture. In addition to prolonged psychological symptoms, the instability and conflict during the regime had lasting impacts on the social structures needed to support the success of younger generations. For instance, the period during which the Khmer Rouge were in power witnessed the breakdown of school systems, depriving thousands of children of complete and continuous education. Those who grew up in the years following the regime experienced second-hand the destructive impact on their family and heritage. Therefore, understanding the unique impact of psychological trauma on Cambodians across the victims' lifespan is particularly important when considering the destruction caused by the Khmer Rouge.

Children were most traumatized by the forced evacuation of cities because they lost hope and dreams for the future and did not have sufficient coping strategies to understand and deal with the loss and chaos. For children who lost their parents, the psychological impacts are even more severe because by the time the Khmer Rouge regime fell, these children had lost their forms of social support and a sense of belonging (Chhim Testimony, 2013). Many children suffered from PTSD and/or exhibited behavioral problems, e.g., anti-social or oppositional behavior. Such behavioral problems are common manifestations of traumatic stress in children due to the disruptions in neurological functioning and related impairment in emotion and behavior regulation skills. These experiences have implications for future parenting styles and the psychological well-being of the next generation (Chhim Testimony, 2013; Field, 2011).

Published studies of Cambodians consistently report high instances of psychological distress years after the fall of the Khmer Rouge. For example, one study reports that among those still living in Cambodia, 28.4% reported PTSD symptoms based on the DSM-IV criteria (a previous version of the DSM).

Additional findings indicated that only conflict-related events occurring after the age of 12 years were significantly related to PTSD (de Jong, et al., 2001). That said, given the impact of traumatic stress on child development, exposure to conflict before the age of 12 may manifest in symptoms and developmental aberrations that are not captured by the PTSD diagnostic criteria. In a separate study, 110 Khmer adolescents living in Portland and 99 Khmer adolescents in Salt Lake City were assessed for mental health issues; 20% of adolescents, over 50% of mothers, and about one-third of fathers diagnosed met criteria for PTSD (Sack et al., 1993). All of these studies show marked increase (indeed an order of magnitude increase) compared to other populations.

In addition, within a random sample of 182 adolescents, aged 12-13, and their parents living in a refugee camp on the Cambodia-Thai border, 53.8% of respondents manifested significant distress in the clinical range as reported by their parents with the aid of a survey tool developed by the study. The most commonly reported symptoms were somatic complaints, social withdrawal, attention problems, anxiety, and depression (Mollica, Poole, Son, Murray, Tor, 1997). In a similar study among 993 Cambodian adults surveyed in a Thai refugee camp, participants reported a mean number of 14 trauma events during the Khmer Rouge era and 1.3 trauma events during the past year (Mollica, McInnes, Poole & Tor, 1998). The number of reported trauma events was highly correlated with depression, PTSD, dissociation, as well as other culturally dependent symptoms.

Another study looked at the psychological health of 40 Cambodian high school students who moved to the United States from Cambodia (Kinzie, Sack, Angell, Manson & Rath, 1986). These adolescents experienced multiple traumatic events from 1975-1979 as a result of the Khmer Rouge regime. Specifically, adolescents reported separation from family, witnessing numerous deaths, and experiencing starvation and forced labor within work camps. After spending two years in a refugee camp in Thailand, these adolescents immigrated to the United States. A high prevalence of mental health issues was observed four years after leaving Cambodia. Fifty percent of students met criteria for PTSD; the most commonly cited symptoms included: recurring nightmares, heightened startle response, feeling ashamed for being alive, and avoidance of memories of Cambodia and/or discussion of the traumatic events. Pervasive depressive symptoms were also commonly reported; these included: appetite or weight changes, loss of energy and interest, difficulty sleeping, impaired concentration, guilt, hopelessness, and rumination. Fifteen percent of students reported suicidal thoughts. Twenty percent described experiencing something akin to a panic attack.

2. Intergenerational Effects of Trauma

Clinicians and physicians have long noted the presence of heightened levels of distress and psychopathology in the children of victims of trauma, even when the children themselves were not exposed to traumatic stress. These observations have led scientists to investigate the mechanisms by which traumatic distress is transmitted inter-generationally from a traumatized (or trauma-exposed) individual to his or her children. We now know that exposure to trauma and adversity can have an impact that spans across multiple generations through the transmission of traumatic stress inter-generationally and the impact of trauma on parenting. Traumatic stress exposure is associated with epigenetic changes in parents (i.e., changes in the expression of DNA) that are passed on to their offspring, altering the biological and physiological functioning of subsequent generations (Yehuda et al., 2015).

Research has confirmed that a parent's trauma exposure corresponds with increased risk for PTSD, mood disorders, and anxiety disorders in their children (Yehuda, Halligan & Bierer, 2001; Yehuda et al., 2015). For example, a study by Yehuda, Bell, Bierer & Schmeidler (2008) revealed a higher prevalence of lifetime PTSD, mood and anxiety disorders, and substance abuse disorders among offspring of Holocaust survivors, compared to controls. Maternal PTSD, in particular, was highly associated with PTSD among adult children. Furthermore, the neurobiological and psychophysiological alterations associated with PTSD and traumatic distress reviewed above have also been observed in the children of victims of trauma (Yehuda et al., 2015).

The experience of trauma and trauma-related symptoms can have significant negative effects on one's ability to parent effectively (Field, 2011). The parent, unable to manage his/her emotional distress, may rely on his/her child for emotional support; in response, the child often sacrifices his or her own needs in order to retain this limited opportunity for closeness. This can have significant long-term consequences for the child's emotional and relational functioning. As a result, children of parents suffering from traumatic stress are at increased risk for psychiatric disorder.

In addition, while the impact of trauma on relationships and parenting may contribute to the increased rates of post-traumatic stress and alterations in neurobiology observed in children of trauma victims, research has now shown that parental trauma exposure affects the expression of that individual's genetic code (Yehuda et al., 2015). Epigenetics is the study of how DNA expression can be altered in a single generation. Past research has demonstrated that environmental influences such as stress exposure can "reprogram" the genetic blueprint for the

development of neural and biological systems in rats and mice; these changes in the blueprint are subsequently passed on to the offspring (Bale et al., 2010; Bale, 2015). These findings have more recently been translated to humans, as parental trauma exposure has been found to alter how the genes that code for psychophysiological stress response (e.g., release of the stress hormone, glucocorticoid) are regulated both in trauma-exposed individuals and in their children. These findings reveal how exposure to trauma can alter the biology of both the individual victim and of their children, providing a biological explanation for the intergenerational transmission of trauma and traumatic stress.

These intergenerational risk factors have been documented in Cambodian families who survived the Khmer Rouge regime (Field, 2011). A sample of 110 Khmer adolescents in Portland and 99 Khmer adolescents in Salt Lake City, aged 13 to 25 years, and their parents were assessed for PTSD (Sack, Clarke & Seeley, 1995). PTSD of the parents was significantly related to PTSD of the adolescent. When neither parent had PTSD, 12.9% of youths received a PTSD diagnosis. When one parent had PTSD, the adolescent prevalence rate increased to 23.3%. When both parents were diagnosed, the rate increased to 41.2%. Likewise, Field, Om, Kim & Vorn (2011) found that among children whose parents had lived through the Khmer Rouge regime, both the mother's and father's Khmer Rouge-related trauma exposure and trauma symptoms were positively correlated with their child's depression and anxiety. The fathers' and mothers' perceived trauma symptoms (not trauma exposure) significantly related to role-reversing parenting style and the mothers' symptoms were also related to an overprotective parenting style. Role-reversing parenting occurs when children must take on the responsibilities usually done by parents. This role reversal is significantly related to childhood depression and anxiety. Overprotective parenting is also related to childhood depression. In addition, there was a significant direct effect for parents' trauma exposure on their children's levels of anxiety.

3. Effects of Trauma and Other Mental Health Problems in Refugees

Moreover, symptoms of trauma and other mental health problems follow the victim, even after fleeing the country where the harm occurred. Refugees are at high risk for the development of mental health problems as a result of pre-migration, migration and post-migration experiences (Boehnlén & Kinzie, 1995). Post-migration problems—such as adaptation difficulties, loss of culture, and loss of support—are significantly associated with PTSD symptoms and emotional distress (Carswell, Blackburn & Barker, 2011). In his testimony, Dr. Chhim noted that although Cambodian people who have resettled overseas may

experience increased security and may enjoy more resources, they lack attachment to their home country and their culture, including religious institutions and buildings (Chhim Testimony, 2013).

Mental health outcomes of Khmer refugees in the United States have been assessed in multiple settlements, including Long Beach, California, which represents the largest Cambodian refugee community in the United States. In a sample of 490 adults from this community, all individuals interviewed had experienced trauma prior to immigration and over 50% reported current symptoms consistent with a diagnosis of PTSD and/or Major Depressive Disorder (Marshall, Schell, Elliott, Berthold & Chun, 2005). Among a sample of Cambodian immigrants living in Utah, 45% met criteria for PTSD and 81% reported five or more symptoms of PTSD (Blair, 2001). Arousal and re-experiencing were the most commonly reported symptoms. In addition to PTSD, 51% met criteria for Major Depression, 27% were diagnosed with social phobia (fear of social situations, isolation), and 14% were diagnosed with Generalized Anxiety Disorder (Blair, 2001). Among Cambodian refugees who had survived 2-4 years of concentration camp experience and who met the then-applicable DSM-III criteria for PTSD, the predominant symptoms reported were avoidance, hyperactive startle reactions, emotional numbness, intrusive thoughts, and nightmares that lasted at least 3 years after imprisonment (David, 1984). Participants within this study also reported high instances of depressive symptoms, including somatic symptoms, poor concentration, insomnia, and poor appetite.

Kinzie (1989) has reported on the results of an Indochinese Refugee Clinic in Oregon (sponsored by Oregon Health Sciences University). In this study, 85 Cambodians were evaluated and 60 were in therapy at the time of publication. The majority of patients demonstrated lasting psychological effects of the Khmer Rouge regime. Depressive symptoms were present in most patients at intake, and 20% of patients had been hospitalized, largely related to depression and suicidality. Intrusive symptoms (e.g., nightmares, intrusive thoughts, feelings that one is re-experiencing the trauma, and startle reactions) and avoidance symptoms (e.g., consciously avoiding memories of or reminders of past events, numbing, social withdrawal) were also common. In a study by Carlson and Rosser-Hogan (1993), fifty adults (26 women and 24 men) were randomly selected from a list of Cambodian refugees who had resettled in Greensboro, North Carolina, between 1983 and 1985. 90% of these refugees displayed marked symptomatology related to PTSD, dissociation, depression, and/or anxiety.

The elevated rates of traumatic stress symptoms and diagnoses reported in all these studies are consistent with the increased risk for post-traumatic stress that

would be expected for a population exposed to the multiple traumas and threats posed by the Khmer Rouge regime.

4. Destruction of Relationships and Social Suffering Amongst Khmer Rouge Survivors

It is estimated that over 20% of the Cambodian civilian population was killed during the Khmer Rouge era (Kiernan, 2003). Social systems along with protective community and cultural structures were dismantled during the civil war, effectively assaulting individuals' source of identity, values, and connection to the past (Summerfield, 2000). Traditional healers, village elders, and those who practiced and disseminated the arts were forced to cease their activities (Eisenbruch, De Jong & Van de Put, 2004). This collective loss compounds the numerous personal losses and interpersonal traumas experienced by the Cambodian people. In one study of 130 survivors of the Khmer Rouge regime still living in Cambodia, 72% of participants reported forced separation from family, 59% witnessed the torture of family or friends, 70% witnessed the death of family or friends, and 49% witnessed the murder of family or friends; furthermore, 43% reported experiencing forced social isolation, and 11% were forced to betray or harm someone (Field & Chhim, 2008).

Dr. Chhim's testimony at trial describes the impact on children who were separated from their family and forced to live in detention centers where they were often subjected to indoctrination. He noted that children were told that they did not belong to their parents and instead belonged to Angkar (the regime); for that reason, they were told they should obey Angkar at all times. Some children reported to Angkar about their parents. The social suffering and relational ruptures resulting from this forced violence and betrayal seriously impact the long-term health of both the individuals and the community. Dr. Chhim's testimony also highlighted the social effect of the forced evacuations during the Khmer Rouge regime, reporting that segregation between the New People and Old People was a serious issue. New People lived in fear, were the target of surveillance, and were prone to attacks and allegations by others, which could lead to being killed (Chhim Testimony, 2013). Indeed, Dr. Chhim testified about his own experience as a New Person, reporting a loss of identity and security, both physical and spiritual. During the Khmer Rouge period when people were forcibly evacuated, they were detached from their loved ones, tortured, subjected to hard labor, and were constantly threatened. In addition to losing housing, employment, and connection to their community, worship traditions and religious rituals were destroyed, further intensifying the sense of disorientation and loss of identity (Chhim

Testimony, 2013).

IV. Psychiatric Outcomes Linked to Statements of Specific Forms of Harm Alleged in Case 002/2

Numerous victims have testified in Case 002/2 and alleged specific harms that constitute gravely traumatic experiences. The following section highlights some of the harms alleged in Case 002/2 and the known mental health outcomes associated with such harms. Given that many of the survivors of the crimes in this case were victims of multiple crimes, it is difficult to untangle the mental health outcomes for each specific crime charged. We can, however, state with certainty that the commission of international crimes (like torture and rape) cause severe and long-lasting mental health damage. It is also clear that multiple traumatic experiences, or the combination of traumatic experiences, make poor mental health outcomes significantly more likely. This section of the Report will review the scientific, psychiatric literature on the mental health outcomes associated with the specific crimes and harms alleged in Case 002/2 and also examine the available data from survivors of the Khmer Rouge regime. It is important to note that the physical and psychological trauma that is highlighted in the literature and throughout this report is congruent with the testimony that was presented in court.

A. Harms Related to the Crimes Committed at Cooperatives and Worksites

Victims testifying in Case 002/2 have identified numerous harms related to crimes committed at cooperatives and worksites under the Khmer Rouge regime. This includes harms associated with enslavement, deportation, forced transfer, and attacks against human dignity such as the deliberate withholding of adequate food, shelter, medical assistance and minimum sanitary conditions.

1. Statements Identifying a Climate of Terror

According to the victim impact statements of several civil parties, fear tactics and excessive punishment of civilians created feelings of helplessness and developed a climate of terror for the population. Terror is defined by acts that produce a state of continued stress, fear, and uncertainty of survival that renders its targets helpless and hopeless (Tilly, 2004). The manipulation of terror in order to gain and maintain control is executed through both the direct destruction of people and property, and the psychic destruction of one's sense of security and

autonomy. This sends a message to the target that a powerful and prevailing threat exists and may manifest at any time. Terror tactics include extreme and highly visible acts of punishment that are carried out in order to demonstrate violent control and unforgiving intolerance of disobedience (Tilly, 2004). In the history of the Khmer Rouge, tactics of terror were used throughout a wide spectrum of situations to control, oppress, and intimidate. The chronic nature of the psychological damage is well evidenced through medical science and also demonstrated in the present discussion of survivors.

The following statements and dialogues have been extracted from Civil Party Testimony from Case 002/02 to illustrate the pervasive condition of terror imposed through fear tactics and excessive punishment at cooperatives and worksites:

Q. You also stated that you tasted the fertilizer you made using excrements. And they said it wasn't—you had to test to make sure it wasn't too salty to destroy the rice shoot. Why did you have to taste the fertilizer made with excrement? A. I was ordered to taste it, so I had to force myself to do that as I was scared. Q. And if the rice shoot died, what would have happened to you according to the orders that were given to you by the Khmer Rouge? A. We were told if the rice seedlings die, then we would be tortured. (E1/286.1 Ms. TAK Sann (Tram Kok) 01 April 2015)

I was afraid. Despite some days I was not feeling well, I decided not to seek permission to rest. I had to go to work. During the six month period that I was at the dam worksite, I actually rested for only two or three times from sickness. But when I was just fairly unwell, I did not dare to ask permission. I had to force myself to work. (E1/339.1 Ms. NUON Narom (1st January Dam) 01 September 2015)

I actually worked extremely hard at the dam construction site. I became so emaciated, I did not have any physical strength, but I had to keep on working in order to avoid being killed. (E1/339.1 Ms. CHAO Lang (1st January Dam) 01 September 2015)

I was brought and when I was asked to climb up to the house, I was tied up and I was told that because I stole something, I was tied up. As I said, I was tied up, and my legs were tied up and my hands were tied

to the back—behind my back. They tied my hair to the window bar. I was thirsty during that time. I called a person, "Bong", and I asked for water. I was deprived of food. I was so starved and hungry. I asked for food and water for a few times and he did not hear what I asked. At the third time when I asked again, I was given water. And after that, the chief of the units brought in a whip or a bamboo stick and they hit on my abdomen and I was warned that next time, please, do not go and steal something. And I replied, "No, I would not do it again." (E1/286.1 Ms. IEM Yen (Tram Kok) 01 April 2015)

I was tortured at that time. I was so hungry at that time that is why I—I went to steal the cassava. I was arrested while I was stealing cassava, and I was throw—thrown on to the cart a few times and after that I was taken to be tortured. (E1/286.1 Ms. IEM Yen (Tram Kok) 01 April 2015)

Q. When you were being buried, were you allowed to have some food? A. At that time I was deprived of food and water. I was starved and so thirsty. My whole body was in pain and I called for my parent's help, but no one could come to help me. After I was arrested, I was buried. Not in front of others. The other children went—already went to work and I was buried at the unit where I was staying at that time. ... A. I was buried alive and nothing could compare to it. I was buried to up to my neck. I could not move and I could not do anything. I tried to call my parents, but no one would answer my call, and it was the greatest pain I experienced. (E1/286.1 Ms. IEM Yen (Tram Kok) 01 April 2015)

She was beaten, and her hands were tied to her back. She was beaten. I witnessed the incident in front of me. I said nothing. I did not reply to the question. She, my colleague, was warned at that time that she was not allowed to go anywhere besides the worksite. (E1/2881 Ms. NUON Narom (1st January Dam) 01 September 2015)

The environment described above fosters paranoia and fear, both of which can deeply damage personal well-being, irreversibly erode interpersonal relationships, and have a lasting negative impact on an individual's level of functioning and personal growth. Expert testimony highlights this environment

of helplessness created by the Khmer Rouge, citing the repeated relocation of people as a means of destabilizing the populace so that they lost their ability to challenge authority and felt incapable of controlling their own lives (Chhim Testimony, 2013).

These reactions were compounded by acts of physical violence, hard labour, insufficient water and food, untreated illnesses and other forms of hardship enforced in cooperatives and worksites throughout the country (Chhim, 2013). In addition, a large number of survivors reported being seriously injured (22%), tortured (37%), and brought close to death (69%) as a result of the Khmer Rouge regime (Field & Chhim, 2008). These stressors continued through the refugee period. Aside from direct physical injury or illness, the indirect effect of continued stress on the immune system has serious implications for one's long-term health. Without adequate treatment, distressing psychological symptoms will likely not improve. Dr. Chhim noted that although many people are able to function in everyday life, there is high potential for decompensation (i.e., deterioration in the mental health status of a person who had previously been healthy) if met with a trigger (Chhim Testimony, 2013).

2. Harms Related to Enslavement and Forced Labor in Cooperatives and Worksites

Many survivors described being dehumanized during the Khmer Rouge regime and treated as “slaves”. This kind of treatment, compounded with hard labor and lack of food, further traumatized individuals (Chhim Testimony, 2013).

The following statements and dialogues have been extracted from Civil Party Testimony to illustrate the harms related to enslavement at worksites:

We stayed at Prey Khab (phonetic) for about 10 days with some of our clothing and then they confiscated the clothes that we had for communal and cooperative use. I asked my elder sibling and I was told that they just kept it for us and let us go to work. And then in return we were given black uniform and I asked my elder sibling again about this and I was told that I had just to put them on. And then a man, Uncle Chorn (phonetic) told me that Khmer Rouge would only allow us to wear black clothing and because of the lack of clothing, lice, we were infested with lice throughout the body. It was as big as the lice of the dogs, because we only had a pair of clothing. So we, I mean my siblings and I blamed my mother for urging us to come in expectation of abundance of food and my mother told us that please bear with her,

it's too late now to go anywhere and we had just to survive. (E1/288.1 Ms. YEM Khonny (Tram Kok) 03 April 2015)

The skin on my shoulder peeled from heavy load of earth on the basket. Then sometimes during the night we were instructed to return to the sleeping quarter and sometimes we had to attend a meeting, and that happened every few nights, then we could sleep. But it was only a few hours before we was woken up again by a whistle blow. [...] When we were carrying the dirt in the open sun, we could have water but the water was muddy and it was brought to us. We had to drink although it was not clean water. At night time I sometimes dreamt that I could have a cold water to drink. The meetings would be held once in every two days and we were told that if we were not in—active and we would obstruct the wheel of the history, although that we were sick we had to go to work. (E1/339.1 Ms. NUON Narom (1st January Dam) 01 September 2015)

Some of my colleagues, those four or five were beaten and they were instructed to carry dirt they were given with a big earth basket to carry dirt. I could not say anything. But it was painful in my heart. I was doing my utmost at that time, I had to work. Women had periods and they had cramps in their abdomen. They need sanitation but we were deprived of this. We were treated as animals. (E1/339.1 Ms. NUON Narom (1st January Dam) 01 September 2015)

Forced labor represents a serious risk factor for the development of both physical and psychological distress, particularly if violence or abuse is experienced or witnessed in concordance with labor exploitation. Within a sample of 35 individuals who had been trafficked for labor exploitation in the United Kingdom, 57% reported one or more symptom of PTSD, and 81% reported one or more physical health symptoms (Turner-Moss, Zimmerman, Howard & Oram, 2014). A study by Kinzie, Fredrickson, Ben, Fleck, and Karls (1984) assessed the psychological health of 13 Cambodians who had spent between 2 and 4 years in Pol Pot's work camps. Of these 13 individuals, 9 displayed symptoms of a major depressive episode, 3 reported issues with anger and irritability, and 1 patient had not spoken in 6 years. The authors concluded that the experiences endured within the work camps had serious consequences on the psychological functioning of the survivors.

3. Harms Related to Forced Starvation

Another key harm identified by civil parties in cooperatives and worksites in Case 002/2 is harms related to forced starvation. Dr. Chhim's testimony highlighted the psychological impact of starvation, noting that the experience of perpetual hunger and famine is an event that overwhelms a person and exhausts one's ability to cope. This experience challenges one's sense of identity and belief system. During the Khmer Rouge regime the victims reported going to extreme lengths to get something to eat, including violating personal values and moral codes. Children witnessed their parents lose their strength and courage and watched their parents fall ill and suffer from hunger (Chhim Testimony, 2013).

The following statements and dialogues have been extracted from Civil Party Testimony to illustrate the harms related to forced starvation:

Q. Did you suffer from hunger while you were at Tram Kak? A. We were given gruel to eat. Q. Was such gruel sufficient for you to eat satisfactorily? A. No, it was not enough and also I had to leave some for my child as well, as my child did not have enough food to eat. Q. To be clear, Madam Civil Party, were you hungry throughout all those years? A. Yes, I was hungry and I did not dare to steal anything as I was afraid, so we had just to try to survive. Q. What were you afraid of? A. I was afraid that I would be taken away and killed so we did not dare to complain even if the food was not enough. (E1/286.1 Ms. TAK Sann (Tram Kok) 01 April 2015)

The food ration was not equal. For Base People, they had more food. And as for us, we were New People, our food were [sic] less. (E1/286.1 Ms. TAK Sann (Tram Kok) 01 April 2015)

Medical science demonstrates the long-term effects of starvation on human medical and mental health. Cambodia suffered severe famine from 1975-1979 during the Khmer Rouge period. Although limited research exists on effects of the starvation during this era, research on other famines has contributed to an increasing body of evidence that suggests that poor nutrition leads to large and long-term negative consequences for both mental and physical health (Roseboom et al., 2011).

Moreover, some victims in Case 002/2 reported experiencing harsh labor conditions and starvation while pregnant (e.g., 2-TCCP- 283 Mom Vun, 16 September 2016). Studies have shown maternal under-nutrition during gestation

has lasting negative consequences for the offspring's health. For example, the well-studied six-month Dutch famine at the end of World War II had a profound effect on the general health of the population. In Amsterdam, the mortality rate in 1945 had more than doubled compared to 1939, likely due in large part to malnutrition. However, there were indications that maternal malnutrition during fetal life may negatively influence aspects of cognitive function in later life as suggested by lower performance on a Stroop-like task of men and women who were *in utero* during the famine (De Rooij, et al., 2010). Other studies have also shown that prenatal famine exposure is associated with affective psychoses and depression, though not all studies replicated this finding (Stein, et al., 1975).

The effects of famine appeared to depend on its timing during gestation, and the organs and tissues undergoing critical periods of development at that time. Early gestation appeared to be the most vulnerable period. People who were conceived during the famine were at increased risk of schizophrenia. People exposed during any period of gestation experience a greater rate of Type 2 Diabetes (Roseboom, et al., 2011). Another study found that exposure to famine during early gestation was associated with an increased blood pressure response to stress (Painter, de Rooij, Bossuyt, et al., 2006), and a striking increase in coronary heart disease in later life (Roseboom, van der Meulen, Osmond, et al., 2000). Despite some differences in individual findings between the different studies, the Dutch famine studies suggest that maternal nutrition before and during pregnancy play an important role in later disease susceptibility (Roseboom, et al., 2011).

One study on the prevalence of adult mental illness in persons who were in utero or in early postnatal life during the 1959-1961 Chinese Famine showed that compared with unexposed women born in 1963, women born during the famine years had higher General Health Questionnaire (GHQ) scores (increased by 0.95 points) and increased risk of mental illness. GHQ scores measure common mental health problems, including depression, anxiety, somatic symptoms and social withdrawal. Compared to men in the 1963 birth cohort, men born during the famine had lower GHQ scores (decreased by 0.89 points) and a non-significant decrease in the risk of mental illness (Huang, Cheng, et al., 2013).

4. Harms Related to Unlawful Imprisonment and Torture

The psychological effects of torture and imprisonment are profound. Civil Parties testifying in Case 002/2 identified harms related to the physical pain directly experienced during their torture and imprisonment, as well as the pain of witnessing the suffering of others.

Political imprisonment has serious and long-lasting psychological effects, including PTSD and dissociative disorders, depression, anxiety, substance abuse, and somatic symptoms (see Willis, Chou & Hunt, 2015 for a systematic review). Phobic disorders, including claustrophobia and social phobias, have also been found at high incidence rates among those who have survived political imprisonment, though PTSD is often the most commonly reported diagnoses (Maercher & Schützwohl, 1997). The combination of prolonged threats to life and derogation of psychological integrity makes political imprisonment a highly stressful and often traumatic experience (Maercher & Schützwohl, 1997).

Torture has been repeatedly correlated with PTSD, major depressive disorder, and organic brain damage across cultures (Basoglu et al., 1994; Bradley & Tawfiq, 2006; Burnett & Peel, 2001). In a meta-analysis comparing torture with other traumatic events, Steel and colleagues (2009) found that torture was the strongest predictor of PTSD. The authors also found that torture was significantly associated with depression. These results, which controlled for methodological factors, show the debilitating nature of this particular kind purposeful pain. Threats and/or harm to one's family resulted in significant increases in suicidal ideation (Lerner, Bonanno, Keatley, Joscelyne & Keller, 2015), indicating the importance of familial relationships in the desire to survive among torture survivors.

In a sample focusing on men, Carlsson, Mortenson, and Kastrup (2005) found that torture was a significant predictor of symptoms of PTSD, depression, and anxiety. In a sample of torture survivors from both Bosnia and Colombia, Alexander, Blake, and Bernstein (2007) found that 100% of Bosnians and 35% of Colombians endorsed clinically significant levels of depression. Similarly, Bradley and Tawfiq (2006) identified significant rates of PTSD, anxiety, and depression in Kurdish survivors of torture. The psychological effects of torture can persist long after the incidences have ceased. Momartin, Silove, Manicavasagar, and Steel (2004), found human rights violations to be associated with complicated grief (a disorder involving prolonged grief coupled with significant functional impairment) in a sample of Bosnian refugees residing in Australia. Experiencing complicated or unresolved grief was also predictive of depression in this sample (Momartin et al., 2004).

The following statements and dialogues have been extracted from Civil Party Testimony to illustrate the harms related to the physical pain directly experienced during their torture and imprisonment, as well as the pain of witnessing the suffering of others:

At that time, I saw a lanterns—the light came—coming out of a

lantern and I thought that that place was the killing site. There was a hall there. There was a hall there in the prison office and the hall wall was made out of wood. Ta Men (phonetic) was the prison chief. Ta Men unlocked the door and I was pushed into the cell. It was—sounds of people in the cell and the light was turned on—the lantern was turned on and shackles—shackles were brought in and I was shackled to both of my ankles. And there was an iron rod putting below the shackles and at that time, my hands were tied behind my back and I could not shackle myself and seeing that, they shackled me with the rod below it. And after I was shackled, my hands were untied. I felt very painful in my hands because I was tied behind my back. I was upset at that time. I did not commit any wrongs, however I was taken to be tortured. I was seriously tortured. Only if I had guilt, I would dare to accept and admit my guilt, however, as I said, I was not guilty. I was put there day and night without releasing to go anywhere else. I was put in that place for a period of three months. (E1/287.1 THANN Thim (Tram Kok) 02 April 2015)

They beat me one after another. After one was tired, another man came in to beat me until I passed out. After I got conscious, I was transported to—I was transported on a horse cart to Angk Roka and detained—I was detained there. (E1/287.1 THANN Thim (Tram Kok) 02 April 2015)

When I was detained within that place I was not beaten up. I was put in the cell in the prison and I was shackled. I was not beaten up. As for food rations—as for food rations, I had just a few grains of cold rice. Actually, they used the cold rice to cook gruel and I could have—I could have the gruel or meat out of a few rice grains only. (E1/287.1 THANN Thim (Tram Kok) 02 April 2015)

The pain inflicted upon me at that time was indescribable. I didn't think that I could survive. I suffered the pain physically and emotionally. We could not even relieve ourselves properly. And since I was born, I never experienced such pain until the time of the Khmer Rouge regime. We were put into row, feet to feet, and the female was placed on one row and the male prisoners were put on another row and there was a footpath in the middle. And it was very, very difficult

for us to relieve ourselves. There was a pot for us to relieve in and then we had to adjust ourselves and our ankles in order to be able to put the container underneath to relieve oneself. And as I just said, I thought I would die and in fact, one prisoner, who was nearby me, died from the lack of food and his body remained there for two nights and three days before it was removed. And he died as I said, due to hunger. His name was Pat (phonetic). He was just lying next to me before he died and that also made me think that my turn would come soon. (E1/287.1 THANN Thim (Tram Kok) 02 April 2015)

In that building, there were female prisoners and as I described, female prisoners were put into a row and we—the male prisoners—were put into another row and we were feet to feet and from my recollection, there were about 10 male prisoners and there were roughly about 10 female prisoners. There was another female prisoner. She was shackled and she had a young baby whom she breastfed and I did not know the reason for her detention. I could not imagine why she was detained there with her young baby. (E1/287.1 THANN Thim (Tram Kok) 02 April 2015)

The impact of Cambodia's killing fields is felt in present day. Mollica, Brooks, Tor, Lopes-Cardozo, and Silove (2014) report 76.2% of individuals interviewed living in Siem Reap, an important cultural community during the Khmer Rouge's reign, reported having suffered some type of torture, and only 2.6% reported no potentially traumatic experiences. The same participants indicated clinically-significant levels of depression (20.6%) and PTSD (49.5%). This level of symptom endorsement provides evidence of the chronic effects of the Khmer's rule and related traumas. The enduring impact of torture is summed up by Ly Hor, one of the Civil Parties from Case 001, in his testimonial: *"Since the collapse of the Khmer Rouge regime, I have lived in pain, with recurring memories of being tortured in prison"* (Chy, 2014).

The physical and psychological consequences of torture are not completely independent. In a study on chronic physical pain and psychological outcomes in Punjabi Sikh survivors of torture, Rasmussen, Rosenfeld, Reeves, and Keller (2007) found a relationship between physical pain severity and PTSD symptoms. Specifically, the results indicate that eleven years post-trauma, the relationship between torture and PTSD was mediated by chronic injury. The mediating effect was most pronounced for the relationship with one of the criteria for PTSD:

emotional numbing (described above). The authors suggest that chronic pain serves as a lasting reminder of the trauma inflicted by the act of torture (Rasmussen, Rosenfeld, Reeves & Keller (2007)).

C. Harms Related to Forced Marriage and Rape

Many survivors of the Khmer Rouge era experienced multiple forms of sexual and gender-based violence (SGBV) with deleterious outcomes.

1. Rape During the Khmer Rouge Regime

Although the Khmer Rouge publicly denounced rape, and any kind of sexual relationship outside of marriage, the policy inadvertently promoted the use of extreme violence to cover up sexual crimes. Those who escaped rarely spoke of, let alone reported, offenses for fear of punishment from government forces and/or retaliation from the perpetrator (Anderson, 2004). The experience of sexual and other gender-based violence represents a significant risk factor for the development of chronic and severe psychological issues, including depression and PTSD (Morof et. al., 2014). Sexual assault is a destructive tool that causes terror and destabilization by undermining feelings of individual and community safety and security (Lee Koo, 2002).

One female respondent in a survey conducted by the Cambodian Defenders Project described the trauma of her rape as follows: *"Every day, I still have physical pain. I have no power, I am weak, I have heart problems, and I get emotional. My vagina still hurts and just gets better once in a while when I take medicine. I feel very angry, painful and ashamed. I have tried to hide it for more than 30 years"* (Braaf 2014). Of the Civil Parties of the ECCC, over one quarter (28.4%) of respondents reported knowing someone who was raped during the Khmer Rouge regime, while 4.1% reported being raped themselves (Chhim, United Nations Women Funded Project 2013).

In the same study, 23% of participants knew someone who traded sex for food or privileges in order to survive (e.g., trading sex with a leader for extra rice, medicine, or a less difficult work assignment) (Chhim, United Nations Women Funded Project 2013). In addition, 14.4% knew of someone forced to undergo sexual acts with members of the Khmer Rouge on a regular basis, 19.8% witnessed or heard about someone being sexually mutilated (e.g., harming sexual organs by cutting them off or electrocuting them), and 23.9% knew someone who experienced other sexual abuse or humiliation (e.g., forced to be naked in front of others, unwanted sexual touching, sexual mocking or harassment, or forced to watch others being sexually abused). A smaller number of respondents reported

having been direct victims of these forms of violence: 1.8% reported having traded sex for food, 1% reported being sexually mutilated, and 7.7% reported being sexual abused or humiliated. 24.8% of respondents reported having witnessed or experienced other types of gender-based violence.

The following statements and dialogues have been extracted from Civil Party Testimony to illustrate the harms related to rape:

There were events that took place before the marriage day and it was painful. Two days before the marriage, at nighttime at around 7 p.m., a group of comrades called me to go to rice storage. There were five of them and it was about 7 p.m. and I could not see their faces. When I arrived there, I was told that in two days time, I would remarry and I was called to up into the rice storage. I did not go, but then my hand was pull to go up and they planned to mistreat me before the—the wedding day. There were five of them and they planned to rape me, one by one. And I was raped and the last one told me to leave after they committed the act. I could hardly walk. I wept and I could not identify them because it happened at nighttime. I bit my mouth and in order to survive and it's also for the sake of my children, I had to keep quiet about what happened to me. (2-TCCP-283 MOM Vun 16 September 2016)

Q. When they called you to go there, did they threaten you? And you said that you were raped, how were you raped; were you raped and after they threaten you?

A. They threatened me. They had a—a gun pointed at my head. I was ordered to take off all my clothes so that they raped me and they raped me, one by one. They threatened that if I—if I said anything, then I would be killed. I remain quiet about this until now. Q. And did you know those people who raped you or their age? A. I did not know their faces as it happened at night time; however, when they were close to me, I could see that—I could say that they were around 26 to 27 years old, though I could not recognize them and it happened in a—a rice storage house and it was dark. (2-TCCP-283 MOM Vun 16 September 2016)

2. Forced marriage during the Khmer Rouge Regime

It is estimated that a quarter of a million Cambodian men and women may have been forced into marriage during the Khmer Rouge regime (Douglas, 1999). Couples were often married in group marriage ceremonies involving upwards of thirty other couples, and women were often “given” to Khmer Rouge cadre. Refusal was met with harsh punishment and often death. Consummation of the marriage was expected and marital rape occurred frequently (Douglas, 1999). Within the sample of 222 Cambodians participating as Civil Parties of the ECCC surveyed on the experience and impact of forced marriage and gender-based violence specific to the Khmer Rouge regime (Chhim, United Nations Women Funded Project 2013), over half (53.6%) of respondents reported being told to marry someone by the Khmer Rouge, and 29.7% reported being forced to have sexual intercourse after the wedding. For women who left forced marriages, many experienced social isolation and ridicule due to the stigma against women who are unmarried, but are no longer virgins (Ye, 2011).

Based on interviews with 106 Civil Parties to Case 002, De Langis, Strasser, Kim, and Taing (2014) highlight the psychological impact of the statewide forced marriages and enforced conjugal relations of the Khmer Rouge regime. The victims suffered physical and mental impact, including trauma, shame and social stigma that persist across generations. This impact is poignantly highlighted in the interviews of several participants from another survey. One female respondent, who had been forced into marriage stated: “I have a sick headache every day. I can't think about what happened. The suffering has continued until now... As for my mental health, it can't be cured, even though I take medicines every day. I can't work daily.” Another was simply incapable of voicing the trauma, stating: “I can say nothing as I am full of suffering” (Braaf, 2014).

In addition, De Langis, Strasser, Kim, and Taing (2014) describe that refusal to comply with a marriage or conjugal relations would result in beatings, rape, sexual slavery, or death. Compliance resulted in psychological consequences for women especially. 24.5% of all forced marriages arranged by the Khmer Rouge are reported to have involved spousal abuse. The research suggests that forced marriage was a leading factor correlated with high rates of domestic abuse, increased desertion rates, polygamy, remarriage, and female-headed households. While some dissolved their forced marriages after the Khmer Rouge fell, many remained intact, 52.9% reporting spousal abuse. Those that still remain in abusive forced marriages report intergenerational trauma. Additionally, the forced marriage system resulted in social exclusion and discrimination for the women who were ultimately abandoned, divorced, in a polygamous marriage or widowed.

25.7% of respondents reported experiencing social problems, such as being shamed, because of the forced marriage. 12% of respondents reported that these social problems have an impact on the social acceptance and inclusion of their children. The majority (70.2%) of all study respondents reported ongoing mental health problems due to their forced marriage, reporting distress and anger toward the conditions of their forced marriage. Other reported long-term symptoms that include: being quick to anger, panic attacks, emotional trauma, and recurring nightmares of spousal rape. The trauma of the forced marriages directly impacted gender identity and valuation. Some victims of forced marriage still feel they cannot share their forced marriage experience with others. Of these individuals, 52.6% reported feelings of shame and 36.8% reported fear of stigma and discrimination. The findings suggest that the victims still are in need of long-term support and social services (De Langis et al., 2014). Braaf (2014) reports that many of the victims of forced marriage still express sadness that they were not allowed to have a traditional wedding or marry an individual for love.

The 2013 Women's Hearing with the Young Generation published testimonies of survivors of SGBV during the Khmer Rouge regime. These personal accounts expand our understanding of violence in conflict and the experiences of women and girls. They also give insight to the longevity of pain and suffering caused by those who perpetrate such crimes. Mom Vun, is one of the many who spoke about the impact of her experience:

*I was forced to get married. They said to me, 'You must get married'. I didn't know my husband, not the name nor what he looked like. Sixty couples were married on that wedding day. Then the Khmer Rouge militia pointed a gun at us and said we must have intercourse. They said, 'You must lie down and let him f**k you. Why is it so difficult?' They just stood there until we had intercourse. Then they said, 'They already f**ked, let's go'. They came on six nights to make sure we had intercourse. We had to do as they told us in order to survive. The gun was there pointing at us all the time. If we refused we could have gotten killed. Someone was killed because she refused in the same situation. In order to survive we agreed to have sexual intercourse even with four people watching. When I got pregnant, they separated me from my husband; they didn't let us live together. I felt very embarrassed and it was a fateful moment in my life. This is very painful and I will remember it until my dying day. I never told this story to anyone because I am embarrassed. I continue to struggle. I try to make sure*

that I earn a living and raise my children and ensure that they are not living in suffering. (B.Y., 2011).

The following statements and dialogues have been extracted from Civil Party Testimony to illustrate the harms related to forced marriage:

I felt so sorrowful that I could not marry my fiancé, who I loved and I wanted to live with her for life. It was like the fruit was about ripe, and then it was picked and taken away from me, and I had no right to protest against that. I felt heavy pain in my chest. And even now when I think about it, it's beyond belief. I scolded myself: how come I was born during such a terrible period of time? And that I have to have her as a wife, but as separated from her. My love for her could not be described for her. We used to go everywhere together [...] but in the end, I lost her. Although later on I was married, I still had feelings for her, and I was wondering why I was so unfairly treated. Even though I was forcibly married, I did not love my wife. (2-TCCP-232 anonymous Civil Party 25 August, 2016)

Q. Civil party, earlier you said that before your forced marriage you first refused to get married once and then you were raped by five people in the night two days, I believe, before your marriage. And I think that you made a link between this rape and the fact that you refused to get married. So on what do you base yourself to make this connection between the fact that you were raped and the fact that you refused once first to get married? A. They came to rape me and after they raped me, my marriage was arranged. And the rapists said to me that people married to a woman who already had sex with others. I felt so painful to hear this. I wanted to commit suicide but I tried to restrain myself from doing so. So that's why I concluded that they had a relationship with each other. (2-TCCP-283 MOM Vun 16, 20 September 2016)

I was also forced to get married. Two days before my marriage, five people took me away and raped me. That is also my suffering. And after the rape, I was asked to get married with my husband, and I was forced to consummate my marriage with my husband. It is a shame for me. I bear all the suffering and pain in my heart, and I did not

disclose that suffering and harm, pain before, but now I am telling the Court about the suffering, about the mistreatment that I went through. It is a shame, as I said. After the marriage, I was forced to consummate my marriage. I was—I had been raped. I was looked down by others. I had suffering in my life. Nothing could compare. Even I die, I still remember about the injury and the mistreatment that was inflicted upon me. (2-TCCP-283 MOM Vun 16, 20 September 2016)

Some of these statements reflect the concept discussed by Dr. Peg Levine of “ritualcide”, or the systematic destruction or alteration of traditional ritual practices and their sequencing. This includes, but is not limited to the Khmer Rouge’s disruption of the normal marriage process through the implementation of forced marriage (Levine, 2010). During her expert testimony at the ECCC, Dr. Levine suggested that forced marriage was a “crime against culture.” She went on to describe “because ritual is so much a foundation in culture, micro-cultures as well as macro-cultures, but I was looking at macro-cultures here, the breakdown of that foundational ritual and the access to that at particular developmental stages in one’s life—that’s important too. Yes, I claim that that is a crime against culture...” (Levine, 2016).

3. Additional SGBV Crimes and Outcomes

The vast majority of those who were exposed to, or who experienced, this panoply of SGBV crimes were without resources to address the deleterious effects of such traumas; within the sample surveyed by Dr. Chhim, only 13.5% reported having received support for the sexual violence experienced during the Khmer Rouge regime. Testimonies of the six survivors at the 2013 Women’s Hearing with the Young Generation on Gender-Based Violence during the Khmer Rouge Regime demonstrate the lasting psychological damage caused by gender-based violence. All survivors experienced at least one instance of rape and some others additionally experienced sexual torture and humiliation. The survivors, even more than 30 years after the trauma, reported feelings of embarrassment, shame, strong emotions, anger, pain, unhappiness, stress, isolation, and suffering from memories of the gender-based violence (Chhim, United Nations Women Funded Project 2013). Most reported struggling today to forget and to move on (Ye, 2014).

Similarly, Braaf (2014) reports on a study conducted by the Cambodian Defenders Project on sexual violence against ethnic minorities during the Khmer Rouge regime within a sample of 105 men and women of Vietnamese, Khmer

Krom, Khmer Islam and Cham and other ethnic backgrounds who survived the Khmer Rouge. Ethnic minorities experienced sexual violence through rape, forced marriage, sexual slavery, and survival sex. According to the victims’ testimonies, instances of these forms of sexual violence were widespread in communities. Though sexual violence was common, it was not often discussed, as the perpetrators of the violence were able to craft a culture of silence surrounding the crimes. Braaf (2014) notes that some victims of sexual violence continue to suffer from physical injury and pain, but that psychological damage is much more common among survivors. The majority of respondents in the study experienced post-trauma psychological issues such as overwhelming anger, grief, fear, nightmares, depression, and suicidal thoughts, all of which made working difficult.

In the study by Dr. Chhim, 17.6% reported that the gender-based violence experienced during the Khmer Rouge regime still affects their physical well-being, 43.7% reported that it still affects them psychologically/emotionally, and 34.7% reported that it affects their social life within a Cambodian community (Chhim, United Nations Women Funded Project 2013). An additional 5.5% reported that being a victim of SGBV under the Khmer Rouge affected their sexual functioning “quite a bit” or “extremely”. 78.8% “agreed” or “strongly agreed” that they worry about what others think about them and 85.6% reported having had to keep feelings about the rape/forced marriage to themselves because they made others feel uncomfortable. 39.7% responded “agree” or “strongly agree” to feeling ashamed for having been raped/forced to get married, and 40.5% to feeling guilty for having been raped/forced to get married. 40.5% felt that because of the rape/forced marriage, their reputation as a Cambodian woman is now destroyed, and 32.4% reported feeling that because of the rape/forced marriage, they are no longer respected members of Cambodian society. Without retribution or even social validation for this offense, the symptoms are often left untreated and have intergenerational effects (Clifford & Slavery, 2008).

The psychological consequences specific to sexual trauma throughout the world have been well documented in scientific literature. In cases of sexual violence, sense of safety is undermined while the individual victim is held captive and is rendered powerless to control what is happening to her/his own body. This effect may become a chronic state. A sense of safety and security is a basic human need that is essential for individuals to perform their daily functions and to engage in activities that promote growth and development (Maslow, 1943). When an individual does not perceive that she or he is safe, basic daily activities such as feeding, sleeping, and self-care are undermined and dysregulated. When this occurs, higher-level pursuits—such as taking care of others, gaining employment,

and pursuing an education—are also threatened and rendered more challenging, if not impossible. In addition, acts of mass rape impact the development and functioning of the individual and the community across multiple generations (Reid-Cunningham, 2008; Seifert, 1994; Wax, 2004). The resulting myriad of individual consequences includes psychiatric disorders such as PTSD, depression, and anxiety (Heim, Shugart, Craighead & Nemeroff, 2010; DSM-III; DSM-IV; DSM-5). Outside of these named mental health diagnoses, individuals suffer from abject feelings of hopelessness (Muhwezi et al., 2011), spiritual degradation (Messina-Dysert, 2012), heightened suspiciousness, persistent confusion, and fear (Kilpatrick, Resick & Veronen; 1981). Victims of trauma see themselves as vulnerable, view the world as lacking meaning, and view themselves as lacking worth (Janoff, Bulman & Frieze, 1983).

Specific diagnoses are associated with sexual assault, with PTSD being one of the most common (Holmes & St. Lawrence, 1983). The National Comorbidity Study indicated that among women, rape is the most commonly associated index trauma with PTSD (not including an “other” category; Kessler et al., 1995). If women had experienced rape as their only lifetime traumatic experience, or if they named rape as their most distressing trauma out of many, 45.9% developed PTSD at some point in their lifetime (Kessler, et al, 1995). There is ample evidence within the psychiatric and psychological literature that links sexual assault to PTSD and related disorders.

Rape victims experience a significantly greater number of anxiety symptoms and specific phobias as well (Kilpatrick, Resick & Veronen, 1981). Ellis, Atkeson, and Calhoun (1981) published congruent results. Mood disorders are a common outcome for rape survivors (Steketee & Foa, 1987). Major depressive disorder or depressive symptomology is associated with a history of sexual abuse (Becker-Lausen, Sanders & Chinsky, 1995; Beitchman, Zucker, Hood, DaCosta, Akman & Cassiva, 1992; Gold, 1986; Kendall-Tackett, 2007; Morof et al., 2014; Trickett, Noll & Putnam, 2011). The National Comorbidity Study results indicate that 39.3% of women who were sexually abused as a child developed depression (Molnar, Buka & Kessler, 2001). In a sample of 3,001 women in a follow-on study (the National Comorbidity Study-Replication), 22% of women who were raped experienced a major depressive episode (Zinzow et al., 2012). Female survivors of rape are 5.46 times more likely to experience a major depressive episode compared to non-sexual assault victims (Zinzow et al., 2012).

4. Physical Consequences of SGBV

The physical consequences of rape and sexual assault involve immediate and

enduring bodily damage. These consequences encompass major harm to reproductive and ano-rectal physiology, unwanted pregnancy, and damage to bone and muscle tissues. Nausea, stomach problems, muscle tension, and headaches are also common. Damage to female reproductive physiology generally affects the labia minora, hymen, posterior fourchette (part of the vulva), and navicularis (Sommers, 2007). Among female rape victims ages 16-48, Bowyer & Dalton (1997) discovered tears in the perineum, hymeneal, and posterior vaginal wall. Cuts and bruises were also found on the fourchette, labia majora, vagina, and anus. In preadolescent children who experience sexual assault and related traumas, ano-genital injuries frequently include bleeding, anal abrasions, and tears in the anus, hymen, and posterior fouchette (Heppenstall-Heger et al., 2003). Sexual violence victims are likely to sustain additional injuries as well. In one sample of 83 women who reported being raped, 80.9% reported some form of injury to the arm (50.6%), neck (26.5%), face/head (18.1%), breast/chest (20.5%), knee (16.9%), upper leg/thigh (43.4%), calf/lower leg (19.3%), buttock (8.4%), hand (15.7%), and/or shoulder (16.9%).

Rape causes long-lasting and potentially irreparable harm to the female reproductive system. Gynecologic fistula (major tissue destruction in the vagina and bladder and/or anus) and chronic pelvic pain are well-documented medical outcomes of rape (Bastick, Grimm & Kunz, 2007; Dossa, Zunzunegui, Hatem & Fraser, 2014; Mukanangana, Moyo, Zvoushe & Rusinga, 2014). Rape and sexual assault are also associated with genital burning, painful intercourse, menstrual irregularity, and loss of sexual interest and/or pleasure. The psychological suffering of rape survivors is compounded by the extent of their physical injuries (Golding, 1996; Roush, 2009). Many women experience social rejection as a result of infertility due to fistulas, or the presence of sexually transmitted diseases including HIV/AIDS. These women often find themselves marginalized by spouses, family members, and communities (Bastick et al., 2007; Hynes, 2004).

The following is a story that helps depict the particularly cruel administration of SGBV under the Khmer Rouge: *Net Savoien is 55 years old and today she is a farmer in Svay Rieng Province and has three children. Ms. Savoien is the sole survivor of 30 women who were taken into the forest to be raped and killed by the Khmer Rouge. One evening in 1979, Ms. Savoien was among 30 women who were selected for their strength to carry large sacks of salt from the forest back to the village. The group was led into the forest by ten local militants, aged around 17 or 18 years old. While walking through the forest the men stopped and tied up the women. Some women were crying and resisted but they were beaten until they complied. They kept walking until they came to a big hole dug in the ground; a mass grave. The men stopped and ordered the*

women to stand in a circle around the grave. The men grabbed the women one by one, tore off their clothes, beat them and raped them. Once a woman had been raped by at least two men, they beat her with an axe and finally cut her throat and pushed her into the ditch. Some women were raped by three to four men before they were killed. Ms. Savoien was the last person alive. She was paralyzed with fear. She was beaten and cut with a knife many times. The men raped her with the knife and verbally tormented her. She was raped by two men and hit in the head with an axe three times before she lost consciousness. When she regained consciousness she was in a ditch surrounded by the bodies of the other 29 women. She was naked, bleeding heavily and barely alive. She checked among the other women to try to find survivors but they were all dead. (B.Y. 2011).

Sexual violence can devastate not only the victim, but also the victim's family and the community (Clifford & Slavery, 2008). The violent and dehumanizing nature of sexual violence, often compounded with shame and fear of disclosure, make it a significant risk factor for severe and persistent psychological distress. Indeed, the experience of gender-based violence during the Khmer Rouge period, both directly and indirectly, has been shown to have serious implications for the physical and psychological health of survivors.

D. Harms related to Killings and Disappearances

Some of the crimes allegedly perpetrated by the Khmer Rouge regime include extermination, murder, and the enforced disappearance of people. Civil Parties in Case 002/2 identified harms related to losing family members through murder or disappearance. This testimony is consistent with the survey literature of other survivors. A large study of 775 Khmer Rouge survivors demonstrated the common finding that most had lost family through murder and enforced disappearance. Moreover, the study demonstrated mental health harm, finding that many survivors with lost family members went on to suffer with “prolonged grief disorder” as well as symptoms of anxiety and depression three decades later. Loss of spouse or children was a higher predictor of mental health symptoms than loss of more distant relatives (Stammel, 2013).

The following statements and dialogues have been extracted from Civil Party Testimony to illustrate the harms related to killings and disappearance of loved-ones and family:

My mother was taken away and killed together with my siblings and other relatives totaling eight. I felt so terrible and so pity for them. They took care of me since I was born, and suddenly, I lost them all. I was told she was crying, she was shouting when they took her away. I

wept so hard when I heard that news. I felt so pity for that and, as a result, I lost more than 10 family members and I am by myself. (E1/394.1 Mr. KUOY Muoy (Treatment of Vietnamese) 1 March 2016)

I am still feeling pain every day. Every time there is a ceremony or celebration, and when I have to pray, I feel so painful that I had to pray for the lost souls of my mother, my father, and my siblings. I am by myself, without parents and siblings, and there is nothing that could compare to the loss of my family members. (E1/394.1 Mr. KUOY Muoy, 1 March 2016)

I lost many family members, including my father and relatives 11 totaling 17 altogether. I also lost my nieces and nephews during 12 the period. And that gave me much pain, and the pain and the suffering stayed with me at the present time. (E1/393.1 Mr. MEU Peou 29 February 2016)

I don't want to claim for anything else but I want to claim for my husband. I want my husband to be back. My husband and my lost child. (E1/286.1 Ms. TAK Sann (Tram Kok) 01 April 2015)

E. Harms related to Persecution on Political, Religious, or Racial Grounds

Civil party testimony in Case 002/2 identified harms related to persecution on political grounds, religious grounds, and racial grounds. The following statements and dialogues have been extracted from Civil Party Testimony to illustrate the harms related to persecution (i.e. Religious Persecution of Cham & Buddhist, Racial Persecution of Vietnamese):

He was so afraid that his children—that is, us, would be raped before we were killed. I was so terrified upon hearing that from my father, and I was afraid that, one day, my turn would come, that I would be taken away because I was half Vietnamese blood. And that thought was with me all the time. (E1/394.1 Ms. SIENG Chanthy (Treatment of Vietnamese) 1 March 2016)

Other people, other workers, did not even dare talk to me because they

knew that I was half-blood Vietnamese, and if they talked to me, maybe they would be implicated. They fear that they were indicated with me and they would be killed, so I had to work alone, by myself. And of course, every time I recall it, the fear comes back to me. (E1/394.1 Ms. SIENG Chanthy 1 March 2016)

Father died because he was a Cham person who adhered to his religious practice, and he didn't abandon his religion when he was forced by Angkar. They forced him to eat pork, but he refused, so Angkar gave him a last warning that he had to eat pork. And if he could not eat pork, then there would be nothing for him to eat. My father refused to eat pork, and he only drank water. And he had to find tree leaves in the forest to eat, and that was terrible for him, living in such a situation. I would think that it would be better if he—if they were to kill him and not to allow him to suffer such a terrible circumstance. (E1/393.1 Mr. MEU Peou T., 29 February 2016)

Q. When you saw the pagodas being destroyed and when you saw the statues that were shattered, what did you feel? A. I was absolutely torn because this was a sacred place and there were no longer any monks there and in the past there used to be celebrations, ceremonies but there were no longer any religious practice so I felt that I was completely deprived of any psychological base. (E1/288.1 Mr. BUN Sarouen (Tram Kok) 03 April 2015)

When I lost my family members and relatives, my own father named Uch Sunli, who was a clergyman at the pagoda, also died. He was killed because the Khmer Rouge witnessed that he practiced the Buddhist religion and someone came to tell me that your father was so much—believed in religion and that's why he was arrested and sent to meet Buddha. I would like to tell the Chamber that even lighting the incense to pay respect to Buddha, he was arrested for that simple reason. (E1/394.1 Mr. UCH Sunlay 1 March 2016)

Beyond the physical dangers and discomforts of imprisonment, the experience of persecution on political grounds represents a serious threat to the individual's ability to maintain a sense of agency and identity (Barudy, 1989). The persecuted group to which the prisoner belongs serves to provide meaning and security to

their existence. Without a structure to support self-esteem strivings, the individual is vulnerable to existential insecurity and despair.

Moreover, some of the killings of Vietnamese and Cham minorities in Case 002/2 are alleged to be an act of genocide, a term defined by the United Nations Convention on the Prevention and Punishment of the Crime of Genocide as a range of criminal acts undertaken with the intent to destroy (in whole or in part) a group of individuals based on their nationality, race, ethnicity, or religion. The long-term consequences of genocide range from increased symptoms of post-traumatic stress, psychological symptoms such as anxiety and depression, and impaired cognitive functioning (Barel, IJzendoorn, Sagi-Schwartz & Bakermans-Kranenburg, 2010). In a study comparing different groups of Holocaust survivors, those who were tattooed with an identification mark (and thus were presumed to have been exposed to more potentially traumatic events) evidenced a greater endorsement of post-traumatic stress, intrusive memories, avoidance of behaviors that reminded them of the experience, and hypervigilance, when compared to those not subjected to concentration camps (Kuch & Cox, 1992). In another study of Holocaust survivors, participants reported an increase in pain level, the number of places where pain existed, symptoms of depression, and use of medical services (Yaari, Eisenberg, Adler & Birkhan, 1999). These comparison studies were completed years after the Holocaust, an event that took place at least thirty years before the Khmer Rouge rose to power. It is safe to assume that similar outcomes as a result of genocide may be found in survivors of Khmer Rouge.

F. Additional Harms Suffered by Children and Vulnerable Populations

Mistreatment and torture of children and separation of children from their family are alleged harms suffered under the Khmer Rouge. It is well established that children's exposure to war is a risk factor for PTSD and other adjustment problems. According to most studies, more than half of children exposed to war meet the criteria for PTSD. In 1984, 50% of Cambodian children who had been exposed to war and genocide during the Pol Pot regime met the diagnostic criteria for PTSD (Kinzie et al., 1986). Follow-up studies found PTSD rates of 48% and 38% in 1987 and 1990, respectively (Sack et al., 1993). The more general children's trauma literature indicates that children exposed to violent trauma, such as witnessing murders, are particularly vulnerable to post-traumatic stress reactions (Horowitz et al., 1995; Pynoos & Eth, 1985). Indeed, war exposure involves multiple traumatic events, including experiencing or witnessing violent acts (e.g., killings, rape, torture) or the results of violent acts (e.g., seeing dead bodies or bombed buildings). One study looked the trauma experience and response of 791

children aged 6 to 16 involved in the 1994 siege of Sarajevo. In this sample, 41% of participants had clinically significant PTSD symptoms.

Children in particular are adversely affected by exposure to both violent and nonviolent war-traumas. Additive effects of violence and deprivations during war may overwhelm the coping skills of children and leave them vulnerable to externalizing and internalizing adjustment difficulties and symptoms of PTSD (Allwood et al., 2002). One study examined the relationship of violent war experiences to children's trauma reactions and adjustment in a group of children from Bosnia. The study found that direct exposure to violence, such as being in threatening situations (including being threatened with being killed) and witnessing killings and injuries, was significantly related to teacher-reported delinquent behaviors and anxiety/depression. Witnessing killings and other injuries was also significantly related to teacher-reported attention problems, whereas being in threatening situations was also significantly related to somatic complaints. As expected, witnessing killings was related to teacher-reported aggressive behaviors (Allwood et al., 2002).

The following statements and dialogues with Civil Parties illustrate the harms related to the mistreatment and torture of children and separation of children from their families:

After they arrested me, they beat me up and that happened for the first time and then for the second time, and for the third time, I became seriously ill. I had a very high temperature, it was a bad fever. It happened day and night and I sought permission to rest but I was not allowed to rest. And I went to seek for some medicine and I was not given any except just a powder from cassava and then my mother gave me some boiled—some boiled water from tree leaves. And then I was caught again by another person for not working but drinking that traditional herb. Then I was arrested, tied against a tree and beaten up and I—at that time there were 20 young children there. I was beaten up while I was seriously ill. And they not only used their hands to beat me up, they used bamboo clubs with nails attached to beat me up physically and there are scars remained on my body. I was tied up to the tree until the morning and when the morning came, I saw blood all over my body. I felt so pity for myself. When I was in this trouble I wanted the comfort of my parents but they were nowhere near me. I shouted asking for my parents but nobody came to help me, only those who actually mistreated me were there. (E1/288.1 Ms. OUM

Vannak (Tram Kok) 03 April 2015)

Q. When you sought permission not to visit your family, was your request actually granted? A. No, it was not. I was not allowed to go. So I did not see my family members. At that time, because I recently separated from my parents, at night time, I wept. And I—they joked at me that I could just continue weeping and maybe I wish that I would see my family members. (E1/287.1 Ms. YEM Khonny (Tram Kok) 02 April 2015)

I said to him, "So my father still alive?" and then he said, "Yes, he was living about 100 meters from Krang Ta Chan". I then asked my mother and other people to go to Krang Ta Chan and when we arrived there, I saw my father carrying water to the vegetable plots and that made me sad. I was crying. He was so thin that I could not even recognize him. He was wearing under drawers and I saw him from a distance and I had a hard time recognizing him. We were hiding, of course, when we were watching him. I almost asked if I could come see him and Uncle Ran said, "No, no, don't do so because it's very dangerous. If you want to go there, you have to speak to me first." And it is especially dangerous for him, we risked endangering him. So I decided not to go to talk to him. So all we could was weep. So we stayed with Uncle Ran for one night. We didn't dare come close to Krang Ta Chan and we would hear cries, I don't know if he was being tortured. We were completely broken. (E1/288.1 Mr. BUN Sarouen (Tram Kok) 03 April 2015)

I missed my mother. I had no information about my mother and siblings. I did not know at that time where they were living. I was living in an open field with no houses surrounding and I did not know at that time the name of that location where I was living. (E1/339.1 Ms. NUON Narom (1st January Dam) 01 September 2015)

The only thing that I recall is the suffering and the loss of my family members. If I could see them together, I would feel warm. But they had all gone and I could not depend on anyone. (E1/287.1 Ms. YEM Khonny (Tram Kok) 02 April 2015)

My main suffering is the loss of my parents and the loss of my siblings. I feel so saddened when I look at other people. They have their families, they have their parents and their siblings. For me, I am by myself. And I try to work hard in order to survive until the fall of the regime. (E1/287.1 Ms. YEM Khonny (Tram Kok) 02 April 2015)

I am still recalling the event and the loss of my mother and the loss of my brothers and sisters. And every time I recall that, it is still painful for me. E1/288.1 Ms. LOEP Neang (Tram Kok) 03 April 2015

And as far as I understood and I learnt, my relatives obtained salt in exchange of a wrist watch. And I asked the Base People there how my relatives were killed. And I was told that my elder sister and her husband were chained to an ox cart, the three year-old-child was also chained and they dragged her crossing the forest. How terrible it was for a three-year-old child. If they were to kill them, why did they have to torture them by chaining them and dragging them behind an ox cart? How terrible it was for my elder sister and her child before they died. I myself upon hearing that almost fainted. All my hopes and expectations disappeared. My knees trembled and became weak. And those people told me that I better leave quickly otherwise I might have been implicated. I didn't stay there for one day as authorized. So I returned. I feared that I would be implicated. I was afraid that they saw me weeping and I was accused, so I returned. (E1/339.1 Ms. CHAO Lang (1st January Dam) 01 September 2015)

Damage to child psychology is well established and documented in the science literature from conflicts throughout the world. Studies of Bosnian children who faced separation from family, bereavement, close contact with war and combat, and extreme deprivation found that almost 94% of the children met DSM-IV criteria for post-traumatic stress disorder (Goldstein et al., 1997). Approximately 40% reported witnessing the violent injury or death of parents or siblings. Significant life activity affecting sadness and anxiety were reported by 90.6% and 95.5% of the children, respectively. High levels of other symptoms surveyed were also found. Children who had witnessed the death, injury, or torture of nuclear family members; children of an older age; and those who came from a large city reported more symptoms (Goldstein et al., 1997). Another study examined trauma exposure and psychological reactions to genocide among 3030

Rwandan children who had been exposed to extreme levels of violence in the form of witnessing the death of close family members and others in massacres, as well as other violent acts. More than two-thirds of the sample actually saw someone being injured or killed, and 78% experienced death in their immediate family, of which more than one-third of these children witnessed the death of their own family members. The study clearly showed that exposure was related to the degree of intrusive memories and thoughts, as well as instances of hyper-arousal. (Dyregrov et al., 2000). Other studies associate exposure to violence with cognitive impairment (Arroyo & Eth, 1985; Diehl, Zea & Espino, 1993).

G. Addressing Mental Harm in Victims of the Khmer Rouge Regime

Victim redress in the form of access to psychological and psycho-social rehabilitation is necessary to address the mental health outcomes connected to the traumatic events experienced under the Khmer Rouge regime. Forms of psychological rehabilitation include education, social services, and culturally appropriate therapeutic interventions to address the psychological consequences and psychiatric disorders that result from exposure to extreme violence.

Psychological treatment and psycho-social interventions have been proven effective rehabilitation measures for the mental health symptoms commonly suffered by survivors of violence (Regehr, Alaggia, Dennis, Pitts & Saini 2013; Resick et al., 2002; Foa, Rothbaum, Riggs & Murdock, 1991; Frank et al., 1988; Nishith, Resick & Griffin, 2002; Resick & Shnicke 1992; Rothbaum, Astin & Marsteller, 2005; Clark, Rizvi & Resick, 2008). Effective, evidence-based interventions (i.e., interventions whose efficacy has been demonstrated) include cognitive-behavioral therapies such as cognitive processing therapy and prolonged exposure treatments (Regehr, Alaggia, Dennis, Pitts & Saini, 2013; Foa, Rothbaum, Riggs & Murdock, 1991; Resick & Shnicke, 1992). Also, mental health treatment and psychosocial interventions can take many forms and should be tailored to cultural and contextual needs and values. Psychological rehabilitation requires the identification of those in need of psychological support as well as measures to reduce barriers to care, including efforts aimed at reducing stigma around mental health difficulties. Reparations for the crimes alleged in the Khmer Rouge situation could include access to culturally-sensitive mental health interventions with the primary aims of (1) promoting psychological healing and growth and (2) restoring and improving daily functioning and quality of life.

In Cambodia, public health care represents the least utilized sector of Cambodia's pluralistic health care system, with most residents not achieving access to care or choosing traditional care (Somasundaram, van de Put, Eisenbruch

& de Jong, 1999). There are also significant concerns with access to care within the public sector. Government hospitals are under-resourced in both materials (i.e. drugs) and personnel (i.e. doctors), making it difficult to adequately address a diversity and multitude of needs. Most Cambodian mental health professionals agree that resources for mental health treatment are under resourced financially (Van Schaack, Reicherter & Chhang, 2011).

Physical and psychological rehabilitation all involve and require educational campaigns. In particular, efforts to provide education about the impact of the harms alleged in Case 002/2 can help to reduce stigma and improve understanding of the physical damage, the psychological consequences, and the material needs of victims, their families, and their communities. Educational and informational campaigns can help to reduce blame that may be directed towards victims. Educational campaigns can also be used to provide and reinforce guarantees of non-repetition and to provide symbolic public acknowledgment of the crimes.

H. Conclusion

The mental health damage caused by the crimes of the Khmer Rouge are well understood and well documented in the medical/psychiatric and psychological sciences. These harms are similar to those caused by violence throughout the world and are consistent with the established science of trauma psychology. This Report demonstrates how the atrocities of the Khmer Rouge damaged the mental health of survivors. Clear links were made between specific alleged crimes of the Khmer Rouge and the mental health harms that these crimes caused. The statements of Civil Parties provided specific examples of the impact of crimes on individuals in the context of psychological suffering. It is hoped that this Report may aid in laying the groundwork for comprehensive reparations addressing ongoing victim impact related to mental harm.

References

- Alexander, A., Blake, S. & Bernstein, M. A. (2007). The staying power of pain. A comparison of torture survivors from Bosnia and Colombia and their rates of anxiety, depression and PTSD. *Torture: quarterly journal on rehabilitation of torture victims and prevention of torture*, 17(1), 1-10.
- Allwood, M. A., Bell-Dolan, D. & Husain, S. A. (2002). Children's trauma and adjustment reactions to violent and nonviolent war experiences. *Journal of the American Academy of Child & Adolescent Psychiatry*, 41(4), 450-457.
- American Psychiatric Association. (1980). *Diagnostic and statistical manual of mental disorders* (3rd ed.). Washington, DC: Author.
- American Psychiatric Association. (2000). *Diagnostic and statistical manual of mental disorders* (4th ed., text rev.). Washington, DC: Author.
- American Psychiatric Association. (2013). *Diagnostic and statistical manual of mental disorders* (5th ed.). Arlington, VA: American Psychiatric Publishing.
- Anderson, K. (2004). Turning reconciliation on its head: responding to sexual violence under the Khmer Rouge. *Seattle Journal for Social Justice*, 3(2), 785-832.
- Arroyo, W. & Eth, S. (1985). Children traumatized by Central American warfare. In S. Eth & R. Pynoos (Eds.), *Posttraumatic stress disorders in children* (pp. 103-120). Washington, DC: American Psychiatric Press.
- Bale, T. E. (2015). Epigenetic and transgenerational reprogramming of brain development. *Nature Reviews Neuroscience*, 16, 332-344.
- Bale, T.E., Baram, T.Z., Brown, A.S., Goldstein, J.M., Insel, T.R., McCarthy, M.M., Nemeroff, C.B., Nestler, E.J. (2010). Early life programming and neurodevelopmental disorders. *Biological Psychiatry*, 68, 314-319.
- Barclay, A. & Ye, B. (2012). *Report on the Proceedings of the 2011 Women's Hearing on Sexual Violence Under the Khmer Rouge Regime*. Phnom Penh, Cambodia: Cambodia Defenders Project.
- Barel, E., Van IJzendoorn, M. H., Sagi-Schwartz, A. & Bakermans-Kranenburg, M. J. (2010). Surviving the Holocaust: a meta-analysis of the long-term sequelae of a genocide. *Psychological bulletin*, 136(5), 677.
- Barudy, J. (1989). A programme of mental health for political refugees: Dealing with the invisible pain of political exile. *Social Science & Medicine*, 28(7), 715-727.
- Basoglu, M., Paker, M., Paker, O., Ozmen, E., Marks, I., Incesu, C., ... & Sarimurat, N. (1994). Psychological effects of torture: a comparison of tortured with nontortured political activists in Turkey. *American Journal of Psychiatry*, 151(1), 76-81.

- Bastick, M., Grimm, K. & Kunz, R. (2007). Sexual violence in armed conflict: Global overview and implications.
- Becker-Lausen, E., Sanders, B. & Chinsky, J. M. (1995). Mediation of abusive childhood experiences: Depression, dissociation, and negative life outcomes. *American Journal of Orthopsychiatry*, 65(4), 560-573.
- Beitchman, J. H., Zucker, K. J., Hood, J. E., DaCosta, G. A., Akman, D. & Cassavia, E. (1992). A review of the long-term effects of child sexual abuse. *Child Abuse & Neglect*, 16(1), 101-118. doi:10.1016/0145-2134(92)90011-F
- Blair, R. G. (2001). Mental health needs among Cambodian refugees in Utah. *International Social Work*, 44(2), 179-196.
- Boehnlein, J. K. & Kinzie, J. D. (1995). Refugee trauma. *Transcultural Psychiatry*, 32(3), 223-252.
- Boyce, W. T. & Ellis, B. J. (2005). Biological sensitivity to context: I. An evolutionary-developmental theory of the origins and functions of stress reactivity. *Development and psychopathology*, 17(2), 271-301.
- Bowyer, L. & Dalton, M. E. (1997). Female victims of rape and their genital injuries. *BJOG: An International Journal of Obstetrics & Gynaecology*, 104(5), 617-620.
- Braaf, R. (2014). Sexual violence against ethnic minorities during the Khmer Rouge regime.
- Bracken, P. J., Giller, J. E. & Summerfield, D. (1995). Psychological responses to war and atrocity: the limitations of current concepts. *Social science & medicine*, 40(8), 1073-1082.
- Bradley, L. & Tawfiq, N. (2006). The physical and psychological effects of torture in Kurds seeking asylum in the United Kingdom. *Torture*, 16(1), 41-47.
- Briere, J., Scott, C. & Weathers, F. (2005). Peritraumatic and persistent dissociation in the presumed etiology of PTSD. *American Journal of Psychiatry*, 162(12), 2295-2301.
- Burnett, A. & Peel, M. (2001). The health of survivors of torture and organised violence. *British Medical Journal*, 322(7286), 606.
- B. Y. (2011). Women's Hearing with the Young Generation. Cambodian Defenders Project.
- B. Y. (2014). Women's Hearing with the Young Generation. Cambodian Defenders Project.
- Cardozo, B. L., Vergara, A., Agani, F. & Gotway, C. A. (2000). Mental health, social functioning, and attitudes of Kosovar Albanians following the war in Kosovo. *Journal of American Medicine*, 284(5), 569-577.
- Carlson, E. B., Dalenberg, C. & McDade-Montez, E. (2012). Dissociation in post-traumatic stress disorder part I: Definitions and review of research. *Psychological Trauma: Theory, Research, Practice, And Policy*, 4(5), 479-489.
- Carlsson, J. M., Mortensen, E. L. & Kastrup, M. (2005). A follow-up study of mental health and health-related quality of life in tortured refugees in multidisciplinary treatment. *The Journal of nervous and mental disease*, 193(10), 651-657.
- Carlson, E. B. & Rosser-Hogan, R. (1993). Mental health status of Cambodian refugees ten years after leaving their homes. *American Journal of Orthopsychiatry*, 63(2), 223.
- Carrion, V. G. & Kletter, H. (2012). Posttraumatic stress disorder: shifting toward a developmental framework. *Child and adolescent psychiatric clinics of North America*, 21(3), 573-591.
- Carswell, K., Blackburn, P. & Barker, C. (2011). The relationship between trauma, post-migration problems and the psychological well-being of refugees and asylum seekers. *International Journal of Social Psychiatry*, 57(2), 107-119.
- Chhim, S. (2012). Baksbat (broken courage): The development and validation of the inventory to measure *baksbat*, a Cambodian trauma-based cultural syndrome of distress. *Culture, Medicine, and Psychiatry*, 36(4), 640-659.
- Chhim, S. (2013) Expert Testimony from ECCC: www.eccc.gov.kh/en/document/court/transcript-hearing-substance-case-002-05-june-2013
- Chhim, S. (2013) Unpublished Collected Data from the Transcultural Psychosocial Organization: United Nations Women Funded Project; Survey on Gender Violence.
- Chy, T. (2014). *When the criminal laughs*. Phnom Penh, Cambodia: Documentation Center of Cambodia.
- Clarke, S. B., Rizvi, S. L. & Resick, P. A. (2008). Borderline personality characteristics and treatment outcome in cognitive-behavioral treatments for PTSD in female rape victims. *Behavior Therapy*, 39(1), 72-78.
- Clifford, C. & Slavery, S. M. (2008). Rape as a Weapon of War and its Long-term Effects on Victims and Society. In 7th Global Conference Violence and the Contexts of Hostility. Budapest. (5-7 May 2008).
- Copeland, W. E., Keeler, G., Angold, A. & Costello, E. J. (2007). Traumatic events and posttraumatic stress in childhood. *Archives of General Psychiatry*, 64(5), 577-584. doi:10.1001/archpsyc.64.5.577
- Creamer, M., Burgess, P. & McFarlane, A. C. (2001). Post-traumatic stress disorder: Findings from the Australian national survey of mental health and well-being. *Psychological Medicine*, 31(7), 1237-1247.
- Cunha, M. P. E., Clegg, S., Rego, A. & Lancione, M. (2012). The

Organization (Ângkar) as a state of exception: The case of the S-21 extermination camp, Phnom Penh. *Journal of Political Power*, 5(2), 279-299.

Dara M. & Dene-Hern C., (2012, December 7). Results from mental health survey 'alarming.' *The Cambodia Daily*. Retrieved from www.cambodiadaily.com/archives/results-from-mental-health-survey-alarming-6491/.

David, J. (1984). Posttraumatic stress disorder among survivors of Cambodian concentration camps. *American Journal of Psychiatry*, 141, 645-650.

De Bellis, M. D., Keshavan, M. S., Shifflett, H., Iyengar, S., Beers, S. R., Hall, J. & Moritz, G. (2002). Brain structures in pediatric maltreatment-related posttraumatic stress disorder: a sociodemographically matched study. *Biological psychiatry*, 52(11), 1066-1078.

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

De Langis, T., Strasser, J., Kim, T., Taing, S. Like Ghost Changes Body: A Study on the Impact of Forced Marriage During the Khmer Rouge Regime (Transcultural Psychosocial Organization, 2014).

De Rooij SR, Wouters H, Yonker JE, Painter RC, Roseboom TJ. Prenatal undernutrition and cognitive function in late adulthood. *Proceedings of the National Academy of Sciences of the United States of America* 2010;107:16881-6.

Diehl, V. A., Zea, M. C. & Espino, C. M. (1993). Exposure to war violence, separation from parents, posttraumatic stress and cognitive functioning in Hispanic children. *Interamerican Journal of Psychology*, 28, 25-41.

Dossa, N., Zunzunegui, M., Hatem, M. & Fraser, W. (2014). Fistula and other adverse reproductive health outcomes among women victims of conflict-related sexual violence: A population-based cross-sectional study. *Birth*, 41(1), 5-13.

Dubois, V., Tonglet, R., Hoyois, P., Sunbaunat, K., Roussaux, J. P. & Hauff, E. (2004). Household survey of psychiatric morbidity in Cambodia. *International Journal of Social Psychiatry*, 50(2), 174-185.

Dyregrov, Atle, et al. "Trauma exposure and psychological reactions to genocide among Rwandan children." *Journal of traumatic stress* 13.1 (2000): 3-21.

Eisenbruch, M. (1991). From post-traumatic stress disorder to cultural bereavement: Diagnosis of Southeast Asian refugees. *Social Science & Medicine*, 33(6), 673-680.

Eisenbruch, M., de Jong, J. T. & van de Put, W. (2004). Bringing order out of chaos: A culturally competent approach to managing the problems of refugees and victims of organized violence. *Journal of Traumatic Stress*, 17(2), 123-131.

Ellis, E. M., Atkeson, B. M. & Calhoun, K. S. (1981). An assessment of long-term reaction to rape. *Journal Of Abnormal Psychology*, 90(3), 263-266. doi:10.1037/0021-843X.90.3.263

Field N. (2011). Intergenerational transmission of trauma stemming from the Khmer Rouge regime: An attachment perspective. In B. Van Schaack, D. Reicherter, Chhang, Y. & A. Talbott (Eds.), *Cambodia's hidden scars: trauma, psychology in the wake of the Khmer Rouge* (pp.70-85). Documentation Center of Cambodia.

Field, N. P. & Chhim, S. (2008). Desire for revenge and attitudes toward the Khmer Rouge tribunal among Cambodians. *Journal of Loss and Trauma*, 13(4), 352-372.

Field, N. P., Om, C., Kim, T. & Vorn, S. (2011). Parental styles in second generation effects of genocide stemming from the Khmer Rouge regime in Cambodia. *Attachment & human development*, 13(6), 611-628.

Foa, E. B., Rothbaum, B., Riggs, D. & Murdock, T. (1991). Treatment of posttraumatic stress disorder in rape victims: A comparison between cognitive-behavioral procedures and counselling. *Journal of Consulting and Clinical Psychology*, 59(5), 715-723.

Frank, E., Anderson, B., Stewart, B. D., Dancu, C., Hughes, C. & West, D. (1988). Efficacy of cognitive behavior therapy and systematic desensitization in the treatment of rape trauma. *Behavior Therapy*, 19(3), 403-420.

Friedman, M. J. (2013). Finalizing PTSD in DSM-V: Getting here from there and where to go next (PDF). *Journal of Traumatic Stress*, 26, 548-556.

Geneffe, I. (2002). Chronic persistent pain in victims of torture. *Journal of Musculoskeletal Pain*, 10(1-2), 229-259.

Golding, J. M. (1996). Sexual assault history and women's reproductive and sexual health. *Psychology of Women Quarterly*, 20(1), 101-121.

Goldstein, Richard D., Nina S. Wampler, and Paul H. Wise. "War experiences and distress symptoms of Bosnian children." *Pediatrics* 100.5 (1997): 873-878.

Heim, C., Shugart, M., Craighead, W. E. & Nemeroff, C. B. (2010). Neurobiological and psychiatric consequences of child abuse and neglect. *Developmental Psychobiology*, 52(7), 671-690.

Heppenstall-Heger, A., McConnell, G., Ticson, L., Guerra, L., Lister, J. & Zaragoza, T. (2003). Healing patterns in anogenital injuries: a longitudinal study of injuries associated with sexual abuse, accidental injuries, or genital surgery in

the preadolescent child. *Pediatrics*, 112(4), 829-837.

Herbert, J., Goodyer, I. M., Grossman, A. B., Hastings, M. H., De Kloet, E. R., Lightman, S. L., ... & Seckl, J. R. (2006). Do corticosteroids damage the brain? *Journal of Neuroendocrinology*, 18(6), 393-411.

Herman, J.L. (1992). *Trauma and recovery*. New York: Basic Books.

Hinton, D., Hinton, S., Um, K., Chea, A. & Sak, S. (2002). The Khmer 'weak heart' syndrome: Fear of death from palpitations. *Transcultural Psychiatry*, 39(3), 323-344.

Hinton, D. E. & Lewis-Fernández, R. (2010). Idioms of distress among trauma survivors: subtypes and clinical utility. *Culture, Medicine, and Psychiatry*, 34(2), 209-218.

Hinton, D. E., Kredlow, M. A., Pich, V., Bui, E. & Hofmann, S. G. (2013). The relationship of PTSD to key somatic complaints and cultural syndromes among Cambodian refugees attending a psychiatric clinic: The Cambodian Somatic Symptom and Syndrome Inventory (CSSI). *Transcultural Psychiatry*, 50(3), 347-370.

Hinton, D. E., Nickerson, A. & Bryant, R. A. (2011). Worry, worry attacks, and PTSD among Cambodian refugees: A path analysis investigation. *Social science & medicine*, 72(11), 1817-1825.

Holmes, M. R. & St. Lawrence, J. S. (1983). Treatment of rape-induced trauma: Proposed behavioral conceptualization and review of the literature. *Clinical Psychology Review*, 3(4), 417-433. doi:10.1016/0272-7358(83)90022-3

Horowitz K, Weine S, Jekel J (1995), PTSD symptoms in urban adolescent girls: compounded community trauma. *J Am Acad Child Adolesc Psychiatry* 34:1353-1361.

Huang, Cheng, et al. "Malnutrition in early life and adult mental health: evidence from a natural experiment." *Social Science & Medicine* 97 (2013): 259-266.

Hynes, H.P. (2004). On the battlefield of women's bodies: An overview of the harm of war to women. *Women's Studies International Forum*, 27, 431-445.

Jacobsen, L. K., Southwick, S. M. & Kosten, T. R. (2001). Substance use disorders in patients with posttraumatic stress disorder: a review of the literature. *American Journal of Psychiatry*.

Janoff-Bulman, R. & Frieze, I. H. (1983). A theoretical perspective for understanding reactions to victimization. *Journal of Social Issues*, 39(2), 1-17.

Kendall-Tackett, K. A. (2007). Inflammation, cardiovascular disease, and metabolic syndrome as sequelae of violence against women: the role of depression, hostility, and sleep disturbance. *Trauma, Violence & Abuse*, 8(2), 117-

126.

Kessler, R. C., Sonnega, A., Bromet, E., Hughes, M. & Nelson, C. B. (1995). Posttraumatic stress disorder in the National Comorbidity Survey. *Archives of General Psychiatry*, 52(12), 1048-1060.

Kiernan, B. (2003). The demography of genocide in Southeast Asia: The death tolls in Cambodia, 1975-79, and East Timor, 1975-80. *Critical Asian Studies*, 35(4), 585-597.

Kilpatrick, D. G., Resick, P. A. & Veronen, L. J. (1981). Effects of a rape experience: A longitudinal study. *Journal of Social Issues*, 37(4), 105-122.

Kinzie, J. D. (1989). Therapeutic approaches to traumatized Cambodian refugees. *Journal of Traumatic Stress*, 2(1), 75-91.

Kinzie, J. D., Fredrickson, R. H., Ben, R., Fleck, J. & Karls, W. (1984). Posttraumatic stress disorder among survivors of Cambodian concentration camps. *American Journal of Psychiatry*, 141, 645-650.

Kinzie J.D., Sack WH, Angell RH, Manson S, Rath B (1986), The psychiatric effects of massive trauma on Cambodian children, I: the children. *J Am Acad Child Adolesc Psychiatry* 25:370-376.

Kuch, K. & Cox, B. J. (1992). Symptoms of PTSD in 124 survivors of the Holocaust. *American Journal of Psychiatry*, 149(3), 337-340.

Lee-Koo, K. (2002). Confronting a disciplinary blindness: Women, war and rape in the international politics of security. *Australian Journal of Political Science*, 37(3), 525-536.

Lerner, E., Bonanno, G. A., Keatley, E., Joscelyne, A. & Keller, A. S. (2015). Predictors of Suicidal Ideation in Treatment-Seeking Survivors of Torture. *Psychological Trauma: Theory, Research, Practice, and Policy*. Advance online publication. <http://dx.doi.org/10.1037/tra0000040>.

Levine, Peg. (2010). *Love and dread in Cambodia: Weddings, births, and ritual harm under the Khmer Rouge* Singapore: NUS Press

Levine, Peg. (2016). Expert Testimony from ECCC: 12, October 2016.

Maercker, A. & Schützwohl, M. (1997). Long-term effects of political imprisonment: A group comparison study. *Social Psychiatry and Psychiatric Epidemiology*, 32(8), 435-442.

Marshall, G. N., Schell, T. L., Elliott, M. N., Berthold, S. M. & Chun, C. A. (2005). Mental health of Cambodian refugees 2 decades after resettlement in the United States. *JAMA: The journal of the American Medical Association*, 294(5), 571-579.

Maslow, A. H. (1943). A theory of human motivation. *Psychological Review*, 50(4), 370-396.

McEwen, B. S. (1998). Stress, adaptation, and disease: Allostasis and allostatic load. *Annals of the New York Academy of Sciences*, 840(1), 33-44.

McEwen, B.S. & Wingfield, J.C. (2003). *The concept of allostasis in biology and biomedicine. Hormones and Behavior*, 43(1), 2-15.

Merikangas K, Pine, D (2002). *Genetic and other vulnerability factors for anxiety and stress disorders. Neuropsychopharmacology: The Fifth Generation of Progress. American College of Neuropsychopharmacology*. 867-882.

Messina-Dysert, G. (2013). Rape and Spiritual Death. *Feminist Theology*, 20(2), 120-132.

Mills, K. L., Teesson, M., Ross, J. & Peters, L. (2006). Trauma, PTSD, and substance use disorders: findings from the Australian National Survey of Mental Health and Well-Being. *American Journal of Psychiatry*.

Mollica, R. F., Brooks, R., Tor, S., Lopes-Cardozo, B. & Silove, D. (2014). The enduring mental health impact of mass violence: A community comparison study of Cambodian civilians living in Cambodia and Thailand. *International journal of social psychiatry*, 60(1), 6-20.

Mollica, R. F., Donelan, K., Tor, S., Lavelle, J., Elias, C., Frankel, M. & Blendon, R. J. (1993). The effect of trauma and confinement on functional health and mental health status of Cambodians living in Thailand-Cambodia border camps. *JAMA: the Journal of the American Medical Association*, 270(5), 581-586.

Mollica, R. F., McInnes, K., Poole, C. & Tor, S. (1998). Dose-effect relationships of trauma to symptoms of depression and posttraumatic stress disorder among Cambodian survivors of mass violence. *The British journal of psychiatry*, 173(6), 482-488.

Mollica, R. F., Poole, C., Son, L., Murray, C. C. & Tor, S. (1997). Effects of war trauma on Cambodian refugee adolescents' functional health and mental health status. *Journal of the American Academy of Child & Adolescent Psychiatry*, 36(8), 1098-1106.

Mollica, R. F., Wyshak, G. & Lavelle, J. (1987). The psychosocial impact of war trauma and torture on Southeast Asian refugees. *The American Journal of Psychiatry*, 144(12).

Molnar, B. E., Buka, S. L. & Kessler, R. C. (2001). Child sexual abuse and subsequent psychopathology: Results from the National Comorbidity Survey. *American Journal Of Public Health*, 91(5), 753-760.

Momartin, S., Silove, D., Manicavasagar, V. & Steel, Z. (2004). Complicated grief in Bosnian refugees: associations with posttraumatic stress disorder and depression. *Comprehensive psychiatry*, 45(6), 475-482.

Morof, D. F., Sami, S., Mangeni, M., Blanton, C., Cardozo, B. L. & Tomczyk, B. (2014). A cross-sectional survey on gender-based violence and mental health among female urban refugees and asylum seekers in Kampala, Uganda. *International Journal of Gynecology & Obstetrics*, 127(2), 138-143.

Muhwezi, W. W., Kinyanda, E., Mungherera, M., Onyango, P., Ngabirano, E., Muron, J., ... & Kajungu, R. (2011). Vulnerability to high risk sexual behaviour (HRSB) following exposure to war trauma as seen in post-conflict communities in Eastern Uganda: a qualitative study. *Conflict and Health*, 5(22), 1-15.

Mukanangana, F., Moyo, S., Zvoushe, A. & Rusinga, O. (2014). Gender based violence and its effects on women's reproductive health: The case of Hatcliffe, Harare, Zimbabwe. *Reproductive Health*, 18(1), 110-122.

Murphy, Z. (2010, July 26). Chum Mey: Tuol Sleng survivor. BBC News. Retrieved from www.bbc.com/news/world-asia-pacific-10602689.

Murthy, R. S. & Lakshminarayana, R. (2006). Mental health consequences of war: a brief review of research findings. *World Psychiatry*, 5(1), 25.

Newman, E., Riggs, D. S. & Roth, S. (1997). Thematic resolution, PTSD, and complex PTSD: The relationship between meaning and trauma-related diagnoses. *Journal of Traumatic Stress*, 10(2), 197-213.

Nock, M. K., Borges, G., Bromet, E. J., Cha, C. B., Kessler, R. C. & Lee, S. (2008). Suicide and suicidal behavior. *Epidemiologic reviews*, 30(1), 133-154.

Nishith, P., Resick, P. A. & Griffin, M. G. (2002). Pattern of change in prolonged exposure and cognitive-processing therapy for female rape victims with posttraumatic stress disorder. *Journal of Consulting and Clinical Psychology*, 70(4), 880.

O'Donnell, M. L., Creamer, M. & Pattison, P. (2004). Posttraumatic stress disorder and depression following trauma: understanding comorbidity. *American Journal of Psychiatry*.

Olsen, D. R., Montgomery, E., Bøjholm, S. & Foldspang, A. (2007). Prevalence of pain in the head, back and feet in refugees previously exposed to torture: a ten-year follow-up study. *Disability and rehabilitation*, 29(2), 163-171.

Painter R.C., de Rooij S., Bossuyt P, et al. Blood pressure response to psychological stressors in adults after prenatal exposure to the Dutch famine. *Journal of Hypertension* 2006;24:1771-8.

Pellizzari, V. 2008 "Kang Khek leu: They all had to be eliminated" The Independent. Retrieved on 24th July 2016, at www.independent.co.uk/news/world/asia/kang-khek-leu-they-all-had-to-be-eliminated-780684.html.

Pynoos, R. S. & Eth, S. (1985). Children traumatized by witnessing acts of personal violence: Homicide, rape, or suicide behavior. *Post-traumatic stress*

disorder in children, 19-43.

Rasmussen, A., Rosenfeld, B., Reeves, K. & Keller, A. S. (2007). The effects of torture-related injuries on long-term psychological distress in a Punjabi Sikh sample. *Journal of Abnormal Psychology*, 116(4), 734.

Regehr, C., Alaggia, R., Dennis, J., Pitts, A. & Saini, M. (2013). Interventions to reduce distress in adult victims of rape and sexual violence: a systematic review. *Social Work Practices*, 9(3), 257-265.

Reid-Cunningham, A.R. (2008). Rape as a weapon of genocide. *Genocide Studies and Prevention Vol 3*(3), 279-296.

Reparation for Torture—A Survey of Law and Practice in Thirty Selected Countries, *The Redress Trust*, London, England, April, 2003.

Resick, P. A., Nishith, P., Weaver, T. L., Astin, M. C. & Feuer, C. A. (2002). A comparison of cognitive-processing therapy with prolonged exposure and a waiting condition for the treatment of chronic posttraumatic stress disorder in female rape victims. *Journal of Consulting and Clinical Psychology*, 70(4), 867.

Resick, P. & Schnicke, M. (1992). Cognitive processing therapy for sexual assault victims. *Journal of Consulting and Clinical Psychology*, 60(5), 748-756.

Rothbaum, B. O., Astin, M. C. & Marsteller, F. (2005). Prolonged exposure versus eye movement desensitization and reprocessing (EMDR) for PTSD rape victims. *Journal of Traumatic Stress*, 18(6), 607-616.

Roseboom T. J., van der Meulen J.H.P., Osmond C, et al. Coronary heart disease after prenatal exposure to the Dutch famine 1944-45. *Heart* 2000; 84(6):595-8.

Roush, K. (2009). Social implications of obstetric fistula: an integrative review. *Journal of Midwifery and Women's Health*, 54(2), 21-33.

Roseboom, T. J., et al. "Hungry in the womb: what are the consequences? Lessons from the Dutch famine." *Maturitas* 70.2 (2011): 141-145.

Sack, W. H., Clarke, G. N. & Seeley, J. (1995). Posttraumatic stress disorder across two generations of Cambodian refugees. *Journal of the American Academy of Child & Adolescent Psychiatry*, 34(9), 1160-1166.

Sack, W. H., Clarke, G., Him, C., Dickason, D., Goff, B., Lanham, K. & Kinzie, J. D. (1993). A 6-year follow-up study of Cambodian refugee adolescents traumatized as children. *Journal of the American Academy of Child & Adolescent Psychiatry*, 32(2), 431-437.

Sapolsky, R. M., Romero, L. M. & Munck, A. U. (2000). How do glucocorticoids influence stress responses? Integrating permissive, suppressive, stimulatory, and preparative actions 1. *Endocrine reviews*, 21(1), 55-89.

Seifert, R. (1994). War and rape: a preliminary analysis. In A. Stiglmayer

(Ed.), *Mass rape: the war against women in Bosnia-Herzegovina*. Lincoln, NB: University of Nebraska Press.

Somasundaram, D. J., van de Put, W. A., Eisenbruch, M. & de Jong, J. T. (1999). Starting mental health services in Cambodia. *Social Science & Medicine*, 48(8), 1029-1046.

Sommers, M. S. (2007). Defining patterns of genital injury from sexual assault: a review. *Trauma, Violence & Abuse*, 8(3), 270-280.

Song, S., Wang, W. & Hu, P. (2009). Famine, death, and madness: schizophrenia in early adulthood after prenatal exposure to the Chinese Great Leap Forward Famine. *Social science & medicine*, 68(7), 1315-1321.

Sonis, J., Gibson, J. L., de Jong, J. T., Field, N. P., Hean, S. & Komproe, I. (2009). Probable posttraumatic stress disorder and disability in Cambodia: associations with perceived justice, desire for revenge, and attitudes toward the Khmer Rouge trials. *JAMA: the journal of the American Medical Association*, 302(5), 527-536.

Stammel, N., Heeke, C., Bockers, E., Chhim, S., Taing, S., Wagner, B. & Knaevelsrud, C. (2013). Prolonged grief disorder three decades post loss in survivors of the Khmer Rouge regime in Cambodia. *Journal of affective disorders*, 144(1), 87-93.

Steel Z, Chey T, Silove D, Marnane C, Bryant RA, van Ommeren M. (2009). Association of torture and other potentially traumatic events with mental health outcomes among populations exposed to mass conflict and displacement: a systematic review and meta-analysis. *Journal of American Medical Association*, 302 :537-49. Stein Z, Susser M, Saenger G, Morolla F. Famine and Human Development. The Dutch Hunger Winter of 1944-45. New York: Oxford University Press; 1975.

Steinberg, D. M. (2014). *A mutual-aid model for social work with groups*. Routledge.

Steketee, G. & Foa, E. B. (1987). Rape victims: Post-traumatic stress responses and their treatment:: A review of the literature. *Journal of Anxiety Disorders*, 1(1), 69-86.

Summerfield, D. (2000). Conflict and health: War and mental health: A brief overview. *BMJ: British Medical Journal*, 321(7255), 232.

Taun, Y. Y. (2005, July). Collective Cambodian memories of the Pol Pot Khmer Rouge regime. In *ASIA Fellow conference paper presented at the Fifth Annual Conference, Bangkok* (pp. 25-26).

Tedeschi, R. G. & Calhoun, L. G. (2004). Posttraumatic Growth: Conceptual Foundations and Empirical Evidence. *Psychological Inquiry*, 15, 1-18.

Teicher, M.H. & Samson, J.A. (2013). Child maltreatment and psychopathology: A case for ecophenotypic variants as clinically and neurobiologically distinct subtypes. *American Journal of Psychiatry*, 170, 1114-1133.

Tedeschi, R. G. & Calhoun, L. G. (1995). *Trauma and transformation: Growing in the aftermath of suffering*. Thousand Oaks, CA: Sage.

Tilly, C. (2004). Terror, terrorism, terrorists. *Sociological Theory*, 22(1), 5-13.

Trickett, P. K., Noll, J. G. & Putnam, F. W. (2011). The impact of sexual abuse on female development: Lessons from a multigenerational, longitudinal research study. *Development and Psychopathology*, 23(02), 453-476.

Trust Fund for Victims (2014). *Strategic Plan 2014-2017 Summary*. Retrieved from www.trustfundforvictims.org/sites/default/files/media_library/documents/pdf/TFV%20Brochure%20ASP%202014%20FINAL.pdf.

Turner-Moss, E., Zimmerman, C., Howard, L. M. & Oram, S. (2014). Labour exploitation and health: a case series of men and women seeking post-trafficking services. *Journal of Immigrant and Minority Health*, 16(3), 473-480.

UNDP Policy Paper on Reparations for Croatian Victims of War Related Sexual Violence, December 2013.

United Nations Human Rights: Office of the High Commissioner (2016). *Convention against Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment*.

Van der Kolk, B. A. (1998). Trauma and memory. *Psychiatry and Clinical Neurosciences*, 52(S1), S52-S64.

Van Schaack, B., Reicherter, D. & Chhang, Y. (Eds.). (2011). *Cambodia's Hidden Scars: Trauma Psychology in the Wake of the Khmer Rouge: an Edited Volume on Cambodia's Mental Health*. Documentation Center of Cambodia (DC-Cam).

Wax, E. (2004, June 6). "We Want to Make a Light Baby" Arab militiamen in Sudan said to use rape as weapon of ethnic cleansing. *Washington Post Foreign Service*. Retrieved from www.washingtonpost.com/wp-dyn/articles/A16001-2004Jun29.html.

Willis, S., Chou, S. & Hunt, N. C. (2015). A systematic review on the effect of political imprisonment on mental health. *Aggression and Violent Behavior*, 25, 173-183.

Yaari, A., Eisenberg, E., Adler, R. & Birkhan, J. (1999). Chronic pain in Holocaust survivors. *Journal of Pain and Symptom Management*, 17(3), 181-187.

Ye, B. (2011). Forced marriages as mirrors of Cambodian conflict

transformation. *Peace Review*, 23(4), 469-475.

Ye, B. (2014). Transitional Justice Through the Cambodian Women's Hearings. *Cambodia Law and Policy Journal*, 3, 23-38.

Yehuda, R., Bader, H.N., Klengel, T., Holsboer, F. & Binder, E.B. (2015, Aug 12). Holocaust exposure induced intergenerational effects on FKBP5 methylation. *Biological Psychiatry*. <http://dx.doi.org/10.1016/j.biopsych.2015.08.005>.

Yehuda, R., Bell, A., Bierer, L., Schmeidler, J., Maternal, not parental, PTSD is related to increased risk for PTSD in offspring of Holocaust survivors. *J Psychiatr Res*. 2008 Oct;42(13):1104-11. doi: 10.1016/j.jpsychires.2008.01.002. Epub 2008 Feb 20.

Yehuda, R., Halligan, S. L. & Bierer, L.M. (2001). Relationship of parental trauma exposure and PTSD to PTSD, depressive and anxiety disorders in offspring. *Journal of Psychiatric Research*, 35, 261-270.

Yi, S., Poudel, K. C., Yasuoka, J., Palmer, P. H., Yi, S. & Jimba, M. (2011). Risk vs. protective factors for substance use among adolescents in Cambodia. *Journal of Substance Use*, 16(1), 14-26.

Zinzow, H. M., Resnick, H. S., McCauley, J. L., Amstadter, A. B., Ruggiero, K. J. & Kilpatrick, D. G. (2012). Prevalence and risk of psychiatric disorders as a function of variant rape histories: Results from a national survey of women. *Social Psychiatry And Psychiatric Epidemiology*, 47(6), 893-902. doi:10.1007/s00127-011-0397-1



All proceeds from this book will be put towards the establishment of the Sleuk Rith Institute as a permanent museum and memorial to the victims of the Khmer Rouge and an institute dedicated to genocide education.

The Sleuk Rith Institute (SRI)
Vision of Youk Chhang and designed by the late Zaha Hadid
Illustration: MIR/Norway, 2014

ABOUT THE EDITORS

Beth Van Schaack (B.A., J.D.) is the Leah Kaplan Visiting Professor of Human Rights at Stanford Law School and a Legal Advisor to the Documentation Center of Cambodia.

Daryn Reicherter (M.D.) is a Clinical Associate Professor in the Department of Psychiatry and Behavioral Sciences of Stanford University's School of Medicine. Professor Van Schaack and Dr. Reicherter are co-founders and co-directors of the Human Rights in Trauma Mental Health Laboratory at Stanford University.

Gillian Reiersen (M.D., Ph.D.) is currently a Child and Adolescent Psychiatry Fellow in the Department of Psychiatry and Behavioral Sciences at Stanford University and graduate of the Adult Psychiatry Residency Training Program at Stanford University.

2016

FRONT COVER PHOTO & CAPTION:
Genocide Memorial stupa, Kraing Ta Chan, Takeo province.
Ouch Makara

