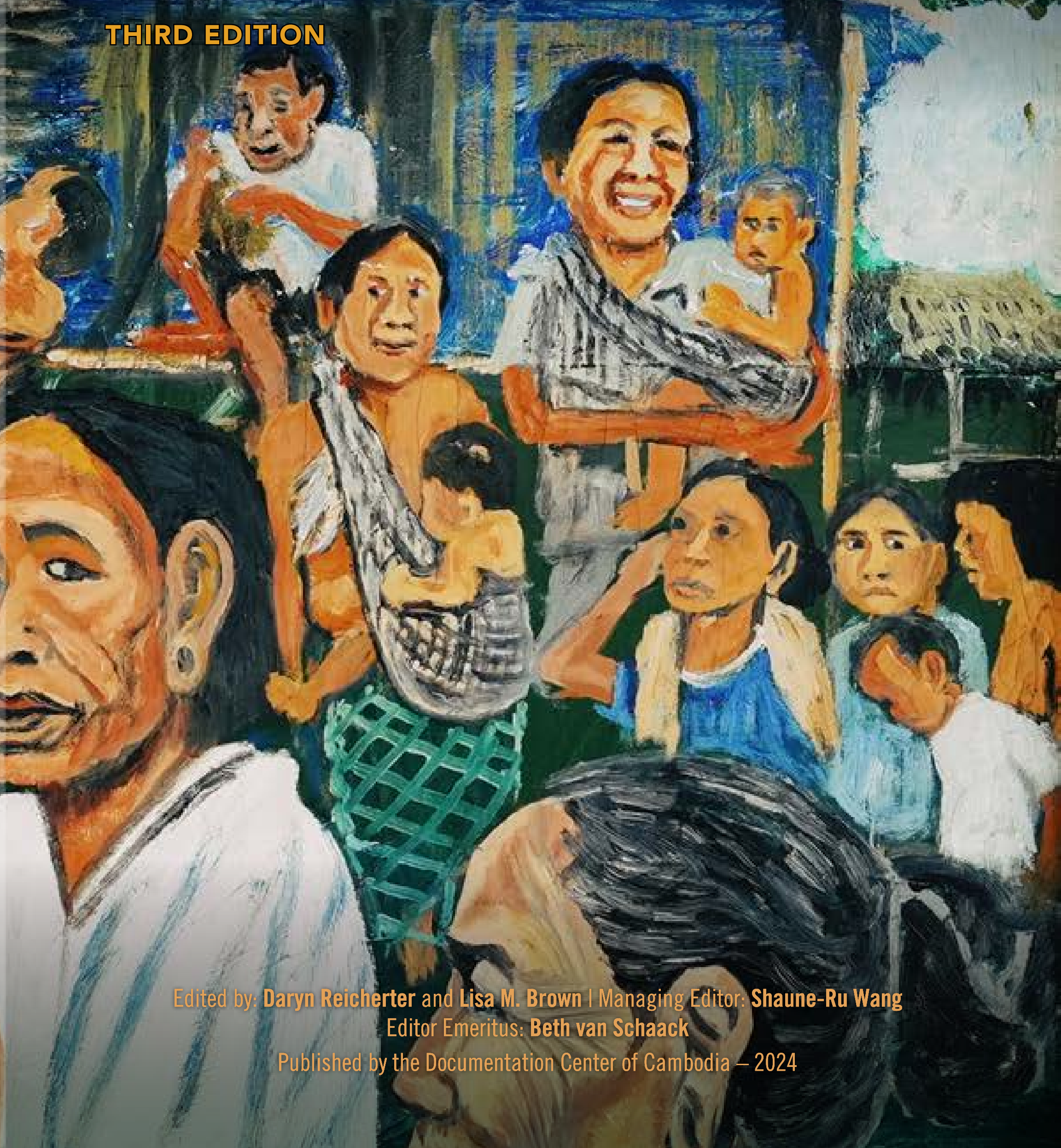
# CAMBODIA'S HIDDEN SCARS

## Healing and Reparations for Trauma Psychology After the Khmer Rouge Tribunal

THIRD EDITION




Edited by: **Daryn Reicherter** and **Lisa M. Brown** | Managing Editor: **Shaune-Ru Wang**

Editor Emeritus: **Beth van Schaack**



Published by the Documentation Center of Cambodia – 2024

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**Cambodia's Hidden Scars:**
Healing and Reparations for Trauma Psychology After the Khmer Rouge Tribunal
Third Edition

Daryn Reicherter
Lisa M. Brown
Shaune-Ru Wang
Beth van Schaack

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

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*This book is dedicated to all future generations of the Khmer people. May the hidden scars be healed forevermore.*

**Gerald "Jerry" Gray,** *a psychotherapist and licensed clinical social worker, founded and played a leading role in a number of lasting organizations devoted to accountability for torture, trauma, and abuse of power. He was a friend, a mentor, an artist, a visionary, and a colleague. He founded the Center for Justice and Accountability in 1998, an organization that works to hold torturers accountable. His private practice clinical experience with torture survivors motivated him to found Survivors International, one of the country's first torture treatment centers. In 2001, Jerry directed the Center for Survivors of Torture in San Jose, affiliated with Asian Americans for Community Involvement. Thereafter, he founded and directed the Institute for Redress & Recovery at Santa Clara University. In the last decade, he spent time working in detention camps on the Southern Border of the United States to support families separated and traumatized by their past experiences and their treatment at the hands of U.S. authorities. Jerry was faculty at Stanford University's Human Rights in Trauma Mental Health Program from its inception until the day he passed.*

*Jerry was a connector of people. He worked with Youk Chhang and the Documentation Center of Cambodia and brought new talent to the mission. Without Jerry, the Cambodia's Hidden Scars Series would never have been created.*

***We all miss you Jerry.***

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# FOREWORD

**Cambodia's Traumatized Generation**

**They survived the Vietnam War and the Khmer Rouge genocide. They still bear the mental and physical scars – and so do their descendants.**

The future of post-conflict countries depends upon how governments and their people confront, reconcile, and move forward from their past. Survivors are the key stakeholders in this process, not only because they are the teachers and storytellers about this past, but also because they are the barometer for their nation's development and achievement of a better future.

Cambodia in the late 1960s and early 1970s was consumed by the Vietnam War and between 1970 and 1975, Cambodia was torn apart by internal conflict, foreign intervention, and ultimately the destruction of society. In April 1975, Khmer Rouge forces captured the entirety of the country and for the next four years, the Cambodian people suffered indescribable horrors including genocide, crimes against humanity and unimaginable human rights violations. Following the collapse of this regime, the Cambodian people continued to be plagued by internal conflict, which was accentuated by international isolation that perpetuated, if not aggravated, the instability, famine, and the most horrendous human conditions. All told, Cambodians suffered through nearly four decades of war, genocide, and inhumanity.

It is believed that approximately 7 million Cambodians survived the Vietnam War period, and approximately 2 million Cambodians died during

the genocidal Khmer Rouge regime. This means that approximately 5 million Cambodians survived both.

There are well-established statistics demonstrating a higher prevalence of trauma-related mental health disorders in post-conflict societies. Although research in this area continues to be challenging, surveys of Cambodian survivors suggest there are many types of mental health disorders and trauma-related health conditions that continue to this day. For more than two decades, the Documentation Center of Cambodia (DC-Cam) has been working with the survivors of the Khmer Rouge regime to develop a better understanding of survivor needs, interests, and perspectives. To this end, DC-Cam conducted its own limited survey.

As of August 2022, DC-Cam has collected information from over 31,000 Khmer Rouge survivors, with the research and analysis of this work compiled into a booklet titled "Information on the Healthcare for Khmer Rouge Survivors." DC-Cam's findings indicate that among the physical and mental health conditions reported by survivors, hypertension, gastrointestinal disorders, malaria, mental illness, and heart disease, were, in this order, the priority health concerns and debilitating conditions for survivors. Further, of the survivors surveyed, 87 percent reported still having disturbing memories of the Khmer Rouge period, and 25 percent of respondents reported still suffering nightmares about this era, even though these experiences occurred more than 40 years ago.

If there is a lesson to be taken from the Cambodian survivors' struggle with physical and mental health, it is that the trauma of this period continues to manifest even decades later – not only in the health of survivors, but also the multiple generations born long after peace came to Cambodia. Trauma can ripple through familial and societal relationships, affecting children and grandchildren and broader family and community networks. Pathological behaviors like domestic violence and substance abuse are linked to trauma-related mental health disorders. Further, mental anguish and suffering from trauma and loss or feelings of shame, guilt, or anger can impact even institutions, including those that are seemingly well removed from a survivor's family and local village.

Without question, the consequences of violent conflict, atrocities, and inhumanity cannot be neatly confined to any category of individual or collective well-being. Post-conflict societies are consumed by the cascading effects of these violent periods that influence all societal and governmental institutions.

Even today, Cambodia continues to grapple with the scourge of landmines and unexploded ordinance from its past. According to the Cambodian Mine Action and Victim Assistance Authority, almost 65,000 people were casualties of landmines or explosive ordinance between January 1979 and July 2021. This number includes almost 20,000 deaths. While the number of injuries and deaths caused by landmines and explosive ordinance has fallen over the years, as recently as 2020, there were 65 casualties to these buried explosives.

In addition to the more observable examples of the impact of Cambodia's violent history on individuals and communities, there are more subtle consequences that pervade Cambodia's socio-political development and national identity. For example, DC-Cam has observed notable examples of how trauma from the Cambodian genocide influences identity, individual and collective relationships, the raising of children, work, schools, and even belief systems. But these observations are just surface level.

At a deeper level, there are numerous accounts about how the trauma from this era influences broader conceptions of society, ethics, and governance. How youth perceive public service; whether survivors trust public or private health services; how public and private health services relate to their patients; and how laws and customs are interpreted, enforced, and complied with – questions like these can reveal deep-seated, unconscious biases that are influenced by, if not originate from, individual and collective survivor experiences that have become multigenerational in their impact.

Going further, even Cambodia's socio-political climate and culture of governance continue to be colored by the experiences of this era. What are the people's responsibilities to their government, and how should government civil servants perceive their responsibilities to their people? These questions and so many more are not only affected by the experiences of this era; indeed, the last 40 years of Cambodia's history significantly shapes how the Cambodian people imagine their individual, collective, and national future.

DC-Cam is nonetheless encouraged by the Pentagonal Strategy of the new Cambodian government. DC-Cam sees this strategy as not only targeting the critical needs discussed above, but also as aligning with DC-Cam's investments in, and advocacy for, the Cambodian people. The Cambodian people are the preeminent variable in the strategy and work toward realizing a better future for the Cambodian nation. The Cambodian people must occupy the top of the Pentagonal Strategy, which they do, and this decision is so important for ensuring the people are not left behind in Cambodia's modernization plans.

Cambodia must modernize its institutions if it is to mature into a developed nation, but modernization cannot be a zero-sum game in which the Cambodian people are sacrificed at the altar of technological, economic, or industrial growth. In fact, Cambodia's future depends upon the prioritization of the poorest and most marginalized of people.

Even though Cambodia's history spans centuries, Cambodia has become defined by its 20th century past. There is no greater way for a country to break from its past and redefine its future than by caring for the people that lived in this past.

The survivors of Cambodia's violent past are Cambodia's Greatest Generation. How we care for this generation of the 20th century will be the proof of Cambodia's commitment to its vision for the 21st century.

***Youk Chhang***
A Founder and Executive Director of the Documentation Center of Cambodia and a Founder of The Queen Mother's Library – a joint genocide museum and research institute – in Phnom Penh, Cambodia

# INTRODUCTION

**Daryn Reicherter (M.D.)** *is a Clinical 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 Program at Stanford University.*

## 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 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 depor-

tations 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) 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 could not help but find itself immersed in the psychology of trauma.

In documenting the history and the crimes of the Khmer Rouge, the Documentation Center of Cambodia (DC-Cam) realized that trauma-related mental health problems 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. 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. Once the ECCC was established, the need to address this societal suffering emerged as a major area of concern for the legacy of Cambodia.

## THE "CAMBODIA'S HIDDEN SCARS" SERIES

During case 002/1, DC-Cam began to publish a book series documenting the mental health consequences of the Khmer Rouge regime titled "Cambodia's Hidden Scars." The series provides academic analysis of interplay between trauma and human psychology in the setting of the war crime tribunal. It also proposed advocacy for progressive advances in the court's handling of trauma mental health issues.

The first edition of Cambodia's Hidden Scars, *Trauma Psychology in the Wake of the Khmer Rouge (2011)* was composed to advocate for the use of trauma mental health as evidence in the tribunal and to advocate for more attention to treatment for survivors. It was accepted as evidence by the ECCC. The research contained in the book was cited in the testimony of expert witnesses on mental health.

In Case 002/1 the ECCC 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 the 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."*

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 treatment programs.

The second volume of Cambodia's Hidden Scars, *Trauma Psychology and the Extraordinary Chambers in the Courts of Cambodia (2017)* expanded on the elements of volume 1. Importantly, it laid out the blueprint for mental health data preparation for expert reporting in war crimes cases and included in its appendix the expert report, "The Mental Health Outcomes Resulting from Crimes Committed by the Khmer Rouge."

The expert report was developed by the Stanford Human Rights in Trauma Mental Health Program and used by civil part attorneys as evidence in ECCC Case 002/2 to properly elucidate the scope of mental health damage suffered by survivors. Its impact cannot be overstated. It provided the court with a comprehensive understanding of the epidemiology of mass trauma as well as insight into the psychological outcomes from specific crimes prosecuted. Again in case 002/2, reparations were granted to mental health and wellbeing projects after the conviction.

Cambodia's Hidden Scars Volume 3, *Healing and Reparations for Trauma Psychology After the Khmer Rouge Tribunal (2024)* is the final book in this series. This volume attempts to highlight the importance of addressing mental health in post-conflict societies, both in transitional justice and in public health. It also advocates for trauma-informed practices throughout any transitional justice process.

***The books structure is as follows:***

*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* examines the responsibility of transitional justice mechanisms toward addressing the mental suffering of survivors, using the ECCC as a case study. It updates the progress in transitional justice mechanisms toward using a trauma-informed techniques throughout the their process. It strongly advocates for justice mechanisms dealing with human rights atrocities to adopt a trauma-informed approach from the outset and use it throughout.

## 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 intended to advocate for respect for the survivors' psychology throughout 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. From the stage of documentation and investigation through the stage of reparations and beyond, any transitional justice process must operate under the assumption that preserving the psychological health of the survivors is a sacred and indelible part of that process and not merely an afterthought. Although there is room for improvement, the ECCC created progress in this area relative to previous international tribunals, particularly when it comes the handling of evidence of mental suffering in court and in the decisions it has rendered.

The ECCC may serve as a turning point for the movement to acknowledge and appropriately handle the trauma intrinsic to the prosecution of war crimes. The ECCC's relatively progressive stance on including trauma throughout its process has set a stage for improvements in justice mechanisms globally. Trauma-informed models have been implemented in investigations and prosecutions globally. The International Criminal Court continues to progress toward trauma-informed practice throughout its mechanism. The United Nations Office of the High Commissioner on Human Rights is beginning to incorporate trauma mental health into its inquiries. Impressively, the Investigative Team to Promote Accountability for Crimes Committed by Da'esh/ISIL (UNITAD) adopted trauma-informed practice into its mandate and implemented the total inclusion of trauma mental health realities throughout its mission. UNITAD has become a model for the best practices in addressing trauma mental health in the setting of grave crimes against humanity.

This edition of Cambodia's Hidden Scars presents the progress made in the arena of trauma mental health within justice mechanisms and advocates for improvements for the future. It is intended to provide a push for the progress of trauma mental health in both justice and in public health for survivors of war crime. With this edition, the series presents conclusions to quandaries pondered and recommendations to inform the future of transitional justice.

In Cambodia, the burden of trauma-related suffering is still 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 four decades after the Khmer Rouge era that 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 in the context of a completed tribunal. With the Khmer Rouge's crimes unveiled and prosecuted, the Kingdom must now attend to the hidden scars of the survivors.

***Daryn Reicherter M.D.***
The Hague, Netherlands
December, 2023

PART | 1

# THE EXPERIENCE OF TRAUMA IN CAMBODIA

# 1 THE IMPACT OF WAR AND GENOCIDE ON PSYCHIATRY AND SOCIAL PSYCHOLOGY

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**Grace Sandman**
*A research assistant and the lead undergraduate research coordinator for the Human Rights in Trauma Mental Health Program at Stanford University where she is currently pursuing a bachelor's degree in psychology with a minor in human rights.*

**Alexandra Aylward (B.A.)**
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Psychological suffering is a well-known consequence of war and genocide. War affects everyone it touches, from soldiers to civilians. The destructive consequences are most often calculated by the number of lives lost, 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.[1]

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."[2] The WHO reports that conflicts, wars, and civil strife are associated with higher rates of mental health problems.[3] The WHO estimates that globally:

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

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

2 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/WHA58/A58_6-en.pdf.

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

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

Clearly, international health organizations have recognized the consequences of mental health disorders for human health and social function as a major, 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)[5] or by the International Classification of Diseases, 9th Revision (ICD-9)[6] 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 major mental health disorder most often associated with war trauma is PTSD. PTSD is defined in the DSM-5 under a new category, Trauma- and Stress-or-Related Disorders[7] . The disorder is characterized by the re-experiencing of an extremely traumatic event. PTSD is not the only mental health disorder expected to increase in a population affected by war. Other anxiety disorders and severe mood disorders, like depression, 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, anxiety disorders are often linked with mood disorders, so PTSD and depression can occur together in the same individual. Similarly, PTSD may increase the likelihood of alcohol use, so an individual with PTSD may also develop alcohol dependence.

These mental health co-morbidities that result from societal trauma are grave. Alcohol and other substance-use disorders are extremely common among persons with PTSD.[8] For example, as many as 75% of combat veterans with lifetime PTSD also met the criteria for alcohol abuse or dependence.[9] Researchers have identified PTSD as a mediating factor in the relationship

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

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

7 American Psychiatric Association. (2022). Diagnostic and statistical manual of mental disorders (5th ed., text rev.).

8 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).

9 R.A. KULKA ET AL., TRAUMA AND THE VIETNAM WAR GENERATION: REPORT OF FINDINGS FROM THE NATIONAL VIETNAM VETERANS READJUSTMENT STUDY (1990).

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.[10] Destructive social phenomena like domestic violence increase after war[11] 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.[12] Additionally, veterans who have comorbid trauma disorders in addition to PTSD are more susceptible to using violence against their intimate partners.[13] The perpetration of violence is a common occurrence for persons affected by violence and by PTSD.[14] 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. 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%.[15]

### Civilians

Civilian populations often suffer significantly during war, both as a result of systemic violence directed against civilian populations in conflict and due to

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10 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).

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

12 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).

13 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).

14 R.A. KULKA ET AL., TRAUMA AND THE VIETNAM WAR GENERATION, *supra* note 9.

15 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).

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.[16] 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.[17]

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.[18]

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

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

17 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), <http://www.un.org/press/en/2008/sc9364.doc.htm>.

18 The United Nations, *Report on the situation of human rights in Rwanda submitted byMr. Rene Degni-Segui, Special Rapporteur of the Commission on Human Rights,* UN Resolution S-3/1, (May 25, 1994); Bunch, Charlotte and Reilley, 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), <http://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.

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.[19]

## 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.[20] These survivors were and are at risk for emotional disorders and adjustment problems, including emotional distress, depression, anxiety,[21] posttraumatic stress disorder,[22] and chronic pain.[23] Moreover, Holocaust survivors with PTSD reported more depressive symptoms than those without PTSD.[24] 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.[25]

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

20 D. NIEWYK & F. NICOSIA, THE COLUMBIA GUIDE TO THE HOLOCAUST (2000).

21 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).

22 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).

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

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

25 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).

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.[26] 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.[27] 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.[28] 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.[29] According to Danieli, the effects of trauma may become intergenerational when they affect families and succeeding generations.[30] 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.*[31]

Yehuda and colleagues observed a higher prevalence of lifetime PTSD, mood disorders, and anxiety disorders in offspring of Holocaust survivors than in controls.[32] 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.[33] This was true in both community and clinical subjects.

26 E. Barel et al., *Surviving the Holocaust, supra* note 18.
27 *Id.*
28 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).
29 H. KEILSON, SEQUENTIAL TRAUMATIZATION IN CHILDREN (1992).
30 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)
31 R. Dekel & H. Goldblatt, *Is There Intergenerational Transmission of Trauma? The Case of Combat Veterans' Children.* 78(3) AM. J. ORTHOPSYCHIATRY 281, 284 (2008).
32 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).
33 R. Yehuda et al., *Vulnerability to Posttraumatic Stress Disorder in Adult Offspring of Holocaust Survivors,* 155(9) AM. J. PSYCHIATRY 1163, 1163-71 (1998).

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.[34] 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.[35]

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 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.[36]

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34 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).

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

36 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).

**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%.[37] 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%.[38]

Amidst the backdrop of ongoing conflict spanning over four decades and recent political shifts, Afghanistan faces profound mental health issues. The Afghan National Mental Health Survey of 2017, engaging 4,474 adults from eight regions, highlighted these challenges.[39] It found that 2.2% of individuals had contemplated suicide within the last year, and over their lifetimes, 7.1% harbored such thoughts. Attempts at suicide were documented by 3.4% of the participants, the majority of which were caused by traumatic events such as sexual assault. The survey revealed a significant prevalence of psychiatric conditions, showcasing a connection between trauma and the development of major depression, generalized anxiety disorder, and PTSD. These disorders significantly contribute to the psychological distress felt across the Afghan community.

The resurgence of the Taliban in 2021, in conjunction with the global crisis triggered by the COVID-19 pandemic, has markedly exacerbated the mental health strain on Afghanistan, amplifying the potential for trauma to be transmitted across generations. Furthermore, in Eastern Afghanistan, a 2022 community survey found alarming levels of psychological distress where 53% felt hopeless and 64% reported uncontrollable anger.[40] Additionally, a 2021 study from Kabul University found that 70% of students experienced symptoms of post-traumatic stress disorder and depression, with 39% showing increased suicidal thoughts and behaviors.[41]

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

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

39 Sabawoon, A., Keyes, K. M., Karam, E., & Kovess-Masfety, V. (2022). Associations between traumatic event experiences, psychiatric disorders, and suicidal behavior in the general population of Afghanistan: findings from Afghan National Mental Health Survey. Injury Epidemiology, 9(1), 31. *Available at* https://doi.org/10.1186/s40621-022-00403-8.

40 S. Van der Walt, *We Are Drowning: Mental Health and Psychosocial Needs Study in the Four Eastern Provinces of Kunar, Laghman, Nangarhar, and Nuristan, Première Urgence Internationale, Afghanistan,* 2022. Retrieved from https://app.mhpss.net/?get=353/pu-ami_mhpss-research-report_east.pdf.

41 A. Naghavi, M. S. Afsharzada, J. Brailovskaia, & T. Teismann, *Mental Health and Suicidality in Afghan Students After the Taliban Takeover in 2021,* 307 J. Affective Disorders 178, 2022. *Available at* https://doi.org/10.1016/j.jad.2022.04.001.

### 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.[42] Violence and a bloody civil conflict ensued, causing an estimated 150,000 to 200,000 deaths and approximately 15,000 forcibly disappearances.[43] FIS and other armed terrorist groups also massacred civilians to punish communities and warn them against withdrawing their support.[44] In 2007, Algeria suffered an upsurge in violence, including suicide bombings that targeted government and foreign interests.[45]

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.[46]

De Jong and colleagues found a 37.4% prevalence rate of assessed PTSD.[47] Women manifested more PTSD symptoms than men.[48] 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.[49] 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.

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42 M. Turshen, *Militarism and Islamism in Algeria,* 39(1-2) J. Asian & Afr. Stud. 119, 2004.

43 Y. Ryan, Uncovering Algeria's Civil War, Al Jazeera, Nov. 18, 2010. *Available at* http://english.aljazeera.net/indepth/2010/11/2010118122224407570.html.

44 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.

45 *Dozens Killed in Algeria Blasts,* BBC News, Dec. 11, 2007. *Available at* http://news.bbc.co.uk/2/hi/7137997.stm; The Associated Press, *Algeria: Suicide Bombing Kills 9,* New York Times, June 11, 2010. *Available at* http://www.nytimes.com/2010/06/12/world/africa/12briefs-SUICIDEBOMBI_BRF.html.

46 M. Sidhoum et al., *supra* note 44.

47 J.T. de Jong et al., *Lifetime Events, supra* note 36.

48 *Id.*

49 M. Sidhoum et al., *supra* note 44. 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.

### Gaza

The prolonged Israel-Palestine conflict, characterized by repetitive violence, significantly intensified after the Hamas terrorist attacks in Southern Israel on October 7, 2023. On October 7, Hamas militants launched an attack from Gaza on Israel, killing thousands of Israelis, including women and children. Hamas also kidnapped an estimated 240 people who remained held in Gaza their will. In response, Israel declared war against Hamas to destroy Hamas's ability to threaten Israel again. While Israel has targeted Hamas leaders and militants, these people live in Gaza among Palestinian civilians. As a result, Israeli attacks have killed over 8,000 Palestinians, including women and children. The aftermath of October 7 has caused severe psychological anguish throughout the country and widened the already protracted conflict. The Ruppin Academic Center and Columbia University started a significant research study to record the ensuing psychological effects.[50]

This extensive study used a longitudinal survey methodology, starting with gathering baseline data from 908 adult Israelis from August 20–30, 2023. The purpose of this initial stage was to determine each participant's psychological state prior to the attack. A follow-up poll was conducted with 710 original participants from November 9–19, 2023, or five to six weeks after the attacks. This resulted in a response rate of 78.1%.

The study's results showed a significant uptick in mental health disorders after the attacks. Specifically, the rate of PTSD jumped from 16.2% before the attacks to 29.8% afterward, generalized anxiety disorder increased from 24.9% to 42.7%, and depression from 31.3% to 44.8%. These sharp increases highlight the profound impact the events had on the mental well-being of both Jewish and Arab citizens. The data points to a critical need for focused mental health evaluations and interventions to address the lasting psychological effects of these traumatic events on the community.

### Iraq

Iraq is facing challenges in delivering mental health and psychosocial support, leading to obstacles in the general well-being of its population. A variety of barriers, including limited resources, a shortage of qualified professionals, and societal prejudice against mental health issues, hinder the provision of mental health services in the country. Moreover, the sociopolitical landscape in Iraq, marked by prolonged unrest and unpredictability, presents an extra obstacle to delivering adequate mental health support. The increased frequency of trauma, displacement,

50 Y. Levi-Belz, Y. Groweiss, C. Blank, & Y. Neria, *PTSD, Depression, and Anxiety After the October 7, 2023 Attack in Israel: A Nationwide Prospective Study*, 68 eClinicalMedicine 102418, 2024. *Available at* https://www.sciencedirect.com/science/article/pii/S2589537023005953. doi: 10.1016/j.eclinm.2023.102418.

and continued violence has exacerbated the mental health requirements of the community, emphasizing the urgency of addressing these issues promptly. In Iraq, it is essential to introduce new methods and actions to improve the delivery of mental health and psychosocial support services.

Negative stigmas about mental illness significantly hinder the provision of mental health services, as societal beliefs heavily impact the challenges faced by those seeking assistance. In Iraq, over half of respondents indicated they would feel ashamed if a family member had a mental illness, highlighting the societal barriers that exacerbate the mental health crisis.[51] Common beliefs that mental illness is a sign of personal weakness or that individuals are to blame for their conditions contribute to the stigmatization.[52] This negative perception prevents individuals from seeking assistance and results in them being socially isolated, with just 1/5 of participants open to marrying someone who has not received treatment for their mental health problems.[53] This ingrained societal stigma in Iraqi society worsens the crisis for people with mental health issues. It adds challenges for both healthcare providers and patients, making it harder to provide adequate mental health services.

Political instability, a direct consequence of prolonged violence and conflict, significantly hinders the consistent provision and availability of mental health services.[54] This instability is exacerbated by the aftermath of the ISIS insurgency, which not only demolished crucial infrastructure but also left a lasting impact on the mental health etiology and care dynamics within the country.[55] The displacement caused by such conflicts, particularly highlighted by the rapid capture of Mosul, has led to one of the fastest displacements in recorded history, underscoring the urgent need for mental health support amidst crisis conditions.[56] The scarcity of mental health services makes the situation more challenging, as evidenced in Mosul, where less than 10% of children in need receive any form of mental health treatment.[57] The political and social turmoil hinders the provision of mental health services. It exacerbates the mental health crisis by increasing levels of depression, anxiety, and post-traumatic stress disorder among the populace.

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51 *Iraq's Quiet Mental Health Crisis, EPIC - Enabling Peace in Iraq Center*, May 5, 2017. Retrieved from https://www.epic-usa.org/iraq-mental-health/.

52 *Id.*

53 *Id.*

54 *Mental Health and Psychosocial Support in Iraq: Challenges and Solutions – SEED Foundation – Kurdistan.* Retrieved April 20, 2024, from www.seedkurdistan.org.

55 J. Meier, *Assessment of Mental Health and Psychosocial Needs and Recommendations to Support Returnees in Iraq's Ninewa Governorate*, Oct. 2019.

56 *Id.*

57 *Iraq's Quiet Mental Health Crisis, EPIC - Enabling Peace in Iraq Center*, May 5, 2017. Retrieved from https://www.epic-usa.org/iraq-mental-health/.

Due to the pressing need for better mental health assistance in Iraq's challenging sociopolitical setting, innovative methods have been implemented to strengthen the delivery and availability of mental health and psychosocial support services. A significant effort involves the partnership between Doctors Without Borders/Médecins Sans Frontières (MSF) and the Iraqi Ministry of Health to incorporate mental health counseling into the healthcare system, filling an essential need for patient care. This partnership has led to the establishment of small clinics, exemplified by the one at the Central Child Hospital in Baghdad, designed to offer focused mental health services with limited resources.[58] Such clinics are pivotal in providing nonpharmaceutical interventions, particularly for addressing common mental health conditions like anxiety and depressive disorders, which have been proven to be effectively managed through psychological counseling.[59] This approach not only aligns with global trends towards incorporating psychological services into primary health care but also directly tackles the challenges posed by Iraq's unique context, where reliance on psychotropic medications has been prevalent, especially among children and adolescents.[60]

The concerted effort to improve resource allocation and staff training further underpins the potential for these initiatives to significantly enhance the quality and reach of mental health and psychosocial support across the country.[61] This critical step towards nonpharmaceutical methods and improving the mental health care system is a strategic move to reduce the effects of Iraq's sociopolitical challenges on mental health services.

**Myanmar**

The mental health landscape for Rohingya refugees is alarmingly complex, marked by a range of conditions that go beyond the initial trauma in Myanmar. Flashbacks, nightmares, and intense anxiety, characterized by heart palpitations, shaking, feeling of suffocation, and excessive sweating, highlight the deep psychological anguish that fills the daily lives of these people.[62] The difficulties experienced in refugee camps in Bangladesh worsen their mental health problems due to factors like survival threats, human rights abuses, and daily stressors such as food insecurity, unsafe living conditions, and exposure to

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58 A. AlObaidi, Iraq: *Children's and Adolescents' Mental Health Under Conditions of Continuous Turmoil,* 8(1) Int'l Psychiatry 4-5, 2011.

59 Doctors Without Borders, *Healing Iraqis: The Challenges of Providing Mental Health Care in Iraq*, April 30, 2013. Retrieved from https://www.doctorswithoutborders.org/latest/healing-iraqis-challenges-providing-mental-health-care-iraq.

60 *Id.*

61 *Id.*

62 A. K. Tay, A. Riley, R. Islam, C. Welton-Mitchell, B. Duchesne, V. Waters, A. Varner, B. Moussa, A. N. M. Mahmudul Alam, M. A. Elshazly, D. Silove, & P. Ventevogel, *The Culture, Mental Health and Psychosocial Wellbeing of Rohingya Refugees: A Systematic Review,* 28 Epidemiology and Psychiatric Sciences 489, 2019. *Available at* https://doi.org/10.1017/S2045796019000192.

violence.[63] In this group, children are especially at risk, showing mood swings, anxiety, and despair, which are signs of intense emotional disturbance affecting their growth and welfare.[64] This combination of mental health issues, including PTSD, depression, and anxiety, shows the urgent requirement for holistic mental health interventions that cater to the immediate and long-term psychosocial needs of the Rohingya refugees.[65]

The profound psychological problems seen in the Rohingya community, particularly in children, stem from the traumatic events of genocide and are worsened by a shortage of suitable healthcare and social support resources. Research has indicated that a notable portion of Rohingya children experience post-traumatic stress disorder (PTSD), anxiety, and grief due to the lasting effects of genocidal violence on their young minds.[66] In spite of the high number of mental health problems among children, only a tiny fraction of them are getting the necessary mental health services during the current humanitarian crisis. The urgent need for culturally appropriate mental health services to address severe mental health problems resulting from the genocide highlights the lack of access to essential mental health care and psychosocial support, calling for increased availability by the international community.

Research shows that particular demographic factors, such as educational attainment, marital status, and age, have a substantial influence on levels of emotional distress in this group. For instance, Rohingya refugees with educational attainments such as a Bachelor's degree or those suffering from chronic conditions like Ischemic Heart Disease (IHD) or Diabetes Mellitus (DM) are found to exhibit higher levels of emotional distress.[67] This correlation suggests that the burden of managing chronic diseases or the stress associated with higher educational achievements in a refugee context exacerbates mental health challenges. Marital status plays a crucial role in mental health, where being married is associated with higher emotional distress compared to being single, indicating the added pressures and responsibilities that marriage entails in a refugee setting.[68] Furthermore, the age factor reveals that young adults (≤ 30 years) experience lower emotional distress than their older counterparts, highlighting the resilience of the youth

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63 *Myanmar/Bangladesh: Rohingya Mental Health Crisis Demands Attention*, Retrieved April 20, 2024, from www.fortifyrights.org/bgd-mya-inv-2020-12-10/.

64 *Id.*

65 *Myanmar/Bangladesh: Rohingya Mental Health Crisis Demands Attention*, Retrieved April 20, 2024, from www.fortifyrights.org/bgd-mya-inv-2020-12-10/.

66 A. K. Tay, A. Riley, R. Islam, C. Welton-Mitchell, B. Duchesne, V. Waters, A. Varner, B. Moussa, A. N. M. Mahmudul Alam, M. A. Elshazly, D. Silove, & P. Ventevogel, *The Culture, Mental Health and Psychosocial Wellbeing of Rohingya Refugees: A Systematic Review,* 28 Epidemiology and Psychiatric Sciences 489, 2019. *Available at* https://doi.org/10.1017/S2045796019000192.

67 S. Palit, H. Yang, J. Li, M. A. S. Khan, & M. J. Hasan, *The Impact of the COVID-19 Pandemic on the Mental Health of Rohingya Refugees with Pre-Existing Health Problems in Bangladesh*, 16 Conflict and Health 10, 2022. *Available at* https://doi.org/10.1186/s13031-022-00443-3.

68 *Id.*

but also the accumulating psychological toll on older refugees.[69] These findings underscore the necessity of targeted mental health interventions that consider these demographic variables to effectively mitigate the emotional distress experienced by the Rohingya refugees, thereby contributing to a more nuanced understanding of their mental health needs and challenges.

Group Integrative Adapt Therapy (IAT-G) has emerged as a potent evidence-based psychological intervention that has shown significant effectiveness in mass humanitarian crises, providing scalable solutions during emergency phases.[70] This aligns with the broader trend of integrating mental health responses into complex humanitarian contexts, which has seen considerable progress over the last two decades.[71] The shift towards implementing community-based mental health service responses from the onset of an emergency underscores a growing recognition of the need to support progress in national mental health policy, moving away from solely focusing on individual trauma responses towards providing comprehensive, culturally appropriate psychosocial services.[72]

Given the complex psychosocial challenges and common mental health issues faced by Rohingya refugees, such as palpitation, tremors, and mood swings, it is imperative to develop and implement strategies that make mental health services accessible to them. Stigma and a lack of familiarity with mental health concepts significantly hinder access to necessary care.[73] Efforts to improve accessibility must, therefore, prioritize the reduction of stigma and the enhancement of mental health awareness within the Rohingya community.[74] This includes informing refugees about where and how they can seek help for their mental health issues. Furthermore, the reliance on informal and traditional methods of treatment, which can sometimes lead to human rights violations, underscores the urgent need for accessible, formal mental health services.[75]

It is crucial to adjust mental health services to fit the psychosocial disruptions caused by displacement, flight, and relocation.[76] This adjustment includes incorporating refugees' traumatic experiences into therapy while also making sure interventions are culturally and linguistically appropriate. The absence of specific words related to mental health in the Rohingya community makes it

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69 *Id.*

70 A. K. Tay, M. A. A. Miah, S. Khan, M. Mohsin, A. N. M. M. Alam, S. Ozen, M. Mahmuda, H. U. Ahmed, D. Silove, & P. Ventevogel, A Naturalistic Evaluation of Group Integrative Adapt Therapy (IAT-G) with Rohingya Refugees During the Emergency Phase of a Mass Humanitarian Crisis in Cox's Bazar, Bangladesh, 38 EClinicalMedicine 100999, 2021. *Available at* https://doi.org/10.1016/j.eclinm.2021.100999.

71 G. M. Dyer & M. Biswas, *Psychological and Psychiatric Care for Rohingya Refugees in Bangladesh,* 17(2) Intervention 217, 2019. doi: 10.4103/INTV.INTV_30_19.

72 *Id.*

73 *Id.*

74 *Id.*

75 *Id.*

76 *Id.*

difficult to offer proper psychosocial assistance.[77] Furthermore, effectively utilizing evidence-based Cognitive Behavioral Therapy (CBT) techniques with refugees necessitates connecting these strategies to their personal experiences to enhance their significance and effectiveness.[78] This underscores the significance of developing mental health interventions that consider cultural nuances and specific needs of diverse refugee communities while being evidence-based.

**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.[79] 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.[80]

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.[81] 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.[82] Importantly, respondents who met PTSD criteria were less likely to have positive attitudes towards the Rwandan national trials and less likely to develop a shared vision and sense of collective future, which suggest that societal interventions should consider the effects of trauma if reconciliation is to be realized.[83]

**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%),

77 W. Ager, R. Horn, M. K. Mozumder, A. Riley, & P. Ventevogel, *From the Editors: Introducing Intervention's Special Issue on the Mental Health and Psychosocial Wellbeing of Rohingya Refugees,* 17(2) Intervention 117, 2019. doi: 10.4103/INTV.INTV_54_19.

78 A. K. Tay, M. A. A. Miah, S. Khan, M. Mohsin, A. N. M. M. Alam, S. Ozen, M. Mahmuda, H. U. Ahmed, D. Silove, & P. Ventevogel, *A Naturalistic Evaluation of Group Integrative Adapt Therapy (IAT-G) with Rohingya Refugees During the Emergency Phase of a Mass Humanitarian Crisis in Cox's Bazar, Bangladesh,* 38 EClinicalMedicine 100999, 2021. *Available at* https://doi.org/10.1016/j.eclinm.2021.100999.

79 *Rwanda: How the Genocide Happened*, BBC News, Dec. 18, 2008. *Available at* http://news.bbc.co.uk/2/hi/1288230.stm.

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

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

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

83 *Id.*

and khat chewers with PTSD consumed significantly higher quantities than khat chewers without PTSD.[84] A UNICEF Study found evidence of psychological effects of the prolonged conflict situation in a high proportion of a sample of 10,000 children.[85] 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.[86]

Somalia has endured years of turmoil and unrest, with widespread absence of governance and social order. Since the fall of Mohamed Siad Barre's regime in 1991, the nation has operated without a stable central authority until the tentative steps toward governance were taken with the 2012 Provisional Constitution, which remains delicate and in flux. Recent studies in Somalia have highlighted a significant mental health crisis, exacerbated by ongoing conflict for the last 33 years, environmental challenges, and economic instability. A 2021 study was carried out jointly by WHO, the Somali National University, and the Federal Ministry of Health involving 713 people (aged 25 to 56 years) from Dolow, Baidoa, and Kismayo.[87] The study found an alarmingly high prevalence of mental disorders (76.9%) and substance use disorders (50.6%), indicating a heavier burden of mental health illnesses among the youth than previously thought.[88] Panic disorder and post-traumatic stress disorder were particularly prevalent, with findings suggesting an increased risk of suicide in young people.

**Sri Lanka**

The conflict between the majority Sinhala and minority Tamil population lasted for nearly thirty years.[89] 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%).[90]

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84 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).

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

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

87 A. M. Salad, S. M. M. R. Malik, J. M. Ndithia, Z. Noor, M. Madeo, & M. Ibrahim, *Prevalence of Mental Disorders and Psychological Trauma Among Conflict-Affected Population in Somalia: A Cross-Sectional Study,* 11 Front. Public Health 1219992, 2023. doi: 10.3389/fpubh.2023.1219992.

88 World Health Organization, *Final Report on Links Between Mental Health and Peacebuilding Among Young People in Somalia*, Research conducted in Jubaland (Kismayo and Dolow) and South West (Baidoa) States of Somalia between October and December 2021. This research was part of the Mental Health and Psycho-Social Support Project implemented by WHO, IOM, UNICEF, and the Ministry of Health, with funding from the UN Peacebuilding Fund. September 2022.

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

90 D. Somasundaram & C. S. Jamunanantha, *Psychosocial Consequences of War, in Trauma, War, and Violence: Public Mental Health in Socio-cultural Context*, 205-258, J. de Jong ed., 2002.

### 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.[91] 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.[92]

A study of former Bosnian refugees who remained in the region found that 45% continued to exhibit psychiatric disorders and disability three years after an initial assessment, and 16% had developed PTSD, depression, or both.[93] 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.[94] 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.[95] 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.[96]

### Ukraine

The ongoing conflict in Ukraine has had a significant impact on the mental health of its citizens, causing increased levels of anxiety, depression, stress, and trauma-related symptoms. Around 9.6 million people in Ukraine are expected to suffer from mental health problems as a result of the war, highlighting the severity of the crisis.[97] Research indicates that being in contact with war can exacerbate current mental health problems and trigger the development of additional cases

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

92 *Id.*

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

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

95 *Id.*

96 P. Smith et al., *War Exposure Among Children from Bosnia-Hercegovina: Psychological Adjustment in a Community Sample,* 15(2) J. Traumatic Stress 147, 2002.

97 World Health Organization, *Scaling-up Mental Health and Psychosocial Services in War-Affected Regions: Best Practices from Ukraine*, Dec. 16, 2022. Available at https://www.who.int/news-room/feature-stories/detail/scaling-up-mental-health-and-psychosocial-services-in-war-affected-regions--best-practices-from-ukraine.

of stress, depression, PTSD, and CPTSD.[98] This correlation is backed by evidence showing a connection between the extent of conflict exposure and elevated levels of anxiety and depression. Significantly, the extent of these mental health impacts seems to be influenced by how close an individual is to the conflict and their encounters. Individuals who stayed in Ukraine exhibit reduced levels of anxiety, depression, and trauma compared to those who departed, indicating that staying in a familiar setting during times of conflict can boost mental resilience.[99] This comprehensive knowledge of the effect of the current conflict on the mental health of Ukrainians highlights the necessity of providing specific help and support to those deeply impacted by the war.

The presence of 90 Community Mental Health Teams (CMHTs) is essential for delivering necessary care to people with severe mental illnesses in conflict-affected regions of Ukraine, where the ongoing conflict has exacerbated the mental health crisis.[100] The CMHTs, with the backing of the World Health Organization, have been essential in delivering tailored and recovery-oriented services to meet the specific requirements of individuals dealing with the profound psychological impacts of war. From the start of the war, these organizations have provided over 23,000 therapy sessions to approximately 1,400 people facing severe mental health challenges.[101] The challenging living conditions in refugee and IDP camps worsen feelings of displacement and significantly raise the likelihood of developing anxiety and depressive disorders.[102] Furthermore, the ongoing uncertain situation and forced relocations significantly add to the increased levels of anxiety and depression experienced by victims.[103] These results highlight the crucial importance of providing extensive mental health assistance and actions, especially in areas affected by conflict, to tackle the substantial and adverse effects of war on people's mental health.

The ongoing war in Ukraine is a stark example of how political instability can permeate the lives of citizens, breeding a deep-seated sense of uncertainty and fear. The continuous conflict disrupts daily life and instills a pervasive insecurity about the future. This atmosphere of instability triggers a broad spectrum of

98 A. Kurapov, A. Kalaitzaki, V. Keller, I. Danyliuk, & T. Kowatsch, *The Mental Health Impact of the Ongoing Russian-Ukrainian War 6 Months After the Russian Invasion of Ukraine*, 14 Frontiers in Psychiatry 1134780, 2023. *Available at* https://doi.org/10.3389/fpsyt.2023.1134780.

99 *Id.*

100 World Health Organization, *Scaling-up Mental Health and Psychosocial Services in War-Affected Regions: Best Practices from Ukraine*, Dec. 16, 2022. *Available at* https://www.who.int/news-room/feature-stories/detail/scaling-up-mental-health-and-psychosocial-services-in-war-affected-regions--best-practices-from-ukraine. *Id.*

101 *Id.*

102 A. Kurapov, A. Kalaitzaki, V. Keller, I. Danyliuk, & T. Kowatsch, *The Mental Health Impact of the Ongoing Russian-Ukrainian War 6 Months After the Russian Invasion of Ukraine*, 14 Frontiers in Psychiatry 1134780, 2023. *Available at* https://doi.org/10.3389/fpsyt.2023.1134780. *Id.*

103 *Id.*

negative emotions among the Ukrainian populace.[104] Individuals find themselves caught in a whirlwind of fear, hopelessness, anger, and exhaustion as they grapple with the immediate and long-term impacts of the war on their lives.[105] Furthermore, the role of modern media cannot be underestimated in this context. The relentless stream of news updates and images of conflict, amplified by social media and streaming platforms, reminds the population of their precarious situation. This nonstop exposure can exacerbate feelings of anxiety and despair, making it increasingly difficult for individuals to find respite from the mental health toll of ongoing political turmoil.

Ukrainian mental health stakeholders and international organizations must collaborate in building capacity and offering targeted support to address the heightened mental health challenges faced by the youth population. By integrating evaluations of interventions that link mental health and poverty, establishing clear causal links, and developing effective strategies, mental health services can better adapt and respond to the evolving needs of those affected by the ongoing conflict.

## 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 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

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104 C. Chaaya, V. Devi Thambi, Ö. Sabuncu, R. Abedi, A. Osman Ahmed Osman, O. Uwishema, & H. Onyeaka, *Ukraine - Russia Crisis and Its Impacts on the Mental Health of Ukrainian Young People During the COVID-19 Pandemic*, 79 Annals of Medicine and Surgery (2012) 104033, 2022. *Available at* https://doi.org/10.1016/j.amsu.2022.104033.

105 *Id.*

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.[106]

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.[107] 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).[108] 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.[109] 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.[110]

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.[111] 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%.[112] Probable PTSD was significantly associated with mental disability (40.2% versus 7.9%) and physical disability (39.6% versus 20.1%).[113] Respondents with high levels of perceived justice[114] for violations perpetrated by the Khmer Rouge were less likely to have probable PTSD than those with low levels (7.4% versus 12.7%).[115]

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

106 J.T. de Jong et al., *Lifetime Events and Posttraumatic Stress Disorder, supra* note 36.
107 V. Dubois et al., *Household Survey of Psychiatric Morbidity in Cambodia,* 50(2) INT'L J. SOC. PSYCHIATRY 174 (2004).
108 *Id.*
109 *Id.*
110 *Id.*
111 J. Sonis et al., *Probable Posttraumatic Stress Disorder and Disability in Cambodia,* 302(5) JAMA 527 (2009).
112 *Id.*
113 *Id.*
114 Perceived justice is measured on a scale that assesses satisfaction with punishment of perpetrators, apologies by perpetrators, and financial restitution for suffering.
115 *Id.*

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.[116]

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.[117]

Adolescent Cambodian refugees, who were child-survivors, have high levels of stress exposure and trauma symptoms.[118] 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 PTSD. Age was strongly related to reporting higher trauma exposure.[119] Likewise, in a sample of Cambodian refugees attending a psychiatric clinic in the United States, 56% met DSM-IV criteria for PTSD.[120]

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.

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116 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).

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

118 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).

119 *Id.*

120 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).

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

## UNMEASURED MENTAL SUFFERING FROM WAR AND GENOCIDE

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

> *The PTSD model has important limitations in capturing the complex ways in which individuals, communities, and larger groups experience massive trauma, socialize their grief, and reconstitute a meaningful existence.*[121]

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

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

> *The health impact of political violence and wars should be examined not only along the lines of sheer number of casualties and trauma related disorders among survivors, but also on the individual and collective levels. Indirect effects such as disintegration of the family and social networks, disruption of the local economies, dislocation of food production systems and exodus of the work force have profound implications in the health and well-being of survivors.*[122]

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121 D. Pendersen, *Political Violence, Ethnic Conflict, and Contemporary Wars: Broad Implications for Health and Social Well-being*, 75 SOC. SCI. & MED. 175 (2002).
122 *Id.*

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.

## 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.*[123]

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.*[124]

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.

123 SOCIAL SUFFERING (A.Kleinman, V. Das, & M. Lock eds., 1997).
124 *Id.*

## 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.

# 2 TRAUMA AND RECOVERY FROM INTERNATIONAL HUMAN RIGHTS LAW VIOLATIONS: UNRAVELING THE COMPLEXITIES OF PSYCHOLOGICAL TERROR

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In the landscape of terror, trauma and recovery, cultural nuances intertwine with the lived realities of human experiences of violence and loss, creating a bidirectional flow where violence and fear inflict wounds shaped by cultural context, past and present. Those exposed to these potentially traumatic events connected to terror become more at risk of perpetuating violence while grappling with their own collective recovery. Language surrounding 'terror' and 'trauma' are both loaded and contextual. Unpacking the relationship between them is often weighed down by the emotionality of their mutual and reinforcing impact. Indeed, terror and trauma are fundamentally bi-directional. Just as an act intended to cause mass harm and panic through violence and

disruption creates a potentially traumatic experience,[125] so can those who have experienced acts of violence and harm more broadly be at risk of heightened exposure to recruitment and kidnapping into groups that continue the intergenerational perpetration of harm. This chapter seeks to investigate the relationship between these two concepts, their limits and impact, and how we can begin to envision a journey towards healing and recovery – both in terms of mental health and more broadly- from human rights violations and atrocities. We will discuss how psychological violence is weaponized within terrorism as a means to sustain and further political and ideological agendas and conduct a deep dive into the psychological impacts of terror, and the driving theories behind its power. Lastly, we will conclude with next steps and recommendations for advocacy in change of policy, the need for trauma-informed contexts when navigating investigation in international court, and a proposal of resources for all those directly and indirectly affected by acts of terror.

On January 30th, 2016, an attack on Dalori village left 86 dead and over 60 injured.[126] This particular attack was in retaliation against the Civilian Joint Task Force that was created to help the Nigerian security forces drive Boko Haram's presence out of the city. Boko Haram, which refers to itself as "Jamaʿatu Ahl as-Sunnah li-Daʿawati wal-Jihad" (JASDJ; Group of the Sunni People for the Calling and Jihad) and "Nigerian Taliban"—other translations and variants are used—is a Nigeria-based group that seeks to overthrow the current Nigerian Government and replace it with a regime based on Islamic law. Since its founding in 2002, Boko Haram has instigated armed attacks across north-eastern Nigeria - including mass killings, sexual violence and the abduction of over 1700 children since 2014, and notably the kidnapping of [276] schoolgirls in Borno State, in April 2014. Boko Haram has been labeled one of the world's deadliest terrorist groups and their operations as acts of terror, violations of international humanitarian law, and a wide array of international human rights law violations. In 2011 in Damascus, civil unrest in Syria escalated into the outbreak of the Syrian civil war, seeing Syrian government forces and armed opposition groups, as well as their allies, perpetrating "millions of civilians to unlawful ground and air attacks, widespread and systematic arbitrary detention, torture leading to deaths in detention, enforced disappearance, sieges leading to starvation, and forced displacement".[127]

125 George Bonanno, The end of trauma: How the new science of resilience is changing how we think about PTSD (Basic Books, 2021).

126 *Nigeria: Deadliest Bok Haram Attack on Rann Leaves at least 60 people murdered* AMNESTY INTERNATIONAL (Feb. 1 2019) https://www.amnesty.org/en/latest/news/2019/02/nigeria-deadliest-boko-haram-attack-on-rann-leaves-at-least-60-people-murdered/.

127 *Ten years on justice for Syrians more important than ever*, AMNESTY INTERNATIONAL (March 21, 2021). https://www.amnesty.org/en/latest/press-release/2021/03/ten-years-on-justice-for-syrians-more-important-than-ever/.

In the Kurdish-majority region of Northeast Syria, the armed forces of Rojava under the Syrian Democratic Forces consist of the Women's Protection Units referred to as the YPJ or "Yekîneyên Parastina Jin" and male-led People's Defense Units referred to as the YPG are one of the only armed opposition groups (AOGs) in Syria that have been able to effectively push back against the Islamic State (IS) in a coalition with the United States and other allied forces.[128] However, President Erdogan and the Government of Türkiye declared the YPG/YPJ a terrorist organization from 2003, and after the end of a two-year ceasefire ordered the scale up of military operations in Syria against the YPG/YPJ.[129] Alongside the Free Syrian Army (FSA) and other allies, Türkiye launched an assault on the city of Afrin in January 21, 2018 resulting in the deaths of at least 26 civilian casualties, including 17 children according to Human Rights Watch.[130] Attacks between Türkiye and Kurdish-held areas of Syria have persisted over the years causing concern regarding the risk of increased terrorist activity and strained intergovernmental relations in the region.

Both of these examples resulted in civilian casualties, destruction of cities, and mass displacement, and are interwoven with geopolitical dynamics. The ten countries reported to be most affected by terrorism are also currently engaged in armed conflict; as a result, terrorist attacks within those countries are seven times more lethal. This rise is also reflected in international research, with the 2023 Global Terrorism Index report finding that the lethality of terrorist acts has increased by 26% since 2022.[131] The report analyzed data on terrorism trends across 163 countries accounting for 99.7% of the world's population. The Sahel region in sub-Saharan Africa remains at the center of terrorism attacks, accounting for 43% of the global lethality statistics in terrorist-afflicted deaths. And the Islamic State has remained the deadliest terrorist group for the last eight years, with recorded attacks across 21 different countries, followed by al-Shabaab Balochistan Liberation Army and Jamaat Nusrat Al-Islam wal Muslimeen. With the increase in deadly terrorism-based violence, the discussion on terminology has come to the fore as governments across the world begin to coordinate and enforce counter-terrorism policies. This leads us to the important question, of what is terror and what is considered a terrorist activity or group. In contexts of mass violence and human rights violations, it is important to unpack how and when we label an activity as one of 'terrorism', when we do not, and the political underpinnings

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128 Tom Perry, What is the Syrian Kurdish YPG?, REUTERS, (Oct 5, 2023 11:01 AM), https://www.reuters.com/world/middle-east/what-is-syrian-kurdish-ypg-2023-10-05/.

129 PKK REPUBLIC OF TÜRK E MINISTRY OF FOREIGN AFFAIRS. https://www.mfa.gov.tr/pkk.en.mfa.

130 *Syria: Civilian Deaths in Turkish Attacks May be Unlawful*, HUMAN RIGHTS WATCH, (Feb. 23, 2018, 12:00 AM EST), https://www.hrw.org/news/2018/02/23/syria-civilian-deaths-turkish-attacks-may-be-unlawful.

131 *Global Terrorism Index: Measuring the Impact of Terrorism*, THE INSTITUTE OF ECONOMICS & PEACE, (Feb, 2023), https://www.visionofhumanity.org/wp-content/uploads/2024/02/GTI-2024-web-290224.pdf.

that contribute to this decision. To do so, we will first discuss the historical underpinnings of terrorism, followed by the current situation with regards to definitions within international law and the parameters within which this chapter will proceed regarding the connection between trauma and terror.

Historically, the word 'terror' first originated during the French period of the Reign of Terror in the late 1700s, referring to the government's use of capital punishment on opponents of the French Revolution.[132] At the time, the royalty press used the phrase 'terrorist deeds' to disseminate news while criminalizing the ideologies of social revolutionaries. While the original usage of "terrorism" referred to the political violence perpetuated by the government, it has since been generalized to also describe acts of violence enacted against the government. The use of the word "terrorism" also continued well into the 20th century to describe acts of violence and destruction, by or against, the government to advance political demands and agenda. These acts most often targeted civilian populations with the intention to push political, religious, or ideological agendas. However, the victims of these acts were often not the end target.

The debate over which words we use to describe terrorism reflect some of the larger questions at play: How are these labels wielded in the domestic political sphere? What power does this word hold? How does it impact civilians on the receiving end of these messages? Martha Crenshaw, a political scientist who researches terrorism, once stated, "The political effectiveness of terrorism is importantly determined by the psychological effects of violence on audiences".[133] The word "terrorism" itself holds the capacity to incite fear and panic, and consequently for these emotions to be weaponized by those in positions of political leadership. Over the evolution of its usage, the impact of the word has become powerful enough to initiate the psychological fear response associated with violent acts. And these acts provoke various emotion-based responses from the public: the fear of being randomly targeted during a mass attack, feeling of terror towards potential perpetrators, and anger or resentment towards the main targets of the attack – for instance, a nation's government, which may then be blamed for failing to prevent such acts of violence. For the perpetrators of these acts of political violence, these deep public emotions – and any casualties from their attacks – can act as leverage against a larger primary target. Psychological distress among a public can place pressure on the primary target to react or make concessions. On the other hand, politicians, organizations, and leaders can also harness this fear response to justify decisions, generate support, degrade opponents, influence legislation, and alter public discourse.

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132 Philip Jenkins, *Terrorism* , ENCYCLOPEDIA BRITANNICA, (Apr. 19, 2024). https://www.britannica.com/topic/terrorism.
133 Martha Crenshaw, *The Psychology Of Political Terrorism* (1st ed. 2004).

For example, throughout the Vietnam War, President Lyndon B. Johnson labeled the Viet Cong and Vietnam itself as terrorists, while strategically praising the efforts of the U.S. and its allies as acts of "counterterrorism".[134] By contrast, military intervention conducted by the U.S against other countries is often framed more from the angle of humanitarian and stabilization. These words, and the way they are utilized by governments, hold significant power. The word's definition has become a strategy in gathering public support by wielding their fears and worries. The threat of a potential terrorist attack can rally a nation or divide its people. 'Terrorism' has become a powerfully loaded word that can be manipulated to broadcast any message for any side.

A recent German study about media reporting on terrorism found that the language used to cover acts of political violence revealed patterns dependent on the country rather than the act itself.[135] For example, lethal attacks in Western countries by Islamist extremist groups are almost always labeled as acts of terrorism. This is particularly true in a post-9/11 climate. Yet there is significant conservatism around usage of the word when reporting on domestic political extremist groups, with regards to Christian extremist groups or as seen by the January 6th attack on the U.S Capitol by armed supporters of former President Donald Trump, where it is (geo)politically inconvenient to be labelled as such.[136] On its flipside, the Amnesty International briefing "Terrorising the dissent" [137] documents how peaceful protesters have been targeted by Russian authorities since the full-scale invasion of Ukraine in February 2022 under the guise of "national security". This is only one example of many.

Media coverage plays a crucial role in shaping public opinion, perceptions of the importance of issues, and national policy conversations. Western media outlets, with their wide reach and influence, tend to have a prominent presence in global news coverage.[138] As a result, they often have a greater capacity to shape the narrative around terrorism. A study from 2005 to 2015139, for example, analyzed the differences in American media coverage of terrorist events in the US and found that attacks perpetrated by Muslims received significantly

134 Tatiana Nigh, *Red Terrorists, or Red, White and Blue Terrorists? A closer look at how the word "Terrorism" was applied to the Vietnam war*, 3 THE ONYX REVIEW (2018).

135 Valerie Hase, *What is Terrorism (according to the news)? How the German press selectively labels political violence as "terrorism"*, 24 Journal (2021)

136 K.Mcbride, *From 'Protest' to 'Riot' to 'insurrection'-How NPR's language evolved* NPR KQED (Jan. 14, 2021, 11:00 AM ET) https://www.npr.org/sections/publiceditor/2021/01/14/956777105/from-protest-to-riot-to-insurrection-how-nprs-language-evolved.

137 *Russia: Surge in abuse of anti-terrorism laws to suppress dissent*, AMNESTY INTERNATIONAL ( Feb. 19, 2024), https://www.amnesty.org/en/latest/news/2024/02/russia-surge-in-abuse-of-anti-terrorism-laws-to-suppress-dissent/.

138 Erik Elejalde et al., *On the nature of real and perceived bias in the mainstream media*, PLOS ONE (March 23, 2018), https://journals.plos.org/plosone/article?id=10.1371/journal.pone.0193765.

139 E.M. Kearns et al., *Why do some terrorist attacks receive more media attention than others?* Justice quarterly, (2019), https://ourworldindata.org/why-do-some-terrorist-attacks-receive-more-media-attention-than-others.

more coverage compared to other perpetrators. On average, attacks received 357% greater coverage when the attacker was Muslim, rising to 758% for major national news sources.[140] The coverage was also higher when the perpetrator was arrested, the attack targeted law enforcement or government, and when more people were killed. This biased portrayal of terrorism can lead to negative consequences. When attacks perpetrated by a certain ethnicity or religion receive disproportionately more coverage compared to other perpetrators, it leads to an unbalanced and skewed perception of terrorism in the public's mind. This can contribute to the reinforcement of negative stereotypes and stigmatization of that ethnicity or religion as a whole, fostering an environment of fear and prejudice. Responsible and unbiased journalism can foster empathy, tolerance, and promote social cohesion. On the other hand, media bias can contribute to the polarization of society and perpetuate harmful stereotypes, leading to real-world consequences for individuals and communities affected.

The political weight and dynamic evolution of the word means that its use — whether by news outlets, social media users or policymakers — often creates a stereotype of what terrorism is and what a terrorist looks like – echoing and reinforcing broader psychological violence rooted in systems of oppression manifesting through heightened micro- and macroaggressions, including sexism, racism, ableism, and xenophobia. Geopolitical interests also play a role in shaping the narratives surrounding conflicts. This not only influences the public opinion on these issues, but consequently impacts decisions around policy development, fiscal spending, and local level responses to issues of terrorism, migration, and human rights in practice.

This brings us to where we are today. The United Nations Human Rights Office of the High Commissioner (OHCHR) defines terrorism as, at a minimum, "the intimidation or coercion of populations or governments through the threat or perpetration of violence, causing death, serious injury or the taking of hostages." [141] However, in the absence of an internationally agreed definition of terrorism, while States would ideally be guided by the Security Council resolution 1566 on threats to international peace and security caused by terrorist acts – in reality, each country has signed into their respective laws their own definitions of terrorism, leaving at least 200 different, overlapping, contrasting definitions of the word. This absence of a common definition creates space

140 Hannah Ritchie et al., *Why do some terrorist attacks receive more media attention than others?*, OUR WORLD IN DATA, (Jul. 1, 2019), https://ourworldindata.org/why-do-some-terrorist-attacks-receive-more-media-attention-than-others.
141 *OHCHR and terrorism and violent extremism*, UNITED NATIONS HUMAN RIGHTS OFFICE OF THE HIGH COMMISSIONER, https://www.ohchr.org/en/terrorism#:~:text=As%20a%20minimum%2CTerrorism%20involves,or%20the%20taking%20of%20hostages.

for the instrumentalizing of anti-terrorism and anti-extremism legislation by governments to control and repress the freedom of speech, and to exacerbate xenophobia and racism through cultivating an environment of fear and harmful stereotypes. Commonalities across definitions include "violent, criminal acts" with the "intention" to create "intense, overwhelming fear" for political and/or ideological aims. The victims and/or survivors of this may experience this violence based on identities they hold (e.g. gender identity, sexual orientation, indigeneity, ethnicity, religion), which will be unpacked regarding its psychological impacts later on in the chapter.

This lack of clear consensus on a singular definition poses a major challenge to countries and entities trying to enact international legislation, preventative action, or coordinate counterterrorism efforts, even as the need for such measures arise around the world. In 1994, the General Assembly's Declaration on Measures to Eliminate International Terrorism, set out in its resolution 49/60, stated that terrorism includes "criminal acts intended or calculated to provoke a state of terror in the general public, a group of persons or particular persons for political purposes" and that such acts "are in any circumstances unjustifiable, whatever the considerations of a political, philosophical, ideological, racial, ethnic, religious or other nature that may be invoked to justify them"[142] These two definitions provided by the UN, while helpful, lack the necessary buy-in from State parties to prevent the racialized politics of terror, the conflation of terror with the weaponizing of islamophobia and white supremacy, and the coloniality that tends to primarily ascribe terrorism to incidents of violence occurring by, or to, LMICs and those in the global majority[143] Galchinsky (2013) argues that removing 'terror' from broader IHRL frameworks, this would allow Western nations through the delegitimizing of IHRL in a Post-9/11 climate to engage in torture and other human rights violations against alleged terrorists by rendering them into a legal "black hole".

Recognizing this risk and the universality of human rights, this chapter seeks to remain firmly aligned with the OHCHR aforementioned definition and within related agreements under International Law, including the Convention on the Rights of the Child (adopted 20 November 1989, entered into force 2 September 1990), the Convention against Torture and Other Cruel, Inhuman or Degrading Treatment of Punishment (adopted 10 December 1984, entered into

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142 *Fact Sheet No.32: Terrorism and Counter-terrorism*, UNITED NATIONS HUMAN RIGHTS OFFICE OF THE HIGH COMMISSIONER, (Jul. 1, 2008), https://www.ohchr.org/en/publications/fact-sheets/fact-sheet-no-32-terrorism-and-counter-terrorism.

143 Michael Galchinsky, *Quaint and Obsolete: The 'War on Terror' and the Right to Legal Personality*, INTERNATIONAL STUDIES PERSPECTIVES (2013).

force 26 June 1987), the International Covenant on the Elimination of All Forms of Racial Discrimination (adopted on 21 December 1965, entered into force 4 January 1969) among others.

## INTERRELATIONSHIP OF TERROR AND TRAUMA IN APPLIED INTERNATIONAL LAW

With the foundation of clear terminology for how we define terrorism, its relationship to psychological harm and potential for perpetuating potentially traumatic experience (PTEs) can now be investigated. The below are the five ways that the authors of this chapter have currently considered the interrelationship between terrorism and trauma with regards to international human rights law and applied human rights in practice:

1. Terror can cause trauma symptoms/ post-traumatic stress disorder.
2. Terrorist groups use the creation of trauma as a tool to create terror.
3. Trauma symptoms from terror can lead to perpetuation of terror and intergenerational violence.
4. Trauma symptoms impact reporting, documentation, and investigations on terror.
5. Investigations into terror and documentation on terror that is not trauma informed risks reinforcing human rights violations and exacerbating trauma symptoms.

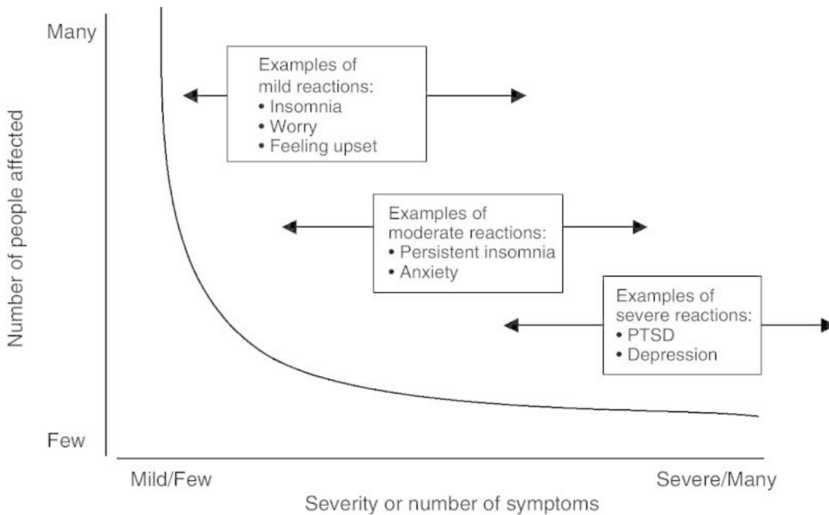
In the 2019 Secretary-General Annual Report on Children and Armed Conflict report on Grave Violations of Children's Rights[144] to the UN, the following detail was provided regarding sexual violence against children in Syria:

144 *Report of the Secretary-General on Children and armed conflict*, UNITED NATIONS, (Jul. 26, 2019), https://www.un.org/sg/sites/www.un.org.sg/files/atoms/files/26-07-2019_SG_CAAC_report_advance_copy_0.pdf

*"The United Nations verified 38 incidents of sexual violence perpetrated against children by ISIL (30), Hay'at Tahrir al-Sham led by Nusrah Front (5), FSA-affiliated Faylaq al-Sham (2) and Syrian Government forces (1), 30 of which occurred in previous years. Incidents included forced marriage, rape, trafficking and sexual violence while children were deprived of liberty. Sexual violence remained underreported owing to access restrictions, the lack of access to services for victims and stigma."*

This example was chosen at random, and is similarly demonstrated in this report and others, year after year, highlighting the incidents that were able to be documented of grave violations of children's rights including by individuals and groups involved in terrorism. The relationship between incidents of such violence and the potential for trauma, including post-traumatic stress disorder, is well documented. As defined by the Diagnostic and Statistical Manual of Mental Disorders—Fifth Edition (DSM-V), trauma is defined as "any disturbing experience that results in significant fear, helplessness, dissociation, confusion, or other disruptive feelings intense enough to have a long-lasting negative effect on a person's attitudes, behavior, and other aspects of functioning" (APA, 2018).

Figure 1



As noted by the above indicative graph (A.S.Butler., et al, 2003) and in the work of George Bonanno and his peers, the majority of individuals demostrate a psychological resilience and do not develop PTSD after a potentially traumatic experience such as witnessing or experiencing an act of terrorism. However, with regards to acts of terrorism, it is noted that the mental health impacts are often directly correlated to exposure level. This includes whether an individual has been *directly, indirectly or remotely* affected-both in relation to geographic proximity, and also with regards to personally experiencing, witnessing or experiencing the death, injury or serious risk of harm to a loved one (e.g. friends, family, spouse). The psychological impacts of terrorism extend far beyond those who have been personally exposed to violence and bodily harm, and beyond the limited scope of the DSM-V definition of PTSD. As such, effective treatment for individuals experiencing trauma symptoms after an experience of terrorism requires a holistic and survivor-centered person in environment approach.

With regards to the use of trauma as a tactic or motive in terrorism, it is important to first note the significant challenges with proving intent under international law. The *mens rea*[145] element of intention to cause psychological harm and trauma poses similar challenges as with proving genocidal intent. If following a similar process with regards to intent to cause psychological harm during and via acts of terrorism, the *dolus specialis* burden[146] has been met in the past when genocide was "the only reasonable inference which can be drawn from the said pattern of conduct".[147] Considering this with regards to the subject under consideration for this chapter, two examples are highlighted as patterns that demonstrate intent to cause psychological harm and trauma-related symptoms within acts of terrorism.

The first of these is the act of forcing children recruited and kidnapped into armed forced and armed groups (CAAFAG) to kill their own parents. Forcing children to engage in acts of brutality and violence against their families, can both cause a psychological break forcing them to attach to the armed group and also makes it almost impossible to return home. Reports from the Democratic Republic of Congo (DRC), Sierra Leone, Uganda and many others center voices of distress and deep psychological damage done to the children forced to commit

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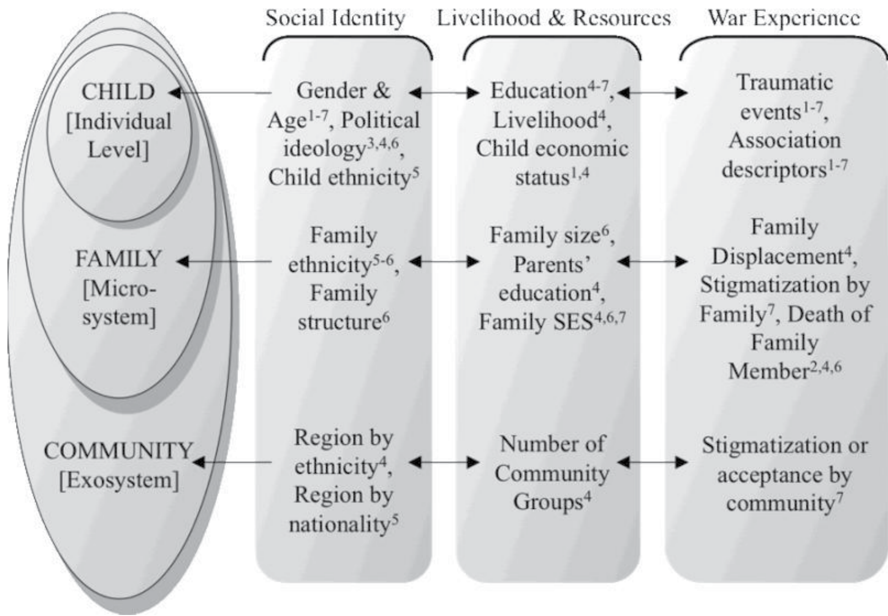
145 What is Mens Rea and Actus Reus? What is Mens Rea and Actus Reus? - Law Legum (Visited May 12, 2024) ("Both the term is very old and is based on the Latin Maxim 'actus non facit reum nisi mens sit rea' which means an act does not make the actor guilty unless his mind is guilty too.")

146 To have a deliberate and specific aim.

147 Application of the Convention on the Prevention and Punishment of the Crime of Genocide (Croatia v. Serbia) at 11 CrY Summary of the Judgment of 3 February 2015 (icj-cij.org) (Visited May 11, 2024)

these crimes, and disruptions to the *microsystem, exosystem* and *macrosystem* within which the children socioecologically existed (Kohrt, B., 2013) becomes a space of violence and fear, and often inaccessible to easily return to.

Figure 2




The above image from Kohrt et. al's 2013 study highlights the multidirectional relationship between these levels, and how traumatic events, stigmatization and loss in the family can cause challenges for the recovery and healing of children in such situations, compounded with existing challenges such as poverty and discrimination.

The second example is sexual violence as a weapon of war. The weaponizing of sexual violence on a mass scale linked with the strategic objectives of an armed group are rooted in an objective to humiliate, demean, and demonstrate power over victims and/or survivors. Meger (2016) notes that "generalized terror is the aim of rape as a weapon of war" and with rising militarization and armed conflict globally, so has sexual violence as a tactic of terror (UN Press, 2023). Women and girls account for 94 per cent of the 2,455 United Nations-verified cases of conflict-related sexual violence committed in 2022, and an OHCHR 2024

Report on the situation in Haiti facing intensive gang violence found that gangs have used "sexual violence to spread fear, subjugate and punish the population". This includes specific targeting of children, persons with disabilities and members of the Lesbian, Gay, Bisexual, Transgender, Queer and Intersex (LGBTQI+) community.

Schmid writes on terrorism as psychological warfare "The immediate human victims of violence are generally chosen randomly (targets of opportunity) or selectively (representative or symbolic targets) from a target population, and serve as message generators. Threat- and violence-based communication processes between terrorist (organization), (imperiled) victims, and main targets are used to manipulate the main target (audience(s)), turning it into a *target of terror, a target of demands, or a target of attention*, depending on whether intimidation, coercion, or propaganda is primarily sought." Acts of terrorism are intended to be psychologically distressing and fear provoking in order to influence the political and ideological underpinnings of a State. In the words of Boaz Ganor, " ... terrorism is a form of psychological warfare against the public morale". As such we can see how terrorism both in its macrolevel construction and in the details and types of violence inflicted connect with psychological motivations to cause distress, trauma, and disruption. The psychological motivations of terrorism requires further detailed exploration and reflection within International Courts and Tribunals, such as the International Court of Justice (ICJ) and the International Criminal Court (ICC), both to assist in the investigative process but also to support in trauma-informed and quality support for victims, survivors and witnesses associated with breaches of IHRL that fall within the aforementioned definition of terrorism. Recognizing the bidirectionality of trauma and terror – both as a motivation and a consequence, enables us to expand our understanding on how to document and investigate IHRL violations, how to establish and contextualize reporting mechanisms and how to support individuals who are willing to testify regarding their experiences.

By understanding the relationship between terrorism and trauma, we are able to better adapt these processes to become increasingly trauma-informed. Additionally, we are able to understand with more nuance the potential coercion and manipulation that underpins recruitment and targeting of potential members by organizations perpetrating acts of terrorism, detail within arguments made in criminal proceedings on 'temporary insanity' as well as how to mitigate potential risks of repeated cycles of violence in future generations.

## PSYCHOLOGICAL THEORIES AND WHY INDIVIDUALS ENGAGE IN TERRORISM

It is an inadequate and broad assumption to state that anyone who becomes involved in terrorism has done so solely due to poor mental health. The following section highlights how some of the key psychological theories can provide some insight into the psychological motivations, drivers and consequences surrounding terrorism and those who perpetuate it.

**Psychoanalytic Perspectives**

For the purposes of this chapter, psychoanalytic and psychodynamic theories will be considered simultaneously. However, these are two different fields in which psychodynamics has evolved past psychoanalytic perspectives in many ways. Psychoanalytic and psychodynamic perspectives on violence, like most psychoanalytic theories, start with Freud. He was interested in violence following World War I; he wanted to understand the 'why' and 'now what' of violence (Cerfolio, 2020). Freud believed that individuals experience a drive for death, *Thanatos,* which pushed up against the drive to survive, *Eros* (Freud, 2003). *Thanatos* manifests in aggression, violence, destruction, and death, while *Eros* manifests in love, life, and sexuality. These two drives are in a constant battle in which *Eros* wins, and *Thanatos* manifests in war, violence, and aggression. Thus, at the most basic level, we all have a drive toward aggression and fighting, but only for some is the drive strong enough to act upon (Borum, 2004). The idea is that everyone has a drive towards violence and, when given a chance, would act upon it.

This belief that we all have a drive toward violence can be reflected in Daniel Goldenhagen's book, *Hitler's Willing Executioners: Ordinary Germans and the Holocaust* (2007). In this book, Goldenhagen argued that it was not only the SS, or people trained to kill, that killed Jewish people during the Holocaust, but regular German soldiers. Furthermore, Goldenhagen argued that these men were regular middle-aged Germans with no particular indications of psychopathology, just men living in a time in which policy and society reflected an 'eliminationist antisemitism' (Goldenhagen, 2007). These soldiers were, as the title suggests, willing executioners in that there was no apparent or knownpunishment if they decided not to kill innocent Jewish people.

While one could argue, then, that anyone is inherently capable of violent acts, psychoanalysis has mostly departed from the death drive hypothesis of violence for more modern perspectives; however, it still remains a part of the discussion as psychologists such as Hanna Segal and Julia Kristeva have discussed how the death drive could be related to political violence for those that are in a state of confusion and want to make sense of the world somehow (Cohen, 2019).

A theory that evolved from Freud's ideas of opposing drives is drive theory, specifically the drive of frustration and aggression. The Frustration-Aggression (FA) drive theory posits that people have some form of frustration in the form of being unable to accomplish things leads to the response of aggression (Berkowitz, 1989). Many future violent actors experience "unfair humiliation," whether it is disenfranchisement, discrimination, or just personal failure, "individuals are motivated to join terror organizations as a mechanism to gain feelings of personal significance." (Webber and Kruglanski, 2018). This theory has been built upon with a modern lens. For example, Wilhelm Reich connected the oppression of authoritarian families to aggression in Germany (Cohen, 2019). This oppression in early childhood led these children to feel the world was "unfair" and thus turned to aggression. There is a synergy with this argument and the connection between systems of oppression, historic marginalization and how individuals may be recruited by groups perpetrating acts of terrorism with the promise of connection, recognition, and community. However, the FA theory fails to clarify why only some individuals may be driven to perpetuate acts of extreme violence and terror, and others do not. FA theory only explains part of the intent behind aggression, as Tedeschi and Felson put it, "it is reasonable to conclude that aversive stimuli do facilitate, but probably not instigate, aggressive behavior" (Tedeschi & Felson, 1994, as cited in Borum, 2004, p. 12).

The aversive stimuli are also relevant in the object relations framework to understand psychological motivations. In object relations, it is believed that negative events that occur in childhood are split and projected onto the bad object (i.e., country, political group, religious group, etc.) and thus justify and preserve a positive image of the self (i.e., individual or group) (Cohen, 2019). This theory is based on the work of Melanie Klein, but Wilfred Bion connected the good object or self to the group dynamics of in-groups and out-groups (Cohen, 2019). The splitting or polarizing beliefs of object relations are also relevant in Robert Lifton's theory that idealization occurs as one takes an absolutist/apocalyptic view of the world (Victoroff, 2005).

**Personality Perspectives**

There is no specific 'personality' trait or style that explains the reasons one turns to terrorism, nor is it by any means always the choice of the individual to enter into groups perpetrating acts of terror. It is important to highlight the fact that these are theories and/or a diagnosis of a personality disorder alone does not indicate whether someone is more likely to commit a violent act. While some traits

and qualities may be associated with heightened risks of violence, the diagnosis itself may not, for example paranoia may be common among aggressors but paranoid personality disorder may not. Furthermore, some of the examples discussed in the literature have outdated diagnoses, e.g., paranoid schizophrenia is discussed, but the diagnosis has since been removed from the Diagnostic and Statistical Manual of Mental Disorders 5. Not only are there changes that have been made regarding the disorders, but also the diagnoses have changed depending on the forensic psychologists working on each case. The personality types are described in the following paragraphs.

The first personality type that most people discuss when referring to violence is antisocial. It's estimated that 40% of cases of conduct disorder in childhood result in a diagnosis of Antisocial Personality Disorder (APD/ASPD) in adults (Searight, Rottnek, & Abby, 2001). Despite the possibility that some perpetrators may have Antisocial Personality Disorder (APD/ASPD), not all will have this diagnosis. Those with ASPD make up a very small percentage of the general population. Still, there are certainly higher rates of ASPD among incarcerated populations, a fact many gravitate towards when theorizing the motivations for violence. While it is true that there are high rates of ASPD among those currently and formerly incarcerated within the United States of America (Dhumad et al., 2020), there are also higher rates of almost every mental health diagnosis among individuals who have been incarcerated (Corner, Gill, & Mason, 2016). Therefore, a particular diagnosis alone is not enough to indicate violence in the future, and the same can be said of all mental health diagnoses. While there seems to be some literature highlighting the association between these traits and aggressors, one cannot establish causation and it is essential to consider human rights violations and trauma from a socio-ecological framing rather than focusing on a list of diagnosable traits. Without the ability to establish causation, one cannot determine whether these traits precede violent acts or if they are the products of the environment and acts themselves.

The belief that narcissistic personality traits are associated with violence actually starts with psychodynamic and psychoanalytic approaches. The theory that narcissism is related to violence first began by psychoanalyst Heinz Kohut (Victoroff, 2005). Kohut developed self-psychology, which focused on the shortcomings of our parents, causing damage to our perceptions of ourselves. The damage to our self-image is called narcissistic injury (Victoroff, 2005). Many researchers then developed explanations to explain how narcissistic injuries created motivations for individuals to incite violence and get revenge. One of the first to build on Kohut's work was Gustov Morf (Abbasi, Khatwani,

& Soomro, 2018). Morf studied convicted members of the armed opposition group Front for the Liberation of Quebec (FLQ) and found that the members did not meet the criteria for Narcissistic Personality Disorder (NPD) but did exhibit narcissistic traits such as wanting to be the center of attention (Victoroff, 2005). Morf's work was also built upon by John Crayton (Abbasi, Khatwani, & Soomro, 2018). Crayton argued that people could experience narcissistic injury as an adult and thus develop a narcissistic rage to destroy the perpetrator of the injury (Victoroff, 2005). He believed that the two key components of narcissism, in this case, are grandiosity and idealized parental ego (i.e. the leader of the terrorist group or group as a whole) (Victoroff, 2005; Borum, 2004). More simply put, when this argument holds that when someone with an elevated sense of self has been humiliated or downcast in some way, they try to correct this incongruence by attacking those that wronged them or by joining a charismatic leader of an armed group to attack those that wronged them. Reflecting back on the example of sexual violence as a weapon of war, we can see that there are two immediate challenges with this personality perspective; firstly, not all of those who are humiliated perpetrate violence, and second, those who perpetrate violence often do so against those who hold less power than they do. As with the profile of the antisocial personality, we see yet again an incomplete narrative surrounding the motivations and profiles of individuals engaged in terrorism as a collective. Considering the debate on situation versus disposition, on the "situational causes of behavior" (Funder, 2014), as opposed to an individual's characteristics and qualities, humanitarian programming focused on reintegration, mental health and psychosocial support and community-based protection of former CAAFAG demonstrates the impact of a strong social support system for healing and recovery, and the risks of assuming a personality disorder versus unpacking the environmental factors surrounding the recruitment or abduction into AOGs inflicting/intending to inflict acts of terrorism.

**Cognitive Perspectives**

Cognitive psychology focuses on mental processes such as learning, memory, and thinking. Most of the cognitive theories covered in this chapter will focus on recruitment and onboarding into groups with 'radical' or extreme views connected to an often political and/or religious ideology (Schmid, 2013). With this process, there are underlying social-cognitive processes at play that will be discussed more in-depth in the following section. That being said, there are no specific psychological mechanisms that define an aggressor, but there may

be specific patterns in decision-making and thought processes that make an individual lean toward violence.

One of the most thorough theories around cognitive mechanisms of violence is Fathali M. Moghaddam's Staircase to Terrorism theory. The theory posits that most people exist on a ground floor of sorts in which they conceptualize (in)justice and (un)fairness, but there are a series of steps that lead to a terrorist act (Moghaddam, 2005). Drawing on the image of the staircase, the individuals who move up beyond the ground floor are those who have been wronged in society and have been socialized to see terrorist acts as a means of communication that will be heard (Moghaddam, 2005). Like many other theories around the reasons behind a terrorist act, this theory involves the socialization into a terrorist organization.

Another theory that has been discussed in the motivations for violent acts is the hypersensitivity to violence theory. This theory posits that individuals who have a lower sensitivity to aggression experience more social cues as aggressive and thus respond with aggression (Dodge & Schwartz, 1997). Biologically, those with low expression of monoamine oxidase-A (MAOA) allele, which gave these individuals increased sensitivity to social and emotional cues, had increased levels of reported trait aggression (Eisenberger et al., 2007). Furthermore, these individuals may also have a hypersensitivity to rejection. Rejection, as previous literature suggests, is one of the risk factors for engagement in violent acts.

Cognitive dissonance is a theory that Leon Festinger proposed in 1957. This theory posits that people can have cognitions that are either consonant (congruent) or dissonant (incongruent). When an individual experiences cognitive dissonance, they experience emotional discomfort (Harmon-Jones & Mills, 2019). The ability to reduce the impact of cognitive dissonance is potentially one way in which people become capable of violent acts. Andrea Kohn Maikovich has used cognitive dissonance to explain violence through cognitive dissonance. She explained that many groups perpetrating violence and terror have origins in peaceful protest and use nonviolent strategies to attempt to get their point across. However, once these peaceful protests fail, the groups begin turning towards violence. Maikovich built some of this theory off of Moghaddam's work which stated that as people rise through the ranks in these organizations, they often engage in or are involved in more violent acts. However, members often join these groups not to be responsible for violence themselves but rather to feel included or because they may genuinely believe in the goals of the group. These members, even if they experience dissonance, are often manipulated into believing what they are doing is right, which reduces dissonance.

## BEYOND THE INDIVIDUAL TO THE SOCIOECOLOGICAL: FROM PREVENTION TO RESPONSE

This brief analysis on a selection of psychological theories demonstrates that terrorism cannot be attributed solely to individual predisposition or innate characteristics. Instead, research suggests that individuals who engage in terrorism are often pushed by sociopolitical structures that foster an environment where violence thrives, and where marginalized communities are at heightened risk of involvement in violent activity (International Crisis Group, 2016). Unsurprisingly, many movements holding 'radicalized' values are characterized by environments of geopolitical instability and poverty. This may manifest itself as political exclusion, autocratic rule, ineffective Western interventions, inadequate governance, and limited opportunities for peaceful political expression. Neglected peripheral areas where the state is not trusted, declining authority of traditional elites, and the lack of opportunities for young people also contribute to radicalization patterns that then lead to the creation of extremist movements (International Crisis Group, 2016).

The common denominator to these geopolitical factors and one of the main contributors to terrorism is social inequality. When individuals are marginalized and lack access to basic resources such as education, healthcare, and employment opportunities, they become vulnerable to extremist ideologies that offer them a sense of purpose and belonging by providing a powerful narrative that explains their grievances and offers a solution to their problems. The simplistic and rigid nature of most extremist groups can be appealing to those who feel unable to cope with the challenges of the world they live in (Borum, 2010).[148] Rather than facing issues of self-identity and significance, marginalized individuals may opt to define themselves based on group membership or identification with a cause (Borum, 2010). Terrorist ideologies often portray the dominant culture or political system as oppressive or corrupt, and present themselves as a righteous alternative that can deliver justice and a sense of identity and community to those who join them (International Crisis Group, 2016). Additionally, many individuals considering joining radical extremist groups find a sense of connection, affiliation, and belonging within such groups, in addition to a sense of purpose.

For example, the Islamic State (IS), al-Qaeda-linked groups, Boko Haram and similar movements prey on young people from disadvantaged backgrounds who feel disillusioned with their current situation and seek a sense of empowerment through violent action. Despite some differences in structure

148 R. Borum, *Understanding Terrorist Psychology*. The Psychology of Counter-Terrorism Routledge at 33 (2010).

and ideology, they all offer a sense of purpose through a radical interpretation of Islam that presents itself as a means of resisting Western imperialism and defending the Muslim world (Luna & Zoltan, 2015).[149] Similarly, white supremacist groups in the United States offer a sense of identity and belonging to those who feel marginalized by the changing demographics and cultural norms of the country. These groups often present themselves as defenders of the white race and those systems that support, reinforce, and reproduce white supremacy such as capitalism, class, and gender. Similarly, to the extremist groups across Sub-Saharan Africa, Asia and the Middle East and North Africa regions, they offer a sense of identity and purpose to those who feel that their identity is under attack.

Moreover, political oppression and state violence can also play a role in creating terrorist groups and ideologies (Kruglanski et al., 2012).[150] State violence, such as excessive force, human rights abuses, or systemic discrimination, can fuel anger, frustration, and a sense of injustice among people, who then join or support terrorist organizations that claim to fight against the oppressive state or seek revenge for perceived wrongdoings (Kruglanski et al., 2012). When people are denied political participation, freedom of expression, or basic rights, they may seek solace and belonging in extremist ideologies that promise empowerment and a sense of purpose. Terrorist groups often exploit these grievances and offer a distorted narrative that justifies violence as a means of achieving political or societal change.

Yet during their time engaged in these groups, whether by choice or through coercion, manipulation and/or abduction, the mental health situation of individuals exposed to mass human rights violations has severe consequences.

> *"Shame and guilt often stemmed from several sources, including being a survivor of traumatic childhood experiences, exacerbated by internalization of stigma, and their inability to fulfill traditional gender roles. Studies support the occurrence of shame and guilt following traumatic events, which is especially relevant for former CAAFAG who were often forced to commit or witness violence against each other and their own communities" (Freeman, 2020)*

149 S. Luna, & S. Zoltan, *The Rise of Islamic State of Iraq and Syria (ISIS)*. 14 AARMS–Academic and Applied Research in Military and Public Management Science at 363 (2015).

150 A. W. Kruglanski et al., *Terrorism as Means to an End: How Political Violence Bestows Significance*. In P. R. Shaver & M. Mikulincer (Eds.), Meaning, Mortality, and Choice: The Social Psychology of Existential Concerns, American Psychological Association at 203 (2012).

The use of psychological techniques to prevent individuals from leaving groups associated with terrorism has been mentioned earlier in this chapter, and raises serious concerns about the hidden scars of trauma connected to this complex phenomenon.

## TRAUMA-INFORMED CARE FOR SURVIVORS AND/OR VICTIMS, FAMILIES, WITNESSES AND PERPETRATORS OF IHRL VIOLATIONS

Survivors of human rights violations including those names in this chapter can experience both physical and psychological symptoms of trauma. They may have endured torture, violence, or witnessed the suffering of loved ones. For this reason, it is crucial to provide them with trauma-informed mental health care, which can help them acknowledging their suffering, restoring their dignity, and rebuilding their lives after enduring profound trauma. Trauma-informed care recognizes and acknowledges the impact of trauma on an individual's mental, emotional, and physical well-being (Butler, 2019).[151] It emphasizes creating a safe and supportive environment that respects survivors' autonomy and promotes their healing without inadvertently retraumatize them. Trauma-informed care often focuses on avoiding practices or interventions that could trigger distress or exacerbate traumatic memories (Butler, 2019). Trauma-informed care also recognizes that trauma is a long-term process that affects every aspect of a person's life, including their physical health, emotions, relationships, and overall well-being (Butler, 2019). It considers the interconnectedness of these domains and adopts a holistic approach to address the multifaceted consequences of trauma. It focuses not only on symptom management but also on building a sense of self and connection to community, fostering coping strategies, and supporting survivors in their journey towards post-traumatic recovery (Butler, 2019). Without proper support, survivors of human rights violations are at risk of being re-victimized or retraumatized. The consequences of unresolved trauma can manifest in various ways, including poor mental health, substance abuse, self-harm, or even perpetrating violence themselves. By providing resources and addressing mental health needs in a holistic, contextualized and trauma-informed manner, we can reduce the risk of further harm and promote long-term individual and collective well-being.

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151 L. D. *Butler, Trauma and Human Rights*. F. Critelli, & J. Carello (Eds.). Palgrave Macmillan (2019).

**Trauma-informed care for the families of survivors of IHRL violations**

Perpetrators and survivors are not the only people impacted after an act of terror. Taking care of the families of survivors and victims is crucial for several reasons. It is a matter of compassion, support, and recognizing the immense impact that acts of terrorism have on individuals and communities. The aftermath of a terrorist attack leaves families grappling with profound grief, loss, and the daunting task of rebuilding their lives. By extending assistance to these families, including access to resources and services and financial funds, societies acknowledge the lasting impact of terrorism and demonstrate compassion and solidarity in their recovery process.

The aftermath of a terrorist attack can disrupt families' lives in significant ways. First, families affected by terrorism undergo profound emotional trauma and grief. Providing support acknowledges their pain and demonstrates compassion and empathy, letting them know that society recognizes their suffering and is there to help them in their journey towards healing. Recovery from the trauma of terrorism is a long-term process that extends far beyond the immediate aftermath of an attack. Continual support and assistance for families, even years after the incident, are crucial for their ongoing well-being. This can involve initiatives such as scholarships and healthcare benefits, which ensure that survivors and victims' families have the necessary support throughout their healing journey, but also specialized services such as counseling, therapy, medical support, and educational assistance. Allocating funds enables these families to access necessary resources and services, which are essential for their physical, mental, and emotional well-being.

A great example can be found in the aftermath of the terrorist attack of 9/11. After the devastating terrorist attacks on September 11, 2001, the United States established the September 11th Victim Compensation Fund (VCF)[152] to provide financial assistance and support to the families of the victims. The VCF was created with the aim of acknowledging the immense loss suffered by these families and assisting them in the process of rebuilding their lives. The primary purpose of the 9/11 funds was to provide financial compensation to the families of those who lost their lives in the attacks. The funds were intended to alleviate the economic burden faced by the families due to the loss of their loved ones, particularly in cases where the victims were the primary breadwinners. By providing financial support, the funds aimed to ensure that the families could maintain their financial stability, meet their basic needs,

152 Victim Compensation Fund (VCF), https://www.vcf.gov (accessed May 16, 2024).

and continue with their lives as best as possible in the aftermath of the tragedy. The distribution of the funds was overseen by the VCF, which was responsible for *assessing* claims and determining the compensation amount for each eligible family. The VCF worked closely with the families, attorneys, and other relevant parties to ensure that the process was fair, efficient, and transparent. The compensation provided by the funds varied based on factors such as the victim's income, age, and dependents, as well as other relevant circumstances.

Beyond financial compensation, the 9/11 funds also offered additional support to the families of the victims. This included access to various resources and services such as mental health counseling, healthcare benefits, educational assistance, and job training programs. These services aimed to address the emotional and practical needs of the families, recognizing that their healing and recovery extended beyond financial assistance. The establishment of the 9/11 funds for the families of the victims was a testament to the government's commitment to supporting those affected by the attacks. It recognized the unique and profound impact of the tragedy on the families and sought to provide them with the necessary means to rebuild their lives and secure their futures. Over the years, the 9/11 funds have been crucial in helping thousands of families affected by the attacks. They have played a vital role in providing financial stability, access to support services, and opportunities for healing and recovery. The funds have been instrumental in recognizing and addressing the significant challenges faced by the families of the victims, demonstrating the importance of comprehensive care and support for those affected by acts of terrorism.

**Community and collective healing**

Supporting the families of victims can also contribute to community healing, a process that seeks to restore collective well-being and resilience in the aftermath of a traumatic event. Community healing involves recognizing the interconnectedness of individuals within a community and understanding that the effects of a tragedy extend beyond the immediate victims. During community healing, individuals unite to provide emotional support, empathy, and understanding to one another. They create spaces for open dialogue, sharing experiences, and processing emotions, which helps to alleviate the pain and trauma experienced by the community as a whole. This collective sharing of grief and healing fosters a sense of togetherness, connection, and shared strength. Additionally, community healing involves implementing initiatives and resources that address the needs of the community affected by the tragedy. This may include establishing support groups, counseling services, memorial

events, or community-led projects aimed at rebuilding and revitalizing the affected area. These initiatives not only provide practical assistance but also symbolize a collective commitment to healing and resilience. Through community healing, affected communities can gradually restore a sense of safety, trust, and normalcy. By supporting one another, acknowledging shared pain, and working towards collective recovery, communities can emerge stronger, more united, and better prepared to face future challenges. Community healing acknowledges the interdependence of individuals within a community and recognizes that the path to healing extends beyond individual experiences, emphasizing the importance of collective support, understanding, and solidarity. Collectivist models of healing highlight a dedication to rebuilding the social fabric that terrorism sought to unravel, fostering a renewed sense of trust, resilience, and shared values becomes clear. Through this collective healing process, communities can gradually move forward, finding strength and hope in their shared experiences and mutual support.

The aftermath of the Rwanda genocide in 1994 against the Tutsi provides a strong example of how community healing and justice played crucial roles in the process of rebuilding Rwandan society and fostering reconciliation among its people. Community healing in Rwanda involved various initiatives aimed at addressing the deep wounds and divisions caused by the genocide. One important aspect of community healing in Rwanda was the introduction of community-based programs focused on reconciliation, forgiveness, and rebuilding social cohesion. These programs involved grassroots initiatives, such as community dialogues, healing workshops, and memorial events. They provided spaces for open discussions, empathy, and understanding, allowing survivors and perpetrators to engage in dialogue and collectively heal the wounds of the past. Through these processes, community healing in Rwanda aimed to rebuild trust and foster a sense of unity among its diverse population. Parallel to community healing, the pursuit of justice was a critical component in the aftermath of the Rwanda genocide. The International Criminal Tribunal for Rwanda (ICTR) [153] was established by the United Nations to prosecute those responsible for the genocide. The ICTR sought to hold high-ranking officials and leaders accountable for their actions, ensuring that justice was served at an international level. This pursuit of justice aimed to provide a sense of closure for the survivors, acknowledge the gravity of the crimes committed, and deter future atrocities. At the community

153 United Nations, *Rwanda: Background to Justice* https://www.un.org/en/preventgenocide/rwanda/pdf/bgjustice.pdf (accessed May 16, 2024).

level, Rwanda also implemented a system of community-based courts called Gacaca to complement the international justice efforts. These courts focused on lower-level offenders who played a role in the genocide. By involving the local communities, Gacaca sought to promote truth-telling, reconciliation, and accountability. The Gacaca process allowed perpetrators to confess their crimes, seek forgiveness, and participate in community service as a form of reparations, thereby contributing to the healing and reintegration of the community.

While the focus of trauma-informed services is typically on supporting survivors of human rights violations, it is important to recognize that individuals who have committed such violations may also have experienced trauma themselves. Although it is crucial to hold perpetrators accountable for their actions, understanding the potential underlying trauma they may have experienced can help inform the development of effective interventions. Within justice systems and in programming focused on reintegration, it is important to consider how we support the wellbeing of those formerly involved in perpetrating terrorism. Processing harmful behaviours of the past has the potential to remind the individual of painful memories, and trauma-informed care should be provided to these individuals to do so safely and aligned with the collective healing of their broader communities.

## CONCLUSION

Over the course of this chapter, we have focused on the complexities of psychological terror and its relationship to trauma. This has included unpacking the terminology surrounding terrorism, and recognizing the geopolitical landscape within which this sits. It is clear that an internationally agreed-upon definition of terrorism is a necessary step towards creating a united approach in addressing how terror and trauma are weaponized by armed opposition groups to distil far and harm on a population, to prevent misuse of anti-terrorism legislation on activists and advocates, or to perpetuate harmful myths and stereotypes rooted in xenophobia and racism. Addressing media bias and ensuring fair and consistent coverage of all acts of violence, regardless of the perpetrators' background, is essential in fostering a more inclusive and united society. It also helps in identifying and addressing the underlying issues that drive individuals towards extremist ideologies, irrespective of their racial or ethnic backgrounds. Recognizing acts of terrorism for what they are, regardless of who commits them, is a vital step towards countering violent extremism and promoting social cohesion. It is important to recognize that media coverage can be influenced by geopolitical interests.

Recognizing that "terrorists" are not born, but rather sociopolitical structures create environments where violence thrives and where individuals holding historically marginalized identities and reduced access to essential services are at heightened risk of involvement in violent activity. The importance for the field of psychology and mental health more broadly to work together with the field of international human rights, criminal and humanitarian law is evident, and the potential in doing so to create stronger, more trauma informed and survivor-centered approaches to this work is clear. This can include advancing how we provide trauma-informed psychological services for survivors and their families, and of IHRL violations, integrating trauma-informed approaches to mental health into detention and other settings of incarceration, continuing to strengthen our trauma informed approach to international investigations, and investing in community-owned and contextualized models of recovery from trauma and abuse. Further research in this area is needed, particularly regarding practical context specific examples, the perspectives of survivors and witness themselves in all their diversity, and recommendations for both the mental health and legal communities on policy, advocacy and programmatic efforts needed in this space.

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

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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.[154] 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

154 J.D. Kinzie et al., Posttraumatic Stress Disorder among Survivors of Cambodian Concentration Camps, 141(5) Am. J. Psychiatry 645 (1984).

of Mental Disorders.[155] 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.[156] A rare exception to this trend was a study that found a PTSD rate of 12.1% among 223 refugees in New Zealand.[157] 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.[158] 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.[159] Probable PTSD was significantly associated with mental disability.

For many years, the validity of applying the PTSD diagnosis cross-culturally was questioned.[160] However, researchers have found that the trauma symptoms noted from Cambodian refugees are nearly ubiquitous with those of trauma victims around the globe.[161] In addition, a report on Khmer adolescents noted that PTSD surmounts variants of language and culture.[162] 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.[163]

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155 Am. Psychiatric Ass'n, Diagnostic and Statistical Manual of Mental Disorders (1980)

156 E.B. Carlson & R. Rosser-Hogan, Trauma Experiences, Posttraumatic Stress, Dissociation, and Depression in Cambodian Refugees, 148(11) Am. J. Psychiatry 1548 (1991).

157 P. Cheung, Post-traumatic Stress Disorder among Cambodian Refugees in New Zealand, 40(1) Int'l J. Soc. Psychiatry 17 (1994).

158 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).

159 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).

160 See, e.g., M. Eisenbruch, From Posttraumatic Stress Disorder to Cultural Bereavement: Diagnosis of Southeast Asian Refugees, 33(6) Soc. Sci. & Med. 673 (1991).

161 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).

162 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).

163 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.

Among Cambodian refugees, there are other psychiatric conditions that co-exist with PTSD. We reported on posttraumatic psychosis among Cambodian refugees in our Intercultural Program.[164] 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.[165] 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.[166] 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.[167] Somatization—the manifestation of physical symptoms with no identifiable physical origin—is often the presenting complaint among Cambodians with depression and PTSD.[168] 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.[169] 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.[170] 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

164 J.D. Kinzie & J. K. Boehnlein, Post-traumatic Psychosis among Cambodian Refugees, 2(2) J. Traumatic Stress 185 (1989).
165 R.F. Mollica et al., Psychiatric Effects of Traumatic Brain Injury Events in Cambodian Survivors of Mass Violence, 181 Brit. J. Psychiatry 339 (2002).
166 Id.
167 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).
168 P. Cheung, Somatisation as a Presentation in Depression and Post-traumatic Stress Disorder among Cambodian Refugees, 27(3) Austl. & N.Z. J. Psychiatry 422 (1993).
169 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).
170 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.

complaints among Cambodian refugees has continued to show the links between trauma and certain somatic symptoms such as dizziness and weakness, and psychological symptoms such as "thinking a lot."[171]

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.[172] 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.[173] Overall, the least acculturated were found to have the highest rate of psychiatric morbidity.[174]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.[175] 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.[176] In the thirty days prior to the interview, only 26% reported any alcohol consumption and only 2% reported heavy drinking.[177] Recent alcohol consumption was not related to the degree of trauma exposure or psychiatric distress.[178]

171 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)

172 R.G. Blair, Risk Factors Associated with PTSD and Major Depression Among Cambodian Refugees in Utah, 25(1) Health & Soc. Work 23 (2000).

173 P. Cheung, Acculturation and Psychiatric Morbidity among Cambodian Refugees in New Zealand, 41(2) Int'l J. Soc. Psychiatry 108 (1995).

174 *Id.*

175 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).

176 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).

177 *Id.*

178 *Id.*

## REACTIVATION

Among the more predominant aspects of PTSD, especially among refugees, is the tendency for remissions and exacerbations of symptoms. New stresses, especially those that are personally threatening, can reactivate the entire syndrome even after a period of quiescence. Our group found that 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.[179]

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.[180] 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.[181]

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 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.

179 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).

180 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).

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

## MEDICAL PROBLEMS AMONG CAMBODIAN SURVIVORS

An early report from Cambodian refugee camps in Thailand indicated multiplecommondiseasessuchaspneumonia, diarrhea, measles, andmeningitis.[182] 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.[183] The original rate of malnutrition among children, which was 15% in 1979, was reduced to 1% a year later.[184] 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.[185] In a community survey of 381 Cambodians in Massachusetts, 44% reported fair or poor health.[186] 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.[187] 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.[188] Particularly, the odds ratio[189]134 for hypertension, or high blood pressure, was 1.49 for Cambodian girls to black and white children.[190]

The high prevalence of diabetes and hypertension among our refugee psychiatric patients is striking. In our study of refugees from Vietnam, Cambodia, 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.[191] 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

182 B. Feldstein & R. Weiss, *Cambodian Disaster Relief: Refugee Camp Medical Care*. 72(6) Am. J. Pub. Health, 589 (1982).
183 B.S. Levy, *Special Report: Working in a Camp for Cambodian Refugees*, 304(23) New Eng. J. Med.1440 (1981).
184 *Id.*
185 S.M. Pickwell, Health of Cambodian Refugees, 1(1) J. Immigrant Health 49 (1999).
186 S. Koch-Weser et al., Self-reported Health among Cambodians in Lowell, Massachusetts, 17(2) Supp. J. Health Care Poor & Underserved 133 (2006).
187 *Id.*
188 R.G. Munger et al., Elevated Blood Pressure among Southeast Asian Refugee Children in Minnesota, 133(12) Am. J. Epidemiology 1257 (1991).
189 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.
190 *Id.*
191 J.D. Kinzie et al., High Prevalence Rates of Diabetes and Hypertension among Refugee Psychiatric Patients, 196(2) J. Nervous & Mental Disease 108 (2008).

and incidence of dementia in older veterans with PTSD.[192] 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.[193] 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.[194]

Furthermore, the norm of children moving away from the family home as

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192 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).
193 J.K. Boehnlein, Clinical Relevance of Grief and Mourning among Cambodian Refugees, 25(7) Soc. Sci. & Med. 765 (1987).
194 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).

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),[195] 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.[196] When Cambodian-American children and adolescents have been studied in community settings over time, they generally function quite well despite a continuingly high prevalence of PTSD.[197] For Cambodian adolescents living in North America, an adverse connection between symptomatology and scholastic achievement[198] or social adjustment[199] has been largely undermined. In fact, the maintenance of core values amid implicit family duty to succeed may foster resilience among these adolescents with an intergenerational legacy of trauma.[200]

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.

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195 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).

196 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).

197 See Kinzie et al., A Three-year Follow-up of Cambodian Young People Traumatized as Children, supra note 195; 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).

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

199 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).

200 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).

## 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.[201] 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.[202] 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,[203] and were associated with older age, poor English language proficiency, unemployment, retirement or disability, and poverty.[204] In Cambodia, a national probability sample found that PTSD was significantly associated with both mental and physical disability.[205]

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.[206] 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 States[207] also showed that, decades after the Khmer Rouge era, comorbid depression and PTSD put survivors at risk for physical health problems.

201 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 179.

202 J.K. Boehnlein et al., A Ten-year Treatment Outcome Study of Traumatized Cambodian Refugees, 192(10) J. Nervous & Mental Disease 658 (2004).

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

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

205 Sonis, supra note 159.

206 IR.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).

207 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).

## 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 prazosin[208] and clonidine.[209] 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.

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.[210] 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.[211] 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.[212]

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208 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).

209 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).

210 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).

211 T.C. Daley, Beliefs about Treatment of Mental Health Problems among Cambodian American Children and Parents, 61(11) Soc. Sci. & Med. 2384 (2005).

212 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).

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 previous trauma.[213] Modifying exposure-based cognitive behavioral therapy (CBT) by using metaphors and a culturally relevant process can be effective and acceptable to Cambodian patients.[214] 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.[215] 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.[216] In this context the role of a healer is to aid in reestablishing equilibrium between the survivor and his or her environment.

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213 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).

214 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).

215 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).

216 R. Hinton Desjarlais et al.., World Mental Health (1995); D. Summerfield, War and Mental Health: A Brief Overview, 321 Brit. Med. J. 232 (2000).

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.[217] 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.[218] Among Cambodian refugees in the United States, parent-child 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 conflict[219] and child abuse and neglect in lieu of parental substance abuse and mental illness,[220] 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.[221]

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

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217 J.K. Boehnlein et al., Cambodian American Families, in Working With Asian Americans: A Guide for Clinicians (E. Lee ed., 1997).

218 J.K. Boehnlein et al., A Comparative Study of Family Functioning Among Vietnamese and Cambodian Refugees, 183(12) J. Nervous & Mental Disease 768 (1995).

219 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).

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

221 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).

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

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This chapter reports on the results of a needs assessment survey of rural Cambodians that was undertaken by the Documentation Center of Cambodia (DC-CAM) as part of their Victims of Torture (VoT) project. The project was conceived by the Director of DC-Cam, Youk Chhang, and implemented by 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 Questionnaire[222] and the Hopkins Checklist.[223] 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.[224] 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.[225] 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

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

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

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

225 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).

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 some smaller resistance groups.[226] 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

226 William Shawcross, The Quality of Mercy: Cambodia, Holocaust, and Modern Conscience (1984); Fiona Terry, Condemned to Repeat? The Paradox of Humanitarian Action (2002).

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.[227] That instrument, however, simply combines an assessment of the 16 DSM-III-r criteria[228]173 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.[229] The components of the SSI and their meaning in the Cambodian culture, including the relationship to PTSD severity, have been documented in multiple articles.[230] 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

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227 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).

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

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

230 *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).

DSM-IV PTSD items, like amnesia or numbing, seem to be a much less salient aspect of the trauma response in non-Western cultures.[231] 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

**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-SS1.*

231 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).

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); ethnophysiology[232]/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.[233]

## 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 example of a noise-caused startle or response to trauma reminders, two of the DSM-IV PTSD symptoms.[234] By bringing about this combination of arousal and arousability, the psychobiology of trauma may cause traumatized

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

233 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).

234 D.E. Hinton et al., *Worry and its Relationship to PTSD among Traumatized Cambodian Refugees: A Path Analysis*, Soc. Sci. & Med. (forthcoming).

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.[235] Indeed, certain Asian populations, such as Cambodian refugees, appear to be particularly predisposed to both of these symptoms.[236]

## 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."[237] 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.[238] 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.

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235 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).

236 *See id.*; D.E. Hinton & B.J. Good, *A Medical Anthropology of Panic Sensations, supra* note 233.

237 D.E. Hinton et al., *Khyâl Attacks: A Key Idiom of Distress among Traumatized Cambodia Refugees,* 34(2) Culture, Med., & Psychiatry 244 (2010).

238 D.E. Hinton et al., *A Unique Panic-disorder Presentation among Khmer Refugees: The Sore-neck Syndrome*, 25(3) Culture, Med., & Psychiatry 297 (2001).

## 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.[239]

## TRAUMA ASSOCIATIONS TO SOMATIC SENSATIONS

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

Certain somatic symptoms are prominent among Cambodians because the specific somatic symptom was strongly and specifically induced by the nature of Khmer Rouge-era trauma. In respect to dizziness, almost all Cambodians were forced to do slave labor while starving, which caused 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

239 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 233. 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 231.

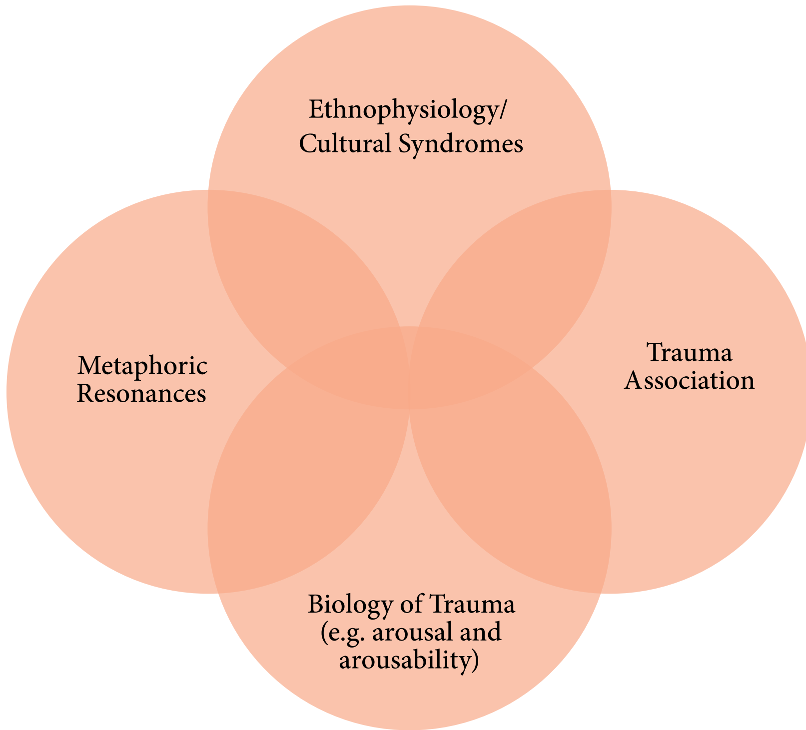


**Figure 1. Dizziness and the Four Symptom Dimensions in the Cambodian Context.** *Dizziness may relate to each of these four processes for certain individuals. For other individuals, dizziness events may involve all four dimensions in reciprocating interaction: trauma causes dizziness (e.g., a predisposition to dizziness upon standing) and that dizziness gives rise to trauma associations, metaphoric associations, andfears of disordered ethnophysiology.*

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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.[240]

240 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).

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.[241]

## 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.[242] 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.

As described above (see Figure 2 and Table 2), Cambodian greatly fear *khyâl* attacks. Most Cambodians consider *khyâl* to be a potentially pathogenic element.[243] 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).[244]

241 D.E. Hinton, *The 'Multiplex Model' of Somatic Symptoms, supra* note 233.

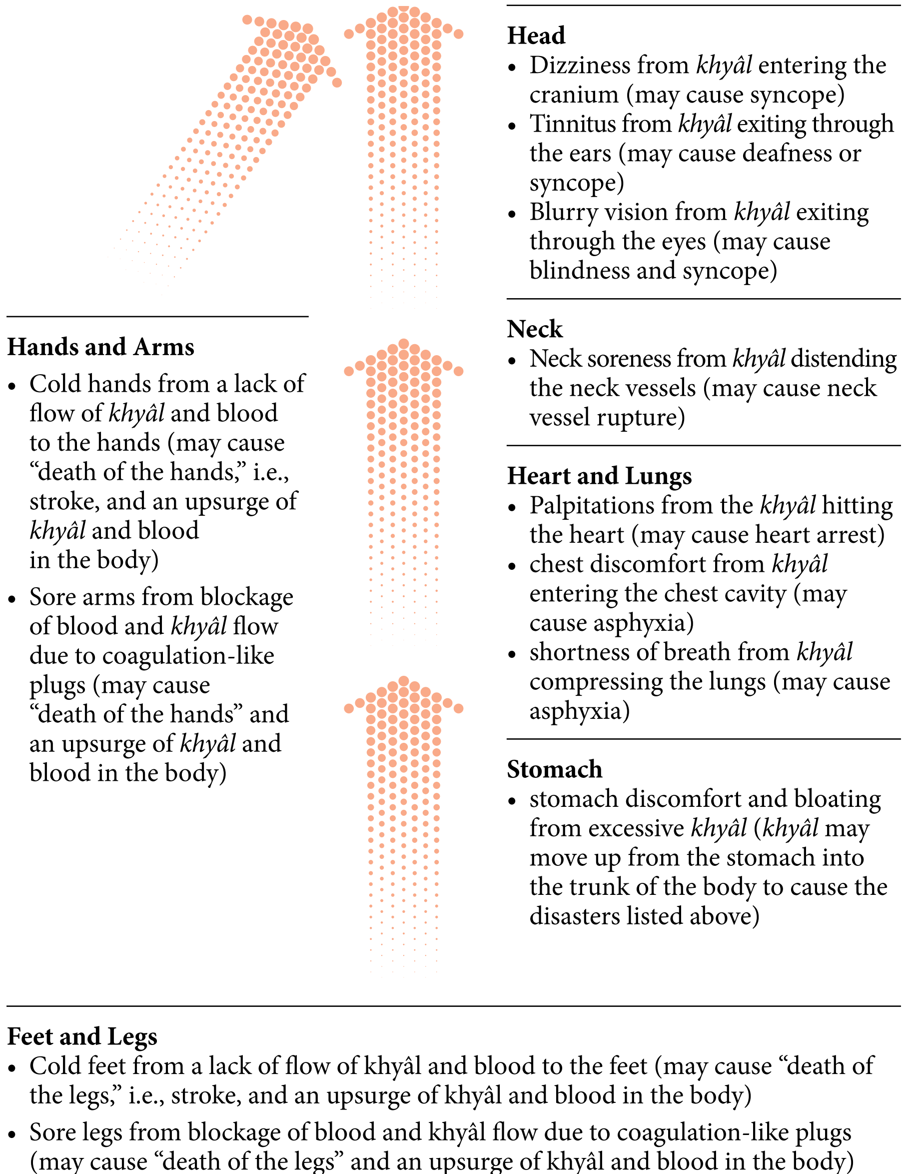
242 For more on these syndromes, see D.E. Hinton et al., The Khmer "Weak Heart" Syndrome: Fear of Death from Palpitations, 39 Transcultural Psychiatry 323 (2002); D.E. Hinton et al., Kyol Goeu ("Wind Overload") Part I: A Cultural Syndrome of Orthostatic Panic among Khmer Refugees, 38 Transcultural Psychiatry 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.

243 D.E. Hinton et al., *Khyâl Attacks: A Key Idiom of Distress, supra* note 237.

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

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




**Feet and Legs**

- Cold feet from a lack of flow of khyâl and blood to the feet (may cause "death of the legs," i.e., stroke, and an upsurge of khyâl and blood in the body)
- Sore legs from blockage of blood and khyâl flow due to coagulation-like plugs (may cause "death of the legs" and an upsurge of khyâl and blood in the body)

**Figure 2. A *khyâl* attack: Ethnophysiology, symptoms, and associated disasters.** *The arrows represent the flow of khyâl and blood up in the body during a khyâl attack. Normally khyâl flows downward in the direction opposite of these arrows, exiting the body through the hands and feet, through bodily pores, and down the gastrointestinal tract.*

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

| 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 |

| Symptoms | Correlated Physiological State | Feared Consequence |
| --- | --- | --- |
| 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 complaintdescribes 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.[245] Because sleep paralysis is given a culturally-specific meaning in the Cambodian context—it is referred to as "a ghost pushes you down" (khmaoch sangot)—we consider this a cultural syndrome. In sleep paralysis, the person suddenly finds him- or herself unable to move or speak, and sometimes sees a shape coming towards his or her body. In the clinical setting, Cambodian patients often describe seeing a shape, usually a black shadow, during almost all episodes of sleep paralysis. The person often experiences chest tightness and shortness of breath as the shape approaches and pushes down on the body. Cambodians often consider this to be a dangerous assault by a malevolent being, such as the ghost of a person they saw killed during the Pol Pot period or of a person who died in the house in which they are now living.

## THE NEEDS ASSESSMENT SURVEY

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

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

245 D.E. Hinton et al., "The Ghost Pushes You Down": Sleep Paralysis-type Panic Attacks in a Khmer Refugee Population, 42 Transcultural Psychiatry 46 (2005).

## 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).[246] In the current study, we used a conservative cut-off score of 34 for assessing probable PTSD.[247]

*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.

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246 D.E. Hinton et al., *Anger, PTSD, and the Nuclear Family: A Study of Cambodian Refugees*, 69 Soc. Sci. & Med. 1387 (2009).
247 S.D. McDonald & P.S. Calhoun, *The Diagnostic Accuracy of the PTSD Checklist: A Critical Review,* 30 Clinical Psychol. Rev. 976 (2010).

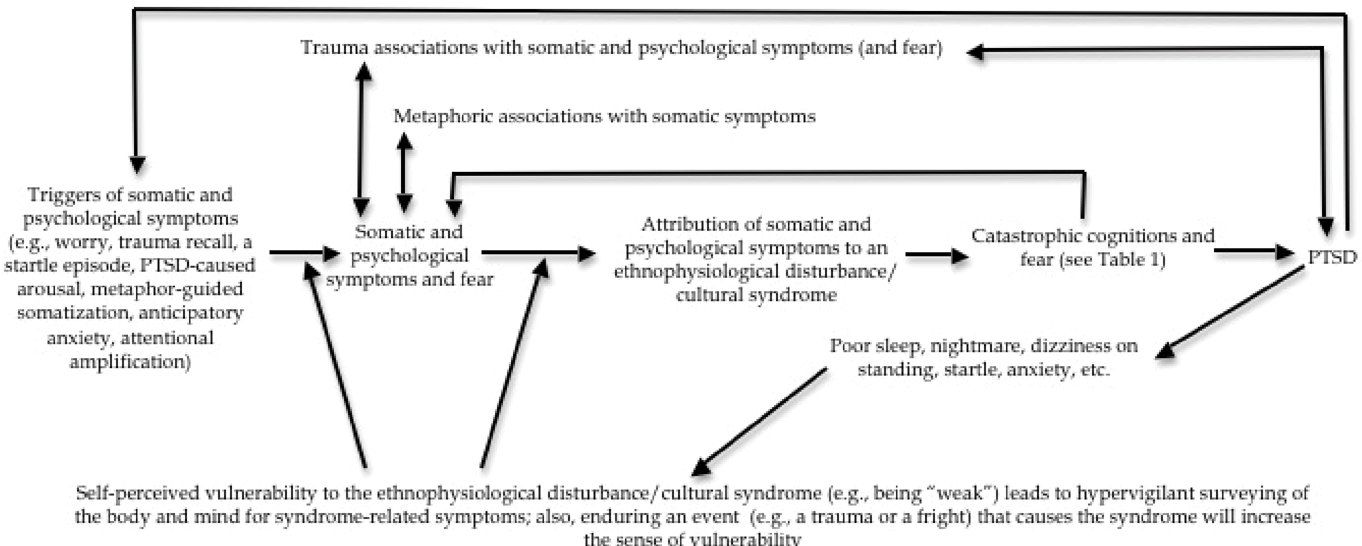


**Figure 3. The Multiplex Model of the Cultural Syndrome–PTSD interaction among patients with PTSD.**

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 theses 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.

*Harvard Trauma Questionnaire: Trauma Event Section.* The Harvard Trauma Questionnaire, which was developed initially for evaluating Southeast Asian populations,[248] 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.[249] 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.[250] 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)*.

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248 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).
249 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).
250 *Id.*

## 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.[251]

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

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

251 $F(2, 63) = 8.1$, $p < .001$.

| 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.*

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.[252] Kleinman and Kleinman[253] 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.[254]

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.[255] 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.[256] 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.

252 D.E. Hinton & B.J. Good, *A Medical Anthropology of Panic Sensations, supra* note 233.

253 A. Kleinman & J. Kleinman, *How Bodies Remember, supra* note 233.

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

255 D.E. Hinton, *The Khmer "Weak Heart" Syndrome, supra* note 242; D.E. Hinton, *The SF-36 among Cambodian and Vietnamese Refugees, supra* note 249.

256 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).

## 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 ethnopsychologial 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.[257] 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.

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257 *See* Edward Shorter, From Paralysis to Fatigue: A History of Psychosomatic Illness in the Modern Era (1992) (discussing "symptom pools").

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

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.

258 *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).

# 5 TRANSCULTURAL PSYCHIATRY

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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.[260] 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.[261]

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

259 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.

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

261 Kent, *A. Reconfiguring security: Buddhism and moral legitimacy in Cambodia*, Security Dialogue, 37(3), 343–361, (2006).

Western psychological practice.[262] 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,"[263] and emphasizes the importance of understanding the cultural meaning of symptoms.[264] Langford argues for the importance of understanding the Khmer cultural significance of ancestor veneration and the "social existence of the dead."[265] 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.[266]

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

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262 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 Cambodiancivilians living in Cambodia and Thailand*, 60(1), International Journal of Social Psychiatry, 6–20, (2014).

263 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).

264 Stevens, C. A., *Perspectives on the meaning of symptoms among Cambodian refugees*, 37(1), Journal of Sociology, 81–98, (2001).

265 Langford, J. M., *Gifts intercepted: Biopolitics and spirit debt*, 24(4), Cultural Anthropology, 681–711, (2009).

266 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).

## 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.[267] However, Eisenbruch has noted the limitations of simply transposing Western diagnostic categories to characterize the distress experienced by Cambodian refugees.[268] 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.[269]

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*[270] (broken courage) should be recognized by mental health professionals in order to "provide appropriate support for traumatized Cambodians."[271] He 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,

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267 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., Hean, 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).

268 Eisenbruch, M., *From post-traumatic stress disorder to cultural bereavement: Diagnosis of southeast Asian refugees,* 33(6), Social Science and Medicine, 673–680, (1991).

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

270 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.

271 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).

and cope with their distress.[272] 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.[273] 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*).[274] 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.[275]

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 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.[276] Nickerson and Hinton also state that many turn to Buddhist monks for advice about managing their

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272 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).

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

274 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 (CSSI),* 50(3), Transcultural Psychiatry, 347–370, (2013).

275 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).

276 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 (CSSI),* 50(3), Transcultural Psychiatry, 347–370, (2013).

feelings and that all of the monks they interviewed cited mindfulness and meditation as key methods for regulating anger.[277]

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.[278] 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.[279] 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

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

277 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).

278 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.

279 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).

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.[280]

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-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.

280 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-securedreparations-victims-khmer-rouge.

## 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.[281]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*

281 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).

> *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*).[282] 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 phluv 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,[283] 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.[284]

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282 Kent, A., *Reconfiguring security: Buddhism and moral legitimacy in Cambodia,* (2006).
283 Right view, right intentions, right speech, right action, right livelihood, right effort, right concentration, and right mindfulness.
284 Kent, A., *Reconfiguring security: Buddhism and moral legitimacy in Cambodia,* (2006).

The Khmer term generally used for wellbeing or peace of mind is *sekkadai sok*. The word sok is derived from the Pali term *sukkha*, 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.[285]

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 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 theending of a relationship has begun to be problematized by Western scholars.[286] In Cambodia, it is recognized that healthy grieving involves maintaining a good relationship with the dead and perhaps assisting the dead

285 *Id,* pp. 351-352.
286 For example, see Berns, N., *Closure: The rush to end grief and what it costs us,* (2011), Philadelphia, PA: Temple University Press.

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 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.[287] 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 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.[288]

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287 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).

288 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).

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,[289] which forms part of the funeral rites in Cambodia and elsewhere in Theravada Buddhist Southeast Asia.[290] The term pansukula refers specifically to a white cloth that is used to cover the corpse and that represents asceticism,[291] but also refers more generally to the ritual process that includes a particular form of rhythmic chanting by the monks: "the chant of death."[292] This chanting follows the rhythm of the breath and is held by many Cambodians to have a powerful, calming effect on the audience—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.[293] 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.*[294]

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

289 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).

290 Davis, E. W., *Treasures of Buddha: Imagining death and life in contemporary Cambodia,* (Unpublished doctoral dissertation, 2009), University of Chicago, IL; Phra Khru Anusaranasanakiarta, & 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).

291 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).

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

293 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)

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

merit-making for the restless souls of the dead continues for a full two weeks.[295] This is also an important opportunity to perform rituals that may alleviate complicated grief among Khmer Rouge survivors.[296] *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.[297]

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 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.[298]

***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,

295 Holt, J. C., *Caring for the dead ritually in Cambodia,* 1(1), Southeast Asian Studies, 3–75, (2012).
296 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).
297 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.
298 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).

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.[299] 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 awide 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 "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."[300] 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.*

299 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).

300 Mey, personal communication, October 25, 2011

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 feel that they are not alone and that they can learn what it means to be a citizen with rights and responsibilities.[301] 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

his 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.

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

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.[302]

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).[303] "Third wave" methods include a heterogeneous group of approaches such as acceptance and commitment therapy (ACT),[304] dialectical behavior therapy (DBT),[305] compassion-focused therapy (CFT),[306] mindfulness-based stress reduction (MBSR),[307] mindfulness-based cognitive therapy (MBCT),[308] and culturally adapted cognitive-behavioral therapy (CA-CBT).[309] 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"[310] correspond well with Western notions of core "emotion reg-

302 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-securedreparations-victims-khmer-rouge.

303 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).

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

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

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

307 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.

308 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.

309 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).

310 Nickerson, A., & Hinton, D. E., *Anger regulation in traumatized Cambodian refugees: The perspectives of Buddhist monks,* 35, Culture, Medicine, and Psychiatry, 396–416, (2011).

ulation and distress tolerance skills,"[311] how to "restore self-regulation,"[312] and "how to tolerate feelings and sensations by increasing the capacity for interception."[313] 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.[314] However, further studies of local therapeutic processes of healing are needed.[315]

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. [316] 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.[317] 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

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311 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.

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

313 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.

314 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).

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

316 Kirmayer, L. J., *Mindfulness in cultural context,* 52(4), Transcultural Psychiatry, 447–469, (2015).

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

truncation" to which Hinton, Peou, et al. allude.[318] 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."[319] 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.

318 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).
319 Good, B. J., *Medicine, rationality, and experience: An anthropological perspective,* (1994), Cambridge, UK: Cambridge University Press.

PART | 2

# THE IMPACT OF TRAUMA ON THE EXTRAORDINARY CHAMBERS IN THE COURTS OF CAMBODIA

# 6 THE EFFECTS OF TRAUMATIC MEMORY AND SECONDARY TRAUMA IN THE EXTRAORDINARY CHAMBERS IN THE COURTS OF CAMBODIA: RECOMMENDATIONS FOR FUTURE TRIBUNALS

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Cambodians who lived through the Khmer Rouge era have endured and survived some of the worst human rights atrocities known to humankind. It is now more than four and a half decades after the Vietnamese invaded Cambodia and ended the Khmer Rouge reign in early 1979. From 2006 to 2022, the Extraordinary Chambers in the Courts of Cambodia (ECCC) investigated and prosecuted a small number of the senior Khmer Rouge leaders and those deemed most responsible for crimes committed from April 17, 1975 to January 6, 1979. Three were convicted of crimes ranging from genocide, crimes against humanity, war crimes, murder, and torture.[321,322] Dozens of Cambodian survivors provided testimony in the ECCC proceedings and some were able to participate in pre-trail and trial processes as Civil Parties.

320 The authors wish to thank Drs. Yael Fischman and John Briere for their contributions in the development of this Chapter.
321 Associated Press, After 16 years and 3 convictions, an international tribunal closes down in Cambodia (22 September 2022) NPR https://www.npr.org/2022/09/22/1124432798/cambodia-khmer-rouge-tribunal
322 United Nations, Cambodia: UN-backed tribunal ends with conviction upheld for last living Khmer Rouge leader (22 September 2022) UN News https://news.un.org/en/story/2022/09/1127521.

This chapter will summarize common psychosocial effects of trauma and examine these effects in the context of Cambodian survivors. We will discuss how trauma and other posttraumatic sequelae[323] might impact a survivor-witness' memory and ability to testify in court. We will also highlight the potential risk for re-traumatization or secondary traumatization of witnesses, legal representatives, adjudicators, interpreters, and other court staff. Finally, we will present recommendations for adopting trauma-informed practices in future tribunals to protect survivor witnesses and promote the well-being of court personnel.

At the time of the writing of this third book of this manuscript, the ECCC has completed all trials and is in its residual phase, focused on ensuring its sentences are enforced, protecting victims and witnesses, managing its archives, and engaging in public dissemination of information. In Case 001, which addressed crimes committed at Tuol Sleng prison (Security Prison S-21), Kaing Guak Eav ("Comrade Duch", who ran the Tuol Sleng prison where thousands were tortured) was convicted of crimes against humanity, war crimes, and torture. He received a 35-year sentence that the appellate court later changed to life in prison. Nuon Chea and Khieu Samphan were convicted in Case 002/01 and Case 002/02 of crimes against humanity, grave breaches of the Geneva Conventions genocide, and war crimes and sentenced to life imprisonment. The first book of *Cambodia's Hidden Scars* was entered into evidence during the trial of Case 002/01, 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.

The updated version of this chapter includes expanded discussion of the importance of mental health and a trauma-informed approach in the ECCC and other human rights tribunal court 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 Unite 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

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

the ECCC Trial Chamber's Judgment in Case 002/01.[324] This Chapter aims to: (1) provide an understanding of the effects of human-induced trauma, so that courts can adequately undertake their work without doing disservice to traumatized witnesses or staff; (2) provide information related to the mental health of survivors and their communities following the commissions of genocide, crimes against humanity, war crimes, and torture that will be useful the judges of human rights tribunals in the future as they deliberate and issue their judgments; (3) and advocate for courts to use an overarching trauma-informed approach in future tribunals.[325]

## PSYCHOLOGICAL CONSEQUENCES OF TRAUMA

Our world is rife with examples of traumatic events accompanied by devastating consequences, dating back to its earliest recorded history. A trauma is generally thought of as a highly stressful event that overwhelms the individual's ability to cope. Common peri-traumatic (occurring at the time of the trauma) and posttraumatic responses include feelings of intense fear, helplessness, loss of control, powerlessness, and sometimes the threat of annihilation. Risk factors for developing traumatic stress and 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 response received by the survivor will shape a survivor's response to trauma.[326] Natural events such as earthquakes can produce such reactions, but human-induced trauma adds the problem of producing distrust of other humans. Indeed, controlling a populace through terror is often one of the intended goals of military and police in repressive regimes, because such a reaction inhibits the political organization of an opposition. A situation of state terror can also inhibit 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. The courts must recognize this disctinction in people whose victimization occurred many years in the past.

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

325 Extraordinary Chambers in the Courts of Cambodia. (n.d.). The Extraordinary Chambers in the Courts of Cambodia (ECCC) were established to bring to trial senior leaders of Democratic Kampuchea and those most responsible for crimes during the period from 17 April 1975 to 6 January 1979. https://www.eccc.gov.kh/en

326 J. Briere & C. Scott, *Principles of trauma therapy: A guide to symptoms, evaluation, and treatment* (2006).

## POSTTRAUMATIC STRESS DISORDER

A major historical turning point in the field of traumatic stress came in 1980 when the diagnosis of posttraumatic stress disorder (PTSD) first appeared in the American Psychiatric Association's *Diagnostic and Statistical Manual* (DSM), Third Edition.[327] 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 phenomenon has retained its currency in the field.[328] In 2018, the World Health Organization (WHO) released its 11th revision of the International Statistical Classification of Diseases and Related Health Problems (ICD-11).[329] In addition to PTSD, the ICD-11 included a new diagnostic category of Complex PTSD (CPTSD) that encompassed posttraumatic reactions that were more wide-ranging and complex. The ICD-11 is the most used diagnostic manual in the world, utilized by all member states of the WHO. The latest version of the DSM (the DSM-5-TR) does not include CPTSD as a distinct diagnosis; however, it does include a sub-type of PTSD (PTSD with dissociative symptoms of depersonalization or derealization) that contains CPTSD symptoms.[330]

Many survivors of trauma—but not all—develop full-blown PTSD, CPTSD and/or clinical depression. Many others experience at least some of the distressing symptoms of these conditions, which can negatively affect their functioning and sense of well-being. PTSD has 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-5[331] diagnostic criteria must be met for a person to be diagnosed with PTSD. CPTSD encompasses the PTSD diagnostic criteria of reexperiencing, avoidance, and hypervigilance and adds the following features that are characteristic of disturbances in self-organization: affect dysregulation, negative self-concept, and difficulties in relationships.[332,333]

327 Am. Psychiatric Ass'n, Diagnostic and Statistical Manual of Mental Disorders: DSM-III (1980).
328 J. Briere, *Psychological Assessment of Adult Posttraumatic States: Phenomenology, Diagnosis, and Measurement* (2d ed. 2004).
329 World Health Organization, ICD-11 – International Statistical Classification of Diseases and Related Health Problems 11th Revision (2018).
330 Am. Psychiatric Ass'n, Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition, Text Revision (2022).
331 Am. Psychiatric Ass'n, Diagnostic and Statistical Manual of Mental Disorders (5th edition): DSM-5 (2013).
332 M. Cloitre et al., ICD-11 *Post-Traumatic Stress Disorder and Complex Posttraumatic Stress Disorder in the United States: A Population-Based Study*, 32 J. Traumatic Stress 833 (2019).
333 M. J. Bovin et al., *Literature on DSM-5 and ICD-11: An Update*, 32 PTSD Res. Q. 1 (2021).

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.[334] A systematic review of studies examining the prevalence of CPTSD in refugees and asylum seekers found high rates of CPTSD, between 16 and 38% in treatment-seeking samples, and between 2.2 and 50.9% in population samples (the prevalence was 2.2 to 9.3% in 4 out of the 5 population samples[335]). In a study of 101 asylum-seekers receiving specialized trauma services in London, 66.23% of those with complete assessments met ICD-11 criteria for CPTSD with a high degree of associated impairment and distress.[336] Studies of settled refugee populations have found higher rates of CPTSD compared to PTSD,[337,338] and while both CPTSD and PTSD were associated with cumulative trauma in refugees.[339] Disturbances in self-organization symptoms (one of the CPTSD criteria) were associated with living difficulties post-migration[340] and insecure visa status.[341] More research is needed to establish CPTSD prevalence in these populations.

## CROSS-CULTURAL APPLICATION OF THE PTSD CONSTRUCT

The role of culture is critical in determining the expression of symptoms (e.g., somatic complaints, cultural concepts of distress), conceptualization of problems (e.g., cultural bereavement342 versus PTSD), causes ascribed to illnesses, causes of trauma, meaning of trauma/distress, coping efforts, and healing practices. PTSD is perhaps the most commonly thought of psychological outcome of trauma, but it does not begin to capture all of what a traumatized person experiences. Briere and Scott note that PTSD should, at least partially, be considered culture-bound in the sense that it most closely reflects the

334 J.T. de Jong et al., *Lifetime Events and Posttraumatic Stress Disorder in Four Postconflict Settings*, 286 JAMA 555 (2001).
335 U. de Silva et al., *Prevalence of Complex Post-Traumatic Stress Disorder in Refugees and Asylum Seekers: Systematic Review*, 7 BJPsych Open 6:e194 (2021).
336 S. Jowett et al., Complex *Post-Traumatic Stress Disorder in Asylum Seekers and Victims of Trafficking: Treatment Considerations*, 7 BJPsych Open 6:e181 (2021)
337 A. Barbieri et al., *Complex Trauma, PTSD and Complex PTSD in African Refugees*, 10 Eur. J. Psychotraumatol. 1700621 (2019).
338 A. Nickerson et al., *The Factor Structure of Complex Posttraumatic Stress Disorder in Traumatized Refugees*, 7 Eur. J. Psychotraumatol. 33253 (2016).
339 B. J. Liddell et al., *Complex Posttraumatic Stress Disorder Symptom Profiles in Traumatized Refugees*, 32 J. Traumatic Stress 822–832 (2019).
340 T. Hecker et al., *Differential Associations Among PTSD and Complex PTSD Symptoms and Traumatic Experiences and Postmigration Difficulties in a Culturally Diverse Refugee Sample*, 31 J. Trauma Stress 795–804 (2018).
341 Liddell, *supra* note 173.
342 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).

posttraumatic responses of Anglo/European people.[343] Great attention has been focused in recent years on the cross-cultural assessment of the impact of psychological trauma and its consequences.[344] The construct of PTSD has been criticized from a transcultural perspective as imposing a Western medicalized approach, requiring avoidant/numbing symptoms that may not be found typically in survivors from some cultures, and failing to include somatic and dissociative symptoms often found in non-North American populations.[345] At the same time, a review found considerable evidence of the cross-cultural validity of PTSD.[346] 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. Significant questions remain, however, about whether the diagnosis of PTSD is applicable in non-Western cultures, in part as it may not capture the full range of trauma reactions in some cultural settings.[347] Cultural variations in how CPTSD symptoms are expressed have been found in populations in Sub-Saharan Africa, pointing to the need to incorporate cultural considerations when diagnosing.[348]

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)*[349] 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.[350] Mollica

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343 J. Briere & C. Scott, *supra* note 160.

344 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).

345 Am. Psychol. Ass'n, Ethnocultural Aspects of Posttraumatic Stress Disorder: Issues, Research, and Clinical Applications (A. J. Marsella et al. eds., 1996).

346 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.

347 R. A. Bryant et al., *Posttraumatic Stress Disorder in Refugees*, 19 Annu. Rev. Clin. Psychol. 413–436 (2023); A. R. Patel & B. J. Hall, *Beyond the DSM-5 Diagnoses: A Cross-Cultural Approach to Assessing Trauma Reactions*, 19 Focus (Am. Psychiatr. Publ.) 197-203 (2021).

348 Hinton, D. E., & Good, B. J. (Eds.). *Culture and PTSD: Trauma in Global and Historical Perspective*. Philadelphia: University of Pennsylvania Press, 2015.

349 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).

350 D.E. Hinton et al., *Khyâl Attacks: A key Idiom of Distress among Traumatized Cambodia Refugees,* 34(2) Cultural Med. Psychiatry 244 (2010).

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).[351]

## MAJOR DEPRESSIVE DISORDER

Persistent depression has been found in many studies of those who have been chronically traumatized.[352] Major Depressive Disorder is one of the primary psychiatric outcomes of trauma, regardless of the type of trauma. In some populations, depression is more prevalent than PTSD.[353] Approximately half of people with PTSD are also diagnosed with Major Depressive Disorder.[354]

## OTHER POSTTRAUMATIC OUTCOMES

The symptoms of distress that are found in the DSM-IV-TR[355] 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,[356] guilt/shame symptoms, dissociative symptoms, aggressive/externalizing symptoms, and negative appraisals about the world and oneself.[357] 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,[358] 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

351 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).

352 J.L. Herman, Trauma and Recovery: The Aftermath of Violence–From Domestic Abuse to Political Terror (1992).

353 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).

354 Flory, J. D., & Yehuda, R. (2015). Comorbidity between post-traumatic stress disorder and major depressive disorder: Alternative explanations and treatment considerations. *Dialogues Clin Neurosci, 17*(2), 141-50. doi: 10.31887/DCNS.2015.17.2/jflory

355 Am. Psychiatric Ass'n, Diagnostic and Statistical Manual of Mental Disorders : DSM-IV-TR (2000).

356 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.

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

358 J. Briere & C. Scott, *supra* note 160.

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.[359]

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 behaviors[360] in the absence of adequate ability to regulate affect (e.g., substance use, binging and purging, self-mutilation, compulsive or indiscriminant sexual behavior, suicidality, other problems with impulse control or forms of externalizing anxiety reduction strategies), psychosis, dissociation, sexual problems, somatic symptoms (including chronic pain), cognitive distortions, and self-blame, guilt, and/or low self-esteem.[361,362] 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.[363] In situations of human-perpetrated trauma, the survivor's capacity to trust others, form healthy interpersonal bonds, retain a positive sense of identity, maintain their 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.[364] The relationship, however, is complex.[365] Episodes of dissociation during and after a trauma are often conceptualized as a psychological defense mechanism,[366] 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 their experience.

359 *Id.*
360 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).
361 J. Briere & C. Scott, *supra* note 160.
362 R. A. Bryant et al., *Posttraumatic Stress Disorder in Refugees,* 19 Annu. Rev. Clin. Psychol. 413–436 (2023); A. R. Patel & B. J. Hall, *Beyond the DSM-5 Diagnoses: A Cross-Cultural Approach to Assessing Trauma Reactions*, 19 Focus (Am. Psychiatr. Publ.) 197-203 (2021).
363 J. Briere, M. Hodges & N. Godbout, *Traumatic Stress, Affect Dysregulation, and Dysfunctional Avoidance: A Structural Equation Model*, 23(6) J. Traumatic Stress 767 (2010).
364 F.W. Putnam, Dissociation in Children and Adolescents: A Developmental Perspective (1997); Dissociative Disorders: A Clinical Review (D. Spiegel ed., 1993).
365 J. Briere & C. Scott, *supra* note 160.
366 D. Spiegel, *Dissociation and Trauma, in* 10 American Psychiatric Press Review of Psychiatry 261 (A. Tasman & S.M. Goldfinger eds., 1991).

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 their trauma. Persistent dissociation has been found to be associated with trauma and PTSD in some traumatized individuals,[367] and the survivor may experience symptoms of depersonalization, amnesia, derealization, and/or fugue.[368] Trauma may have an impact on memory years later as a result of symptoms of persistent posttraumatic dissociation in those survivors who experience this phenomenon.

## PTSD AND DEPRESSION RATES IN TRAUMATIZED POPULATIONS

By the time they reach adulthood, many people around the world have experienced some trauma in their lives. The possible consequences of trauma exposure are many, and include chronic physical and mental health conditions and health-related diminutions in quality of life.[369] 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.[370] 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).[371] The most recent National Epidemiologic Survey on Alcohol and Related Conditions in the U.S. (the NESARC-III survey) found a 6% lifetime prevalence of PTSD in the general U.S. population, and a higher prevalence (7%) in U.S. Veterans.[372]

The rate found in refugees and torture survivors is higher.[373,374] 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

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

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

369 G.N. Marshall et al., *Diabetes and Cardiovascular Disease Risk in Cambodian Refugees*, 18(1) J. Immigrant & Minority Health 110-117 (2016); M. Bogic et al., *Long-term Mental Health of War-Refugees: A Systematic Literature Review*, 15 BMC Int'l Health & Hum. Rts. 29 (2015); P. S. Corso et al., *Health Related Quality of Life Among Adults Who Experienced Maltreatment During Childhood*, 98(6) Am. J. Pub. Health 1094 (2008).

370 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).

371 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).

372 R.B. Goldstein et al., *The Epidemiology of DSM-5 Posttraumatic Stress Disorder in the United States: Results from the National Epidemiologic Survey on Alcohol and Related Conditions-III*, 51(8) Soc. Psychiatry & Psychiatr. Epidemiol. 1137-1148 (2016)

373 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).

374 Bryant, *supra* note 181.

counterparts from the general population among whom they are residing.[375] 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.[376] 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,[377] especially in those with PTSD. In one review, 40% of refugees with PTSD made suicide attempts.[378] A more recent 2010 review found a prevalence of suicidal behavior ranging from 3.4% to 34% in refugees.[379] In another study, the primary cause of premature death in Australian detention centers was suicide.[380]

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 enormous strengths that have enabled them to endure and survive their experiences, as well as persevere and thrive in their lives.[381,382] Indeed, trauma treatment can facilitate resiliency in some survivors.

## POSTTRAUMATIC SEQUELAE IN CAMBODIA AND IN CAMBODIAN REFUGEES

Between 1975 and 1979, the Khmer Rouge killed approximately two million Cambodians. In 1975, the population of Cambodia was estimated at 7.1 million. An additional one million were killed in the civil wars prior to and following the Khmer Rouge era.[383] The persecution experienced by Cambodians at the hands of the Khmer Rouge amounted to crimes against humanity, war crimes, 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

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375 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).

376 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).

377 L. Vijayakumar, *Suicide Among Refugees – A Mockery of Humanity*, 37(1) Crisis 1 (2016).

378 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).

379 L. Vijayakunar & 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).

380 N. G. Procter, *Suicide and Self-Harm Prevention for People In Immigration Detention*, 199(11) Medical Journal of Australia 730 (2013).

381 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).

382 M. Alachkar, *The Lived Experiences of Resilience Among Syrian Refugees in the UK: Interpretative Phenomenological Analysis*, 47(3) BJPsych Bull. 133-139 (2023)

383 R.J. Rummel, Death by Government (1994).

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 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.[384]

Cambodians who survived the Killing Fields and remained in Cambodia, and those who fled as refugees, have experienced extremely high levels of trauma.[385] 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,[386] 15% were

384 See Cambodian Genocide Databases (CGDB) at Yale University: https://gsp.yale.edu/cambodian-genocide-databases-cgdb. The CGDB were developed by a team from Yale University, the Documentation Center of Cambodia (DC-Cam), and the University of New South Wales (UNSW) in Sydney, Australia.

385 J.T. de Jong et al.*, Lifetime Events, supra note 168; 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).

386 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.

found to suffer from PTSD, 55% suffered from depression, and 20% reported health impairments.[387] Mollica, Poole, and Tor[388] 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.[389]

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.[390] 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.[391]

The lifetime PTSD rate among the population in Cambodia has been estimated to be over twenty percent.[392] 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.[393] 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. Face-to-face interviews conducted with a national probability sample of 1017 adult Cambodian residents before the Khmer Rouge trials started found that probable PTSD was common and associated with mental and physical disability.[394] The prevalence of current probable PTSD in the overall sample was 11.2% (14.2% in those who were at least

387 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).
388 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).
389 *Id.*
390 G.N. Marshall et al., *Mental Health of Cambodian Refugees, supra* note 219.
391 J.K. Boehnlein et al*., A Ten-year Treatment Outcome Study of Traumatized Cambodian Refugees*, 192 J. Nervous & Mental Disease 658 (2004).
392 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).
393 J.T. de Jong, D.H. Komproe & M. Van Ommeren, *Common Mental Disorders in Postconflict Settings*, 361(9375) Lancet 2128 (2003).
394 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 JAMA 527–536 (2009).

3 years old at the start of the Khmer Rouge genocide in 1975 and 7.9% in those who were not alive during the Khmer Rouge era).

It is common for traumatized individuals to experience fluctuating symptoms, with periods of exacerbations and remissions in response to traumatic triggers.[395] 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.[396] Among Cambodian refugees treated at psychiatric clinics in the United States, similarly high rates of psychopathology have been found (92% PTSD,[397] 56% PTSD,[398] and 60% panic disorder[399]). 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.[400] 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.[401] THI can result from blows to the head, anoxia (from water-boarding, near drowning, and suffocation), strangulation, and other head injuries. In a study with Vietnamese ex-political prisoners who were tortured, THI was found to have harmful effects on their brains and to be correlated with depression. The authors concluded that PTSD and depression resulting from THI can be associated with difficult to treat chronic post-concussive symptoms.[402] Clinicians should assess for possible underlying traumatic brain injuries in refugee survivors who present with PTSD and depression, as they would likely require a different approach to treatment.[403]

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

396 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).

397 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).

398 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).

399 D. Hinton et al., *Panic Disorder Among Cambodian Refugees Attending a Psychiatric Clinic: Prevalence and Subtypes*, 22(6) Gen. Hosp. Psychiatry 437 (2000).

400 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).

401 R.F. Mollica et al., *Psychiatric Effects of Traumatic Brain Injury Events in Cambodian Survivors of Mass Violence*, 181 Br. J. Psychiatry 339-347 (2002).

402 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); Mollica, R. F., Chernoff, M. C., Berthold, S. M., Lavelle, J., Lyoo, I. K., & Renshaw, P. (in press). The mental health sequelae of traumatic head injury in South Vietnamese ex-political detainees who survived torture. *Comprehensive Psychiatry*. Advance online publication. doi: 10.1016/j.comppsych.2014.04.014

403 R.F. Mollica et al., *Psychiatric Effects of Traumatic Brain Injury Events in Cambodian Survivors of Mass Violence,* 181 Br. J. Psychiatry 339-347 (2002).

Cambodian refugees in the United States have been found to have unusually high rates of serious chronic physical health problems that jeopardize their functioning, quality of life, and longevity when compared to the general U.S. population and other Asian immigrants. This is true even when matched on demographic indicators often found to be associated with poor health.[404] 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.[405] 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).[406] The literature in Cambodian and other populations on high rates of Type 2 diabetes, metabolic syndrome, and hypertension[407,408,409] and the relationship between trauma, PTSD, and chronic physical health problems is growing.[410] 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 painful.[411] 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

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404 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* http://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).

405 J.D. Kinzie et al., *High Prevalence Rates of Diabetes and Hypertension, supra* note 238.

406 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.

407 *Id.*

408 M. Tamaoki et al., *Prevalence of Metabolic Syndrome and Its Components in Urban Cambodia: A Cross-Sectional Study,* 12(3) J. Epidemiol. Glob Health 224-231 (2022).

409 J. Wagner et al., *Diabetes and Cardiometabolic Risk Factors in Cambodia: Results from Two Screening Studies,* 10(2) J. Diabetes 148-157 (2018).

410 J.D. Kinzie et al., *High Prevalence Rates of Diabetes and Hypertension, supra* note 238.

411 R.F. Mollica, Healing Invisible Wounds: Paths to Hope and Recovery in a Violent World (2009).

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. In the late 1990s, in an effort to rebuild mental health services in Cambodia that were destroyed during the 1970s Khmer Rouge era, significant mental health education and training was conducted in Cambodia. A large treatment gap remains, however, for those with mental health conditions, particularly in rural areas.

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.[412] 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).[413] 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.[414]

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412 M. Eisenbruch, J.T. de Jong & W. van de Put, *Bringing Order Out of Chaos, supra* note 178; 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).

413 M. Eisenbruch, J.T. de Jong & W. van de Put, *Bringing Order Out of Chaos, supra* note 178.

414 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).

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

### 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.[415] In particular, The sequelae of trauma can have a profound effect on the ability of Cambodian survivors to testify effectively in ECCC proceedings. Several factors can greatly interfere with the ability of survivors to provide a consistent and coherent narrative account of their relevant trauma experiences in formal court proceedings, including the nature of the trauma 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 they must do so in front of authorities, individuals who perpetrated atrocities, their family members, and their fellow countrymen and women. These testimonial problems may occur even if a given survivor does not meet the full criteria for PTSD or Major Depressive Disorder. The problems that these survivor-witnesses exhibit in court may contribute to their testimony being found unreliable or not credible. It is critical that the court be knowledgeable or educated about these issues in victims and witnesses. The impact of head trauma can have a negative impact on their functioning.

Although the experiences of Cambodian survivors vary, all of these impediments to victim-witnesses providing effective testimony before the ECCC existed in Cambodian survivors. Although the witness's age and region of residence during the Khmer Rouge reign may have given 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,[416] researchers on the mental health consequences of the Cambodian killing fields,[417] reports provided to the authors during the

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415 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).

416 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).

417 G.N. Marshall et al., *Mental Health of Cambodian Refugees, supra* note 219; R.F. Mollica, G. Wyshak & J. Lavelle, *The Psychosocial Impact of War Trauma, supra* note 234; 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).

course of clinical work with Cambodian survivors in the 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 of the Killing Fields) is impairment of the ability to concentrate. This inability to concentrate can make it difficult for the survivor to focus on lengthy and complex questioning in ECCC proceedings and to respond to questions with all of the relevant facts.

Avoidance of traumatic reminders, including avoiding thinking or talking about one's traumatic experiences, is 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 traumas[418] 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.[419] 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.

The complexity, scope, intensity, and duration of the traumas experienced by survivors of the Khmer Rouge era makes it particularly difficult for them to quickly or concisely summarize or even describe their trauma.[420] This can be compounded by their mental health status[421] and the understandable mistrust that some survivors have 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

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418 R.F. Mollica, Healing Invisible Wounds, *supra* note 245.

419 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.

420 R.F. Mollica, Healing Invisible Wounds, *supra* note 245.

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

stress symptoms: avoidance and the inability to recall aspects of the traumatic experiences. If Cambodian survivors have been psychologically invested for several decades in avoiding thinking about or talking about what happened to them, they may not have had the opportunity to integrate their memories or to sufficiently revisit the details to be able to accurately recount them. Similar to findings in Western populations, diverse refugees and asylum seekers with PTSD and depression have been observed to have lower memory specificity (i.e., a lower proportion of specific memories) and refugees and asylum seekers with PTSD more frequently did not report any memory.[422]

Additionally, flashbacks during court proceedings may occur when the survivor feels as though they are reliving the trauma in the present. The survivor's recalling and retelling of their traumatic experiences and their 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.

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 their testimony may be affected by the threats (e.g., withholding some facts).

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422 B. Graham et al. *Overgeneral Memory in Asylum Seekers and Refugees,* 45(3) J. Behav. Therapy & Experimental Psychiatry 375-380 (2014).

**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.[423]

High levels of emotion have been found to result in impaired memory of even non-traumatic events.[424] 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. Refugees struggle more with retrieving specific autobiographical memories,[425] which may be especially pronounced in refugees who have PTSD when they seek to retrieve traumatic memories.[426]

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

424 J. Herlihy & S. Turner, *Asylum Claims and Memory of Trauma: Sharing our Knowledge*, 191 Brit. J. Psychiatry 3 (2007).

425 Graham, *supra* note 256.

426 C.E. Wittekind et al., *Age Effect on Autobiographical Memory Specificity: A Study on Autobiographical Memory Specificity in Elderly Survivors of Childhood Trauma*, 54 J. Behav. Therapy & Exp. Psychiatry 247–253 (2017).

Often the person does not compose a complete verbal narrative for their 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 or fragments that evoke similar feelings as those they 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. Inconsistent memories, particularly the fluctuation of memories of traumatic experiences over time, are often reported with refugees and should not be construed as evidence of fabrication.[427,428,429]

**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

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427 S. Khan et al., *A Systematic Review of Autobiographical Memory and Mental Health Research on Refugees and Asylum Seekers,* 12 Front. Psychiatry 658700 (2021).

428 C. Panter-Brick et al., *Trauma Memories, Mental Health, and Resilience: A Prospective Study of Afghan Youth*, 56 J. Child Psychol. Psychiatry 814–825 (2015).

429 A. Saadi et al., *Associations Between Memory Loss and Trauma in US Asylum Seekers: A Retrospective Review of Medico-Legal Affidavits*, 16 PLoS One e0247033 (2021).

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. 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 them or the emotional content) rather than precise, specific details that were peripheral to their experience (e.g., the exact number of people present in the room, the color of the wall in the room in which they was gang raped, exactly how many times they 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.[430] 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. 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.[431] Testifying about one's traumatic experiences is a time of high arousal that tends to invoke defensive strategies in the witness, particularly if they are feeling threatened. Such feelings of threat may occur during an aggressive cross-examination that feels like interrogation (as if they were on trial themselves).

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 their 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

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

431 J. Briere, *supra* note 194; F.W. Putnam, *Dissociative Phenomenon, in* Dissociative Disorders: A Clinical Review (D. Spiegel ed., 1993).

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. All of these challenges may be intensified by the distress of testifying in formal proceedings in front of powerful officials and those responsible for their 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 Protection by the Court, Including Preparation & Support of Survivor- Witnesses**

Witnesses often must confront their alleged perpetrator(s) and relive their traumas in court proceedings, including through sometimes intense cross examination. There is significant risk that the survivor witnesses may develop powerful psychological and physiological reactions (e.g., extreme fear, anger, trembling, sweating, flashbacks, or other forms of dissociation) that may overwhelm and harm them and jeopardize their ability to testify. Witnesses frequently worry about their ability to testify publicly about their experiences and express concern for their own and/or their loved ones' safety if they testify.[432]

Given the great potential for retraumatization and for compromising survivor- witnesses' ability to testify, human rights courts should proactively adopt protocols to psychologically protect survivor-witnesses and make resources available to adequately prepare and support these witnesses. The International Criminal Court has recognized this. The Rome Statute of the ICC, adopted in 1998 and entered into force in 2002, requires the Court's

432 Human Rights Center, UC Berkeley School of Law, Bearing Witness at the International Criminal Court: An Interview Survey of 109 Witnesses (2014), https://www.law.berkeley.edu/files/HRC/Bearing-Witness_FINAL(3).pdf.

Registry to establish and sustain a Victims and Witnesses Unit (VWU). As part of its charges, the VWU provides, "in consultation with the Office of the Prosecutor, protective measures and security arrangements, counseling and other appropriate assistance for witnesses, victims who appear before the Court, and others who are at risk on account of testimony given by such witnesses."[433] The ICC has trauma experts on staff who are victim- (or survivor-) centered, have expertise related to sexual trauma, and whose role it is to advise the Court on measures that should be taken to support and prevent psychological harm to survivor witnesses, and follow up with witnesses after they have finished testifying and returned home.[434] The Court has adopted special measures related to trauma and vulnerability to attend to and protect the mental health of witnesses as they work to facilitate their testimony while also preventing psychological harm that may come from testifying.[435] For example, wide ranging measures have been taken such us having a psychologist monitor the witness' wellbeing during a court proceeding, shielding the accused in the courtroom so that the accused is not able to make eye contact with the witness (which could be intimidating or frightening for the witness), permitting the witness to testify from outside the courtroom through a video-link, allowing the witness to have a support person sit next to them in court, or adapting the questioning to the capacities or needs of the witness (e.g., in the case of sexual violence, limiting unnecessarily repetitive, intrusive or embarrassing questions[436]).

In the case of the ECCC, the TPO 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.[437]

Ideally, all survivors appearing in court would receive official clinical support.[438] Specifically, psychological preparation is strongly recommended to facilitate the witness's understanding of the court process, the scope and purpose of their testimony (including the limits of the testimony that they will be asked to supply), as well as the reasons why certain questions may

433 Rome Statute, art. 43(6).

434 International Criminal Court. [n.d.] The trauma expert. https://www.icc-cpi.int/get-involved/justice-at-work/story/the-trauma-expert

435 International Criminal Court. [n.d.] Witnesses. https://www.icc-cpi.int/about/witnesses

436 *Id.*

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

438 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).

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 post-traumatic 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 support[439] Many will not have the resources to access the care that they need. Institutional support from the Court is recommended to ensure that essential services are available when the witnesses return home. 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).[440]

## 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,

439 J. Strasser, et al., *Engaging Communities - Easing the Pain: Outreach and Psychosocial Interventions in the Context of the Khmer Rouge Tribunal, in* We Need the Truth. Enforced Disappearances in Asia (K. Lauritsch & F. Kernjak eds., 2011).
440 Extraordinary Chambers in the Courts of Cambodia, Internal Rules, (Rev 8) (adopted 3 August 2011)

loss of dignity, psychological trauma and grief arising from the loss of relatives."[441] It has been noted (including in other chapters of this volume) that there is room for improvement in the way mental health was 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.[442]

*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 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.[443] 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 publicly speak out against human rights abuses.

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,[444] a view not held by all mental health professionals and trauma specialists. The impact on victims is individualized.[445] Public testimony is not universally beneficial and can have some unintended negative

441 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

442 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/

443 ECCC, *supra* note 158.

444 *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).

445 Human Rights Center, UC Berkeley School of Law. (2014). Bearing witness at the International Criminal Court: An interview survey of 109 witnesses. https://www.law.berkeley.edu/files/HRC/Bearing-Witness_FINAL(3).pdf

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 that they would 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 the possibility of retraumatization or secondary/vicarious trauma in the staff of the Court.[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 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 are at risk for developing symptoms of secondary trauma or, in some cases, being re-traumatized in the

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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); E. Stover et al., *Confronting Duch: Civil Party Participation in Case 001 at the Extraordinary Chambers in the Courts of Cambodia*, 93(882) Int'l Rev. Red Cross 503-546 (2011).; I. Agger & S. Chhim, *Psychological Aspects of Victim Participation in Cambodia's Extraordinary Chambers*, 22 VRWG Bulletin 7 (2013).

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.

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[450,451] somewhat in lawyers and judges[452,453,454] and least of all in interpreters.[455]

**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 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.*[456]

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

450 J.M. Hensel et al., *Meta-Analysis of Risk Factors for Secondary Traumatic Stress in Therapeutic Work with Trauma Victims*, 28 J. Trauma Stress 83-91 (2015).

451 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.

452 S. Iversen & N. Robertson, *Prevalence and Predictors of Secondary Trauma in the Legal Profession: A Systematic Review*, 28 Psychiatry, Psychology and Law 802-822 (2021).

453 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).

454 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).

455 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).

456 Y. Fischman, personal communication (on file with authors).

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.[457] Further work is needed to advance the field, in terms of defining secondary traumatic stress and in developing appropriate and effective assessments and interventions.[458]

**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.[459]

These symptoms may also appear in court personnel who work in settings in which violations of human rights are adjudicated.[460] 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.[461] 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.

457 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.

458 G. Sprang et al., *Defining Secondary Traumatic Stress and Developing Targeted Assessments and Interventions: Lessons Learned from Research and Leading Experts*, 25 Traumatology 72–81 (2019).

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

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

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

It is important to note that not all vicariously traumatized professionals will develop PTSD or depression. 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,[462] the intensity and extent of the impact of these symptoms in court personnel will tend to be less than that experienced by the primary survivor150. 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. 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 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 their 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.

Court 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

462 K.W. Saakvitne et al., Transforming the Pain: A Workbook on Vicarious Traumatization (1996).
463 R. Janoff-Bulman, Shattered Assumptions: Towards a New Psychology of Trauma (1992).

different for different personnel. The ECCC was a hybrid institution with many Cambodian staff members who were victims themselves and/or who knew 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 suffering distressing consequences. They are usually 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 their personal life; and significant isolation from others in their 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.

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.

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.[465] 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.[466] 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. The researchers identified that the interpreters' distress was related to triggers of their own traumas before they fled Serbian persecution in Kosovo. In particular, their clients' stories evoked anxiety about the well-being of family members left behind in Kosovo. This distress was also linked to the perceived lack of recognition and respect they received for their difficult work.

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

When secondary trauma develops in those who work in the legal arena, it typically transforms them (sometimes permanently) and affects not only their professional life, but their personal life as well. 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

465 S.L. Lustig et al., *Inside the Judges' Chambers, supra* note 288.

466 P.G. Jaffee, et al. *Vicarious trauma in judges: the personal challenge of dispensing justice*, 54(4) Juvenile and Family Court Journal 1 (2003).

clients.[467] The result can damage the attorney-client relationship if clients feel that their attorney is insensitive to their experiences and pain.[468] 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.[469] Interpreters may fear being perceived as emotionally weak and unable to deal with certain cases and therefor 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 study of U.S. immigration judges concluded with a number of recommendations to alleviate the judges' symptoms of secondary traumatic stress and burnout.[470] 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.[471]

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.[472] Mentoring and supervision that routinely addresses secondary trauma can be valuable as well.[473]

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467 Y. Fischman, *Secondary Trauma, supra* note 294.

468 T. Sagy, *Even Heroes Need to Talk, supra* note 298.

469 Y. Fischman, Secondary Trauma, *supra* note 294; A.P. Levin & S. Greisberg, *Vicarious Trauma in Attorneys, supra* note 287; T. Sagy, *Even Heroes Need to Talk, supra* note 298.

470 S.L. Lustig et al., *Inside the Judges' Chambers, supra* note 288.

471 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.*

472 A useful video training resource on vicarious trauma and vicarious resilience in forensic evaluators can be found at: https://asylummedtraining.org/module-11. It is one module in a larger online training on best practices in conducting forensic medical examinations in asylum cases developed by The Asylum Medicine Training Initiative (AMTI) based on content from the updated Istanbul Protocol 2022 (see https://www.ohchr.org/en/publications/policy-and-methodological-publications/istanbul-protocol-manual-effective-0).

473 H. Holmgren, H. Sondergaard & A. Elklit, *Stress and Coping in Traumatized Interpreters, supra* note 289; Y. Fischman, *Secondary Trauma, supra* note 294; S.M. Berthold & Y. Fischman*, Social Work with Trauma Survivors: Collaboration with Interpreters*, 59 Social Work 103-110 (2014)

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.[474]

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.[475] Our experience, however, shows that lack of funding may prevent these services from being offered. In addition, the problem of secondary trauma is only just becoming understood in legal circles. This may mean that lawyers, interpreters, judges, and others must take care of themselves in settings where exposure to trauma is high and institutional pressure to ignore secondary trauma requires handling as many cases as possible.

Even in such circumstances, there are steps that individuals can take to care for themselves.[476] 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),[477] which is a thirty-item, self-reported measure of the positive and negative aspects of

474 T. Sagy, *Even Heroes Need to Talk, supra* note 298.

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

476 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 285.

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

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),[478] 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[479]). In a relatively recent convening of experts on secondary traumatic stress, one priority identified was the need for further development of comprehensive and validated assessment measures.[480]

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.[481] 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.[482] 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)[483] secondary trauma training model addresses professionals' personal motivations for working with traumatized populations and connects it to larger issues of 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 tribunal staff should also be assessed and addressed, as such stressors have been identified as potential contributors to burnout in other settings.[485]

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478 B.E. Bride et al., *Development and Validation of the Secondary Traumatic Stress Scale*, 14(1) Res. Soc. Work Prac. 27 (2004).

479 The current version of the DSM (the DSM-5-TR) includes a fourth symptom cluster of negative alterations in cognitions and mood associated with the traumatic event(s). See: Am. Psychiatric Ass'n, Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition, Text Revision (2022).

480 G. Sprang et al., *Defining Secondary Traumatic Stress and Developing Targeted Assessments and Interventions: Lessons Learned from Research and Leading Experts*, 25 Traumatology 72–81 (2019).

481 This self-care worksheet was developed by K.W. Saakvitne et al., Transforming the Pain, *supra* note 296.

482 *Id.*

483 *Id.*

484 Y. Fischman, *Secondary Trauma, supra* note 294.

485 C. Maslach, et al., Job Burnout, 52 Annual Review of Psychology 397 (2001).

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 trials and other human rights tribunals.

486 J. Herlihy, *Improving Psychological Understanding in International Human Rights Trials*, Blogspot http://cselblog.blogspot.com/2012/01/improving-psychological-understanding.html; G. Langdon-Down, *Beyond the Killing Fields – Unlocking Witness Testimony*, The Times (Feb. 16, 2012), www.thetimes.co.uk/tto/law/article3321378.ece.

487 L. Marschner, *Implications of Trauma on Testimonial Evidence in International Criminal Trials, in* The Transformation of Human Rights Fact-Finding (P. Alston & S. Knuckey eds., 2016).

## CONCLUSIONS

Our overarching key recommendation, underscored by experiences from the ECCC legal proceedings and process, is that adopting trauma-informed practices in future tribunals is essential not only to protect survivor witnesses (and encourage their willingness to testify at all), but also to promote the well-being of court personnel who are at risk for secondary trauma. A trauma-informed approach promotes access to justice[488] and is consistent with theories and practices recognized and used in some courts: restorative justice, procedural justice, gender-responsive treatment, and therapeutic jurisprudence (where the well-being of those affected by the law or legal actions is taken into account by the court).[489] The Substance Abuse and Mental Health Services Administration, an agency in the U.S. Department of Health and Human Services, developed a widely used model of trauma-informed practices that includes: identifying the impact, signs, and symptoms of trauma; recognizing that those involved in court proceedings may have memories of their trauma(s) triggered; and designing practices and policies to lessen re-traumatization.[490]

Six key principles of this model are: safety; trust and transparency; peer support; collaboration and mutuality; empowerment, voice, and choice; and acknowledgment of cultural, historical, and gender issues.[491] Training court staff in this approach can contribute to reduce triggers and foster an increased sense of safety and well-being for those involved.

Information related to mental health and trauma following the commission of genocide and crimes against humanity is valuable for justices of 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 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. The proceedings of future tribunals should ensure that the questioning of survivor-witnesses is constrained to reduce retraumatization and the discounting

488 S. Cook, *Promoting Access to Justice Through Trauma-Informed Courts* (Aug. 19, 2021), https://www.prainc.com/gains-promoting-justice-trauma-informed-courts/.

489 N.C. McKenna & K. Holtfreter, *Trauma-Informed Courts: A Review and Integration of Justice Perspectives and Gender Responsiveness*, 30 J. Aggression, Maltreatment & Trauma 450-470 (2021); D.B. Wexler & B.J. Winick, Law in a Therapeutic Key: Developments in Therapeutic Jurisprudence (1996).

490 Substance Abuse and Mental Health Services Administration, SAMHSA's Concept of Trauma and Guidance for a Trauma-Informed Approach (2014).

491 *Id.*

of survivors' testimony because of the effects of trauma. Psychological preparation and support during and after testimony is highly recommended for the survivor-witnesses who participate in the tribunal 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 THE IMPORTANCE OF MASS TRAUMA EVIDENCE IN ACCOUNTABILITY BEFORE THE ECCC

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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 which, if unaddressed, 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, known as 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.[492]

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

492 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* http://www.eccc.gov.kh/en/document/court/case-00201-judgement.

on mental trauma related to Khmer Rouge atrocities. The impact hearing was widely publicized and broadcast throughout Cambodia, providing an opportunity for much needed education on 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 import 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 incorporated testimony from Case 002/1 and more evidence relating to psychological harm across victim populations to prove the link between crimes of the Khmer Rouge alleged in the case 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.[493] 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.[494] 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.[495] 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.[496]

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 and the subsequent forced transfer of the population as well as executions of members of the Lon Nol regime at Tuol Po Chrey in Pursat, and sentenced the Accused to life imprisonment.[497] 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, which began on 17 October 2014, included the remaining crimes charged in the original Closing Order and applied to a broader class of victims.[498]

493 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* http://www.eccc.gov.kh/sites/default/files/documents/courtdoc/D427Eng.pdf.

494 *See ECCC at a Glance*, ECCC (April 2014), http://www.eccc.gov.kh/sites/default/files/ECCC%20at%20a%20Glance%20-%2 EN%20-%20April%202014_FINAL.pdf (providing figures on victim participation and figures on the Court's outreach initiatives).

495 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.

496 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 http://www.eccc.gov.kh/en/document/court/severance-order-pursuant-internal-rule-89ter.*

497 See Case 002/1 Judgment, *supra* note 492, at 622.

498 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* http://www.eccc.gov.kh/en/document/court/decision-additional-severance-case-00202-and-scope-case-00202.

The judgment in case 002/02 was announced on 16 November 2018. The Chamber found Nuon Chea and Khieu Samphan guilty of crimes against humanity, grave breaches of the Geneva Conventions, and genocide of the Vietnamese ethnic, national and racial group, additionally convicting Nuon Chea of genocide of the Cham ethnic and religious group under the doctrine of superior responsibility. Both Accused were sentenced to terms of life imprisonment. The Chamber merged the sentences of each Accused in cases 002/01 and 002/02 into a single term of life imprisonment.[499]

The ability of victims to participate directly in criminal trials as Civil Parties and to request reparations were key components of the ECCC's adjudicatory process. To be admitted as a Civil Party before the ECCC, a victim was required to "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."[500] In Case 002, 3,867 victims were admitted as Civil Parties, with rights to seek reparations before the Court. The ECCC's reparation system was 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."[501] The Court's reparations were 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.[502] Due to the large volume of victims, individual Civil Parties were organized as part of a consolidated group made up of all victims participating in Case 002, and the request for reparations was submitted as a single request on behalf of the consolidated group.[503]

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499 See Co-Prosecutors v. Nuon Chea & Khieu Samphan, Case File No. 002/19-09-2007-ECCC/TC, Judgment (November 16, 2018) *available at* https://www.eccc.gov.kh/en/document/court/case-00202-judgement [hereinafter Case 002/2 Judgment].

500 Internal Rules of the Extraordinary Chambers in the Courts of Cambodia (rev. Jan. 16, 2015) [hereinafter "ECCC Internal Rules"], r. 23bis(1)(b).

501 *Id.* at r. 23*quinquies*(1).

502 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* http://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 Judgement, ¶658 (Feb. 3, 2012), *available at* http://www.eccc.gov.kh/en/document/court/case-001-appeal-judgement;

503 ECCC Internal Rules, *supra* note 500, 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

For judicial reparations, lawyers representing Civil Parties needed to establish a nexus between the harm suffered by the consolidated group of Civil Parties and the crimes upon which the Accused were convicted.[504] Before a decision on reparations could be made, Civil Party Lawyers had first to 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 was then made to address these harms.[505] The Victim Impact Hearing was designed to provide the evidence necessary to establish this nexus. Moreover, evidence of the lasting impact of these crimes on the Cambodian people was a relevant factor in determining the gravity of each crime for the purpose of sentencing the Accused as well as the issuance of appropriate reparations.[506] In Case 002/1, 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.[507]

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*

504 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, http://www.eccc.gov.kh/en/victims-support/vss-structure (last visited May 1, 2016).

505 ECCC Internal Rules, *supra* note 500, r. 23*quinquies*(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 23*quinquies*(3)(a)-(b) sought.").

506 Case 002/1 Judgment, *supra* note 492.

507 See Case 002/1 Judgment, *supra* note 492.

> *reparations claimed to remedy these harms. Accordingly, the Hearings on Impact are an essential mechanism for bringing the human toll of these crimes into the proceedings.*[508]

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.[509] 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.[510] 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.[511] 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.[512] The victims described being "terrified and shocked" at the sight of seeing corpses,[513] and the experience of ongoing nightmares and recurring memories of the traumatic events.[514]

In Case 002/1, the Trial Chamber permitted Civil Parties to express general statements of suffering, describing the overall harm suffered as a result of

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508 *The Purpose of Hearing Victims' Suffering*, ECCC Public Affairs Section (June 7, 2013), http://www.eccc.gov.kh/en/blog/2013/06/07/purpose-hearing-victims-suffering.

509 *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* http://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 492, ¶ 466 (Section 10: Movement of the Population (Phase One), ¶ 1144 (Section 19.4 Harm Suffered by the Civil Parties)).

510 *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 492, ¶1144.

511 *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 Vanndy); 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 492, ¶¶491, 1145.

512 Case 002/1 Trial Transcript, at 12 (June 4, 2013) (Testimony of Civil Party Ms. BAY Sophany).

513 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).

514 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).

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.[515] In Case 002/2, the Chamber split the trial into five segments, with a victim impact hearing at the end of each segment, during which hearing civil parties spoke directly to the court. In total 64 civil parties testified before the Chamber during hearings over the course of Case 002/02, providing evidence on the facts of the crimes under consideration during that segment and the harm they suffered as a result.[516] Although the Civil Party lawyers submitted no new oral testimony by psychological experts, they did submit a report, initially published in the previous editions of this book, entitled "The Mental Health Outcomes Resulting from Crimes Committed by the Khmer Rouge Regime."[517] And, the Trial Chamber recalled "testimony heard in Case 002/01 from Expert CHHIM Sotheara" in its final judgement and rulings on reparations.[518]

This testimony not only helped the Court to evaluate the magnitude of harm experienced by the victims, but it also contributed to a greater understanding and recognition of victim harm amongst Cambodian survivors in Cambodia and in the diaspora. 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.*[519]

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515 *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).

516 Co-Prosecutors v. Nuon Chea, et al., Case File No. 002/19-09-2007-ECCC-OCIJ, CIVIL PARTY LEAD CO LAWYERS' AMENDED CLOSING BRIEF IN CASE 002 02, ¶24, page 16 of 522 (October 2, 2017), *available at* https://www.eccc.gov.kh/en/document/court/civil-party-co-lawyers-amended-closing-brief-case-00202

517 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 Court s of Cambodia in Case 002/2, E285/2.1, The mental health outcomes resulting from crimes committed by the Khmer Rouge regime, Case 002/2, E3_10790_EN, *available at* https://www.eccc.gov.kh/en/document/court/corrected-1-mental-health-outcomes-resulting-crimes-committed-khmer-rouge-regime

518 Co-Prosecutors v. Nuon Chea & Khieu Samphan, Case File No. 002/19-09-2007-ECCC/TC, Judgment at ¶ 4437 (November 16, 2018) *available at* https://www.eccc.gov.kh/en/document/court/case-00202-judgement.

519 *The Purpose of Hearing Victims' Suffering*, ECCC Public Affairs Section (June 7, 2013), http://www.eccc.gov.kh/en/blog/2013/06/07/purpose-hearing-victims-suffering.

## THE EXPERT TESTIMONY OF DR. CHHIM SOTHEARA

The Case 002/1 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 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.[520]

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).[521] 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.[522] 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.[523] 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."[524] 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

520 See Case 002/1 Judgment, *supra* note 492, at 522 – 24, 582, 1142, 1150.
521 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)"].
522 *Id.* at 71.
523 *Id.*at 72.
524 *Id.* at 84.

to avoid discussing Khmer Rouge history with family members.[525] 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.[526] 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.[527]

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.[528] 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.[529] The avoidance of communicating about Khmer history can also lead to long-term suffering.[530]

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."[531] 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.[532]

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525 *Id.* at 71-72.
526 *Id.* at 104.
527 *Id.* at 85-86.
528 *Id.* at 71.
529 *Id.* at 72.
530 *Id.* at 86-87.
531 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").
532 Transcript of Dr. CHHIM Sotheara (June 5, 2013), *supra* note 521, at 73, 105.

## OBJECTIONS AND DIFFICULTIES PRESENT IN THE EXAMINATION OF DR. SOTHEARA

Throughout the examination of Dr. Sotheara several problems arose related to the relevance of the testimony, the psychological methodology, and simply understanding 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.

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.[533] Such damage is widespread, impacts future generations, and can result in severe mental disorders and even new pathologies unique to the crimes.[534] 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 would have 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

533 *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) (In a household survey of 1,320 Cambodians, 7% 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) (In a national, longitudinal study that covered a randomly selected sample of 813 Cambodians, 14% 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) (In a comparative community survey, 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).

534 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). The International Criminal Tribunal for the Former Yugoslavia heard evidence of a new pathology category called the "Srebrenca 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. Prosecutor v. Radislav Krstic, Trial Judgment, Case No. IT-98-33-T, ¶93 (Int'l Crim. Trib. for the Former Yugoslavia Aug. 2, 2001).

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 leaving their homes…."[535] 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?"[536] 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.[537]

This line of questioning elicited objections and concerns about the foundation of the evidence and the methodology underlying the expert's conclusions.[538] For example, in one exchange, lawyers for Civil Parties asked if the expert had ever encountered a victim who had suffered from hunger or

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535 Transcript of Dr. CHHIM Sotheara (June 5, 2013), note 850, 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?")

536 Transcript of Dr. CHHIM Sotheara (June 5, 2013), *supra* note 521, at 102.

537 *Id.* at 110. See Jeffrey Sonis et al., *Probable posttraumatic stress disorder and disability in Cambodia*, 302 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.

538 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 521, 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.

famine and what the 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."[539] 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.[540]

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.[541] Dr. Sotheara admitted that the research he had done thus far had come from clients who had sought out counseling and treatment from TPO.[542] 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 JUDGMENTS

In spite of several sustained objections by the defense, the evidence of psychological impact played a significant role in three aspects of the Case 002/1 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 judgment in Case 002/2, the Trial Chamber similarly relied on psychological evidence for deteriming the gravity of the harm at sentencing and to establish impact of the crimes on victims and victim communities in its rulings on reparations.[543]

In the final judgment against the two Accused in Case 002/1, 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

539 Transcript of Dr. CHHIM Sotheara (June 5, 2013), *supra* note 521, at 97.

540 Transcript of Dr. CHHIM Sotheara (June 6, 2013), *supra* note 531, 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."].

541 *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?")

542 *Id.* at 94.

543 See Case 002/2 Judgment, *supra* note 499, at ¶ 4453.

crimes against humanity.[544] "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.[545] 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*.[546]

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."[547]

in the Judgment in Case 002/1, 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.*[548]

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.[549] In addition, the Trial Chamber acknowledged that even witnessing or hearing traumatic events during the evacuation caused psychological disorders amongst surviving victims.[550]

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544 See Case 002/1 Judgment, *supra* note 492, at ¶¶ 552, 565, 645.

545 *Id.* at ¶¶ 434-437 (citing Prosecutor v. Kaing Guek Eav alias Duch, Case No. 001/18-07-2007/ECCC/TC, Trial Judgement, ¶ 368 (July 26, 2010), and Prosecutor v. Dragomir Miloševi , Case No. IT-98-29/1-A, Appeal Judgement, ¶108 (Int'l Crim. Trib. for the Former Yugoslavia Nov. 12, 2009)).

546 Case 002/1 Judgment, *supra* note 492, at ¶ 438 (citing Prosecutor v. Vasiljevi , Case No. IT-98-32-A, Appeal Judgement, ¶ 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 Judgement, ¶ 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 Judgement, ¶ 369 (ECCC, July 26, 2010).

547 Case 002/1 Judgment, *supra* note 492, at ¶ 439 (citing Prosecutor v. Kaing Guek Eav alias Duch, Case File No. 001/18-07-2007/ECCC/TC, Trial Judgement, ¶369 (July 26, 2010), and Prosecutor v. Vasiljevi , Case No. IT-98-32-A, Appeal Judgement, ¶165 (Int'l Crim. Trib. for the Former Yugoslavia Feb. 25, 2004). As noted in the Case 002/2 Judgment, some of these convictions were overturned by the Supreme Court Chamber on other grounds. See Case 002/2 Judgment, *supra* note 499, at ¶10.

548 *Id.* at ¶ 522 (citing 5 June 2013 Transcript of Dr. CHHIM Sotheara, *supra* note 521, at 71, 83).

549 *Id.* at ¶ 523 (citing 5 June 2013 Transcript of Dr. CHHIM Sotheara, *supra* note 521, at 80-82, 93-94).

550 *Id.* at ¶ 524 (citing 5 June 2013 Transcript of Dr. CHHIM Sotheara, *supra* note 521, at 95-96).

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 victims identified as "New People."[551]

Psychological trauma was also used to evaluate the gravity of the crimes for the purpose of sentencing. In Case 002/1, 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.[552] 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.[553]

This, along with several aggravating factors and the lack of significant mitigating factors, resulted in the first maximum sentence of life imprisonment against both Nuon Chea and Khieu Samphan in Case 002/1.[554] In Case 002/2, the Trial Chamber applied these same principles to impose a second (merged) life sentence on each Accused, relying this time primarily on victim statements to detail the mental and emotional harm victims suffered as a result of the crimes.[555]

Lastly, the testimony played a significant role in the findings for Civil Party reparations in both Case 002/1 and Case 002/2. Internal Rule 23 *quinquies*(1) requires that reparations awarded by the Chamber acknowledge and address the

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551 *Id.* at ¶ 582 (citing 5 June 2013 Transcript of Dr. CHHIM Sotheara, *supra* note 521, at 80-84, 95).

552 *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.").

553 *Id.* at ¶ 1077.

554 *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 Judgement, ¶583 (July 26, 2010), and Prosecutor v. Deronji , Case No. IT-02-61-A, Judgement on Sentencing Appeal, ¶¶106-107 (Int'l Crim. Trib. for the Former Yugoslavia July 20, 2005).

555 See Case 002/2 Judgment, *supra* note 499, at ¶¶ 4372-4376.

harm suffered by Civil Parties as a result of the commission of these crimes.[556] Citing several of the conclusions made by Dr. Sotheara in his testimony, the Court found in Case 002/1 that victims suffered from long-lasting trauma as a result of their experience under the Khmer Rouge. This trauma 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.[557]

The Trial Chamber returned to Dr. Sotheara's testimony in its rulings on reparations in Case 002/2, recalling that "the suffering inflicted on the Civil Parties as a result of the crimes committed by the Accused" had contributed to symptoms of long-term psychological damage.[558] The Trial Chamber recalled Dr. Sotheara's explanation of how many victims had suffered lasting trauma caused by their experiences of the Khmer Rouge, including post-traumatic stress disorder, depression, anxiety, paranoia, and nightmares.[559] On the basis of this expert testimony, the Trial Chamber was in a position to find that as a consequence of the crimes of the Accused, the Civil Parties and a broader class of victims had "suffered immeasurable harm, which includes physical suffering, economic loss, loss of dignity, psychological trauma and grief arising from the loss of family members or close relations."[560]

## 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

556 ECCC Internal Rules, *supra* note 500, 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.").
557 Case 002/1 Judgment, *supra* note 492, at ¶ 1150 (emphasis added).
558 Case 002/2 Judgment, *supra* note 499, at ¶ 4453.
559 *Id.*
560 *Id.*

conflict-affected individuals and communities.[561] 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, *inter alia*, for 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 the control of adults and cannot meaningfully choose to enlist in armed forces.[562] 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 defined and elaborated.[563] Dr. Schauer highlighted transgenerational trauma, whereby traumatic memory can be passed to the children and even grandchildren of the victims.[564] 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.[565] Finally, the expert explained what difficulties former child soldiers typically face in their re-integration into civilian society, especially for women and girls.[566] 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."[567]

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561 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* https://www.icc-cpi.int/iccdocs/doc/doc670786.PDF); *see also* vivo international Home Page, http://www.vivo.org/en/.

562 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 https://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* https://www.icc-cpi.int/iccdocs/doc/doc636752.pdf.

563 Testimony of Trial Chamber Expert Dr. Elizabeth Schauer, *supra* note 562, at 14-33; Dr. Shauer's Expert report, *supra* note 562, at 10-34.

564 Testimony of Trial Chamber Expert Dr. Elizabeth Schauer, *supra* note 562, at 30-31; Dr. Schauer's Expert Report, *supra* note 562, at 25-27.

565 Testimony of Trial Chamber Expert Dr. Elizabeth Schauer, *supra* note 562, 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.

566 Testimony of Trial Chamber Expert Dr. Elizabeth Schauer, *supra* note 562, at 76-77; Dr. Schauer's Expert Report, *supra* note 562, at 27-29.

567 Dr. Schauer's Expert Report, *supra* note 562, at 28.

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.[568] Mr. Lubanga was sentenced on July 10, 2012 to a total of 14 years of imprisonment,[569] and, on December 1, 2014, the Appeals Chamber confirmed, by majority, the verdict declaring Mr. Lubanga guilty as well as the sentencing decision.[570] 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 enlistment.[571]

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*

568 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).
569 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).
570 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).
571 Lubanga Trial Judgment, *supra* note 568, 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.)

> *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, 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 subjects suffering from the effects of trauma, including child soldiers and ex-combatants, children living in IDP camps, or children simply living in a country in conflict.[572] 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, where the crimes occurred. In fact, only one study she relied on drew information from Congolese subjects.[573] 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.[574]

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

572 See e.g., Testimony of Trial Chamber Expert Dr. Elizabeth Schauer, *supra* note 562, 23-26.
573 Dr. Schauer's Expert Report, *supra* note 562, at 10n.38.
574 *See, e.g.,* Lubanga Sentencing Decision, *supra* note 569, at ¶¶ 39-45; *Id.* at 45 – 48, ¶¶ 12-18 (Odio, J., dissenting).

hearing, as seen in the ECCC.[575] 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").[576] The TFV, a non-judicial entity established by the same Rome Statute that established the ICC, was created to assist victims of crimes within the jurisdiction of the Court and to support programs that address the harms resulting from these crimes.[577] As such, "where appropriate," court-ordered reparations may be implemented through the TFV.[578]

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."[579] In turn, the Court retained a monitoring role and oversight function for reparations "including considering the proposals for collective reparations that are to be developed in each locality, which [would] be presented to the Chamber for its approval."[580] 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

575 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).

576 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.").

577 Rome Statute, *supra* note 575, 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, http://www.trustfundforvictims.org/about-us.

578 Rome Statute, *supra* note 575, 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.").

579 Lubanga Trial Chamber Decision on Reparations, *supra* note 576, at ¶ 285.

580 *Id.* at ¶ 289.

acknowledgement by the Court. By contrast, the ECCC judgment in Case 002/1 provided each of these elements, which are crucial to victims.[581]

On appeal, the ICC Appeals Chamber recognized this challenge 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 be assessed 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.[582] 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."[583]

As detailed above, the Trial Chamber's methodology and determination were primarily based on Dr. Schauer's written and oral expert testimony.[584] 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.[585] 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.[586]

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

581 See Case 002/1 Judgment, *supra* note 492, at ¶¶ 597-620 (section of Judgment on Civil Party Reparations, including assessment of harm suffered by the civil parties).

582 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).

583 *Id.* at ¶187 (quoting Lubanga Sentencing Decision, *supra* note 569, at ¶ 44).

584 *Id.* at ¶¶188-89.

585 *Id.* at ¶189.

586 *Id.* at ¶ 198. Such a finding does not prevent the TFV from providing appropriate assistance to such victims, however. See *Id.* at ¶ 199.

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."[587] 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.[588]

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.[589] Dr. Adeyinka M. Akinsulure-Smith, an expert witness on gender crime and PTSD, spoke to the mental impact and ostraticization of rape victims in the Central African Cepublic.[590] 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 and humiliate a particularly vulnerable victim population.[591] 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 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."[592] Portions of the testimony of each of the three experts were cited in the sentencing order against Jean –Pierre Bemba Gombo[593] and used to support the

587 *Id.* at ¶ 190.
588 *Id.*
589 The 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) (overturned on other grounds by the Appeals Chamber in Case No. ICC-01/05-01/08 A (June 8, 2018) *available at* https://www.icc-cpi.int/court-record/icc-01/05-01/08-3636-red
590 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).
591 Transcript of Trial Proceedings, Case File No. ICC-01/05-01/08 (Apr. 13, 2011).
592 Bemba Sentencing Decision at ¶37; Transcript of Trial Proceedings Case File No. ICC-01/05-01/08, at 86, 98, 109 (May 16, 2016).
593 Bemba Sentencing Decision, ¶¶ 36-37, 44.

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 confict, gave rise to two separate aggravating circumstances: namely that they were committed (i) against particularly defenceless victims, and (ii) with particular cruelty.[594]

This expert testimony on mental harm and ongoing psychological impact, in addition to statements of mental suffering by victims, was crucial to the Trial Chamber's sentencing of Bemba to 18 years in prison. Although the accused was ultimately acquitted by the Appeals Chamber, 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 reparations order that might have been, would likely have put significant emphasis on the immediate and ongoing mental harm of victims from the conflict.

Since these decisions, the ICC has continued to rely on psychological testimony to help prove cases of atrocity crimes. However, reliance on such testimony to show the broad psychological impact of atrocity crimes on victims and their communities has not been consistent.[595]

In spite of its limitations, the ICC's decisions on sentencing and reparations accord with the ECCC's reliance on psychological trauma evidence. Future proceedings on atrocity crimes may benefit from following the ECCC's model by requesting 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.

594 Bemba Sentencing Decision, ¶¶ 40, 95.

595 *Compare* The Prosecutor v. Bosco Ntaganda, ICC-01/04-02/06 (presenting psychological expert testimony regarding the impact of trauma on memory, Report of John Yuille DRC-OTP-2085-0221, transcript of testimony 18 April 2016 ICC-01/04-02/06-T-84-ENG; 21 April 2016 ICC-01/04-02/06-T-87-ENG; 22 April 2016, ICC-01/04-02/06-T-88-ENG; presenting psychological expert testimony regarding causes of delay in reporting on sexual violence crimes, Testimony of Maeve Lewis, 30 June 2016 ICC-01/04-02/06-T-113-Red2-ENG; 01 July 2016 ICC-01/04-02/06-T-114-Red-ENG, reports filed confidentially); The Prosecutor v. Al Hassan Ag Abdoul Aziz Ag Mohamed Ag Mahmoud, ICC-01/12-01/18 (presenting psychological expert testimony regarding the impact of extrinsic and intrinsic interrogation conditions on cognitive functioning and recall, transcript of testimony of Dr. Charles Morgan, ICC-01/12-01/18-T-179-Red-ENG; ICC-01/12-01/18-T-180-ENG); *with* The Prosecutor v. Dominic Ongwen, ICC-02/04-01/15 (presenting psychological expert testimony regarding impacts of attacks on Odek IDP camp, Lukodi IDP camp and Abok IDP camp, Report of Dr. Teddy Atim, UGA-V40-0001-0010, transcript of testimony ICC-02/04-01/15-T-174-ENG; presenting psychological expert testimony regarding mental health outcomes of rape and other forms of sexual violence, forced marriage and forced pregnancy, Report of Daryn Reicherter, UGA-PCV-0001-0020, transcript of testimony ICC-02/04-01/15-T-175-Red-ENG; presenting psychological expert testimony regarding the psychological, social, developmental and behavioural consequences of enlistment, conscription and use of children under the age of 15 to participate actively in hostilities, Report of Michael Wessells, UGA-PCV-0002-0076, transcript of testimony ICC-02/04-01/15-T-176-ENG).

## OTHER RELEVANT JUDICIAL DECISIONS

Apart from the ECCC and the ICC, international criminal proceedings 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.[596] 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 that suffered by 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.[597]

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596 *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* http://www.sierraleonetrc.org/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* http://www.sierraleonetrc.org/images/docs/statistical_report.pdf; Sierra Leone Truth and Reconciliation Commission ,Volume Three B Files (Witness to Truth Reports), *available at* http://www.sierraleonetrc.org/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), *availablen at* http://www.sierraleonetrc.org/index.php/view-the-final-report/download-table-of-contents/appendices/item/appendix-3-transcripts-of-trc-public-hearings?category_id=15.

597 *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

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 Dr. Teufika Ibrahimefendić —a psychotherapist from Vive Zene, a women's organization in the Balkans—to provide her expert opinion regarding common psychological impacts of the Srebrenica massacres in Bosnia and Herzegovina.[598] Specifically, Dr. Ibrahimefendić described symptoms of trauma suffered by individuals that 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.[599] She highlighted a new pathology to the Court called "the Srebrenica syndrome," which is 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.[600] The new pathology, coupled with the social impact of the massacre on the community, was identified in the Trial Chamber judgment against Krstić and the Court found that "the impact of these events on the Bosnian Muslim community of Srebrenica has been catastrophic."[601] The factual finding on impact pointed to Vive Zene's findings of 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.[602] 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

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.

598 Prosecutor v. Radislav Krstic, Case No. IT-98-33-T, Judgment, at 30-31 (Int'l Crim. Trib. for the Former Yugoslavia Aug. 2, 2001). Dr. Ibrahimefendic 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. Plavšic, Case No. IT-00-39 & 40/1, Transcript of Hearing with Dr. Ibrahimefendic (Int'l Crim. Trib. for the Former Yugoslavia Dec. 16, 2002), *available at* http://www.icty.org/x/cases/plavsic/trans/en/021216IT.htm; Prosecutor v. Tolimir, Case No. IT-05-88/2, Transcript of Hearing with Dr. Ibrahimefendic (Int'l Crim. Trib. for the Former Yugoslavia Feb. 17, 2011); Prosecutor v. Karadži , Case No. IT-95-5/18, Transcript of Hearing with DrIbrahimefendic (Int'l Crim. Trib. for the Former Yugoslavia Mar. 22, 2012), *available at* http://www.icty.org/x/cases/karadzic/trans/en/120322ED.htm; Prosecutor v. Ratko Mladic, Case No IT-09-92-T, Transcript of Hearing with Dr. imefendic (Int'l Crim. Trib. for the Former Yugoslavia July 18, 2013), *available at* http://www.icty.org/x/cases/mladic/trans/en/130718ED.htm; *see also* Prosecutor v. Milorad Trbic, Case No.: X-KR-07/386, at ¶ 848 (National Court of Bosnia and Herzegovina, Apr. 29, 2010).

599 Prosecutor v. Radislav Krstic, *supra* note 598, Judgment, at ¶¶ 91-94.

600 *Id.* at ¶ 93 (citing Prosecutor v. Radislav Krstic, Case No. IT-98-33-T, Transcript of Dr. Ibrahimefendic, at 5817-5818 (Int'l Crim. Trib. for the Former Yugoslavia July 27, 2000), *available at* http://www.icty.org/x/cases/krstic/trans/en/000727it.htm).

601 Prosecutor v. Radislav Krstic, *supra* note 598, Judgment, at ¶ 90.

602 *Id.* at ¶ 93.

Court nevertheless explained that it was "imperative to document these 'incredible events' in detail." [603] 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 the Srebrenica Syndrome affecting the women and children survivors.[604]

On the other hand, the International Tribunal for Rwanda ("ICTR"), even when it received evidence of victim trauma, failed to marshal that evidence in support of the legally-significant outcomes of gravity of the crimes, sentencing, or 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.[605] Thus, the court 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

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603 *Id.* at ¶95.

604 *Id.* at ¶720.

605 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)).

where psychological evidence on victim impact has also been considered.[606] 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 had on the surviving victims of the Dos Erres Massacre.[607] 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.[608] The expert statements contributed to the Court's factual findings, linking the crimes to the grave damages identified to the mental integrity of the victims.[609] Moreover, the testimony aided the Court's understanding of 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.[610] As a result, the Court found it necessary to order reparations that provide adequate attention and counseling to the psychological issues and moral damages suffered by the victims, and reparations that memorialize and publicly acknowledge the responsibility and harm to victims of the massacre in Dos Erres.[611]

Guatemala's National Court also utilized expert testimony on psychological impact in the trial against former Guatemalan President Efrain Ríos Montt and former Chief of Military Intelligence Mauricio Rodriguez Sanchez for genocide, forced disappearances, torture, crimes against humanity, and state terrorism

606 See e.g., Case of the Plan de Sánchez Massacre v. Guatemala, Reparations and Costs, Judgment, Inter-Amer. 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* http://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* http://www.cja.org/downloads/Romagoza%20Trial%20Transcript,%20Volume%209,%20pages%201531-1691.pdf); Farhan Mohamoud Tani Warfaa v. Yusuf Abdi Ali, No. 1:05-CV-00701-LMB-JFA, (presenting psychological expert testimony of Dr. Daryn Reicherter re the Mental Health Consequences of Torture in Somaliland, *available at* https://cja.org/wp-content/uploads/2019/07/Psychological-Expert-Report-on-Somaliland-Trauma-Dr.-Reicherter.pdf, transcript of testimony on file with the authors; presenting psychological expert testimony of Dr. Allen Keller regarding the medical evaluation and treatment of survivors of torture and abuse, transcript on file with the authors).

607 Case of "Las Dos Erres" Massacre v. Guatemala, Preliminary Objection, Merits, Reparations, and Costs, Judgement, Inter-Am. Ct. H.R. (ser. C) No. 31, ¶ 56 (Nov. 24, 2009), *available at* http://www.corteidh.or.cr/docs/casos/articulos/seriec_211_ing.pdf.

608 *Id.*

609 *Id.* at ¶139.

610 *Id.* at ¶¶ 211-213.

611 *Id.* at ¶¶ 257-64, 269-70.

primarily against the country's indigenous population.[612] 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.[613] Gómez described this psychological damage as causing strong disorientation, feelings of loss of control, severe anxiety and post-traumatic stress among individual victims.[614] This mental harm caused destruction of culture, stigmatization of women who had been raped, and a rupture of the social fabric.[615] 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 Rios Montt's rule.[616] 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 prove the crime of genocide.[617] 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 society at large.[618] Accordingly, portions of the expert evidence were used to prove the underlying crime and support the claims for reparations.[619]

## 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 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

612 State v. Efrain Ríos Montt and Mauricio Rodriguez Sanchez, Case No. C-01076-2011-00015 of. 2nd, Sentence and Judgment of National Courts of Guatemala, (May 17, 2013) (*available at* http://www.ijmonitor.org/2013/05/718-page-rios-montt-judgement-released-all-eyes-on-constitutional-court/) (Judgment overturned by Constitutional Court of Guatemala on May 20, 2013).

613 International Justice Monitor, *Prosecution Experts Testify on Psychological, Cultural, Statistical, and Gender Issues*, Open Society Foundation (Apr. 2013), *available at* http://www.ijmonitor.org/2013/04/prosecution-experts-testify-on-psychological-cultural-statistical-and-gender-issues/.

614 *Id.*

615 *Id.*

616 State v. Efrain Ríos Montt and Mauricio Rodriguez Sanchez, Case No. C-01076-2011-00015 of. 2nd, Sentence and Judgment of National Courts of Guatemala, 205 (May 17, 2013) *available at* http://www.ijmonitor.org/2013/05/718-page-rios-montt-judgement-released-all-eyes-on-constitutional-court/ (Judgment overturned by Constitutional Court of Guatemala on May 20, 2013).

617 Genocide in Guatemala: Rios Montt Found Guilty, International Federation for Human Rights (FIDH), at 14, *available at* https://www.fidh.org/IMG/pdf/rapguatemala613uk2013.pdf (July 2013).

618 State v. Efrain Ríos Montt and Mauricio Rodriguez Sanchez, Case No. C-01076-2011-00015 of. 2nd, Sentence and Judgment of National Courts of Guatemala, 698, 707 (May 17, 2013), *available at* http://www.ijmonitor.org/2013/05/718-page-rios-montt-judgement-released-all-eyes-on-constitutional-court/.

619 *Id.* at 714-18.

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 general 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, meaning it should include 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 have reviewed 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 should also be reviewed and incorporated into reports and the presentation oral testimony.

Expert testimony on victim trauma should explain general 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-V), which is published by the American Psychiatric Association, 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-V.

In addition, such expert testimony should incorporate a comprehensive literature review identifying empirically-validated research articles related to topics to be addressed.[620] 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 be 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.

620 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 judgments, and this evidence has been widely publicized by local media. Despite the success of the Victim Impact Hearing in Case 002/1 and accompanying expert testimony, more and better evidence on impact can be developed in similar hearings in the future. The Trial Chamber of the ECCC'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 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 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 population wide trauma.

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.

PART | 3

# MENTAL HEALTH AND HEALTH AS REPARATION FOR HUMAN RIGHTS VIOLATIONS

# 8 31,000 KHMER ROUGE SURVIVORS SPEAK: RESULTS OF THE HEALTH AND WELFARE STUDY

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## ABSTRACT

This chapter provides an overview of a survey conducted by the Documentation Center of Cambodia (DC-Cam) on the health and welfare of 31,000 survivors of the Khmer Rouge regime (i.e., people who lived in Cambodia between 1975 and 1979). The Khmer Rouge regime, also known as Democratic Kampuchea, was responsible for war crimes, crimes against humanity, and genocide, which ultimately resulted in the death of over 2 million Cambodians. DC-Cam's survey provides insights into the health and welfare of the survivor population in Cambodia, which may be relevant to public health policy and transitional justice-related actions directed at the survivors of the Khmer Rouge regime and the survivors of atrocity crimes in other post-conflict countries.

## BACKGROUND

On April 17, 1975, communist forces, commonly known as the Khmer Rouge, seized control of Cambodia and established a government they named "Democratic Kampuchea." The Khmer Rouge endeavored to implement a rapid socialist revolution in Cambodia through a radical Maoist and Marxist-Leninist transformation program that centered on the re-organization of society. The Khmer Rouge believed that through these radical policies they would be able to maximize agricultural output and realize otherwise unattainable levels of efficiency and development. To this end, large portions of the population were forcibly moved from their homes to often distant locations in the countryside. This policy of forcibly moving people from one location to another (i.e., forced transfer) caused incredible suffering and strain on people and communities.

The Khmer Rouge regime also employed forced labor through cooperatives and worksites to strictly control the population and support their strategy of class struggle. Money, markets, and private property were abolished, and the regime sought to dismantle or prohibit religious and cultural practices and institutions. Public schools, pagodas, mosques, churches, and shops were closed or converted into prisons, re-education camps, or other government-prescribed purposes.

The Khmer Rouge administered their policies through forced deprivation, terror, violence, and, in many cases, torture and murder. During the almost four years they ruled the country, it is estimated that 1.4 to 2.2 million people lost their lives through executions or deaths caused by starvation, overwork, and the most extremely inhumane conditions.

The Documentation Center of Cambodia (DC-Cam) was established in 1995. The Center is a non-profit, non-governmental, apolitical Cambodian research institute dedicated to documenting the history of the Democratic Kampuchea regime of Pol Pot (1975-1979). For over two decades, DC-Cam has been surveying the survivors of the Khmer Rouge regime to develop a better understanding of survivor needs, interests, and perspectives.

Thanks to a generous grant from the United States Agency for International Development (USAID) in the summer of 2021, DC-Cam was able to significantly expand its efforts in this area, particularly as it relates to developing a better understanding of the health and welfare conditions of survivors and establishing its volunteer youth leadership corps dedicated to this endeavor.

## RESEARCH METHODS AND PROCESS

### Questionnaire Development

This questionnaire was developed to better understand the general health and socio-economic conditions of survivors and their attitudes, practices or preferences on health care and the perceived causes of current ailments or conditions. Most questions were designed around a set of prescribed responses to support convenient processing and analysis of data; however, a limited set of questions allowed for open-ended response. These open-ended responses were analyzed, summarized (or categorized) and incorporated into the results that are included in this study. The questionnaire was reviewed by senior DC-Cam staff and international consultants who had experience in survey design and monitoring and evaluation. The questionnaire was also informed by an earlier, small pilot study of survivors' health and welfare conditions conducted by DC-Cam, which was similarly developed by staff in consultation with international

advisors. Both the pilot study and the design of this survey were overseen by an internationally-trained medical consultant.

The questionnaire comprises approximately 60 questions or points for data collection for an interviewee, along with some simple directions for the interviewer. These directions or guidance were further supplemented by guidance from DC-Cam staff who supervised the volunteers that collected the data. Whereas the questionnaire allowed for approximately 60 questions or points for data collection, not all questions and their associated data are included in this chapter. Certain questions were found to be too narrowly focused on a topic or issue unrelated to the general health and welfare of survivors, such that the data was not relevant for this work. In other circumstances, after reviewing certain questions and their associated responses, it was determined the question and the associated data were subject to multiple interpretations, which undermined any finding associated with the responses. In these few instances, the data was not included in this study. The figures that are shown in this chapter provide the relevant question and the data from respondents.

**Recruitment and Training of Volunteer Data Collectors**

DC-Cam collected survey data by administering the questionnaire that was distributed by volunteers who visited survivors in their local community. DC-Cam relied upon volunteers to collect most of the data for this study. Volunteers were young students recruited for a three to six-month period of volunteer service under the CamboCorps initiative.

CamboCorps is a DC-Cam-managed Cambodian youth volunteer service that was inspired by the United States volunteer corps known as Ameri Corps.[621] AmeriCorps is a U.S.-based, national-level community development program that supports leadership training and professional development in the context of revitalizing communities across the United States. Using AmeriCorps as inspiration, CamboCorps gave youth experience in public health and community service projects dedicated to helping survivors of the Khmer Rouge regime.

Volunteers were recruited based on their education and professional experience, particularly on projects or work related to public health. Most volunteers were students ranging in age from 17 to 24 - years old. Most volunteers had completed their secondary education and were in the process of completing

621 DC-Cam credits USAID for its generous support, guidance, and mentorship in the organization and advancement of this volunteer youth leadership corps—from a pilot project in its inception to a national-level programme today.

an undergraduate degree or, in some cases, a graduate degree program. Volunteers demonstrated extraordinary skill with digital media, which was demonstrated in the audio-visual recordings of their interviews. Youth demonstrated excitement in the project and often collaborated in teams when they conducted interviews. Using volunteers presented an increased risk of deviation between how the survey was designed and conducted, who participated, and how responses were recorded. Volunteers were provided with written instructions and a brief orientation training on how to administer the survey. Volunteers were given guidance on how to introduce themselves to survivors, explain the purpose of the study, describe how the survey data would be used, and inform survivors that they do not have to answer questions and can decline to participate.

**Recruitment of Khmer Rouge Survivors**

Volunteers frequently sought out survivors they knew based on family or community background in their local communities. Volunteers collected the survey responses in either one-on-one interviews or focal group sessions with survivors and their families. Sometimes, other community members would sit and attend the interview sessions to hear the stories.

Survivors were generally identified based on their age and the volunteers' (or other community members) knowledge of their status as survivors. However, in many instances, survivors were discovered by the volunteers choosing to walk in a particular area or community, which was a common practice amongst certain volunteer teams.

DC-Cam required staff to presume an individual was a survivor of the Khmer Rouge regime if they were 40 years old or older to provide them with services or support under the project. However, because most individuals who were in their 40s would have been infants during the Khmer Rouge regime, the priority of efforts for collecting oral history was directed to survivors who were 50 years old or older. As discussed later in this report, DC-Cam did not select individuals solely based on their reported victimization under the Khmer Rouge regime. DC-Cam also did not attempt to categorize survivors—i.e., identifying certain survivors as "victims" and other survivors as "potential or reported perpetrators." DC-Cam also did not discriminate in its support or services to survivors based on evidence or allegations of having an association with the Khmer Rouge regime or acts committed under the regime.

Most survivors were selected based on their accessibility and availability to DC-Cam's youth volunteers. Youth volunteers were not provided with specific lists of survivors; instead, they were directed to "canvass"[622] a particular area or community—asking individuals if they were survivors of the Khmer Rouge regime or if they knew anyone who was a survivor.

**Data Collection and Analysis**

After obtaining consent to administer the questionnaire, volunteer interviewers verbally asked each question. Responses were transcribed or, in some cases, summarized on a notepad or other media by other volunteers supporting the main interviewer. In some cases, particularly in more remote communities, a volunteer may interview survivors on their own; however, this was the exception, and generally, these interviews comprised survivors in the volunteer's extended family. These notes would then be physically delivered, mailed, or electronically sent to DC-Cam for review and analysis. Although volunteers collected information from a survivor's family members to supplement their surveys, the data reflected in this report (unless otherwise noted) was based upon entirely survivor responses to questions.

DC-Cam implemented multiple precautions or controls to mitigate the risk of re-traumatization of survivors. First, all DC-Cam staff receive training on working with survivors of atrocity crimes and how to identify, communicate with, and support persons suffering from post-traumatic stress disorder. These trainings are conducted at least annually either through internal DC-Cam-organized workshops or workshops managed by DC-Cam partners like the Transcultural Psychosocial Organization (TPO).[623] DC-Cam provided an orientation to volunteers, which included information on these topics, and DC-Cam staff provided oversight, and in many instances, on-the-ground supervision, to the volunteers. DC-Cam engaged in pre- and post-interview meetings with volunteers to gauge their understanding of key fundamentals of working with survivors and collecting oral history, how the sessions were conducted, lessons learned, and best practices. DC-Cam organized the visit of public health fellows, i.e., medical students, to multiple program activities for purposes of supporting quality control and innovation in DC-Cam's work with

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622 The term "canvass" means to conduct non-experimental door-to-door engagement with people to identify those people who meet the criteria for a particular survey or study. In many circumstances, "canvassing" is a technique that is used in political initiatives such as voter registration. Because there is no comprehensive database of survivors, let alone survivor communities (i.e., communities where the survivors are concentrated), canvassing was identified as the most cost-effective, efficient method for having volunteers identify and engage with survivors for DC-Cam's study.

623 See TPO Cambodia, (n.d.) http://tpocambodia.org/.

survivors, and DC-Cam regularly engaged multiple experts in public health, organizational development, and monitoring and evaluation as data was received on its activities with survivors. Finally, DC-Cam fielded a draft public health information guidebook, with support from international experts in public health from Stanford University, which provided some general information on PTSD.

**Limitations of the Study**

The team anticipated several methodological challenges and risks for this study, such as selection bias, measurement error, and potential confounding, i.e., the spurious association of a cause and an effect relationship for certain observations.

It has been over forty years since the fall of the Khmer Rouge regime. Many survivors of the Khmer Rouge period have died, and the memory of survivors today continues to fade and, in some circumstances, become more difficult to recall and document due to mental and physical decline. On this point, there was an anticipated selection bias based on the extent to which a survivor could (and desired to) communicate that he was a survivor of the Khmer Rouge regime.

There was no comparison (or control) group, so the data does not provide any insights into differences between people exposed to genocide and atrocity crimes and individuals without this experience.[624] There was also the risk of error and confounding with the data.

In terms of error, there was a risk that data may not have been collected uniformly by all interviewers, e.g., different interviewers may have asked different questions, or they may have taken different approaches to engage with survivors, such that some responses may differ slightly because of how the question was asked, in what context did the survivor respond, and how the interviewer recorded the response.

Using a low-technology approach and diverse means of survey recordation and transmission further increased the risk of error. Some surveys were recorded on paper, some in digital format, and some volunteers chose to record their interviews in an audio-visual format that was not easily analyzed or processed with automated analytical or information management tools. Different survey formats resulted in other means of transmission, which created challenges with the processing and analysis of data. Because volunteers transmitted their surveys in various formats and media, the challenges and resource requirements associated with data review and analysis were significantly higher than if they had used a single form, format, and transmission protocol.

624 In future studies, DC-Cam believes it would be helpful to study any similarities or differences in physical or mental health between people who experienced the Khmer Rouge regime (i.e., survivors who lived in Cambodia from 1975 to today) and people who fled Cambodia before 1975 and returned after 1979.

The risk of confounding[625] was recognized as a significant risk of this study because it was a common risk associated with most if not all other related studies of survivors of atrocity crimes.[626] There was no approach or analysis taken that studied or considered potential recent (or post-atrocity crimes) life events that may have moderated, aggravated, or otherwise influenced the physical or mental health of the survivors who participated in the study. There also was no study of trauma arising from trauma, i.e., the effects of trauma on post-conflict/post-genocide generations. The association between periods of genocide- and atrocity crimes-related exposures and specific adverse effects on a survivor's physical and mental health and welfare remain largely unmeasured in general[627] and completely unknown in Cambodia. DC-Cam did, however, limit the types of questions in the survey to partly account for the risk of confounding.

The preceding weaknesses and challenges with the study were balanced by efficiencies and advantages determined to be preferable for the conduct of the study and the overarching goal of maximizing impact to the project's beneficiaries. The use of volunteers allowed DC-Cam to scale up the number of surveys completed far beyond what could have been collected by core staff, given budgetary parameters. DC-Cam's decision to accommodate multiple forms and formats for surveys ensured that volunteers could use the media, format, and protocol that was most accessible, convenient, and comfortable for them based on local circumstances. Using volunteers allowed DC-Cam to achieve unparalleled cost-efficiency and reach survivors from every province and those living in remote communities.

There was no comparison between the data DC-Cam collected and previous reports or studies per se. Even though there were outcome measurements for the project's impacts (in terms of measuring any changes on direct beneficiaries based on DC-Cam's inputs, activities, or services), there was no comprehensive approach or analysis taken that allowed for potential recent (or post-atrocity crimes) life events that may have moderated or

625 Confounding refers to the mistaken or misinterpreted association between perceived injury, harm or disease and the experiences, trauma, or related circumstances of the relevant period. Confounding is a common variable that influences both dependent and independent variables in studies into the cause-and-effect relationships between mental health conditions and the atrocity crimes of the relevant case study.

626 See generally, Jutta Lindert, et al., "Psychopathology of Children of Genocide Survivors: A Systematic Review on the Impact of Genocide on their Children's Psychopathology from Five Countries," Int'l J. Epidemiology 246-257 (2016) (discussing how the literature on genocide and psychopathologies is characterized by low epidemiological rigor, which includes lack of control for confounding).

627 Even though there have been several different studies that provide insights into the association or effects of genocide and other atrocity crimes on survivors' physical and mental health, the findings and conclusions remain open for further analysis and confirmation. See e.g., Stephen Z. Levine, et al., "Genocide Exposure and Subsequent Suicide Risk: A Population-Based Study," PLoS ONE 11 (2), (2016), *available at* https://journals.plos.org/plosone/article?id=10.1371/journal.pone.0149524.

otherwise influenced the physical or mental health or welfare of the survivor either in the past or in current project impacts. The study did endeavor to capture data related to the COVID-19 pandemic, and it is believed that COVID-19 likely impacted data because the data collection occurred during various community outbreaks. However, the extent of this impact is not measurable. These weaknesses, both in data collection and comparative study, are compounded by the relatively few studies about the long-term effects of genocide in Cambodia.[628]

Because the survey sought to identify the general conditions of health, welfare, and other conditions of survivors (as the survivors perceived them), there was a risk that any survivor's response of poor health, welfare, or other conditions was not based on any circumstance or experience related to the Khmer Rouge regime. Indeed, without the specific facts of an individual's background, a survivor's description of hypertension, stomach ailments, or depression could be arguably associated with their current socio-economic, homelife, or other circumstances as their experience under the Khmer Rouge regime. Notwithstanding this risk, the findings of the study should be able to overcome the influence of confounding, such that by looking across the population, regardless of time and circumstance, there are notable characteristics, patterns, and findings that are, more likely than not, directly derived from experiences or circumstances of the Khmer Rouge regime. This assertion could be measured in a study targeting specific individuals or small groups. However, this assertion was not backed up by sufficient data for this study, given the prioritization of reaching the highest number of beneficiaries.

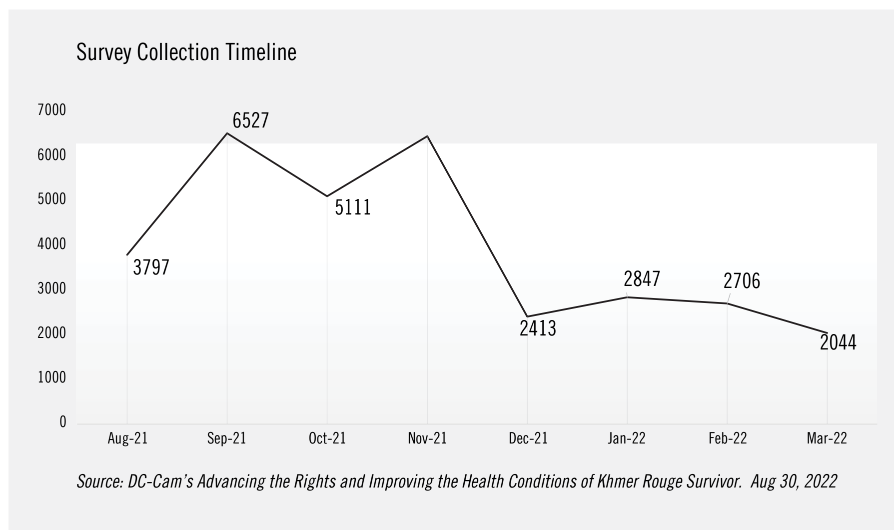
There were standardized instruments and methods to assess physical or mental health outcomes; however, to support the project's prioritization of impact on beneficiaries, the instruments that were utilized were subject to some variation (i.e., as mentioned above, data may have been collected in more than one format or collection method).

Expectedly, there were also different ethical challenges in collecting the data. DC-Cam did not include standardized questions addressing (nor did DC-Cam encourage volunteers to request information on) survivor positions, roles, or responsibilities in relation to actions or decisions relevant to the commission of atrocity crimes. The decision to omit these types of questions was based on DC-Cam's interest in maximizing survivor participation in the project, regardless of their culpability in atrocity crimes or association with the Khmer Rouge regime.

628 See Damien de Walque, "The socio-demographic legacy of the Khmer Rouge period in Cambodia," Population Studies, Vol. 60, No. 2, 223-231 (2006). (Using data from two micro-level representative surveys of Cambodia in 2000, Damien de Walque attempted to look at the long-term socio-demographic consequences of the Khmer Rouge period).

Notwithstanding this decision, many survivors provided information about their positions, roles, and responsibilities during the Khmer Rouge regime. Some volunteers took the initiative to ask survivors these questions, though, in most circumstances, survivors voluntarily provided the information without prompting or solicitation.

Figure 1: Survey collection timeline




*Source: DC-Cam's Advancing the Rights and Improving the Health Conditions of Khmer Rouge Survivor. Aug 30, 2022*

Between September and November 2021, DC-Cam collected surveys reflecting 18,000 survivors. After November 2021, DC-Cam collected approximately 2,500 surveys per month through March 2022.

The majority of respondents were between the ages of 60-69 (approximately 38 percent of all surveys collected). The next largest population of respondents were between the ages of 50-59 (30 percent) and 70-79 (23 percent). Broken down by region, DC-Cam received 3,405 surveys from the Pursat province, which reflected almost 11 percent of all surveys. The next largest province represented in the collection was Kampong Chhnang, where 2,618 surveys were collected (or 8 percent of the total collection).

Over 63 percent of survivors who participated in the study resided in either the Tonle Sap Lake (32 percent) or Plains regions (31 percent) of Cambodia, as noted in Figure 2.

Figure 2: Percentage of survivors (i.e., respondents) by region

| CAPITAL/PROVINCES | SURVIVOR AGE BY GROUP | | | | | | |
|---|---|---|---|---|---|---|---|
| | 30-49 | 50-59 | 60-69 | 70-79 | 80-89 | 90-ABOVE | TOTAL |
| Banteay Meanchey | 4 | 547 | 695 | 409 | 102 | 9 | 1766 |
| Battambang | - | 165 | 245 | 147 | 58 | 4 | 619 |
| Kampong Cham | 9 | 441 | 677 | 592 | 196 | 12 | 1927 |
| Kampong Chhnang | 17 | 789 | 945 | 611 | 223 | 33 | 2618 |
| Kampong Speu | - | 132 | 188 | 148 | 43 | 2 | 513 |
| Kampong Thom | - | 58 | 42 | 40 | 13 | - | 153 |
| Kampot | 18 | 425 | 545 | 416 | 122 | 21 | 1547 |
| Kandal | 2 | 335 | 504 | 294 | 109 | 9 | 1253 |
| Kep | 4 | 629 | 772 | 427 | 196 | 30 | 2058 |
| Koh Kong | 4 | 180 | 154 | 79 | 42 | 3 | 462 |
| Kratie | 2 | 243 | 376 | 289 | 84 | 5 | 999 |
| Mondulkiri | 7 | 229 | 194 | 106 | 38 | 6 | 580 |
| Oddor Meanchey | 2 | 81 | 135 | 53 | 15 | - | 286 |
| Pailin | 5 | 183 | 282 | 76 | 20 | 2 | 568 |
| Phnom Penh | 4 | 360 | 479 | 268 | 101 | 9 | 1221 |
| Preah Vihear | 6 | 592 | 619 | 324 | 132 | 26 | 1699 |
| Prey Veng | 7 | 333 | 531 | 360 | 60 | 7 | 1298 |
| Pursat | 12 | 1153 | 1328 | 715 | 180 | 17 | 3405 |
| Ratanakiri | 45 | 578 | 636 | 322 | 169 | 52 | 1802 |
| Siem Reap | 3 | 203 | 313 | 182 | 33 | 3 | 737 |
| Sihanouk Ville | - | 11 | 31 | 24 | 2 | - | 68 |
| Stung Treng | 15 | 563 | 660 | 384 | 147 | 41 | 1810 |
| Svay Rieng | 1 | 130 | 147 | 120 | 41 | 3 | 442 |
| Takeo | 6 | 365 | 523 | 359 | 136 | 8 | 1397 |
| Tbong Khmum | 20 | 532 | 797 | 533 | 205 | 30 | 2117 |
| Total | 193 | 9257 | 11818 | 7278 | 2467 | 332 | 31345 |

*Source: DC-Cam's Advancing the Rights and Improving the Health Conditions of Khmer Rouge Survivor. Aug 30, 2022*

Figure 3: Survey collection locations

| | TOTAL | % | WOMEN | % | MEN | % |
|---|---|---|---|---|---|---|
| Capital/Provinces | 31346 | 100% | 21844 | 69.69% | 9501 | 30.31% |
| **Plain Region** | 9569 | 30.99% | 6751 | 31.40% | 2818 | 30.05% |
| Phnom Penh | 1221 | 3.95% | 934 | 4.34% | 287 | 3.06% |
| Kandal | 1253 | 4.06% | 874 | 4.07% | 379 | 4.04% |
| Kampong Cham | 1877 | 6.08% | 1260 | 5.86% | 617 | 6.58% |
| Svay Rieng | 442 | 1.43% | 317 | 1.47% | 125 | 1.33% |
| Prey Veng | 1297 | 4.20% | 929 | 4.32% | 368 | 3.92% |
| Takeo | 1397 | 4.52% | 878 | 4.08% | 519 | 5.53% |
| Tbong Khmum | 2082 | 6.74% | 1559 | 7.25% | 523 | 5.58% |
| **Tonle Sap Lake Region** | 10061 | 32.58% | 7217 | 33.57% | 2844 | 30.32% |
| Banteay Meanchey | 1681 | 5.44% | 1134 | 5.27% | 547 | 5.83% |
| Battambang | 620 | 2.01% | 414 | 1.93% | 206 | 2.20% |
| Kampong Chhnang | 2611 | 8.46% | 1961 | 9.12% | 650 | 6.93% |
| Kampong Thom | 153 | 0.50% | 117 | 0.54% | 36 | 0.38% |
| Siem Reap | 737 | 2.39% | 521 | 2.42% | 216 | 2.30% |
| Oddor Meanchey | 286 | 0.93% | 175 | 0.81% | 111 | 1.18% |
| Pailin | 568 | 1.84% | 350 | 1.63% | 218 | 2.32% |
| Pursat | 3405 | 11.03% | 2545 | 11.84% | 860 | 9.17% |
| **Coastal Region** | 5550 | 17.97% | 3742 | 17.40% | 1808 | 19.28% |
| Kampot | 1546 | 5.01% | 1053 | 4.90% | 493 | 5.26% |
| Koh Kong | 462 | 1.50% | 320 | 1.49% | 142 | 1.51% |
| Preah Vihear | 1416 | 4.59% | 937 | 4.36% | 479 | 5.11% |
| Kep | 2058 | 6.66% | 1382 | 6.43% | 676 | 7.21% |
| Sihanouk Ville | 68 | 0.22% | 50 | 0.23% | 18 | 0.19% |
| **Plateau and Mountainous Region** | 7115 | 23.04% | 4727 | 21.99% | 2388 | 25.46% |
| Kampong Speu | 513 | 1.66% | 388 | 1.80% | 125 | 1.33% |
| Mondulkiri | 575 | 1.86% | 368 | 1.71% | 207 | 2.21% |
| Preah Vihear | 1416 | 4.59% | 937 | 4.36% | 479 | 5.11% |
| Kratie | 999 | 3.24% | 669 | 3.11% | 330 | 3.52% |
| Ratanakiri | 1802 | 5.84% | 1165 | 5.42% | 637 | 6.79% |
| Stung Treng | 1810 | 5.86% | 1200 | 5.58% | 610 | 6.50% |

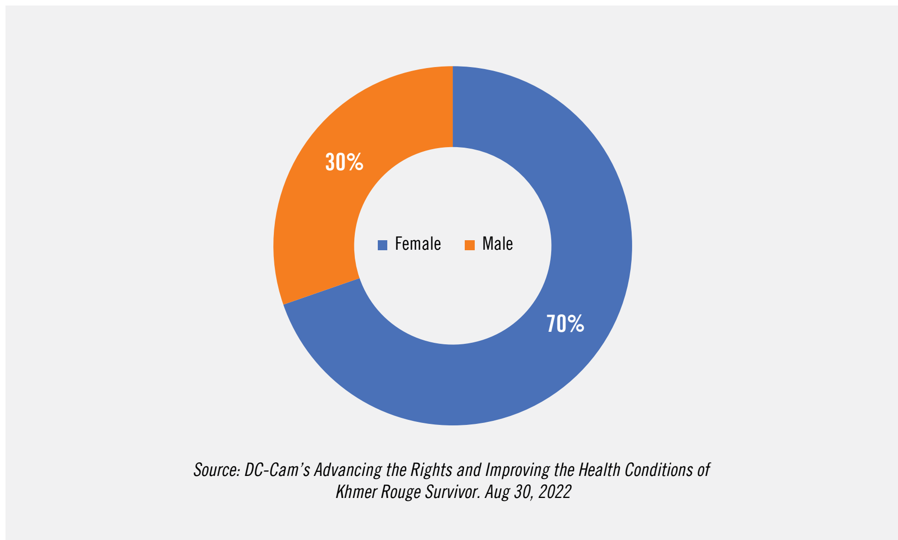
Whereas DC-Cam collected responses from survivors in every province, certain provinces and specific age groups in these provinces represented a slightly higher percentage than other provinces. For example, survivors in the 60–69-year age group represented the largest number of respondents for Pursat (1,328 out of 3,405 respondents, representing 39 percent of the responses for Pursat). In nearly all the provinces, the 60–69-year-old age group was the largest

population of survivors. The two exceptions to this pattern were in Kampong Thom and Koh Kong. In both provinces, the 50-59-year age group represented a slightly larger group in collecting responses.

The Kampong Chhnang, Kampong Cham, and Kep provinces had the largest number of respondents aged 80-89. In Kampong Chhnang, DC-Cam received data from 223 respondents in this age group (or almost 9 percent of the total responses (2,618) for this province). In Kampong Cham, DC-Cam received data from 196 persons out of a population of 1,927 persons, and in Kep, DC-Cam received 196 persons out of a population of 2,058 respondents. Both Kampong Cham and Kep's population of respondents in the 80-89-year age group made up approximately 10 percent of the population of respondents for the province.

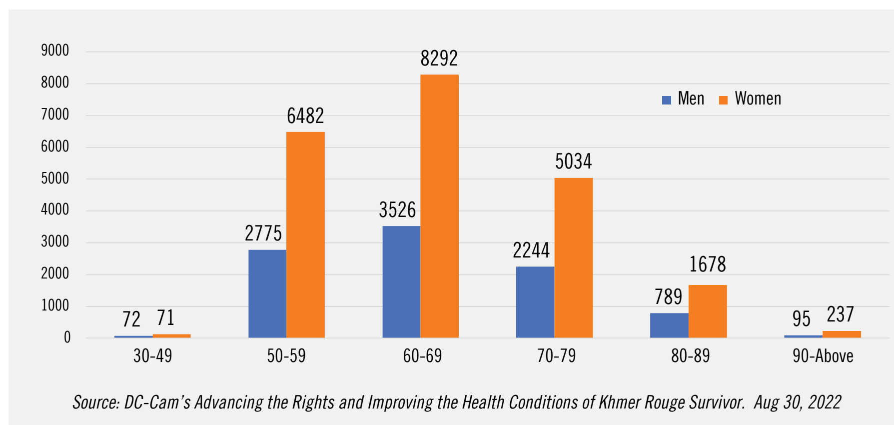
The province of Ratanakiri produced the largest population of survivors in the age group of 30 to 49 years of age. Out of a population of 1,802 respondents for Ratanakiri province, 45 (or just over 2 percent of the respondents) are reflected.

Figure 4: Percentage of survivors (i.e., respondents) by gender




*Source: DC-Cam's Advancing the Rights and Improving the Health Conditions of Khmer Rouge Survivor. Aug 30, 2022*

Figure 5: Survivor age group




*Source: DC-Cam's Advancing the Rights and Improving the Health Conditions of Khmer Rouge Survivor. Aug 30, 2022*

Figure 6: Survivor age group categorized by provinces

| Capital/ Provinces | CAMBODIA POPULATION STATISTICS DISAGGREGATED BY AGE (2021) | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|
| | Total Population 2021 | | | Total 60-80plus 2021 | | | Total 60-69 2021 | | |
| | Total | M | F | Total | F | M | Total | M | F |
| Banteay Meanchey | 838070 | 408420 | 429650 | 60138 | 36746 | 23393 | **55069** | **15476** | **22943** |
| Battambang | 1277395 | 638369 | 639026 | 119055 | 72214 | 46840 | **76915** | **31653** | **45262** |
| Kampong Cham | 1189756 | 585676 | 604080 | 68092 | 42668 | 25425 | **65807** | **16372** | **26023** |
| Kampong Chhnang | 584079 | 281903 | 302176 | 6076 | 3117 | 2959 | **30480** | **2266** | **2389** |
| Kampong Speu | 866445 | 421061 | 445385 | 10100 | 5541 | 4558 | **42394** | **3397** | **3714** |
| Kampong Thom | 791738 | 386125 | 405614 | 31616 | 18260 | 13358 | **41563** | **8372** | **11087** |
| Kampot | 698161 | 348016 | 350145 | 3549 | 1869 | 1680 | **38419** | **1245** | **1259** |
| Kandal | 1258007 | 612369 | 645639 | 106422 | 64792 | 41628 | **74954** | **25861** | **39946** |
| Kep | 43792 | 21810 | 21982 | 70259 | 43257 | 27003 | **2295** | **17167** | **27299** |
| Koh Kong | 139704 | 70312 | 69392 | 77453 | 50206 | 27247 | **7111** | **18655** | **29782** |
| Kratie | 398387 | 194358 | 204029 | 24469 | 13717 | 10751 | **19457** | **7629** | **9214** |
| Mondul Kiri | 83062 | 41890 | 41172 | 97728 | 61403 | 36324 | **2504** | **21885** | **33248** |

| Capital/ Provinces | CAMBODIA POPULATION STATISTICS DISAGGREGATED BY AGE (2021) | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|
| | Total Population 2021 | | | Total 60-80plus 2021 | | | Total 60-69 2021 | | |
| | Total | M | F | Total | F | M | Total | M | F |
| Oddar Meanchey | 273346 | 136057 | 137289 | 114221 | 72072 | 42147 | **13598** | **24033** | **46139** |
| Pailin | 77677 | 38935 | 38742 | 56694 | 36519 | 20174 | **4654** | **12594** | **23906** |
| Phnom Penh | 1910149 | 931104 | 979045 | 82902 | 48902 | 34000 | **130760** | **22782** | **32287** |
| Preah Sihanouk | 291457 | 144514 | 146944 | 15402 | 8388 | 7014 | **16842** | **4982** | **5661** |
| Preah Vihear | 284201 | 141312 | 142889 | 44206 | 27440 | 16766 | **10643** | **11364** | **18201** |
| Prey Veng | 1316637 | 640277 | 676359 | 48084 | 29550 | 18533 | **70172** | **12210** | **18271** |
| Pursat | 517394 | 250558 | 266835 | 199519 | 118095 | 81422 | **29565** | **53001** | **77758** |
| Ratanakiri | 211798 | 104223 | 107576 | 11605 | 6397 | 5208 | **8128** | **3743** | **4385** |
| Siem Reap | 1061063 | 516378 | 544685 | 125066 | 76284 | 48781 | **48437** | **30421** | **44532** |
| Stung Treng | 145470 | 73184 | 72286 | 8944 | 5025 | 3920 | **6398** | **2854** | **3545** |
| Svay Rieng | 652834 | 323846 | 328988 | 18567 | 9980 | 8588 | **36501** | **6545** | **7053** |
| Takeo | 1044708 | 506004 | 538703 | 62323 | 36649 | 25675 | **55133** | **18223** | **23340** |
| Tbong Khmum | 918458 | 452531 | 465927 | 3477 | 2160 | 1318 | **44466** | **886** | **1410** |
| Total | 16873788 | 8269232 | 8604558 | 1465967 | 891251 | 574712 | **932265** | **373616** | **558654** |

*Source: https://data.humdata.org/m/dataset/770386b0-d7c6-4ea7-abbc-beccac38c192?force_layout=light*

Seventy percent of survivors who participated in the survey were female, and 30 percent were male. Throughout all age groups, women represented a higher percentage of the respondents to DC-Cam's study. This circumstance seems consistent with the fact that the Khmer Rouge regime targeted occupations, institutions, and roles in Cambodian society that were typically held by males, thus indirectly resulting in the presumed death of more males than females under the regime. At least one study concluded that adult males were the most likely to die in comparison with other members of society.[629]

The Khmer Rouge specifically targeted former members of the Lon Nol regime, in particular members of the military, in addition to anyone who held positions of authority in Cambodia's society and culture, i.e., teachers,

629 See Damien de Walque, "The socio-demographic legacy of the Khmer Rouge period in Cambodia," Population Studies, Vol. 60, No. 2, 223-231 (2006). (using data on sibling mortality, the author draws the conclusion that adult males were the most likely to die in society).

religious leaders, and individuals with education, training, or relationships with the international community. Because of the patriarchal nature of traditional Khmer institutions and culture, most persons who filled these positions or roles were male. Notwithstanding this circumstance, no evidence would indicate females received any preferential treatment by the regime, such that they could avoid suspicion, arrest, or death. There are numerous accounts of women who were associated with men who were targeted by the regime and, for this reason, were killed. In sum, though it is believed that more male adults than female adults died under the regime, no evidence demonstrates that women were less likely to be targeted because of their gender.

Breaking the data down based on the actual metrics of DC-Cam's study, within the 30-49-year-old age group, women also constituted almost 63 percent of the total respondents (121 out of a group of 193 respondents aged 30-49). Within the 50-59 age group, women constituted 70 percent of the total respondents (6,482 out of 9,257 respondents aged 50-59). Within the 60-69 age group, women also constituted 70 percent of the total respondents (8,292 out of 11,818 respondents aged 60-69). Within the 70-79 age group, women constituted 69 percent of the total respondents (5,034 out of 7,278 respondents aged 70-79). Within the 80-89-year-old age group, women constituted 68 percent of the total respondents (1,678 out of a group of 2,467 respondents aged 80-89). Within the 90-year-old and above age group, women constituted 71 percent of the total respondents (237 out of 332 respondents in this group).

## DIMENSIONS OF SURVIVOR HEALTH AND WELFARE

DC-Cam studied different dimensions or aspects of survivor welfare, ranging from occupation and marital status to economic conditions and sources of income. Without question, atrocity crimes destroy infrastructure, wealth, and progress, and they perpetuate, if not precipitate, poor or failing social services, poverty, and insecurity. During the Nazi German regime, Jewish business owners were forced to sell or, in most circumstances, abandon their businesses, property, and wealth. The confiscation or misappropriation of Jewish and other targeted groups' property is well-documented.[630] A 2008 study of survivors of the Rwandan genocide noted that almost all orphaned heads of households that were observed in the study reported low social support, high levels of poverty, and high rates of post-traumatic stress disorder (PTSD)

630 See e.g., "Decree for the Reporting of Jewish-Owned Property," (April 26, 1938), Bulmash Family Holocaust Collection, *available at* https://digital.kenyon.edu/cgi/viewcontent.cgi?article=2705&context=bulmash.

and distress symptoms.[631] Likewise, in Sri Lanka, which has suffered terror, protracted conflict, and chronic insecurity, one of the "key factors distinguishing the chronically poor from the transiently poor is the lack of access to state services[,]" which is perpetuated and aggravated by conflict.[632]

In this study of Cambodian survivors, the highest percentage of men and women respondents reported their occupation as a farmer. Overall, 63 percent of men and 53 percent of women reported farming occupations.

The next highest category of occupations was unemployed or unable to work.[633] One could say this higher percentage of relatively low-wage agricultural work aligns with the general history of the Khmer Rouge movement, which was overwhelmingly made up of the poorest and most economically marginalized members of Cambodian society. In addition, it is notable that the central aim of the Khmer Rouge movement was the exponential increase of Cambodia's agricultural output, which precipitated a forced labor movement that essentially pushed skilled or otherwise trained and educated classes (i.e., "New People") into agricultural occupations. Complementing this regime policy, the Khmer Rouge granted higher status and privileges to Cambodians with a rural, agricultural, or "unprivileged" background (i.e., "Base People"). This reordering of society and the socio-economic classes directly or indirectly meant that individuals from the agricultural class/Base People possessed at least a higher likelihood of survival, if only because they were trusted over people with a non-agricultural background, i.e., the New People.

DC-Cam's observance of survivors who identify as farmers provides indirect support for the conclusion that a high percentage (if not most) of Cambodia's educated people from this generation who did not flee the country before 1975 died under the regime.[634]

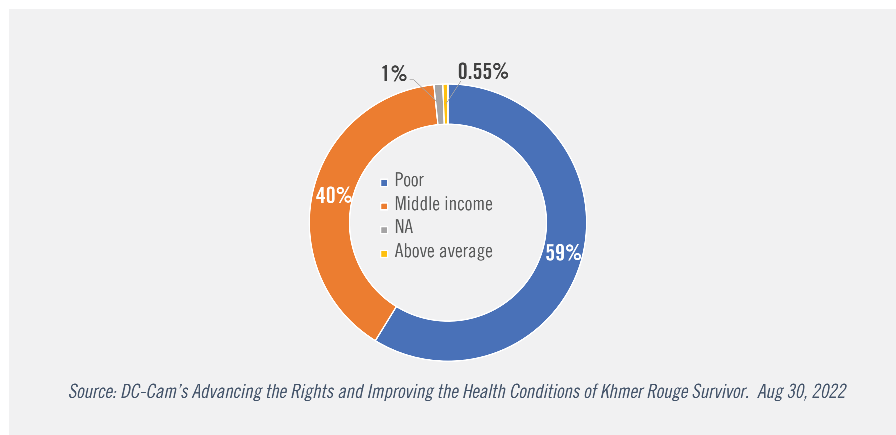
631 See generally Lauren C. Ng, et al., "Life after Genocide: Mental Health, Education, and Social Support of Orphaned Survivors," 2 Int. Perspective Psychology 2015, 4, 83–97 (2015), *available at* https://www.ncbi.nlm.nih.gov/pmc/articles/PMC4517679/

632 Jonathan Goodhand, "Violent Conflict, Poverty, and Chronic Poverty," Chronic Poverty Research Centre, 10-11 May 2001, *available at* https://www.files.ethz.ch/isn/128062/WP06_Goodhand.pdf.

633 In addition, looking from the lens of gender, it was found that almost 15 percent of men and 24 percent of women reported their occupation as unemployed. Five percent of men and 6 percent of women reported that they are "unable to work." Almost 4 percent of men reported their occupation as civil servants and a nominal 82 women (out of 21,844 respondents) reported they were civil servants (or well below 1 percent). Three percent of men (313 men) and 6 percent of women (1,411) are local business owners and a smaller number occupy a few other professions most notably laborers, educators, fishermen, and handicraft workers.

634 See Khamboly Dy, A History of Democratic Kampuchea 16 Documentation Center of Cambodia: Cambodia (2007). To fulfill the Khmer Rouge's ideological vision, the Khmer Rouge abolished money, free markets, and normal schooling, and they targeted the wealthy, educated, and any persons that identified with the former government or with an association with religious, scientific, cultural, or foreign interests. Ultimately, the Khmer Rouge effectively purged the country of a significant percentage of its educated classes, leaving what would be a significantly higher percentage of survivors with a relatively lo-w income background that was predominantly based on farming or low-skilled, rural occupations.

Figure 7: Economic conditions of survivors

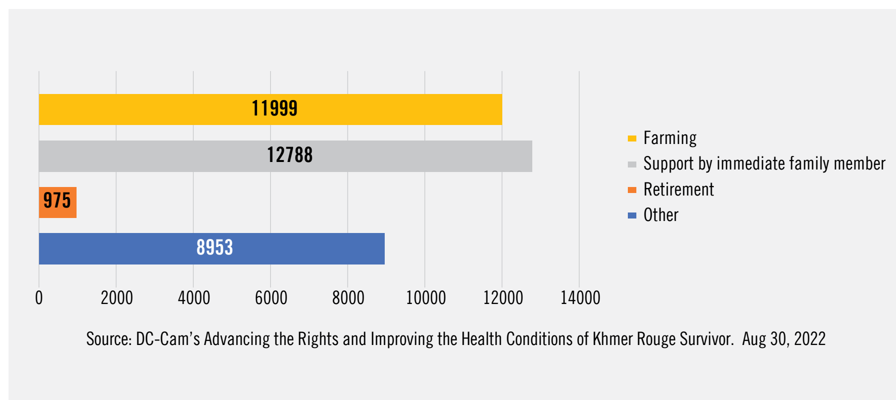



*Source: DC-Cam's Advancing the Rights and Improving the Health Conditions of Khmer Rouge Survivor. Aug 30, 2022*

Approximately 70 percent of respondents identified either farming or support by a family member as their primary source of income. Support from family members received a slightly larger number of affirmative responses than farming. Outside of these choices, approximately 26 percent of respondents identified other sources, which ranged from business-related fields to civil service, fishing, or crafts, and a small percentage (roughly 3 percent) received a pension or annuity as the primary source of income.

Fifty-nine percent claimed poverty, and 40 percent claimed middle-class income. Less than 1 percent claimed to have an income above average.

Figure 8: Source of income




Source: DC-Cam's Advancing the Rights and Improving the Health Conditions of Khmer Rouge Survivor. Aug 30, 2022

Figure 9: Occupation by gender

| OCCUPATIONS | BY MEN AND WOMEN | | | | | |
|---|---|---|---|---|---|---|
| | Men | % | Women | % | Total | % |
| Farmer | 6022 | 19.21% | 11640 | 37.14% | 17662 | 56.35% |
| Unemployed | 1416 | 4.52% | 5236 | 16.70% | 6652 | 21.22% |
| Unable to Work | 489 | 1.56% | 1374 | 4.38% | 1863 | 5.94% |
| Local Business Owner | 313 | 1% | 1411 | 4.50% | 1724 | 5.50% |
| Housewife | 17 | 0.05% | 1022 | 3.26% | 1039 | 3.31% |
| Public Servant | 377 | 1.20% | 82 | 0.26% | 459 | 1.46% |
| Labor Worker | 172 | 0.55% | 273 | 0.87% | 445 | 1.42% |
| Retired | 213 | 0.68% | 120 | 0.38% | 333 | 1.06% |
| Other | 99 | 0.32% | 216 | 0.69% | 315 | 1% |
| NA | 63 | 0.20% | 235 | 0.75% | 298 | 0.95% |
| Fisherman | 118 | 0.38% | 81 | 0.26% | 199 | 0.63% |
| Educator | 92 | 0.29% | 55 | 0.18% | 147 | 0.47% |
| Handicraft Worker | 21 | 0.07% | 98 | 0.31% | 119 | 0.38% |
| Transport Worker | 89 | 0.28% | 1 | 0% | 90 | 0.29% |

*Source: DC-Cam's Advancing the Rights and Improving the Health Conditions of Khmer Rouge Survivor. Aug 30, 2022*

Sixty percent of survivors are married or living together, and 33 percent are widowed. Three percent never married or lived with a partner; 2 percent are divorced or separated; and 2 percent did not respond.

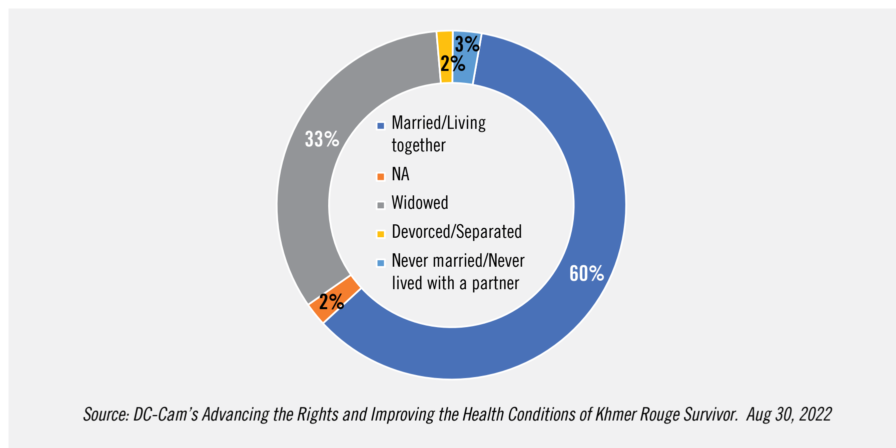
During the Khmer Rouge period, couples were often forcibly married, and many were married in mass ceremonies in which there could be a few or as many as a hundred couples at a ceremony. The Khmer Rouge did not allow men and women to choose their partners. Instead, men and women were designated as couples to wed, principally to produce children, and the strict regulation of the family was under the Khmer Rouge's ideological vision for Cambodian society. In some circumstances, couples did not even know the names of their future spouses or even who they were before the ceremony. The nationwide policy to regulate family-building and marriage under a climate of fear and without the consent of the individuals amounted to the crime of forced marriage and rape as determined by the Extraordinary Chambers in the Courts of Cambodia (ECCC) in Case 002.[635]

The high percentage of survivors that remain married or living together as opposed to divorced speaks possibly for the resilience of the institution of marriage in Cambodia despite the history of forced marriage that occurred in the Khmer Rouge regime; however, the study did not specifically ask survivors whether their marriage occurred before, during or after the Khmer Rouge regime, such that the

635 See Case 002/19-09-2007-ECCC-SC, "Appeal Judgment", Extraordinary Chambers in the Courts of Cambodia (ECCC) , Supreme Court Chamber, December 23, 2022, *available at* https://www.eccc.gov.kh/sites/default/files/documents/courtdoc/%5Bdate-in-tz%5D/F76_EN.pdf.

percentage of married versus divorced survivors is associated in some way with the Khmer Rouge regime. In addition, the study did not explore the question of how many survivors were forced to marry under the Khmer Rouge regime and how many of these couples remained married to their spouses from this period.

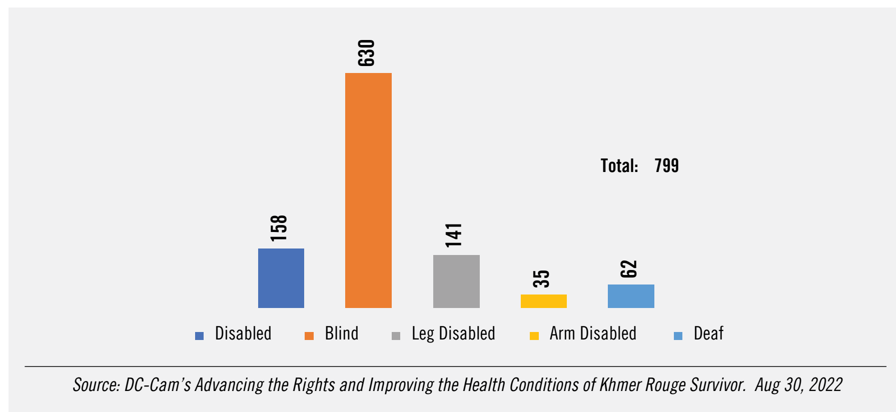
Figure 10: Marital status of survivors



*Source: DC-Cam's Advancing the Rights and Improving the Health Conditions of Khmer Rouge Survivor. Aug 30, 2022*

Approximately 3 percent of the total population of respondents claimed a physical disability (799 out of a population of 31,345 respondents). Of this group, almost 62 percent were blind, 17 percent had a disability with an extremity (i.e., leg or arm), and 6 percent claimed complete hearing loss. Approximately 15 percent claimed another form of physical disability besides these.

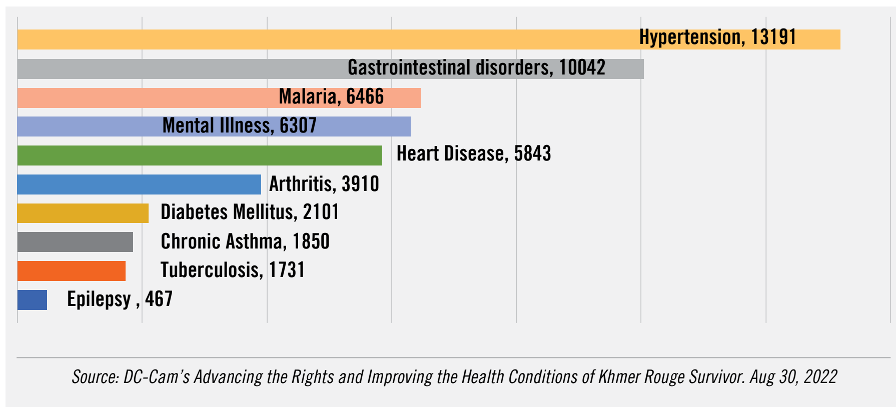
Figure 11: Disability of survivors



*Source: DC-Cam's Advancing the Rights and Improving the Health Conditions of Khmer Rouge Survivor. Aug 30, 2022*

Survivors of the Khmer Rouge suffered from several common diseases, health conditions, and ailments. Respondents were allowed to select from a few options, and they could mark down more than one response to the question, "What are diseases or physical ailments that you are currently experiencing on a daily basis?" Forty-two percent of respondents endorsed "hypertension" and 32 percent reported "gastrointestinal disorders." Twenty percent of respondents claimed malaria, and 20 percent claimed mental illness. Almost 19 percent of respondents claimed heart disease, and 12 percent claimed arthritis. Over 6 percent of respondents claimed they were suffering from diabetes mellitus, and almost 6 percent claimed chronic asthma. Finally, nearly 6 percent of respondents stated they were suffering from tuberculosis.

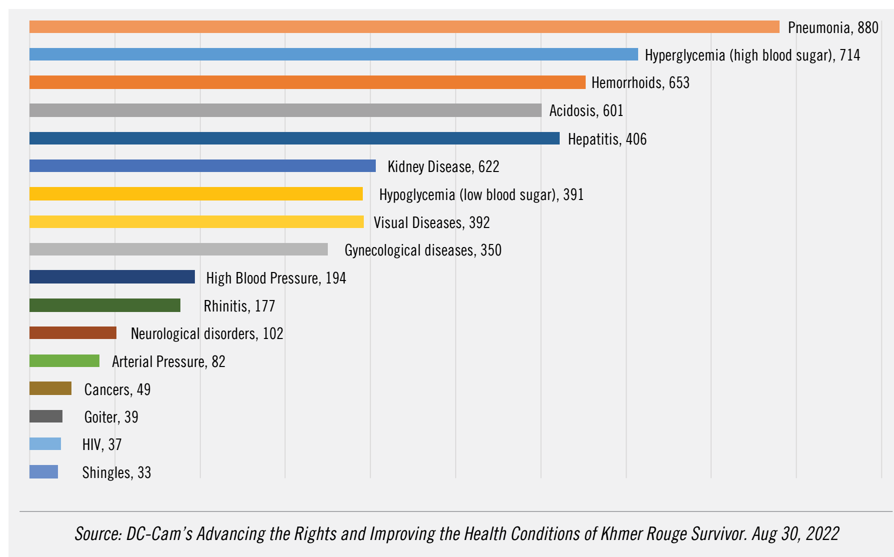
Figure 12: Common diseases faced by survivors




*Source: DC-Cam's Advancing the Rights and Improving the Health Conditions of Khmer Rouge Survivor. Aug 30, 2022*

The respondents also listed a variety of other ailments, diseases, or chronic conditions, which are listed below in order of largest to smallest number of responses: Pneumonia; Hypoglycemia (high blood sugar); Hemorrhoids; Acidosis; Kidney disease; Hepatitis; Hypoglycemia (low blood sugar); Eye (or optical) diseases or impairments; Gynecological diseases; Cancers; Goiter; Human Immunodeficiency Virus (HIV); and Shingles.

Figure 13: Diseases faced by survivors

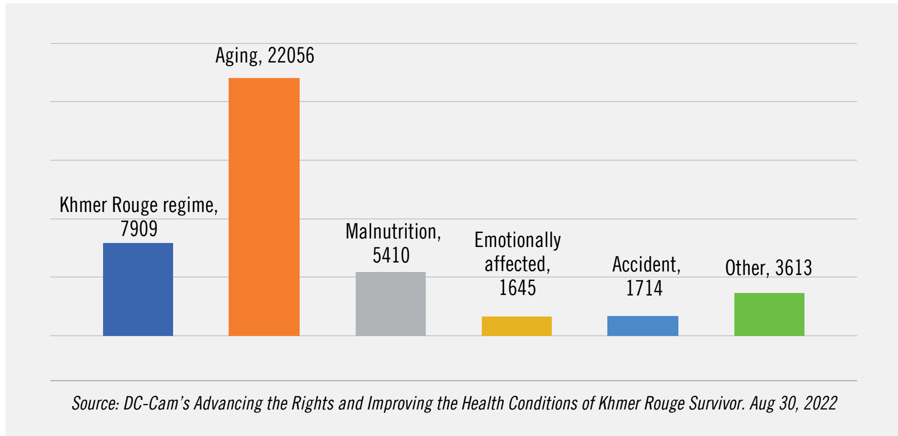



*Source: DC-Cam's Advancing the Rights and Improving the Health Conditions of Khmer Rouge Survivor. Aug 30, 2022*

Respondents identified several causes for their illness, disease, or ailment. Seventy percent of respondents attributed their illness, disease, or ailment to old age. Twenty-five percent of respondents attribute the cause of their illness, disease, or ailment to their experiences under the Khmer Rouge regime. Seventeen percent also attribute their conditions to malnutrition, 5 percent associated their conditions with unknown emotional affliction or trauma, and 5 percent associated their conditions with an accident.

As noted previously, confounding is a significant factor impacting the value of the preceding data as reported by survivors. First, because the data is based on survivors' perceived health conditions, the reported conditions must be considered subjective, such that survivors could claim a particular condition that may not be accurate as determined by a medical diagnosis by a licensed health provider. There is a risk that survivors may underreport or overreport their conditions, and there is also a risk that survivors' reported conditions may be based on an outdated medical diagnosis, such that the conditions may be significantly better or worse since this last diagnosis and their current health is different than what they are reporting. Finally, the survivors' reported causes for their conditions may be speculative at best or worse, based on their personal beliefs that a licensed medical provider has not validated. These circumstances reduce the validity and reliability of the data; however, the data nonetheless provides an essential reference for understanding how survivors perceive their health and underlying causes or bases.

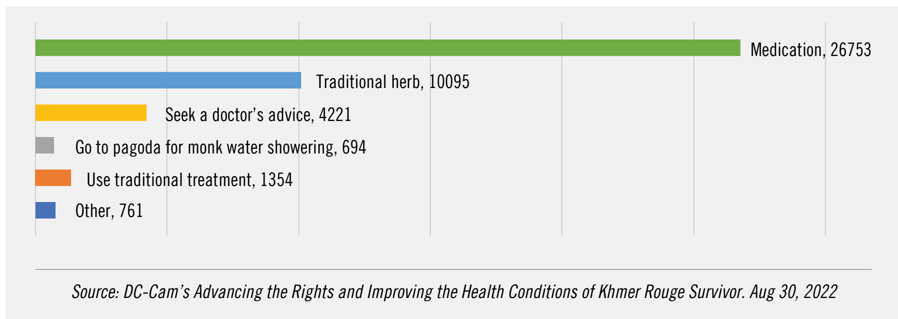
Figure 14: Cause of illness




Over 85 percent of the respondent population relied upon medication, and 32 percent depended upon traditional herbs as treatment methods for their ailments. Only 13 percent received medical advice from a trained medical professional. Almost 7 percent relied upon conventional healing methods or the water blessing of a monk as treatment for ailments.

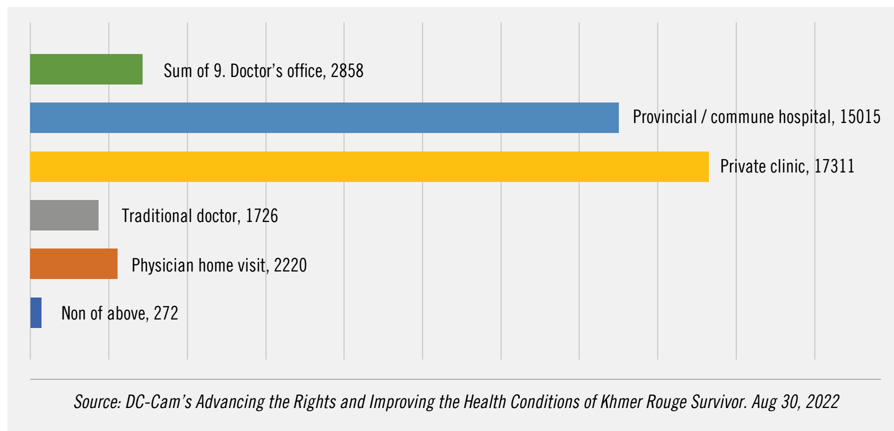
Notably, this study did not identify specific types of medicine or traditional herbs. Additionally, this study did not clarify whether medicine or traditional herbs were ever based on or overseen by a licensed medical provider. Further research may identify other factors that predispose survivors to depend upon medication or provide context to the significant reliance on medicine or traditional herbs as a form of treatment.

Figure 15: Treatment methods



In response to the question of treatment locations, 55 percent reported they sought treatment at a private clinic, and almost 48 percent also reported seeking treatment from a provincial/ commune hospital. Approximately 16 percent received care at a doctor's office or based on a doctor's home visit. Five percent received care from a practitioner of traditional medicine.

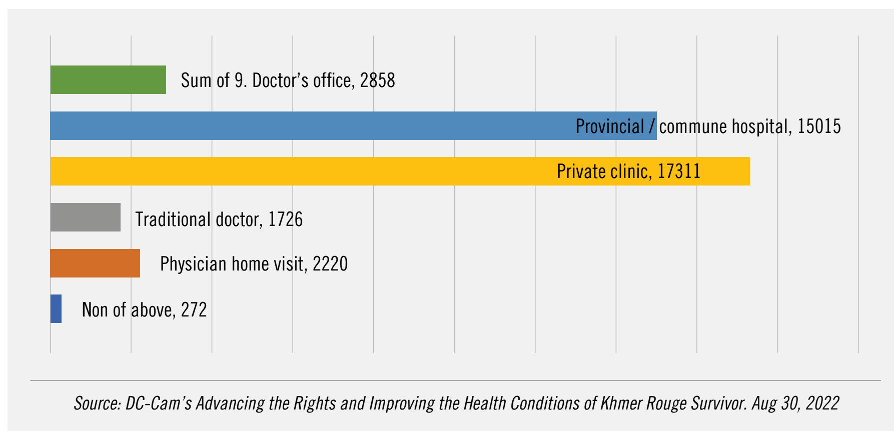
Figure 16: Treatment locations




*Source: DC-Cam's Advancing the Rights and Improving the Health Conditions of Khmer Rouge Survivor. Aug 30, 2022*

In response to the question, "Have you or anyone in your household needed medical treatment in the past year, 76 percent of respondents stated "yes." Broken down by gender, 75 percent of female respondents and 78 percent of male respondents stated they required medical care.

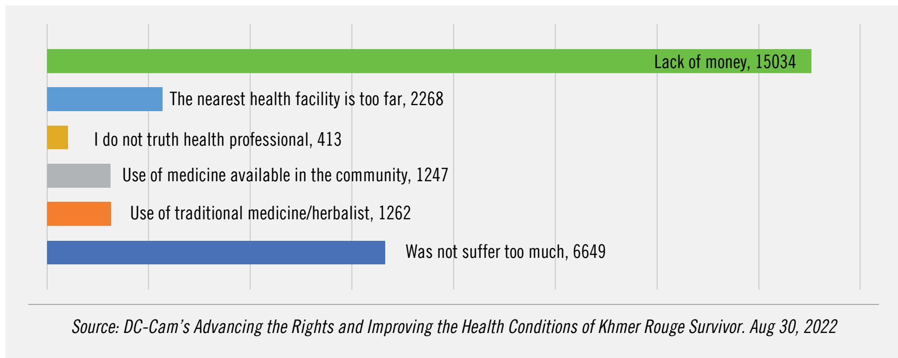
Figure 17: Access to medical care




*Source: DC-Cam's Advancing the Rights and Improving the Health Conditions of Khmer Rouge Survivor. Aug 30, 2022*

In response to the question, "Were you or your household member able to access medical treatment," 58 percent of respondents stated "yes," and 34 percent reported "no." Seven percent of respondents marked "did not know or no response" to the question. Broken down by gender, both female and male survivors responded with the exact percentages: 58 percent of female and male survivors for their respective gender population responded "yes," and 34 percent answered "no."

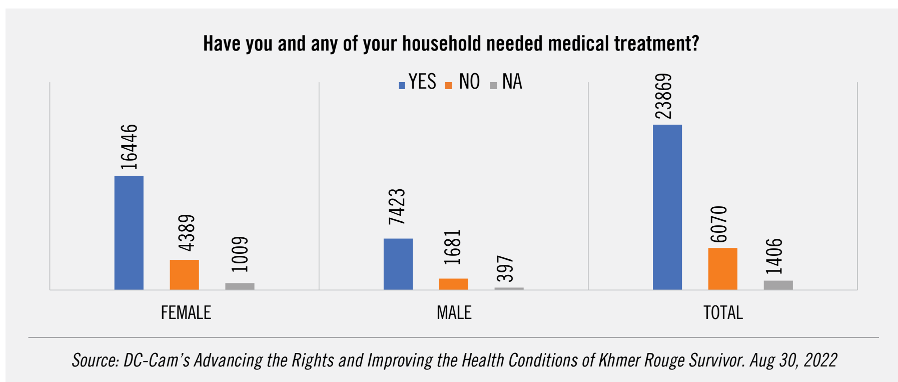
Figure 18: Access to medical care




*Source: DC-Cam's Advancing the Rights and Improving the Health Conditions of Khmer Rouge Survivor. Aug 30, 2022*

Nearly 48 percent of respondents reported the lack of financial resources as the reason for not receiving adequate medical care. Twenty-one percent of respondents stated they did not seek care because they felt they could endure the illness, ailment, or disease. Almost 7 percent of respondents reported they were too far from a health facility, and nearly 4 percent preferred to rely on traditional health medicine or herbs for treatment.

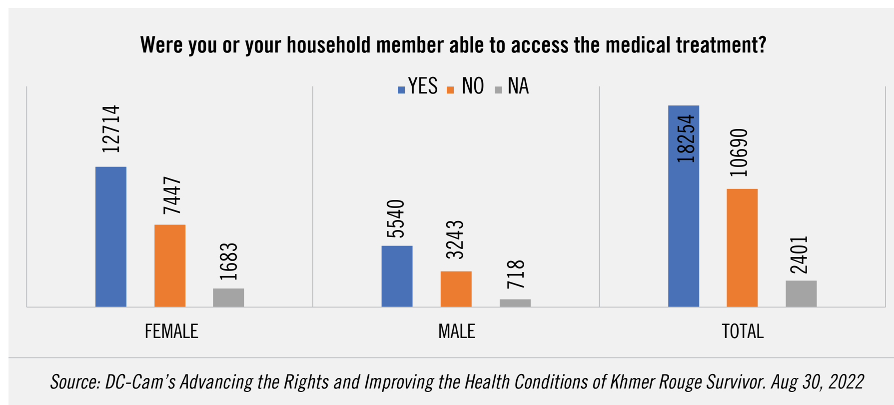
Figure 19: Access to medical care




*Source: DC-Cam's Advancing the Rights and Improving the Health Conditions of Khmer Rouge Survivor. Aug 30, 2022*

In response to the question, "What was the main reason you and your household members were not able to access medical treatment," an overwhelming percentage of respondents identified the lack of financial resources. Forty-two percent of all respondents identified financial resources as the primary reason for their inability to receive medical treatment. Broken down by gender, 42 percent of female survivors and 41 percent of male survivors identified financial resources as the primary impediment to access to medical care. The availability of medical personnel was the second most identifiable reason for not being able to access medical care. Almost 7 percent of survivors identified this circumstance as the primary reason for not obtaining care. At a smaller percentage, nearly 3 percent of survivors stated they did not receive care because they were turned away as a consequence of the facility being at or beyond its capacity to accept them as patients. Two percent of the respondents stated they were refused treatment. The questionnaire did not record the reasons for refusal.

Figure 20: Access to medical care




*Source: DC-Cam's Advancing the Rights and Improving the Health Conditions of Khmer Rouge Survivor. Aug 30, 2022*

Almost 84 percent of respondents stated they received a COVID-19 vaccination, and approximately 65 percent agreed to receive one in the future. Over 83 percent of female and almost 86 percent of male survivors received vaccinations. Sixty-three percent of female survivors and almost 68 percent of male survivors also stated they would get a vaccine.

Interestingly, there was an inverse relationship between the survivors' age group and their response to receiving a vaccine. The older the generation of survivors, the less likely they were to receive a vaccine. Over 95 percent of women aged 30-49 stated they received a vaccine. Ninety percent of female

survivors between the ages of 50-59 stated they received a vaccine, and approximately 85 percent of women aged 60-69 stated they received a vaccine. Roughly 78 percent of female survivors aged 70-79 received a vaccine, and almost 60 percent of survivors aged 80-89 received a vaccine. Only 49 percent of female survivors aged 90 and above stated they received a vaccine.

For male survivors, the pattern was similar. Approximately 93 percent of male survivors aged 30-49 received a vaccine, and approximately 90 percent of male survivors aged 50-59 received a vaccine. For male survivors within the 60-69 age group, almost 88 percent stated they received a vaccine, and approximately 83 percent of male survivors aged 70-79 reported receiving a vaccine. Approximately 71 percent of male survivors aged 80-89 received a vaccine. Of survivors 90 years or older, 67 percent reported receiving a vaccine.

In response to whether they agreed to get vaccinated in the future, almost 74 percent of female survivors between the ages of 30-49 stated "yes." This response diminished to 66 percent and 64 percent for female survivors between 50-59 and 60-69. Approximately 61 percent of female survivors between the ages of 70-79 and 53 percent of female survivors between the ages of 80-89 affirmed they would get vaccinated in the future. Only 54 percent of survivors who were 90 years old or older stated they would receive a vaccine in the future.

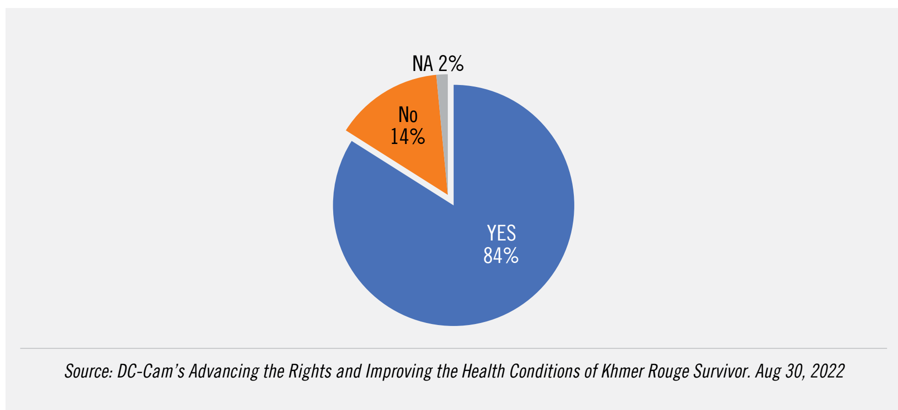
The male respondents reported a similar pattern of responses concerning receiving future vaccinations. Approximately 76 percent of male survivors between the ages of 30-49 and 69 percent of male survivors between 50-59 and 60-69 stated they would receive a vaccination in the future. This response decreased slightly with the rise in age of the respondents. Almost 67 percent of male respondents between the ages of 70-79 and 63 percent of male respondents between the ages of 80-89 reported "yes" to receiving future vaccinations. The one age group that differed from the reporting patterns was male survivors who were 90 years old or older. Sixty-seven percent of individuals in this age/gender group stated they would receive future vaccinations, which is commensurate with the responses of male survivors between the ages of 70-79.

Figure 21: Survivors and vaccinations

| Survivor by Age and Gender | Vaccinated | | | | Agree to get vaccinate in Future | | | | |
|---|---|---|---|---|---|---|---|---|---|
| | Yes | No | NA | Total | Yes | No | Not Sure | NA | Total |
| **Women** | 18154 | 3360 | 330 | 21844 | 13794 | 2059 | 110 | 5881 | 21844 |
| **30-49** | 115 | 5 | 1 | 121 | 89 | 4 | - | 28 | 121 |
| **50-59** | 5853 | 536 | 93 | 6482 | 4282 | 385 | 27 | 1788 | 6482 |
| **60-69** | 7110 | 1064 | 118 | 8292 | 5336 | 665 | 44 | 2247 | 8292 |
| **70-79** | 3953 | 996 | 85 | 5034 | 3065 | 589 | 22 | 1358 | 5034 |
| **80-89** | 1006 | 643 | 29 | 1678 | 893 | 365 | 15 | 405 | 1678 |
| **90-Above** | 117 | 116 | 4 | 237 | 129 | 51 | 2 | 55 | 237 |
| **Men** | 8168 | 1184 | 149 | 9501 | 6460 | 621 | 40 | 2380 | 9501 |
| **30-49** | 67 | 3 | 2 | 72 | 55 | 5 | - | 12 | 72 |
| **50-59** | 2509 | 227 | 39 | 2775 | 1918 | 131 | 7 | 719 | 2775 |
| **60-69** | 3100 | 376 | 50 | 3526 | 2427 | 196 | 20 | 883 | 3526 |
| **70-79** | 1868 | 337 | 39 | 2244 | 1501 | 167 | 11 | 565 | 2244 |
| **80-89** | 560 | 210 | 19 | 789 | 495 | 104 | 2 | 188 | 789 |
| **90-Above** | 64 | 31 | - | 95 | 64 | 18 | - | 13 | 95 |
| **Total** | 26322 | 4544 | 479 | 31345 | 20254 | 2680 | 150 | 8261 | 31345 |

*Source: Advancing the Rights and Improving the Health Conditions of Khmer Rouge Survivor/DC-Cam, Aug 30, 2022*

Figure 22: Survivors' willingness to obtain vaccines in the future




*Source: DC-Cam's Advancing the Rights and Improving the Health Conditions of Khmer Rouge Survivor. Aug 30, 2022*

## MEMORIES OF SURVIVORS

There is a significant need for research on the impact of atrocity crimes on mental health, as most studies of the survivors of atrocity crimes are largely observational and lacking in epidemiological rigor.[636] Notwithstanding this circumstance, it seems like an irrefutable fact that individuals who experience atrocity crimes can be said to have experienced stressors that will make them more likely to suffer from mental health problems than individuals who have not had such experiences. "The impact of genocide continues long after the killing has ended, leaving lifelong scars on survivors and, potentially, their offspring."[637] Based on a review of studies conducted from 2000 to 2017, the World Health Organization estimated that in conflict-affected areas, the prevalence of mental health disorders, including post-traumatic stress disorder, depression, and anxiety, is approximately 22 percent.[638] It should be noted that those who do not meet the criteria for a mental health disorder may likely still experience significant and potentially debilitating symptoms that negatively impact their life.

For Cambodia, the survivors of the Khmer Rouge were generally exposed to a broad spectrum of torture, depravation, forced labor, and forced transfer, in addition to crimes of violence, including mass executions. Given the amount of time that has passed, there is no question that there are many possible confounding variables between the experience of the Khmer Rouge regime and current mental health symptoms. However, this circumstance should not diminish the presumption that there is a percentage of the survivor population suffering from mental health disorders and other potentially debilitating mental health symptoms that at least partially originate from the Khmer Rouge period.

Out of the entire survivor population who participated in the study, 25 percent stated they still had recurring nightmares about life under the Khmer Rouge (and the remainder, or 75 percent, stated "no"). This response percentage was the same for both genders, with 25 percent of both female and male respondents stating they had recurring nightmares. In response to the question, what feelings do they have when they reflect upon the Khmer Rouge period? Approximately 65 percent

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636 See Jutta Lindert, et al., "Psychopathology of children of genocide survivors: a systematic review on the impact of genocide on their children's psychopathology from five countries," Int'l J. of Epidemiology 2017, 246-257 (finding that the "literature on genocide and psychopathologies is characterized by low epidemiological rigor" and "there is a lack of longitudinal studies in the field of genocide and health studies.").

637 See Jutta Linder, et al., "The long-term health consequences of genocide: developing GESQUQ – Genocide Studies Checklist," Conflict and Health 13:14 (2019).

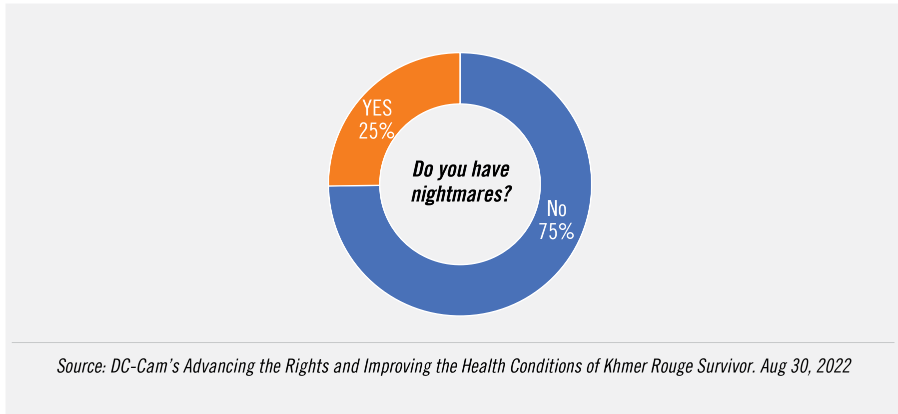
638 See Fiona Charlson, et al., "New WHO prevalence estimates of mental disorders in conflict settings: a systematic review and meta-analysis," Lancet 240–248 (July 20, 2019).

felt anger when they reflected on the Khmer Rouge period; almost 45 percent felt afraid, and nearly 36 percent felt sad.

Figure 23: Memories of survivors

| Age Group/ Gender | Haunted by KR Experience | Night-mare About KR Experience | WHEN REMEMBER ABOUT KR, I FEEL: | | | | |
|---|---|---|---|---|---|---|---|
| | | | Angry | Afraid | Forgotten | Forgive them | Sad |
| **Total** | ***26983*** | ***7784*** | ***20464*** | ***14096*** | ***1977*** | ***1167*** | ***11148*** |
| **50-59** | 8149 | 2558 | 6085 | 4368 | 549 | 285 | 3397 |
| **60-69** | 10359 | 3069 | 7889 | 5244 | 693 | 432 | 4209 |
| **70-79** | 6245 | 1654 | 4802 | 3306 | 476 | 326 | 2597 |
| **80-89** | 1989 | 454 | 1493 | 1040 | 219 | 116 | 833 |
| **90-Above** | 241 | 49 | 195 | 138 | 40 | 8 | 112 |
| | | | | | | | |
| **Female** | ***18734*** | ***5365*** | ***14204*** | ***10202*** | ***1435*** | ***752*** | ***7820*** |
| **50-59** | 5680 | 1787 | 4224 | 3171 | 395 | 195 | 2407 |
| **60-69** | 7253 | 2142 | 5536 | 3837 | 505 | 275 | 2950 |
| **70-79** | 4291 | 1102 | 3313 | 2356 | 345 | 202 | 1802 |
| **80-89** | 1340 | 297 | 995 | 735 | 161 | 74 | 581 |
| **90-Above** | 170 | 37 | 136 | 103 | 29 | 6 | 80 |
| | | | | | | | |
| **Male** | ***8249*** | ***2419*** | ***6260*** | ***3894*** | ***542*** | ***415*** | ***3328*** |
| **50-59** | 2469 | 771 | 1861 | 1197 | 154 | 90 | 990 |
| **60-69** | 3106 | 927 | 2353 | 1407 | 188 | 157 | 1259 |
| **70-79** | 1954 | 552 | 1489 | 950 | 131 | 124 | 795 |
| **80-89** | 649 | 157 | 498 | 305 | 58 | 42 | 252 |
| **90-Above** | 71 | 12 | 59 | 35 | 11 | 2 | 32 |

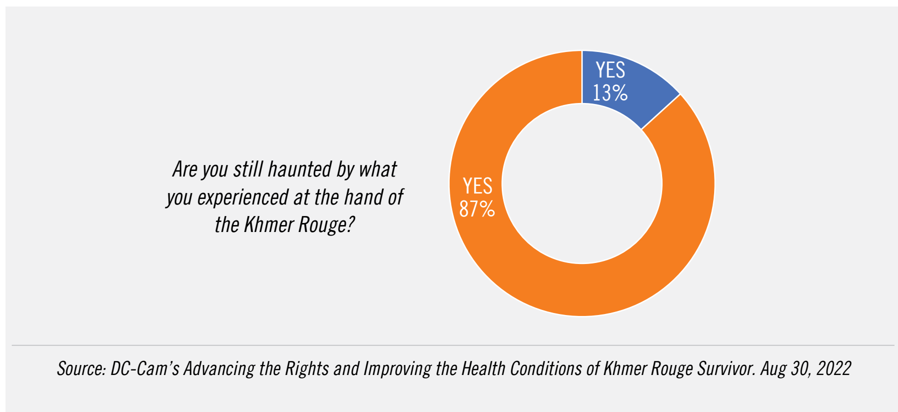
Figure 24: Nightmares of survivors




*Source: DC-Cam's Advancing the Rights and Improving the Health Conditions of Khmer Rouge Survivor. Aug 30, 2022*

In response to the question, "Are you still haunted by what you experienced at the hands of the Khmer Rouge?" 87 percent of respondents stated "yes," and the remaining (13 percent) said "no."

Figure 25: Memories of survivors




*Source: DC-Cam's Advancing the Rights and Improving the Health Conditions of Khmer Rouge Survivor. Aug 30, 2022*

## CONCLUSION

DC-Cam found most Khmer Rouge survivors who took part in its survey cited financial circumstances as the primary reason for not seeking treatment for mental or physical health conditions, disabilities, or ailments. DC-Cam also found that among the physical or mental health conditions reported by survivors, hypertension and gastrointestinal disorders, followed by malaria, mental illness, and heart disease, were, in this order, the most important health concerns and debilitating conditions for survivors. While DC-Cam has more work to do in developing an understanding of these issues, it is notable that these conditions also coincide with survivors' reported mental health conditions and concerns from their experiences under the Khmer Rouge regime. Eighty-seven percent of survivors who were surveyed by DC-Cam reported having troubling memories of the Khmer Rouge period that resonated with them to date, and 25 percent of respondents reported still suffering nightmares of this period, even though these experiences occurred over forty years ago.

DC-Cam found that medication, as opposed to visits to a public or private healthcare provider or hospital, is the primary method used to treat lingering or unexpected medical care needs. Survivors' reliance on medicine to meet medical care needs may indicate that, rather than financial resources alone, one's access to care may be significantly influenced by other overlapping geographic or socio-organizational accessibility conditions.

Access can be conceptualized in different ways—from the distribution of medical services, resources, and facilities to the external characteristics of a population, such as insurance coverage, attitudes to medical care, and income. It is possible that improving access and consequently improving the health and welfare of survivors of atrocity crimes may be less a matter of addressing the financial circumstances of survivors and more a question about how to make medical care more convenient, trusted, and reliable. The data from this survey invites as many questions as it does observations. Future research can focus on these questions, many of which are driven by limitations or gaps in the information collected in this study. Further research can also be oriented to the recommendations drawn from this study. A list of the essential findings and recommendations is provided below.

## KEY FINDINGS

1. Cambodian survivors predominantly identify as poor, unemployed, or employed in relatively low-wage occupations (particularly agriculture).
2. Women represented a higher percentage of the respondents across all age groups.
3. Cambodian survivors predominantly attributed any illness, disease, or ailment they are suffering to old age.
4. Survivor communities appear to be concentrated in Cambodia's Tonle Sap Lake and Plains regions.
5. Hypertension, gastrointestinal disorders, and mental illness stood out as the most reported potential health conditions that could have been directly or indirectly associated with life under the Khmer Rouge regime.
6. A notable percentage of survivors (at least 1 out of 4 respondents in this study) are reported to still suffer from some type of mental health condition or symptom that can be attributed to experiences under the Khmer Rouge.
7. Medication, as opposed to visits to a public or private healthcare provider or hospital, is the primary method used for treatment by survivors of lingering or unexpected medical care needs.
8. The majority of survivors received a COVID-19 vaccination; however, the fact that the older the generation of survivors, the reduced likelihood they received a vaccine raises an untested hypothesis that the older the generation, the greater the challenge in providing new information, medicine, or treatment.

## RECOMMENDATIONS

1. Actions, policies, or programs to address or offset the cost of medical care for survivors should be explored to improve survivors' access to medical care.
2. Actions, policies, or programs aimed at addressing or supporting the support networks of survivors will also improve survivors' access to care for survivors, particularly in remote and marginalized populations.
3. Because women represented a higher percentage of the respondents across all age groups, there may be a potential need for greater attention to sex- and gender-sensitive care, resources, and support services for survivors.
4. There is a need for greater attention to information, services, and resources that support healthy behaviors and routines among survivors.

5. Future direct action or research programmes targeting survivor communities can target Cambodia's Tonle Sap Lake and Plains regions; however, other areas of Cambodia, such as the Anlong Veng region, present possibilities for further research.
6. There is a need for greater attention to information, services, and resources that support mental health among survivors and their families.

# EXTRAORDINARY CHAMBERS IN THE COURTS OF CAMBODIA REPORT ON MENTAL HEALTH

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## ABSTRACT

This chapter examines the Extraordinary Chambers in the Courts of Cambodia and its pioneering approaches to integrating considerations of psychosocial wellbeing into justice proceedings in order to address the traumatic effects of the Khmer Rouge regime on impacted populations. It explores the strategies of the tribunal for the support of witnesses and support personnel, assessment of the mental fitness of the accused, and the implications of reparations and public outreach programs, which illuminate the Court's comprehensive approach to addressing psychosocial wellbeing on individual and societal levels. The ECCC adopted innovative practices for participants such as in-court psychological support and extensive mental health services based on its appreciation of the severe psychosocial repercussions of the crimes being adjudicated in the tribunal. The chapter also discusses the provision of reparations to facilitate collective healing. It argues that the Court's integration of mental health support facilitated a more humane and effective judicial process and has set an important precedent in conducting international tribunals with the aim of societal healing and reconciliation.

## HOW THE ECCC HANDLED MENTAL HEALTH IN THE PROCEEDINGS

The Extraordinary Chambers in the Courts of Cambodia (ECCC), also known as the Khmer Rouge Tribunal, was a court established in 2006 to adjudicate the most senior officials of the Khmer Rouge for international crimes and serious violations of Cambodian penal law. In these legal proceedings, mental health was a crucial consideration for witnesses, the accused, and the collective psychosocial well-being of Cambodian society.

The ECCC recognized that participation in the tribunal could be a traumatic experience for witnesses and victims, particularly those who were survivors of the Khmer Rouge regime. As a result, the court took steps to proactively mitigate this trauma, including through witness support, protective measures, in-court support, outreach programs, and reparation projects.

As with other international tribunals, the ECCC had procedures in place to assess the accused's fitness to stand trial, including evaluating whether the accused were mentally competent to understand the charges against them and to participate in their defense. The court could order a psychiatric evaluation if concerns regarding mental competence arose. For example, former Khmer Rouge minister Ieng Thirith and another defendant were declared unfit to stand trial due to dementia. This chapter describes the witness support endeavors, reparation projects, that were initiated during this time.

**Witness Support**

The Victims Support Section (VSS) and the Witness/Expert Support Unit (WESU) supported witnesses and experts before, during, and after their testimony, including psychological preparation and counseling. In ECCC proceedings, "experts" generally refers to a range of professionals contributing specialized knowledge and necessary skills for the tribunal, particularly to contextualize and assess the impact of crimes. In addition, "support personnel" include these experts and those who provide essential services such as translation and interpretation to ensure clear communication. Experts in ECCC proceedings included psychiatrists, forensic psychologists, legal scholars, historians, and other specialists able to provide testimony and insights that could inform the tribunal's understanding of relevant events, their psychosocial contexts, and the psychological state and mental health impacts of witnesses and victims. Psychiatrists and forensic psychologists were needed to assess the psychosocial impact of actions by the Khmer Rouge on victims and the mental competence of the accused on trial. Their provision of expert testimony regarding traumatic effects helped convey the severity of the crimes and impact on victims. The expertise of legal scholars and historians helped establish the facts and contexts of

the crimes as well as assisted in interpreting relevant international law. The ECCC was a multilingual proceeding in which translators and interpreters facilitated communication to ensure that all parties were able to comprehend the testimonies and legal arguments presented.

Psychological support was provided to these groups of support personnel due to the expected stressors associated with their roles and the traumatic material with which they would frequently contend, victims' testimonies regarding the severe human rights abuses they endured. The ECCC proactively considered the gravity of secondary or vicarious traumatic stress often resulting from exposure to the traumatic content of others' experiences, and offered psychological support before, during, and after the proceedings to mitigate such risks, which contributes to the psychosocial well-being and effectiveness of all support personnel in fulfilling their roles in the tribunal.

The ECCC implemented various protective measures for the safety and psychological well-being of witnesses providing testimony in support of prosecutions, including testifying via video link or with the assistance of a psychologist or psychiatrist. The court also took measures to ensure that the environment in the courtroom was as supportive as possible. For some witnesses, recalling their experiences could be re-traumatizing. Having mental health professionals present during their testimony was a way to provide immediate support if needed.

To promote broader societal healing and reconciliation, the ECCC's Public Affairs Section decided to inform the Cambodian public about the court's work. An integral part of this effort was acknowledging the psychosocial impact of the Khmer Rouge era on Cambodian society.

**Reparation Projects**

The ECCC included a mandate for non-judicial measures of reparation, which aimed to provide collective and moral reparations to victims. These reparations often included components designed to address the long-term psychosocial consequences of the crimes committed by the Khmer Rouge. The ECCC's approach to mental health reflected a growing recognition within international criminal justice that addressing psychological well-being and trauma was crucial to the process of justice and reconciliation. By incorporating mental health support into its proceedings, the ECCC aimed to facilitate a process that was as restorative as possible for all participants while acknowledging the deep scars left by the events it was investigating.

Part of ECCC's mandate was to provide justice to victims of the Khmer Rouge regime through symbolic (e.g., apologies, memorials, and educational programs) or material (e.g., monetary compensation) reparations. The reparations aimed to address past harms, acknowledge the suffering of victims, and provide restitution by restoring dignity and contributing to personal and communal healing.

The collective psychological effects of the ECCC's reparations include providing a sense of justice, empowerment, and reconciliation.

**Acknowledgment of Suffering**

For many victims, the formal acknowledgment of their suffering and the recognition of the injustices they endured can validate their experiences and serve as an important means of healing, particularly when validated in the final decisions of an authoritative court such as the ECCC.[639]

Another critical aspect of healing is a sense of closure for victims. Reparations and formalized authoritative decisions can signify a public societal acknowledgment that wrongdoing occurred and that it was unjust.[640] The Handbook of Reparations[641] describes reparations policy redressing human rights violations in Chile, Brazil, El Salvador, Haiti, South Africa, and various countries where mass crimes have occurred. In Chile, for example, these have included pensions, social services, educational benefits, public recognition of violations, and health assistance—a combination of societal acknowledgment of past wrongs and victim support in the healing process. The sense of justice provided through transitional justice mechanisms such as the ECCC often encompasses restorative and retributive justice elements.

Importantly, court decisions and reparations acknowledging suffering can act as a bulwark against historical revisionism by formalizing and preserving collective memory to learn from past atrocities.[642]

Collective acknowledgments can assist with the societal reintegration of victims, allowing impacted groups to experience a sense of belonging to a society that once ostracized and mistreated them. It is also crucial to rebuilding trust within communities. Although no form of compensation can completely undo the harm, pain, and suffering that victims endured, it is essential to find ways for societies to acknowledge and repair the injuries.[643] A broad scope of actions, such as historical education, social repair, and community rebuilding, have

639 E. Stover. The Witnesses: War Crimes and the Promise of Justice in the Hague (2005).
640 A. Ferrara. Assessing the Long-term Impact of Truth Commissions: The Chilean Truth and Reconciliation Commission in Historical Perspective (2015).
641 P. De Greiff. The Handbook of Reparations (2006).
642 Ferrara, *supra* note 640.
643 M. Minow. Between Vengeance and Forgiveness: Facing History after Genocide and Mass Violence (1998)

been shown to help victims and their families and to serve broader societal goals. These can be achieved through financial payments, returning land or artifacts, and public commemorations or apologies. This approach to reparations aims to address past mass violence using mechanisms such as trials and truth commissions, as well as therapeutic and educational functions of reparations for acknowledging the past and aiding in societal healing.

Acknowledgment and reparations may also impact future generations, offering a narrative that duly recognizes past atrocities. Documentation is essential for societal healing and the prevention of future escalation of violence that threatens to erode human rights. Benefits include deterring future crimes, eradicating systems and cultures of impunity, and rebuilding fractured societal relations, especially by repairing relationships damaged by violence.[644] This process is most effective when part of a holistic approach to post-conflict reparations, including material reparations, truth-telling, and measures that guarantee non-recurrence.

A just recovery and solid foundation for sustainable peace and justice requires addressing all dimensions of injustice (symptom, consequence, and cause) and rebuilding all dimensions of justice (legal, rectification, and distributive).[645] Critical of limiting solutions to legalistic, minimalist, or superficial remedies that do not consider cultural and political context, a comprehensive approach involves understanding the full spectrum of injustices that arise during conflicts. Injustices can be visible (symptoms), have secondary effects (consequences), and have underlying issues (causes) that lead to conflict. Legal justice involves the rule of law and establishing fair legal systems to address crimes and wrongdoings. Reification justice requires correcting wrongs through measures such as reparations or restorative practices. Distributive justice focuses on equitable distribution of resources and opportunities—a cornerstone of redressing economic disparities that often contribute to conflict. Mani argues that successful justice interventions require consideration of local traditions and situational specificities and addressing deeper, systemic issues in these ways to disrupt cycles of violence and injustice.

Reparation efforts involving community-based processes can support collective healing, as they tend to be more culturally appropriate and responsive to the needs of victims. Local responses to transitional justice are more attuned to local realities and cultural specifics. They may destabilize the assumptions of global or standardized approaches but tend to align more closely with the needs

644 L. Huyse & M. Salter. Traditional Justice and Reconciliation after Violent Conflict: Learning from African Experiences (2008).
645 R. Mani. Beyond Retribution: Seeking Justice in the Shadows of War (2002).

and expectations of local populations.[646] Local, responsive approaches to post-conflict social reconstruction have a greater probability of success in fostering healing and justice. For example, the prioritization of international models of retributive justice over local demands for third-party facilitation of dialogue and reconciliation, as in the case of the ICC's intervention in Uganda from 2006 to 2008, can undermine communal efforts for social solidarity in the aftermath of violence.[647] However, researchers warn against undermining the universality of human rights and discourage assumptions that it is necessarily appropriate or fair because a norm is local or considered a traditional practice. Solutions must be aligned with systemic equity and justice in accordance with the spectrum of justice required for a comprehensive approach that creates conditions to prevent conflict.[648]

**Sense of Justice**

Reparations may contribute to a sense of justice, which can be therapeutic for survivors. The ECCC provided a forum for victims' voices to be heard and their accounts to be officially recorded, facilitating personal and collective healing processes.

During periods of significant societal transformation, such as from authoritarian to democratic rule, the law can play a profound role through its application and the symbolic acts of justice it provides, helping to establish a normative order, societal stability, and restoration of trust in legal and governmental systems.[649] The stabilizing role of law through court decisions leading to reparations can reinforce legal norms and expectations that establish predictable patterns necessary to fulfill social, economic, civil, political, and cultural rights. Court decisions culminating in reparations, such as those of the ECCC, can reinforce the rule of law and generate predictability in a society that has experienced lawlessness and arbitrariness, such as Cambodia during the Khmer Rouge, which contributes to restoring trust in legal institutions.

The act of witnessing perpetrators held to account and the receipt of reparations can be therapeutic for survivors. However, in the case of survivors of sexual and gender-based violence (SGBV), Herman advocates for justice systems that integrate the strengths of both retributive and restorative modes with a sharp focus on the specific needs of victims, which requires prioritizing the active involvement of victims in the justice process, genuine

646 R. Shaw, L. Waldorf & P. Hazan. Localizing Transitional Justice: Interventions and Priorities after Mass Violence (2010).

647 Finnstrom, S. *Reconciliation Grown Bitter? War, Retribution, and Ritual Action in Northern Uganda*. Localizing Transitional Justice: Interventions and Priorities After Mass Violence. (2010).

648 J.S. Jiang. Localizing Transitional Justice: Interventions and Priorities after Mass Violence. 36 Yale Journal of International Law 1 (2011).

649 R.G. Teitel. Transitional Justice (2000).

acknowledgment of harms perpetrated against them, and ensuring their safety and dignity.[650] This is based on findings that neither retributive nor restorative models of justice adequately address the needs and wants of SGBV survivors, who often seek validation, vindication, and safety rather than revenge or reconciliation with perpetrators or bystanders.

Conventional legal systems routinely fail SGBV victims by sidelining their experiences and by adhering to societal biases that implicitly support SGBV perpetrators or fail to acknowledge and address the harm to SGBV victims adequately. Survivors value community condemnation of the perpetrator and reaffirmation of their worth and societal standing in the aftermath of such crimes. Restorative justice processes struggle to provide this given the heavily skewed power dynamics between victims and perpetrators of SGBV, its inability to validate survivors' experiences adequately, the need for safety, and the acknowledgment of harm.

This is an especially weighty problem given that perpetrators of SGBV are known to the victim and often respected or beloved by the community or family members, including often in the eyes of the victim. Community support for victims, including de-stigmatization, combined with efforts to transform societal attitudes condoning SGBV crimes toward gender equity and understanding SGBV as causing severe harm, are crucial from the perspective of SGBV survivors. Moreover, the inequitable distribution or perception of insufficiency of reparations risks undermining survivors' sense of justice, leading to discontent and feelings of re-victimization.

In the context of the ECCC and its handling of mental health issues during proceedings, Lederach developed a helpful framework for understanding the tribunal's approach to peacebuilding and reconciliation.[651] This framework promotes the construction of sustainable relationships through reconciliation processes involving truth, justice, mercy, and peace. All are critical elements supported by the ECCC for addressing psychosocial well-being and survivors of trauma through various support and reparations programs. This model also advocates for involving leaders at all societal levels in peacebuilding efforts, which aligns with ECCC's approach of engaging stakeholders in the tribunal process and outreach programs—an inclusive strategy that facilitates grounding the court's processes in community need and experience—and its efforts to integrate mental health support into proceedings. The focus on relationship-building and comprehensive, sustained community-based processes promotes

650 J.L. Herman. *Justice from the Victim's Perspective*. 11 Violence Against Women 5 (2005).
651 J.P. Lederach. *Building Peace: Sustainable Reconciliation in Divided Societies*. Washington, DC: United States Institute of Peace Press (1997).

the restoration of trust and a sense of justice and reconciliation in Cambodian society in the aftermath of genocide and other severe forms of trauma. Such an approach accords with extending transitional justice beyond legalistic resolutions to consider societal aspects of psychosocial healing fully. In these ways, collective reparations and the public acknowledgment of wrongs can promote social solidarity and rebuild a moral community.

The perception of justice through reparations addresses grievances that might otherwise fuel future conflict, which is vital for sustainable peace and reconciliation. Like challenges faced in other post-conflict contexts, such as the ECCC, Gibson noted the difficulties of redressing deep-seated divisions through truth commissions.[652] Just as the ECCC has needed to balance legal processes with larger goals of societal healing and reconciliation, the Truth and Reconciliation Commission of apartheid South Africa aimed to support human rights and racial justice, enhance political tolerance, and legitimize political institutions. Approximately half of the respondents in Gibson's survey felt a degree of reconciliation as of the early 2000s,[653] which indicates the need for improvement and potential contributions of reparations to bridging this gap. The study also found that "truth acceptance" regarding the Commission's narrative of apartheid predicted greater feelings of reconciliation, which should be tracked longitudinally. While increased racial interaction promoted reconciliation, the effects of interracial contact vary significantly by race and hierarchical workplace relationships as well as negative public perceptions regarding amnesty for perpetrators often dilute positive social effects.

Procedural aspects of justice administration and decision-making regarding reparations, specifically perceived transparency and fairness of the judicial process, often generate positive therapeutic effects for survivors. Procedural justice—fair decision-making processes—influence acceptance of rulings and foster societal cooperation. When decision-making processes are perceived as just, people are more likely to accept outcomes even when they may contradict their personal beliefs or expectations. This is particularly important for tribunals where the mental health of witnesses, survivors, and the accused is a central concern. The essential elements for ensuring procedural fairness—opportunities for participation, neutrality, trust in authorities, and respectful treatment of all parties—provide agency, dignity, and respect for tribunal participants and have positive psychosocial effects.[654] Procedural fairness also

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652 J.L. Gibson. Overcoming Apartheid: Can Truth Reconcile a Divided Nation? (2004).
653 *Id.*
654 T.R. *Tyler. Social Justice: Outcome and Procedure.* 35 International Journal of Psychology 2 (2000).

helps bridge differences in values and interests among conflicting parties, which reduces tensions and promotes cooperative relationships.

Transitional justice should be conceptualized and implemented as a legal or political process and a means of recognizing and affirming the dignity and rights of survivors of systemic injustices.[655] Authentic transitional justice involves addressing legal violations through courts and tribunals. Acknowledging victims' experiences and suffering at a societal level needs to occur to counteract the misrecognition of victims and the failure to recognize the dignity, suffering, and rights of victims of atrocities or systemic injustices by ignoring, denying, or minimizing their suffering, validation, and redress. This perpetuates societal divisions, inequity, institutional mistrust, and conflicts, which transitional justice aims to heal. These findings support the ECCC's approach of addressing the mental health of participants by acknowledging their suffering and engaging deeply with affected communities to ensure comprehensive healing and societal restoration.

Thus, the collective psychosocial effects flowing from a sense of justice among members of a post-conflict society are largely determined by acknowledging harm, restoring rights through reparations, reinforcing the rule of law, and recognizing victims' experiences. Perceived fairness and legitimacy of the justice process and the social and cultural context in which these processes occur greatly influence these outcomes.

The ECCC made notable efforts to fulfill the sense of justice of survivors through reparations and procedural justice, often aligning with but, at times, falling short of the principles laid out in reparations studies. Including victims in proceedings as civil parties helped validate and document their experiences through a legitimate and powerful official institution, contributing to personal and collective healing. ECCC reparations, such as acknowledgments and memorials, were largely symbolic, publicly affirming victims' suffering and dignity. However, the lack of provision of financial compensation directly to victims limited the sense of complete justice for some survivors, particularly those who suffered immense economic damage and personal losses. In this sense, the ECCC was more restrictive than other international criminal courts. Participation as a civil party was a pre-condition for claiming reparations, critiqued as the "projectification of reparation," in which reparations are implemented through symbolic projects rather than direct payments to

655 F. Haldermann. *Another Kind of Justice: Transitional Justice as Recognition*. 41 Cornell International Law Journal 3 (2008).

survivors who suffered damages.[656] Restorative justice and its impacts were limited by a lack of direct reparative actions such as financial compensation or health services, which provide tangible assistance for rebuilding lives.

The ECCC's procedural justice and fairness efforts maintained transparent procedures and provided ample opportunities for extensive participation by impacted parties, which helps foster acceptance and legitimacy for the judicial process. At the same time, its outreach programs promoted community rebuilding, and its legal and psychosocial supports have promoted holistic healing. The tribunal also took significant measures to redress SGBV, through which specific charges and judgments reflected the gravity of these crimes. However, the extent to which the therapeutic needs of SGBV survivors were met is debatable, as systemic and societal biases were not entirely overcome during the trials. A detailed assessment of the ECCC's contributions to international criminal law and its legacies showed that despite the tribunal's innovative approaches to victim participation and efforts to acknowledge survivor harms, SGBV was not prominently featured in the charges against many of the accused.[657] This limited the scope of the charges. Thus, the full extent of sexual violence during the regime was not thoroughly examined nor prosecuted. For example, sexual assault was not initially included in the list of crimes committed by the regime but was incorporated only after advocacy by civil rights organizations. Later inclusion meant that systematic sexual violence was not centered from the outset of the justice process and, therefore, not as prominently prosecuted down the line. Significant social stigma associated with sexual victimization predictably impacted survivors' willingness to identify themselves and testify in court. This is a cross-cultural problem that manifests in various ways, including in Cambodia, where victims of rape are threatened with shame and social isolation, which causes underreporting and reluctance to admit or discuss sexual violations openly in a public forum such as a tribunal. When sufficient resources are not allocated to centering SGBV in tribunals for mass atrocities, their inability to redress such crimes is to be expected, as with ECCC.

Moreover, the court was inconsistent in its treatment of SGBV-related testimony, at times not fully supporting the dignity or emotional state of survivors, which risks re-traumatization. Its procedural settings sometimes did not provide necessary protective measures to protect them from further

656 C. Sperfeldt. *Targeting, Participating and Representing*. PRACTICES OF REPARATIONS IN INTERNATIONAL CRIMINAL JUSTICE (2022); C. Sperfeldt & R. Hughes. *The Projectification of Reparation.* 12 JOURNAL OF HUMAN RIGHTS PRACTICE 3 (2020).

657 V. OOSTERVELD. THE CONTRIBUTIONS OF THE ECCC ON SEXUAL AND GENDER-BASED VIOLENCE (2016).

harm while on the stand, such as psychosocial support services tailored to SGBV survivors. Lack of specialized care tends to undermine therapeutic aspects of justice and healing for SGBV survivors. The outreach programs of ECCC that successfully educated the Cambodian public could have been more effective at addressing and destigmatizing SGBV, which could have encouraged and increased participation from survivors. Although the ECCC made significant contributions to the international legal frameworks related to SGBV, its redress of these crimes was limited in these crucial ways.

**Empowerment**

The ECCC exemplifies the potential for profound psychosocial transformation in post-conflict contexts through reparations efforts and court decisions. Involvement in reparations decisions can empower victims by providing a sense of agency and control in the justice process.

The act of narrativizing and contributing to constructing a historical record effectively promotes or restores survivor agency, control, and self-worth. Active engagement in these reconstructive processes helps establish personal narratives from the survivor's point of view while contextualizing them in the larger historical narrative of the event that they also recount and document. A cross-regional study with over 1,000 participants found that many victims had severe and multiple victimizations, including deaths of family members, bodily injuries, displacement (i.e., forcible removal from their homes), and financial losses.[658] Non-state armed groups and sometimes civilians acted as perpetrators, demonstrating the informal and personal nature of many conflicts. Most victims supported perpetrators' prosecutions, mainly through international law mechanisms. They also felt survivors should actively participate in the justice process as witnesses, which aligns with the operations of the ECCC. Survivors favored monetary and symbolic reparations, indicating the need for acknowledgment and material support to remedy their pain and suffering.

Empowering effects are contingent upon aligning reparation outcomes with victims' expectations. Reparations programs must be designed and implemented to meet such expectations or risk further disempowering survivors, particularly given that overly ambitious promises regarding the healing and reconciliatory power of truth commissions often fail to materialize.[659] Material compensation is often an indispensable form of reparations, creating

658 E. Kiza, C. Rathgeber & H.C. Rohne. Victims of War: An Empirical Study on War-victimization and Victims' Attitudes towards Addressing Atrocities (2006).

659 E. *Daly. Truth Skepticism: An Inquiry into the Value of Truth in Times of Transition.* 2 International Journal of Transitional Justice 1 (2008).

economic stability and foundational for survivor empowerment. For example, North American governments enacted laws in the late 1980s that successfully provided reparations to redress Japanese citizens unjustly interned during World War II, which assisted them in rebuilding their lives and livelihoods.[660]

Regardless of survivors' level of knowledge about truth commissions and reparations processes, they tend to have positive perceptions of these, which suggests that increasing awareness and education about these legal remedies can enhance their utility.

Collective empowerment can occur through reparations directed at community projects that strengthen communal bonds and resilience, such as revitalizing essential services and infrastructure, laying the foundation for sustainable development and societal healing.[661] Survivor participation in post-conflict policymaking is equally essential for collective empowerment, societal reconstruction, and positive psychosocial transformation from passive recipients of justice to active agents of shaping a just and democratic society that universally values its citizens. Women must be involved in formulating reparation policies to address their specific needs, which furthers the aim of increasing survivor agency and control.[662] Reparations programs have a history of marginalizing women that requires a female-centered, harms-based approach—a method of designing reparations policies that focus directly on specific injuries and damages suffered by individuals, particularly women, during conflicts or as a result of human rights violations, e.g., traumatic injuries from sexual violence.

The collective identity of a community is often fragmented by conflict but can be reconstructed through acknowledgment and the reparative process.[663] Truth commissions and reparations can help redefine national narratives and identity. However, the process is fraught with challenges, such as the inability to form a consensus among all community members toward a unified narrative, especially in cases of deeply divided societies where different groups may accept or reject findings based on pre-existing biases or interests, which undermines social cohesion in post-conflict settings. Generally, the act of truth-telling is an effective means through which personal and social identities can be reclaimed and reconstructed. For example, in the context of Rwandan Gacaca truth-telling courts, the "talking cure" served as a form of psychotherapeutic intervention through which genocide survivors cathartically recounted their

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660 J. Torpey. Making Whole What has been Smashed: On Reparation Politics (2006).

661 Mani, *supra* note 645.

662 R. Rubio-Marin. *What Happened to the Women? Gender and Reparations for Human Rights Violations.* New York: Social Science Research Council (2006).

663 *Id.*

traumatic experiences, which aims to assist in personal and collective healing through validation. However, critical examination of the assumption of such positive effects found that the process may retraumatize survivors in hostile public settings, adding to their distress and insecurity, and that survivors must be able to recount their experiences in supportive contexts in order for it to facilitate a genuine healing process.[664]

The ECCC undertook several initiatives to fulfill reparations that were aligned with principles established by studies that found victims benefited and were empowered by legal, psychological, and societal aspects of reparations. The tribunal made efforts to engage with survivors through its Civil Parties system, which allowed survivors and their families to directly participate in adjudication, providing legal representation, the right to present their accounts and concerns, and seeking collective and moral reparations. The ECCC is the first international court adjudicating mass crimes to have developed an unprecedented scheme for the participation of survivors of atrocities in tribunals by incorporating survivors as parties directly contributing to the proceedings—not just as witnesses but as recognized parties to the proceedings with specified legal rights. Through legal representation, Civil Parties could have their lawyers present arguments, question witnesses, and suggest evidence, which empowers survivors beyond the provision of testimony and legitimates court proceedings.[665]

According to the Victims Support Section of the ECCC, "Victims of crimes that fall under the jurisdiction of the Court are given a fundamental role in the ECCC. They can submit complaints to the Co-Prosecutors, who consider the victims' interests when considering whether to initiate prosecution. Victims may also participate as Civil Parties. In this capacity, they are recognized as parties to the proceedings. They are allowed to seek collective and moral reparations".[666] The ECCC's civil party participation model aimed to "acknowledge the harm suffered by civil parties as a result of the commission of the crimes for which an Accused is convicted" and to provide them with the opportunity to recount their story and to know the truth.[667]

The ECCC approach to reparations included judicial and non-judicial measures beyond the courtroom, which focused on broader societal impacts

664 K. Brounéus. *Truth-telling as Talking Cure? Insecurity and Retraumatization in the Rwandan Gacaca Courts*. 39 Security Dialogue 1 (2008).

665 J. Ciorciari & A. Heindel. *A Historic First: Recognizing Victims as Case Parties*. Hybrid Justice: The Extraordinary Chambers in the Courts of Cambodia (2014).

666 Extraordinary Chambers in the Courts of Cambodia. (2006-2024). *Victims Support Section*. Retrieved from https://www.eccc.gov.kh/en/organs/victims-support-section

667 *Id*.

by implementing reparative measures such as the establishment of memorials, educational programs, and the creation of a national day of remembrance. These efforts aimed to restore the dignity of survivors and deceased victims, which addresses rectification and distributive aspects of justice. Various psychosocial support and health care services that ECCC facilitated through its Victims Support Section provided tailored care, which helped address long-term psychological scars remaining from the Khmer Rouge regime. ECCC outreach programs educated and engaged with the Cambodian public to help rebuild trust and reliable knowledge regarding the era of the regime, which is critical for establishing collective memory and reconciliation.

**Community Healing and Reconciliation**

The ECCC has helped to advance therapeutic jurisprudence, which considers the psychosocial impacts of the law and legal processes on the well-being of individuals and communities. A study of victim participation in the International Criminal Court (ICC) found that the ICC incorporated a formal mechanism for victim participation to ensure the right to present views and concerns at appropriate stages of proceedings.[668] This approach was grounded in the Rome Statute's commitment to simultaneously respecting the rights of the accused and the interests of victims. While this tended to affect recognition, validation, and healing positively, it can be limited by implementation ambiguity, participation variability, and resource constraints. Lack of clarity in the legal framework regarding how victims' rights to participate are to be implemented creates inconsistencies in how victims may engage in proceedings, which can jeopardize their sense of being genuinely heard or acknowledged. Variability in victim participation may result in inequitable experiences and less validation, impacting their contributions to justice. Balancing the rights of the accused or having to confront the accused in proceedings may also retraumatize victims or undermine their validation. At the same time, resource constraints in a resource-intense process requiring legal representation, translation services, and logistical support to facilitate participation can hinder victim participation.

The social repair work of tribunals and reparations aims to facilitate healing by restoring social networks and fostering inclusion and belonging.[669] Reparations programs must recognize diverse victim experiences, address the experiences and needs of all impacted community members, and promote

668 J.A. Wemmers. *Victims' Rights and the International Criminal Court: Perceptions within the Court Regarding the Victims' Right to Participate*. 23 Leiden Journal of International Law 3 (2010).
669 P. De Greiff. The Handbook of Reparations (2006).

an environment conducive to healing and reconciliation.[670] While truth commissions and reparations can help construct a unified memory through shared historical narratives that incorporate diverse experiences, they often prioritize national unity over individual healing needs, which tends to subsume diverse experiences of trauma into a single narrative of national reconciliation.[671] This may create tensions between national objectives and personal healing processes, which is particularly detrimental to survivors of violence and trauma.

Importantly, reparations must be sustainable. Short-term measures (such as focusing on achieving temporary relief or short-term peace) most often cannot address the long-term needs of post-conflict societies. Sustainable, ongoing programs that can adequately address deep-seated trauma and ensure the continuity of reconciliation require more structural and systemic solutions, often disrupted or destroyed by conflict. Reparations should ensure economic stability and promote sustainable development, including access to education, job training, and employment opportunities, which are crucial for livelihoods and reducing poverty.[672] Long-term access to social services such as healthcare, including mental health services, provides continuous support that helps people and communities heal from physical injuries and psychosocial wounds resulting from conflicts. Systemic solutions in the form of legal and institutional reform can prevent future abuses and strengthen the rule of law when institutions build capacity for addressing grievances and operate with transparency and fairness. Community-based approaches that engage local communities in designing and implementing reparations programs help ensure these initiatives are culturally appropriate, accepted, and sustained through community involvement, empowering local populations as stakeholders in their recovery and stabilization. Ensuring the accurate documentation of the history of conflict through truth projects and memorialization can assist long-term peace and reconciliation through the educational effects of learning from past harms.

Per challenges noted by Wemmers (2010)[673] regarding the ICC, the ECCC's implementation of rights has been criticized for the limitations of its legal framework, which initially did not clearly define the extent and manner of victim participation, leading to inconsistent and ad hoc interpretations over time. Victims' rights to participation were, therefore, not uniformly applied and

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670 K. Theidon. Transitional Subjects: The Disarmament, Demobilization and Reintegration of Former Combatants in Colombia (2007).

671 B. Hamber. *Symbolic Closure through Memory: Reparation and Revenge in Post-conflict Societies*. Braamfontein, Johannesburg, South Africa: Centre for the Study of Violence and Reconciliation. (1999).

672 R. Shaw, L. Waldorf & P. Hazan. Localizing Transitional Justice: Interventions and Priorities after Mass Violence (2010).

673 J.A. Wemmers. *Victims' Rights and the International Criminal Court: Perceptions within the Court Regarding the Victims' Right to Participate*. 23 Leiden Journal of International Law 3 (2010).

implemented. Similar to other tribunals of mass crimes, the resource constraints of the ECCC limit its effectiveness regarding the scope of legal representation, translation services, and other logistical support needed for efficacious, equal, and full participation by survivors. Although the ECCC aims to be victim-centered, ensuring fair adjudication for the accused can make victims believe their contributions are secondary to procedural safeguards. This may detract from ECCC's efforts to integrate therapeutic jurisprudence principles into its reparations and victim participation frameworks. The ECCC implemented reparative measures to acknowledge the pain and suffering of victims of the Khmer Rouge regime, including by integrating diverse victim accounts into a national, historical narrative. Despite efforts to integrate collective memory in this way, tensions between fostering national unity and individual healing needs were often resolved by sacrificing the therapeutic needs of the latter, with the worst outcomes for those with the most severe trauma or those in the most marginalized groups. The tribunal deemphasized sustainable development and economic stability to focus more on symbolic and moral reparations. Efforts also require greater continuity and sustainability of healthcare and psychosocial support to victims. Although the ECCC has helped strengthen legal frameworks in Cambodia by establishing legal precedents and enhancing judicial practices to enforce human rights, comprehensive legal reforms and capacity building that extends beyond the tribunal to broader governmental structures are also needed. The court engaged local communities through public trials and involving civil parties, but the design of reparations programs required greater community engagement than had been achieved.

Crucially, the ECC has succeeded in memorializing the history of Khmer Rouge atrocities. However, a survey of the societal impacts and perceptions regarding ECCC efforts found several areas needing enhancement.[674] A significant portion of the Cambodian population had limited knowledge regarding the ECCC's mandate and the outcomes of senior officials' trials such as the Duch case—the trial of Kaing Guek Eav (AKA "Duch"), a former senior figure of the Khmer Rouge responsible for the notorious S-21 prison in Phnom Penh, in which thousands of people were detained, tortured, and killed during the regime. Duch was the first official to be tried by the ECCC, charged with crimes against humanity, grave breaches of the Geneva Conventions, and other serious crimes. Duch was convicted in 2010 and sentenced to 35 years imprisonment,

674 P. Vinck, et al. After the First Trial: A Population-based Survey on Knowledge and Perception of Justice and the Extraordinary Chambers in the Courts of Cambodia. (2011).

which was increased to a life sentence upon appeal. His trial was the first to address the atrocities of the regime under an international tribunal—essential for addressing past impunity and injustices against survivors and victims' families. Although the trial was a significant milestone in international justice, it generated mixed feelings in the public regarding its impact on societal healing, as some Cambodians felt that the trial provided closure and helped alleviate pain and reduce resentment. In contrast, others worried about re-traumatization from facing past atrocities.

While many Cambodians valued judicial measures, others preferred reparative measures directly assisting their livelihoods, access to essential services, and generally more practical and community-centered reparations, including public memorials and ceremonies that facilitate healing. The authors recommended enhancing outreach efforts, including clearer communication about the court's functions, more inclusive judicial participation, and adequate recognition of survivors' needs.

## ENHANCING WITNESS PROTECTION IN THE ECCC

The ECCC implemented measures for witness support, protection, and psychosocial support. However, additional approaches could have been considered to strengthen these important aspects of their work.

### Witness Education and Preparation

Educating witnesses about the judicial process and preparing them to provide testimony can alleviate associated anxieties. Witness preparation can serve as psychological support, enabling witnesses to provide the highest quality testimony in a high-stakes, high-pressure, and unfamiliar court environment. However, several limitations and challenges observed regarding implementing such measures for witnesses in international tribunals should be considered, including logistical complexities, legal and procedural inconsistencies, and varying levels of effectiveness in different contexts.

Witnesses in international tribunals often come from different countries, and securing their safe passage requires international cooperation and co-ordination, including possible negotiations with multiple governments and international agencies.[675] Secure transportation and protected accommodations are often needed to ensure physical security, such as secure vehicles, guarded residences, and temporary relocation to safe houses. This requires meticulous planning and execution to prevent threats from materializing. Identity protection for witnesses is crucial, particularly in war crimes or crimes against humanity,

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675 L. Waldorf. *Mass Justice for Mass Atrocity: Rethinking Local Justice as Transitional Justice*. 79 Temple Law Review 1 (2006).

because the risk of retaliation is typically high in such cases, necessitating restricted access to witness identities and special handling of witness documentation and communication to maintain confidentiality on top of other previously discussed measures. Compliance with domestic and international law requires obtaining clearances for movements and actions integral to witness protection schemes. Long-term safety planning for high-risk witnesses and relocation and integration into new communities may be needed.

Inconsistent protection measures risk a detrimental impact on the effectiveness and fairness of international tribunals due to the variability of resources, different legal frameworks, contextual specificities, and other disparities or challenges. Different tribunals have various funding levels and resources available or allocated for witness protection and varying political will for such protection, leading to different degrees of witness security. Legal frameworks and mandates can also differ, alongside measures that work well or not, depending on geographical or cultural settings, such as local understandings around privacy, security, or the social consequences of testifying against authority figures. Technological disadvantages may also hinder methods of securing witnesses. These can also create coordination challenges, erode witness trust, and create discontinuity for post-trial security. In addition to ensuring the fulfillment of such measures, socio-economic security and long-term solutions are most effective at ensuring post-trial security for witnesses. Protection measures should be dynamic and responsive. Systems should incorporate feedback and adaptation capacities to adequately address new threats or specific needs for witnesses in future cases.

**Physical Protection and Anonymity**

Measures beyond in-court protection are required to safeguard witnesses against potential threats and intimidation for their participation in tribunals for mass crimes. The importance of physical safety for witnesses or parties participating in international tribunals explains that witness protection strategies extending beyond the courtroom are required for the effectiveness of justice processes and prevention of retaliation in post-conflict settings.[676] Robust protection measures include relocation services, anonymity provisions, and post-trial protection measures to secure those who provide testimonies against perpetrators, which is vital for prosecuting high-level offenders in crimes against humanity.

676 P.N. Pham, et al. *Perspectives on Memory, Forgiveness and Reconciliation in Cambodia's Post-Khmer Rouge Society.* 101 International Review of the Red Cross 910 (2019).

To prevent retaliation or stigma against participants, the ECCC utilized various in-court protective measures such as voice distortion and pseudonyms to maintain witness anonymity. Secure transportation and accommodation during witnesses' stay in Phnom Penh when attending trials also helped ensure that victims felt safe. At the same time, while they testified, there was a particular focus on those from communities in which the accused or their sympathizers might pose a threat. The ECCC recognized the traumatic nature of testimonies and the stress of participation. Therefore, it offered psychological support to participants through its Victims Support Section to help them cope with the emotional burden of recounting their experiences and maintain overall well-being during and after the trial. The legal framework supporting witness protection was integral to the tribunal's operational procedures and was designed to adhere to international standards. However, the ECCC could have augmented its protection measures by providing secure housing, relocation services, or even new identities for the most at-risk witnesses or parties.

**Psychosocial Support**

Comprehensive psychosocial support is required to address the mental health and social needs of witnesses and participants in the judicial process. As discussed, therapeutic jurisprudence aims to address the psychosocial impacts of trauma through victim participation and reparation programs toward self-efficacy and healing through counseling, social reintegration programs, and community-based initiatives to fulfill long-term needs. For example, an analysis of education systems in post-conflict societies revealed the psychological impact of continued ethnic hatred and stereotypes perpetuated through educational narratives.[677] This necessitated educational reforms that incorporated comprehensive psychosocial support in educational settings to assist in healing inter-ethnic divisions by dispelling the discriminatory beliefs and practices underwriting them.

The provision of counseling and psychological services is necessary to mitigate the re-traumatization risks inherent in testifying about war crimes and genocide, and this support could have been systematically integrated into the ECCC's witness protection program to ensure continuity before, during, and after the provision of testimonies. As observed with other tribunals, ECCC has struggled with resource constraints, undermining its ability to offer the extensive

677 S. Freedman, et al. *Confronting the Past in Rwandan Schools*. My Neighbor, My Enemy: Justice and Community in the Aftermath of Ethnic Cleansing. (2004).

psychosocial services needed to facilitate effective healing processes from severe, large-scale trauma. It has also experienced gaps in fully integrating Cambodian cultural practices and community norms into its operations. The ECCC's efforts are tied to its operational timeline, which risks the post-tribunal continuity of long-term services.

**Long-term Witness Support**

As noted, the ramifications of testifying can extend well beyond court proceedings, which require ongoing support structures in the aftermath. Based on the results of a survey of 1,200 Rwandans that assessed the psychological impact of participating as witnesses in Gacaca courts, the presumption that such truth-telling processes are inherently healing and provide significant evidence to the contrary.[678] Measuring indicators of psychological health such as levels of depression and PTSD and comparing witnesses to non-witnesses (while controlling for factors such as gender and trauma exposure), the study found significantly higher levels of psychological distress (depression and PTSD) in witnesses, persisting even after accounting for other contributing factors. Prolonged exposure to the gacaca process did not correlate with reduced psychological distress, which undermines the idea that extended involvement in justice processes facilitates the healing process. There was a lack of evidence for the psychological distress of participants decreasing over time, challenging the notion that truth-telling reduces psychological trauma and provides long-term benefits. Moreover, it might exacerbate existing trauma. Implications for the tribunal process include the need for careful consideration, design, and implementation of truth, reconciliation, and reparations processes, especially the inclusion of psychological preparation and follow-up for participants.

The extent to which culturally appropriate services were rendered through the ECCC varies across reports. Brounéus' observations regarding the necessary but insufficient need for truth-telling should be incorporated into the psychosocial support of tribunals for mass crimes.[679]

**In-court Protection Measures**

The ECCC's strategies for in-court protection included voice and face distortion and using pseudonyms to de-identify participants. However, additional protective measures can reduce the stress and potential harm

678 *Id.*
679 K. Brounéus. *The Trauma of Truth Telling: Effects of Witnessing in the Rwandan Gacaca Courts on Psychological Health.* 54 Journal of Conflict Resolution 3 (2010).

observed in other tribunals, especially for SGBV survivors or other particularly traumatic crimes. Video link testimonies that allow witnesses to testify via video link have the potential to reduce emotional distress associated with being physically present in the same space as the accused and having to confront them directly.[680] The use of screens or physical barriers to prevent facing the accused can also help lessen anxiety and re-traumatization risks. Such measures, along with psychological support aimed at coping with testifying, can help alleviate negative psychological impacts associated with the role of witnesses.

**Community-based Protection**

Engaging with communities from which witnesses originate assists in protecting witnesses through effective communication and trust-building in the social contexts that will support and receive them before, during, and after trial. Community liaison offices can facilitate this process, adding a layer of protection for witnesses returning home. For example, local NGOs in Cambodia played a significant role in nearly every aspect of the civil party participation process, from informing victims of their rights to assisting in completing necessary forms and managing their participation in court.[681] Their extensive involvement helped ensure the safety and support of witnesses required throughout the process and post-trial.

680 M. Eikel. *Witness Protection Measures at the International Criminal Court: Legal Framework and Emerging Practice.* 23 Criminal Law Forum 1-3 (2012).

681 E. Stover, M. Balthazard, & K.A. Koenig. *Confronting Duch: Civil Party Participation in Case 001 at the Extraordinary Chambers in the Courts of Cambodia.* 93 International Review of the Red Cross 882 (2011).

## CONCLUSION

The ECCC has set an important precedent for integrating mental health considerations into the mechanisms of transitional justice. The court has acknowledged and proactively addressed the issue of psychological trauma stemming from atrocities such as those committed by the Khmer Rouge regime. This promotes judicial procedures that value and facilitate the psychosocial wellbeing of all parties to the tribunal as well as in processes of reconciliation and societal healing. The comprehensive approach of the ECCC has aimed to reflect the deep interconnectedness of justice, psychosocial wellbeing, and societal restoration. These include psychological support for experts and witnesses, protective measures during testimony provision, and extensive public outreach and reparations programs. The tribunal can be seen as promoting a paradigm shift in which the mental health of all participants is viewed as central rather than peripheral to processes of justice and reconciliation. The ECCC has elucidated and exemplified a holistic approach to redressing legacies of mass violence and atrocities through psychosocial support of witnesses and experts and reparations for healing collective societal wounds. It serves as a compelling model upon which to build future tribunals redressing grave injustices that integrate mental health support. The pioneering efforts of the ECCC have helped forge a promising pathway in international criminal justice for legal redress that promotes healing and recovery at all levels of social ecology, which, in turn, strengthens the foundation of durable justice and peace in post-conflict settings.

# 10 TRAUMA-INFORMED JUSTICE MECHANISMS

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## INTRODUCTION

This chapter hopes to examine the evolution of the use of trauma-informed techniques in transitional justice mechanisms. We do so by examining the needs and attentions to trauma in progressing mechanisms through time. We also interviewed persons involved in these justice mechanisms to understand their view on the past, present, and future of attention to trauma psychology in transitional justice.

## THE EVOLUTION OF MENTAL HEALTH CONSIDERATIONS IN TRANSITIONAL JUSTICE

In the domain of transitional justice mechanisms, a pivotal transformation has been observed in the integration of mental health and psychosocial support (MHPSS) considerations, transitioning from a historical backdrop characterized by significant oversight to a current focus on trauma-informed practices. This evolution is underscored by the initial proceedings of the Nuremberg trials, which, despite their groundbreaking role in the adjudication of war crimes, did not give a role to victims and markedly overlooked the implications of MHPSS

for witnesses and survivors, thus sidelining the profound psychological repercussions of such atrocities. This period highlighted a considerable gap in the development of justice processes in the aftermath of conflict, wherein the pursuit of legal retribution frequently overshadowed the mental well-being of survivors. In the decades that followed, a growing attention to human rights, including victims' rights and women's rights, enhanced a focus on crimes of sexual and gender-based violence and gradually moved survivors more at the center of justice efforts. This shifting focus became evident with the establishment of tribunals for the former Yugoslavia and Rwanda, where efforts were made to acknowledge the trauma inflicted upon individuals and integrate witness support alongside psychological services. However, the mainstreaming of trauma-informed practices in these mechanisms was largely lacking, and victims were not allowed to participate in the proceedings other than by giving testimony. Nevertheless, this development signifies an enhanced awareness of the need to embed a trauma-informed model at the inception of justice mechanisms, emphasizing the indispensable nature of MHPSS support in the realms of healing, justice, and reconciliation.

The exploration of the historical context of MHPSS acknowledgment within transitional justice mechanisms unveils a continued oversight in the aftermath of mass atrocity crimes, including The Holocaust and the Bosnian war, thus underscoring a lacuna in a truly holistic approach to justice, where legal pursuits have often eclipsed the mental well-being of survivors. Despite the initial steps observed in the ad hoc tribunals that marked a commencement towards integrating MHPSS considerations, they also emphasized the extensive scope for enhancement. This narrative from neglect towards integration encapsulates a vital transition towards a justice mechanism that not only acknowledges but acknowledges and addresses the trauma experiences of individuals and gives victims an active role in the proceedings, thereby creating an environment conducive to healing. It sets a precedent for future transitional justice mechanisms to prioritize mental health considerations as an integral component of their processes, embodying the core principle that prosecuting perpetrators and addressing the health and mental health needs of survivors are not mutually exclusive but rather complementary facets of a comprehensive justice process. This underscores the foundational idea that it is paramount to attend to the health and mental well-being of survivors while pursuing retribution, challenging the traditional norms of modern trials that commenced with the Nuremberg tribunal and extending beyond to include truth and reconciliation efforts, which, despite their intentions, have fallen

short in fully addressing these critical aspects. However, just adding a focus on MHPSS is insufficient for fundamentally transforming these systems. In order to truly shift to a restorative justice approach, the process itself needs to be fundamentally altered to fully integrate and prioritize these efforts, ensuring they play a central role in shaping the justice system rather than just supplementing it.

## NUREMBERG TRIALS

After World War II, the Nuremberg trials marked a significant development in international criminal law, highlighting a time when focusing on the mental health impact on witnesses and survivors was secondary to prosecuting war crimes. This era was  a significant start in the history of transitional justice, with a strong focus on legal processes over the psychological impacts of war crimes.[682]

Although the trials were primarily focused on the punitive aspects of post-conflict resolution, they inadvertently set the stage for the incipient consideration of witness support within the context of mental health, albeit in an implicit and initially unstructured manner.

As the trials unfolded, a gradual yet significant shift became evident. The profound psychological impact of war atrocities on individuals, previously relegated to the margins of legal considerations, began to garner attention. This emerging acknowledgment among tribunal prosecutors and the broader legal and psychiatric community illuminated a critical oversight in the justice process, sparking a nascent discourse on the imperative of providing support to witnesses burdened with testifying about their harrowing experiences.

Even though there was no official structure for mental health assistance during the Nuremberg trials, the conversations that took place among experts in fields like psychiatry and law laid the groundwork for understanding the importance of addressing the emotional well-being of witnesses within the legal system. This changing conversation highlighted the importance of taking a comprehensive outlook on justice that goes beyond just legal punishment to include the recovery and support of people affected by war.

This change emphasized the important connection between accountability mechanisms for atrocity crimes and mental health, pushing for the development of nurturing settings to protect the witnesses' well-being. These thoughts were the first steps in recognizing how traumatic experiences are shared, and the support given afterward greatly impacts the effectiveness of the healing process.

682 T. Rosen, *The Influence of the Nuremberg Trial on International Criminal Law*, Robert H. Jackson Center, 2015. Available at https://www.roberthjackson.org/speech-and-writing/the-influence-of-the-nuremberg-trial-on-international-criminal-law/.

When looking at how mental health concerns have evolved in transitional justice systems over time, it is clear that as we move from the Nuremberg trials to later tribunals focusing on crimes in Yugoslavia and Rwanda, there is an increasing recognition of the importance of addressing the mental health needs of survivors as part of the transitional justice process. This development highlights a crucial change from focusing on punishment through the legal system to acknowledging the essential need for mental health assistance in the healing and justice procedures.

## MECHANISM FOR FORMER YUGOSLAVIA

The ICTY stands out as a significant advancement in transitional justice, especially in its focus on gender crimes, which necessitated the involvement of many survivors of sexual violence who needed psychosocial assistance to testify. The increasing emphasis on gender crimes, with the heightened attention to women's rights, played a crucial role in elevating the focus towards the well-being of survivors. This shift required a significant move towards recognizing and dealing with the psychological needs of witnesses and survivors, integrating a trauma-informed approach into the legal system.

The ICTY has made significant contributions to the progress of international criminal law, although it presents a complicated scenario that intersects transitional justice and efforts to hold perpetrators accountable for war crimes. The tribunal has achieved great success in documenting terrible crimes and prosecuting well-known offenders and has paved the path for the prosecution of gender crimes. Simultaneously, it struggles to integrate international justice mechanisms with the broader goals of transitional justice, such as fostering reconciliation, healing communities, and restoring law in war-torn communities.

The ICTY made advancements by challenging sovereign immunity and enforcing a global justice standard through the prosecution of key individuals responsible for serious violations of international law, including figures like Slobodan Milošević. However, this emphasis on prosecution often meant that efforts to foster peace, reconciliation, and justice in the former Yugoslavia were neglected.[683] Critics argue that the tribunal may have unintentionally upheld nationalist stories and worsened ethnic tensions, thus impeding efforts to promote unity among opposing groups.[684]

683 M. Biro, D. Ajdukovic, D. Corkalo, D. Djipa, P. Milin, & H. M. Weinstein, *Attitudes Toward Justice and Social Reconstruction in Bosnia and Herzegovina and Croatia*, in My Neighbor, My Enemy, 183–205, 2004. Available at https://doi.org/10.1017/cbo9780511720352.013.

684 J. Meernik, *Justice and Peace? How the International Criminal Tribunal Affects Societal Peace in Bosnia*, 42 J. PEACE RESEARCH 271, 2005. Available at https://doi.org/10.1177/0022343305052012.

Complications in establishing a comprehensive and universally acknowledged historical narrative of the conflicts, along with the tribunal's failure to avert subsequent atrocities like the Srebrenica massacre, underscore the intricate balance required between securing legal accountability and catering to the broader, post-conflict societal needs, emphasizing the imperative for a more encompassing approach to transitional justice.

Challenges such as inadequate witness protection, a limited understanding of the role and benefits of victim support, transparency issues, and vulnerability to political influence, coupled with the ICTY's detachment from the affected communities, have sometimes led to perceptions of the tribunal as an aloof entity rather than an instrument of local justice. The physical and figurative distance of the proceedings in The Hague, the alienation due to legal terminologies, and restrictions on witness testimonies have notably diminished the tribunal's potential for facilitating societal reconciliation, highlighting the need for justice mechanisms that are more deeply rooted in and connected to the communities they aim to serve.

Additionally, the ICTY's selective prosecutorial emphasis on high-ranking officials has sparked debate over the scope of accountability and the inadvertent implication of innocence for those not charged.[685] Such prosecutorial strategies, while legally meticulous, have not fully met the victims' desires for recognition of their traumas, underscoring a preference for personal acknowledgment over an abstract categorization of criminal acts.

Reflecting upon the ICTY's legacy illuminates the critical role of international prosecutions within the broader spectrum of transitional justice but also points to their insufficiency as standalone solutions. The tribunal's experiences accentuate the value of integrating legal actions with additional measures like Truth and Reconciliation Commissions, truth-telling endeavors, and lustration practices. This broadened perspective on transitional justice stresses the empowerment of local populations and the recognition of shared humanity as crucial elements in the journey towards peace, reconciliation, and justice following conflict.

## RWANDA

The establishment of the ICTR represented a significant change in the field of international law. It demonstrated a fresh emphasis on mental health in legal processes. The ICTR's primary objective was to hold individuals accountable for committing atrocities, including genocide. The tribunal was confronted with the

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685 M. deGuzman, *Choosing to Prosecute: Expressive Selection at the International Criminal Court*, 33 MICH. J. INT'L L 265, 2012. Available at https://repository.law.umich.edu/mjil/vol33/iss2/2/?utm_source=repository.law.umich.edu%2Fmjil%2Fvol33%2Fiss2%2F2& utm_medium=PDF&utm_campaign=PDFCoverPages.

deep emotional injuries experienced by survivors and witnesses and also dealt with the fact that many survivors suffered from significant health problems, such as HIV/AIDS, due to the crimes they experienced. This resulted in the critical development of establishing a robust psychological and medical support network for victims and witnesses.

The Witness and Victims Support Section (WVSS) was a pioneering effort implemented at the ICTR to support the psychological needs of witnesses and victims. The WVSS offered various services such as therapy, healthcare, and support to the organization. These actions demonstrated a shift to a more holistic concept of justice. The ICTR's aim went beyond just punishing offenders and focused on a more extensive objective of rehabilitation and reparation However, the legal framework did not foresee any provisions for reparations for victims also for those who did not participate as witnesses in the trials.

Facing various difficulties, the ICTR had to navigate the complexities of incorporating mental health support within its legal framework. Juggling the safeguarding of witnesses with the rights of the accused, all while upholding the integrity of the legal system, presented complex ethical and procedural challenges. In addition, witnesses frequently had to face and express their traumatic experiences due to the necessity of giving testimony, leading to potential re-traumatization or adverse psychological effects in some cases. These facts emphasize the importance of customized support systems that address the specific vulnerabilities of those who experience atrocities and, above all, the need for a strong legal framework, mainstreaming trauma-informed practices and facilitating victim participation.

Despite these obstacles, the ICTR's deliberate integration of mental health factors represented a significant step forward in developing transitional justice. The tribunal's emphasis on supporting witnesses and providing psychological services helped further legal justice and greatly assisted in achieving societal healing goals. These efforts have dramatically influenced the design of future transitional justice methods, setting an important precedent for incorporating mental health assistance into initiatives to address the aftermath of mass atrocities.

The interplay between the ICTR's international framework and the localized gacaca courts offers a compelling lens through which to examine transitional justice mechanisms. Despite aiming to blend elements of retributive and restorative justice while promoting community participation, the gacaca courts and the ICTR's approaches managed to balance global justice expectations and Rwanda's post-conflict societal requirements. This split underscores

the continuing discussion on the efficiency of transitional justice systems in reconstructing societies after conflict, underscoring the importance of striking a delicate balance that upholds victims' rights while also advancing community reconciliation and healing.

The introduction of the Rome Statute in 1998, after the creation of the ICTR, marked a significant advancement in providing psychosocial assistance to witnesses and victims in international justice. Moving from the makeshift tribunals in Rwanda and the former Yugoslavia to the establishment of the Special Court for Sierra Leone (SCSL) in 2002, and eventually the International Criminal Court (ICC), this development highlighted the increasing focus on incorporating a psychological approach throughout all stages of the judicial process. This important development went hand in hand with an increasing focus on victim participation and on the responsibility of tribunals to grant reparations.

## KHMER ROUGE TRIBUNAL

Formerly known as the Khmer Rouge Tribunal, the Extraordinary Chambers in the Courts of Cambodia (ECCC) is a significant milestone in the development of transitional justice because it wove mental health considerations into the fabric of seeking justice for the grave human rights transgressions perpetrated by the Khmer Rouge regime. This tribunal reflected an increasing awareness of the importance that trauma-informed care has in legal processes addressing historical injustices. It marked a significant step towards acknowledging and addressing deep mental health repercussions for survivors and witnesses of such atrocities.

One of the factors that played a significant role in the success of the ECC was its collaboration with mental health experts and organizations in Cambodia, including the Transcultural Psychosocial Organization (TPO). This allowed for a diverse range of psychological interventions to be made available to those affected by trauma, ensuring that trauma therapy was both affordable and culturally sensitive. The witnesses and civil parties involved in the court proceedings received on-site psychiatric treatment before, during, and after hearings, catering for their immediate and ongoing mental health needs. This type of support went beyond the courtroom.

Moreover, the tribunal's commitment to addressing mental health was demonstrated through local community-based truth-telling and memorialization efforts, which aimed at promoting collective healing while also providing the Cambodian populace with knowledge about the tragic history of the Khmer Rouge rule. Furthermore, the Victim Support Services of the ECCC, in collab-

oration with the Witness and Expert Support Unit, placed significant emphasis on witness safety and mental health education. This demonstrates a thorough comprehension of the survivors' needs throughout the emotionally demanding journey of pursuing justice.

The Khmer Rouge Tribunal faced considerable difficulties when attempting to incorporate mental health assistance completely into its procedures. The tribunal failed to sufficiently address the mental health needs of survivors and the larger Cambodian society, although playing a trailblazing role in the quest for transitional justice. This left a gap in the comprehensive rehabilitation of both individuals and the community. The existing climate in Cambodia, which was marked by a conspicuous absence of national dedication to thoroughly confronting the traumatic remembrances of the Khmer Rouge era, exacerbated this deficiency. People's mental health problems worsened as a result of the lack of a national effort to address collective trauma, and it became more challenging for them to comprehend the atrocities that were committed and make sense of them in light of their personal and collective pasts.

The experience of the Khmer Rouge Tribunal offers vital insights for future transitional justice mechanisms, illustrating both the potential and limitations of integrating mental health considerations into such frameworks. It emphasizes the importance of adopting a holistic approach that seeks not only legal justice but also prioritizes the mental health and well-being of survivors, fostering an environment conducive to healing and the acknowledgment of past abuses. By examining the Cambodian approach, which integrates elements of Buddhism into healing trauma, the significance of cultural practices in reconciliation and mental health recovery following mass atrocities is revealed.

## YOUK CHHANG INTERVIEW

***Youk Chhang*** is the director of the Documentation Center of Cambodia. He was disappointed with the mental health efforts through the process of the ECCC. Ultimately he concludes that the trauma mental health efforts in the ECCC should have been carried out by the public health system and not by the court.

***REICHERTER:*** In the context of justice processes, such as those conducted by the ECCC, how crucial is it to adopt a trauma-informed approach in any transitional justice process?

***CHHANG:*** In the last couple of years, we have met with over 30,000 survivors. Even our volunteers, some of whom visit survivors at home, have the capacity to detect when something is wrong. Survivors may show erratic emotional responses and often dismiss their own suffering as destiny. We've created simple resources to help them cope when professional help is unavailable, but the real challenge is that there is no specific method that truly resonates with them, given their history of repeated trauma since the 1960s.

***REICHERTER:*** But even with some stigma, I know that the ECCC created special mental health protections for people that were traumatized. Can you talk a little bit about what was done in the ECCC that was different from things that were done before?

***CHHANG:*** The ECCC relied on a group of doctors from Calmette Hospital and an international expert from New Zealand for the accused and witnesses. However, the problem is the ECCC has finished, and its building is now neglected. Addressing trauma wasn't a legacy of the ECCC; it should have been but wasn't integrated into their operations as it should have been.

***REICHERTER:*** So you feel like the ECCC, even though they put measures in place, weren't very successful. They weren't really helpful for traumatized individuals?

***CHHANG:*** Correct, they are not a hospital or a psychiatric facility. The ECCC is a court meant to deliver justice, not to provide mental health support. We burdened it with too many expectations, linking everything back to it. But fundamentally, it's a court, where outcomes inevitably make some people angry and others happy.

***REICHERTER:*** And what about Sotheara's program and some of the mental health stuff that he did? Was that just kind of on the side? Or was that really a major project within the ECCC?

***CHHANG:*** TPO, started by the Dutch and worked with by Sotheara, was significant, but they are young and still developing their capacity to deliver services. We continue to engage with them for group counseling, but their involvement was not as part of the primary team which consisted of a comprehensive care team from Calmette Hospital.

***REICHERTER:*** Do you think that transitional justice courts and courts dealing with genocide should have some kind of responsibility toward capacity building for the welfare of the country, like capacity building toward mental health or health or other things?

***CHHANG:*** No, the ECCC is a court; its primary role isn't to shoulder responsibilities outside its judicial proceedings. Its mission is to acknowledge crimes and render judgment. Imposing expectations beyond its judicial function detracts from its primary objective. It's about legal conclusions, not about providing counseling or treatment.

***REICHERTER:*** So that's true of the ECCC. Do you think that when courts are designed in the future, they should be designed in the same way, where the court is just the court, or should they create a wider mandate?

***CHHANG:*** The court must fundamentally remain a court. The creation of overly broad mandates, such as the office of co-investigator or victim units, can lead to inefficiencies and ethical concerns, especially when victims are used to raise funds. The primary focus should be on upholding judicial integrity without imposing additional social responsibilities on the court.

## TRAUMA PSYCHOLOGY IN THE INTERNATIONAL CRIMINAL COURT

The Rome Statute provides a legal framework that emphasizes the protection of dignity and privacy of victims and witnesses in an unprecedented way, and which allowed for the creation of a detailed mental health and psychosocial support program at the ICC, specifically offering trauma-informed assistance to individuals involved in its legal proceedings as witnesses and victims. The system illustrates the ICC's understanding that engaging in the legal process can significantly impact individuals who have suffered from trauma due to war crimes, genocide, and crimes against humanity.

The Registry's Victims and Witnesses Section (VWS) is essential in the ICC's support system, offering personalized protective measures, counseling, and various support services based on individual needs. The VWS has a diverse team of psychologists and other support staff ready to facilitate the participation of victims and witnesses in the proceedings and protect them against psychological harm as a consequence of this involvement.s. The Court provides psychological evaluations and psychosocial support to witnesses and victims as they navigate the legal system in order to avoid additional trauma. Thanks to the Rome Statute's stipulation to take into consideration the vulnerability of witnesses and victims and the requirement to include a trauma expert to advise the Court, essential trauma-interviewing techniques can be provided. These techniques are specifically crafted to ensure interactions with witnesses take place in a manner that regards the emotional health of the witness or victim. These interviewing methods are designed to assist witnesses and victims in giving precise and trustworthy testimonies while acknowledging the effects of trauma on memory and communication to prevent exacerbating their trauma.

By applying an individual approach, the ICC can ensure the implementation of mental health and psychosocial support (MHPSS), which is adapted to the needs and capacities of each witness and victim. These approaches are developed on the basis of individual psychosocial vulnerability assessments and are regularly reassessed to accommodate the evolving requirements of witnesses and victims during the trial proceedings. Within the limitations of a clear legal, operational, and ethical framework, and in case needed, elaborate support plans can be designed, including culturally appropriate psychosocial support, medical care, or other forms of assistance. The purpose of the support is to increase the well-being of vulnerable witnesses and victims, mitigate potential harm, and enhance the quality of testimony in court.

Working with outside mental health organizations greatly increases the ICC's ability to offer comprehensive psychological assistance. By forming these partnerships, the Court can utilize specialized therapeutic interventions and support networks, providing witnesses and victims with a wider range of mental health and psychosocial services. These partnerships expand the ICC's psychosocial support services and bring in extra skills and resources, enhancing the quality of care given.

The ICC's dedication to trauma psychology and application of a comprehensive psychological support system shows its commitment to seeking justice and promoting the recovery of those impacted by crimes within its authority.

## INTERVIEW WITH AN MICHELS

***An Michels*** is the psychologist and trauma expert of the Victims and Witnesses Section of the International Criminal Court. In this capacity she advises the Court on issues in relation to mental health and trauma She has worked with survivors for more than two decades. An Michels thinks that trauma-informed justice processes are essential.  She is passionate about developing and implementing standards for the field.

***REICHERTER:*** In the context of justice processes, such as those conducted by the ECCC, how crucial is it to adopt a trauma-informed approach in any transitional justice process?

***MICHELS:*** Adopting a trauma-informed approach is absolutely essential. Throughout my career, I've observed the paradox where these mechanisms rely on testimonies from individuals already burdened by exposure to violence and trauma. This double burden can be debilitating. My current project advocates for comprehensive mental health and psychosocial support aimed at making these mechanisms more victim-aware and centered. This is not just about providing support but reevaluating how we gather and utilize evidence to enhance both the well-being of victims and the quality of the evidence they provide.

***REICHERTER:*** Why do you think some mechanisms still do not utilize this evidence-based approach effectively? Why is it not universal at this point?

***MICHELS:*** The adoption varies due to historical and structural differences in how mechanisms were created and evolved. Early tribunals gave minimal attention to victim and witness care, focusing more on the perpetrators. This approach has slowly evolved with the establishment of the Rome Statute, which included provisions for psychosocial support. However, many mechanisms, especially those at the national level, still lack the resources and understanding necessary to implement comprehensive support systems effectively.

***REICHERTER:*** Could you describe the model you developed at the ICC?

***MICHELS:*** At the ICC, we've developed a robust framework that prioritizes comprehensive support for victims and witnesses. This includes protection, counseling, and medical assistance. We have established clear protocols for requesting special measures for vulnerable witnesses, which allows us to provide tailored support that respects their dignity and enhances their ability to participate effectively in trials.

***REICHERTER:*** How has this approach evolved over time at the ICC?

***MICHELS:*** This approach was instituted following an incident where a witness's breakdown highlighted the need for psychological support. The procedures we developed have been integrated into the ICC's regulations, allowing us to consistently support vulnerable individuals. The judges trust our expert assessments, which has led to a nearly perfect record of approval for requested measures.

***REICHERTER:*** Do you think transitional justice courts should include capacity building for mental health as part of their mandate?

***MICHELS:*** Definitely. While delivering justice is their primary role, these courts also have a responsibility to prevent psychological harm. And they should promote broader mental health support not only within the courts but also within the communities they serve.

***REICHERTER:*** Is expanding mental health support within the ICC's mandate realistic?

***MICHELS:*** It is realistic and necessary. We should be facilitating the exchange of mental health expertise and supporting capacity building at the national level. Establishing networks or communities of practice would allow us to extend our support beyond the immediate needs of the court.[686]

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686 A. Michels, P. Javidan, E. de Bruijn, & L. M. Brown, *Integration of Mental Health and Psychosocial Support Approaches in Accountability Mechanisms for Atrocity Crimes*, 2024. Available at https://www.kpsrl.org/publication/integration-of-mental-health-and-psychosocial-support-approaches-in-accountability-mechanisms-for-atrocity-crimes.

***REICHERTER:*** You know there's going to be a collaboration with Stanford and you for the office of the prosecutor. Can you describe what you hope we're going to be able to do to make things more streamlined and create some standardization of how people should be trained and how people should behave?

***MICHELS:*** This collaboration with Stanford is crucial as it brings in external trauma expertise, which will enhance our capacity to build a more standardized approach across different organs of the ICC. By harmonizing our processes, we ensure that all parts of the ICC are equipped to handle cases in a trauma-informed manner, enhancing the overall effectiveness and sensitivity of our operations.

***REICHERTER:*** What do you think is needed to improve the current model at the ICC?

***MICHELS:*** We need to continue integrating and standardizing trauma-informed practices in case management, protection and support services and in investigative and prosecutorial strategies. This requires a commitment from the highest levels of the court and should be viewed as an integral part of our mandate, not just an add-on service.

## TRAUMA PSYCHOLOGY IN THE UNITED NATIONS INVESTIGATION OF ISIL

Incorporating trauma-informed approaches into international criminal investigations makes the United Nations Investive Team to Promote Accountability for Crimes Committed by Da'esh/ISIL (UNITAD) a significant advancement in post-conflict transitional justice. Recognizing the significant emotional harm suffered by victims of human rights violations, the establishment of UNITED indicated a shift towards emphasizing the mental well-being of survivors during the inquiry. This novel approach aims to minimize the risk of retraumatizing individuals during investigative interviews, addressing a fundamental limitation in conventional investigative techniques.

UNITAD's trauma-informed interviewing approach is based on knowledge of trauma's psychological impacts, which is integrated into its methods and procedures. UNITAD strongly emphasizes the inclusion of clinical psychologists in its investigative teams, ensuring that psychological aspects are central to its mission. These experts are crucial in assessing witnesses' vulnerabilities, preparing them for interviews, and providing psychological support. This includes offering psychoeducation to equip witnesses with skills to manage emotional and adverse reactions triggered by recounting traumatic events.

Moreover, UNITAD's commitment to trauma investigations extends beyond assisting individual witnesses to encompass broader efforts to enhance regional trauma support networks. UNITAD works with local mental health providers and organizations to improve mental health services through specific capacity-building programs. These efforts guarantee that survivors are provided with all-inclusive care that meets their requirements, promoting a setting supportive of healing and reconciliation.

UNITAD's innovative method ensures the mental health of witnesses and survivors while improving their testimonies' integrity and reliability. By understanding and adapting to the diverse and intricate ways people remember traumatic events, UNITAD improves the chances of obtaining consistent and trustworthy evidence. This trauma-informed approach emphasizes the necessity for upcoming transitional justice systems to integrate mental health factors into their functions, guaranteeing that justice procedures aid in the recovery of victims and the rebuilding of communities impacted by large-scale atrocities.

Integrating trauma psychology into UNITAD's operational structure is a significant progression in transitional justice. By giving importance to survivors' psychological well-being and incorporating trauma-informed practices into its investigative procedure, UNITAD establishes a new benchmark for how post-conflict justice mechanisms can and should function. This method helps hold others accountable and promotes healing and empowerment for individuals and communities affected by conflict and violence.

## INTERVIEW WITH NENNA NDUKWE

***Dr. Nenna Ndukwe*** is a clinical and forensic psychologist. She created and directed the trauma mental health response at UNITAD. She believes that trauma-informed practice is essential to transitional justice. She is also an advocate for capacity building in mental health in parallel with justice processes.

***REICHERTER:*** Why is it important to use trauma-informed models for transitional justice processes? How is it sometimes an error to not have trauma-informed? And in what ways does the trauma-informed model help the process and the witnesses?

***NDUKWE:*** The first thing that comes to mind is that transitional justice mechanisms often deal with witnesses and victims who have survived the worst crimes imaginable. It seems like a straightforward connection to make, considering these victims and witnesses, having survived such atrocities, are going to be interviewed. This highlights the importance of adopting a trauma mental health perspective—it would be almost incomprehensible to think that victims and witnesses will participate in investigative interviews or any other aspect of the legal process without any preparation. Having a mental health consideration is crucial. This is where the trauma-informed approach comes in, ranking high on the list of priorities for transitional justice mechanisms to have in place. It's about ensuring that whether you're a lawyer, psychologist, or administrative assistant, your approach to handling victims and witnesses is trauma-informed.

***REICHERTER:*** Some critics might say there is a downside because it adds extra steps and knowledge requirements for investigators. What are your thoughts on this?

***NDUKWE:*** I suppose some people might see it as, "Oh, I have to have the training. Why can't I just continue the way that I've been doing?" But I think it's akin to empathy training. Some people have natural empathy, and others need to be trained to move from being sympathetic to empathetic, really putting themselves in the shoes of the person they are interviewing. Then, they can construct their approach in a way that's meaningful. Ultimately, they may get justice, or they may not, but they have to live with that event.

***REICHERTER:*** How have you integrated trauma-informed practices into your work at UNITAD?

***NDUKWE:*** At UNITAD, we've integrated a trauma-informed framework into the strategy of the organization from the outset. This includes thinking about the type of staff recruited and ensuring they are well-trained to understand what trauma is and how it can manifest in the work they do. Another crucial stage is ensuring that whatever processes are in place within transitional justice processes, namely interviewing, that the interviewer is well-trained in a trauma-informed approach. The ultimate goal is to do no harm and also to achieve better evidence.

***REICHERTER:*** How do these practices impact the broader transitional justice process?

***NDUKWE:*** Trauma-informed practices not only protect and minimize re-traumatization but also improve the overall effectiveness of justice mechanisms. By ensuring that everyone, regardless of their role, views their work through the lens of trauma, we foster an environment that is conducive to both healing and effective justice.

***REICHERTER:*** Considering the effectiveness of these practices at UNITAD, do you see this model being applicable in other transitional justice settings?

***NDUKWE:*** Absolutely. The trauma-informed approach we've developed at UNITAD can serve as a model for other transitional justice mechanisms. It's crucial, however, to adapt these practices to fit the specific cultural and societal contexts of different settings. Sharing our practices and collaborating with other entities can help to standardize trauma-informed approaches across various international and national justice mechanisms.

## TRAUMA-INFORMED STANDARDS FOR THE FUTURE OF MECHANISMS

Envisioning the future of transitional justice mechanisms necessitates a profound integration of trauma-informed standards across all operational and strategic dimensions. As the nature of atrocity crimes cases is inherently suffused with trauma, a shift in approach is mandated; these are not ordinary judicial processes but ones deeply marred by human suffering and psychological scars. Ignoring the trauma inherent in these cases undermines the essence of the justice sought. Acknowledging and addressing psychological trauma is not just a moral responsibility but a necessity for effective justice mechanisms.

From the initial Nuremberg Trials to the more recent efforts of the International Criminal Tribunal for the former Yugoslavia (ICTY) and Rwanda (ICTR), the Special Court for Sierra Leone (SCSL), UNITAD and the Extraordinary Chambers in the Courts of Cambodia (ECCC) to the work of the ICC, there has been a clear progression towards a more compassionate and comprehensive justice system. This evolution reflects a growing acknowledgment that justice must heal as much as it adjudicates.

An Michels underscores the importance of establishing standardized trauma-informed practices within these mechanisms. "We have clearly lots of work that's been done on creating a trauma-informed healthcare system," she explains. "And so I think there's a need to have a standard understanding of that within our type of work, which builds upon the existing knowledge of what a trauma-informed approach is, but how does it apply to the cause? To the investigation, to the wider transitional justice system?"

The need for a universal standard is critical, Michels argues, to ensure consistency and effectiveness in handling cases suffused with trauma. "Many stakeholders told me it would be great to have a set of guidelines or a set of standards so that we do not have to reinvent the wheel every time we set up such processes," she says.

Michels highlights the ongoing development of a study providing recommendations which can become guidelines and standards, which is poised to be published soon.[687] This document aims to guide the implementation process across different justice mechanisms, ensuring that trauma-informed practices are not only adopted but also tailored to fit the specific needs of the work.

Dr. Ndukwe emphasizes the transformative potential of these standards. "Having a clear standard would help in increasing adherence to the model, maybe more understanding," she notes. "And it's also thinking from a research point of view, easier to audit like practice, and how having a benchmark on how the organization is doing and adhering to a trauma-informed approach within the organization."

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687 *Id.*

However, challenges persist that underscore the limitations of these mechanisms in their traditional form. Critics point out that merely filing charges often do not result in substantive justice and can retraumatize individuals, giving false hope to victims that judicial proceedings will address their suffering. This is evident in the work of the UNITAD project and the Cambodian tribunal, where even successful legal actions have felt insufficient in addressing the broader impacts of trauma and suffering.

For instance, UNITAD, despite having extensive information on ISIS, has been criticized for minimal legal actions. Yet, it has made significant contributions to health and mental health opportunities for survivors, especially women, which would otherwise have been unavailable. Similarly, the Khmer Rouge tribunal managed to imprison only a few elderly perpetrators, which did little to satisfy victims' and communities' broader expectations for justice.

These examples underscore a growing recognition that transitional justice must evolve beyond traditional legal frameworks to effectively address the myriad impacts of atrocities. Future frameworks should extend the precedent set by earlier tribunals and innovate by integrating mental health professionals into the core of their operational teams. Such integration ensures that trauma-informed approaches influence everything from procedural design to the training of personnel and interaction with survivors and witnesses.

Moreover, leveraging partnerships with academic institutions and mental health organizations can enhance the capacity of justice mechanisms to provide targeted and culturally sensitive support. Collaborations, like those forged by the ECCC with organizations such as TPO Cambodia, offer a model for building robust support networks that cater to the diverse needs of survivors across different contexts.

The future of transitional justice mechanisms must prioritize recognizing and addressing trauma with comprehensive support systems as foundational principles. By doing so, these frameworks will not merely pursue accountability but will also foster environments that promote healing and reconciliation, understanding that the pursuit of justice is intrinsically connected to the healing journey. This envisioned future, where justice mechanisms fully embrace their role in addressing the profound impacts of war crimes, solidifies trauma-informed care as an indispensable standard for their operation, potentially more vital than the pursuit of legal action alone.

# 11 MENTAL HEALTH TREATMENT IN THE DIASPORA: FROM AN NPR PODCAST OF INVISIBILIA, "THERAPY GHOSTBUSTERS"

**Stephanie Foo**
*A Malaysia-born American radio journalist, producer and the author of the book, "What My Bones Know: A Memoir of Healing from Complex Trauma."*

## INTRODUCTION

I grew up in a place called the Valley of Heart's Delight, specifically San Jose, Calif. It got that name because it's beautiful - 75 and sunny most of the time, streets lined with cherry and citrus trees, air that smells of eucalyptus - maybe why so many of our parents flocked there. My community was full of immigrants. All of our parents had accents. My high school was majority minority. There was a huge Vietnamese population, lots of Filipino, Mexican, Korean and Chinese kids like me. The local hangout spot was literally called the Great Mall. Though we also played a lot of DDR at Golfland, and every party featured King Eggroll. If you know, you know.

But in this paradise, something darker was happening. You'd catch glimpses of it when report cards came out, when we got caught wearing skimpy dresses at homecoming, when someone's secret boyfriend got found out - because that's when we could expect the abuse at home. It didn't happen to all of us. Lots of us had loving, supportive parents, but it happened to a lot of us, most of my close friends. At home, we were neglected, beaten and yelled at so much that it was normalized in my community. My trauma wasn't just personal. It was shared, with a lot of my friends' traumas mirroring my own. And we're still affected by it every day.

A lot of things have changed since I was in high school 15 years ago, and I was hopeful that this abuse had lessened in that time. But recently, when I went back to my old high school and I talked to the new counselor there, she said it's still happening. That she has so many students that are being physically abused at home, she can't even count them. When I found this out, I wanted to figure out if there was a way to fix this, to make it stop. For years, I went to therapy, and that

helped me. But that was never an option for my parents' generation. I believe that my parents abused me and eventually abandoned me because they were hurting so deeply from their own wounds. And they never sought help for those wounds because they told me that therapy was for crazy people, and they weren't crazy. This stigma prevented most of my friends' parents from getting help, too. So I set out to see if there was a way to heal our parents, and in doing so, even heal ourselves.

## GHOSTS

And that's how I heard about this community clinic in my hometown that was trying to solve the same problem and in the process found themselves in the middle of a ghost story.

> ***REICHERTER:*** *When something comes at you that you don't know what it is, don't make any assumptions.*

This is Dr. Daryn Reicherter. He's a white dude who kind of looks like Dr. House if Dr. House was really into surfing. And about 20 years ago, Daryn was a young psychiatry resident moonlighting at Gardner Health Services, a community clinic that was providing mental health care to the local Cambodian community. But shortly after starting this job, Daryn noticed something strange.

> ***REICHERTER:*** *At the time, I think we had close to 200 Cambodian patients here. I think we had, like, 180 people. And we kind of got a spreadsheet and realized that almost all of them, maybe 160 of them, were on antipsychotics. I mean, think about that. That's 90%.*

So Daryn immediately thought, "That cannot be right. Ninety percent of a population cannot be psychotic. That's just not how mental illness works." And if these clients were on the wrong medication, it could have scary consequences.

> ***REICHERTER:*** *Antipsychotic medication is super dangerous. The new generation antipsychotics put people at risk for high blood pressure, obesity, diabetes. What are Cambodian Americans at risk for? Blood pressure, diabetes. And so we're giving them a medicine that puts them even at higher risk for something that's already a terrible risk for them.*

Daryn was stumped, so he asked for help.

> ***BOPHAL PHEN:*** *I got hired not because I has a psychology degree. I got hired because I know Cambodian culture. It's a culture-specific program.*

This is Bophal Phen, a Cambodian therapist who had recently been hired at Gardner. He reminds me of a big, soft teddy bear, with '80s-looking wire-rim glasses and a little mustache. He provided case management, counseling and medication support to Cambodian clients. And Daryn thought that in order to get to the bottom of this mystery, he and Bophal needed to reevaluate every single client… together. So together, they start with one client. And pretty quickly, she starts telling the two of them about how she sees ghosts at night.

> ***REICHERTER:*** *Luckily, I have Bophal in the room. So I'm able to say, is this symptom, what she's talking about - what the heck, is she psychotic? What's going on? And Bophal said, oh, no, no. This happens all the time. And I was like, are you psychotic? Like, what are you talking about?*

> ***PHEN:*** *In our culture, we believe that when you are waking up from sleep, you will see this big, black shadow that sit on you, pinning you down. You cannot wake up. You cannot scream. You cannot move your body. And I think in the Western world, they call that sleep paralysis.*

Sleep paralysis - the feeling you get when you can't move as you're waking up or falling asleep. Daryn and Bophal talked to the clients one by one. Over and over, it was confirmed - all these patients had sleep paralysis. It happens a lot in people who are stressed and not getting enough rest, like these Gardner clients who are often not getting more than two hours of sleep per night. In the end, only about 4 out of the 160 patients were suffering from actual psychosis. So Daryn started weaning the clients off antipsychotics, which, sure, was a relief, but also worrisome that the practitioners had so dangerously misunderstood the ghosts on their clients' chests.

> ***REICHERTER:*** *If I don't take it seriously, you know, I can make a misdiagnosis. But also, I can miss an important part of someone's real, lived experience and just really not be as good of a psychiatrist.*

Daryn said dismissing people's experiences felt condescending, even kind of racist.

> ***REICHERTER:*** *You know, silly little person, there's no spirits. I know better 'cause I'm a scientist - whatever.*

And there was another lingering question - why were so many of the clients suffering from sleep paralysis? If it's caused in part by lack of sleep, then why wasn't anyone sleeping? Daryn had a hunch. As he paged through stacks of hundreds of charts of Cambodian patients, he noticed a red flag. None mentioned the Cambodian genocide.

> ***REICHERTER:*** *Every Cambodian patient I've ever worked with has been affected by Pol Pot. Seeing that the word Pol Pot or the word Khmer Rouge or the word trauma wasn't in those charts - right? - you're like, how can you not ask about trauma when you're working with a Cambodian patient?*

No wonder these practitioners had totally misread their clients. They had no idea what their clients had gone through. But Bophal did. And he looked into his own story for clues on how to make the ghosts go away.

> ***PHEN:*** *Frankly, I did not know what kept me going, but I knew that I had to survive. I had to live and not die.*

> ***FOO:*** *What was it like for you when you were really young and, you know, you were happier?*

> **PHEN:** *(Laughter).*

**Bophal Phen**

Bophal was born in Cambodia. He lived with his parents and nine siblings. And he said the thing that he remembers about his early childhood was…

> ***PHEN:*** *Back then, I remember that I was able to play. I could make my own kite using old newspaper, catch crickets in a field, finding fish…*

But in 1975, when Bophal was just 10 years old, the Cambodian communist guerillas, also known as the Khmer Rouge, took over the country. Under the dictator Pol Pot, the Khmer Rouge systematically murdered hundreds of thousands of people. They forced most of the surviving population into farm work and manual labor. So at just 10 years old, Bophal was separated from his family and forced to work the fields from dawn to dusk. He only got two small bowls of rice porridge a day, so he was often looking for food.

> ***PHEN:*** *Whether it's wild fruit, rats, frogs or whatever, fish - anything that I could catch, I would eat them.*

Nighttime was hardest for Bophal. He says that some Cambodians believe when you hear the cry of a barn owl, it means that someone has died, and the owl is there to take away their soul. He would hear these owls crying all night in the darkness.

> ***PHEN:*** *Terrifying, every time you hear them cry, for a 10-year-old or 11-year-old, because you know that people are dying.*

Roughly 2.2 million people, about a quarter of Cambodia's population, died as a result of these policies.

In the aftermath, four of Bophal's nine siblings had either gone missing or were dead. After a few years in refugee camps in Thailand and the Philippines, an 18-year-old Bhopal made it to America with his parents and remaining siblings. Things were better, but far from perfect. Bophal's parents turned to him for support - a lot of support. They needed him to fill out forms for social services. They needed him to translate at the hospital because they had a bunch of chronic medical conditions. On top of that, Bophal's parents had mental health issues and struggled with alcohol. Even something like an unlocked door at night could make his parents and siblings panic.

> ***PHEN:*** *They still anxious at nighttime. Nighttime is the scariest time because it - our bodies remember that - when darkness set in, the door has to be closed and locked. My mom, my dad, my older siblings, all of them is like, oh, don't leave the door unlocked. Somebody's going to come in and slit your throat.*

Maybe that's why Bophal ended up studying psychology in college.

> ***PHEN:*** *Oh, my God. I started to understand human behavior and what we've gone through.*

And that's how in the early 2000s, after getting the job at Gardner, Bophal found himself trying to figure out not just where the ghosts on his clients' chests had come from, but what to do about them. The ripple effects of the Khmer Rouge were everywhere in this community. Refugees suffered from high rates of anxiety and addiction, plus other health problems like heart disease and kidney failure. Gang violence was a big issue, too. Santa Clara County had been trying to support this community with mental health services, but retention rates were miserable, success rates even worse. Psychiatrists even called their patients "treatment resistant."

But Santa Clara had just decided to pump a lot more money into a new movement of culturally responsive programming at places like Gardner, which meant hiring a bunch of Cambodian practitioners like Bophal, and telling them, basically, "Have at it. Do what you think will help your community heal." But Bhopal had no idea where to start. So he literally looked back at his psych textbooks from college. And Step 1 was: "Assess the client and find the right diagnosis." which, for these Khmer Rouge survivors, was post-traumatic stress disorder, or PTSD - symptoms like chronic nightmares, trouble sleeping, extreme fear. He expected for this to be a kind of turning point. Like, they'd get their diagnosis and realize, oh, wow, this is serious. I need to get help. But as he saw in his sessions with clients, diagnosing people with PTSD meant nothing to them.

> ***PHEN:*** *Some of them didn't even know what PTSD. But all they know is that you're scared all the time, you're worried all the time.*

And when he tried going home and diagnosing his own parents, it didn't work with them either.

> ***FOO:*** *Did you try going up to your mom and saying, mom, I think you have PTSD?*
>
> ***PHEN:*** *Yes. But there's no terminology in most Asian language.*
>
> ***FOO:*** *Yeah.*

> ***PHEN:*** *Yeah. There's no term in Cambodian to tell, oh, this is major depression, this is schizophrenia, this is PTSD. But you can say that you're scared all the time because of your trauma from your past. And when there's a loud noise and something happen, you just shake and all of these. And you describe the symptom.*
> ***FOO:*** *Yeah. Yeah, yeah. So you explained it to your parents?*
>
> ***PHEN:*** *I did.*
>
> ***FOO:*** *And how did it go over?*
>
> ***PHEN:*** *Well, it's tough because parents, they don't listen to kids.*
>
> ***FOO:*** *Of course.*
>
> ***PHEN:*** *Why would they listen to their son?*
>
> ***FOO:*** *Yeah.*
>
> ***PHEN:*** *My parents did not understand mental health at all. They did not think that they're having mental illness.*

So what could he do next? In school, Bophal had learned to ask new clients open-ended questions like, so what are you in here for? Then, a patient might say, "Well, I've been feeling really depressed lately and anxious." Or, "I haven't been able to sleep." But Bhopal's Cambodian clients, they'd say…

> ***PHEN:*** *You're the doctor. You know everything. I don't need to tell you. You should know what I need, right?*

Still, Bhopal tried. Sitting in his office, he used some classic talk therapy techniques like, "Tell me about your past. Let's process what happened. How is that showing up in your day to day?" But his clients were hesitant.

> ***PHEN:*** *For Cambodians, there's a proverb that said, 'if you have an open sore on your body, why poke it with a stick to cause more bleeding?'*

## TRAUMA IN THE CAMBODIAN COMMUNITY

I talked to a woman I'm calling C. to protect her privacy. She's 60 years old with dyed brown hair and gentle eyes. She told me how her early visits with Bhopal and Daryn - aka Dr. Reicherter - weren't exactly pleasant.

> ***C:*** *(Through interpreter) Me, before, whenever I saw Dr. Reicherter, I was scared of him. Even just seeing him scare me.*
>
> ***FOO:*** *Were you scared of him 'cause he's white?*

C: (Through interpreter) No. White people, I'm not scared of them. It was because I saw him typing into his computer as he talked to me. And he would look like the people in the Khmer Rouge tribunal. My mind just go there.

During the Khmer Rouge, people had been interrogated about their pasts and their education to determine whether they should live or die. So when clients came into Bophal's office and saw his notepad and computer, they didn't see a friendly face or shared experiences. They saw a threat.

> ***PHEN:*** *Clients were, like, throwing up in session, the client was so scared. So they don't want to talk - don't want to be reminded about the killing field, obviously. Why do I do that? When I'm talking about it, it cause more problem, more nightmare, more headache and stuff.*

So to zoom out a bit… lots of trauma treatments focus on exposure therapy. It asks clients to retell or relive their trauma, and hopefully get better by becoming desensitized to that trauma. But this treatment can sometimes do more harm than good. People can get triggered and shut down, or even drop out of therapy because it's so unpleasant, which is what Bophal was noticing with his clients at Gardner. It felt like everything he knew about therapy just wasn't working. For years, he went to conferences, did a lot of research, tried different modalities. Even his cultural knowledge wasn't really helping.

He didn't know how to heal his friends, his family, let alone his clients. How could he help anyone if they didn't want to talk to him, if the word "trauma" didn't even mean anything to them? He felt like he was falling short, which isn't surprising, because Bophal and most therapists around him were never taught to treat communities like this. But eventually, something started to shift in his practice.

> ***S.** will help you understand how.. She's 59, has dark eyes surrounded by tattooed eyeliner, and her whole body starts rocking when she's transported, when she talks about her past.*

> ***S:** Whenever April comes around, my kid know their mom will have heartbreak. They say, oh, heartbreak again.*

Cambodian New Year happens in April, her favorite holiday as a child. But in 1975, just after Cambodian New Year, when S. was 12, Phnom Penh fell to the Khmer Rouge. S. had to watch as the Khmer Rouge murdered 13 people, almost her entire family, right in front of her.

> ***S:** Of course, that story…. there are times when you can put it out of your mind. But how can you forget about it - the blood, the people's throat being cut, my parents' throats being slit right in front of my eyes?*

Years later, she came to the United States as a refugee, and she thought she'd be safe. But when she got here, the violence continued. Her husband, also a survivor, became extremely abusive. He threatened her with a gun when she was pregnant, beat her so badly that she's covered in scars. When she tried to take adult education classes, he'd come to her school and scream at her. She endured his abuse for over 20 years.

> ***S:** I was almost going insane, saying things that were off the mark, sitting somewhere and then just drifting away. I was at zero, not even number one - zero. Absolute zero.*

S decided to divorce her husband, but she didn't have any of the resources to do it - no way to file paperwork, no way to support herself or her kids financially. The Khmer Rouge killed almost the entire educated class of Cambodia, killing teachers, soldiers, doctors, artists and writers. That meant that most refugees couldn't read or write Khmer, making it exceptionally hard for them to learn English. They had trouble navigating the systems around them for support, like school or health care. For S, it was hard to survive, let alone heal, and she was losing hope.

> ***S:** ( Like, I was at the end of my life. When you're at the end of your line with no physical strength and no emotional strength, you just want to die.*

And then someone suggested she talk to Bophal at Gardner.

S's story - her trauma and her abuse at home - unfortunately, it wasn't uncommon among Bophal's clients. And Bophal was slowly realizing that the reason he'd been hitting a wall was because his clients didn't have the mental space to process the past when so many of them were struggling to meet their basic needs in the present. To feel safe, they had to be safe. And so when Bophal met S. and heard about her abusive husband, he immediately helped her file paperwork for her divorce, and found her Section 8 housing and welfare so she could escape her household.

> ***S:*** *I didn't know that in this country I have rights. I didn't know. There are people that check in on you.*

Bophal started doing this kind of thing for every client. Remember, Bophal was hired to do counseling and case work for Gardner. So even though he was still struggling as a therapist, he started going way above and beyond as a super involved social worker. He wasn't just booking them healthcare or welfare appointments. He was also accompanying his clients to every single one.

> ***PHEN:*** *I was driving my clients everywhere. I took them to see every doctor out there, every specialist out there, legal services that they needs, housing, social services, wherever.*

He translated and advocated for his clients at every appointment. He knew how necessary this was because of the years he'd spent doing the same thing for his parents when he was a teenager. And there was an unexpected upside to these drives. He got to spend hours with his clients. There in the car, not in a scary office with the ominous computer, his clients started looking forward to their time with Bophal.

> ***PHEN:*** *So while driving, you get a lot more information because it's not like conventional therapy. You're just driving. It's going…"How's your life; how's your family?" And all this small, little talk along the way, right? And then you get to a doctor. You fill out a form. You wait to be seen, like, 30 minutes to an hour. You talk more and more. They open up a lot more that way.*

In that car, in those doctor's offices, in their homes where people sat at their kitchen tables, people started to trust him, finally. But this was not a quick process.

> ***PHEN:*** *Sometimes it takes a year to a year and a half just to earn their trust.*

> ***FOO:*** *To be able to…*

> ***PHEN:*** *To tell you the truth, I guarantee you a year to two years.*

For a practitioner to take two years to address trauma, that's pretty unique. But Bophal had to build a remarkably close relationship with his clients before they could even consider being a little bit vulnerable with him. That's what surprised me. Generally, our mental health care system discourages these kinds of super close relationships. There's usually more professional distance. But our system didn't work for both Bophal's clients. Driving around, buying them sandwiches, becoming a part of their lives… that did help.

> ***PHEN:*** *They don't see me as a counselor. They see me as a friend or a brother or father. I don't mind that terminology. If they're feeling comfortable seeing me as a brother, then call me a brother.*

It was then and only then, once they were family, that the real therapy could begin. Clients would open up to him about how they felt, about their anger, their fear. And there was one thing they kept saying, an idea that Bophal worried was keeping them from healing. That they deserved their pain. When a person survives something like this, something truly, unspeakably awful, it's natural to wonder, "Why did this happen? How could something like this take place? It can't be random. There has to be a reason." And the reason Bophal heard from many of his Buddhist clients was… karma.

> ***PHEN:*** *Karma, clients think that you cannot change it - it's unalterable. Meaning whatever that you have, it's there.*

They felt like they had probably done something horrific in their past lives and were being punished in this life. Like, take C. She's the woman with the gentle eyes who was at first scared to open up because the process reminded her of the Khmer Rouge tribunals. When Bhopal met C., she was dealing with trauma from watching many people in her family die during the genocide. And she was also heartbroken. When C. was granted the ability to move to America, she had to leave her husband behind in a refugee camp. Eventually, he got remarried and started a new family, a fact that C. would obsess over for decades.

> ***C:*** *The failure of my relationship with my husband, lingering in the form of me constantly thinking about him, missing him, loving him - that was my bad karma.*

Her trauma and her belief that she was doomed made her incredibly anxious. For years, she barely left her house. She'd have panic attacks constantly. Her stress got so bad, she had a stroke. Bophal wasn't religious and at this point didn't know much about Buddhism or karma. But it was coming up all the time with his clients. So he bought books on Buddhist psychology and partnered with a local Cambodian temple where he learned from the monks. And he realized there was another way to understand the concept of karma that could maybe help his clients.

> ***PHEN:*** *Karma is not pain or suffering, karma is just action, things that you do. It's like the freeway. If you are on that freeway of suffering, you would just go along the freeway. But every freeway has an exit, and that exit requires a choice. So, same thing with karma. There's always a choice along the way.*

Bophal really wanted to teach his clients that they had agency, that there was hope for change. And so he decided to try mixing Buddhist philosophy with a technique he thought might help: CBT, or cognitive behavioral therapy. It centers around identifying negative or unhelpful thoughts and trying to practice better reactions in the future.

> ***PHEN:*** *We don't say, oh, let's do CBT. We would say, OK, like, in Buddhism, you know, how do you commit karma?*

In Buddhist thought, you can commit karma through your words and actions. But you can also commit it through your thoughts, by thinking more positively, which Bophal thought was kind of like CBT, but more intuitive for his clients like C. She tried Bophal's hybrid of Buddhism and CBT. She liked it– this idea that she was improving her karma all the time just by trying to let go of some of her repetitive thought patterns around her ex-husband.

> ***C:*** *Now, not thinking about him, not being reminded about him, not loving him anymore - I think this means that I don't have that kind of karma anymore. I think that karma can change - change because of our actions, the way that we think.*

In moments of crisis, C. would head to Gardner, to the room where they treat Cambodian patients. It has a basket of plastic grapes and rambutans, tea sets, and a small altar with a lot of Buddhas. Then, C. would sit across from the giant wall of windows, bathed in light, and Bophal would breathe with her.

At first, every time she closed her eyes, she'd see a man coming towards her, grasping for her throat.

> ***C:*** *It was difficult inside my body. I was unable to breathe.*

But every time they'd breathe together, she could keep the man away for a little longer. Eventually, with the help of medicine and meditation, she started leaving her house, volunteering at the temple, and learning to make new friends. Plus, she went from sleeping two hours a night to 11 or 12.

> ***C:*** *Feel fresh, you know?*
>
> ***FOO:*** *Feel good in the morning.*
>
> ***C:*** *Yeah. Feel good in the morning. Like, (singing) "I'm alive, I'm alive!" You know?*
>
> ***FOO:*** *(Laughter) Yeah.*

Bophal was figuring out what culturally responsive care actually looked like for his clients. But what about the people around them - their kids, their grandkids?

Where I grew up in San Jose, so many of our parents had fled conflict and poverty just like Bophal's clients. They were refugees and sometimes veterans of the Vietnam and Korean Wars, Chinese parents that had escaped the Cultural Revolution where some had been in labor camps. My own parents were born during the Malayan emergency, a brutal war that targeted ethnic Chinese and caused my grandfather to be imprisoned for five years. And maybe that pain was trickling down to their kids. Like, in my case, I endured really extreme abuse growing up.

My parents held knives to my throat for talking back. I was beaten so severely that I thought I might die. Both of my parents abandoned me for other families by the time I was a teenager. So even though Bhopal was finally helping survivors

cope better with their trauma, there was still one critical problem that I was most curious about, the question that could have helped me. How could he help his clients stop passing their trauma down to their kids? C, for instance, the woman with the gentle eyes who missed her husband… for a long time, before meditation, therapy and medication, she struggled with her children.

> ***C:** (Through interpreter) In Cambodia, when children don't listen, we can hit, discipline them. But here we cannot. If we hit them or something like that, there will be problems legally. It is difficult to raise them.*

At one point, she was estranged from all five of her grown children. Bophal would hear about what happened in other homes, too - corporal punishment, emotional abuse.

**Mr. T., L.C.S.W.**

> ***T:** You know, mom and dad screaming, yelling all day, all night long, a lot of stress. And, you know, that's not a good feeling.*

This is T. His parents were Cambodian genocide refugees in San Jose. And to cope with the chaos at home when he was growing up, T. turned to a different community.

> ***T:** So instead of coming home, you'd stay after school. And you're out in the streets pretty much. I pretty much got involved with gangs. You know, I had a lot of friends that end up going to jail, doing life in prison. Some of my friends died.*

When parents would hear about their kids joining gangs, they couldn't understand how this had happened. Wait, they thought. We escaped a war zone just so you could replicate one here? But that's what happens when trauma goes untreated. It can ripple out and harm others.

I have met so many Asian parents who have fled conflict and who don't like to talk about their pasts, the whole not-poking-the-wound thing. But also, they believe they can protect us from that trauma by not sharing it. I had never even heard about what my grandparents had gone through in the Malayan Emergency until I started researching it for my book when I was 31 years old. Most of my friends didn't know the details of the Vietnam or Korean Wars either, and we definitely didn't learn about the Khmer Rouge in my school in San Jose. Our parents were failing us. But what was missing was Why. We had no context.

And neither did a lot of Bophal's clients. So one day when a young woman complained to Bophal, "My mom is nagging again. She's so crazy."

> ***PHEN:*** *It was like, you know what? Just for your information, your mom is not crazy. It was, like, eye-popping for this young lady. It's like, what are you talking about? In a way, I was like, you know, what your mom's been through is the killing fields of war and stuff. I started to talk about Cambodian history, open up her mind a little bit.*

The woman was shocked, and Bophal realized these kids had to know what their parents survived. So for 10 years, Bophal volunteered at a Saturday school for Cambodian children to teach them to read and speak Khmer and to learn about their culture, including lessons on the Khmer Rouge. In T.'s case, when he learned his parents' story, it changed the way he saw them.

> ***T:*** *Once I was able to hear what my family went through, and then I kind of, like understood, like, you know, it's not really their fault, you know? And so it gave me a sense of healing. You know what? Hey, my parents aren't bad. My parents had problems, and they didn't know how to cope with it. You know, they tried their best.*

Eventually, T. left the gang and turned his life around. He got his degree and joined Gardner, where he worked for years as a counselor to youth in gangs. And when he'd tell them about their parents' history…

> ***T:*** *They see more empathy, you know, for the parents. And then they started to maybe say, you know what? I'm just putting more hurt on my parents when they've been through a lot already. And here I am messing it up for them.*

## INTERGENERATIONAL TRAUMA AND HEALING

Of course, just having that context is not necessarily enough. When I learned about the Malayan Emergency, I had more empathy for my parents. But one-sided empathy can't heal a relationship. Obviously, the most important change that needed to happen was for parents to parent better.

So in order to truly repair these relationships, Bophal helps survivors learn to parent in a healthier way. Like, he told many parents, "Hey, instead of hitting your kids, maybe try taking away privileges." And he tried helping people like C. better communicate with their kids.

> ***C:*** *One story - a daughter that lives far, I miss her. And I want her to visit me because she said that she's working and doing more school. So then I asked her once, twice, but she still didn't have time. So I wanted to scream, "Oh, God, just visiting your mother is impossible?" But after learning from Bophal, I didn't scream. I instead compromised with her and said, "When are you free to come visit me? Do you know that I miss you?" And saying kind words, like asking nicely and not aggressively demanding what I want. Then suddenly, she was still and didn't say anything. And then two days later, she visited me as a surprise. Because I talked, asked in the new way, she came to see me.*

Her relationships with most of her children have been improving steadily ever since.

Bophal and his team have now been practicing these techniques at Gardner for about 20 years. And Daryn, who now specializes in creating culturally responsive treatment programs for refugees, he says he still hasn't seen this level of success in any of his other programs, anywhere. Lots of other programs implement things like prioritizing social work, relationship and community building, being respectful of cultures and religions. But Gardner still stands out. Clients stick around for decades. Many find community at temple. Some have fewer nightmares. Others graduate from the program altogether.

It's a hard job, though. Hearing his clients' stories can be really triggering for Bophal.

> ***PHEN:*** *But I feel that my skill - I could relate with them. I could help them. Therefore, this is the place for me. This is the place where I kept coming year after year. I did not move up. I did not move on. I'm just staying where I am.*

Both C. and S. recommend Bophal to anyone who will listen, and have convinced some of their friends to come to Gardner. I mean, to any Asian kids of immigrants, seriously. Two 60-year-old immigrant women insisting to all their friends that they need therapy?!

> ***C:*** *(Through interpreter) My friends, when they looked at me before, they could see that I was sick every day. But now, these past two years, how could I become cheerful and agreeable and not be sick? I would tell them that this place is not the place for crazy people. This is a place for healing.*
>
> ***S:*** *(Through interpreter) The warmth and comfort from them constantly checking in on me, it protected me. This place is a safe space. Even if you want to die, they won't let you die. They wouldn't let me hurt myself. This is where people live. It helped me survive. It gave me hope.*

Honestly, I got emotional listening to these testimonies and conveyed this to C., the woman who was able to convince her daughter to visit her in healthier ways.

> ***FOO:*** *And me personally, I really wish that my parents had gotten help so I could have a better relationship with them. I think it's, like, a beautiful act of love for your kids that you are taking care of yourself.*
>
> ***C:*** *Oh, your parent have family issue, too?*
>
> ***FOO:*** *I haven't talked to my mom since I was 13.*
>
> ***C:*** *Because of conflicts? Is she still around? Maybe she need treatment, counseling.*
>
> ***FOO:*** *(Laughter) Yeah, she doesn't want to go. But I'm so proud of you for going.*

In interviewing C. and S., I thought often about what would have happened to me and my classmates if our families had participated in a program like Bophal's. What if my parents had gotten those parenting lessons? What if they'd learned how to better manage their own pain? Maybe they could have fought less with each other. Maybe I wouldn't be estranged from both of them now. Maybe we could have all felt a little bit safer. Maybe I would have been loved like I deserved. What a dream, right? But for any of that to have happened, my parents would have needed to be OK with getting help. They would have needed to understand that going to therapy didn't mean that they were crazy, which makes me wonder - if I

dared to keep dreaming - what if going to therapy wasn't walking into someone else's office? What if it was about opening a door for someone to walk into your life to help you learn how to love and be loved in ways that made sense to your culture and your community? What if your trauma wasn't yours alone to carry? I think that world, it just might have a lot more joy in it.

At one point in my conversation with C., she got tired of talking about her trauma and just wanted to show me and Bophal cute pictures of her grandkids.

> ***C:*** *And I just want you to see my daughter.*
>
> ***FOO:*** *You're going to show me more pictures?*
>
> ***C:*** *Yeah. Picture, picture.*
>
> ***FOO:*** *Very cute.*
>
> ***C:*** *I know. Cambodian.*
>
> ***FOO:*** *(Laughter).*

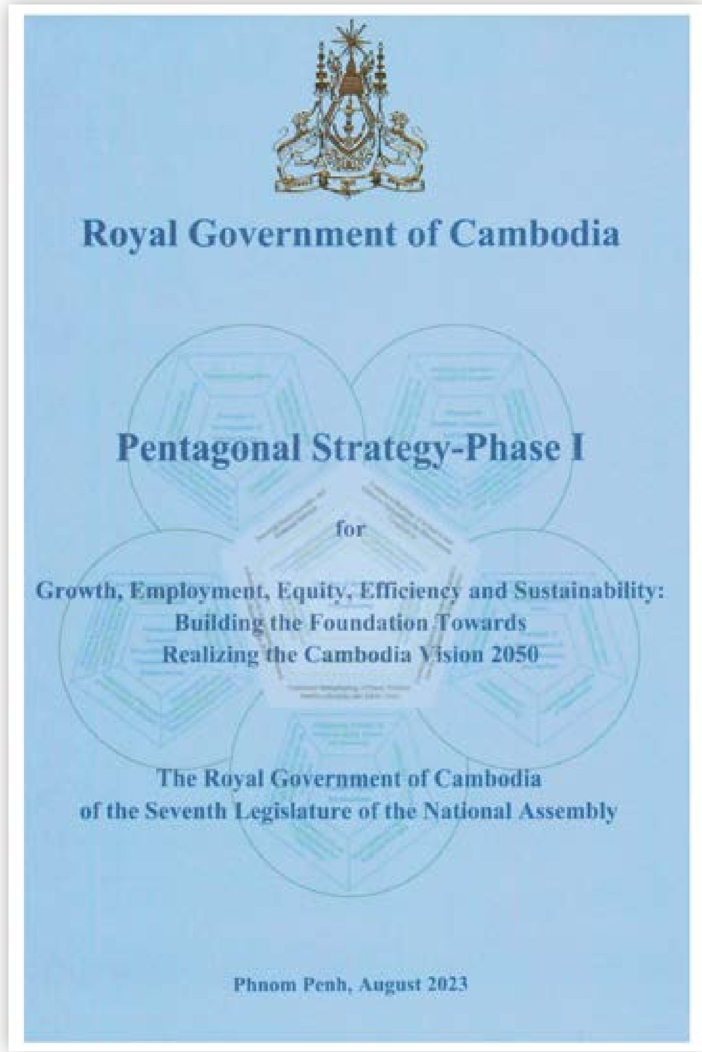
Remember how hard the Cambodian New Year could be because it marked the week the Khmer Rouge came to power? But C. brought up colorful pictures of this year's celebration.

> *C: I want to show you the New Year, New Year.*
>
> *FOO: Oh.*
>
> *C: Look at the temple. Yeah.*
>
> *FOO: New Year can be happy again.*
>
> *C: Oh, my God, it's so happy.*
>
> *Bophal sits and watches, smiling.*
>
> *PHEN: And that's the moment you go like, yeah, I feel good (laughter).*

## END NOTES

The podcast is an episode of Stephanie Foo's Invisibilia. This episode is titled "Therapy Ghostbusters." It is available in its full form on NPR, National Public Radio at: https://www.npr.org/2022/09/20/1124139592/therapy-ghostbusters

# APPENDIX A


Royal Government of Cambodia

Pentagonal Strategy-Phase I

for

Growth, Employment, Equity, Efficiency and Sustainability:
Building the Foundation Towards
Realizing the Cambodia Vision 2050

The Royal Government of Cambodia
of the Seventh Legislature of the National Assembly

Phnom Penh, August 2023

For full details of the Pentagonal Strategy - Phase I,
please refer to the following link:
https://mfaic.gov.kh/files/uploads/1XK1LW4MCTK9/EN%20PENTAGONAL%20STRATEGY%20-%20PHASE%20I.pdf

# APPENDIX B

## FULL WRITTEN JUDGEMENT IN CASE 002/02 REGARDING KHIEU SAMPHAN

Khmer: https://www.eccc.gov.kh/sites/default/files/documents/courtdoc/%5B-date-in-tz%5D/F76_KH.pdf

English: https://www.eccc.gov.kh/sites/default/files/documents/courtdoc/%5B-date-in-tz%5D/F76_EN.pdf

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