DC-Cam's Victims of Torture Project: An Evaluation

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I. Background

Upon taking power on April 17, 1975 after a bloody civil war that had devastated the country, the Khmer Rouge, a Maoist-inspired group of revolutionaries headed by Pol Pot, enacted a series of policies that radically transformed life in Cambodia, which they renamed Democratic Kampuchea (hereafter "DK"). Attacking major social institutions that they perceived as corrupted by capitalism, imperialism, and neo/colonialism, the Khmer Rouge banned Buddhism and many aspects of traditional ritual life, collectivized economic production and consumption, shut down markets and schools, dissolved the judiciary, eliminated monetary exchange, disbanded former patronage networks, and undermined familial solidarity by sorting people by age and gender into different work teams and taking over key familial duties such as providing food and arranging marriages. Everyone now ate in communal mess halls as they worked day and night, often on starvation rations, in the name of revolution.

These socioeconomic changes, meant to catalyze a "super great leap forward," were paralleled by direct attacks on "reactionary" elements of the population. Most immediately, tens of thousands – perhaps even hundreds of thousands – of former government officials, civil servants and military and police officers were rounded up and killed *en masse*. After a brief lull, an atmosphere of fear and terror spread throughout the countryside as the Khmer Rouge leadership, convinced that "hidden enemies burrowing from within" were subverting the revolution, initiated mass purges of suspect elements both within its own ranks and in the population at large. Spies crept about at night, listening for signs of subversion. Anyone who had a suspect background – "new people" from the cities, former students and professionals, those who wore glasses or had soft hands, low-ranking soldiers and police from the former regime, those who complained or didn't work hard enough – might suddenly be taken away or disappear. If the Khmer Rouge threatened "To keep you is no gain; to destroy you is no loss" and that "Angkar [the organization] has the eyes of a pineapple," the people whispered, "Be careful – bodies disappear" or "Angkar kills but never explains."[1] Ultimately, one should "See nothing, hear nothing, know nothing and understand nothing."

In this atmosphere of fear, constant anxiety, suffering, and death, one in which traditional methods of coping such as Buddhist ritual and familial solidarity had been shattered, many people withdrew. As the late Haing Ngor, the actor who played Dith Pran in the movie *The Killing Fields*, recalled, "I could feel my brain slowing down. It was hard to think about anything…Food – that was our main obsession." But "what was worse," he continued, "was the terror, because we couldn't do anything about it. The terror was always

[1] See David P. Chandler, The Tragedy of Cambodian History: Politics, War and Revolution since 1945, Yale University Press, New Haven, 1991, Pp. 260; Haing Ngor, A Cambodian Odyssey. New York: Warner Books, 1987, Pp. 235; Henri Locard, Pol Pot's Little Red Book: The Sayings of Angkar, Silkworm, Chiang Mai, 2004; François Ponchaud, Cambodia, Year Zero, Holt, Rinehart and Winston, New York, 1978, Pp. 65.

there, deep in our hearts. In the late afternoon, wondering whether the soldiers would choose us as their victims. And then feeling guilty when the soldiers took someone else. At night, blowing out our tiny oil lanterns so the soldiers wouldn't notice the light and come investigate, and then lying awake wondering whether we could see the dawn. Waking up the next day and wondering whether it would be our last."[2] Such suffering was further amplified by the uncertainty of death: not knowing what had happened to friends and family members who disappeared and, even when they did, being unable to ritually lay them to rest.

II. Mental Health in Cambodia

There are many legacies of DK, which was toppled on January 6, 1979 by the future leaders of the Peoples Republic of Kampuchea backed by up to 150,000 Vietnamese troops. One legacy is the astounding death toll: perhaps 1.7 to 2.2 million of Cambodia's inhabitants, almost a quarter of the population, died of disease, starvation, overwork, and execution. A second repercussion of the genocidal past was significant suffering and trauma. While no one knows the exact prevalence of trauma and associated disorders like PTSD, evidence – including studies of PTSD carried out with refuges on the Thai-Cambodian border, with Cambodian diaspora populations, and in Cambodia after the UN-sponsored elections – suggests that many Cambodians were severely traumatized during the genocide and a number continue to suffer from PTSD today.

Yet another legacy of DK was the destruction of the country's infrastructure both in terms of its abolishment of government institutions like the Ministry of Justice and Ministry of Education and its policy of targeting former civil servants, educators, students, and professionals for execution. The medical and mental health sectors were hit particularly hard as trained professionals perished or fled abroad in large numbers. In 1979, only a handful of doctors remained to treat a population that had suffered enormously. And there was no formal mental health care. Cambodians suffering from PTSD and other mental health problems related to DK often sought help by consulting monks and traditional healers, utilizing local healing practices such as coining, massage, and meditation, and relying on family support networks. Due to Cold War politics and international sanctions against the PRK regime, this situation remained largely unchanged until the early 1990s when UN-sponsored elections were held.

Cambodia's formal mental health sector, therefore, has only recently begun to be rebuilt. After the Cambodian National Health Plan listed mental health as a priority area in 1993, the Ministry of Health, working with the University of Oslo and the International Organization for Migration, embarked upon a program that, as of 2006, had trained 26 psychiatrists and 40 psychiatric nurses and established small clinics in most of Cambodia's provinces.[3] Their efforts have been supplemented by the work of non-governmental agencies, particularly the Transcultural Psychosocial Organization (TPO), which has opened several provincial clinics, provided training in the field, engaged in outreach efforts, and treated patients.

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[2] Haing Ngor, A Cambodian Odyssey, Pp. 289.

[3] "Cambodian National Program for Mental Health," International Organization for Migration, (http://www.iom.int/jahia/webdav/site/myjahiasite/shared/shared/mainsite/projects/showcase_pdf/Cambodia.pdf, accessed December 17, 2009).

Despite these gains, the mental health infrastructure in Cambodia remains quite weak more than 30 years after the fall of the Khmer Rouge regime. While there are no firm figures about the prevalence of PTSD in Cambodia, with estimates ranging from 28.4% in a 2001 study to 11.2% in a 2009 study,[4] there is no doubt that many Cambodians, particularly those who lived through DK, suffer from trauma and related mental health disorders, which are exacerbated by problems like poverty, chronic uncertainty, alcoholism, domestic abuse, and the lack of social and/or therapeutic support. The vast majority of these people do not have access to formal mental health care, lacking access, knowledge about, and money to the few mental health clinics exists. As Sotheara Chhim, one of the first graduates of the Ministry of Health / Oslo University program and currently the Director of TPO stated when giving expert testimony before the Khmer Rouge Tribunal on August 25, 2009, "Some foreigners probably are in doubt why after 30 years or so Cambodian people still [suffer] from this traumatization. And the answer is that Cambodian people have not had the appropriate opportunity to be treated, due to the fact that the services are inadequate and that people are very busy [earning a] living to feed their famil[ies]."

III. Victims of Torture Project

1. Origins of the Victims of Torture Project: DC-Cam's Victim of Torture project is a response to this mental health situation. The inspiration for the project originated from a 2000 conversation that the Director of DC-Cam, Mr. Youk Chhang, had with Cees Kieft from the Netherlands Embassy about the possibility of undertaking a PTSD project in partnership with TPO that would heal the wounds of the Khmer Rouge "one soul at a time."[5] A 2003 pilot project laid the groundwork for the first Victims of Torture project, which got underway in January 2004.

The basic idea of the project was for a DC-Cam team, which had received basic mental health training from TPO, to document experiences under the Khmer Rouge, administer trauma assessment questionnaires, and provide basic mental health information to villagers from Kandal, Takeo, and Kampot. Those identified as having PTSD (95 out of the

[4] "Lifetime Events and Posttraumatic Stress Disorder in 4 Postconflict Settings," Joop T. V. M. de Jong, Ivan H. Komproe, Mark Van Ommeren, Mustafa El Masri, Mesfin Araya, Moureddine Khaled, Willem van de Put, and Daya Somasundarram, JAMA 286:55-562, 2001 (http://jama.ama-assn.org/cgi/content/full/286/5/555, accessed December 17, 2009); "Probable Postraumatic Stress Disorder and Disability in Cambodia: Associations with Perceived Justice, Desire for Revenge, and Attitudes Toward the Khmer Rouge Trials," Jeffrey Sonis, James L. Gibson, Joop T. V. M. de Jong, Nigel P. Field, Sokhom Hean, and Ivan Komproe, JAMA 302(5): 527-536, 2009 (http://jama.ama-assn.org/cgi/content/abstract/302/5/527, accessed December 17, 2009). Even these studies must be read with care since the psychiatric diagnostic tools that exist are difficult to utilize in radically different sociocultural contexts.

[5] "Healing from the Trauma of the Khmer Rouge: One Soul at a Time," Youk Chhang, Documentation Center of Cambodia, n.d. (http://www.dccam.org/Projects/VOT/Youk_One_Soul_at_a_Time_Final.pdf, accessed December 19, 2009).

302 people interviewed) were referred to TPO for treatment.[6] Due to staff and time constraints, TPO was only able to treat 60 of these individuals suffering from PTSD. One distinctive aspect of the project was the use of culturally-sensitive techniques, such as relaxation, breathing, and meditation exercises. This author and two colleagues conducted an evaluation of this project and recommended its continuation with certain improvements, such as increased training and the use of government clinics as another possible source of treatment.[7]

2. Current Victims of Torture Project: The USIP-funded Victims of Torture Project, which ran from June 2008 through May 2009, builds upon these earlier incarnations even as it has been reconfigured, in part due to the fact that TPO has had to devote its already thin resources to the Khmer Rouge Tribunal, which began operation in 2006 and is, at the time of writing, just concluding its first trial. Drawing upon recommendations made during the last evaluation, the current project called for training DC-Cam staff to enable them to work with trauma victims, for developing local capacity for dealing with mental health issues by training community leaders both to recognize symptoms and to use relaxation and breathing techniques to help those suffering and under stress, and for continuing to document, identify, and refer those suffering from PTSD – in this case by sending them to government clinics. DC-Cam's aim was to identify 90 cases of PTSD, provide counseling to 60 of these individuals, and train 58 community leaders from four provinces.[8]

IV. Process Evaluation

1. DC-Cam Staff Training: In order to enhance their ability to provide basic counseling in the field, DC-Cam staff received three types of training.[9] First, two psychiatrists who had experience working with Cambodian patients in the United States, Dr. James Boehnlein (Psychiatry, Oregon Health and Science University) and Dr. Daryn Reicherter (Psychiatry, Stanford University), each visited DC-Cam for two weeks. During this time, the psychiatrists journeyed into the field with the DC-Cam's Victims of Torture team to observe their activities (see below) and held formal training seminars on "Recognition and Treatment of PTSD: Biopsychosocial and Cultural Approaches" for 30 DC-Cam staff members, including the core Victims of Torture team members.

In addition, the project team leader attended a two-week training seminar (November 7-24, 2008) on "Global Mental Health: Trauma and Recovery," which was held in Italy by the Harvard Program in Refugee Trauma. Besides such international training, DC-Cam also

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[6] "Victims of Torture (VOT) Project: Helping the Victims of the Khmer Rouge – Final Report, October 2003 through September 2005," Documentation Center of Cambodia, n.d. (http://www.dccam.org/Projects/VOT/Fianl_Report_2005.pdf, accessed December 19, 2009).
[7] "Truth, Trauma, and the Victims of Torture Project: Helping the Victims of the Khmer Rouge," Alex Hinton, Nela Navarro, and Tom La Pointe, Documentation Center of Cambodia, April 5, 2006.
[8] DC-Cam's original grant application to the United States Institute of Peace.
[9] The information in the process and impact evaluation are based on information gathered during the author's November 18-24 evaluation, which included staff interviews, examination of documentation (ranging from materials distributed to villagers to DC-Cam's proposal and final report to USIP), and three trips to the field where village and community leader project participants were interviewed.

liaisoned with the Ministry of Health's National Program for Mental Health to enlist the assistance of a Cambodian psychiatrist, Dr. Koeut Chhunly. Dr. Koeut Chhunly traveled to the field with the team on numerous occasions both to observe them at work in the field and to train the team in counseling and psychoeducation as needed.

2. Identification and Referral: The Victims of Torture project included two field activities, the first and most critical of which was interviewing and identifying villagers suffering from PTSD. To heighten the impact of the study, three field site clusters were selected for their proximity both to DC-Cam's office in Phnom Penh and to former Khmer Rouge prisons and mass graves, one each in Kandal (near Sa'ang Prison), Takeo (near Wat Ka Koh prison), and Kampot (near the Ta Manh killing field), where local populations were thought to have been more likely to have suffered a trauma event.

Interviewees were identified using a snowball method in which the project team would consult with local officials and villagers to identify individuals who were known to have had trauma events or evinced signs of mental health stress. To assess the mental health status of interviewees, the project team documented their experiences during DK before administering a series of questionnaires, including the Harvard Trauma Questionnaire, a Forgiveness and Reconciliation Survey, and a pilot Cambodian Addendum of Culturally Sensitive Items that had been designed by the author and the Harvard psychiatrist, Dr. Devon Hinton, after the previous Victims of Torture project.

In total, the Victims of Torture team made 24 trips to the field to conduct interviews. The team was able to interview 150 people, 90 of whom were identified as having PTSD. In keeping with the projects goals, 60 of these 90 individuals were referred to government clinics in Phnom Penh, Takeo, and Kampot. A grant from the Swedish International Development Agency provided funds to assist with their initial transportation and clinical fees. At the clinics, patients were interviewed by trained medical staff, diagnosed, and, if appropriate, given a one-month supply of medication.

3.Psychoeducation: Many of these trauma victims were also assisted by the Victims of Torture team's second field activity, psychoeducation. This activity was two-fold. First, the Victims of Torture team held six psychoeducation sessions for approximately 500 villages living in six villages, a number of whom had been identified as having PTSD. During these sessions, the Victims of Torture team used four mental health posters designed by TPO (see figures 1 and 2 below) to educate villagers about stress, including its definition, etiology, and treatment. To supplement the verbal training, the team distributed related materials, depending on supply, that might include copies of the TPO posters, mental health education leaflets designed by TPO or the National Program for Mental Health, Khmer Rouge Tribunal booklets, and copies of DC-Cam's magazine, *Searching for the Truth*. During the evaluation, villagers sometimes showed us the magazines they had been given or where they had put up the TPO posters.

Figure 1: “Causes of Stress.” The poster describes, clockwise from top left corner, domestic violence, disaster and poverty, war and displacement, drought and flood, unemployment, crimes and social threats, death of loved ones. Mental Health Education Poster designed by TPO.

Figure 2: “Positive Ways to Cope with Stress.” The poster describes, clockwise from top left corner, playing sports and working in the field, religious healing, breathing exercise, meditation, relaxation, group discussion, talking to trusted person or getting counseling. Mental Health Education Treatment Poster designed by TPO.

The second psychoeducation activity involved training community leaders (primarily commune and village chiefs and their deputies but also monks, religious lay practitioners, and other local leaders) about mental health issues so that they could potentially recognize symptoms and perhaps even help people alleviate their stress with basic breathing and relaxation techniques. Exceeding their original goals, the Victims of Torture team held four psychoeducation training sessions for over 200 community leaders from four different communes. This training was more in-depth and expansive than the psychoeducation sessions for villagers, involving education about symptoms related to anxiety, depression, post-traumatic stress disorder, and other psychosocial problems. Community leaders were given the same materials as the villagers along with more in-depth mental health booklets from TPO, DC-Cam's new education text, *A History of Democratic Kampuchea, 1975-1979*, and instructional materials from a mental health guide.

V. Impact Evaluation

1. DC-Cam Staff Training: During the project period, the Victims of Torture team accomplished its major goals and had a clear impact on the communities involved. A key objective was to procure additional training for the Victims of Torture team itself so that they could more effectively engage with trauma victims. As with the previous incarnation of the Victims of Torture project, DC-Cam staff uniformly agreed that the international training was quite useful and wished that they could have even more. While logistics did not permit it, the international training might have been even more valuable had it taken place earlier in the project since Dr. Boehnlein visited in December 2008 and Dr. Reicherter visited in April 2009, shortly before the conclusion of the project.

2. Identification and Referral: The Victims of Torture project clearly made a significant difference to the lives of villagers. 60 people suffering from post-traumatic stress disorder had the opportunity to travel to a government clinic for formal diagnosis and treatment – most for the first time in their lives. However, almost every person we interviewed during the evaluation lamented the fact that the funding to visit the government clinics was temporally limited (since the Swedish funding ran out). As a result, many of their symptoms, which had been alleviated at least to an extent by medication, had returned. As we re-administered the trauma questionnaires, we found that patients continued to score for PTSD but would often make caveats to the effect of "Yes, I have [symptom X] a lot now, but it abated while I was taking the medications I received at the clinic."

These medications were one of a number of self-treatments a villager might use when distressed. Others included traditional healing methods like coining, pinching, massage, using tiger balm and other oils, and engaging in meditation or prayer. Finally, as with the previous Victims of Torture project, there are clearly gender issues that need to be addressed by mental health practitioners in Cambodia. Women more readily agreed to be interviewed and self-reported symptoms than men. It is likely that there is a gendered dimension to trauma due to the structural position of women (for example, the difficulties widows sometimes have in remarrying and in providing for their families), but it also seems that men tend to under-report their stress, perhaps due to norms of masculinity. In any event, this issue requires further examination. Finally, the project also helped advance our knowledge of the cultural dimensions of Cambodian trauma by piloting the Cambodian Addendum of Culturally

Sensitive Items, which proved a sensitive instrument for assessing psychosocial distress on the village level. Several publications will result from this pilot research.

3. Psychoeducation: Through its psychoeducation program, the Victims of Torture team also made inroads in educating local officials and villagers about mental health issues and building local capacity to help individuals who are under stress. While the team reached an even a larger audience than originally planned, there clearly was a desire for even more training. One commune chief with whom we spoke said he greatly appreciated the training he received but that, without follow-up sessions, he had begun to forget some of the things he had learned. Even as he pulled out various materials that the Victims of Torture team had distributed at the training session he had attended, this commune chief asked for even more educational materials and suggested that they might be distributed prior to the psychoeducation training session whenever possible to allow time for preparation.

It is also clear that there is great variance in the level of formal education among community leaders and villagers. Victims of Torture staff suggested that, if the project were to be continued in some form, additional posters and short video clips might be created specifically for an audience of villagers. Such materials, combined with additional follow-up training, would help increase the retention of psychoeducational training and perhaps move the community leaders and villagers to a point where they could utilize and help others use basic relaxation and breathing techniques.

VI. Conclusions and Recommendations

Two things emerged clearly during the study. First, there is a somewhat of a mental health crisis in Cambodia, one that has been going on below the radar for years and that may escalate as the Khmer Rouge Tribunal proceeds and potentially reactivates traumatic memories. Unfortunately, besides some very broad surveys, such as Jeffrey Sonis's recent study (see footnote 4), it will be very hard to track such trends. And, second, Cambodian needs more initiatives like DC-Cam's Victims of Torture project to address this deficiency, ideally ones that are supported with more funding and training and conceptualized for the long-term. (With regard to this project, I would strongly urge that donors be re-approached and funds found to enable the villagers who scored for PTSD and visited the government clinics to return for follow-up visits.)

During the evaluation, two interrelated ideas emerged that could potentially help address Cambodia's mental health needs, particularly given that the tribunal is underway. First, to pull together the state of the art knowledge about Cambodian mental health, it would be useful to have a conference and related book publication on this topic. Leading psychiatrists, psychologists, and other experts on Cambodian mental health would contribute to this volume, which would not just enhance our understanding of the consequences of trauma in Cambodia but lay out a vision of how mental health efforts might be improved in the future. Ideally this project would have a web presence so that it could reach diaspora communities, which often have an even higher incidence of post-traumatic stress disorder due to issues of culture loss and relocation.[10] Particular emphasis should be paid to local

[10] "PTSD, Depression Endemic among Cambodian Refugees," National Institute of Health, NIH News, August 2, 2005.

understandings and treatment of PTSD and related disorders in contrast to the more experience-distant biomedical mental health models that are too frequently used in international mental health.

This volume, combined with DC-Cam's past experience with the Victims of Torture project, could serve as a guidepost for the second important initiative, the creation of a mental health clinic at DC-Cam's permanent center, which will be built within the next couple of years. Working with international and Cambodian mental health experts who are well-versed in culture-specific issues and treatments (ideally these experts would be invited to participate in the aforementioned conference and book), DC-Cam clinic staff would diagnose and treat individuals suffering from PTSD and psychological distress (the clinic would already have a large clientele consisting of the individuals who have already been identified with PTSD during the Victims of Torture project), conduct research on mental health issues in Cambodia (the pilot study with the Cambodian Addendum of Culturally Sensitive Items illustrates how this might be done), conduct on-site psychoeducation training, and include a "traveling clinic" team that would, as in the Victims of Torture project, travel into the countryside to document, identify, and provide basic counseling for villagers who have long lacked access to professional mental health care. In addition, following up on a recommendation from the previous evaluation, this team could interface both with community officials and "local healers," such as Buddhist monks and traditional healers to further build capacity on the ground. Given its almost decade-long work on mental health issues and long record of organizational excellence, DC-Cam is ideally posed to successfully undertake such a project.

VII. Evaluator Biography

Alex Hinton is Director of the Center for the Study of Genocide and Human Rights (CGHR) and Associate Professor of Anthropology and Global Affairs at Rutgers University, Newark (http://cghr.newark.rutgers.edu/). He is the author of *Why Did They Kill? Cambodia in the Shadow of Genocide* (California, 2005), which received the 2008 Stirling Prize, and six edited or co-edited collections, *Transitional Justice: Global Mechanisms and Local Realities after Genocide and Mass Violence* (Rutgers, 2010), *Genocide: Truth, Memory, and Representation* (Duke, 2009), *Night of the Khmer Rouge: Genocide and Democracy in Cambodia* (Paul Robeson Gallery, 2007), *Annihilating Difference: The Anthropology of Genocide* (California, 2002), *Genocide: An Anthropological Reader* (Blackwell, 2002), and *Biocultural Approaches to the Emotions* (Cambridge, 1999). He is currently working on several other book projects, including an edited volume on the legacies of genocide and mass violence, a book on 9/11 and Abu Ghraib, and a book on memory and justice after the Cambodian genocide. He serves as an Academic Advisor to the Documentation Center of Cambodia, on the International Advisory Boards of *Genocide Studies and Prevention*, the *Journal of Genocide Research* and the *Online Encyclopedia of Mass Violence*, as Vice-President of the Institute for the Study of Genocide, as the editor of the CGHR / Rutgers University Press Series "Genocide, Political Violence, Human Rights," and as the First Vice-President of the International Association of Genocide Scholars. In 2009, the American Anthropological Association selected Hinton as the recipient of the Robert B. Textor and Family Prize for Excellence in Anticipatory Anthropology "for his groundbreaking 2005 ethnography *Why Did They Kill? Cambodia in the Shadow of Genocide*, for path-breaking work in the anthropology of genocide, and for developing a distinctively anthropological approach to genocide."