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Healing and Reconciliation for Survivors of Torture during the Khmer Rouge Regime

TPO
Transcultural Psychosocial Organization
Community Mental Health Programme

in cooperation with

KDEI KARUNA

BASELINE SURVEY REPORT

Healing and Reconciliation for Survivors of Torture during the Khmer Rouge Regime

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HEALING AND RECONCILIATION FOR SURVIVORS OF TORTURE DURING THE KHMER ROUGE REGIME

BASELINE SURVEY REPORT

A TPO CAMBODIA REPORT **2017**

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PROGRAM NAME

Healing and Reconciliation for Survivors of Torture during the Khmer Rouge Regime

IMPLEMENTING ORGANIZATIONS

Lead: Transcultural Psychosocial Organization Cambodia (TPO; www.tpocambodia.org)

Partner: Kdei Karuna Organization (KdK; www.kdei-karuna.org)

DISCLAIMER

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ACRONYMS & ABBREVIATIONS

CP	Civil Party
CAS	Center for Advanced Study
DK	Democratic Kampuchea
DC-Cam	Document Center of Cambodia
ECCC	Extraordinary Chambers in the Courts of Cambodia
FKR-MS	Former Khmer Rouge Member-Survivor
FKR-VS	Former Khmer Rouge Victim-Survivor
KdK	Kdei Karuna Organization
KR	Khmer Rouge
LA	Local Authority
M&E	Measurement and Evaluation
PTSD	Posttraumatic Stress Disorder
SD	Standard Deviation
SOT	Survivor of Torture
TT	Testimonial Therapy
TVRA	Torture Victims Relief Act
TPO	Transcultural Psychosocial Organization Cambodia
UN	United Nations
US	United States

1. EXECUTIVE SUMMARY

After the KR ceased control of Phnom Penh on April 17, 1975, they forcefully evacuated all urban centers and moved its citizens into the countryside to live and work in forced labor camps and mobile units. A system of over 158 prisons was established across the country to eradicate any perceived threat or enemy of the newly established Democratic Kampuchea state. The *Santebal*, or internal security forces in charge of the prisons and interrogations, committed the more brutal forms of DK torture, as well as executed an estimated half million people.

The definition of torture used by this study included three criteria: 1) Experiencing significant physical or emotional suffering during the civil war; 2) This significant physical or emotional suffering was caused by an individual or individuals from an army, armed faction, or state; and 3) This harm was forced upon the survivor specifically, rather than vicariously or unintentionally. So in essence, if any Cambodian can answer these questions in the affirmative, they can be considered an SOT. As such, most survivors of the DK regime could theoretically be considered a survivor of torture.

Most of the methods of torture endorse by the SOT sample were consistent with the literature and ECCC documents on the subject. The most common forms of torture include forced labor and evacuation, starvation, forced family separation, humiliation, unsanitary living conditions, humiliation, and threat of death or severe punishment. Those who were arrested or detained reported being forced to make false confessions, being tied up or shackled, and being forced to hold stress positions. The most common GBV reported was forced marriage, spousal rape, and forced sexual touching. Interestingly, generally half of these responses were given by male SOTs, which highlights the need to include them in therapies focused on GBV traumas. The residual effects of torture described by SOTs included psychological trauma symptoms, grief, chronic medical conditions, and physical disabilities. This suggests that any psychological intervention should include components to deal with grief and loss, as well as, adjunct assistance with to help with medical problems. Lastly, the high level of religious persecution among Cham SOTs indicates that any intervention conducted with this ethnic minority should be culturally sensitive and include input from members and elders of their community.

SOT family/caregivers also reported a significant level of distress. The findings of the current study showed that they assist their SOT with medical care and activities of daily living (showering, toileting, shopping, dressing), and provide emotional support. They noted a considerable financial and physical burden to their care, which is consistent with the literature on caregiver burnout. SOT family/care givers also endorsed having difficulty with communicating

and understanding their SOT. As such, group interventions for caregivers and family members of SOTs should include psychoeducation on the ongoing effects of torture, communication skills training with the SOT present, as well as, self-care techniques to promote the overall well-being of SOT caregivers.

When asked about what could be done to help SOTs, the village authority and community member FGDs overwhelmingly suggested religious participation as a means of support. This is likely a reflection of Cambodia's spiritually-based culture, the lack of mental health awareness, and the paucity of available mental health services. It also indicates that incorporating religious elements into interventions, such as the ceremonies that are conducted at the end of Testimonial Therapy are well suited for the participants. The inclusion of religious aspects in other protocols, such as group and supportive therapy would likely be beneficial. This FGD response also underscores the need for psychoeducation regarding torture, its ongoing effects, and what lay people can do to help those in their communities who still struggle from being tortured during the civil war.

Regarding increasing empathy and understanding for SOTs, the most common response was to educate children of the FGD participants and other youth. These responses generally referred to the lack of knowledge or belief among Cambodian youth that the DK atrocities actually occurred. This response presumes that if young Cambodians were taught and believed what happened during the DK regime, empathy would naturally arise. The second most common response was "NGO support," which referred to interventions provided by non-governmental agencies to organize events at the grassroots level that raised awareness about torture and its adverse effects.

2. INTRODUCTION

The Transcultural Psychosocial Organization Cambodia (TPO) is Cambodia's foremost NGO in the field of mental health care and psychosocial support. TPO Cambodia was established in February of 1995 as a branch of the Netherlands-based NGO TPO International with the aim of alleviating the psychological and mental health problems of Cambodians. In 2000, it was registered as an independent local NGO and staffed by Cambodians. Since 1995, TPO has provided mental health care and support to over 200,000 Cambodians. TPO collaborates with a vast network of other organizations, including a number of Cambodian government bodies and ministries, as well as other organizations such as UN Women, international NGOs, and many other Cambodian NGOs.

Kdei Karuna (KdK), formerly the International Center for Reconciliation (Cambodia), has established itself as a leading Cambodian peacebuilding and reconciliation NGO that contributes to sustainable peace efforts in post-conflict Cambodia by working to enable individuals to live together with dignity, tolerance, and harmony. KdK utilizes a unique form of participatory sustained dialogue between various groups, including: Former Khmer Rouge Member-Survivors (FKR-MS) and Former Khmer Rouge Victim-Survivors (FKR-VS), as well as various minority groups in Cambodia who are often marginalized and experience discrimination. KdK implements a number of projects that emphasize grassroots interventions, which are tailored to each community based on their specific needs. Over the past 10 years, KdK has developed close working relationships with 16 different rural communities, including ethnic minorities, such as Khmer Cham, Vietnamese, and Khmer Loeu communities.

In 2016, TPO and KdK came together to address the needs of individuals and communities affected by torture inflicted by the Democratic Kampuchea (DK) state, better known as the Khmer Rouge (KR) regime. Together, they implemented the project "Healing and Reconciliation for Survivors of Torture during the Khmer Rouge Regime," which includes both psychological and psychosocial interventions aimed to reduce the psychological distress and increase the coping and resilience of SOTs, as well as increase the understanding and empathy of SOT family and community members. The Project is possible thanks to the generous support of the American people via the United States Agency for International Development (USAID), USAID Grant Number AID-442-G-16-00004 under the Healing and Reconciliation for Survivors of Torture during the Khmer Rouge Regime program. The Project spans three years and aims to help Cambodians heal from the effects of torture. Working at the community level, it involves

providing individual and group therapy, psychoeducation sessions, forum theater, and community-based dialogues.

This baseline report provides an initial insight into the kinds of torture experienced by survivors in three communities across Cambodia, including how torture continues to adversely affect their lives today. It also examines the condition of family members and caregivers of SOTs, and provides insight into community members' beliefs and attitudes towards SOTs. The study also served to develop clinical and M&E reporting measures for the Project. It is expected that these baseline results will be compared to data gathered at the mid-term and the end of the Project. Given that the sampling method was not random, these results cannot be generalized to SOTs or community members in other communities throughout Cambodia.

3. BACKGROUND

There are two primary international conventions banning torture and genocide that guided the definitions of torture for this Project. The first was the UN Convention on the Prevention and Punishment of the Crime of Genocide, which was adopted by the UN in 1948 and received Cambodia's accession in 1950. The second was the UN Convention against Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment, which was adopted by the UN in 1984 and received Cambodia's accession in 1992. Given that the major funder of the project was USAID, two US laws governing torture and aiding torture survivors were also used as guides for defining torture. These were the US Torture Victims Relief Act, which was passed and signed into law in 1998, as well as US Code, Title 18, Part I, Chapter 113C, § 2340.

Stated succinctly, torture is an act committed by a person acting under the color of law, generally meaning a state or armed faction within the DK regime context, specifically intended to inflict severe physical or mental pain or suffering upon another person within his or her custody or physical control. Torture includes the administration or application, or threatened procedures meant to profoundly disrupt the senses or the personality. Personality, within this context, refers to an individual's sense of self-determination, identity, and core beliefs. The threat of imminent death, or the threat that another person will imminently be subjected to death are also included. The US law includes the use of rape and other forms of sexual violence.

3.1 COMMOM DK METHODS OF TORTURE

After the KR ceased control of Phnom Penh on April 17, 1975, they forcefully evacuated all urban centers and moved its citizens into the countryside to live and work in forced labor camps and mobile units. The KR banned currency and destroyed the central bank in an attempt to return the country back to a rice-based, agrarian economy, akin to the Ankgorian Golden Age. Private property, religion, traditional family structures, and most other cultural practices were systematically repressed and abolished (Dy, 2007). A system of over 158 prisons was established across the country to punished those accused of any infraction, as well as eradicate any perceived threat or enemy of the newly established Democratic Kampuchea state (Yale University, n.d.).

The *Santebal*, or internal security forces in charge of the prisons and interrogations, committed the more brutal forms of DK torture. Their torture manual, the Discipline Santebal (S-21) stated, "The purpose of torturing is to get their responses. It's not something we do for the fun of it. Thus, we must make them hurt so that they will respond quickly. Another purpose is to break them [psychologically] and make them lose their will." While the exact number of individuals tortured at the hands of the Santebal is not known, only 20-30% were estimated to

have survived (Barber, 2000). And of the nearly two million Cambodians who were killed under the DK regime, 30% were estimated to have been executed. (Etcheson, 2000, April 14).

Yet, torture was not restricted to prisons and re-education centers. The findings of the current study, as well as the volumes of evidence submitted to the ECCC for prosecution of those most responsible for the crimes committed during the DK regime, demonstrate that most common forms of torture were forced labor, starvation, forced eviction, and threat of severe punishment and death. In practical terms, most Cambodians who lived through the DK regime could be considered survivors of torture.

4. METHODS

The goals of the current study were four-fold: 1) Identify the current distress, coping, resilience, and psychosocial functioning of SOTs; 2) Identify the current distress, difficulties, and needs of caregivers and supporting family members of SOTs; 3) Identify the knowledge, beliefs, and attitudes of community members regarding torture; and 4) Identify the means through which empathy and understanding can be increased towards SOTs in their respective communities. A secondary goal was to collect a sufficient amount of data that would enable the development of measurement tools, like the coping and resilience measures, to be more precise and efficient for both clinical use and M&E reporting.

4.1 Development of the Questionnaires

Three different questionnaires were developed for each of the following types of participants: 1) SOTs; 2) SOT family/caregivers; and 3) Local authorities (LAs) and community members. Each were developed to reflect and assess the indicators listed in the Program's M&E agreement, while keeping test-burden in mind and using cultural sensitivity as guideline. Four measures were developed to assess the resilience, the coping, and the psychosocial functioning of SOT participants in accordance with the Program's M&E indicators. A fourth measure was developed for caregivers of SOTs, which aimed to assess empathy and caregiver burnout.

The resilience, coping, and psychosocial functioning measures were not available in Khmer, and so they were translated by two master-level psychologists, and then rigorously vetted by the CAS team during the administration training sessions with TPO staff. The gold standard translation process, which includes: 1) Translation; 2) Blind reverse-translation; 3) Group review; 4) Expert review; and then 4) Pilot testing was not employed. Nevertheless, the SOT questionnaire was pilot tested to ensure the participants' understanding of the item content. Prior to its full deployment, the SOT questionnaire was administered to 16 SOT participants in Kampong Chhnang. Kampong Chhnang was selected because KdK already had established relationships in the community. After pilot testing the questionnaires, several iterative changes were made to make the items more easily understandable. The pilot test also served to help the CAS data collectors become familiar the questionnaire. The FGD and caregiver questionnaires were not pilot tested.

Of note, a total of seven questions per measure were developed assuming that not all questions would be appropriate or specific to Cambodian SOTs. After statistical analyses, the best four questions from each the seven items assessing coping, resilience, and psychosocial functioning would be retained for both clinical and M&E reporting. The rationale for doing so

was not only to reduce the assessment or test-taking burden for the older SOT participants, but also to develop measures that would be more specific to Cambodian SOTs.

4.1.1 SOT Screening Questions

The SOT questionnaire was the most time intensive, given that a screening method needed to be developed that could screen, or differentiate, between SOTs and non-SOT survivors of the civil war. In short, three brief questions were developed based on the definition listed in the Torture Victims Relief Act (TVRA) of 1998 that could be understood by any Cambodian. Three criteria from the TVRA definition were identified by the current author as being essential for identifying SOTs. These included: 1) Experiencing significant physical or emotional suffering during the civil war; 2) This significant physical or emotional suffering was caused by an individual or individuals from an army, armed faction, or government; and 3) This harm was forced upon the survivor specifically, rather than vicariously or unintentionally.

A fourth question was added, but it was not used as criteria to define an individual as an SOT, given the cultural beliefs of some Cambodians that certain psychological distress symptoms may be interpreted as an effect of bad karma, lack of religiosity, or the actions of displeased ancestors. This fourth question was, "Are you still experiencing distress related to the civil war?" If the respondent answered the first three questions in the affirmative, they were assumed to qualify as a SOT. The four screening questions were as follows:

1. Did you ever experience significant physical or emotional suffering during the civil war?
2. Was this physical or emotional suffering caused by an individual or individuals who were part of a government, army, or armed faction?
3. Was this suffering intentional, that is, was your suffering forced upon you specifically rather than you observing it vicariously?
4. Are you currently struggling or suffering either physically or emotionally from what happened during the civil war?

If the participant qualified as being a SOT, they were asked a series of demographic questions and read the following statement, "I will ask you now about specific experiences you may have had during the civil war. After I read a question, please respond by saying 'yes' if you experienced it, 'no' if you did not experience it, or 'I do not want to answer,' if you don't feel comfortable responding to the question." A list of common DK torture methods common was then read to them.

4.1.2 Common DK Torture Methods

The quantitative or closed-ended list of DK torture method questions was developed and compiled after a review of the literature, which included a review of source documents from the Documentation Center of Cambodia's (DC-Cam) archive using the word "torture" as a search criteria on their website (http://www.d.dccam.org/Database/Lod/index.php). Certain types of torture listed in the TVRA definition were not considered in the current study given that there was no documented evidence of their use during the Cambodian civil war, including sound and temperature manipulation and the use of psychedelic drugs.

For the purposes of the administration, torture categories were listed as being either: 1) Common methods of DK torture; 2) Those occurring during arrest, detainment, imprisonment or re-education; and 3) Those described as being GBV. For a complete list of torture types used in the current study, kindly see the SOT questionnaire in Appendix, as well as in the Results section, which lists the percentages and frequencies of the torture methods endorse by the SOT participants. In addition to the listed torture methods, the participants were asked in an open-ended question format to report any other significant suffering they endured during the civil war, in addition to any ongoing suffering related to their previously reported methods of torture. While some SOT responses may not have constituted torture as defined by the TVRA definition, they are still listed given that they were noted by the SOT as significant suffering.

4.1.3 SOT Resilience

Resilience can be described as an individual's ability to withstand or recover from a physical or psychological trauma or significant life stressor. Researchers have listed various qualities of resilience, including: "commitment, humor in the face of adversity, patience, optimism, faith, and altruism" (Connor & Zhang, 2006). The CD-RISC was originally developed as a 25-item measure of resilience related to trauma-exposed individuals in the US. The content was derived from earlier works based on the construct of resilience, including self-control, optimism, adaptability, social bonding, resistance to stressful situations, etc. Campbell-Sills and Stein (2007) then modified the CD-RISC to a 10-item version after conducting a series of statistical analyses to identify the best items describing resilience. Their revised scale consisted of two item groupings: Hardiness and persistence. More recently, Duong and Hurst (2015) conducted validity study of the CD-RISC-10 in a Cambodian sample of 798 high school students, aged 14 to 24 years, in urban and rural areas of Phnom Penh, Battambang, and Mondulkiri. The Cambodian 10-item measure demonstrated sufficient psychometric properties in their study. Given these findings and the lack of any other validated resilience measure in Khmer, the current

author selected seven items from the original 10-item measure, which were chosen to for their cultural salience and a priori specificity to the SOT sample.

4.1.4 SOT Coping

Coping can be defined as an individual's response style, or characteristic responses, to life stressors (Lazarus, 1966). The original COPE inventory (Carver, Scheier, & Weintraub, 1989) was comprised of 60 items measuring varies types of coping styles including: planning, substance use, social support, religiosity, acceptance, and denial, etc. Given the length and breadth of the original scale, a brief version consisting of 28 items was developed by the original author for researchers. A modified version of the BriefCOPE (Carver, 1997) was used to assess the coping styles of the SOT participants in the current study. The current author reviewed these 28 items and, again, selected those with more cultural salience and a priori, or assumed, relevance to the SOT sample.

4.1.5 SOT Psychosocial Functioning

Psychosocial functioning is a broad construct, or clinical concept, which describes an individual's ability to function healthfully in a variety of social contexts. A modified version of the Brief–Inventory of Psychosocial Functioning (B-IPF; Marx, 2013) was employed to measure the psychosocial functioning of the SOT participants. The B-IPF was originally developed to assess the level of psychosocial functioning in psychological trauma patients within Veterans Affairs hospitals in the US. After an exhaustive review of the psychosocial functioning literature, Marx (2013) identified specific areas of functioning frequently impaired by individuals suffering from psychological trauma. These include: intimate relationships, friendships and socializing, parenting, occupational functioning, and financial problems. The original version was comprised of 80 items and was published with a shorter 14-item version. The current author reviewed the brief 14-item version and, again, selected and then modified those with more cultural salience and a priori, or assumed, relevance to the SOT sample.

4.1.6 SOT Psychological Distress

The 14-item Cambodian Symptoms and Syndromes Addendum (C-SSA) was employed to measure the general psychological distress levels of the SOT participants. With over ten years of clinical experience working with Cambodian DK refugees in the US, Dr. Devon Hinton and colleagues studied many of the symptoms and syndromes commonly experienced and described by his patients. Over this period of time, he and his colleagues systematically and methodically studied each of these symptoms and syndromes in a series of over 15 peer reviewed journals (e.g.,

Hinton, Chhean, Fama, Pollack, & McNally, 2007; Hinton, Chhean, Pich, Hofmann, & Barlow, 2006; Hinton, Chhean, Pich, Um, Fama, & Pollack, 2006; Hinton, Hinton, Pich, Loeum, & Pollack, 2009; Hinton, Pich, Chhean, & Pollack, 2005; Hinton, D. E., Pich, V., Marques, L., Nickerson, & Pollack, 2010; Hinton, Pich, Safren, Pollack, & McNally, 2006; Hinton, Um, & Ba, 2001). This body of work culminated in the development of the Cambodian Symptoms and Syndrome Inventory (C-SSI; Hinton, Kredlow, Pich, Bui, & Hofmann, 2013). A shorter version of the C-SSI called the Cambodian Symptom and Syndrome Addendum (C-SSA) is comprised of 15 items, which were selected based on their "clinical salience" (D. E. Hinton, personal communication, March 19, 2016).

The C-SSA has been widely used a culturally sensitive measure of general psychological distress and trauma in both adult and child populations in Cambodian studies. Item 15, which queries the number of sleep paralysis episodes, "Ghost pushing you down," was removed for the current study because it uses a different response category: the specific number of sleep paralysis episodes, rather than the ordinal zero to three response type of the other items. The C-SSA correlates, or is associated, highly with other measures of depression, anxiety, and PTSD. The purpose of using the C-SSA was not to diagnose a particular disorder, rather, it was used to briefly measure the relative magnitude of psychological distress of the SOT participants. The C-SSA was also administered to SOT caregivers.

4.1.7 SOT Caregiver Burnout and Empathy

A modified version of the Caregiver Strain Questionnaire-Short Form (CGSQ-SF; Brannan, Heflinger & Bickman, 1997) was used to assess SOT caregiver empathy and burnout. The original CGSQ contained 21 items and was then shortened to 10 items. The original CGSQ was developed to measure caregiver strain for parents whose children were undergoing chemotherapy. As such, the wording of each question needed to be modified to assess the distress of SOT caregivers. The main assumption was that conceptually, caregiver strain or burnout was an aspect of empathy, or more particularly, a lack of empathy. Some questions querying understanding and empathy directly were written by the current author in order to assess the M&E indicator more precisely.

4.1.8 FGD Questionnaires

The TPO team decided it was best to hold FGDs with local authorities (LAs) separately given their previous experience that LAs tended to dominate FGDs if they were held with non-LA members of their community. The same FGD questionnaire was used for both groups and included the following open-ended questions:

1. SOTs within your community reported that they continue to struggle with [TOP FIVE RESPONSES FROM SOT SURVEY]. How can you and members of this community help the SOTs with these problems?
2. Why do you and members of your community think that SOTs continue to struggle with the effects of the civil war?
3. How do you and members of your community feel towards SOTs and those who continue to struggle with the effects of the civil war?
4. What can be done to increase the empathy that you and your community members feel towards SOTs?
5. What can be done to increase the understanding that you and your community members have regarding SOTs and their problems?

4.2 Sampling Method

Two sampling methods were used to select participants in the current study: Non-random purposive sampling and snow ball sampling. Non-random purposive sampling means that participants were selected based on a specific location and classification of individuals. The main benefit of non-random purposive sampling is that it is relatively easy to collect data from a specific population, but the primary limitation to the method is that it is difficult to generalize the findings to the general population, in this case: SOTs in other regions of Cambodia. Snow ball sampling means that you identify potential participants through referrals from participants already involved in the study. After interviewing an SOT, each were asked if they knew anyone else who may want to participate in the current study.

In accordance with the agreement with USAID, 15 communities were selected for the Program's intervention, including: Battambong, Kampong Cham, Kampong Chhnang, Kampong Thom, Kampot, Kandal, Kep, Kratie, Mondulkiri, Prey Veng, Pursat, Siem Reap, Svay Rieng, Takeo, and Tbong Khmum. For the purposes of this Program, a community was defined as two to three villages within a commune in each targeted province or region, which was known to be significantly affected by the civil war. The selection of these communities, more specifically, was based on the presence of larger DK mass-grave sites and prisons, documentation from DC-Cam, as well as grassroots discussions with provincial- to village-level authorities, and local religious leaders. Other inclusion criteria included communities with: 1) The presence of both former KR member-survivors (FKR-MS) and former KR victim-survivors (FKR-VS) living amongst each other; 2) The lack of any other similar intervention deployed in the community previously; and 3) The presence of a large number of gender-based violence (GBV) survivors, most likely civil parties (CPs) from the ECCC.

Figure 1. Map of Program's targeted communities with former DK prison sites. Modified and retrieved from http://www.un.org/Depts/Cartographic/map/profile/cambodia.pdf.

Given their previous experience with baseline studies, the TPO team selected three communities in order to assess at least 150 SOTs. Battambang, Kratie, and Pursat were chosen given their distinct geographic locations and unique cultural characteristics. The KdK team was integral in the selection of these communities based on their knowledge from working previously in many of the Project's targeted communities. Kratie was selected because of the relatively high number of Muslim Cham SOTs living in the area. Battambang was selected because both former KR member-survivors (FKR-MS) and victim-survivors (FKR-VS) were known to reside there. Pursat was selected based on KdK's desire to continue the momentum of their work in the area and the large number of FKR-VSs. As can be seen from viewing the map in Figure 1, most of the targeted communities are located in areas where former DK prisons operated. Many of the mass-grave sites are also located around these areas, but not were included in the map given that the focus of the current study was on those who survived DK torture.

Prior to deploying the CAS data collection teams into the three targeted communities, ground preparations were conducted by TPO and KdK staff to identify and collect a list of potential participants. Once on the ground, the TPO and KdK teams assessed how many villages in each community needed to be assessed to reach the predetermined number of study SOT

participants, which was approximately 50 per community. The goals of the Project were explained to each of the local chiefs, acquire their approval for conducting the study, and ask if any their villagers fell into the following categories: GBV survivors aged 55+, substance abusers aged 45+, war-related amputees or disabled individuals, Cham or other ethnic minorities aged 45+, former prisoners during the civil war, individuals aged 45+ who were known to have been adversely affected by the civil war.

4.3 Safety Protocol and Informed Assent

The current study's protocol was not reviewed by an Internal Review Board or any similar secondary body. Despite this, care was taken to ensure adherence to international standards of protecting the rights of participants, including gaining their consent for participation in the study and safeguarding their emotional and physical well-being. All CAS data collectors were trained on administering basic psychological first aid and were instructed to give information containing TPO's counseling hotline number to each potential participant they came into contact with during data collection. The data collectors were also informed to call their managers if any individual they were assessing had a significant adverse emotional reaction. All participants were made aware of their rights regarding consent to being assessed, including their right to decline to participate. Additionally, those questions that were deemed sensitive had a "declined to answer" response. All participants were required to provide verbal consent, known as assent, prior to being interviewed due to the reluctance of many Cambodians to provide written consent. Kindly review the Informed Assent section of the SOT administration form in the Appendices section of this report.

4.4 Coding the Open-Ended Responses

The translation from Khmer to English of the open-ended responses from the SOTs, SOT caregivers, and FGD participants was performed by Ms. Sonary Chor and Ms. Rattana Sorm, both bilingual, bachelor-level, Cambodian therapists. The coding, or categorization of the open-ended responses was conducted by the current author, an American doctoral-level psychologist, and Ms. Chariya Om, a Masters-level, bilingual, Cambodian therapist. In general, the coding process involved reviewing the all of the responses to a question and then agreeing upon the number and type of categories for each respective question using consensus as a guide. Ms. Om also reviewed the translation of some of the responses, when necessary, to ensure proper coding. Given that some of the categories were broad, each will be described with more detail in the following Study Findings section.

5. Study Findings

All of the computer analyses of this study were performed using FACTOR 10.4.01 by Lorenzo-Seva and Ferrando (2016) and SPSS 21 Statistics software package published by International Business Machines Corp. for the Microsoft Windows environment. The results of the study will be presented in the order described in the Methods section: 1) SOTs; 2) SOT caregivers; and 3) FGDs. After listing the demographic information for each of these groups, their responses will be described in kind.

Each of the SOT and SOT caregiver scales were analysed using a statistical method called *exploratory factor analyses* (EFA). EFA can help identify which items in a particular measure contribute best to the overall measure. For example, the best four items in the Coping, Resilience, and Psychosocial scale were selected using EFA. As noted previously, the number of items in each scale was reduced from seven to four in order to minimize the testing burden for the SOTs, given their advanced age and potential health problems related to torture. This also increased the efficiency of assessing the Program's indicators, which would allow the TPO therapists to spend more time providing interventions and other work related to all of the Program's stakeholders.

5.1 SOT Demographics

The average age of the individual SOT participants was 61 years with values ranging from 44 to 86. The average education of SOTs spanned just over two years. Education was defined as the number of years of formal education, including both traditional and monastic settings. Historically, poorer families sent there male children to be educated at Buddhist pagodas, given the level of wide-spread poverty and the valued cultural status having a child in the monkhood. Of note, 49 (29.2%) SOT participants reported having no formal education and only one reported receiving 12 years of formal education. The average number of children for SOTs was about five. This reflects the older age of the participants, as the fertility rates have fallen in Cambodia to three children per female (UN Department of Economic and Social Affairs, Population Division, 2009). The house dweller variable described the number of individuals living at an SOT's residence. A residence or tract of land in the rural areas of Cambodia can have multiple small domiciles housing various groups of an immediate and extended family.

There were slightly more males (55.2%) than females (44.8%) in the SOT sample. A large majority reported being married (69.6%), while 28.6% reported being widowed. A majority of the SOTs were Khmer Buddhists (64.9%), while the remaining sample were Cham Muslims (35.1%). The participants were recruited nearly equally along the three targeted provinces. Just

Table 1
Continuous Demographic Characteristics of the SOT Sample

Variable	Mean	*SD*	Median	Mode	Minimum	Maximum
Age	60.98	8.50	60	67	44	86
Education (years)	2.41	2.51	2	0	0	12
Number of Children	5.37	2.44	5	5	0	11
Household Dwellers	5.11	2.43	5	4	1	12

Note. n = 168. Mean = the average value of a variable in the sample. *SD* = standard deviation, which describes how much the entire sample values differ from the mean value. The median is the value of the variable that falls into the middle of all the sample values. The mode is the most commonly endorsed value of the variable by all of the participants.

Table 2
Categorical Demographic Characteristics of the SOT Sample

Variable	Category	Frequency	Percentage
Gender	Male	91	55.2%
	Female	74	44.8%
Marital Status	Married	117	69.6%
	Widowed	48	28.6%
	Divorced	2	1.2%
	Single	1	0.6%
Ethnicity	Khmer	109	64.9%
	Cham	59	35.1%
Religion	Buddhist	109	64.9%
	Muslim	59	35.1%
Province	Kratie	59	35.1%
	Battambang	57	33.9%
	Pursat	52	31.0%
Occupation	Farmer	89	53.0%
	Other	31	18.5%
	Retired/Unemployed	15	8.9%
	Salesperson	14	8.3%
	Housewife	11	6.5%
	Unskilled laborer	4	2.4%
	Civil servant	2	1.2%
	Skilled laborer	1	0.6%
	Other professional	1	0.6%
Wealth Status	Poor	106	63.1%
	Average	62	36.9%
Current Debt	$0 USD	95	56.5%
	$1 to $999 USD	36	21.4%
	$1,000 to $2,000	25	14.9%
	$2,001 to $6,000	10	6.0%

Note. n = 168. The total percentages of each category may not add up to 100% due to rounding error.

over half of the participants reported farming as their primary occupation. A majority endorsed being poor (63.1%), while none endorsed being rich when given the choice of responding between rich, average, or poor. Lastly, a majority of the sample reported having no current debt (56.5%), with remaining sample carrying a debt of up to $6,000 USD.

5.2 SOT Methods of Torture

As noted previously, there were four screening questions, which were asked of all potential SOT participants. The first three questions qualified the participant as being an SOT if answered in the affirmative, while the fourth question queried any ongoing physical or emotional suffering related to the participant's torture experiences. Since only those individuals who answered the first three questions in the affirmative were included in the current study, there were only differences found in the fourth question. More specifically, only 29 (17.4%) of the SOT participants did not endorse having ongoing physical or emotional suffering related to their torture experiences. This is likely due to the SOT's actual level of resilience or internal and external resources, a lack of self-awareness, or the attribution of current psychological or physical suffering to religious or spiritual causes.

Figure 2 examines the frequency and percentages of common methods of torture reported by the SOT sample, which were listed in order from the highest to the lowest level of endorsement. Over 90% of the entire SOT sample endorsed starvation (denial of adequate food or water), forced eviction from their homes, forced labor (working hard for extended periods of time under harsh conditions), and forced separation from family members. These responses are consistent with the large body of evidence submitted to the ECCC which exposed DK policy and crimes committed by the leadership. Over half of the SOT sample endorsed living in poor conditions (unsanitary, over-crowded, or uncomfortable temperatures), humiliation (getting insulted or screamed at in front of others), sleep deprivation (being repeatedly awoken to restrict sleep), and being threatened with death or severe physical harm. Roughly a third of the SOT sample endorsed being denied medical care and being forced to engage in military fighting (forced soldiering). Nearly 20% of the SOT respondents endorsed being physically beaten or being forced to witness the torture or execution of others.

SOTs were also asked if they were ever arrested, detained, imprisoned, or send to a security or re-education center. Again, most of the questions queried specific methods of torture known to be used by DK prison guards while detaining suspects or attempting to extract confessions. Twenty-seven of the 168 SOTs (16.1%) reported being arrested, detained, or

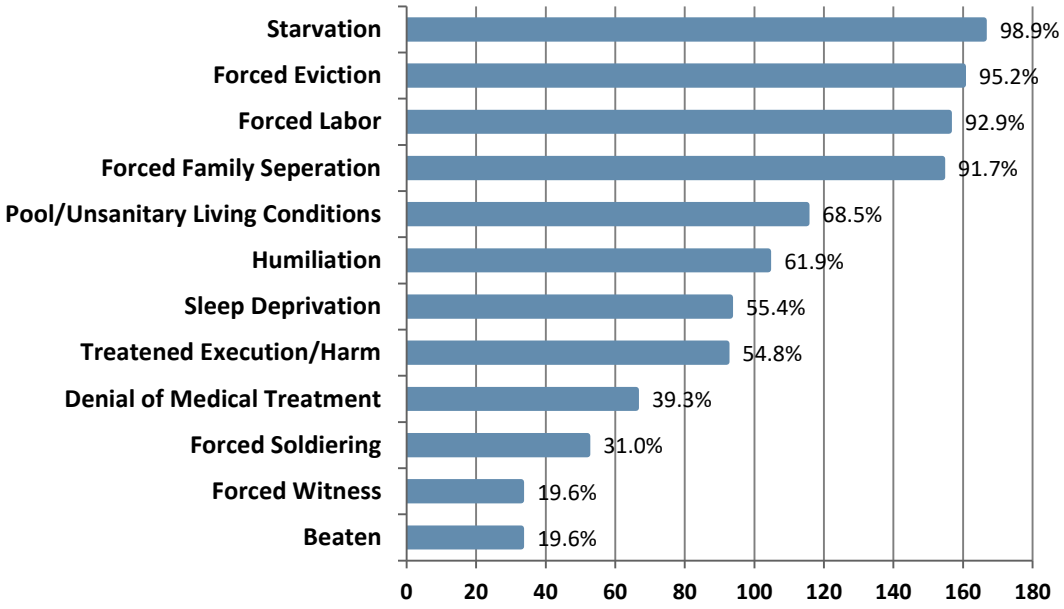

Figure 2. SOT-endorsed common DK torture methods. These percentages were calculated from the quantitative, or closed-ended, questions asked of all 168 SOT participants. The horizontal axis of numbers describes the frequency, or count, of the endorsed method of torture.

imprisoned and each of these endorsed being falsely accused or arrested. Seventeen (10.1%) of the SOT sample stated they were forced to make false confessions. Given that these were closed-ended questions, the content of these accusations were not collected, however, it was not uncommon for DK prison guards to falsely accuse FKR-VSs, FKR-MSs, or their family members of working for the Vietnamese, the US Central Intelligence Agency, the KGB (Soviet Union secret police), or being previous member of the Lon Nol regime (Barber, 2000). Others were arrested and tortured for small infractions, such as stealing small amounts of food given the pervasiveness of starvation. Twelve (7.1%) SOTs reported being held in isolation for extended periods of time.

Eight (4.8%) SOT participants reported be having their hands tied, being blindfolded, or having a cloth sack place over their head during their detention. The same number endorsed being forced to walk or withstand stress positions, which is being forced to kneel or hold an uncomfortable posture for long periods of time. Four SOTs (2.4%) reported the use of water as means of inflicting physical or emotional suffering. This may have included having boiling water thrown upon the SOT or using water to induce the sensation of drowning, otherwise known as *waterboarding*. Four SOTs (2.4%) also reported being burned, shocked or cut with various instruments of torture. Only two SOTs (1.2%) reported having their fingernails and hair pulled out or being hung up with roped or wire. No SOTs in sample endorsed being tortured with

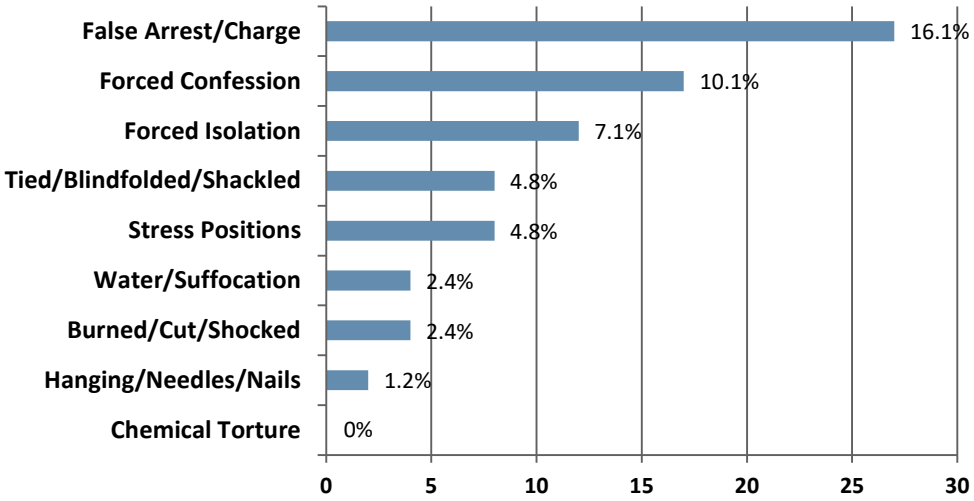

Figure 3. SOT-endorsed torture methods during arrest and imprisonment. These percentages were calculated from the quantitative, or closed-ended, questions asked when the SOT participant endorsed being arrested, detained, imprisoned or sent to a security or re-education center. The horizontal axis of numbers describes the frequency, or count, of the endorsed method of torture.

corrosive chemicals, such as having lye placed on open wounds. From the responses given by the current SOT sample, it appears that those torture methods that were harsher were endorse to a lesser degree. From this, it could reasonably be assumed that as the methods of torture became harsher, the chances of survival diminished.

All SOTs were also asked if they were sexually abused during the civil war, including being forced to marry someone they did not know or did not want to marry. If they answered this question in the affirmative, they were asked a list of common acts of GBV known to have occurred during the DK regime. The most common form of GBV was forced marriage, as this was endorsed by 19 SOTs (11.3%). Remarkably, six of these forced-marriage SOTs endorsed being forced to have sex with their spouse, despite the strong cultural biases and conspiracy of silence regarding GBV and other crimes that occurred during the DK regime. In light of this, the number of spousal rape survivors was likely higher, as with other surveys of GBV. Surprisingly, half of those who endorsed being forced to have sex with their spouse were male. This was likely a reflection of forced consummation, whereby death was threatened by DK spies or security forces if the couple did not copulate after their forced marriage.

Another six SOTs (3.6%), four of whom were male, endorsed being touched or being forced to touch another person in a sexual manner. Among these six SOTs who reported unwanted sexual touching, three also endorse spousal rape and five endorsed forced marriage. So, it is likely that unwanted sexual touching occurred within the context of forced marriage. Only two SOTs endorsed being forced to remove their clothes in the presence of others and only one

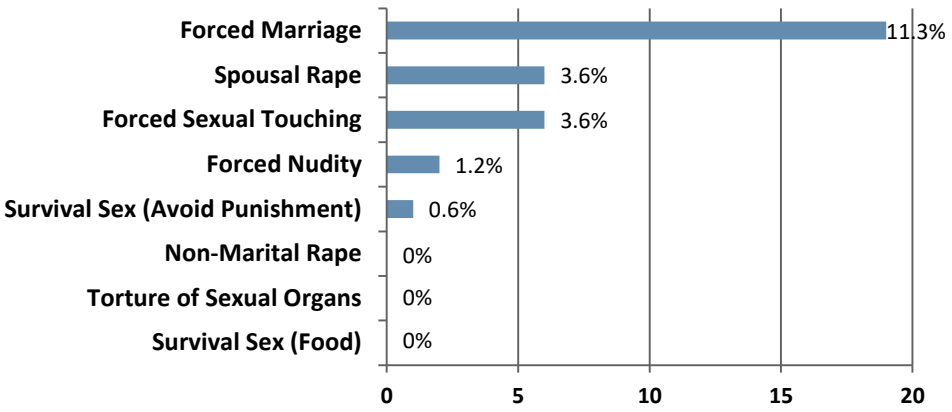

Figure 4. SOT-endorsed gender-based violence (GBV). These percentages were calculated from the quantitative, or closed-ended, questions asked when the SOT participant endorsed forced marriage or being sexually abused. The horizontal axis of numbers describes the frequency, or count, of the endorsed method of torture.

reported having sex in order to avoid punishment. None of the SOTs endorsed being raped outside of marriage, having their sexual organs tortured, or having sex in exchange for food.

After being ask the above closed-end questions regarding known methods of torture, all SOTs were asked in open-question format if they had any other experiences which caused them significant physical or emotional suffering. As described in the Methods section above, these responses were translated and then coded according to type of experience or method of torture. Not all of these experiences would constitute torture by definition, but they underscore the difference between bona fide torture and psychological trauma. It should be noted that this was an open-ended question, only those SOTs who responded were tallied leaving open the possibility that other SOTs may also have had these experiences, but declined to answer.

The most frequent response was the killing or execution of relatives. Eighty-one (48.2%) of the SOT sample reported that their relatives had been executed or killed. Relatives in their responses included their spouse, children, siblings, or extended relatives, and most participants reported losing multiple family members. A few reported losing their entire family. These particular responses were coded with "orphaned/parents killed" given the magnitude of the loss in a collective culture where family is held in high regard. Sixteen (9.5%) of the SOT participants reported being orphaned or losing both parents. Grief and psychological trauma were the most frequently reported effect of losing both parents. The following response highlights the tone of some of the more heart-wrenching responses: "I still suffer from when all my family members were taken away. I still don't know where they were taken. I was left alone and my parents were mistreated and starved to death. When I think about it, I feel so much pain."

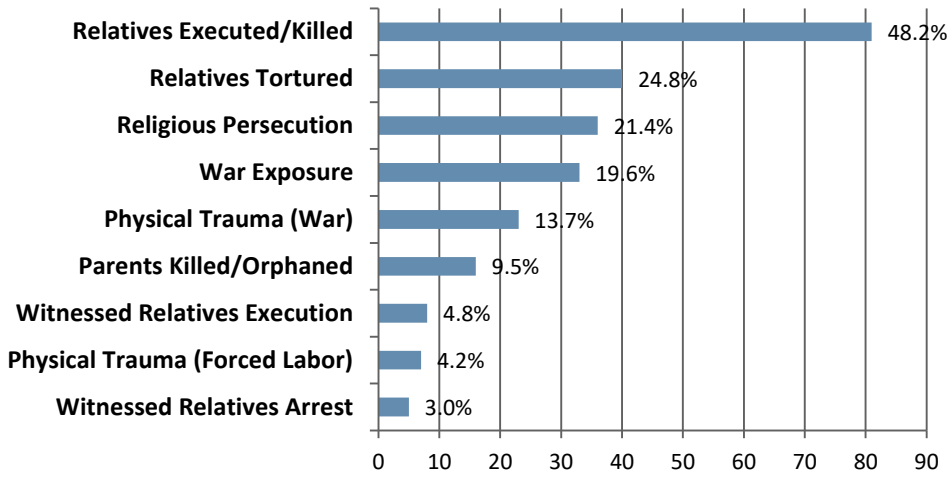

Figure 5. SOT self-reported suffering. These percentages were calculated from the qualitative, or open-ended, question "Are there any other experiences you had during the civil war that were not listed above and caused you significant emotion or physical suffering?" The horizontal axis of numbers describes the frequency, or count, of the response code.

These particular responses made no reference to the SOTs witnessing the killings themselves. In order for the killing or execution of relatives to be considered torture, the intention criteria must be met. That is, the individual who killed or tortured the SOTs' relatives must have done so to knowingly inflict suffering specifically upon the SOTs. This implies that the SOT must have had either close proximity in time or distance to the killing and this cannot be readily known from their translated response. As such, most of these responses likely constitute psychological trauma rather than torture, given the assumption that the SOTs most likely heard of their relatives' killing after it occurred. If an SOT did, in fact, state that they witness the killing or execution of a relative or relatives, his or her response was coded separately. Eight (4.8%) SOTs did report witnessing the killing or execution of their relatives and five (4.0%) reported witnessing their relatives' arrest.

The second most common response was the torture of relatives. Forty (24.8%) SOTs reported that their relatives had been tortured, which included either non-specific torture, common DK methods of torture, and those methods committed during detention or re-education as described above. While no SOT specifically reported witnessing a relative's torture, it is likely they witnessed the more common forms of torture, such as starvation and forced labor. Torture that was perpetrated upon the SOTs' relatives in detention settings were most likely not witnessed by the SOTs and therefore do not constitute torture specifically for the SOTs. However, the knowledge of its occurrence would indeed be psychologically traumatic.

The next highest reported adverse experience was religious persecution. Of the 36 SOTs who fell into this category, 35 were Cham Muslims. Most of the responses involved being forced

to eat pork. A handful of others mentioned being forced to eat dog and being denied the freedom to practice their religion. A common consequence of being forced to eat pork was ongoing psychological trauma as described well by the following response: “They forced me to eat pork and didn't allow me to worship God. I still feel ashamed because it was contrary to my religion.” Given the common responses across the SOTs, it would be beneficial in therapies provided to Cham SOT to include a discussion of religious persecution. Involving mosque elders and leaders may also aid in the healing process.

Thirty-three SOTs (19.6%) reported war exposure as source of significant suffering. These responses could be divided into escaping an invading armed force and destruction, being caught between two waring forces, or actually serving in the military. Twenty-three SOTs (13.7%) described physical trauma related to war, yet nine of these did not report any war exposure. This is likely due to the most commonly reported cause of war-related injuries: land mines. Reported physical trauma occurring from forced labor (4.2%) were coded separately due to the distinct natures of the injuries.

5.3 SOT Ongoing Effects of Torture

The open-ended responses querying ongoing effects of torture or trauma experiences are listed in Figure 6. *Psychological suffering* was the most common response with 82 SOTs (48.8%) reporting one or more symptoms of depression, anxiety, PTSD, or baksbat. A common response under this category was that SOTs “can’t forget” their traumatic experiences. From a Western psychological perspective, not being able to forget likely refers the intrusion symptoms of PTSD, such as recurring and intrusive thoughts and nightmares. Responses by 44 (26.2%) SOTs, which included the loss of family members, ongoing pain from their losses, and living alone were coded as *grief*. Twenty-seven SOT (16.1%) responses were coded as a *chronic medical condition* if they mentioned any chronic or ongoing physical illness. Some of these responses were non-descriptive such as “poor health,” but others often included recurring cough, fever, and fatigue.

Twenty-five (14.9%) SOT participants reported having a physical disability related to forced labor, some other torture method, or war-related injury. Most mentioned that their physical disability adversely affected their occupational functioning to some degree. Thirteen (7.7%) SOT participants reported having chronic pain or ongoing pain in certain parts of their body, while 11 (6.5%) reported economic hardship, which generally included loss of wealth due to injury and looting, or having one’s property stolen. A small percentage (1.2%) of SOT participants reported ongoing domestic violence related to their forced marriage.

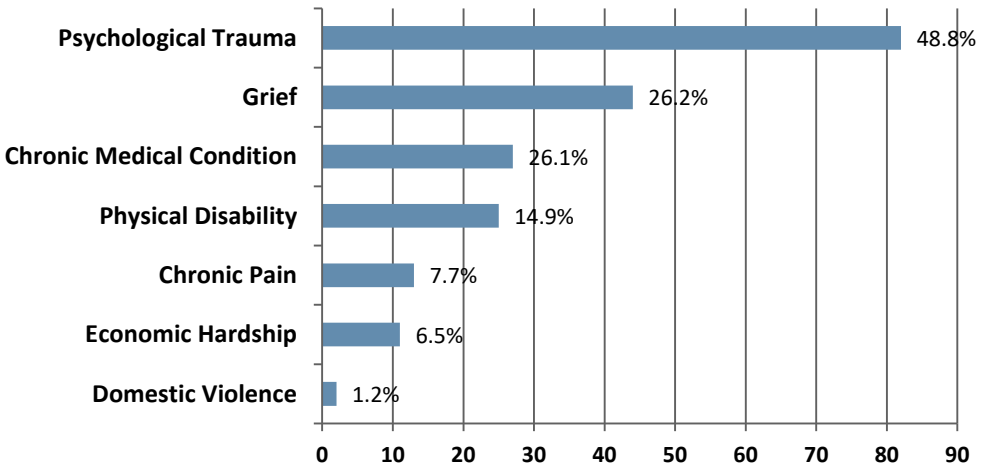

Figure 6. SOT self-reported ongoing effects of torture. These percentages were calculated from the qualitative, or open-ended, question "Please list the ways in which your experiences during the civil war are affecting your life today" The horizontal axis of numbers describes the frequency, or count, of the response code.

Table 3
SOT Resilience Items and Response Percentages

Question	Response	Count	Percentage
1. Dealing with stress can make me stronger.	Not at all	6	3.6
	A little bit	57	33.9
	Often	76	45.2
	Always	29	17.3
2. I believe I can achieve what I want, even if there are problems.	Not at all	4	2.4
	A little bit	52	31.0
	Often	82	48.8
	Always	30	17.9
3. Under pressure, I still think clearly.	Not at all	3	1.8
	A little bit	53	31.7
	Often	73	43.7
	Always	38	22.8
4. I do not lose hope after failing at something.	Not at all	11	6.5
	A little bit	37	22.0
	Often	88	52.4
	Always	32	19.0

Note. n = 168. The total percentages of each category may not add up to 100% due to rounding error.

5.4 SOT Resilience

The results from the analyses of the SOT Resilience scale are shown in Table 3. Upon cursory review, the distribution of scores appear to have a slight positive skew meaning that more participants endorsed higher levels of resilience across each item. More specifically, about 2/3 of the sample endorsed better than average resilience. Likewise, the average item score was 1.83, which means that the SOT participants endorsed a level of resilience that was slightly above the middle score of 1.5 on the zero to three scale. The average Resilience measure score for the SOTs in the baseline sample was 7.31 (*SD* = 2.31) which can be used as a comparison value for the postline study.

5.5 SOT Coping

The results from the analyses of the SOT Coping scale are shown in Table 4. A majority (73.9%) of SOT participants endorsed engaging in distraction coping, "often" or "always." While some distraction coping can be healthy, too much of it can be unhealthy and lend to avoidance, which is a symptom of PTSD. Item 2 measures *active coping*, or taking substantive measures to deal with problems, and only about half of the SOT sample (51.8%) endorsed doing so "often," or "always." Coping item 3 queries *instrumental coping*, or asking others for advice regarding how to deal with a problem, and just over half of the participants (56.0%) endorse do so "often," or "always." This suggests that there some potential to encourage participants to seek advice and support from others, including friends and family. The fourth Coping item measured *positive reinterpretation*, or looking back a problem and trying view it positively, such as learning how to deal with a similar problem in the future. Nearly half (49.4%) of the SOT sample endorse this item as "often," or "always," suggesting that there is some potential for using positive reinterpretation, which is a focus of cognitive behavioral therapies, with future participants. The average item score was 1.63, which means that the SOT participants endorsed a level of coping that was slightly above the middle score of 1.5 on the zero to three scale. The average Coping measure score for the SOTs in the baseline sample was 6.51 (*SD* = 2.62) which can be used as a comparison value for the postline study.

5.6 SOT Psychosocial Functioning

The results from the analyses of the SOT Psychosocial Functioning measure are shown in Table 5. Of note, the items querying closer social relationships, such as partners and children, were not strong items for the measure and so they were removed. This is likely due to the social values and norms of Cambodians to not discuss personal family matters, especially with strangers. As such, the first two items examined community integration, as well as spending time

Table 4
SOT Coping Items and Response Percentages

Question	Response	Count	Percentage
1. I turned to work or other activities (like radio, TV, or sleeping) to take my mind off things.	Not at all	13	7.7
	A little bit	31	18.5
	Often	62	36.9
	Always	62	36.9
2. I tried to do something about the situation I was in.	Not at all	24	14.3
	A little bit	57	33.9
	Often	71	42.3
	Always	16	9.5
3. I got advice or help from other people.	Not at all	25	14.9
	A little bit	49	29.2
	Often	73	43.5
	Always	21	12.5
4. I tried to look for something good in what happened.	Not at all	24	14.3
	A little bit	61	36.3
	Often	63	37.5
	Always	20	11.9

Note. n = 168. The total percentages of each category may not add up to 100% due to rounding error. None of the participants endorsed being rich in the Wealth Status variable. The Other category in the Occupation variable included such occupations as…

with friends and neighbors. Just over three-quarters (76.8%) of the SOT participants endorsed engaging in community activities "often," or "always," whereas over half (58.9%) endorsed enjoying time with neighbors and friends at the same levels. These results follow given the collectivist social fabric which binds many of the villages together. The two other items examined social avoidance and social anxiety. Thirty-six (21.8%) SOT participants endorsed having aspects of social avoidance at the "often," or "always," level, where as 26 (15.5%) of the participants rated similar values for social avoidance. These numbers are likely tempered given the tightknit, collectivist villages, however, impaired social functioning is generally observed in PTSD patients. If you bring the "a little" response option into consideration, response bias not withstanding, each of these last two items demonstrate that above half endorsed some magnitude of social anxiety and avoidance. The average Psychosocial Functioning measure score for the SOTs in the baseline sample was 8.38 (SD = 5.26) which can be used as a comparison value for the postline study.

Table 5
SOT Psychosocial Functioning Items and Response Percentages

Question	Response	Count	Percentage
1. I got along well with others in my village and sometimes helped with organizing ceremonies.	Not at all	6	3.6
	A little bit	33	19.6
	Often	78	46.4
	Always	51	30.4
2. I enjoyed visiting or communicating regularly with my friends and neighbors.	Not at all	7	4.2
	A little bit	62	36.9
	Often	62	36.9
	Always	37	22.0
3. I stayed at home rather than attend social events because I felt afraid to go.	Not at all	80	47.6
	A little bit	51	30.4
	Often	30	17.9
	Always	6	3.6
4. I felt anxious or thought to much when preparing to leave my home.	Not at all	91	54.2
	A little bit	51	30.4
	Often	19	11.3
	Always	7	4.2

Note. n = 168. The total percentages of each category may not add up to 100% due to rounding error.

5.7 SOT Psychological Distress

As described above in the Methods section, SOT psychological distress was measured using the C-SSA. The average score for the sample was 20.5 (*SD* = 8.19). Given that this average score represents a baseline value, no comparison can be made within the Cambodian SOT population. However, some comparisons can be made using average scores from other unpublished studies conducted in Cambodia using the C-SSA. The first unpublished study used the C-SSA in a sample of parents who lost a daughter in the Diamond Bridge Disaster at Phnom Penh in 2010. The average C-SSA score for 102 of these parents one year after the tragedy was 15.44 (*SD* = 13.58). In another unpublished study called *Parenting and Parent-Child Interactions in Three Generations after the Khmer Rouge Regime in Cambodia*, the average C-SSA score was 14.13 (*SD* = 9.46) for 210 second-generation, female KR survivors who lived with or close to their daughter and mother.

While no inferential statistics were used to examine if these differences were significant, the SOT sample clearly had a higher average score compared with the other two samples, suggesting that SOTs continue to struggle with relatively high levels of psychological distress. Of note, women SOTs tended to endorse higher levels of distress in the baseline sample compared to

Table 6
Continuous Demographic Characteristics of the SOT Family/Caregiver Sample

Variable	Mean	*SD*	Median	Minimum	Maximum
Age	49.96	12.86	54.5	23	68
Education (years)	2.50	2.74	2.5	0	9
Number of Children	4.79	2.59	4.5	0	10
Household Dwellers	5..39	2.15	6.0	2	10

Note. n = 28. Mean = the average value of a variable in the sample. *SD* = standard deviation, which describes how much the entire sample values differ from the mean value. The median is the value of a variable that falls into the middle of all the sample values.

Table 7
Categorical Demographic Characteristics of the SOT Family/Caregiver Sample

Variable	Category	Frequency	Percentage
Gender	Male	27	96.4%
	Female	1	3.5%
Marital Status	Married	24	85.7%
	Widowed	1	3.6%
	Divorced	2	7.1%
	Single	1	3.6%
Ethnicity	Khmer	18	66.7%
	Cham	9	33.3%
Religion	Buddhist	18	66.7%
	Muslim	9	33.3%
Province	Kratie	10	37.0%
	Battambang	9	33.3%
	Pursat	9	33.3%
Occupation	Farmer	2	64.3%
	Other	5	17.9%
	Salesperson	3	10.7%
	Housewife	2	7.1%
Wealth Status	Poor	16	57.1%
	Average	12	42.9%
Current Debt	$0 USD	11	40.7%
	$1 to $999 USD	5	18.5%
	$1,000 to $2,000	9	33.3%
	$2,001 to $6,000	2	7.4%

Note. n = 27. The total percentages of each category may not add up to 100% due to rounding error. None of the participants endorsed being rich in the Wealth Status variable.

their male counterparts, which may be an artifact of male SOTs underreporting their distress or that women experience more of the symptoms listed in the C-SSA. Given that this was not a random sample, the result cannot be generalized to the entire SOT population in Cambodia. Nevertheless, therapists assessing and selecting potential candidates for therapy should be mindful of this potential gender effect during their work on the Project.

5.8 SOT Family/Caregiver Demographics

The average age of the individual SOT family/caregiver participants was about 50 years with values ranging from 23 to 58, which was significantly younger than the SOT sample. All of the other demographic variables were proportional to the SOT sample, except the gender variable, which was predominately (96.4%) female. This is likely a reflection of the gender-based division of household labor in rural Cambodia. In sum, SOT family/caregivers were predominately young females.

5.9 SOT Family/Caregiver Tasks and Burdens

SOT Family/Caregivers were asked two open-ended questions: 1) In what ways do you assist or support your SOTs in their daily lives?; and 2) What difficulties do you have when caring for your SOT? The results for both of these questions are listed in Figure 7. The most common response for assisting and supporting SOTs was *medical support*, which was reported by 24 (85.7%) family/caregiver participants. Medical support included responses referring to any medical care of an SOT, including transporting and attending the SOT during medical visits, caring for the SOT when they are sick, and paying for any medical services or medications. Thirteen (46.4%) SOT family/caregivers reported providing emotional or *psychological support*. Psychological support responses included calming the SOT when they were agitated or distressed, and encouraging the SOT to forget their traumas and focus on the present. Twelve (42.9%) SOT family/caregiver participants reported that they assisted with their SOTs *activities of daily living*, which included dressing, preparing meals, showering, and generally "looking after her/him." Four (14.2%) SOT family/caregiver participants reported providing some form of *material support*, including providing money for food and necessities, and transporting the SOT to places other than for medical visits, such as temples or markets.

The most common difficulty related to caring for an SOT was *financial burden*. Sixteen (57.1%) SOT family/caregiver reported various financial burdens related to paying for medical treatment, food, as well as taking time away from work to care for the SOT. Half of the SOT family/caregivers (50%) reported some form of physical burden, such as transferring or moving the SOT, lack of sleep, caring for the SOT while being tired from work or some physical illness.

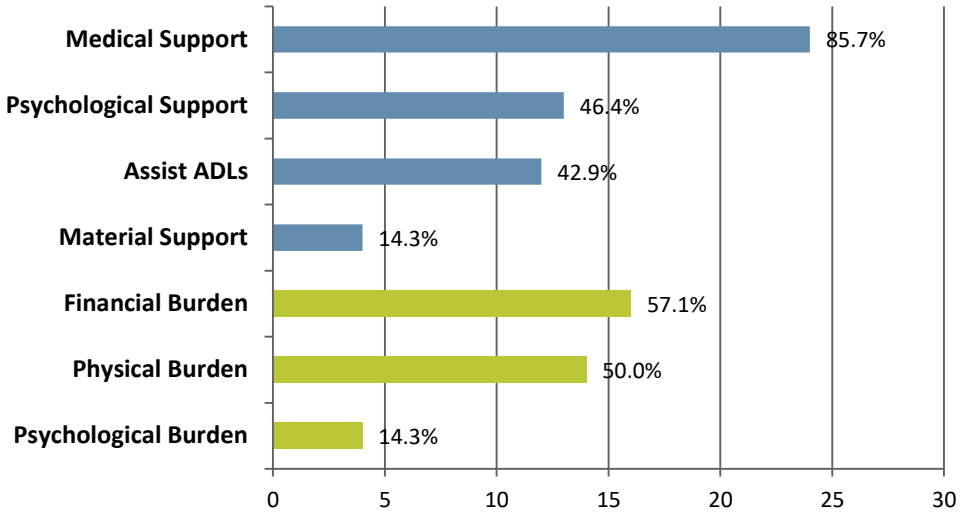

Figure 7. SOT family/caregiver tasks and burdens. Tasks are in blue and burdens are in gold. These percentages were calculated from the qualitative, or open-ended, questions asked of the SOT family/care giver. The horizontal axis of numbers describes the frequency, or count, of the response code.

Only four (14.3%) SOT family/caregivers reported some form of psychological burden, which included coping with an SOT's anger or incessant complaining.

5.10 SOT Family/Caregiver Psychological Distress

SOT family/caregivers were also administered the C-SSA to assess their current level of psychological distress. Their average C-SSA score was 18.6 (*SD* = 8.74), which was a couple points lower than the SOTs average score, but higher than the two other comparison groups mentioned in the SOT psychological distress section. This suggested that SOT family/caregivers also have relatively higher levels of distress, which may be related to caring for their SOT.

5.11 SOT Family/Caregiver Empathy and Burnout

The SOT family/caregiver empathy and burnout was assessed using a modified version of the CGSQ-SF as noted above in the methods section. Five items were retained after removing two, which led to a more robust measure according to the statistical analysis. The results were listed in Table 8. Ten (35.7%) SOT family/caregivers endorsed feeling isolated or alone as a result of caring for their SOT at the "often," or "always," levels. Over half (57.1%) reported feeling sad or unhappy due to caring for their SOT at the "often," or "always," levels. Almost all (96.5%) of the family/caregiver participants endorsed not knowing how to effectively communicate with their SOT. Similarly, 89.3% of family/caregivers endorsed low levels of understanding regarding their SOTs thoughts and behaviors. Conversely, only three (10.7%) family/caregivers endorsed feeling stressed or tired as a result of caring for their SOT. Lastly, the

Table 8
SOT Family/Caregiver Burnout and Empathy Response Percentages

Question	Response	Count	Percentage
1. I felt isolated or alone as a result of [SOT's name]'s emotional or physical problem.	Not at all	7	25.0
	A little bit	11	39.3
	Often	6	21.4
	Always	4	14.3
2. I was sad or unhappy because of [SOT's name]'s emotional or physical problem.	Not at all	7	25.0
	A little bit	5	17.9
	Often	9	32.1
	Always	7	25.0
3. I know how to communicate well with [SOT's name].	Not at all	15	53.6
	A little bit	12	42.9
	Often	1	3.6
	Always	0	0.0
4. I understand why [SOT's name] does or thinks what [SOT's name] does.	Not at all	11	39.3
	A little bit	14	50.0
	Often	3	10.7
	Always	0	0.0
5. I feel tired or strained as a result of caring for [SOT's name].	Not at all	17	60.7
	A little bit	8	28.6
	Often	1	3.6
	Always	2	7.1

Note. $n = 27$. The total percentages of each category may not add up to 100% due to rounding error

average Empathy and Burnout measure score for the SOT family/caregivers in the baseline sample was 8.18 ($SD = 5.56$) which can be used as a comparison value for the postline study.

5.12 FGD Demographics

Table 9
Continuous Demographic Characteristics of the FGD Sample

Variable	Mean	*SD*	Median	Minimum	Maximum
Age	56.19	13.21	56.2	28	79
Education (years)	4.17	3.47	4.0	0	12
Number of Children	5.22	2.19	6.0	0	10
Household Dwellers	5.64	2.07	6.0	2	11

Note. $n = 47$. Mean = the average value of a variable in the sample. *SD* = standard deviation, which describes how much the entire sample values differ from the mean value. The median is the value of a variable that falls into the middle of all the sample values.

Table 10
Categorical Demographic Characteristics of the FGD Sample

Variable	Category	Frequency	Percentage
Gender	Male	24	51.1%
	Female	23	48.9%
Marital Status	Married	35	75.0%
	Widowed	10	22.2%
	Divorced	2	2.8%
Ethnicity	Khmer	26	55.6%
	Cham	21	44.4%
Religion	Buddhist	26	55.6%
	Muslim	21	44.4%
Province	Kratie	21	44.4%
	Battambang	18	38.9%
	Pursat	8	16.7%
Occupation	Farmer	30	63.9%
	Civil servant	6	11.1%
	Salesperson	8	13.9%
	Unskilled labourer	1	2.8%
	Housewife	2	5.6%
Local Authority	Village Deputy	7	29.4%
	Village Chief	3	17.6%
	Village Assistant	4	23.5%
	Team Leader	4	23.5%
Wealth Status	Poor	21	44.4%
	Average	26	55.6%

Note. $n = 47$. The total percentages of each category may not add up to 100% due to rounding error. The total number of participants in the local authority FGDs were 18 with 29 participants in the community member FGD.

A total of 47 FGD participants were recruited for the study. The average age of the community member and local authority participants was about 56 years with values ranging from 28 to 79. All of the other demographic variables were proportional to the SOT sample.

5.13 FGD Responses

The first question asked during the FGDs was "What is torture?" This was queried to assess laypersons' understanding regarding what constituted torture. The coded responses are listed in Figure 8. The two most common responses to this question were "mistreatment," and "forced labor." All the other remaining responses were listed in the closed-question portion of the SOT administration form described above, except having one's relatives killed. As mentioned previously, in order for an act to constitute torture, the intention criteria must be met. That is, the

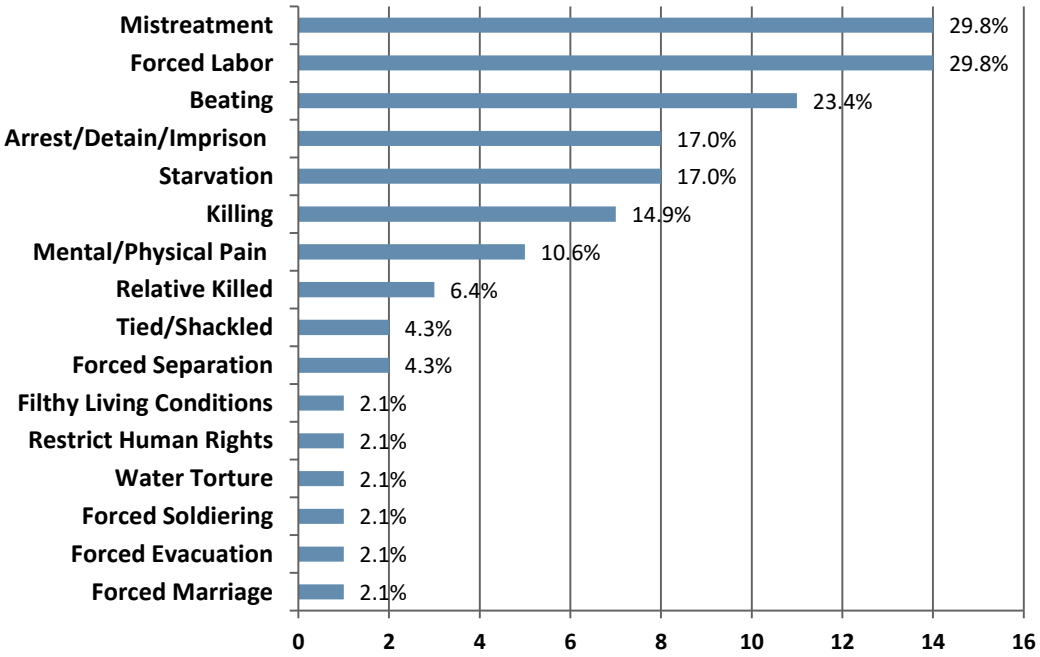

Figure 8. FDG: What is torture? These percentages were calculated from the qualitative, or open-ended, questions asked when the FGD participants were asked, "What is torture?" The horizontal axis of numbers describes the frequency, or count, of the response code.

torturer must have been aware or knowingly killed an SOTs relative in order to inflict the emotional suffering upon the surviving SOT. In cases were SOTs were forced by KR soldiers to watch the killings, that would certainly be considered torture. SOTs in close time and distance to the killing may also be considered torture, but if the SOT found out after the KR fell, this likely would be considered psychological trauma and not torture.

The second FGD question asked, "How can your community help SOTs with these problems?" The most common response was coded as *religious participation*. Responses referring to bad karma, lack of religiosity, and any alleviation of suffering secondary to religious observance or ceremonial participation were coded as such. The large occurrence of these responses is likely a reflection of Cambodia's spiritually-based culture, the lack of mental health awareness, and the paucity of available mental health services. Responses coded as *psychological support* generally included offering lay advice to individuals psychological pain, such as trying to forget about the trauma or losses, assuring the individuals that they are safe and that the civil war has ended, or some other proverb to instil hope. *Social support* responses referred to SOTs receiving emotional support from family members, friends, and other community members. *Material support* described those responses which generally entailed giving an SOT for food or medicine. *Family support* responses included those with any reference to children or extended family caring for the SOT. *Report to authority* were responses only given by local

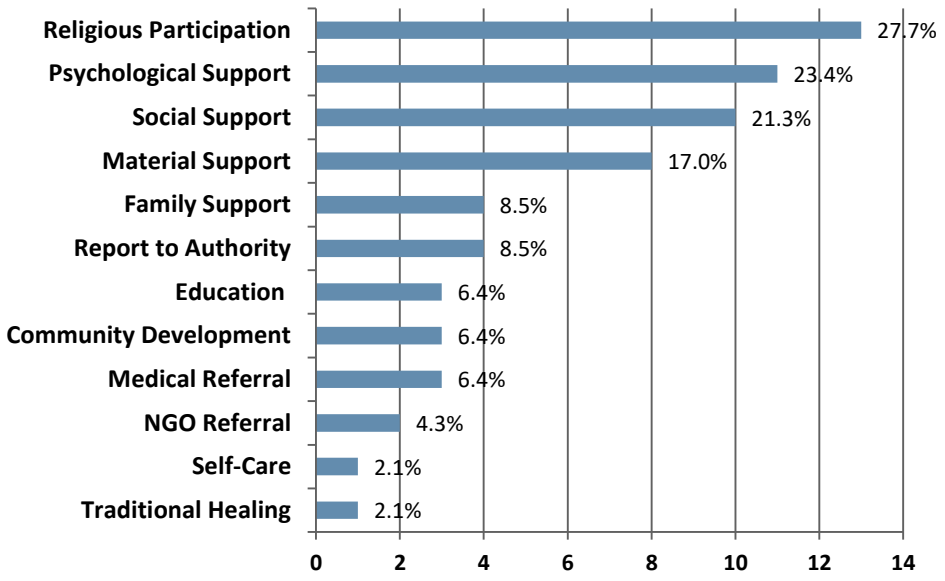

Figure 9. FDG: How can your community help SOTs? response frequencies. These percentages were calculated from the qualitative, or open-ended, question. The horizontal axis of numbers describes the frequency, or count, of the response code.

authority FGDs and involved connecting SOTs with any available governmental services. Responses coded as *education* referenced learning about KR history. *Community development* describes those responses by LA FGDs which suggested mobilizing community resources to support SOTSs. The medical and NGO referral coded responses are self-explanatory and describe connecting SOTs in need of medical care or services not provided through governmental agencies. *Self-care* and *traditional healing* responses mentioned any form of healthful living and acupuncture or massage, respectively.

When the FGD participants were asked "Why do SOTs continue to struggle with the effects of the civil war?," the most common response was that they "*can't forget"* their traumatic experiences. From a Western psychological perspective, this eludes to the intrusive thoughts criteria of PTSD, whereby the SOT becomes distressed when recalling or dreaming about a traumatic event. Responses coded as *physical illness/trauma symptoms* included ongoing medical conditions from war- and torture-related injuries, and impairing trauma-related symptoms, such as significant anxiety and fear. FGD participants also stated that poverty contributed to ongoing suffering, mainly through the stressors related to poverty as well as the lack of access to needed medical and mental health services. Lack of religiosity/bad karma were also reported to be contributors, which is logical considering Cambodia's spiritually-based culture which attributes some types of suffering to spiritual causes, and that religious adherence was the most common solution offered by the FGD members to help SOTs. Lack of *social/family support* was the least

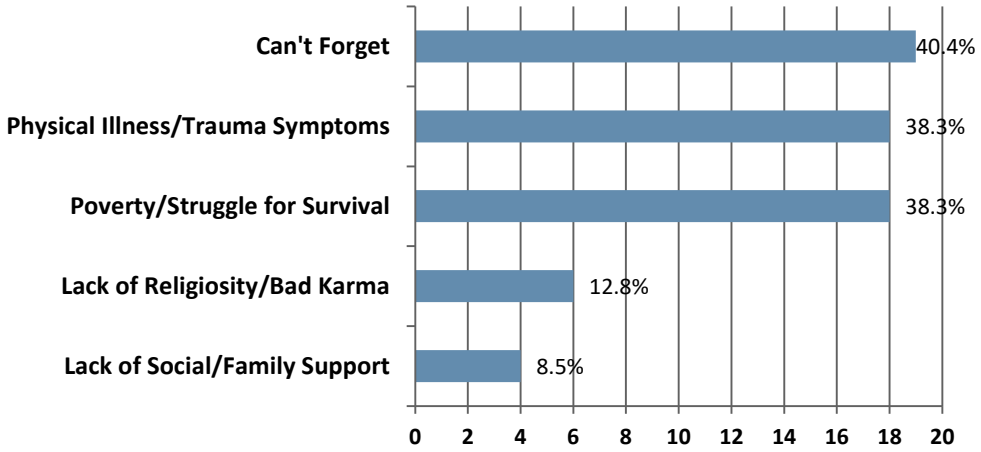

Figure 10. FDG: Why do SOTs continue to struggle with the effects of the civil war? response frequencies. These percentages were calculated from the qualitative, or open-ended, question. The horizontal axis of numbers describes the frequency, or count, of the response code.

reported cause of ongoing suffering, but the Western trauma literature views the lack of social support as one of the most robust factors in prolonging the symptoms of PTSD (Friedman, Resick, & Keane, 2010).

The FGD participants were also asked, "How do you and your community feel towards SOTs?" The most common response was pity and sorrow, which in theory may suggest a high level of community empathy towards SOTs. It is possible, however, that there is some social desirability bias to these coded responses. Reponses referring to younger Cambodians and participants' children not believing the stories they were told about the DK regime were coded as "indifference/disbelief." Whenever a participant described an SOT's antisocial behavior, including public intoxication, alcohol dependency, and other disruptive behaviors related to a mental health disorder, it was coded as "mental health stigma." When an FGD reported feeling fearful of an SOT or if any reference to regret was mentioned, it was coded as "Regret/Fear." It is likely these responses were from FKR-MS, but former party or state affiliation was not queried in order to foster an open FGD and gain the broadest range of responses. Lastly, responses coded as "understanding," were from former SOTs themselves and refer to knowing through their experiences what an SOT has gone through.

The FGD participants were also asked, "What can be done to increase empathy towards SOTs?" The most common response was to educate children of the FGD participants and other youth. See figure 13. These responses generally referred to the lack of knowledge or belief among Cambodian youth that the DK atrocities actually occurred. This response presumes that if young

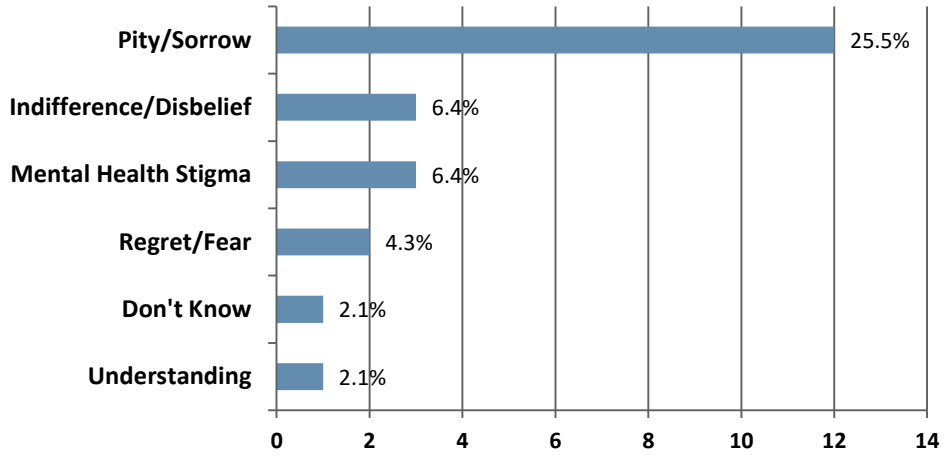

Figure 11. FDG: How do you and your community feel towards SOTs? These percentages were calculated from the qualitative, or open-ended, question. The horizontal axis of numbers describes the frequency, or count, of the response code.

Cambodians were taught and believed what happened during the DK regime, empathy would naturally arise. The second most common response code was "social/family support," which referred to engaging an SOT's family and community to care for and support the SOT. Those responses that described giving aid to SOTs including money, food, or medical care, were coded as "material support." FGD participant responses that suggested engaging in religious ceremonies, rituals or teachings, either for the SOTs or community members, were coded as "religious practices." Responses coded as "communication/conflict resolution" referenced resentment stemming from the civil war among community members and suggested interventions by NGOs or local government could help improve communication and resolve ongoing schisms at the community level. "Psychological support" responses included any reference to providing emotional support by lay individuals. FGD participant responses which noted the benefits of visiting DK memorial sites, such as Choeung Ek and S-21, were coded as "memorialization."

Lastly, the FGD participants were asked "What can be done to increase understanding towards SOTs?" The majority of FGD participant responses to this question revolved around educating and documenting the atrocities that occurred during the DK regime. See figure 14. The most common response again was to "educate" individuals, but rather than just targeting youth, all community members were generally mentioned in these responses. The second most common response was "NGO support," which referred to interventions provided by non-governmental agencies to organize events at the grassroots level that raised awareness about torture and its adverse effects. "Memorialization/documentation," coded responses included visiting mass grave sites, creating new memorials, and further efforts to documents SOTs histories for current and

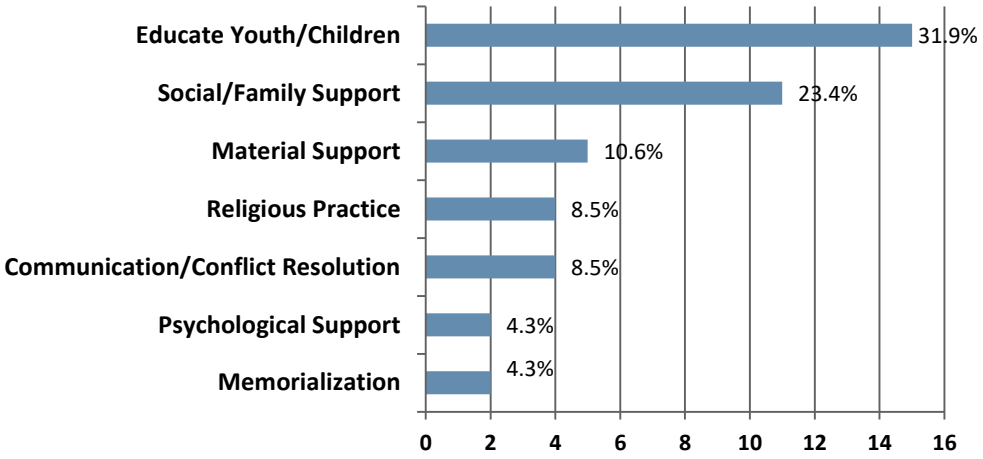

Figure 12. FDG: What can be done to increase empathy towards SOTs? response frequencies. These percentages were calculated from the qualitative, or open-ended, question. The horizontal axis of numbers describes the frequency, or count, of the response code.

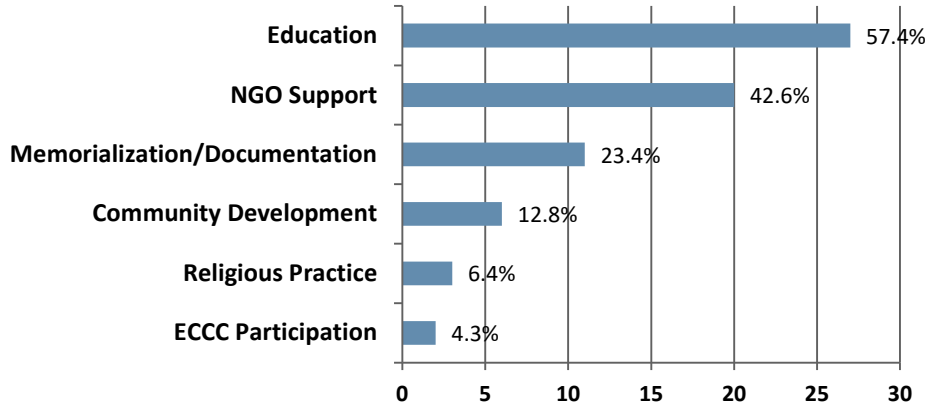

Figure 13. FDG: Increasing understanding towards SOTs responses. These percentages were calculated from the qualitative, or open-ended, question. The horizontal axis of numbers describes the frequency, or count, of the response code.

future generations. Responses coded as "community development," referenced local authorities mobilizing individuals at the grassroots level to form groups to address the needs of SOTs as well as raise awareness about their traumatic experiences. Engaging in "religious practices" again was mentioned in reference to its perceived benefits, such as gaining compassion and understanding of others' suffering. A few FGD participants responded that engaging in the ongoing "ECCC proceedings" would inform individuals about the plight of SOTs and offer an avenue for potential reconciliation.

6. RECOMMENDATIONS

The most notable finding regarding the SOT GBV questions was the relatively high level of male SOTs who endorsed being forced to have sex with their spouse. The question was intentionally written to be gender-neutral and so included the scenario of forced consummation within the context of forced marriage. It stated, "Were you ever forced to have sex with your spouse after being marriage?" Traditionally, the focus of forced marriage, which has been seen as tantamount to rape, has been on women and there has been little research into the effects of forced marriage on their male counterparts. While women continually bear the brunt of GBV in Cambodia, the current data suggests that men who were forced to marry suffered as well. Also, those men who endorsed forced marriage scored higher on the psychological distress scale, however, the difference was not statistically significant. Within the milieu of this Project, the data suggested that group therapy or TT for men who were forced married would be beneficial, if feasible and a sufficient number of men are identified and agree to participate.

Given the common responses of religious persecution and ongoing suffering among Cham SOTs, it would be beneficial to modify any intervention to meet the specific needs of this ethic group. Incorporating Islamic rituals and sensibilities with the assistance of a knowledgeable Cham historians or community members would ensure cultural sensitivity. Also, involving mosque elders and leaders in the ceremony protocol may also aid in the healing process. Regarding Buddhist SOTs, involving a Buddhist ceremony at the end of group therapy, similar to TT would also likely benefit the participants.

Both war-related and forced-labor physical traumas were associated with having a physical disability. However, having a war-related injury was related to having a chronic medical condition, whereas having a forced-labor injury was related to having chronic pain. This follows logically given the nature of the injuries: musculoskeletal problems and chronic pain versus loss of limbs or eye sight and chronic medical conditions. This distinction may help to inform how the limited budget for SOT medical services should be spent. Also, given the pervasiveness of forced labor, treatments focusing chronic pain, such as yoga, may be well-suited for the Cambodian SOT population. Also, many of SOTs report vision problems and suffer from high blood pressure. Engaging with other NGOs who specialize in providing these treatments would be beneficial to most of the SOT participants receiving therapy.

The results from the SOT family/caretaker indicate that they are also experiencing significant distress. The results from their questionnaire also suggest that those who care for SOTs need to learn effective communication as well as gain a better understanding into the SOTs behaviors and thoughts. While over half of SOT family/caretaker felt isolated, fewer endorsed

feeling strained or tired as a result of caring for their SOT. Taken as a whole, group interventions for caregivers and family members of SOTs may include psychoeduction on the ongoing effects of torture, communication skills training with the SOT present, as well as, self-care techniques to promote overall well-being.

Lastly, when asked what communities members could do to help SOTs, the overwhelming answer was "religious participation." Given the spiritually-based culture of Cambodia and the lack of available psychological treatments, this makes logical sense. It also underscores the importance of including religious ceremonies in intervention protocol, such as what is currently done in TT. The inclusion of religious aspects in other protocols, such as group and supportive therapy would likely be beneficial. This FGD response also underscores the need for psychoeducation regarding torture, its ongoing effects, and what lay people can do to help those in their communities who still struggle from being tortured during the civil war.

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APPENDICES

SURVIVOR OF TORTURE BASELINE SURVEY QUESTIONNAIRE

TRANSCULTURAL PSYCHOSOCIAL ORGANIZATION CAMBODIA

A. INTRODUCTION

"Hello. My name is _____ and I work for (TPO Cambodia/on half of TPO Cambodia). TPO Cambodia is a local organization that provides mental health care throughout Cambodia. We are currently working on a project focused on providing treatment and support to individuals and families who are continuing to struggle with the emotional and physical wounds from the civil war. If you agree and have at least 10 minutes, I would like to ask you a few brief questions to see if you qualify for these services. Do you agree to kindly answer questions?"

If "Yes," continue to **B. INFORMED ASSENT**.

If "No," say "Thank you for your time. I apologize for interrupting your day. If you ever have any need for emotional support or guidance in the future, please call the TPO hotline at (089) 666-325 or (089) 666-782. [Give TPO brochure]. Before I go, do you know anyone who may have been seriously affected, either emotionally or physically, by the civil war and may benefit from this treatment?" If "Yes," list here:

1. _____

2. _____

3. _____

If "No," say "Ok. Thank you again for your time and consideration." [End interview].

B. INFORMED ASSENT

"Your participation in this study would be important and contribute greatly to the development of mental health and reconciliation in Cambodia. If you agree, your participation in this study would be entirely voluntary. If you feel the desire to end the interview at any time, you may do so freely without hesitation. Also, if you feel reluctant to answer any specific question, you may simply state that you do not want to answer the question."

"Some of the content that I will be asking you may be disturbing. If you feel upset emotionally after our interview for any reason, please call the TPO hotline at (089) 666-325 or (089) 666-782 to receive emotional support and guidance. Also, please know that no monetary or material compensation will be given to you as a result of your participation. But again, your participation would contribute greatly to the development of mental health and reconciliation in Cambodia.

Lastly, all information you provide during this interview will be kept confidentially and stored in a secure manner."

"Do you agree to be interviewed?"

If "Yes," continue to **C. SOT INTRODUCTION**.

If "No," say "Thank you for your time and I apologize for interrupting your day. If you ever have any need for emotional support and guidance in the future, please call the TPO hotline at (089) 666-325 or (089) 666-782. [Give TPO brochure]. But before I go, do you know anyone who may have been affected adversely by the civil war and may benefit from this treatment?" If "Yes," list here:

1. _____

2. _____

3. _____

If "No," say "Ok. Thank you again for your time and consideration." [End interview].

C. SOT INTRODUCTION

"Many people were personally harmed by events that occurred during the civil war in Cambodia. First, I would like to ask you several questions regarding your current background information. After this, I will ask you four brief questions regarding your experiences during the civil war."

SURVIVOR OF TORTURE SURVEY		
DEMO1	Name:	
DEMO2	Gender:	□ Female □ Male
DEMO3	Age (Years):	(If younger than 40, STOP interview)
DEMO4	Marital status:	□ Single □ Married □ Divorced □ Widowed
DEMO5	Number of Children:	
DEMO6	Number of individuals living in household:	
DEMO7	Ethnicity:	□ Khmer □ Cham □ Vietnamese □ Chinese □ Hmong–Mien □ Tai □ Khmer Loeu □ Khmer Krom □ Mixed/Biracial □ Other
DEMO8	Religion:	□ Buddhist □ Muslim □ Christian □ Other
DEMO9	Years of formal education:	

DEMO10	Demographic region:	□ Urban □ Rural
DEMO11	Current occupation: (If retired, former occupation)	
DEMO13	Current debt ($US):	
DEMO14	Cell phone number:	
DEMO15	Are you currently a civil party member of the ECCC?	□ No □ Yes

Instructions: "Now, I would like to ask you a few questions about your experiences during the civil war.
Please answer these questions as either 'Yes' or 'No.'"

TORTURE1	Did you ever experience significant physical or emotional suffering during the civil war?	□ Yes □ No (If yes, go to 2. If no, STOP).
TORTURE2	Was this physical or emotional suffering caused by an individual or individuals who were part of a government, army, or armed faction?	□ Yes □ No (If yes, go to 3. If no, STOP).
TORTURE3	Was this suffering intentional, that is, was your suffering forced upon you specifically rather than you observing it vicariously?	□ Yes □ No (If yes, go to 4. If no, STOP).
TORTURE4	Are you currently struggling or suffering either physically or emotionally from what happened during the civil war?	□ Yes □ No (Continue to D. COMMON FORMS OF DK TORTURE).

STOP Instructions:

If the respondent says "No," to questionsTORTURE1, TORTURE2 or TORTURE3, say:

"Your responses indicate that you do not appear to qualify as an individual we are seeking in our study. However, if you ever feel that you need support for your experiences during the civil war, please call the TPO hotline at (089) 666-325 or (089) 666-782 to receive emotional support and guidance."

"Before I go, do you know anyone who may have been seriously affected by the civil war and may benefit from our services?"

1. _____

2. _____

3. _____

If the respondent doesn't list any potential SOTs, then say "Ok. Thank you again for your time." [End interview].

If the respondent says "Yes," to the first three torture questions above, then continue with the **COMMON FORMS OF DK TORTURE** section.

D. COMMON FORMS OF DK TORTURE

"I will ask you now about specific experiences you may have had during the civil war. After I read a question, please respond by saying 'yes' if you experienced it, 'no' if you did not experience it, or 'I do not want to answer,' if you don't feel comfortable answering the question."

"Think back now during your time in the civil war."

COMMON FORMS OF DK TORTURE		
TOR1	Were you ever denied adequate food or water?	□ Yes □ No □ Decline to answer
TOR2	Were you ever awakened repeatedly and deprived of sleep?	□ Yes □ No □ Decline to answer
TOR3	Were you ever denied medical care when you were very sick?	□ Yes □ No □ Decline to answer
TOR4	Were you forced to live in very poor conditions (including over-crowding, poor sanitation, or uncomfortable temperatures)?	□ Yes □ No □ Decline to answer
TOR5	Were you ever forced to work hard for a long periods of time or under harsh conditions?	□ Yes □ No □ Decline to answer
TOR6	Were you ever humiliated (insulted, screamed at, forced to bow to animals) in front of others?	□ Yes □ No □ Decline to answer
TOR7	Were you ever forcibly removed from your home?	□ Yes □ No □ Decline to answer
TOR8	Were you ever forcibly removed from your family members?	□ Yes □ No □ Decline to answer
TOR9	Were you ever threatened with severe injury or death?	□ Yes □ No □ Decline to answer
TOR10	Did you ever witness anyone ever threatening your family with severe injury or death?	□ Yes □ No □ Decline to answer
TOR11	Were you ever hit, slapped, beaten, or kicked with a hand or foot?	□ Yes □ No □ Decline to answer
TOR12	Were you ever beaten with an object such as an electrical cord, bamboo stick, or iron rod?	□ Yes □ No □ Decline to answer

TOR13	Were you forced to become a soldier or did you become a soldier because you were afraid of being killed or severely punished?	□ Yes □ No □ Decline to answer
TOR14	Were you ever forced to watch the arrest, torture or execution of a family member?	□ Yes □ No □ Decline to answer
TOR15	Were you ever forced to watch others being arrested, tortured, or executed?	□ Yes □ No □ Decline to answer
TOR16	Were you ever forced to do something that was forbidden by your religion?	□ Yes □ No □ Decline to answer
TOR17	Were you ever denied the freedom to practice your religion?	□ Yes □ No □ Decline to answer

E. ARREST/DETENTION/RE-EDUCATION

Were you ever arrested, detained, jailed, or sent to a re-education or security center during the civil war?

If "yes," mark TOR18 "Yes," and continue with the remaining questions.
If "no," go to GENDER-BASED VIOLENCE (GBV).

ARREST/DETENTION/RE-EDUCATION		
TOR18	Were you ever arrested, detained, jailed, or sent to a re-education or security center?	□ Yes □ No □ Decline to answer
TOR19	Were you ever falsely accused or arrested for something you did not do?	□ Yes □ No □ Decline to answer
TOR20	Were you ever forced to make a confession about yourself or others?	□ Yes □ No □ Decline to answer
TOR21	Was your family ever threatened in order to force you to make a confession?	□ Yes □ No □ Decline to answer
TOR22	Were you ever forced to be isolated from other people for long periods of time?	□ Yes □ No □ Decline to answer
TOR23	Were you ever forced to stand, kneel, or hold an uncomfortable position for a long time?	□ Yes □ No □ Decline to answer
TOR24	Were you ever handcuffed, tied up, or shackled?	□ Yes □ No □ Decline to answer
TOR25	Were you ever blindfolded or was a cloth sack ever placed over your head?	□ Yes □ No □ Decline to answer
TOR26	Were you ever buried in the ground with only your head exposed above ground?	□ Yes □ No □ Decline to answer

TOR27	Were you ever burned by a cigarette, boiling water, or an electrical wire?	□ Yes □ No □ Decline to answer
TOR28	Did you ever have your fingernails or hair pulled out?	□ Yes □ No □ Decline to answer
TOR29	Was water ever used to cause suffocation or other physical or emotional suffering?	□ Yes □ No □ Decline to answer
TOR30	Was a plastic bag ever put over your head to cause suffocation?	□ Yes □ No □ Decline to answer
TOR31	Were tools such as hammers or plyers used to inflict pain or injury?	□ Yes □ No □ Decline to answer
TOR32	Were you ever hung up or suspended by ropes, chains or wires?	□ Yes □ No □ Decline to answer
TOR33	Were you ever cut with knifes, needles or other sharp objects?	□ Yes □ No □ Decline to answer

F. GENDER-BASED VIOLENCE

Ask all participants the GBV questions below:

GENDER-BASED VIOLENCE (GBV)		
TOR34	Were you ever abused sexually during the civil war?	□ Yes □ No □ Decline to answer
TOR35	Were you ever forced to marry someone you did not know or did not want to marry?	□ Yes □ No □ Decline to answer

G. SOT OPEN-ENDED QUESTIONS

OPEN1. Are there any other experiences you had during the civil war that were not listed above and caused you significant emotion or physical suffering? □ Yes □ No □ Decline to answer

If yes, say "Please list these experiences."

1.1

1.2

1.3

OPEN2. Please **LIST** the ways in which your experiences during the civil war are affecting your life today:

2.1

2.2

2.3

H. RESILIENCE AND COPING

"Now, I would like to ask you about how you deal with the problems in your daily life. After asking you a question, please answer to it according to the following scale [show cup scale]. 0 means 'not at all,' 1 means 'a little,' 2 means 'often,' and 3 means 'always.' Think now about how you have dealt with the problems in your life **over the past 30 days**. After I read a statement, please tell me how much you agree or identify with each statement. Then respond according to the scale. If you have any questions, please ask me."

RESILIENCE		Not at All (0)	A little bit (1)	A lot (2)	Always (3)
RESIL1	Dealing with stress can make me stronger.				
RESIL2	I believe I can achieve what I want, even there are problems.				
RESIL3	Under pressure, I still think clearly.				
RESIL4	I do not lose hope after failing at something.				

COPING		Not at All (0)	A little bit (1)	Often (2)	Always (3)
COPE1	I turned to work or other activities (like radio, TV, or sleeping) to take my mind off things.				
COPE2	I did something about the situation I was in.				
COPE3	I got advice or help from other people.				

COPE4	I tried to look for something good in what happened.				

I. SOCIAL FUNCTIONING

"Now, I would like to ask you about how you interact with the people in your life. After asking you a question, please answer to it according to the same scale [show cup scale]. 0 means "not at all," 1 means "a little," 2 means "often," and 3 means "always." Think now about all the relationships in your life. After I read a statement, please tell me how much you agree or identify with each statement. Then respond according to the scale. If a question does not apply to you, simply say that it does not apply. If you have any questions, please ask me."

"In the past **30 days**, please tell me how you interacted with the people in your life and how you felt about being in social situations:"

PSYCHOSOCIAL FUNCTIONING		Not at All (0)	A little bit (1)	A lot (2)	Always (3)
SOCIAL1	I got along well with others in my village and sometimes helped with organizing ceremonies.				
SOCIAL2	I enjoyed visiting or communicating regularly with my friends and neighbors.				
SOCIAL3	I stayed at home rather than attend social events because I felt afraid to go.				
SOCIAL4	I felt anxious or thought to much when preparing to leave my home.				

J. PSYCHOLOGICAL DISTRESS

"Now, I would like to ask you about how you how you have been feeling over the **past 14 days**. After reading you a symptom, please rate the intensity of the symptoms according to the same scale [show cup scale]. "0 means 'not at all,' 1 means 'a little,' 2 means 'often,' and 3 means 'always.' Think now about how you have been feeling. After I read a symptom, please tell me how intensely you feel the symptoms according to the scale. In the **past 14 days**, please tell me about any symptoms you may have felt:"

PSYCHOLOGICAL DISTRESS		Not at All (0)	A little bit (1)	A lot (2)	Always (3)
PSYCH1	Weakness				
PSYCH2	Wind attacks				
PSYCH3	Cold hands, cold feet				
PSYCH4	Dizziness				
PSYCH5	Feeling nervous or anxious				
PSYCH6	Thinking or worrying too much				
PSYCH7	Feeling sad, depressed, or hopeless				

K. INTERVIEW CLOSING

"Thank you so much for your participation. People for TPO Cambodia will contact you regarding any assistance you may need. Also, if you know of anyone else who may be struggling with the effects of the civil war, we would like to speak with them and offer our services. Do anyone who is still struggling with the effects of the civil war? Who might they be?"

1._____

2. _____

3. _____

"Before I go, please know that it is not uncommon to experience emotions like anger, guilt, grief or sadness after being asked questions such as these. Please know that these emotions should reduce to normal levels in a week or so. If you continue to experience these emotions or they get worse, please call the TPO Hotline at (089) 666-325 or (089) 666-782,[Give TPO brochure], and someone will be able to assist you and guide you to any available services."

"Thank you again for agreeing to answer my questions. We will contact you in the future. Good bye."