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**Trauma and Healing: The Construction of Meaning
Among Survivors of the Cambodian Holocaust**

By

Paula Toki Tanemura Morelli

**A dissertation submitted in partial fulfillment
of the requirements for the degree of**

Doctor of Philosophy

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Approved by *Anthony H. Ishisaka*
Anthony H. Ishisaka

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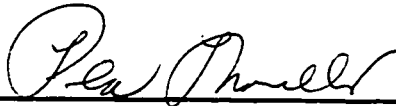
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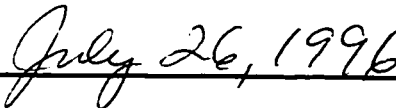
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Doctoral Dissertation

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Abstract

**TRAUMA AND HEALING: THE CONSTRUCTION OF MEANING AMONG
SURVIVORS OF THE CAMBODIAN HOLOCAUST**

by Paula Toki Tanemura Morelli

**Chairperson of the Supervisory Committee:
Professor Anthony H. Ishisaka
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The purpose of this study was to examine Cambodian Holocaust survivors' experiences of trauma, suffering and adaptation, and to explore what part these personal constructions based on experience played in their healing. Utilizing constructivist and critical theoretical lenses survivor accounts of trauma and suffering were analyzed within a larger structural context of: historic geopolitical events, culture, class, ethnic and gender factors, economic and political structures, ideology and praxis.

Cambodian survivors, ranging in age from 30 to 60 were interviewed in three to six, one and a half to two hour sessions, using open-ended and semi-structured questions. The interviews were conducted over a six month period between 1995 and 1996.

From a larger sample of an on-going study, a purposeful sample of four survivor-cases was selected for analysis using critical social research and

qualitative research methods. The analysis yielded concepts useful for sensitizing social and health services practice as well as health and mental health policy. 1) The survivors in this study suffered from: cultural bereavement, physical illness, pain of unknown etiology, posttraumatic stress disorder, major depression, or combinations of physical and psychological illness. 2) Their suffering was obdurate and continuous, despite years of Western bio-medical and/or traditional Cambodian treatment. They sought help from sources that were respectful of this need for long-term care. 3) Within the biomedical system, some physicians regard the symptoms of Posttraumatic Stress Disorder as without medical basis, discredit the sufferer and make unrealistic demands for short-term recovery. 4) A survivor who was able to associate his suffering with the collective pain of his countrymen was able to use this externalizing construction as a source of strength and meaning. 5) The systemic lack of understanding of how the geo-political history of Southeast Asia is related to social structures, such as immigration-refugee policy and the Western biomedical system, operates to isolate the phenomenon of trauma and suffering, and thereby, perpetuates the oppression of refugees.

TABLE OF CONTENTS

LIST OF MAPS.....	iv
LIST OF TABLES.....	v
INTRODUCTION	1
PURPOSE OF STUDY.....	1
CRITICAL THEORY AND THE CONSTRUCTIVIST PERSPECTIVE.....	9
<i>Constructivism</i>	9
<i>Critical Social Research</i>	12
SUMMARY AND ORGANIZATION OF CHAPTERS	17
CHAPTER 1: TRAUMA THROUGH THE WESTERN LENS: A BIO-MEDICAL APPROACH TO CAMBODIAN TRAUMA AND HEALING.....	19
KHMER MEANINGS OF PAIN AND SUFFERING	20
WESTERN BIO-MEDICINE VS. ASIAN PERSPECTIVES OF HEALING	22
POST-TRAUMATIC STRESS SYNDROME.....	27
<i>Problems with the Current Diagnostic Criteria</i>	29
<i>Variation in Trauma Constructions</i>	29
PROBLEMS WITH STUDIES OF TRAUMATIZED CAMBODIANS.....	31
CLINICAL STUDIES OF CAMBODIAN SUFFERING	34
TREATMENT STRATEGIES.....	36
IMPLICATIONS FOR SERVICE UTILIZATION.....	41
CHAPTER 2: CULTURAL IMPERIALISM: THE HISTORIC GEO-POLITICAL CONTEXT OF WAR IN SOUTHEAST ASIA	43
THE FIRST INDOCHINA WAR: FRENCH IMPERIALISM	47
THE SECOND INDOCHINA WAR: POWER AND IDEOLOGY	53
<i>U.S. Leadership</i>	53
<i>Deception, Miscalculation, and Cultural Imperialism</i>	54
PRELUDE TO THE CAMBODIAN HOLOCAUST	59
<i>Cambodia's History</i>	60
<i>Communism in Cambodia</i>	63
<i>The Fall of Phnom Penh: Enter the Khmer Rouge</i>	65
<i>The Holocaust</i>	67
CHAPTER 3: PERPETUATING OPPRESSION: UNITED STATES IMMIGRATION-REFUGEE POLICY	70
HISTORICAL GENESIS OF OPPRESSIVE POLICIES	71
<i>Controlling the Yellow Hordes</i>	72

SUSTAINING OPPRESSION THROUGH REFUGEE-IMMIGRATION POLICY.....	81
SOCIAL SERVICE IMPLICATIONS	84
THE LINKAGES	87
CHAPTER 4: TRADITIONAL CAMBODIAN SOCIETY, HEALTH BELIEFS AND PRACTICES	91
TRADITIONAL CAMBODIAN SOCIETY	91
THERAVADA BUDDHISM	94
KHMER BELIEFS ABOUT NATURAL CAUSES OF HEALTH AND ILLNESS.....	97
SPIRITS AND THE SUPERNATURAL	99
EMOTIONAL STRESS AND BEHAVIOR	101
AGE, GENDER AND GENERATIONAL DIFFERENCES RE: DISTRESS, SYMPTOMS, ETIOLOGY	103
<i>Traditional Healers and Forms of Treatment</i>	105
CAMBODIANS IN AMERICA: PERCEPTIONS RE: EMOTIONAL ILLNESS	107
CHAPTER 5: LISTENING TO THE ACCOUNTS OF CAMBODIAN SURVIVORS LIVING IN SEATTLE	110
METHODOLOGY.....	110
SAMPLING.....	111
FIELDWORK.....	113
INTERVIEW PROCESS	114
<i>Narrative as Healing</i>	117
DATA ANALYSIS	118
<i>First Level</i>	119
<i>Second Level</i>	123
STUDY LIMITATIONS.....	125
CHAPTER 6: NEAR DEATH EXPERIENCES, SUFFERING AND HEALING: FIRST LEVEL ANALYSIS	128
CHOMREUN: A TEACHER'S STORY	129
<i>Near Death Experiences and Survival</i>	131
<i>Flashbacks and Personal Pain</i>	135
<i>Chomreun's Healing Strategies</i>	135
SOPHIAP: AN ORPHAN'S STORY.....	138
<i>Near Death and Trauma</i>	139
<i>Sophiap's Suffering</i>	143
<i>Attempts at Healing</i>	148
CHANDA: A MOTHER'S STORY	149
<i>Forced Labor, Starvation and Death</i>	151
<i>Illness and Suffering</i>	153
<i>Attempts To Heal</i>	156
SORYA: A STORY OF SPOUSAL ABUSE	158

<i>Death, Constant Fear and Starvation</i>	160
<i>New Suffering in the US</i>	163
<i>Forgetfulness, Depression, Anger</i>	165
<i>Resources Utilized in Coping</i>	167
SUMMARY OF FIRST LEVEL FINDINGS.....	168
<i>Survivors' Traumatic Experiences</i>	168
<i>Suffering: Illness, Symptoms, Spirits</i>	170
<i>Paths to Healing</i>	171
CHAPTER 7: SURVIVAL IN A NEW SYSTEM: SECOND LEVEL ANALYSIS	176
SECOND LEVEL FINDINGS	176
<i>The Ripples of Oppression</i>	176
<i>Other Effects of Dispersal and Disruption</i>	179
<i>Systemic Effects of Culturally Imperialized Policies</i>	181
CHAPTER 8: SUMMARY AND IMPLICATIONS: SYNTHESIS TOWARD CHANGE	188
IMPLICATIONS FOR PRACTICE	189
IMPLICATIONS FOR POLICY	193
IMPLICATIONS FOR SOCIAL WORK EDUCATION	197
IMPLICATIONS FOR RESEARCH	198
CONCLUSION	200
REFERENCES	203
APPENDIX A: DIAGNOSTIC CRITERIA FOR POSTTRAUMATIC STRESS DISORDER	210
APPENDIX A-1: COMPLEX POST-TRAUMATIC STRESS DISORDER	212
APPENDIX B: HUMAN SUBJECTS REVIEW COMMITTEE APPROVAL	214
APPENDIX B-1: PARTICIPANT INFORMED CONSENT	215
APPENDIX C: NIMH STUDY INSTRUMENT	217
APPENDIX C-1: INTERVIEW GUIDE	229

LIST OF MAPS

Number		Page
Map 1.	Cambodia: Provinces and Major Cities	127

LIST OF TABLES

Number		Page
Table 1.	Initial Codes: Line by Line Coding	121
Table 2.	Categories Derived from Initial Coding	122
Table 3.	Survivor Characteristics and Formulations of Survival, Suffering and Healing	175

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As with all research, many individuals have contributed their time and energy to permit this work to be completed. I owe much gratitude to my friends and colleagues in the Seattle community who aided my fieldwork contacts, locating participants, data collection, translation, transcription and research collaboration. Orgoon (thank you) to: Sokhateyadevi Aksobhya, Sorom Anderson, Molly Daggett, Sithan Keo, Louise Lew, Sandy Lew, Pat Norikane, Sona Pel, Sokha Saing-Fekete, Sopha Sar, Dany Sun, Van Sun, Dharamuni Phala Svy, Sorya Svy, Poly Tieng, and Sar Van. Many thanks to the Asian Counseling and Referral Service agency and the Seattle Khmer Buddhist

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INTRODUCTION

Purpose of Study

It is clear to everyone that the suicide of civilization is in progress. Wherever there is lost the consciousness that every man is an object of concern for us, just because he is man, civilization and morals are shaken and the advance of truly developed inhumanity is only a question of time.

Albert Schweitzer, The Philosophy of Civilization

The equivocal commitment of the United States to halt the spread of communism in Southeast Asia manifested ideological imperialism assumed and implemented at staggering human cost. The Second Indochina War (referred to as the Vietnam War in the U.S., 1959-1975), resulted in the deaths of over 58,000 Americans and 2 to 3 million Indochinese (Taylor 1996; World Almanac 1996). On April 30, 1975, when Saigon fell to the communists and the last U.S. troops departed, Cambodia, Laos, and North and South Vietnam had sustained massive destruction, both in physical and human terms, and the social structures and economies of these countries were devastated. The United States paid well over 150 billion dollars (Taylor, 1996; World Almanac, 1996) for a war that ultimately lost its meaning in the changing world of geo-politics, yet would continue to have painful, far reaching human consequences.

One of these consequences was the over two million refugees who fled their countries in fear of communist retribution and sought international asylum

in the wake of U.S. withdrawal from Southeast Asia. From 1982 to 1995, more than 668,431 Southeast Asian refugees resettled in the United States (Refugee Reports, 1995). These Cambodian, Laotian and Vietnamese refugees suffered extreme trauma¹ through experiencing the bombing of their homes and villages, the arbitrary and preventable deaths of family members, being orphaned, torture, rape, witnessing mass killings, brutal robberies, disease and illness without medical care, starvation, torturous escape through mine-infested jungles or by inadequate sea vessels, and serious injury, such as, amputation as the result of land-mine encounters.

To the disbelief of the world at large, 600,000 Cambodian refugees sought asylum at the Thailand border after 1979, fleeing not only the ravages of war within their country, but the horrors of genocide. Under the leadership of Pol Pot, the Khmer Rouge directed the mass murder and torture of intellectuals, professionals, people from urban backgrounds, Buddhist monks, Chinese ethnics (Hood and Ablin 1990) and members of the preceding Lon Nol regime. These "New People" were identified via their physical appearance, actions, deeds, words and language, and any other form of association with Western

¹The Diagnostic and Statistical Manual of Mental Disorders (DSM-IV) (APA, 1994) defines an extreme traumatic stressor as, "... direct personal experience of an event that involves actual or threatened death or serious injury, or other threat to one's physical integrity or another person; or learning about unexpected or violent death, serious harm, or threat of death or injury experienced by a family member or other close associate."

imperialism. Those that survived the killing fields endured starvation, forced separation from family, the murder of loved ones, torture, chronic illness and constant fear.

Approximately 150,000 of the more than 600,000 Cambodian refugees who fled Pol Pot's "killing fields" were subsequently resettled in the United States. The resettlement of Cambodian refugees in the U.S. was concentrated in a few states. California received approximately 50 percent, Texas 14 percent and Washington State 8.6 percent (Duncan 1987). In 1986, Washington State was estimated to have a population of 12,000 Cambodian refugees, concentrated in King (3,500) and Pierce (5,100) counties. By 1990, King County, in which the city of Seattle is located, had a population of 4,973 Cambodians (King County Census 1990). Due to extreme difficulties in coping with survival demands and assimilating the traumatic experiences associated with the war, escape and transcultural resettlement, Southeast Asian refugees are at extremely high risk for emotional dysfunction. For example, the prevalence of mental illness for Cambodians in King Country stands amongst the highest for Asians, at 34 percent of their population (Bertorell and Associates, population study for King County, Washington State 1991).

Clinical studies of Southeast Asian refugees report a high incidence of chronic depression, anxiety, somatic symptoms and posttraumatic stress

disorder² (Rumbaut 1985, Kinzie et al. 1984, Mollica, Wyshak and Lavelle 1987 all cited in Kroll et al. 1989; Carlson and Hogan 1994; Carlson and Rosser-Hogan 1991). For example, in a study of psychiatric diagnoses among Hmong, Laotian, Cambodian and Vietnamese refugees, Kroll and others (1989) found that 73.3 percent of the 404 participants in the study were diagnosed with a Major Depressive Episode according to DSM criteria. The second most frequent diagnosis was Posttraumatic Stress Disorder (PTSD), occurring at a rate of 13.3 percent, and often diagnosed in combination with depression. Cambodian refugees were reported with the highest rate of diagnosed PTSD among Southeast Asian refugees.

In a random sample study of fifty male and female Cambodian refugees selected from 500 Cambodian refugees resettled between 1983 and 1985, who departed from their homes in Cambodia an average of 9.9 years ago, and had been living in the U.S. for an average of 5.4 years, Carlson and Rosser-Hogan (1993) found the rates of PTSD (86%), depression (80%), anxiety levels (78%), and dissociation (mean score 37.1) extremely high. They found that these

² Posttrauma Stress Disorder (PTSD) is characterized by: intense fear, helplessness or horror, persistent reexperiencing of the traumatic event, persistent avoidance of stimuli associated with the trauma and numbing of responsiveness, and persistent symptoms of increased arousal. These symptoms much be present for more than one month in important areas of functioning.

Cambodian refugees continued to suffer mental distress without seeking mental health treatment.

The effectiveness of Western bio-medical psychiatry in treating severely traumatized Southeast Asian refugees has been found to be limited (Morris, Silove, et al. 1993, Kinzie, Leung, et al. 1987, Cheung 1993, Kroll, Linde et al. 1990, Kinzie 1989). Clinical studies of Southeast Asians receiving Western psychiatric care have reported: some symptom reduction (Mollica et al. 1988 cited in Cheung 1993), temporary deterioration after receiving treatment (Kinzie, Fredrickson et al. 1984 cited in Cheung 1993), or adverse effects (Silove et al. 1988 cited in Cheung 1993). Psychodynamic interpretation and insight-oriented psychotherapy appear to be of little use to Southeast Asian refugees (Nguyen 1984 cited in Cheung 1993) who expect more concrete, i.e., physical or social, forms of intervention. Moreover, the Southeast Asian patient's attributional beliefs are often in conflict with the basic tenets of Western assessment and treatment. For example, in Cheung's case study (1993), of Cambodian patients diagnosed with Depression and Post-traumatic Stress Disorder, the patient's belief in "karma" was cited as the "main stumbling block" or resistance to psychotherapy. It is unfortunate that the patient's beliefs were conceptualized as a obstacle rather than as an avenue to understanding the patient's world view which could have informed treatment. But such discounting of patient accounts is common in current medical practice and provides one major example of how

different systems of cultural attributions and meanings collide in the context of cross cultural service provision.

Such findings must lead us to question what is missing from our approach to facilitating the healing³ of severely traumatized refugees. Medical anthropologists have suggested that understanding how survivors of torture and extreme stress conceptualize their suffering is essential to facilitating healing. Differing normative definitions of illness and suffering within societies not only are linked to differing systems of intervention, but may ultimately determine the appropriateness and effectiveness of treatment. Thus, a societal group in which illness is "... defined and caused by anatomical and physiological alterations will focus on these physical characteristics ... in seeking prevention or cure" (Hahn 1995, 19). In such a society, the system of medical evaluation does not ordinarily consider the individual capable of self-diagnosis and will often not listen to the attributions or complaints of the afflicted person. By contrast, a society which defines illness through, "... human experience and caused by human interactions -- physiological as well as social -- may attend more to its social organization and the understandings of its patients in addressing prevention and cure" (Hahn 1995, 19).

³ The term *healing* is used in this study is used to describe the mitigation or alleviation of pain and suffering. The Western bio-medical definition of *healing* in contrast focuses primarily on the cure of illness, restoration, and rehabilitation (Hahn 1995, 7).

In the pre-war culture of Cambodians, the collective efforts of the family, traditional healers and Buddhist monks were important in the diagnosis and healing of individuals afflicted with illnesses of the body and spirit. Although the traditional healing practices of Cambodian refugees residing in the United States have been disrupted and Western bio-medicine thrust upon the community, there is great risk of discounting a critical aspect part of traditional healing processes if there is no attempt to understand the Cambodian survivor's accounts of his or her trauma and suffering.

Gaining a deeper understanding of suffering⁴ from the perspective of refugees exposed to extreme trauma is an urgent priority if effective healing strategies are to be developed. Fuller understanding of the role of traditional attributions in the healing process is a topic of continuing importance in light of the increasing number of regional wars and ethnic cleansings which affect large numbers of people throughout the world. These wars of nationalism and liberation have already yielded a tragic harvest of human suffering and there are hundreds of thousands who must seek international refuge to avoid death and persecution in their homelands. These people too will be cultural minorities who

⁴ In this study the term *suffering* is used to describe the many forms of illness, pain and PTSD symptomatology that survivors have experienced usually as a result of traumatic experiences during the war. Suffering also refers to the core belief, stemming from Theravada Buddhism, that life itself is suffering (Marcuci 1994, 130) (more discussion follows in Chapters 1 and 4).

will challenge the helping systems of their host societies to provide culturally, linguistically and clinically appropriate services. There are at present, an estimated fifty million refugees who have been uprooted from their countries of origin (UNHCR, 1995). These victims of persecution and violence from areas such as Bosnia, Burma, Chechnya, Iraq, Liberia, Rwanda, and Somalia await asylum and seek international assistance in healing the personal ravages of war and its multiple traumas. The provision and improvement of such services, including mental health service, must also be an integral extension of our moral obligation to those afflicted by American geo-politics, the cold war and proxy conflicts subservient to the interests of the superpowers. Meeting our moral obligations to those allied with our interests in losing causes and those caught in political struggles secondary to superpower and regional conflict, is also needed to advance the world's pursuit of peace and social justice. For the knowledge needed for these tasks will come from those affected, those whose lives have been tragically altered by war and its aftermath. These are the witnesses whose accounts we must accept and understand in order to know what must be changed if the world is to find peace and the needs of victims of war adequately met.

The primary purpose of this study is, therefore, to explore and describe how survivors of the Cambodian holocaust conceptualize their suffering and

what part these attributions and conceptualizations play in their coping, survival and healing processes. The study asked:

How do survivors understand the trauma and suffering they experienced?
 How do these constructions mediate their healing?
 What forms of intervention did they find most helpful to their healing?

The constructivist approach guided the perspective from which narrative elicitation and the initial level of analysis proceeded. The narratives, obtained through in-depth interviews, were examined in light of survivors' experiences, suffering and their attempts to heal.

Critical Theory and The Constructivist Perspective

Constructivism

Constructivism assumes that reality is formed by multiple, intangible mental constructions which are socially and experientially based, local and specific in nature (Guba and Lincoln 1994, 110). These constructions may be shared among individuals within and across cultures, but are dependent for their form and content on the people or groups that created the constructions. Constructions are not absolute in any sense, rather more or less informed by an individual's perceptions and associated realities, and subject to change. The researcher and subject of investigation are interactively linked, thus findings are created as the research proceeds. The methodology in constructivism is

hermeneutical and dialectical. It calls on the investigator and participant to elicit and refine collaboratively the constructions inferred from personal narratives. These constructions are interpreted using hermeneutical techniques, then compared and contrasted through dialectical interchange. The goal is, "... to distill a consensus construction that is more informed and sophisticated than any of the predecessor constructions including ... the etic construction of the investigator" (Ibid.).

The examination of cross-cultural dynamics and explanations of illness stemming from trauma (the concept as used here, refers to severe mental or physical injury) or other etiology has often centered around what Kleinman (1978) refers to as cultural or social constructions of reality. These constructions of illness are not limited to an individual's beliefs and behaviors regarding his or her illness, but also encompass the family and interventionists' responses to, and interaction with, the identified patient. They are reflexively influenced by the culture, society, setting and situation in which they occur.

Over years of cross-cultural work with the health beliefs of Asians, Kleinman (1978) utilized the theory of socio-cultural construction to explain the dynamics of illness. His early investigations suggested that social constructions of medical problems can inform practitioners about the ways society deals with illness. Despite the long standing recognition that belief systems play an important part in illness construction and recovery, few studies have been

undertaken to reveal the nature of these conceptualizations or what part they perform in the healing process.

In Kleinman's (1978) experience, the theory of socio-cultural construction of illness, though a powerful clinical tool, has been actively resisted by the health sciences in favor of orthodox Western biomedicine. One of the goals of this study was to examine survivors' constructions of suffering and illness in relation to the forms of healing that were sought.

The examination of individuals' accounts of war trauma as discrete units of study, however, restricts findings to surface elements. This decontextualization of war trauma and its corollary reliance on isolated data analysis fails to critically assess those larger interconnected structural forces which must bear responsibility for war suffering and potentially play an important part in healing. Deeper analysis of war trauma within its multiple contextual levels required a methodological framework which epistemologically and ontologically grasps the complexity of the problem.

Critical social research is a reflexive process which invites examination of "... the conditions of social regulation, unequal distribution, and power" (Popkewitz 1990) that have given rise to the oppression of refugee populations and is aimed at consciousness raising which enables direct action in pursuit of social justice.

Critical Social Research

In utilizing a critical theoretical framework, this study begins with the premise that the suffering of war trauma victims is inextricably linked to historic geo-political events, racial, cultural, gender and class factors, daily life practices, and the prevailing oppressive social structures which are maintained through political and economic power and legitimated through ideology (Harvey 1990, 19). The work of research is recognized as an on-going process of reconceptualization shaped by everyday practice and application which is itself also a part of the social structure. Within this context, this dissertation research will, hopefully, make a contribution as a small political act directed toward social change.

Harvey's (1990) work on critical methodology delineates seven elements of critical theory that may be "drawn together in various ways in the process of deconstruction and reconstruction." The elements are abstraction, totality, essence, praxis, ideology, structure and history. This study modified and utilized these elements of critical research in ways that allowed the data to yield its meaning.

In critical research the *abstractive* process is the reverse of normative scientific procedure which begins with factual observations and abstracts from them. Critical research assumes that facts do not exist independently of their theoretical context, therefore, they are not self-evident and cannot be abstracted

from. Instead, critical research begins with abstract conceptualizations and explores them through concrete observations. A fundamental requirement is thorough understanding of how the concept or abstraction is customarily employed. This study begins with an examination of the concept of Posttraumatic Stress Disorder as utilized in Western bio-medical practice. The study then moves beyond the review of practice effectiveness to examine the “taken-for-granted underpinnings” of war trauma as part of a larger whole or totality.

Totality is defined as, “... the view that social phenomena are interrelated and form a total whole. This implies more than that a social phenomenon should be situated in a wider social context, it requires that social phenomena should not be analyzed in isolation” (Harvey, 21). From this perspective the components which comprise a phenomenon are interrelated in a coherent structure. Thus, the components and structure rely on and only have meaning in terms of each other. In this contextual totality, analysis of present social structures is critical to interpreting past events, as is the understanding of historic events critical to understanding of the present.

Essence in critical research refers to a fundamental concept that is identified as pivotal to the analytic or deconstructive-reconstructive process. In this study, the essential nature of the trauma-suffering-healing process refers not only to the individual's meaning making process through which they negotiate

healing, but about the ways in which cultural imperialism fomented war and internal unrest leading to survivors' traumatization and is continued through systemic oppression into everyday health care. The trauma-suffering-healing process is essentially a mechanism through which cultural imperialism and oppression are perpetuated.

In critical social research, *praxis* refers to purposeful contemplative activity which has the potential to bring about change. According to Harvey, critical research "... must in some way take into account that changes in social formations are the result of praxis." Praxis is also at the core of recursive activity between knowledge development and change. For critical research, it is about knowledge gathering with the intent to change oppressive social structures.

Karl Marx utilized the concept of *ideology* as an analytic and critical tool in his work. According to Marx, ideology is extant as soon as social relations become hierarchical. Ideology may be analyzed as positive and negative forms (Larrain, 1979, 1982 cited in Harvey 1990, 23-24). Ideology in the positive sense refers to class-based world views (*weltanschauung*), which are thought to be transcendable. However, these dominant world views actively obscure the concerns of dominated groups from themselves.

In its negative definition, ideology is seen as opposed to a *Weltanschauung* which promotes the obfuscation of class differences as intrinsic and normal. Ideology in this negative sense is, "... all pervasive and grounded in

the material relations of production" (Harvey, 25). In order to reveal the nature of an ideology the researcher needs to identify the essence of social relations or the core concept underlying social relations, and separate it from structural forms via a process of dialectical deconstruction and reconstruction.

The term *structure* in critical research is used in two ways. In its primary usage it refers to, "... a complex set of interrelated elements which are interdependent and ... can only be adequately conceived of in terms of the complete structure." Wholeness, transformation and self-regulation (Piaget 1971 cited in Harvey 1990, 25) are at the core of this definition. Wholeness refers to a structure's internal coherence, how its parts conform to intrinsic laws and determine the nature of the structure and the parts. Transformation and self-regulation refer to a structure's ability to change, independent of outside forces. In this second usage, structure is also used to describe, "... something that can be reduced to its elements." In this sense, a structure's complexity is simplified and exposed by deconstructing it into its component parts.

Social change is possible from the critical theorist's perspective because history is not immutable. *History*, the knowledge-product of historians, is the product of an interpretive process. It results from the active interpretation of available documentation, archaeology or oral evidence, and is a reconstruction of the meanings of events, or texts of an author, informed by current conceptualizations (Harvey 1990, 26). In Chapter 2, a segment of the historic

events surrounding the First and Second Indochinese Wars is examined to expose the decision-making processes which constituted the genesis of imperialist policies in Southeast Asia. These policies wasted the lives of the countless millions of war-dead, those physically and emotionally maimed, and of those forced into flight as international refugees. In Chapter 3, to emphasize the collusive nature of oppressive structures and demonstrate how oppression is sustained through social structures, the historic emergence of discriminatory immigration policies, and their extension to Southeast Asian refugees are also examined.

In social research informed by critical theory, deeper analysis of a phenomenon necessitates targeting sub-surface relationships, from a perspective that recognizes: 1) "... social relations are historically specific", 2) there are "... structural relations operating within that historical moment", and 3) there is a "... reciprocal nature to the determinacy of historically specific structure and specific phenomenal forms" (Harvey 1990, 22). Harvey states:

The deconstructive-reconstructive process which is at the heart of dialectical analysis involves a constant shuttling backwards and forwards between abstract concept and concrete data; between social totalities and particular phenomena; between current structures and historical development; between surface appearance and essence; between reflection and practice Harvey (1990, 29).

Utilizing the critical social research lens, this study attempted to go beneath the surface of the individual's traumatization and suffering, as portrayed

in presenting symptoms and accounts, by interrogating the narrative data in terms of oppressive social structures, and examining those experiences in terms of the social structural relationships that informed them.

The methodological framework used in this study attempts to examine portions of the specific historic context, which led to the traumatization of refugees. Thus the examination itself represents a portion of the *totality*, and not the absolute truth, rather, "... an approximate reflection of reality which is subject to continuous change" (Harvey 1990, 197), yet ultimately, plays a significant part in survivors' healing dynamics.

Summary and Organization of Chapters

In the chapters that follow, the position is taken that facilitating healing for survivors of the Cambodian holocaust necessitates an understanding of their cultural context, the differences in healing approaches including Western bio-medicine and traditional healing practices, the specific historic geo-political context of the refugee's experience, and the national policies which affected and continue to affect these refugees. This position is supported through critical examination of these various contexts and the findings generated from the narratives of Cambodian survivors.

Utilizing a critical research perspective, Chapter 1 examines Western bio-medicine as the prevailing social structure through which Cambodian refugees

must negotiate their health care. In this section the reported lack of effectiveness of Western treatment and its implications for service utilization are reviewed.

Maintaining the critical perspective, Chapter 2 provides an overview of the historic geo-political context and events leading to the traumatization and oppression of Southeast Asians, specifically, of Cambodians. The core constructs which underlie the historical context are cultural imperialism and racism.

The Cambodian refugee's flight to safety placed her/him in direct contact with national immigration and refugee policy which judged her/his suitability for resettlement. Chapter 3 examines the historical emergence of immigration and refugee policy as an oppressive structure.

In Chapter 4 the pre-war culture of Cambodia is described in terms of health practices and gender expectations, and as a basis for comparison with post war practices.

Data collection and analysis methodologies employed in this study are discussed in Chapter 5.

Analysis of Cambodian survivors' narratives is delineated and supported through case examples in Chapters 6. Chapter 7 summarizes the major findings and discusses implications for policy and practice.

CHAPTER 1: TRAUMA THROUGH THE WESTERN LENS: A BIO-MEDICAL APPROACH TO CAMBODIAN TRAUMA AND HEALING

The veil of apparent reality can only be pierced when as much of the totality which gives rise to or supports a phenomenon is apprehended (Harvey 1990). The vast and devastating sequelae of the Cambodian holocaust can only be fully understood within its historic geo-political context, and the Cambodian survivors' current condition within the prevailing social structure.

In this chapter, the Western bio-medical approach to the treatment of Cambodian holocaust victims is critically examined in terms of cross-cultural diagnosis, practice and treatment efficacy, and service utilization. Irrespective of its short-comings, Western ethnomedicine's contributions to the search for better understanding of health phenomena and the peoples it serves cannot be overlooked. It is from this foundation that better understandings in the service of sound practice will arise. Thus, because the Cambodian culture lacks a comparable biomedical lexicon, this study utilized the conceptualizations and language of Western medicine not merely to question the appropriateness and effectiveness of Western treatment efforts, but in the service of furthering our understanding about the traumatization, suffering and healing of Cambodian refugees.

Khmer Meanings of Pain and Suffering

Critical to a deeper understanding of Cambodian constructions of trauma and healing is the knowledge that the Khmer concept of pain and its expression in suffering is significantly different from Western beliefs and forms. In the Khmer culture the concept of pain extends beyond pain as an indication of illness, it is part of a larger process of suffering and healing, which continually contributes to their kinship and familial solidarity and reciprocity, and ethnic identity maintenance (Marcucci 1994).

Although the Khmer acknowledge scientific explanations of pain, such knowledge is not separated from the spiritual aspects of pain derived from Buddhism. The values and practices of Theravada Buddhism contribute to the Khmer formulation of the meaning of pain, and also constitute a core element of Khmer identity. In the Khmer belief system, "... life itself is the essence of suffering" (Robinson and Johnson 1982 cited in Marcucci 1994, 130). Through the syncretic use of both Buddhism and folk religion, Khmer are able to explain the transcendental questions of existence and take responsibility for coping with more immediate problems (Ebihara 1968, 442; Marcucci 1994, 130-131).

In John Marcucci's (1994) study of the meanings of pain in relation to Khmer identity, the words "affliction" and "infliction" are used to stress the difference in meanings that Khmer attribute to pain depending on the context of the pain experience. Afflictions of suffering, whether from natural or

supernatural causes, refer to pain that is difficult to endure for which relief is sought. Afflictions of suffering in various painful forms are experienced by Khmer in both their body and psyche inclusively (Marcucci, 130).

Inflictions of pain in the context of healing, "... are endured because of a perceived benefit or integration as a part of life" (Marcucci, 132). For example, the infliction of pain by coining, pinching and moxibustion cause painful bruising and skin burns, but in the Khmer context of meaning, such pain restores the humoral balance of "wind" in the body (see Chapter 4).

Ordinary imbalances of "wind" may be treated by pinching, cupping and coining. In the Khmer health belief system, it is critical that treatment be directed to the cause or causes of affliction, if the individual is to be healed (Marcucci 1994, 135). These causal factors may include social, psychological, supernatural, or magical conditions. Khmer distinguish the degree of an individual's suffering by the type of affliction and the type of treatment.

The sharing of pain is part of the Khmer socialization process and is important to developing one's identity within a group. This collective sharing of pain, "... distinguishes Khmer identity and provides meaning to their existence" (Marcucci 1994, 129).

Cambodians in this study speak in the language of suffering, that is, they describe their suffering in terms of various experiences of pain, but not always using the term "suffering". Thus, the suffering documented by Western bio-

medical studies and discussed in this study, refers to the manifestations of afflicted pain as interpreted through the Western perspective. Attempting to discuss and describe the suffering of Cambodians from a cross-cultural perspective risks describing their suffering in terms unfamiliar to Khmer themselves. Discussion of study participants' narratives in the analysis, therefore, walks the tightrope between the Cambodian survivors' voices and that of the researcher's interpretive perspective, the major elements of which are grounded in constructivism and critical social research.

Western Bio-Medicine vs. Asian Perspectives of Healing

During this century, Western biomedicine, one of many ethnomedicines⁵ throughout the world, has become the predominant influence on the health and healing practices in a majority of societies vulnerable to influence from the West. Hahn (1995) describes biomedicine as a cultural system, in which complex interaction occurs between the system's domains of knowledge and beliefs, values and ideals of behavior, teaching practices, norms of behavior and

⁵ Ethnomedicine refers to the various medical subcultures found in different societies. As a culture, biomedicine is supported by a complex network of social and cultural arrangements of physicians, a multitude of health care provider-specialists, auxiliary personnel, administrators, institutions of care, extensive industries, health insurance programs, research, government and private agencies. In the United States, 8 percent of the civilian work force is employed by the health care industry, which exhausts more than 14 percent of the gross domestic product (Hahn 1995).

practice. Within these domains, Western biomedicine is characterized by: a focus on maintenance and promotion of individual life rather than service to the whole of society (Freidson 1970 cited in Hahn 1995); a paternalism in which the physician or interventionist is expert and knows what's best for the client; individual and collective professional autonomy; an insistence on practice grounded in science, objective evidence, logical inference and rationality; certainty and control of uncertainty; a hierarchy of authoritative knowledge; an urge to over-utilize a favorite procedure; and a tendency toward curative over preventive interventions. Through this dense undergirding of ideological and institutional systems of support, Western biomedicine maintains the central authority, which endorses certain practices of healing, treatment and associated care in this country.

A major assumption of the Western biomedical model is the arbitrary separation of mind and body in the evaluation of functioning and treatment of an individual. This assumption is in direct opposition to traditional Asian models of health, which tend to view an individual's well-being as a function of the balance between body and mind. Moreover, mental health in Asian conceptualizations of well-being, unlike Western models, cannot be separated from bodily health or spiritual well-being. This can be seen in the health beliefs and practices of Cambodians which are grounded in their spiritual and religious beliefs (see Chapter 3 for discussion of Cambodian Health Beliefs and Practices). It is of

vital importance that the relationships between health beliefs, attributions and logically related interventions among cultural minorities be better understood by those involved in the delivery of health and mental health services in diverse communities. Without such knowledge societal efforts to provide needed assistance are doomed to failure and will contribute further to nativist sentiments which blame victims for their distress and stigmatize communities for their presumed deficiencies.

Another important perspective from which to view certain problems encountered in trans-cultural practice and healing is to examine what Hall (1977) refers to as the *continuum of contexting* within cultures. Cultures in which people are deeply involved with one another, where information is widely shared and commonly understood, and relatively simple messages convey deep meanings are considered to be "high context" (Hall 1977); such cultures are "... rooted in the past, slow to change and highly stable," and may become "... overwhelmed by mechanical systems and lose their integrity" (Hall 1977). In contrast, low context cultures are characterized by relatively shallow involvement between people, high individualization, need for large amounts of detailed information, and alienation and fragmentation. These cultures appear to utilize technological extensions without loss of integrity, but their people tend to become more mechanical (Hall 1977). Understanding the nature (high-low) of contexting within a culture is important in determining what is important to the

individual and community, i.e., what is attended to or not attended to. Hall's anthropological observations make vital contributions to understanding the meaning making ways of cultures. The point to be emphasized is that understanding a culture's contexting is critical to understanding the conflict that is inevitable when members of high context cultures must adapt to the cultural milieu and practices of a low context host society. High context patterns such as expecting service providers to intuit what is ailing the high context patient come into conflict with health and mental health practices that are based on client self disclosure. Moreover, high context individuals may assume, consistent with their high context experiences, that service providers will understand the complex interconnections involved in the patient's attributions of his/her difficulties. In only a few instances can this degree of ethnographic expertise be relied upon and it is far more likely that the patient's constructions will remain a mystery to those practitioners unprepared to ask for such information, and likely to be discounted by those who do seek the patient's own accounts of their suffering. Understanding what is important to an individual, and how that individual structures experience is vital to effective facilitation of the individual's healing processes.

The hegemony of Western health belief systems is deeply rooted in the politics and history of the medical profession in this country, and in practice remains unchallenged and unquestioned. Even when medical knowledge

upheld by research endorses more effective procedures, actual practice may persist in inefficient or harmful ways (Hahn 1995, 35). Similarly, in the social and health services, culturally relevant practice has been discussed for years yet actual practice remains relatively biased in favor of Western biomedicine. For example, current research suggests that Western psychiatric treatment applied to Southeast Asian refugees diagnosed with posttraumatic stress disorder and related disorders has been relatively ineffective, yet Western treatment protocols still dominate practice. Actual acceptance and legitimization of various traditional, ethnic specific models of attribution and treatment by the Western medical establishment must await future changes in both the mentality and structure of health and mental health training, service infrastructure and accepted modes of practice. Until that point, health and mental health services will continue to be experienced as alien and thus, suspect extensions of a dominating culture upon vulnerable minority groups who have only limited options to seek services elsewhere.

The effects of repeating the colonization process by imposing a social service and therapeutic ideology rooted in the host community's culture on a survivor from a country that has been colonized by foreign powers (Blackwell 1993) has not been adequately explored. The meaning of the survivor's experience may be lost in the differences between the cultures, and misread as resistance to treatment services (Blackwell 1993). When the cultural context in

which the survivor has lived, reasoned, adjusted and found meaning is cut away, the individual's identity in relation to that culture is also discounted. This decontextualization, ultimately, perpetuates cultural oppression and reduces the chances for accurate assessment as well as creative avenues to healing.

Post-Traumatic Stress Syndrome

The painful consequences of man-made and natural traumatic events can be seen throughout the history of mankind. However, not until the end of the Second World War were large scale efforts made to understand trauma's impact on individuals and whole cultures. In the United States, this effort resulted in the emergence of the American Psychiatric Association's (APA) diagnostic category of Posttraumatic Stress Disorder (PTSD) in 1980 (Wilson and Raphael 1993, xviii-xix) (see Appendix A for the current diagnostic criteria for PTSD).

The development of traumatic stress theory currently flows in two major directions: one emphasizes the psychobiological origins and effects of trauma while the other attempts to clarify the various psychoemotional sequelae of posttraumatic stress syndromes (Wilson and Raphael 1993). Studies examining the biological response to trauma have found that the most basic organic impairment occurs in the brain and central nervous system which governs memory, affect, thought and sociability (van der Kolk and Saporta 1993; Krystal et al. 1989). Psychobiological effects are thought to be manifested in a

generally uniform response to trauma in all humans (van der Kolk and Saporta 1993; Weisaeth and Eitinger 1993). However, this supposition is contradicted by evidence which suggests clinically debilitating responses to trauma are not universal among people who have experienced trauma (Gaines 1986). It is commonly noted that many individuals who have experienced severe trauma do not manifest symptoms of PTSD, while others, whose exposure to stressors may have been significantly reduced, may develop the full clinical syndrome. The question of differential vulnerability to PTSD and the risk factors associated with this vulnerability constitute an important arena for mental health research.

Over the years there have been attempts to develop a more comprehensive PTSD symptom picture. Such a symptom picture is, however, far from complete, and as indicated, may be heavily colored by cultural biases stemming from Euro-American conceptions of trauma and reactions to trauma. Studies are needed that will further knowledge of trauma in the context of culture, especially concerning differences in response to stressor events for people of various cultures. Similarly there is much that must be learned about coping processes within the context of culture and the process of trans-cultural adaptation among immigrants and refugees.

Problems with the Current Diagnostic Criteria

As indicated, current definitions of PTSD do not take into account the historical and cultural contexts of trauma or culturally influenced interpretations of, and responses to, trauma. We also do not understand the nature of survivor experiences, that is, how survivors conceptualize their traumatic experiences and what part these conceptualizations play in their coping, adjustment and recovery.

Judith Herman (1992) writes that the PTSD diagnosis, and its criterion indicators, does not accurately fit survivors of prolonged, massive and severe abuse, whose symptom picture can be far more complex than the currently accepted DSM IV criteria. The need for an expanded concept is also suggested by psychiatrists and other mental health personnel who work with Southeast Asian refugees (Kroll et al. 1989). Herman formulated the diagnostic criteria for "Complex Post-Traumatic Stress Disorder" (see Appendix A-1 for Complex Post-Traumatic Stress Disorder criteria) which provides a more comprehensive symptom picture. Her conceptualization, however, remains disease oriented and ignores cultural constructions of trauma.

Variation in Trauma Constructions

As can be expected, the concept of trauma has significant variation across cultures in terms of the events and situations perceived as traumatic.

Gaines (1986, 5-13) reviewed several cases which demonstrate the wide differences in "psychocultural meaning of and responses to perceived trauma" (Gaines, 3) within various cultures. Iatmul males of New Guinea, for example, gain prestige and esteem by committing murder. The most honorable, generous gesture an Iatmul uncle could provide for his 5 or 6 year old nephew would be to assist him in killing a captive human. The gift of assisted killing would give the child social distinction and status at a young age. Among the Iatmul murder, as such, is not construed as a trauma but is placed within a traditional ceremonial context which not only legitimizes the behavior but also provides cultural meaning to the act. The Western assumption that murder must also be considered a trauma to witnesses and/or perpetrators appears to be culturally bound. Similarly the common Western assumption that such an event will have harmful if not extremely damaging effects on the child, such as personality dysfunction in adulthood, appears to be equally bounded by culture. The Iatmul are not subject to such beliefs. Gaines points out that many cultures do not associate the events of infancy or childhood with psychological organization or social functioning in adulthood, such an assumption is absurd from their perspective. It should also be noted that throughout American history there are many instances, for example warfare, in which individuals are decorated for their courageous acts of "murder".

There are also culturally patterned responses to trauma in certain ethnic traditions such as Hispanics among whom, for example, denial of the existence of a problem or its severity by the significant others of an identified patient is normative (Gaines, 6). And in France "triste tout les temps" is comparable to the American diagnosis of "chronic reactive depression", but is not referred to as depression or perceived as mental abnormality (Gaines, 7). Thus, the experience of trauma depends on the individual's culturally shaped definitions of attributions, events, symptoms, and potential consequences. Gaines conceptualizes trauma as, "a psychocultural event occurring within and ... created through, interactions of elements of given social/cultural systems."

Problems with Studies of Traumatized Cambodians

Over the last eight years, clinical studies of Cambodian refugees have focused primarily on the prevalence of trauma symptomatology, as defined by Western medical diagnostic tools, and evaluation of the effectiveness of Western forms of treatment. Findings of these studies indicate a high percentage of Cambodians suffer from Posttraumatic Stress Disorder (PTSD) (Carlson & Rosser 1991; Kinzie, Boehnlein et. al. 1990), depression and anxiety (Muecke & Sassi 1992; see also Carlson & Rosser 1994; Carlson & Rosser 1991 Kroll et al. 1989). Few studies discuss the effectiveness of Western medical treatment with Cambodian survivors. Those that provide some discussion offer

no evidence of long term treatment effectiveness (Bemak & Timm 1994; see also Boehnlein & Kinzie 1992; Kinzie, Sack et. al 1989). The exclusive application of Western medical diagnoses and treatment to Cambodians, as well as other cultural minorities, has tended to exclude and or discount the unique perspectives of refugees and their traditional cultural conceptualizations of illness and disease which some researchers suggest are critical to the processes of healing and adaptation. For example, Eisenbruch (1991) observes that Cambodian refugees have suffered different kinds of objective traumas and a range of circumstances surrounds each experience which needs to be understood. As is true of other cultural minorities, Cambodians' interpretations of these experiences reflect their cultural explanations of loss and death. Eisenbruch also argues that the cumulative effects of being estranged from their homeland and detached from their past may predispose Cambodian refugees to develop the disabling symptoms of PTSD. In addition, the use of Western psychiatric nomenclature complicates understanding the refugee experience by laying the ground work for cultural assumptions which ignore the appropriate cultural context of Cambodians and deprives service delivery of the cultural meanings about suffering and loss which may provide the basis for recovery. Eisenbruch submits that a comprehensive diagnosis of refugee mental health should be culturally relevant, incorporating Cambodian constructions of mental health. He proposes that the use of "cultural bereavement" to describe refugees'

response to massive losses involving social structures, cultural values and self-identity, would provide diagnostic refinement, by recognizing PTSD-like symptoms as normal, constructive behaviors, which are a rehabilitative response to devastating trauma.

The use of Posttraumatic Stress Disorder as a diagnosis for Cambodian refugees presenting with criterion symptoms would appear to be appropriate, especially in light of their suffering and traumatization at the hands of the Khmer Rouge. However, Brody (1990 cited in Eisenbruch 1991) and Eisenbruch (1991) argue that the Diagnostic and Statistical Manual of the American Psychiatric Association criteria for PTSD makes no allowance for cultural background or circumstances surrounding trauma and that refugee distress labeled with DSM categories may pathologize behaviors that are, "... normal, even constructive, existential response rather than a psychiatric illness ..." (Eisenbruch, 673). The hegemony of Western psychiatry privileges biology over culture by assuming that symptomatic behaviors are innately determined, prescribing how adjustment should proceed for immigrants, defining appropriate expressions of distress, structuring the classification of disorders and dictating how treatment should proceed (Eisenbruch 1991, 673-678).

Clinical Studies of Cambodian Suffering

Clinical depression, somatization, post-traumatic stress syndrome, suicide, and sudden unexpected nocturnal death syndrome (SUNDS) are among the conditions with which Cambodian refugees have been diagnosed (Baron et al. 1983; Blanchard et al. 1986, Boehnlein 1987, Kinzie et al. 1984, Lin et al. 1985, Meinhardt et al. 1984, Mollica et al 1987, Nicassion & Pate 1984, Nolan et al. 1988 all cited in Frye 1993). High levels of depression and anxiety are consistently reported in studies of Cambodian refugees (Muecke & Sassi 1992; Kroll et al. 1989; see also Carlson & Rosser 1994; Carlson & Rosser 1991). For example, Mollica et al.'s (1987 cited in Carlson & Rosser 1991) study of Cambodian psychiatric patients found that eighty-one percent met criteria for major affective disorder, and sixty-nine percent of the Cambodian psychiatric patients in Kinzie et al.'s (1984 cited in Carlson & Rosser 1991) study had experienced a major depressive episode.

In a study designed to determine whether people from a different culture have similar symptoms in response to traumatic experiences as trauma survivors in the U.S., Carlson and Rosser (1994) found that Cambodian trauma victims showed the same basic symptom picture as other U.S. trauma survivors. In the Cambodian version of the Hopkins Symptom Checklist-25, the three highest mean scores on anxiety items were for headaches, faintness, dizziness/weakness while the three highest depression items were difficulty

falling or staying asleep, worrying too much, poor appetite, and predominantly somatic symptoms. The two highest mean dissociative experiences scores (DES) were for items which describe the severe PTSD symptoms of flashbacks and amnesia. Cambodians in this study had high mean scores for 19 other DES items which indicates that a wide array of disturbances in identity and consciousness disrupt their lives. On the PTSD Checklist the mean was 11.7 (SD=2.8) of 14 with a median of 13. 86% of the subjects met the modified DSM-III-R criteria for PTSD; 40% endorsed all 14 items; 94% endorsed seven or more Checklist items.

Boehnlein (1987b) confirmed, in his work with Cambodian patients with PTSD, that, like the survivors of Hiroshima, these survivors of severe trauma have great difficulty reestablishing trust with other individuals (Lifton 1982, 1979, 1973 cited in Boehnlein 1987b). In addition, as a result of suffering great cruelty, survivors tend to internalize a sense of their own worthlessness and powerlessness. The work done with holocaust survivors found they frequently avoid emotion and affect (Krystal 1978, 1984 cited in Boehnlein 1987b). This reality is doubly challenging when working with some Asian patients because of their general tendency to minimize outward emotional expression.

In case studies of Cambodians in New Zealand, Cheung (1993) reports that depression most frequently presents with a mixture of somatization, anxiety and PTSD symptoms. After ruling out physical etiology, Cambodian patients

who were referred for psychiatric work-up described symptoms which included: chronic headaches, dizziness, sore neck, chest pain, pounding heart, dull abdominal pain, and others. Along with these somatizations, patients usually suffered from insomnia, nightmares, and recurrent distressing thoughts about life in Cambodia. Patients were reluctant to discuss the details of trauma stating that talking about it only made it worse or that everything was fine. Cambodian patients often made no connection between emotional problems and the catastrophes of the Pol Pot regime, their escapes and adaptation to international refuge.

Eisenbruch (1991) found that many Cambodian refugee patients describe themselves as having "the Cambodian sickness", *chii kbaal* or headaches, which refers to a constellation of chronic symptoms including lethargy, headaches and worrying about the family in Cambodia. *Chii kbaal* might be triggered by remembrances of Cambodia during an anniversary or ceremony, the smell of the wind, or the felt presence of ancestors in their daily life. *Chii kbaal* is said to often affect a whole community and may thus reflect deep communal suffering.

Treatment Strategies

Western psychiatry has practiced two primary strategies in the treatment of Cambodians diagnosed with PTSD, the use of medication and the use of psychotherapy. There are no studies which demonstrate the effectiveness of

psychotherapy alone. Cambodian refugees in New Zealand, for example, are unwilling to utilize "talk therapy" exclusively. Within the context of Asian cultures, insight oriented therapy is deemed to have little practical value (Nguyen 1984 cited in Cheung 1993) unless offered along with pharmacotherapy or other social/physical interventions. Cheung's study found that exclusive use of insight oriented psychotherapy did not lead to diminished symptoms or an increase in effective functioning.

Psychopharmatherapy is the primary initial treatment used to ameliorate the more intrusive symptoms of nightmares and aggravated startle reactions (Boehnlein 1987b). Cheung (1993) found depressive and post-traumatic stress symptoms decreased with the use of small doses of the antidepressant doxepin. These results were maintained over a year after treatment.

Boehnlein (1987b) and Kinzie (1989), in describing their practice, indicate that they utilize psychotherapy in conjunction with medication to provide a sense of security, and support. The major psychotherapeutic task is often helping Cambodians to create meaning for their personal experiences and those of their countrymen while recreating a hopeful future for themselves and their families (Boehnlein 1987b).

Boehnlein (1980) has also found cognitive psychotherapeutic approaches to be relevant to work with Cambodians. He argues that with compulsive personalities, for example, asking for concrete details during history taking and

using frequent questioning to clarify and deepen the topics discussed, allows the patient to gradually access highly defended emotions and exert some control over how much is revealed and the pace at which such revelations occur. This structured, pragmatic approach appears to be consistent with what Asians value in treatment (Boehnlein 1987b).

In contrast, in a cross cultural study comparing the value of discussion of the trauma story as part of the therapeutic process, Morris et al. (1993) found that trauma disclosure was less important to Cambodian patients than Chileans. Chilean mental health practices, were founded in the Western European tradition of psychotherapy, which supports self disclosure, personal autonomy, self-assertion and situational ethics (Morris et al. 1993). In contrast, Western concepts of mental health and illness are alien to many Indochinese and psychiatric services historically have been rudimentary. Thus, while Chileans find Western psychotherapy compatible with their cultural traditions and expectations of treatment, Cambodians seem to benefit more from interventions that are consistent with their own unique traditions and cultural expectations. The Chileans are an example of a, traditionally, high context culture whose elite were influenced by Euro-American values, and consequently, reflect a shift to low context behavior requiring extensive verbalization, while the culture's peasants reflect more traditional, high context values.

In working with Asian patients with PTSD, Boehnlein (1987b) determined that therapists must be aware of their own affective responses, the ways in which they can communicate a sense of security and trust to the patient, and need to be particularly aware of subtle cues of internal distress communicated by patients, although no outwards sign of emotion are visible. For example, Cambodian patients often communicated distress levels through dream content or an increase in the number and intensity of somatic symptoms, a culturally sanctioned way of communicating depression or anxiety (Boehnlein 1987b).

In high context cultures somatization also functions in a manner that is congruent with religious beliefs and cultural practices, such as “bearing up” under extreme pain or not complaining under any circumstances since such complaints are thought to burden others. Sufferers are taught to display only minimal signals of distress depending on others to accurately construe these signals. In this way, members of the collective can reciprocate by interpreting the sufferer’s behavior and responding with appropriate care. In contrast, low context cultures require precise articulation of symptoms in order for the caregiver to understand that suffering exists and provide care because caregiver and patient cannot depend on minimal signals in the absence of extensive shared cultural information.

Southeast Asians also hold certain values which can affect the course of psychotherapy such as an orientation to the past, with great respect for

ancestors; primary reliance on the family as the basis of personal identity and self-esteem; tolerance for multiple belief systems in religion and cosmology; and acceptance of life as it is, rather than what it could be. Cambodians are Theravada Buddhists who believe in reincarnation, personal control of one's own destiny through free will, and the inability to escape the suffering of this world (Boehnlein 1987b).

Consistent with traditional cultural emphases on education, Cambodians have a great deal of respect for trained professionals and other educated people. Thus, the assurance by professionals that their symptoms and feelings are a normal response to extraordinary events beyond their control tends to be immensely reassuring (Boehnlein 1987b). Cambodians with PTSD may need a great deal of assurance that the chronic nature of their symptoms, and often slow progress to recovery, is not a reflection of their own character or weakness, but something to be expected after the devastating events and experiences which have so profoundly affected their lives.

Boehnlein (1987a) suggests that for the traumatized refugee the therapeutic relationship must provide security and acceptance as a basis for rebuilding trust, reconstructing self-identity and the meaningfulness of life. Clinicians must be prepared to be involved in a long-term therapeutic relationship due to the chronic nature of PTSD, to understand Cambodian cultural beliefs and practices, and to synthesize an effective balance between

the Western biopsychosocial model and traditional Cambodian health care theories and practices (Boehnlein 1987a, 771).

Implications for Service Utilization

In a qualitative study conducted with thirty Cambodian refugee women in Southern California, data were gathered regarding health care decision making for 226 illness episodes which occurred among 157 family members (Frye 1990). The majority of women making health care decisions used services that they viewed as culturally compatible. They employed traditional home remedies and/or sought the help of a physician who spoke their language and was experienced at providing "cultural comfort". Although many primary and tertiary care facilities were within a five mile radius of their homes, these facilities were not perceived as "comfortable or accessible", and as a result most women drove sixty miles or more to obtain culturally sensitive health care (Frye 1990, 117).

Cambodians' reluctance to use mental health services may be attributed to the scarcity of culturally, linguistically and physically accessible psychological counseling services for Southeast Asians (Gong-Guy et al. 1991 and Vernez 1991 cited in Carlson and Rosser-Hogan 1993). Moreover, few mainstream providers seem to recognize or appreciate the cultural stigma associated with mental illness within traditional Southeast Asian societies which prevents refugees from seeking treatment for fear of shame and community disapproval.

There are, in addition, cultural differences in regards to treatment priorities which also contributes to the lack of successful treatment (Gong-Guy et al. 1991 cited in Carlson & Rosser-Hogan 1993).

Case examples in this study underscore that taking the patients' constructions and attributions into account, as well as linguistic and cultural accessibility, and comfort of service provision are key elements in promoting service utilization among Cambodian patients. For example, participant Chanda⁶ said:

People would say this clinic is good, people really care for you here ... I went to almost every clinic, at that time, as long as they had a Cambodian interpreter.

⁶ The name of this participant was changed to protect her privacy.

CHAPTER 2: CULTURAL IMPERIALISM: THE HISTORIC GEO-POLITICAL CONTEXT OF WAR IN SOUTHEAST ASIA

*Our deepest fear is not that we are inadequate.
Our deepest fear is that we are powerful beyond measure.
It is our light, not our darkness, that most frightens us.
We ask ourselves, who am I to be brilliant, gorgeous, talented, and
fabulous?
Actually, who are you not to be?
You are a child of God. Your playing small doesn't serve the world.
There's nothing enlightened about shrinking so that other people
won't feel insecure around you.
We were born to make manifest the glory of god that is within us.
It's not just in some of us; it's in everyone.
And as we let our own light shine, we unconsciously give other
people permission to do the same.
As we are liberated from our own fear, our presence automatically
liberates others.*

Nelson Mandela, 1994 Inaugural

The continued suffering of traumatized Cambodian refugees in this country is not a function of mere local circumstance, for such suffering can be clearly and emphatically linked to the geo-political events spawned by the struggle for economic, political and ideological hegemony between the superpowers, their allies and client states. This is not to say that the Cambodians as well as Laotian and Vietnamese people were perfectly content with their lot prior to the First and Second Indochinese Wars, or that the Western governments represented the sole exploitative, oppressive force ever to enter these countries. For example, internecine warfare and oppression from within by competing elites has been a chronic feature of the histories of the nations of

the area, as is true throughout the world. But, as will be described in the section on the history of Cambodia, foreign domination was a constant threat throughout history and the particular imperialist endeavors of Europeans and Americans provide the proximate historical context that must be understood for an adequate accounting of the plight of Southeast Asian refugees.

This chapter describes and examines the involvement of Western powers in Southeast Asia beginning with French colonialism, whose declared intent was to protect the “primitive” Southeast Asian states against neighboring aggressors and the ignorance of their own citizenry. As French imperialist avarice for economic gain and power became increasingly obvious, their colonial control in Indochina was transformed, with assistance from the United States, into an ideological struggle between communism and democracy. The possibility that colonized states would engage in prolonged struggle to throw off the imposed benefits of Western colonial powers seems not to have played a meaningful role in the minds of European and American policy makers. The prevailing zeitgeist, with its tendency to construct world events into a simplified struggle between the virtues of democracy in life or death conflict with the evils of communism, seems to have obviated whatever historical consciousness available to those seeking ideological domination through making total war on poverty ridden colonized states.

This overview addresses the larger historic context of French and U.S. involvement in the First and Second Indochinese Wars, particularly the interrelated Vietnamese and Cambodian struggle for survival against Western imperialist forces. It then focuses on the unique historical oppression which Cambodia experienced in relation to her neighbors and the impact of United States imperialist intervention, which triggered the Khmer Rouge take over and ensuing genocide. This historic overview provides the background necessary for an adequate understanding of the forces unleashed during the Second Indochina War, their antecedents and, perhaps most importantly, the heritage of conflict which is part of the psychoemotional legacy carried by all Southeast Asian survivors of that conflict.

Beneath this surface struggle, the core constructs of white racism and cultural imperialism permeate the historic context and continue to influence current social structures. Young (1990, 122-123) formulates racism as a kind of oppression encompassed in the general forms of cultural imperialism and violence. In practice, cultural imperialism involves a group being invisible at the same time it is targeted and stereotyped. Young (Ibid.) pinpoints the characteristics of cultural imperialism, saying:

Culturally imperialist groups project their own values, experience, and perspective as normative and universal. Victims of cultural imperialism are thereby rendered invisible as subjects, as persons with their own perspective and group-specific experience and interests. At the same time they are marked out, frozen into a being marked as Other, deviant in relation to the dominant norm. The dominant groups need not notice their

own group being at all; they occupy an unmarked, neutral, apparently universal position. But victims of cultural imperialism cannot forget their group identity because the behavior and reactions of others call them back to it.

She further points out that a critical component of this oppression is, "... the group-connected experience of being regarded by others with aversion." This reaction of aversion deeply structures the oppression of all culturally imperialized groups.

Racial oppression, in part, involves being treated with aversion: being feared, hated, seen as ugly or stupid, ignorant and loathsome. Joel Kovel's (1970 cited in Young 1990, 141) study describes white racism's three ideal forms: dominative racism, aversive racism and metaracism. Dominative racism manifests itself in enslavement, forced labor, race status rules which privilege whites, and genocide. Aversive racism plays itself out in avoidance and separation. In metaracism, all traces of racial superiority appear to be non-existent, "... only the grinding processes of a white-dominated economy and technology account for the continued misery of many people of color" (Ibid.).

In this chapter and the following one, the process of oppression via cultural imperialism and dominative racism is traced through historic events leading to the Cambodian holocaust and examined in terms of the continuing oppression to which refugees are subjected in national immigration policy.

The First Indochina War: French Imperialism

Now, the supreme requirements of generalship are a clear perception, the harmony of his host, a profound strategy coupled with far-reaching plans, an understanding of the seasons and an ability to examine the human factors. For a general unable to estimate his capabilities or comprehend the arts of expediency and flexibility when faced with the opportunity to engage the enemy will advance in a stumbling and hesitant manner, looking anxiously first to his right and then to his left, and be unable to produce a plan. Credulous, he will place confidence in unreliable reports, believing at one moment this and at another that. As timorous as a fox in advancing or retiring, his groups will be scattered about. What is the difference between this and driving innocent people into boiling water or fire? Is this not exactly like driving cows and sheep to feed wolves or tigers?

Duke Li Ching of Wei, Sun Tzu, 500 B.C.

Western political domination and manipulation in Southeast Asia was initiated by the French during the 1850s with the conquest of Southern Vietnam and continued for nearly 100 years. Cambodia came under French domination during the 1860s and Laos in the 1890s. The French established a single colonial government, the Union of Indochina in 1897, to efficiently administer their Tonkin and Cochin China colonies as well as their protectorates of Laos, Cambodia and Annam (Karnow 1991, 688).

France maintained a policy of total domination and control toward her colonial possessions. "Assimilation" as well as anything that might permit natives to challenge French authority was proscribed as a way of maintaining

control. The prevailing wisdom suggested that allowing Vietnamese natives access to French culture was like arming the “enemy” against themselves (Short 1989, 22). This form of political control is of considerable interest given France’s oft stated colonial mission of extending the benefits of French civilization to the far corners of the earth. Under this compulsion to control, any individual advocating Vietnamese nationalism was dealt with harshly. Even the collapse of France in June of 1940 to the German army did not deter French forces from suppressing insurrections at Lang Son on the Chinese border in September of 1940 and in Cochinchina in November of 1940 (Short, 33).

French determination to retain her colonies was answered by the ever-strengthening tenacity of nationalist Vietnamese resistance and revolutionary activity. In 1940, after 30 years of active involvement with the French, Russian and Chinese Communist movements, nationalist leader, Ho Chi Minh returned to Indochina to continue the resistance against Western imperialism. Joined by Vo Nguyen Giap and Pham Van Dong, Ho formed the League for the Independence of Vietnam (the Viet Nam Doc Lap Dong Minh or Vietminh⁷) in preparation for the *thoi co*, “moment of great opportunity” to be liberated from French domination (Short, 33-34). Historic interpretations indicate that Ho Chi Minh and the

⁷ Vietminh-founded by Ho Chi Minh in May 1941, was the communist coalition that ruled the Democratic Republic of Vietnam (DVR), established September 2, 1945 and the designation for Vietnam since 1975.

Vietminh leadership, expected that their restraint and reasonableness would ultimately succeed in convincing the French and their allies of the Vietnamese cause.

Unfortunately, France had no intention of relinquishing control of Indochina. After all, the resources of Indochina played an integral role in French plans to rebuild her war-shattered economy. In a ruse to placate the colonies, the Provisional French Government was established on March 24, 1945. In this declaration, Vietnam, Cambodia and Laos were promised “appropriate liberty” as members of the French Union, however, French plans and actions in no way supported their full independence (Short, 47-48)⁸.

At the close of World War II, when Japan formally surrendered to the Allies, Ho Chi Minh saw his opportunity to declare Vietnam an independent state. He hoped that the support of the U.S., “a democracy without territorial ambitions” (Karnow 1991, 163), would place pressure on France to rethink her colonial policies. However, the restoration of French rule in Vietnam was deliberately condoned by American as well as British leadership (Karnow, *Ibid.*). Both Great Britain and the U.S. were deeply concerned about the ability of a war shattered European economy to resist the overtures of communism and sought

⁸Anthony Short and Stanley Karnow in their respective works cited here provide more detailed descriptions of French motivations to remain in control of Indo-China.

to assist France to rebuild her colonial empire as a means of strengthening her role in the cold war.

Following a series of violent clashes between rival Vietnamese factions, and the Vietminh and the French, on September 22, 1945, French soldiers joined by French civilians rampaged through Saigon (Karnow 1991, 164). They ousted the Vietminh Provisional Executive Committee from Saigon city hall, took over police stations, public buildings, broke into Vietnamese homes and shops, and indiscriminately brutalized men, women and children⁹. Karnow's account suggests that this attack and the ensuing general strike called by the Vietminh, more than any other incident, marks the beginning of the First Indo-China War.

In negotiations to stem continuing violence, Ho Chi Minh made major concessions to the French, while he bought time to strengthen the Vietminh and cleverly found a way to eject the Chinese Nationalists¹⁰ rather than chance their

⁹ Karnow describes retaliatory carnage on both sides.

¹⁰The Potsdam agreement of W.W.II had assigned the Chinese Nationalists to disarm Japanese troops in northern Vietnam and Great Britain in southern Vietnam. Ho Chi Minh was careful to handle the Chinese with care when they entered Hanoi. In permitting the French to stay, he cleverly expelled the Chinese, who he feared more than the French. When criticized he said, "You fools! Don't you realize what it means if the Chinese remain? Don't you remember your history? The last time the Chinese came, they stayed a thousand years. The French are foreigners. They are weak. Colonialism is dying. The white man is finished in Asia. But if the Chinese stay now, they will never go. As for me, I prefer to sniff French shit for five years than eat Chinese shit for the rest of my life."

indefinite stay. On March 6, 1946, Ho agreed that reunification of Vietnam (Tonkin, Annam and Cochin-China) would be determined by referendum, that Vietnam would be recognized as a free state within the French Union, and the French would be permitted to return to Vietnam for five years with 25,000 troops. Although Ho was greatly criticized by militants within the Vietminh for this accommodation, and personally regretted the need for this decision, under the circumstances, he had made the most strategic decision possible.

Months of unyielding negotiations had made it clear to the Vietminh that France was determined to keep Indochina without regard to the will of the Vietnamese people and at all costs. This was evidenced by the installation of de Gaulle appointed Admiral Georges Thierry d'Argenlieu as high commissioner of Indochina (Short 1989, 55), whose attitude was to teach the colonies a lesson through brutal force. By November 1946, clashes at Haiphong escalated the conflict. The First Indochina war had begun.

Ho Chi Minh and the Vietminh had indicated on several occasions their willingness to develop a plan for French departure, and requested U.S. help in finding a solution, but the French and their allies considered negotiation with communists against their principles (see Karnow and Short for details). Vietminh efforts to reach an accord and have their grievances heard by the world at-large were ignored and thwarted. The attitudes and actions of the Western leadership

demonstrated that Vietnamese desires for peace, stability and democracy were of no concern to the Western powers.

In the midst of the intensifying cold war, the United States was secretly financing the French in their effort to maintain colonial possession of Vietnam (Karnow 1991, 192). Between 1950 and 1954 the U.S. spent almost \$3 billion to aid the French in Indochina. By January, 1954, unable to finance and equip their own war, and surrounded by Vietminh ground forces at Dienbienphu, the French were in serious trouble. The Eisenhower administration set up a Special Committee on Indochina to deal with the French request for aircraft, carriers and mechanics (Short 1989, 127-128). Although the U.S. Senate Armed Services Committee was not pleased with this development, neither were they in favor of a negotiated peace, preferring to hold out for a clear French victory. Committee members like Senator Mansfield considered continued French hegemony in Indochina important enough to provide another \$120 million to the effort and promised more if needed (Ibid.).

The turning point of the war came on March 13, 1954, at Dienbienphu when General Vo Nguyen Giap launched what proved to be the final and decisive attack against the French. Contrary to China's advice and what the French expected, Giap had decided to avoid a headlong charge and chose a strategy of cautious planning and preparation which took nearly two months. The plan involved moving ordinance to higher ground to fire on French posts

while the infantry crept through several hundred miles of underground tunnels surrounding Dienbienphu (Karnow 1991, 210-211).

On May 7, 1954, after 57 days of siege, the French were defeated by the Vietminh. In the subsequent Geneva agreements of July, 1954 the war in Vietnam, Cambodia and Laos was officially ended and the independence of each country recognized (Karnow, 220). Vietnam was temporarily divided at the 17th parallel pending national election in 1956, and French troops were withdrawn from the North and the Vietminh from the South.

The Second Indochina War: Power and Ideology

U.S. Leadership

Throughout the Eisenhower presidency (1952-1960), governmental debate raged regarding how much involvement the U.S. should have in Indochina. Eisenhower supported the prevailing wisdom that any sort of open intervention would entail an escalating commitment for which the U.S. public was not prepared (Short 1989, 146-147). However, many members of the Eisenhower cabinet including Secretary of State John Foster Dulles, Howard Stassen, Richard Nixon, and members of the State Department favored some type of intervention (Ibid.).

John F. Kennedy, elected to the presidency in 1960, was not willing to plunge the country into another war, however, he was also determined not to

withdraw from Vietnam (Karnow 1991, 264-267). His strategy was to engage in counterinsurgency against communism by creating a task force which would bolster the economic, social political and military programs of South Vietnam. In doing so, however, the U.S. steadily found itself mired in what President de Gaulle warned would be, "a bottomless military and political swamp" (Ibid.).

Deception, Miscalculation, and Cultural Imperialism

Although standard history books proclaim January 2, 1963 as the date the U.S. officially entered the Second Indochina War, January, 1955 is the date Congress began to funnel direct monetary aid to the Saigon government and agreed to train the South Vietnamese army (Karnow 1991, 692). This deceptive manipulation of history unravels the myth that U.S. involvement in Southeast Asia came only after the crisis of President's Diem's death or that it was precipitated by the Tonkin Gulf incident.

Both Indochinese Wars were a series of disastrous multilevel miscalculations and presumptions about the enemy based on French and American military arrogance and ill-conceived plans to dominate the Southeast Asian states. Many critical decisions made regarding United State's commitment to war in Vietnam were grounded in the assumption that if one country neighboring Mao's China fell to communism all countries in the area would be brought down, hence the "domino theory". Throughout this tragic era, the U.S.

consistently confused the nationalist aims of movements like the Vietminh with purely communist insurgency targeted on the advancement of that political ideology. For the duration of the conflict, Nationalist Vietnamese aims were confused with the interests of both the Peoples Republic of China and the Soviet Union. Many believed that the Vietnamese insurgency was simply a cover for Chinese invasion of Southeast Asia.

U.S. leadership was uninterested in information that could have provided critical insight into understanding why the Vietnamese resisted foreign influence and the long standing nationalism that supported such resistance. In a mind set replete with racism, ethnocentrism and cultural arrogance, American planners dismissed the possibility that Vietnamese leadership and citizenry were capable of conducting an intelligent war, let alone winning it. These sentiments were uncannily reminiscent of U.S. sentiments before W.W.II which suggested that Japanese could not successfully engage in aerial combat because of congenitally deficient eyesight. The U.S. leadership purposefully ignored the historical reality that the Vietnamese interest in communism and nationalism was motivated by the universal hunger of colonized peoples for freedom from oppression. These failures, among others, reveal critical elements of underlying cultural imperialist beliefs and processes.

Guided by erroneous notions of superiority, a clear understanding of the historic relationships between the peoples of Southeast Asian was neither

sought nor considered by U.S. leadership. If such an understanding had been sought and valued, it would have revealed that the Chinese and Vietnamese had long been enemies; that Chinese imperialism had been resisted for over 1600 years and had galvanized nationalistic resolve in Vietnam. Such inquiry would have revealed that it was simplistic to assume that distinct ethnic groups such as the Khmer, Hmong, Annamese and Chinese, historic antagonists for territory, would lock step into a common communist ideology and purpose. More likely, the threat that would propel them toward communism was Western imperialism.

Similarly, the U.S. and French military underestimated the leadership of men like General Giap, and the indefatigable motivation of Vietcong¹¹ soldiers to do the "impossible". Secretary of Defense, Robert McNamara, during a trip to Vietnam in May 1962, evaluated the situation by saying that, "every quantitative measurement ... shows that we are winning the war" (Karnow 1991, 271). But as Karnow aptly points out, neither McNamara nor other government policymakers were able to measure qualitatively the strength of the Vietcong motivation to succeed. At the military ground forces level, Americans made the error of ascribing their own practices and reasoning to the Vietminh.

¹¹ In use since 1956, Vietcong was originally a derogatory reference to members of the National Liberation Front (NFL) whose goal was to overthrow the government of South Vietnam in order to reunite both North and South; its members were Communists and non-Communists; a contraction for Vietnam Cong Son (Vietnamese Communist).

In 1946, Ho said, "You can kill ten of my men for every one I kill of yours, but even at those odds, you will lose and I will win" (Karnow 1991, 20). In this statement lies the essence of what Americans did not understand about the strength that many Asian societies and cultures derive from long periods of suffering.

Another important oversight was the U.S. leadership's failure to heed the well-founded observations of several U.S. government and military officials, as well as many civilians, that South Vietnamese at all levels of society had lost faith in President Ngo Dinh Diem, a fervent anti-Communist puppet chosen by the U.S.

On June 1, 1966, Thich Nhat Hanh, a Vietnamese Zen Buddhist monk, read a statement at a press conference in Washington, D.C. which was reprinted in the Congressional record. In his statement, he asked that U.S. military forces cease bombing North and South Vietnam, and cease fire if the Vietcong responded in kind. He asked for a clear statement and demonstration of U.S. desire to help the Vietnamese people. Part of what Thich Nhat Hanh, so eloquently, said was:

If anti-Americanism seems to be emerging as a focus for some of the recent protests, it is because the Vietnamese people recognize that it is really only the awesome U.S. power that enables the Saigon governments to rule without a popular mandate and to follow policies contrary to the aspirations of the Vietnamese people. This is not the independence for which the Vietnamese people fought so valiantly.

The war in Vietnam today pits brother against brother, the Vietcong against the supporters of the Saigon government. Both sides claim to represent the Vietnamese people, but in reality neither side does. The most effective Vietcong propaganda says that the Saigon governments are mere puppets of the U.S., corrupt lackeys of the imperialists.

Every escalation of the war, every new contingent of U.S. troops confirms these charges and wins new recruits to the Vietcong, for the overwhelming majority of the Vietnamese people now thirst desperately for peace and oppose any further expansion of the war. They see clearly that the present policy of constant escalation only puts peace even further into the future and merely guarantees an even greater destruction of Vietnamese society. There are now more than 300,000 Americans in my country, most of them knowing and caring little about our customs and practices and many of them involved in destroying Vietnamese people and property.

This creates friction which generously feeds the anti-American propaganda, and the fact that the war kills far more innocent peasants than it does Vietcong is a tragic reality of life in the Vietnamese countryside. Those who escape death by bombings must often abandon their destroyed villages and seek shelter in refugee camps where life is even more miserable than it was in the villages. ..

To us, America's first objective is to have an anti-Communist, or at least a non-communist, Vietnam, whereas the Vietnamese people's objective is to have peace. They dislike communism, but they dislike war even more, especially after twenty years of fighting and bitterness which has rotted the very fabric of Vietnamese life. Equally important, we now see clearly that continuance of the war is more likely to spread communism in Vietnam than to contain it (Nhat Hanh 1993, 50-52).

Despite such warnings, the U.S. leadership rigidly clung to the belief that the war could be won because of superior military resources and prowess, and cultural superiority supported by the might of democratic ideology. By 1970 with mounting civil unrest against the war within the U.S. and anti-American feelings

at their peak in South Vietnam, the U.S. via Secretary of State Henry Kissinger began secret talks in Paris with Le Duc Tho.

The escalation of the Second Indochina War in Vietnam and its major dynamics provide a needed backdrop for understanding the eventual spread of the conflict into neighboring states. Moreover, as indicated earlier, such information is vital to the process of *amanuensis* which some have suggested is integral to assisting people heal the mental and spiritual wounds of war. Such witnessing, with information sufficient to allow understanding of the degree of hurt, the extent of pain, the causes of suffering and the sources of existential malaise and confusion, depends on great understanding of the geopolitical contexts and historical events which, in the aggregate, provides the fabric from which human experience is tailored.

Prelude to the Cambodian Holocaust

Knowledge of Cambodia's complex history is an essential prerequisite to understanding the current state of its people. For over 400 years foreign governments such as Thailand, Vietnam, France, China, Japan, the Soviet Union and the United States were either directly involved in Cambodia's affairs or conducted "proxy wars" within its borders (Haas 1991). These intrusions, along with complex internal factors, eventually, unleashed the rage of the Pol Pot regime. Anthropologist E. T. Hall (1977) has observed that,

"...powerlessness and lack of self-affirmation lead to aggression." And that rage which engulfed so many millions in forms of barbarism unparalleled in modern times was the experiential context which shaped the lives of Cambodian refugees residing in the U.S. This history is a critical part of their lives and their truths must guide our work.

Cambodia's History

At its zenith in the 12th century, the Khmer empire, encompassed all of what is currently known as Cambodia, parts of Burma, Laos, Malaysia, Thailand and the southern portion of Vietnam, once known as Kampuchea Krom (Haas 1991). Thai aggression from Southwest China in the 13th century resulted in the Khmer abandoning Angkor as their capital, and moving to Oudong by 1431, and later to Phnom Penh. During the 17th century, the Khmer King Chettha II married a Vietnamese princess from the Annam court at Hue, instigating a series of intrigues between the royal sons which involved control of Cambodia, the throne, as well as Vietnamese and Thai interests in Cambodia. In 1674, Chey Chetta IV became King of Cambodia, aided by the Thai's who held the Annamese at bay, while encouraging Cambodian civil war. However, Cambodia remained subservient to Annam (later called Vietnam), which by 1780 controlled the Mekong Delta portion of Kampuchea Krom.

The Thai and Vietnamese were in constant competition for Cambodian territory at their southern borders, however, they were also involved in warding off enemies on their respective northern frontiers. At the beginning of the nineteenth century, Siam was victorious over Burma, and Vietnam was unified in 1802 by a victory over the Tonkin kingdom. In 1845, the Siamese-Vietnamese war ended in a draw, leaving Cambodia as a pawn between both countries (Haas 1991).

In 1850, the French hopes for Southeast Asia as open territory between India and China, led to their attack on Danang. The near by Nguyen dynasty of Hue, which was suffering from peasant revolts, saw in French policy an opportunity to stabilize their rule. The Nguyens invited French support for their dynastic ambitions and this *invitation* initiated French colonization of Kampuchea Krom in 1863, which was renamed "Cochin China". Like a spreading plague, the French established Cambodia as a protectorate in 1864, and although King Norodom signed a secret treaty with Siam to avoid subordination, the French were able to extricate the Thai from involvement. With French troops posted in Phnom Penh, the king agreed to cede more of the eastern portion of Cambodia to the French Cochin China colony.

The French maintained direct rule over Cochin China during World War II. Failing to manipulate Khmer labor in their interests, the French brought in Vietnamese to run the civil administration of Cambodia and work the rubber

plantations (Haas 1991). In 1940, after Hitler invaded France, the Thai's attempted to regain Angkor and Battambang and eventually succeeded in an alliance with France. In 1941, King Sisowath Monivong died and the French invited eighteen year old Norodom Sihanouk to become the Cambodian ruler.

In 1940, Khmer émigrés in Bangkok formed the Khmer Issarak (Independence) Movement under the Buddhist monk, Son Ngoc Thanh, who was forced by French authorities to escape to Japan. However, Cambodian communists remained under Ho Chin Minh's influence during W.W.II.

As indicated earlier, Vietnamese resistance to French colonialism began to take shape in 1930 when Ho Chi Minh founded the Vietnamese Communist Party (VCP), which later became the Indochinese Communist Party (ICP) in order to include Cambodians and Laotians. In 1941, Ho began the Vietnamese Independence League or Vietminh, which relied initially on Republic of China (ROC) aid. In July 1945, Franco-American forces joined the Vietminh to expel the Japanese from Hanoi. With the end of W.W.II in August of 1945, Ho proclaimed the formation of the Democratic Republic of Vietnam (DVR).

From 1945 to 1955, those world powers with influence or interests in Southeast Asia were entangled in the affairs of the region. France promised to recognize Ho's DVR as an independent state, and to move toward reunification of the country within an Indochinese federation of states much like the British Commonwealth of Nations. But these promises were forgotten when the French

determined that an independent Republic of Cochin China was of more value to them. In 1947, Ho Chi Minh sought the help of the United Nations and asked to join the French Union on condition that France would unify all of Vietnam into one state. The French refused, the UN did not respond and war ensued. The French installed Bao Dai as proxy emperor of the united Vietnam in 1949.

During this period of French control of Vietnam, Cambodia was granted more authority over its own affairs. King Sihanouk instituted a constitution, elections, parliament and political parties. The French made Cambodia a state in the French Union in 1949 in order to hold the Vietminh in check.

Communism in Cambodia

In 1946, Ho Chi Minh provided financial support to the communist Cambodian resistance. However, it must be noted that Cambodians were politically divided into the Khmer Issarak in the west, Communists in the east, democratic dissidents in Phnom Penh and scattered Buddhist dissidents. Other groups formed as well, for example, the Nekhum Issarack Khmer (Khmer Freedom Front) on the Thai border and the Khmer People's Liberation Army, which was part of the Vietminh, on the Vietnam Border. This factioning led to the First National Congress of Khmer Resistance which met in 1950 and formed the United Issarack Front or UIF.

A new generation of Cambodian Communist Party members returned from education in France around 1953, among them were Saloth Sar, who later took the identity of Pol Pot, Khieu Samphan, Ieng Sary and Son Sen. These men had no relationship with the Ho Chi Minh-supported ICP members and chose to attack these individuals as traitors and collaborators of the Vietnamese. In 1960, Cambodian Communists reorganized themselves as the Worker's Party of Kampuchea (WPK) with the hope that the DRV would help them. Saloth Sar, a member of the Central committee, was at that time eager to take over control of Phnom Penh. In 1966 the WPK reorganized again and became the Communist Party of Kampuchea (CPK). In the same year the CPK lost the election to conservative candidates. General Lon Nol became premier under Sihanouk.

The Cambodian economy began to falter in the late 1960s and Sihanouk increased taxes and decreased the military budget. The military take over of the rice trade caused peasant uprisings in 1967 and 1968, which led to the slaughter of innocent people. Sihanouk and Lon Nol blamed the communists for the demonstrations and rounded up CPK members for execution. The CPK went underground and formed the Revolutionary Army of Kampuchea (RAK) and Saloth Sar was transformed into the radical revolutionary Pol Pot.

On March 18, 1970, Lon Nol ousted Sihanouk and declared himself president of the Khmer Republic. This corrupt government with its weak economy and increasing RAK insurgent activity was a tinder box. Pol Pot

refused any negotiation efforts suggested by the U.S. Supported by Hanoi, RAK leaders sought self-sufficiency, the abolition of a money economy and private property, the ban of travel between security zones, and the collectivization of land. On April 17, 1975, in violation of the agreement to cease fire against the Khmer Republic, Pol Pot led RAK forces into Phnom Penh. On April 30, 1975 President Nixon announced that American and South Vietnamese forces had attacked Communist sanctuaries in Cambodia. It was later revealed that the U.S. had supported counter-insurgents in Laos, conducted extensive secret bombing of Cambodia and supported the Lon Nol government. The upheaval which resulted in Laos and Cambodia can be directly traced to the U.S.-conducted proxy war against communism. In Cambodia, this interference resulted in appalling destruction of the fabric of life in a centuries old society.

The Fall of Phnom Penh: Enter the Khmer Rouge

In April of 1975, Khmer Rouge revolutionaries effectively defeated the U.S. backed forces of Lon Nol and entered the capital of Phnom Penh to take control of Cambodia. Their seemingly peaceful entry into the city gave rise to some brief rejoicing in the streets. But the atmosphere quickly turned to fear, terror, and panic, as expressionless, intense, young Khmer Rouge, barely in their teens, dressed in black, carrying grenades and assault guns moved door to door directing residents to leave their homes immediately (Ponchaud 1977).

The entire city was emptied, thousands of Cambodians were forced to relocate on the pretext that they would return in a few days because, "...the Americans were going to bomb the city." In reality, the Khmer Rouge intended to eliminate their "enemies" and relocate the population to villages for work and reeducation for Angkar (the organization, party and state).

Many died during the forced removal as a result of starvation, illness, and murder. Terrorized at gun point, children were forcibly separated from their parents, the infirm were forced to leave hospitals regardless of their condition, and those that refused were killed. An escapee recounted of the march out of Phnom Penh:

Here and there we could see the bodies of villagers who had been killed by the Khmer Rouge, presumably because they didn't want to leave their homes.

On April 19, at ten in the morning, I saw the Khmer Rouge arrest about twenty young men with long hair; they shot them before our eyes.

Everybody was terrified and had their hair cut at once, even in the middle of the night.

When we got to Ang Long Kagnanh (10 kilometers from Phnom Penh) the road was blocked by Khmer Rouge who searched us, tore off wristwatches, and took away radios, necklaces, and gold rings. They told us the Angkar needed them and was only borrowing the jewels for a while but would give them back later. From there we were made to turn back to Highway 5. We reached Prek Phneuv on April 25 ... (Ponchaud 1977, 26).

This reign of terror under Pol Pot's direction sought to eliminate "enemies" of the Khmer people. Enemies were defined as capitalists including shopkeepers and traders, feudalists among whom were counted Buddhists,

intellectuals and royalty, imperialists, which included ethnic minorities, and anyone who dressed or spoke differently from the Khmer (Haas 1991). These designated enemies of Angkar were hunted down and systematically executed with entire families tortured and murdered.

The Holocaust

Conservative estimates are that over one million Cambodian men, women and children died as the result of murder, torture, starvation and disease during the purge of Pol Pot's killing fields (Jackson 1989), while other estimates suggest 3 million Cambodians died (Kinzie 1989). Thus, less than 6 million of the 7.3 million Cambodians alive on April 17, 1975 when the Khmer Rouge took over, remained alive after their departure in 1979 (Jackson 1989, 3). The horror and devastation of the Cambodian holocaust remained largely out of the American consciousness until 1984 when the movie, "The Killing Fields" brought the atrocities to our attention.

Over 150,000 Cambodian refugees have resettled in the United States since 1975. At extreme peril to their lives, Cambodians fled on foot, in many cases over half the breadth of the country (200 miles), to the Thai and Vietnam borders. These survivors of the Cambodian holocaust endured a wide range of life-threatening and traumatic experiences. They were dislocated from their homes, forcibly separated from their children and other family members, watched

family members taken to their death, given little or no food, denied medical care, tortured, raped, witnessed mass executions, or the murder of individuals who did something minor, like covertly eating a grasshopper (Martin 1994, 194).

The escape from Cambodia was equally torturous. The conditions and experiences encountered at refugee camps prolonged or increased distress. The final leg of a survivor's journey to freedom and relocation in a new country involved new challenges. These challenges included adjustment to new cultures, acculturation stress, accelerated modernization, minority status, social isolation, status inconsistency, dealing with loss and grief, and the long-term impact of traumatic experiences (Lin 1986).

In the wake of this human devastation, Cambodians have sought to rebuild their lives in and away from their motherland. Many who sought refuge overseas hope to return one day, others say they will never return, for there are too many painful memories, too much to forget (Cambodian residing in San Francisco, personal communication, April 1995). Many survivors have been able, in some way, to "move on" or "deal with" their experienced traumas, however, others continue to suffer from the aftereffects of trauma. A Khmer Buddhist monk observes that, although Western psychiatry and medicines have been helpful in alleviating some symptoms, such as sleeplessness, these treatments have not been effective in facilitating the long-term *healing* that needs to occur (Khmer Buddhist monk, private communication, Seattle, May, 1995).

Currently these ways of dealing with trauma are described from a western theoretical perspective, and a comprehensive view of cultural context in understanding illness and healing is only now being pursued.

The complicated web of events described in this chapter, was triggered by colonialization, and advanced into an ideological struggle between communism and democracy without regard for the will of Southeast Asian people. Grasping the specificity of historic events and relations is critical to understanding why Southeast Asian refugees are in this country, and more importantly, the significance of our obligation to these refugees. This geopolitical context, however, is merely a portion of the total context within which Southeast Asians, and more specifically Cambodian refugees, were traumatized and are attempting to heal. The development of discriminatory immigration policies in the U.S., as will be discussed in the following chapter, had direct links to foreign policy, and the control of racial and ethnic groups entering this country. These discriminatory immigration policies were extended to Southeast Asian refugees, who, despite our alleged commitment to their welfare, have become trapped within the dominant culture's oppressive social structures.

CHAPTER 3: PERPETUATING OPPRESSION: UNITED STATES IMMIGRATION-REFUGEE POLICY

*The bosom of America is open to receive not only the
opulent and respectable stranger, but the oppressed and
persecuted of all nations and religions.*

President George Washington, 1783

In the United States structures of social oppression exist at many levels. One such structure is U.S. immigration and refugee policy, which continues to be an instrument of exploitation and cultural imperialism¹².

This chapter examines the history of U.S. immigration and refugee laws as they relate to Asians and can be linked to the position of powerlessness in which the structure places refugees and immigrants at both national and international levels.

The critical research framework forces the investigator to examine the Southeast Asian refugees' condition, not merely within its historic context, but through the examination of how oppressive structures emerged and the extent to which prevailing structures are sustained throughout history. The pieces of this examination do not fit neatly together, because the objective is not to solve a

¹² For complete explanations of exploitation, marginalization, powerlessness, violence and cultural imperialism see I. M. Young's, Justice and the Politics of Difference (Princeton: Princeton University Press, 1990).

particular problem, but to examine the circumstances within which refugee trauma occurred and is perpetuated (Harvey, 28).

Historical Genesis of Oppressive Policies

As a newly formed republic the United States did not always welcome the oppressed. In 1798 the U.S. congress passed four acts known as the Alien and Sedition Acts, which were supported by the Federalists in an effort to incapacitate their Democratic-Republican political opponents who were supported by radical immigrants largely from Ireland (Borden 1996). Although these acts were repealed or allowed to expire when the political tides turned and the Republicans came to power in 1800 (Borden 1996), these events foreshadow the politicization of refugee and immigration policy in which decisions allowing particular refugee groups' asylum are guided more by domestic politics and foreign policy (Zolberg 1988, 650) than humanitarian commitment.

Until the end of the 19th century, immigration into the United States primarily from Northern Europe remained unrestricted. During the 1880s, laws were enacted to prevent criminals, prostitutes, those who were unable to support themselves and other undesirables from entering the country (Abrams 1984, 108). Simultaneously, congress granted an exemption for those who sought "to avoid persecution or punishment on religious or political grounds" (Hutchison,

1981 cited in Zolberg 1988, 653). However, by 1893, the ideological threat posed by “anarchists” against private property caused U.S. foreign policy to tacitly approve the repression of radicals in other countries, and considered them undesirables, no longer eligible for refugee status under our laws (Zolberg, 654).

Nativist sentiment toward immigration policy continued to be a major determining force, which waxed and waned depending on arguments posed by those who required cheap labor and those that saw immigrants as a threat to their livelihood in competition for the same jobs. In this era, policy makers and profiteers joined forces to manipulate immigration so that it could be exploited to benefit the economic development of this country.

Controlling the Yellow Hordes

Prior to the mid-19th century, Asian immigration to the United States was rare. Beginning in the 17th century, the Japanese, Koreans and Chinese enforced formal isolationist policies by execution of émigrés upon their return (Hing 1993, 19). The Japanese, fearing the encroachment of foreign governments, prohibited emigration until 1868 (Ichihashi 1915, 1-3, cited in Hing 1993, 237). Korea was known as the Hermit Kingdom during two and a half centuries of self-imposed isolation following the invasion of the Manchus in 1627 and 1636 (Choy 1979, 19, Kim 1971, 3, Kitano and Daniels 1988, 107 all cited in

Hing, 237). And China under the Quing dynasty (1644-1911) banned emigration or exiles until the Burlingame Treaty in 1868¹³ (Tsai 1986, 8-11, Hsu 1975, 4 all cited in Hing, 237).

The isolation of China, Japan¹⁴ and Korea¹⁵ was not to last for long as political, economic and external forces came to bear. In China, isolationist

¹³In the Burlingame Treaty between the U.S. and Chinese governments, China agreed to permit her citizens to emigrate. The U.S. congress was exceptionally pleased with this agreement, anticipating the benefits of free trade and insinuating that, "... the removal of surplus population of China" would be of mutual benefit to both countries (Hing 1993, 22).

¹⁴19th Century Japan was opened to foreign trade by the ships and guns of Commodore Perry in 1853. In the 250 years prior to his visit Japan remained isolated from foreign influence under a policy imposed by the Tokugawa shogunate. In 1868, a group of samurai from western Japan succeeded in overthrowing the Tokugawas and began the restoration of an imperial government (Meiji Restoration) ending the rule of samurai and the feudal economy (Tamura 1994, 9).

Aware of China's inability to control foreign influences, Japan's leaders began a program to transform the country into an industrial and military power capable of repulsing Western imperialism. To fund this ambitious program, in 1873 the government imposed heavy taxes based on land value rather than on the value of the past year's crops. This had a devastating effect on farmers, between 1883 and 1890 over 367,000 farmers were brought to financial ruin and lost their land for failing to pay taxes (Tamura 1994, 9).

¹⁵Between 1903 and 1920, approximately 8,000 Koreans left their home land for the islands of Hawaii (Takaki 1990, 53). These immigrants came to escape Japanese imperialism and persecution, poverty, famine and drought. Many Korean immigrants found opportunities in Hawaii limited and re-immigrated to the west coast states. There they faced many of the discriminatory practices confronted by Chinese and Japanese: racism, exclusion from services, disrespect, cruelty, physical violence, hatred, exclusion from citizenship, restricted employment opportunities, and exclusion from land ownership. The first generation of Koreans in America found solidarity in their emotional

policies were eroded by a dramatic increase in population (275 million in 1779 to 430 million in 1850) which led to scarcity of food, the ravages of the 1839-42 Opium War with Britain, and the cession of Hong Kong to Britain at the end of the war in 1842 (Hing, 19). The 1850-64 Taiping Rebellion, eventually, opened China to trade and travel.

The discovery of gold and expansion of the American West fueled demand for labor which the Chinese were able to provide cheaply and abundantly. As long as a critical need for exploitable labor existed the Chinese were welcomed and encouraged to settle with state legislative support and promises of land grant incentives (Hing, 20). They were prized as cooks, laundry workers, and servants and found to be indispensable in the completion of the transcontinental railroad. Thus, by 1882 approximately 300,000 Chinese were brought in to work on the West Coast (Hing, 21).

Almost immediately, however, exploitative labor practices which bought Chinese labor for two-thirds the cost of white labor became the source of racial animosity between nativists and all foreign labor. Irish and German miners in California demanded the passage of a foreign miners' tax, which required all non-native born to pay an exorbitant license to mine and effectively forced the Latinos out (Hing, 20-21). As the largest remaining group of foreign laborers,

commitment to liberating their country from Japanese oppression. They considered themselves exiles not immigrants (Takaki 1990, 285).

the Chinese were attacked through anti-Chinese newspaper editorials, "Anti-coolie" clubs, miner and merchant tax laws specific to them.

By 1870, nativist demands denied Chinese the right to citizenship through an amendment to the Nationality Act of 1790. In this amendment, Chinese were described as having "undesirable qualities" (Hing, 23), which made them unsuitable for citizenship through naturalization. Furthermore, to be certain that any doors in family immigration policy were closed, in 1875 Congress passed the Page Law which forbade the entry of Chinese women thought to be "prostitutes"; this law interpreted to an extreme, practically excluded all Chinese women from entering the country.

The furor and fear contrived around the presumed evils of Chinese immigrants culminated in the passage of the Chinese Exclusion Act, on May 6, 1882. This law prohibited the entry of Chinese laborers for 10 years, and with the exception of a small quota of professionals, effectively ended Chinese immigration. The scope and effectiveness of this law notwithstanding, unrelenting fear and paranoia led anti-Chinese movement leaders to press for more legislation, in order to further protect themselves from the yellow peril. For example, the Scott Act of 1888 prohibited the re-entry of all Chinese laborers who temporarily left the U.S. regardless of whether they held a valid re-entry certificate. The Geary Act of 1892 extended the exclusion laws for ten more years, and required the registration of all Chinese laborers since they were

perceived as all looking alike and it was necessary to distinguish those who were illegal entrants. Furthermore, the law denied bail in habeas corpus proceedings, and in its original form, required that an illegal Chinese immigrant be imprisoned to hard labor for up to a year. In 1904, after the Chinese government refused to renew their acceptance of the Geary Act, concessions to the Scott Act were rescinded and an indefinite ban on Chinese immigration was enacted. While anti-Chinese sentiment ran high, and further exclusionary laws were being passed, the presence of European foreigners was not considered a threat (Hing, 24).

Succeeding Asian immigrants, for example, Japanese, Koreans, Filipinos, and East Indians, all encountered short-lived welcomes followed by anti-immigration protest from nativist, exclusionist, and racist elements. By 1884, the Japanese government yielding to internal economic pressures, began allowing her citizens to fill the need for cheap labor on Hawaiian sugar plantations¹⁶. In 1888, the first Japanese labor was introduced in Vacaville, California to pick fruit (Takaki 1990, 29). The success of Japanese farming in California again led nativists and xenophobes to clamor for exclusionary policies. Groups like the Japanese and Korean Exclusion League (later known as the Asiatic Exclusion

¹⁶The Japanese government of the Meiji Restoration (1868) passed the first modern emigration law in 1885, which permitted government-sponsored contract laborers to work on Hawaiian sugar plantations (Hing 1993).

League), Anti-Jap Laundry League, and the Anti-Japanese League of Alameda County sprang up in California (Hing, 28) to fan the flames of anti-Japanese hysteria and resurrect immigration as a political issue.

However, Japan's emergence as a world power demonstrated by her defeats of China in 1895 and Russia in 1905, made exclusionary policies directed at Japanese citizens more difficult to accomplish than with the Chinese. When violent anti-Japanese rioting erupted in the aftermath of the 1906 San Francisco earthquake, Japanese students were segregated by order of the school board. The Japanese government vehemently protested on behalf of her citizens. As a result, President Theodore Roosevelt's administration softened the terms of the Gentlemen's Agreement (1907-08). In exchange for reunification of families with their fathers in the U.S. and removal of the San Francisco school segregation order, Japan agreed to restrict travel documents issued to laborers (Hing, 29).

The progression of anti-Asian immigration policies reached its zenith in the 1930s and was maintained up through 1952. In *United States v. Singh Thind* (1923) the court determined that Asian Indians, like Japanese, were not considered white, and therefore, were not permitted to become citizens. In 1924, the National Origins Quota Act, aimed at limiting the large numbers of immigrating Jews, Italians, Slavs and Greeks, curbed immigrants from any particular country to 2 percent of their nationality in 1890 (Hing, 33). The Act

further barred any "alien ineligible to citizenship". Asians were ineligible under the 1870 law and were, thus, excluded from entry indefinitely (Ibid.).

The repetitive pattern of welcoming groups that appeared exploitable and rejecting them as soon as their tendencies toward resourcefulness or capitalism appeared, played itself out again with Filipinos, the only Asians not affected by the National Origins Act. In 1934, the Tydings-McDuffie Act, supported by exclusionists, anti-colonialists and Filipino nationalists, limited Filipino immigration quota to only 50 visas (Hing, 35).

The onset of World War II gave U.S. foreign policy an increasingly major role in the definition of immigration practices. After the U.S. and China allied themselves against Japanese aggression, the Chinese Repealer, passed by Congress in 1943, eliminated most of the Chinese exclusion laws, allowed Chinese to naturalize, but only provided for a yearly quota of 105 immigrants of Chinese decent. As relations with Asian allies became favorable, the Page Law (in 1945) and the Tydings-McDuffie Act (on July 2, 1946) were also modified to permit spouses and children entry into the country. However, at the close of W.W.II nativist sentiment in U.S. remained strong, relieved by short-lived legislative windows of opportunity such as the War Brides Act (December 28, 1945), the Fiancees Act (June 29, 1946), and the Displaced Persons Act (June 29, 1946) for refugees.

It was not until the U.S., having assumed leadership in the United Nations after W.W.II, received glaring world criticism for its domestic and immigration policies, that policy makers began to seriously reflect on the implications of such practices in the climate of the communist-capitalist cold war. Thus, despite post war anxieties about enemy aliens and after much consideration, the McCarran-Walter (Immigration and Nationality) Act was enacted by Congress in 1952. It's primary achievement was reversal of the 1924, National Origins Quota Act's prohibition of Asian naturalization. The McCarran-Walter Act abolished the Asiatic barred zone, and limited immigration to 2,000 within the Asia-Pacific triangle; it was repealed in 1965, but retained country quotas of 20,000 under the auspices of family reunification.

The critical issue to note is that U.S. immigration policy had been formulated and continues to be shaped and directed by immediate internal economic pressures, nativist-exclusionary propaganda, and foreign policy. Despite efforts by Presidents Truman, and Eisenhower to strike down quotas based on national-origin, race, creed or color, and President Kennedy's hopes for immigration policies which recognized skills, family reunification and interdependence among countries, the best Congressional efforts resulted in the Immigration and Nationality Act of 1965, which primarily modified quotas. The 1965 Act created enlarged annual ceilings for immigrants from the Eastern Hemisphere with an equal limit of 20,000 for every country, and created a

preference system to allocate visas to those with close family ties in the United States. Modified in 1976, the Act created a ceiling for Western Hemisphere immigrants at 20,000 and in 1978, a worldwide ceiling was set at 270,000 with provision for unrestricted admittance of spouses and minor children (Fuchs 1993).

Currently, the Immigration Act of 1990 provides for a ceiling of 700,000 immigrants annually (excluding refugee groups whose admission numbers are determined annually), with specific quotas allocated between a four tiered admission preference system (World Almanac 1996). However, legal immigration into the United States may be reduced by 25 percent over the next five years with the passage of S.1394, which was approved by the Senate Subcommittee on Immigration, November 29, 1995 (Refugee Reports 1995).

America's preoccupation with racial, ethnic and other differences persists and is the source of resistance to directing our energies toward well thought-out, life-enhancing policies for our diverse citizenry. The immigration "quota response" to domestic strife is symptomatic of shallow, reactive, self-serving, racist policies which perpetuate cyclic oppression and insidiously permeates, to greater and lesser degrees, humanitarian efforts directed toward refugees entering our country. Moreover, our mercurial admissions policy is an example of how short-sighted, reactive foreign policy enveloped this country in the

Second Indochina War: a war that seemed to have no beginning, and at its close 15 years later, appeared to have no end in terms of its human consequences.

Sustaining Oppression Through Refugee-Immigration Policy

Since 1975, following the Second Indochina War, an estimated 2 million Cambodians, Laotians and Vietnamese have fled their homelands (Taylor 1996; Karnow 1991). 1.75 million were resettled in other countries; eighty-percent of these in Western Europe, North America and Australia. By 1992, some 200,000 Indochinese refugees remained in first-asylum countries in Southeast Asia. 370,000 Cambodians were encamped on the Thai-Cambodian border as displaced persons waiting for repatriation. In their attempts to escape to Thailand an estimated 60,000 Cambodians, 15,000 Hmong and 5,000 Laotians perished. And an estimated 30,000 to 100,000 Vietnamese boat people also met death while trying to escape.

These Southeast Asian refugees, our “allied aliens”, are foreigners to whom the nation promised to extend protection because of their voluntary or coerced allegiance to America’s foreign policy objectives. The United States is responsibly linked to the Indochinese arena because of failed attempts to control communism in their homelands from the 1930s to 1975.

Historically, refugee law and policy has been considered distinct from immigration law and policy. Refugee law is thought to reflect the nation’s ability

to respond in a flexible manner to humanitarian needs. By comparison, immigration law and policy represents decisions about population growth in relation to political, social and economic concerns (Hing, 122). These distinctions, in reality, are blurred when their actual applications are examined.

The humanitarian aspect of refugee law and policy is clearly evidenced by the hundreds of thousands of refugees that have been accepted for asylum. The Displaced Persons Act (1948) admitted 400,000 refugees and displaced persons from Europe; the Refugee Relief Act (1953) admitted 200,000 refugees; the 1953 Refugee Relief Act admitted 200,000 which included 38,000 Hungarians and 2,800 refugees of the Chinese Revolution (Hing, 123). More recently, between 1982 and 1995, 1,299,937 refugees were accepted for resettlement in the United States (Refugee Reports, 1995).

However, contrary to the assumed neutrality of our humanitarian refugee laws, foreign and domestic issues and trends have had a direct impact on alien admissions. For example, Congress consistently refused entry to thousands of Jews fleeing Nazi persecution during the 1930s, because of "restrictive views" dominating immigration laws (Hing, 124). After 1952, the discretionary authority of the McCarran-Walter Act, was used by Congress to offer entrance to any alien for emergency or public interest reasons. During the 1960s and 1970s this policy granted admission preference to refugees from communist countries while

refugees from other countries were wait-listed. This interpretation of refugee law represents foreign policy aimed at demonstrating the failings of communism.

As is evident from the previous discussion, U.S. immigration policy, as applied to Asians for more than 150 years, has been ruthlessly discriminatory. Further, these same practices seem to appear in refugee policy in regard to Southeast Asians. This perpetuation of policy has been demonstrated in decisions regarding Southeast Asian refugee resettlement. As was the case with Asian immigrants who began entering the U.S. in the later part of the 19th century, Southeast Asian refugees have had their employment, geographic location of residence, and the likelihood of family members joining them predetermined by government policy (Hing, 122).

The United States Congress, historically, has shaped refugee-immigration procedure as an instrument of foreign policy (Loescher & Scanlan 1986, Tucker et al. 1990, Zucker & Zucker 1987 all cited in Hein 1993). This practice of mixing foreign policy with refugee-immigration policy has led to a lack of clearly defined national policies that effectively enable refugee-immigrants to make a relatively healthy, trauma-free adaptation to the various geographic areas of the United States.

Social Service Implications

At the close of the Second Indochina War, Southeast Asian refugees posed a formidable resettlement problem. In 1975 plans had been made for the resettlement of approximately 18,000 refugees. To the surprise of policymakers 130,000 refugees entered within an eight month period (Hing 1993, 128). In response to the antagonism this influx was causing in areas where they were resettled, President Gerald Ford created the temporary Interagency Task Force (IATF) which was to coordinate the activities of the twelve Federal agencies responsible for refugee resettlement (Ibid.).

The IATF's ad hoc status caused a perception of the refugee resettlement situation as only temporary. Thus, the policies formulated by the IATF were ill-conceived (Hing, 129) given the adaptational needs of Southeast Asian refugees. The long term consequences of IATF policies on refugee communities were not taken into consideration, the history of Asian immigration in this country was not considered, nor attempts made to accommodate the cultural traditions and life styles of Southeast Asians in the interest of their adjustment. From the beginning, refugees were subjected to poorly developed sponsorship arrangements. In many instances, when sponsorship did not work out, refugee families were left without assistance to negotiate the complexities of American urban life, in which they no or limited ability to communicate. In some cases,

refugees were sponsored by employers primarily interested in exploiting them for cheap labor (Ibid.).

The resettlement of Southeast Asian refugees within forty-nine states was handled initially through a policy of wide dispersal. This policy, according to Hing (Ibid.), was based on the belief that dispersal would prevent economic stress on host communities and encourage more rapid assimilation by causing refugees to rely on Americans. However, this policy proved to be "ill-advised and unpopular" (Ibid.). By 1980, 45 percent of the first arrival Southeast Asian refugees secondarily migrated from their assigned locations to a different state. Unlike other refugee groups, Southeast Asian refugees had no previously established indigenous communities to which to turn for sponsorship or other support. Thus, the forced dispersal policy initially deprived Southeast Asian refugees of seriously needed familial, cultural and ethnic support.

The influx of Southeast Asian refugees during the 1970s constituted the largest ever "nonwhite, non-English speaking group" to enter the U.S. (Hing, 130). In order to deal with this situation, the 1980 Refugee Act established the Office of the Coordinator of Refugee Affairs which was charged with formulating relocation guidelines. These guidelines would standardize resettlement programs in service of more thoughtful planning that took refugee communities into consideration.

Through a more realistic examination of the dynamics of refugee movement and their needs, the IATF concluded that ethnic coalescence was inevitable, and moreover, helpful to the resettlement process, providing that the group size would not become a burden to the local infrastructure (Hing, 131). Programs like the Khmer Cluster Project placed 8,500 Cambodian refugees, in groups of 300 to 1,300 people, in twelve sites located in ten states chosen on the basis of their capacity to assimilate refugees.

This type of program, however, was not always successful. For example, some 30,000 Hmong, on advice from their leaders, secondarily migrated to the Central Valley of Fresno, California from 1980 to 1986 (Hing, 132). Thus, although California, initially, received only 25 percent of the Southeast Asian refugee population, currently the State is home to 40 percent of all Southeast Asian refugees (Ibid.). This movement provides evidence of the Southeast Asian refugees' dissatisfaction with the dispersal policy.

The importance of understanding the trans-historical and cultural context from which refugees come is critical to providing services that aid in their stabilization, adjustment and on-going healing. Refugee dissatisfaction with resettlement programs needs to be examined in order to understand why they are unsuccessful. What about the resettlement program does not meet refugee needs?

The Linkages

Despite the pride with which America claims to be a "nation of immigrants," U.S. immigration and refugee policies have lacked well-thought-out infrastructures to accommodate resettlement. The difficulties of resettlement impact both immigrants and native born residents, yet little is done to prevent politically manipulated resentment directed toward immigrants. On the contrary, Congress has enacted immigration and refugee laws that reflect popular racist attitudes, prevailing economic pressures, and foreign policy goals.

Decisions regarding U.S. foreign policy were also made without adequate planning for downside risks or consideration of long-term-consequences. For example, U.S. leadership during the 1950s and 1960s designed foreign policy aimed at thwarting communism, but underestimated the determination of Southeast Asians to stop foreign domination, of whatever political ideology, within its borders. The U.S. military made promises to protect and provide resettlement in the U.S. for Vietnamese, Laotians and Cambodians who joined the cause to deter communism. However, United States citizens were ill prepared to accept their moral obligation to bring home the nation's allies once we were defeated.

The government's complicity in creating a problem with which they were unprepared to deal has kept the country in denial about the facts surrounding the Second Indochina War. Information about responsibility for the war remains

out of sight, misunderstood, and subject to judgment that blames the victim. No concerted effort is made to educate the American public about the political history which undergirds the reasons why Southeast Asians are refugees in the first place. Nor is there any mutual encouragement to foster understanding of differences in cultures which could facilitate the adjustment of refugees as well as the receptiveness of native citizens. Thus, upon entering this country, refugees have found their hosts unable or unwilling to assist their adjustment and sometimes openly subjecting them to dominative exploitation and discrimination.

The citizenry and leadership of the United States have long avoided recognizing who Americans really are, and shun examining the deeper issues which underlie the cavernous divisions within this country. Americans of European ancestry cling in fear to their construction of a "white" America by granting entry and citizenship preference to European immigrants, while rejecting non-Europeans on arbitrary grounds. As has been indicated earlier, documented within the annals of U.S. immigration and refugee legislation is evidence of this penchant for racist, biased policies.

The history traced here, provides a perspective of how U.S. immigration and refugee policy emerged as an oppressive social structure and how it has been maintained and applied to Southeast Asians. Beginning with the exploitation of Chinese, Japanese, Koreans and Filipinos for inexpensive labor,

immigration policy was purposefully used as means of controlling the influx of Asians and influencing Asian governments. Immigration-refugee policies which have been created in response to nativism, racism, domestic economics, and political ideology, ultimately, care not about people. Rather, they are the instruments of a culturally imperialized society, which endeavors to distance itself from and discredit other cultures, thereby, perpetuating the exploitation, marginalization and powerlessness of non-dominant groups.

As a result, immigrant and refugee resettlement services are provided haphazardly and without a clear understanding of its consumers. This oversight in combination with the persistent use of Western treatment modalities with Asian clientele, whose belief systems in no way overlap with mainstream views, subjects refugees to the many forms of oppression which minority groups in this country have historically encountered.

Displaced, war-ravaged refugees may be traumatized and re-traumatized not only in their quest for asylum, but within resettlement countries. In the United States, well-intentioned but untrained, uninformed government bureaucrats, medical and social service staff, teachers and others, who interface with refugees, may know little the refugee experience. They may not even know what culture a refugee is from, what their customs are or how important such information is in welcoming, comforting and enabling their adaptation. Finally, though infrequently reported, some refugees have fallen prey to sponsors who

exploited their labor and thereby, exacerbated and protracted their deprivation, oppression and trauma (anonymous Cambodian female, personal communication, November 24, 1995).

In the subsequent chapter, the social structure, religious-spiritual beliefs and traditions, and health traditions of traditional Cambodian culture are explored as a backdrop to the analysis of survivors' narratives.

CHAPTER 4: TRADITIONAL CAMBODIAN SOCIETY, HEALTH BELIEFS AND PRACTICES

When I was young I studied Buddhism, Confucianism, Christianity, as well as Marxism. There is something good in each doctrine.

Ho Chi Minh

Lord Buddha, please forgive me. I do not steal to get rich. I share with others. Please protect my life once again.

Haing Ngor

Traditional Cambodian Society

Prior to the Communist take over in 1975, the population of Cambodia was an estimated 7.3 million by U.S. Central Intelligence figures, and 7.9 million based on United Nations figures (Ea 1990, 4). The population was comprised of diverse ethnic groups: Khmer, Vietnamese, Chinese, Cham-Malays, tribal peoples, Thai, Laotians, Eurasians, and Indians (Ebihara 1968, 51). According to Ebihara's (1968) study, the Khmer were numerically and culturally dominant, and constituted approximately 87% of the total population within both peasant and ruling groups.

The largest minority groups were the Vietnamese, approximately 8% of the population, and the Chinese about 5% of the population (Ebihara, 52-54). The Vietnamese, who were brought in by the French to work on or administer their plantations, lived in their own communities, thereby maintaining their ethnic

identity and distinct cultural traditions. The Khmer, generally, regarded Vietnamese with malice and antagonism because of historic hostilities. The Chinese, on the other hand, have had relatively amiable contact with the Khmer since the first century A.D. They have been primarily in commercial occupations as merchants, bankers, export-importers, hotel and restaurant owners. The Khmer attitude toward Chinese was more favorable than toward Vietnamese and resulted in considerable inter-marriage.

Traditional Cambodian society was hierarchically structured by gender, social status and age. The male was head of the household, "... with almost absolute powers over his wife, children, and household matters, and possesses certain prerogatives denied to women" (Ebihara 1968,113). Cambodian law and Buddhist doctrine legitimated the male's superior position in Cambodian society. Ebihara (1968) also notes, that in practice, the Cambodian woman was accorded many rights and privileges, such as the ability to initiate divorce, and to consent to her husband's entry in the monastery or to take another spouse. In addition, in her role as mother and co-worker she had primary responsibility to care for children and household, and to maintain the economic stability of the family.

Ebihara observed that the division of labor among men and women of the traditional Khmer village was not as rigidly bound to sex as in other societies, although certain activities were considered more appropriate to one sex, such as men plowing rice fields and women caring for the home. Certain activities,

however, were stringently restricted by sex. For example, only males could become monks.

In traditional Khmer culture, the age of an individual had an important affect on behavior in general. A person substantially older than oneself was accorded deference. Thus, it followed that anyone fifty or older by virtue of age would receive special treatment and veneration from the younger generation.

There were three major social rankings. Individuals of high social status in Cambodia were royalty, aristocracy, government and religious leadership of high rank, and the wealthiest of Khmer or Sino-Cambodian business and professional people (Welaratna 1993, 28). The middle class was composed of doctors, teachers, businessmen, lower-ranking government officials and white-collar commerce workers. Farmers, rural area peasants and laborers in urban areas were at the base of society.

The peasantry could also be divided into five sub-groups. Wealthy landlords who did not work their own land were at the top. Followed by rich peasants who owned land, as well as rented it from landlords. A the third group were the peasants who owned some and rented part of it. Eighty percent of the rural population were part of a fourth group, the poor peasants who owned very little or no land, and usually rented land. At the very bottom were the agricultural workers who owned no land, whose primary source of subsistence was their labor. These individuals often migrated to the cities to work in the streets as

laborers, pedicab drivers, road workers, water carriers, servants, peddlers and repairmen (Kiernan and Boua 1982, 45 cited in Welaratna, 29).

Regardless of their rank in society, with the exception of Cham-Malays who are Moslems, the majority of Cambodians are Theravada Buddhists. As indicated in an earlier section, Buddhism plays a central role in the values, beliefs, social and cultural traditions of Cambodia.

Theravada Buddhism

Theravada Buddhism, the national religion of Cambodia, is practiced with a blend of elements from Hinduism (although not recognized as such in daily custom) and the traditional, indigenous folk religion. In her study of Cambodian life in the Village of Svay, Ebihara (1968) observed that for the ordinary Khmer villager the traditions from these religious sources were conceived of as part of a single religious system in which different aspects are called upon at distinct, appropriate times. In this discussion, for the sake of clarity, the tenets of Theravada Buddhism in relation to healing are first examined and later traditional folk healing is explored.

Practitioners of Buddhism take refuge in the Three Jewels¹⁷ or Three Refuges: the Buddha, the Dhamma and the Sangha. The title Buddha means "Enlightened" or "Awakened". In taking refuge in the Buddha, Buddhists are

¹⁷ Technical Buddhist terms are capitalized.

thinking of Gotama Buddha. His personal name was Siddhattha and at the age of 35 attained Enlightenment through the realization of the Dhamma, the Truth (Gombrich 1988). Although outside interpreters of the religion consider Gotama founder of Buddhism, Buddhists see the Truth as eternal, but, not always realized. Buddhism conceives of time as having no beginning or end and proceeding in vast cycles. At times during these cycles, a religious genius comes forth, a Buddha, having infinite wisdom to apprehend the Truth and infinite compassion to teach it in a suffering world, in order that others may attain Enlightenment (Gombrich 1988).

The Sangha is an Order founded by Gotama Buddha, which consists of monks who have decided to devote their lives to striving for Enlightenment and preserving the memory of the Buddha's Teaching. The Buddha as the great physician, is the central metaphor of Buddhism; the Dhamma is the treatment he prescribes and Sangha is the nurse who administers that treatment (Gombrich 1988). The Sangha originally consisted of male and female monks, nuns and novices, however, early in the present millennium female ordination was lost (Ibid.).

Theravada Buddhism means 'Doctrine of the Elders', referring to senior monks who preserve the tradition; it is also a term which makes claim to conservatism (Gombrich 1988). Around 250 BC Theravada reached Ceylon from India and remained in that area for more than a thousand years. In the

11th century it traveled from Ceylon to Burma and spread to Thailand, Laos and Cambodia. The Theravada denomination of Buddhism is also currently preserved in Sri Lanka and in other parts of Southeast Asia.

Theravada Buddhism has been the primary influence on Khmer behavior and belief since the fourteen century (Aronson 1987; Frye 1993). Buddhist practices became fused with earlier forms of animism and subsequently with Islam and Christianity (Chandler 1972; Ebihara 1986; Edmonds 1970, Ponchaud 1977, Song 1979, Refugee Reports 1984 all cited in Frye 1993).

In Cambodia, during the 1950's, it was estimated that there were 37,000 to 68,000 Buddhist monks, and between 2,500 and 2,800 temples (Martini 1955 and Delvert 1961 cited in Ebihara 1968). Between 1975 and 1979, the Pol Pot regime massacred most of the monks and defrocked the remaining. The Sasana, the Teaching (the view of Buddhism as a phenomenon in history), as a result was virtually extinguished (Gombrich 1988). Since 1979, Theravada Buddhism has experienced a revival in Cambodia as well as in those areas in which refugees have settled: in Western countries such as the United States and Australia and non-communist countries in Asia including: Nepal, Malaysia, Singapore and Indonesia (Ibid.).

The Cambodian weltanschauung and beliefs about health and illness have evolved in large part from Cambodian interpretations of Buddhist principles. These principles include the law of *karma*, in which the individual's present good

or bad actions affect his/her well-being in a future incarnation. Thus, a child's congenital defect, such as being born without a hand, could be explained by accumulated sin from a previous life, or the child's mother having committed a sin (Aronson 1987).

Buddhist teachings submit Four Noble Truths: life is suffering; suffering is caused by desire; suffering can be eliminated by eliminating desire; to eliminate desire one must follow the eight fold path of: right understanding, right purpose, right speech, right vocation, right effort, right thinking and right meditation (Aronson 1987). Through these teachings the individual is held responsible for his or her actions and the resulting good or bad consequences.

Khmer Beliefs about Natural Causes of Health and Illness

The health beliefs and practices of Cambodians living in the United States are no longer entirely traditional (Aronson, 1987). However, traditional beliefs and practices continue to influence Cambodian help-seeking behavior in response to illness.

Cambodians do not have a single, dominant perspective on health and illness such as the Western bio-medical model. Disease is believed to result from of a state of imbalance caused by the natural or supernatural environment. The existence of vital organs is recognized, however, their functions are not understood in Western medical terms. Metaphysical and supernatural forces

such as "offended spirits, moral transgressions, diet or behavior-induced humoral imbalances and sorcery..." are deemed responsible for health status (Aronson 1987, 74).

Equilibrium is the core principle of health within the traditional Cambodian belief system (Frye 1993), which is directly related to the Buddhist and Daoist teachings of taking the "middle road". The balance of food intake, emotional states, interpersonal relations, pace of work and rest, and interaction with the environment, are all understood to contribute to an individual's well-being. A "hot" or overactive physiological state is exacerbated by culturally defined "hot" foods (meat, salt, alcohol and spicy food). And a "cold" or weak physiological state is exacerbated by "cold" foods (fruits, vegetables). In traditional practice, oppositional food treatment is used to bring the body back into balance.

Environmental winds can be a source of imbalance and illness. The body is thought to be in disequilibrium when the individual experiences deep states of anger, grief, or overwork, resulting in what is described as "wind illness" (Frye 1993). In a mild state, wind illness may take the form of a headache, and would be treated with dermabrasive therapy, such as *khyal* (coin rubbing), skin pinching or moxibustion. These techniques bring "bad wind" to the surface of the body for excretion (Kemp 1985, Marcucci 1986, Martin 1983, cited in Frye 1993).

Kchall koo, for example, is a life-threatening form of wind illness, in which bad wind has become "frozen wind" as a result of extreme exhaustion, emotional distress or spirit possession. The *kchall koo* afflicted person may become immobilized. Treatment includes emergency acupuncture, family members praying, chanting and holding the sick person to impede the process of immobilization (Duncan 1987, Marcucci 1986 all cited in Frye 1993).

Spirits and the Supernatural

Cambodians often practice Buddhism along side animism, sorcery, magic and elements of Brahminism. In certain instances, supernatural forces/spirits are thought to be responsible for misfortune, accidents, certain bodily illness and insanity (Aronson 1987). These spirits are considered to act in both good and bad ways, and if not properly respected and propitiated may cause illness. Of the large number of spirits recognized by Khmer, particular spirits are considered to be more critical to health than others.

Neak Tha, *Preay* and *Ab*, for example, are spirits identified with matters of personal health and well-being. One or two *Neak Tha* guardian spirits protect each community or social group, but not their individual members. *Neak Tha* is conceptualized as the spirit of an old man or grandfather, usually benevolent, but easily angered and vengeful. *Neak Tha* may live in a tree, forest, mountain, river or rice paddy. If a *Neak Tha* is not properly worshipped illness and

misfortune will result. *Neak Tha* are thought to cause abdominal pain, vomiting, high fever, constipation, nightmares, inappropriate laughing and crying, and sudden death from cardiac arrest or trauma (Aronson 1987; Frye 1993). *Preay* and *Ab* are ancestral spirits and spirits of those who have suffered untimely deaths and are believed to affect an individual's health. *Preay* are demon spirits which can scare people to death, cause high fevers, sleeplessness and weightloss. *Ab* are witch spirits which cause illness to all individuals with whom they come in contact.

Spirits of stillborn children, women in labor and those who experienced untimely deaths which did not permit necessary Buddhist funeral rituals are considered to be especially dangerous (Aronson 1987). Evil spirits are thought to rise from slowly decaying bodies, hence the strict observance of cremation (Zadronzny 1955 cited in Boehnlein 1987). Immoral behavior is also thought to cause ancestral spirits to haunt a family (Duncan 1987, Frye 1986, Kemp 1985, Marcucci 1986, Martin 1983, Ong in Bowland & Bruna 1985 all cited in Frye 1993).

Spirit invasion as an explanation for bodily illness and severe emotional distress is neither understood nor accepted by Western health care providers. Since it cannot be "scientifically" proven, such occurrences may be thought of as cultural artifacts, or the conversion of emotional distress into physical complaints, as in somatic complaints. However, for the Cambodian the use of

spirit invasion in explanations of illness provides the sufferer with a greater latitude for explaining the often unexplainable and more avenues to healing.

Emotional Stress and Behavior

Western medical providers find that emotionally distressed Cambodian refugees commonly present with somatic complaints, such as many forms of physical pain (headaches, abdominal pain, chest pain, etc.) and sleep disturbance (Cheung 1993; Kroll et al. 1989). Somatization may be thought of as an alternative form of communication, in which the individual's expression of emotional suffering is translated into physical suffering. According to the American Psychiatric Association's DSM-IV (1994, 445), a common feature of Somatoform Disorders, "... is the presence of physical symptoms that suggest a general medical condition and are not fully explained by a general medical condition, by the direct effects of a substance, or by another mental disorder" such as Panic Disorder. Somatoform Disorders are characterized by "... recurring, multiple, clinically significant somatic complaints", which are not under the voluntary control of the sufferer (see DSM-IV for detailed characteristics).

In some traditional Asian cultures, somatization is thought to occur because of several factors. The first of these is the tendency to minimize or often ignore the symptoms of trauma because of guilt and shame (Cheung 1993, 425). The Buddhist belief that suffering is an expected part of life and that

expression of dissatisfaction or strong display of affect are incongruent with these tenets is considered another factor contributing to somatization (Seanglim 1991; Cheung 1993). The display of strong and uncontrolled emotions is considered pathological (Landerman & Esterik 1988 cited in Cheung 1993), thus, predisposing the individual to suppress emotional distress, which may be somatized. Within this high context culture, somatization provides a non-verbal signal which enables family members to respond to the sufferer's affliction. According to Cheung (1993) Cambodians and other Southeast Asians associate the concept of "madness" with all psychiatric conditions, the sole treatment for which is long term confinement in a rudimentary psychiatric institution.

Koucharang (thinking too much), an apparently culture bound syndrome indicating severe stress, is identified by complaints of headaches, somatic complaints of chest pain, palpitations and shortness of breath, excess sleeping and withdrawal (Frye & D'Avanzo 1994). In Frye & D'Avanzo's (1994) comparison study of Cambodians in Massachusetts and California, the primary cause of *koucharang* was attributed to memories associated with the Khmer Rouge precipitated by nightmares or flashbacks of the killing fields. Cambodians describe management of *koucharang* as involving respect for cultural taboos and the use of certain coping strategies. Avoidance of alcohol, drugs and sad thoughts are the three most important proscriptions to observe in dealing with *koucharang*. When a family member is afflicted by *koucharang*

becomes emotionally or physically violent the primary management strategies used are to verbally discourage sad thoughts, and not leave the individual alone. The afflicted individual similarly uses the coping strategies of avoidance of sad thoughts and being alone. However suicide is a considered option and other coping behaviors might include alcohol and substance abuse to control stress and spousal abuse. These traditional beliefs form an important context for understanding Cambodian conceptualizations of illness. However, adherence to their beliefs may vary by age and gender.

Age, Gender and Generational Differences re: distress, symptoms, etiology

Adolescents. In Frye's (1993) study which observed age, gender and generational differences in examining health care management, the commonly reported illnesses of male and female Cambodian adolescents were not the illnesses that were seen as actually occurring. The perceived problems were menstrual disorders and "bad" behavior (substance abuse, sexual promiscuity, disobedience and being separated from the family), however, the diagnosed conditions included upper respiratory infections and chronic physical and psychiatric disabilities.

The emotional difficulties of Cambodian youth appear to be more often expressed psychosomatically than through acting out (Messer & Rasmussen 1986 cited in Frye 1993), for example, headaches are common among

adolescents and are attributed to "sadness". Chronic physical and psychiatric conditions are attributed to the severe and traumatic environmental conditions of the holocaust. Adolescent behavioral problems in this country are usually considered the result of American cultural influences, because in the traditional Cambodian culture, adolescence was not perceived as a difficult time.

Women. Frye (1993) found that respondents in her study perceived women at high risk for reproductive and gynecological problems as well as death due to a combination of Western and traditional reasons. However, women did not perceive themselves as highly susceptible to the effects of stress. For example, a woman exhibiting hallucinations, withdrawal and severe startle reactions was observed by her sister to be "very sad", but atypical of most Khmer women, who, she believed, are by nature strong.

Men. According to the Cambodian women in Frye's study, stress is a major problem among their Khmer husbands. One form of stress men are reported to suffer is "thinking too much" (Koucharang), which is often attributable to rumination about losses during the holocaust. Wives also observed that men's stress was manifested by insomnia, substance abuse, suicide attempts, physical problems, and violence toward their spouse and children.

The women in Frye's study define themselves as "stress-bearers for the men". They must be counselors to their husbands, listening gently with them, making them laugh and advising them to avoid injurious behaviors like drinking

alcohol or worrying, and encouraging them to pray and meditate in order to promote their mental balance.

Elderly. Elderly Khmer experience the highest incidence of illness episodes. Their perceived and reported disorders include acute illness, stress and chronic degenerative diseases. Explanations for their illnesses include "thinking too much" and imbalance. Despite their liberal use of both traditional and Western forms of health care, the elderly reported that neither system of care was effective in their healing (Frye 1993,105). One can only speculate why the elderly perceived both systems as ineffective, however, a short examination of traditional Cambodian health care may provide some understanding.

Traditional Healers and Forms of Treatment

The primary forms of traditional treatment for illness in Cambodian medicine are herbal remedies, dermal techniques, such as pinching, coining, moxibustion, cupping and acupuncture, and rituals of exorcism (Aronson 1978; Buchwald, Panwala & Hooton 1992). When traditional forms of treatment that may be carried out within the family do not prove effective or illness is sudden or acute, suggesting the work of supernatural forces, traditional healers or Kru Khmer are consulted (Aronson 1987, 70). A Kru (also spelled Kruu and Krou) is a traditional healer or teacher, who is considered generally wise and knowledgeable. Kru are trained in several ways depending upon the type of

healer he/she wishes to become. Training and knowledge may come from a relative, Buddhist monk or master healer. Prior to communist rule, incurable illness or sudden-onset illnesses were treated by Kru Khmer and often different treatments and healers were used at the same time. Western medicine was considered the last resort in rural areas, and therefore, most often associated with death. City families followed the same general path to health care, but traditional healers were used less often while Western medicine was used more frequently. However, the prevailing view is that Western medicine is an additional option or supplement not a substitute for traditional healing (Aronson 1987).

Kru Khmer in pre-revolutionary Cambodia were trained by Buddhist monks for a minimum of three years (Frye 1993). This was followed by an apprenticeship with experienced Kru pursuant of a traditional specialization in herbal medicine, talisman and amulet preparation, black magic or meditation.

There are four principal types of Kru Khmer. A *Kru Thanam* has diagnostic techniques and treatment practices most closely similar to those of Western physicians. Kru Thanam utilize careful observation of the physical and social environment of the patient in making diagnoses and in prescribing treatments. Assessment also includes, reading the patient's pulse, measuring the strength of breath, and abdominal palpitations. Medication is the most common type of treatment. *Kru Banebat* utilize meditation and incantation to

diagnose and treat the patient. The Kru Banebat communicates with the spirit world to discover the source of illness. He is an astrologer who makes predictions and diagnoses based on the patient's birthday and planet forces. A *Kru Robien* influences people's health by making protective amulets and tattoos for them. A *Kru Thmop* treats diseases caused by black magic and evil spirits. The evil spirit is exorcised with magic words and spraying water made holy by incantations of the Kru (Aronson 1987, 78).

This limited discussion of traditional healers is merely an entry point into understanding the ways in which Cambodians received treatment for illnesses. A greater understanding of the choices that were available to Cambodians prior to the war and what part they played in the healing process would add to our knowledge base in providing culturally sensitive practice with Cambodians residing the U.S.

Cambodians in America: Perceptions re: emotional illness

The process of understanding Cambodian perspectives of illness and well-being is in its infancy, despite numerous articles that have been published. Much of the research that would enable an understanding of the maintenance of traditional perceptions of illness and their degree, and rate of change must be conducted within the Cambodian community. Key questions include: What factors mediate the change in perceptions regarding the cultural construction of

illness? What is the nature of the process? Are traditional views of mental illness retained and how can they serve as a resource for treatment? For example, in a field interview, a Cambodian program manager for refugee affairs, and community activist in mental health, indicated that, from his point of view, the concepts of mental illness and mental health care continue to have negative implications to Cambodians with whom he is acquainted (anonymous Cambodian, personal communication, 1995). Cambodians, he stated, are either "normal" or "crazy" in their conception of mental states, there is no in-between.

Studies by Boehnlein (1987) and Kinzie (1989) tend to verify their personal communication. They report that Cambodian culture, as is true of most Asian cultures, attaches intense stigma to mental illness. The fear that members of one's family could be labeled "crazy" is supported by negative economic and social consequences accruing to the insane. Cambodian expectations for treatment, whether provided by Western medicine or native healers, include rapid diagnosis, and brief effective treatment resulting in rapid reduction of symptoms (Kinzie 1989).

There is no equivalent in traditional Cambodian culture for "self-revelation of feelings" as practiced in Western psychotherapy. Feelings are personal and are not shared in public or with strangers. And group psychotherapy is an unknown treatment form (Kinzie 1989).

This basic knowledge regarding Cambodian perceptions of mental illness clearly indicates that traditional Western psychiatric approaches to mental states may be incompatible with the needs of traumatized Cambodian refugees. The study analysis which follows examines the ways in which Cambodians perceive the Western health care system and its efficacy.

CHAPTER 5: LISTENING TO THE ACCOUNTS OF CAMBODIAN SURVIVORS LIVING IN SEATTLE

This study was part of a larger research effort which centered on the social networks of Cambodians seeking mental health care in Seattle (National Institute of Mental Health, Grant #2 PO1 MH44331-07 to National Research Center on Asian American Mental Health (NRCAAMH)), University of California, Los Angeles, Edwina Uehara, principal investigator, David Takeuchi, co-investigator, and Stanley Sue, principal investigator of NRCAAMH. It was also funded by a small grant from the Fahs-Beck Fund for Research and Experimentation.

Methodology

The study required the use of research methods that would reveal the richness and complexity of the “lived experience” and the meanings that people affixed to events, processes and structures within their lives (Miles and Hubberman 1994, 10). Skillfully collected qualitative data have the capacity to yield locally grounded “thick descriptions” with the potential to disclose the underlying dynamics of phenomena that may lead to theory building. The sampling was directed, therefore, toward case to case analytic generalizations, not sample to population generalizations. The goal was to uncover common factors or processes which underlie the phenomenon in question across cases.

As Miles and Hubberman (1994, 29) state, "The prime concern is with the conditions under which the construct or theory operates, not with the generalization of the findings to other settings."

The first level method of analysis was partially derived from grounded theory with modification to preserve each participant's narrative. Constructivism and critical theory provided the guiding conceptual frameworks and stance from which the analysis proceeded.

This study limits itself to the examination of survivors' experiences through their narratives and components of the historic geo-political, cultural and structural contexts within which these experiences occurred. It attempted to delve below the surface of apparent reality in order to reveal the nature of oppressive social structures, and examine the circumstances under which they are maintained.

Sampling

Volunteer participants were screened from two sites: the Asian Counseling and Referral Service (ACRS) in Seattle, Washington, which services ninety percent of the Cambodian and other Asian refugees seeking mental health care, and Dhakmar Chakarum, the Khmer Buddhist Society. The ACRS volunteers were actively receiving mental health services, and Dhakmar Chakarum referrals were not currently receiving Western mental health services.

This distinction enabled the researchers to examine differences between those diagnosed with PTSD and receiving treatment in contrast to those who were not receiving treatment but could also be diagnosed with PTSD.

Study participants were required to meet the initial sampling criteria of being between 30 to 60 years of age, who had lived in Cambodia between 1975 and 1979.

The locus of analysis was on twenty interviews conducted with four participants selected from the first series of twelve interviewees seen for the larger study. "The case" or unit of analysis was the Cambodian refugee's *on-going process of healing, in the context of survivor-defined traumatic experiences encountered during the Pol Pot-Khmer Rouge rule of Cambodia, escape, and resettlement.*

Purposive, within-case and multiple-case sampling were utilized to gather data that would allow for in-depth analysis of how the survivor constructs her or his trauma and what conditions mediate the survivor's healing. Thus, each case was selected on the basis of its ability to increase knowledge about the variation in individuals' construction of trauma, to extend information about how trauma is dealt with, and to provide evidence for important research themes.

The sample size was limited to 4 cases for empirical and practical reasons. These particular cases were purposefully selected, from the initial cases available in the larger NIMH study, for their maximum variation in trauma

experience and response to trauma. The limited number of cases enabled an in depth examination of survivors' constructions of trauma and their choices of interventions, and provided an opportunity to explore in detail the linkages between the everyday experiences of refugee-survivors and systemic forms of oppression. Thus, as indicated earlier, the objective was case to case analytic comparison and generalization, not sample to population generalization. The sample size also reflects the practical concerns of the amount of time needed for translation, transcription and analysis.

Fieldwork

The initial field work designed to gain entry into part of the Cambodian community in Seattle began in March 1995, when the investigator met with a person who is informally recognized as a respected leader within the Cambodian community. This meeting was followed by an invitation to attend the Cambodian Buddhist New Year celebration on April 15, 1995. It was on this occasion that the investigator was introduced to an individual, formerly a Buddhist monk, who was a lay leader within Dhakmar Chakarum, the Seattle Khmer Buddhist temple, and employed as a social worker within the community. I met with this individual, whom I shall refer to as Sok, on a weekly basis. Sok patiently and generously shared information about the community, the temple and his own personal history of escape from Cambodia.

In early fall of 1995, Sok offered to have the study officially blessed at the Dhakmar Chakarum Buddhist temple. On October 1, 1995, in a heartening ceremony, attended by members of our research team, the monks of Dhakmar Chakarum blessed the research project, and participated in a dialogue with us affirming the study's intent to be of benefit to the Cambodian community. As field coordinator, I attended subsequent meetings with the monks to provide more information about the study, which led to approval by the members of the temple and resulted in a portion of the volunteers who participated in the study.

Human subjects procedures were documented and approval was received in August, 1995 (see Appendix B). The Human Subjects Review Committee approved participant consent form may be found in Appendix B-1.

Interview Process

Data collection involved intensive ethnographic interviewing with an instrument which contained open-ended and semi-structured questions (see Appendix C). This interview guide evolved with the help from lay and professional members of the Cambodian community in Seattle. The questions formulated for this study's area of inquiry overlapped with or were merged into the NIMH project instrument (see Appendix C-1 for the question submitted to and approved by Human Subjects review). The instrument also included a modified version of the traumatic events list from the Harvard Trauma Questionnaire

(Mollica 1992) and posttraumatic stress disorder screening protocol (DSM-IV, APA 1994).

Although each case narrative most often began with questions about the survivor's early history, the interview guide was not designed to be followed in a rigid manner. Further, emphasis was placed on facilitating the survivor's chosen manner of narrative telling, while learning about critical areas of inquiry.

Each participant was interviewed from three to six times. The interviews were conducted through a Cambodian-English interpreter or, if the participant was able, in English. A Cambodian survivor's narratives were heard by the same interviewer-translator team throughout the several interviews it took to complete the case. All interviews were audio tape recorded, then translated from Cambodian to English when necessary, and transcribed. Although our translators and transcribers were all Cambodian speakers, the study may be limited by the precision of cross-cultural language translations and well as interpretation.

All six interviewers were clinically trained professionals with an average of 13 years of experience. Interviewers received three, half-day training sessions in ethnographic interviewing, study content, and protocols, and conducted practice interviews with our Cambodian translators which were audio recorded and reviewed by the primary investigator prior to entry into the field.

This researcher was one of three interviewers who conducted the interviews used for this study's analysis. All of the interviews utilized in this study were conducted between November 1995 and March 1996. In one case, the researcher returned to visit the interviewee with copies of his transcripts to request his collaboration on their interpretation.

The interviewing method encouraged the participant to tell her/his story in detail and without constraint. This meant allowing the participant to tell her/his story without interruption, thereby enabling the participant to clarify and affirm his/her experiences. The interviewer needed to trust that the interviewee would lead the researcher in fruitful directions. When I asked a respondent to speak freely and tell his or her story, I committed myself to hearing the narrative as the survivor wished to tell it.

This approach also meant redefining the investigator as learner and listener rather than expert or researcher, and taking the participant at his or her word. If doubts arose, questions were raised for clarification, but the goal was not falsification (Mishler 1986; Riessman 1994; Devault 1990 and Reinhartz 1987).

Although the final interpretation remained the responsibility of the researcher, reciprocal participation gave respondents the opportunity to receive feedback and the ability to correct or dispute findings. In the interpretive

interviewing process, respondent and researcher collaborated toward authentic reflection of the complexities that constitute life phenomena.

Narrative as Healing

Physician and philosopher Howard Brody (1987, 5 cited in Hahn 1995, 19) states that, "...suffering is produced, and alleviated, primarily by the meaning one attaches to one's experience." In addition, healing according to Hahn (1995, 19), "...requires listening and responding to the patient's story." The construction of the individual's reality is filtered through his/her cultural lens (Maretzki 1973), which brings with it, "... deep cultural undercurrents [structuring] life in subtle but highly consistent ways that are unconsciously formulated," (Hall 1977) but play a critical role in our ways of thinking and behaving. Listening without attempting to interpret too quickly, waiting for responses to come in the course of conversation and posing questions in indirect forms were key elements in eliciting the narratives, while providing a healing opportunity for the survivor.

This study attempted to clarify the experiences of Cambodian Holocaust survivors through eliciting their personal narratives. The study attempted to identify the meanings Cambodian survivors assigned to their experiences and what part these constructions played in their healing. The study is based on the premise that apprehending the depth and complexity of a survivor's experience also necessitates understanding the historic, geo-political context within which

developed those events leading to their refugee status. Furthermore, contextual knowledge is essential to understanding the degree of a survivor's traumatization and facilitating healing in a culturally effective manner.

From this standpoint, the survivor-experience cannot be separated from its cultural and historic context without distorting, either through misunderstanding or minimizing, its severity. This means that examining the traumatization of war-refugees outside of the totality of events, and social structures which contributed to their trauma limits our knowledge of the types and degree of trauma the refugee experienced. The lack of contextual information initiates the dynamics of oppression between service providers and refugees, as well as within the political context of this society.

Data Analysis

The survivors' narrative data were initially analyzed using a coding method derived from qualitative data analysis. As will be discussed further in this section, this portion of the analysis dealt with identifying the major themes presented in the survivors' narratives and examining the relationship between their experiences, suffering, healing and what meaning these constructions had for them. Simultaneously, in what will be referred to as the second level of analysis, the critical theoretical framework was utilized to interrogate the

narrative data in order to identify central concepts and how they related to the area of investigation.

First Level

Audio-recorded interviews were translated and transcribed by Cambodian speaking members of the research team. These Cambodian translator-transcribers were different individuals from those who did the field interviews. In two of the cases, the Cambodian participants spoke English during the interviews. In these two cases the interviewers were able to check the transcriptions for content validity by direct review of the audio-recordings. In the other two cases, interviewers read over the translations for possible inconsistencies in the content. In one case, this researcher was able to return to the participant with the transcriptions in order to have him check the translation-transcription for errors.

In the first level of analysis, the transcriptions of audio-recorded interviews with survivors were coded and memoed line by line using a process derived from grounded theory¹⁸. Atlas text interpretation, a qualitative data analysis computer software, was used to keep track of the initial coding. The first four interviews from two cases yielded over fifty codes (see Table 1). These

¹⁸ Grounded Theory was initially developed by Glaser and Strauss (1967), subsequently many works have elaborated and expanded on this research methodology.

codes eventually evolved into five major categories (see Table 2) which became the framework for deeper analysis of the trauma-healing process.

The major categories or areas which emerged out of the study were: the survivors' construction of their trauma experiences, suffering and healing, their explanations of why they were suffering, and explanations of why they believed they survived.

The remaining sixteen interviews were analyzed through a constant comparison of the data in relation to the identified conceptual areas. This was conducted to determine whether the concepts continued to be supported by the data, and to discover new conceptual areas.

Table 1**Initial Codes: Line by Line Coding**

CODES:	
categorical killing confidence validated coping corruption despairing duping escape risks folk medication forced labor forced separation foretelling freedom obliteration healing helping others helpless rage intentional starvation KR killing criteria lack of medical care life threats luck maddening accusation murder	paradoxical acts personal loss physical trauma political threats present personal threats protective factors rapacious murder refugee hardship righteous anger risking for survival spying threat stranger interceding suffering survival opportunism survival philosophy survival resources survival skills survival strategizing treacherous help witnessing death

Table 2:
Categories Derived from Initial Coding

CATEGORY DESCRIPTIONS:	CODES:
<p><u>TRAUMA EXPERIENCES:</u> survivor's experiences of extreme stress; what the survivor experienced</p> <p>TR: personally experienced: beatings and other forms of torture, physical and verbal threats to life, starvation, forced separation, forced labor, duping, re-education (brainwashing), mass murder, orphan status, emotional/physical abuse, rape, eating corpses</p> <p>TR: witness to any of the above</p> <p>TR: heard about any of the above</p> <p>TR: on the way to or at refugee camps: any of the above, robberies,</p> <p>TR: inter-familial abuse (emotional or physical), prior to coming to US</p> <p>TR: sponsor, agency, inter-family abuse after coming to US</p>	<p>tr/exp</p> <p>tr/witn</p> <p>tr/heard</p> <p>tr/camp</p> <p>tr/fam/prior</p> <p>tr/US</p>
<p><u>PROCESS OF SUFFERING, OVER TIME:</u> manifestation of survivor suffering, symptoms; how survivor experiences her/his suffering</p> <p>PR: suffering/interpersonal: suicidal thoughts, thinking too much, depression, lack of concentration,</p> <p>PR: suffering/flashbacks (auditory/visual)</p> <p>PR: suffering/suicide attempts</p> <p>PR: suffering/invalidation of illness by Western medicine</p> <p>PR: suffering/constant: physical pain, lack of energy, illness</p> <p>PR: suffering/cultural bereavement</p>	<p>pr/suf/interp</p> <p>pr/suf/flash</p> <p>pr/suf/suicide</p> <p>pr/suf/invalid</p> <p>pr/suf/physical</p> <p>pr/suf/breave</p>
<p><u>STRATEGIES FOR HEALING:</u> ways in which survivor deals with suffering; what survivor does to relieve suffering</p> <p>STR: healing/Buddhism</p> <p>STR: healing/Christianity</p> <p>STR: healing/folk medicine</p> <p>STR: healing/western medicine</p> <p>STR: healing/self control</p> <p>STR: healing/family & social support</p>	<p>str/buddh</p> <p>str/chris</p> <p>str/fkmeds</p> <p>str/wesmed</p> <p>str/self</p> <p>str/famsoc</p>

CATEGORY DESCRIPTIONS:	CODES:
<u>EXPLANATION OF SUFFERING:</u> ways in which survivor understands why he/she is suffering EXP: suffer/karma EXP: suffer/war EXP: suffer/Western God	exp/karma exp/war exp/god
<u>EXPLANATION OF SURVIVAL:</u> survivor's understanding of why he/she survived the war SURV: spiritual protection SURV: use of prior knowledge SURV: compliance SURV: belief in self	surv/spirit surv/know surv/compli surv/self

Second Level

At the second level of analysis, the data were examined in terms of processes and interactions that could be linked to social structures and the larger historical context as a totality. Application of the critical research process proved to be difficult because the barrier-breaking process required a measure of creativity, flexibility, and patience. The challenge of critical research skill development, for this investigator, is the continual questioning of self in the process of developing new perspectives and piercing the veil of apparent reality.

Through the utilization of concepts which emerged from the first level of analysis, the data were interrogated to examine the survivors' present situation and condition within the context of Western health care in relation to their previous condition in the context of the traditional Cambodian culture. This

interrogation of data, which constituted an attempt at the deconstructive-reconstructive process, was also used to examine the refugee's relationship to social structures such as refugee immigration policy and Western bio-medicine. This meant asking questions about why and how the Cambodian refugee was here and in this situation. Such questions included: What is the relationship between Cambodian refugees and the social structures they use? What are the underlying assumptions operating in these situations? How do they relate to the area of investigation? Throughout the process of attempting to utilize the critical research methodology, I had to keep asking myself: How am I deluding myself? What's here that I don't see? What does my internalized oppression keep me from seeing?

Throughout this process of continual questioning and reconceptualization it was necessary to remember that the investigator needed to be, "... prepared to abandon lines of thought which are not getting beneath surface appearances," with an understanding that the identified core concept provided, "... the best focus for deconstructing and reconstructing the phenomenon in its sociohistoric context," within the context of the current analysis (Harvey 1990, 30).

The deconstructive-reconstructive process may be summarized as focusing on the structural totality or historical moment within which a phenomenon occurs and critically reflecting on its essential nature (Harvey 1990, 31). The process involves purposeful interrogation of taken-for-granted

events, concepts, relationships and social structures which may conceal oppressive mechanisms.

Study Limitations

Writing this dissertation has been a progressive learning process. The dissertation focus has evolved in a direction different than that originally planned. The original proposal designated a constructivist perspective in data collection and analysis. However, in the course of the data collection and analysis, the narratives of Cambodian survivors began to reveal a complex array of oppressive forces, historic and current, which continue to have impact on refugees. The data, therefore, required a conceptual-methodological framework that would permit fuller, larger-perspective analysis of data. This researcher believed that critical research methodology would more likely reveal the complex forces involved in the traumatization of refugees, and expose linkages within their current context which perpetuate their suffering and oppression.

Cross-cultural differences in the conceptualization of “suffering” and “healing”, and the use of terminology which has its basis in Western bio-medicine and social research methods to describe Cambodian behaviors intended to alleviate pain and suffering, also placed this study’s data analysis at risk for over or under-description. Although the interview process attempted to clarify and verify the survivor’s meanings through reiteration, and reach sought-

after information from several perspectives, the interview translation process may have missed subtle leads to follow-up questions.

Another limitation of this study lies in the interpretive process, which, despite outside consultation from colleagues at various points in the analysis, remained largely self-reflective and constrained to a Western perspective. This attempt at accommodating both constructivist and critical research perspectives has made obvious the need for a process which includes the power of multiple points of view to apprehend as much of the contextual totality as possible and to reveal essential dynamics which undergrid social structures.

Furthermore, the interpretations rendered in this study are informed, as well as limited, by my twenty years of social work practice experience in various settings with various populations in California and Hawaii, by my multi-ethnic Asian-Pacific American cultural background and socialization as a woman in the dominant Euro-American culture of the 60s and 70s.

CHAPTER 6: NEAR DEATH EXPERIENCES, SUFFERING AND HEALING: FIRST LEVEL ANALYSIS

It looked like, we say in Cambodian, the whole country of Cambodia was a great prison without walls, because you could not even move. You could not even see your parents without authorization.

Chomreun 1995

Mentally, you still miss the hometown...still grieve over the country's scattering and separation...coming to stay in other's country...just like staying in other's house...

Yes, my soul still lingers there [Cambodia], my thoughts...still daydream of walking in our land here and there...but ...we are actually here. Even through those sufferings, our land had war and suffering...our land rarely had peace but...why do I still miss it...wanting...regretting because we were born there seeing our friends. Living over here we do have relatives but it's not the same like over there.

Sopha 1996

In this chapter, four survivor experiences during the Pol Pot era explicating the ways survivors suffered, and what forms of healing they utilized are examined. The torture, near death encounters, abuse, fear and the day to day struggle to survive are examined from four survivors' perspectives. This analysis utilized a constructivist framework in attempting to understand the interconnected processes of trauma construction and healing. This approach required eliciting narratives of survivor's experiences, refining these constructions hermeneutically, and comparing and contrasting them with other constructions (Guba 1990, 25-27). The resulting core concepts may be used in the service of consciousness raising and the facilitation of healing practices.

Although some participants offered to have their true identities revealed, all names and specific identifiers have been changed to protect their privacy. The survivor's expression of thoughts, feelings, motivations, actions and the events which transpired remain true to their original narrative.

Chomreun: A Teacher's Story

In 1975, Chomreun was thirty years of age, at the prime of his life with a bright future ahead of him. He was well educated, knowledgeable in many areas, and, with seven years of teaching experience, had taken his place as a highly respected educator in the city of Battambang.

Chomreun's parents raised their nine children in the Eastern province of Kompong Cham. Prior to World War II, Chomreun's father made his living as a French customs officer. When the Japanese invaded Cambodia, Chomreun's father left his position and became a rice merchant.

In 1952, insurgents called Issarak began disrupting life in the smaller villages in outlying areas. Robberies, shootings and kidnappings became common-place. Chomreun's father, by then a successful rice merchant, was betrayed by a close colleague who stole a great deal of his money and joined the insurgents. Chomreun recalls:

I remember when I was 7 years old ..., [a] Chinese family lived across the road ... a group of robbers came, 10 to 15 people with some guns; they cut through the door and arrested the father and took [him] away and took everything, all the gold and everything ... and asked for a ransom.

In order to escape the escalating turmoil, Chomreun's family moved to Phnom Penh the same year.

In 1967, Chomreun attended medical school for a year, but was unable to continue since his father did not have the funds to maintain all his sons in school. Chomreun decided to quit medicine in favor of a career in education. In 1968, with his educational requirements completed, he accepted a teaching position in the city of Battambang.

When the Khmer Rouge entered Phnom Penh in 1975, Chomreun's parents, two daughters, three sons and a daughter-in-law were evacuated from the city. He has not seen them since that time. After the war Chomreun learned that his father was separated forcibly from his mother in 1977 and murdered by the Khmer Rouge. His mother, ill and lacking medical care, starved to death. He also learned that one of his younger brothers was stabbed in the neck and killed for taking corn to feed his starving mother. Ultimately, five of his seven younger siblings, a sister-in-law and his parents were killed either at the hands of Khmer Rouge or died because of their harsh practices.

Early in 1975, Chomreun's fiancée was also killed by Pol Pot's forces as she entered Phnom Penh in an attempt to reach her family. That year, partly as a strategy to avoid Khmer Rouge suspicion, Chomreun married Tia, who came from a family of farmers.

Near Death Experiences and Survival

In 1975 there were 256 teachers employed at the school where Chomreun taught; after the war only six remained alive. Chomreun was one of the survivors. Because his appearance, education and ability with foreign languages made him a prime target for elimination by the Khmer Rouge, Chomreun narrowly escaped death on many occasions. The following passages from his narrative relate a few near death experiences. Chomreun recalls:

When they saw me wearing glasses, they said, "Oh, you look like a minister [state official], still wearing glasses! You should be killed! We don't need that [kind of] people!" He yelled to me like that! But a friend walked beside me, he was former soldier. He said, "Oh, brother [to the Khmer Rouge official], he cannot see, if you take his glasses off. It's not for beauty, it's for seeing, he cannot see." Yeah, I cannot see far away. We have learned French in Cambodia, so when speaking, sometimes French will come out easily. If when the red guard heard that, 100% you [will] get killed. I almost lost my life too, during [that time] because of my glasses.

Chomreun was under constant suspicion and the watchful eye of the Khmer Rouge village chief. In this passage he describes how the village chief's two killers spied on him, isolated and tested him:

...The chief of the village named Yeng had his own three killers. If he wanted to kill anybody he sent these three killers.
 ,, he sent [the killers], because he already knew what I [was] talking [about]! About my past, what I am. He sent Muen, the mean killer to take me at night at 9 p.m. with his motorcycle ... and I'm sure that he wanted to kill me or to doing something to me, because that place the orange orchard, it's a killing place. He [would] just take anybody on the list and kill [them] in that place. I know that. He brought me inside. That village chief, didn't say anything, just let me stand around [while] ... he talked with his three killers. I thought, if they try to kill me, I will fight back! Yeah, yeah, I decided at that time. But I didn't show my reaction yet, I was just thinking

in my mind... [it] was a very hard time, you see. I thought I would be killed at that time. So if you could not control yourself, the expression can come out. So they wanted to see what my reaction was. [That's] what I thought. So, I had to control, you see, control my, my brain, control my reactions everything, don't show anything.

... I wait about 2 hours and the village chief showed me the radio, a Philips radio. Oh, they said, "Oh, fix that." To extend the time, see, I just pretended to look, unscrew, screw it back, many times to take about one and a half hours. But I already knew what was wrong! ... why it didn't work! He put the batteries backward!

It is evident how Chomreun's knowledge of electronics, his ability to control his anxiety in the face of death and his quick-wittedness played a critical part in his survival. Many an evening he was called out to fix a generator. But Chomreun knew his position was precarious, thus he was ever watchful, cautious, not given to believing rumors, and always thinking ahead.

Chomreun was shot at several times, had a gun held on him on many occasions, was threatened verbally with death and lived under the constant fear of having his previous professional status exposed.

Chomreun recalled another near death experience in 1978 when the Khmer Rouge, fearing the invading Vietnamese troops, rounded up civilians to take into the forest with them. Chomreun decided to remain hidden with his wife and one year old son on the top of their house, but his son began to cry.

They [Khmer Rouge] heard the cry, they said, "Oh, some people are hiding upstairs!" They came up, the black one, loaded the gun, all ready to shoot me, "You want to betray the organization!" "You want to join the Vietnamese troops!" [I was] almost killed, but another man, clear skinned, who looked like he knew something, he pushed the [gun] barrel up, "Don't shoot, my comrade." And he talked very softly to me, "Please brother, join them so you won't be killed." So, I took some belongings with my wife

carrying the small kid... And got down out of the house, walked along the road. They stationed the troops, along the road. [digging] the trench. They insulted me a lot along there! "You better [be] killed, you deserve to be] killed ... you traitor, you want to join the Vietnamese group!" Oh, but along the road, I saw a lot of corpse they killed.

Chomreun believes that in addition to his own capabilities, a combination of elements enabled him to survive the certain death that awaited him. These consisted of spiritual forces that forewarned him of danger, protective incantations which he learned from his family, Buddhist teachings, and rare objects which contained protective spirits. He recalled an incident in which a spiritual forced saved his family:

[Whether] It's real or not real it can't be proven, you see, but I experienced it [spiritual forewarning] 2 or 3 times, during Pol Pot era. ... we didn't have anything like electric lighting... I worked at the commune and brought the oil that they emptied from the generator, [to use for lighting]. When my wife fell asleep, ... her hand which was resting the child, hit the lamp like this [showing a falling motion], and caused it to fall. ... fire caught on the mosquito net which covered our sleeping area... Something happened to me! Pulled my leg, pulled my leg and said, "Fire, wake up!" Two times, "Fire, wake up!" It happened two times! About month later the same thing. And the first time the fire got up to the roof only. But I grabbed the blanket and to stop it. But the second time the same thing, but because the pillow was very close to the lamp, it burnt the pillow. The pillow burned slowly, we could not feel anything, you see, but they [the spirits] pull me again, pull my leg again. The fire was way up, oh, about one quarter of pillow was on fire....

Yeah, something got me up. I believe it, because the Cambodians believe, that the spirit of relatives are still around and the spirit of teacher, the Cambodian worship the teacher, "guru". I learned, I have some guru too, like martial arts, incantation guru, because I learned martial arts too. I've learned some incantations. But a lot of Cambodians who have a high education don't believe it. Yeah, I say, if I believe it, I've lost nothing!

Chomreun showed me some of the rare objects which he believes have protected his family: an elephant tusk which broke off in a tree, a solid core boar's fang, and some frizzy hair. According to Chomreun, elephants are known to punch their short tusks into trees and break them off. After about a year or two the tree bark will grow to cover the tusk. It is believed that spirits protect the elephant's broken tusk. He stated:

A former Lon Nol soldier, colonel, saw it [his broken elephant tusk], and wanted to buy it from me, but I told them [the soldiers] that I couldn't sell it. It was handed down from my father. They tried to convince me to cut it, because they wanted to carve it into a Buddha statue. I told them that I did not want to cut it; I wanted to keep it as a whole. Another [type of amulet] is the fang of the boar, most fangs have a hole inside. It's very rare that you can find the fang that does not have a hole, a solid fang. Luckily, I found one and those are good talisman too. It was handed down from my father. I have a cousin, so I divided it into three: one gets the end, I wanted the middle and the other got the other end... We believe that the fang could protect us against fire, and bullet, but I have not tried with the bullet.

Yes, and frizzy hair, I have a bundle of it. The frizzy hair has spirit in it Yes, but it's not as strong as the broken elephant's tusk and the solid boar's fang.

Chomreun's escape with his family to the refugee camps was also dangerous and difficult. They reached the Thai border camps in October of 1978 and remained there until 1981, at which time Chomreun and his family were transferred a camp in the Philippines in preparation for his resettlement in the U.S. in January of 1982.

Flashbacks and Personal Pain

Chomreun describes his suffering as “personal pain”. He states:

Almost every night I dream that I still live in the Pol Pot era. They question me and sometimes they chase me and shoot me. I always dream of when I was in the Thailand camp, and we didn't have freedom to get out of the barbed-wire encircled camp. If you get out, you would be beaten or shot by the Thai guard. The Thai guards treated us like animals!

Chomreun describes having flash-backs about the Pol Pot era while driving his car, which caused him receive speeding tickets on two occasions. During these times questions would occur to him. “Why did they kill my friends? Why did they kill the people? A lot of questions, I still have.” He states he had a lot of problems, mental, physical and sometimes an inability to control his anger.

However, Chomreun's narrative-telling never dwelt on his suffering. Revelations of his suffering would quickly be followed by the ways in which he strategized to survive during intense moments of fear generated by the Khmer Rouge, or discussions of how he currently controls his suffering.

Chomreun's Healing Strategies

Chomreun said he has never sought out traditional Kru Khmer or Western help for his suffering. He states:

I don't think that they understand how to heal me. The only time that this suffering will go away is when I die. What happened in the past is the past. Right now, I just try to find ways to control my suffering.

Throughout his narrative, Chomreun described several strategies to control his suffering. Most frequently, Chomreun uses *incantations*, which he learned from his grandfather who was a Kru, his father and other Kru, to control his suffering. Even prior to the Pol Pot era, Chomreun attempted to research the origins of these incantations, which he found traceable to Hinduism. Buddhism, he states, considers such incantations, “wrong knowledge” and forbids their practice. But Chomreun argues that Cambodians practiced Hinduism in ancient times, and that Buddhist incantations have their roots in Hinduism. To make his point, he related that an anthropologist friend requested a translation of Buddhist incantations, which he found impossible to translate because they are a combination of several old languages.

Chomreun believes in the teachings of the Buddha. Buddhism preserved his hope during Pol Pot and currently aids in controlling his suffering. He says:

...the Buddhists say you have to accept what you have. Don't worry too much, don't be happy too much, go in the middle. I use that part. When it's right I do it, if it's not right I don't do it. I just keep that in mind...
 ... I use the Buddhist philosophy to control that [suffering]. To avoid that [suffering], I pray.

Perhaps one of the most powerful ways in which Chomreun is able to control his suffering is through his writings: “When I get angry I cannot control, after I wrote that book, I’m a little bit calm. It helped me to express what I thought, what I saw, what I suffered.” Through the writing of a book and articles

for Cambodian newspapers in the United States, Chomreun was able to express his anger about past as well as current injustices perpetrated on Cambodians.

Chomreun knows, however, that he speaks out in his writings at risk to his life:

... Sihanouk got angry with me, because I accused him. ... if I step into Cambodia, one hundred percent, I'll be killed! They don't want any opposition over there...

... Khmer Rouge [in the US] ... use their hidden power as informant of the FBI ... to treat those people [Cambodians living here] to make them fear ... I know that if I ... don't keep my mouth shut, one day they will shoot me.

Chomreun's desire to seek out subterfuge and deception has aided him in looking below the surface of apparent reality. This skill was critical to his survival during the Pol Pot era. Chomreun's knowledge and attempts to grasp the larger political power struggle and structural aspects which were responsible for the Cambodian holocaust provide an avenue to make meaning of his suffering as part of the larger, collective suffering of fellow Cambodians. His strong feelings and opinions about justice for the Cambodian people enable him to channel the energy of his suffering. He says of Cambodia's future:

I wrote this in 1981,1983, I predicted that we cannot solve the problem with the Khmer Rouge, but we can solve the problem with the Vietnamese... The Americans don't know the truth that Vietnamese people are still in control. I am sure that in the next 40 to 50 years, if Cambodian cannot bind together, to liberate themselves, the Vietnamese will take over, a whole new change. In Laos right now, Vietnam controls most of it. In Veang Cham, capitol of Lao, 60% of the of the people who are living in that city are Vietnamese. They don't even speak Laotian. They are trying to do that and it's the same in Cambodia. They have already done this in the low land. South of Vietnam used to belong to Cambodia... the Cambodians still have the right to claim for it before international law. ... if 100 years haven't passed, then the owner country can still claim it back. Cambodia still has

the right to claim South Vietnam. We still have about 5 to 6 million of Cambodians still living over there. [Historically] To stop Cambodian people from moving in, they went into the heart of Cambodia to make them fight each other and we lost everything. Everything is the Vietnamese's trick. Even the king fell into their trick, because his wife... is half-Vietnamese... Even before the UN went in and many groups tried to make a political party, ... they tried to contact me, after they had read my book. I told them that I didn't want to join in the group, [unless] they joined all those 20 groups... If they wouldn't agree to join together, 100% they would lose.... How is the fight, right now? Who will lose? It's the Cambodian people. People are dying everyday, but few people have the true view of that.... I've said what's need to be said, because it's my duty as an Cambodian. Whether you listen to it or not, it's up to you.

Sophiap: An Orphan's Story

Sophiap was born in 1965 to a farming family in the province of Kompong Speu. Her father died several months after she was born, leaving her mother to raise and support their seven children. Sophiap was the sixth of seven children. Her eldest sister, Sokha was followed by four brothers. The seventh child was a female. Her third brother died of illness some time in the early '70s. Following that period, the family was unable to make a living in farming due to a drought and they moved to Svay Sisophon.

In 1975, the Khmer Rouge evacuated the entire family from Svay Sisophon. During the evacuation Sophiap's mother became ill, she worried about the home they used to live in, and without medication she became increasingly sick and died. Shortly after that, Sophiap's three brothers were taken away by the Khmer Rouge; she has never seen two of them since that time. She recalls:

They [her brothers] knew the written language and they used to live with big people, a colonel in Phnom Penh. So when it was all done, they [Khmer Rouge] came, they investigated and they knew that my bothers were knowledgeable. So they said they want them to study abroad for several months. So they took them, perhaps to kill them, because they have disappeared since. I searched and could not find them. They were soldiers.

At that time Sophiap was 9 years old, her eldest sister, Sokha, possibly 18 or 19 years of age and the youngest sister, perhaps 7 or 8 years old. Sophiap was separated from her sisters and sent to a work camp. Eventually, her youngest sister was separated from Sokha and placed in a koma (a group for children under ten).

Near Death and Trauma

Sophiap's remarkable story of survival is difficult to do justice to. At nine years of age she demonstrated amazing strength and resilience in the face of death. Her emotional bond to her eldest sister went beyond any fears the Khmer Rouge attempted to instill in her. She says:

... And then I heard about my sister so I walked for two nights and two days to her. And then I got to her, but they [Khmer Rouge] knew and called me ... an enemy, because I didn't follow their rules. Then they beat me close to death. And then they took me real far away, away from my older sister that I ran to. And why did I run? I had nothing to eat, nothing at all...
... I was so hungry. At the age of nine, I was so hungry.

Over a four year period under Pol Pot and another six years in the refugee camps, Sophiap endured forced separation from her family, beatings, starvation, forced labor, reeducation, her own attempted murder, being shot and

wounded, and the tragic death of her oldest sister. She witnessed mass killings, and the daily deaths of individuals by starvation or murder.

Despite her parents' deaths and having come from a peasant background, Sophiap's family was falsely accused of having official importance and condemned to death. In reality, her brothers were educated, and one of them was a soldier, but the family had not been involved with the government.

Under the pretext of reeducation, the Khmer Rouge took hundreds of men and women to a mass grave to be killed. Sophiap was among them; she recalled her ordeal as follows:

... I just saw humans, males and females, bound up in ropes all the way around the road ...

... They tied me in it. And then they dug a pit with a bulldozer. ... Some people were shot, some were beaten with bamboo sticks. I was at the end of the line, seeing people ahead of me being killed, I was in shock. I kept moving like I didn't have consciousness.

And then they got to our row, my hands were tied behind my back. So then what I saw clearly was a bamboo stick, then they beat me but I didn't die, I just lost consciousness, because they only gave a single blow and I already fell. My head cracked open where the blow was from, the front all the way to the back.

As they gave me a blow, I didn't seem to feel the pain. ...it [her head] cracked, blood seeped through my hair.

... I don't know how many days or nights...

... when I came to, in that pit, you know, there were a lot of dead corpses, hundreds and thousands. So the pit became more shallow, as I was one of the last ones to fall. So I crawled out, all were gone.

Miraculously, Sophiap kept crawling, she is not certain about how many days, for she was near death. An elderly man found her and carried her to safety and recovery. From that point, she did whatever she could to survive.

She lied about her identity, and said she had no relatives. Sophiap ate whatever she could find to supplement her diet including frog embryos, crickets, snails, and snakes. Although her work group harvested a great deal of rice and were promised food, their regular diet consisted of boiled morningglory with rats.

When the Vietnamese invaded Cambodia, Sophiap was shot in the foot by the Khmer Rouge as she attempted escape. She was again near death as her foot became infected, and without medical attention, the flesh began to decompose. As the battle grew more intense, the Khmer Rouge abandoned their hostages. Sophiap states the Vietnamese rescued her, operated on her foot and medicated it, so that it eventually healed.

Sophiap was taken to Srok Tmar Gole where the fighting between the Rouge and Vietnamese forces continued. It was there, fortunately, that she was reunited with Sokha, her eldest sister, but not for long. Getting to the refugee camps was treacherous, and life in the camps dangerous and meager, as they faced starvation on a daily basis. Sophiap describes her last time with Sokha:

...there was too much fighting, the Thai's shot their artillery at us, the Vietnamese fought with the Khmer Rouge, the people were stuck in the middle like that, so my sister died. The child [Sokha's] was with me, I took care of her. Well, the bunker was big like the soldiers bunker. Too much artillery came in, the bullets penetrated through, many died, not just us. I was hit too, but it was minor, scattering all over my body. So I kept digging through dead bodies. When I made it out, everyone was gone, they all ran away. So I was totally disoriented.

... and then I came out to the top of the bunker and I sat there thinking that when we went in, there were three of us, my sister held my hand and she held her child's on her side, running into the shelter, too many people, we got separated. So it came to me that we went in, three of us. ... I

gained my self-awareness, I jumped to dig through, not too deep, only several people buried on top of her, her hands embracing her child. I turned her around to see that her back was totally hit every where. I looked at her stomach, the intestine came out, the feet were amputated, and the fingers were cut...

... her eyes were still open. She hadn't died yet. So I tried to pull them out. While she held the child, the bullets got through to the baby and she lost consciousness, so I tried to pull them out but couldn't because I was too small. So I sat there not being able to do anything.

Then I saw two Cambodians and I put my hands together asking them to take my sister too, they had American doctors that helped, but they were too far. I asked for help because I couldn't carry her, so they, with their dharma compassion, helped carry my sister to the doctor.

When they cut her broken bones and stuff, her breasts were all torn, so they bandaged her and stuff, put in the intravenous and stuff. She was alive all this time, but when all was done, she broke her last breath.

... the baby didn't get taken care of yet. They shelled the hospital and burnt everything down. So I snatched the baby and ran for three days and three nights. And I ran without food or water, people were dead everywhere. Sometimes while running, the bullets hit people and they would just drop dead. So I ran into Thailand, about three days and three nights later. They called it "Red Road" or something like that.

Sokha's child survived a broken spinal cord and major wounds. Sophiap begged the doctor not to amputate the child's legs, which he agreed not to do. After three operations and a year in the Khao-I-Dang hospital, Sophiap's niece had partially recovered.

For all intents and purposes, Sophiap, now 13 years of age, and her niece were considered orphans. They were sent to an orphanage, where a French citizen prepared to sponsor them for resettlement. Her niece, however, continued to suffer seizures and needed to be seen at the hospital. On one such occasion, Sophiap was reunited fortuitously with her eldest brother:

... he brought his wife to deliver her baby at that clinic. Well, he kept staring at me and I at him, we seemed familiar to each other...I couldn't really remember [him]...because I met him once only for a very short time when the Vietnamese came and was separated from him again since. So he sat at the table facing me, then he finally asked where I was from. Me, I kept saying I don't know, and then he asked my name, I told him and he said, "So you must be my sister and none other." Then he embraced me and wept. So then he sponsored me [as well as Sokha's child] out of the orphanage to live with his wife and his child.

After six years in the camps, Sophiap and her family were finally resettled in the U.S. in December 1985. She was twenty years old, much of her childhood lost, having faced and survived extreme physical and emotional injury, Sophiap has been continuously ill since 1987. Sophiap has had two children: a girl, born in 1987 and a boy, in 1992, resulting from her relationship with their father, but has not married.

Sophiap's Suffering

Sophiap spoke no English when she arrived in Washington State. Her family was sponsored by a Cambodian family who provided them with enough money for a deposit and a month of rent. Church groups donated beds, blankets and food, but unable to communicate in English, the family often sat staring at the Americans. She began English as a second language classes and vocational training, but says, "I fell ill and I haven't been able to do anything since." Sophiap describes her initial suffering this way:

I could not pinpoint it, like headaches and dizziness. And inside, my physical body was not well, my hands and my legs started shaking. So my sponsor advised me to go to the doctor. They checked my blood and

everything else but could not find anything. So in June 1987, they looked and said I had a bladder infection. I no longer had the energy that I used to have...I became very thin, 98 pounds. Like walking around, I could hardly do that. I got thinner and thinner, not knowing the reason why. I kept going to the doctor, they said I wasn't sick, but I kept losing pounds. They gave me TB test and stuff like that.

... So I kept getting sick until 1990. One day in 1990, I was not able to get out of bed, I could no longer walk, I kept on having pain, starting in 1987. Whatever I ate hurt me, I could not eat a lot. So the doctor said I had an ulcer, the doctor in Beaverton. So in a week I was put to sleep twice, they gave me shots then they inserted a tube down my throat to my stomach.

After continuing to experience extreme pain in her stomach area, she was brought by a friend to the emergency room and an x-ray was taken. Sophiap states she was diagnosed with gallstones and was operated on in December 1990. Her experience in the hospital left her somewhat confused, as she recalled:

I was a bit disappointed, because when they explained, they only talked about removing gallstones, but then they also removed the gallbladder. When I was in surgery, I didn't have a Khmer translator... [I] understood some and not some, because according to what I understood, it was not the removal of gallbladder, but just the stones.

... I have had a change of heart [about doctors], but I never mention it. And ever since the time of the operation up until now, inside of my body is not well. When I'm exhausted, I'm just so totally exhausted...without energy.

Although the gall bladder operation relieved the acute pain, she continued to experience bodily pain and other symptoms. Her heart beat irregularly, her hands and feet shook, she could not sleep and she experienced pain all over her body. She says of the pain:

It's like I'm being stabbed by a knife...the pain spreads to my chest.

... The pain lasted throughout the night, then it exhausted itself out. It broke me to the point that I could not walk, then it went away. Sometimes if it's not the severe sharp pain, it would be a mild pain like cramps. It goes on like that, sometimes throughout the whole day...starting in the morning...goes away the next morning. And the last two weeks I had stomach pains, when that is gone I now start having bladder infection...it's painful...I don't know what to do...

Sometimes if I had the Tylenol Three, I would fall asleep. I sleep like that, but when the medicine potency runs out, the pain starts again...Sometimes I go to the emergency [room].

She has been prescribed more than fifty different kinds of medication since 1987, but their effects are not long-lasting and she struggles with how to deal with the pain:

...those medications, you can't say they don't help, when I take them they help, when I stop, it hurts again and that's how it's been. That's why I say, how long am I going to live if I keep getting sick like this. If not this, it's that. When it hurts bad, I think in my thoughts that I do not want to live.

From the Western psychiatric standpoint, Sophiap has the classic symptoms of posttraumatic stress disorder. Throughout the course of her six interviews, Sophiap described re-experiencing traumatic events through auditory and visual flashbacks, emotional numbing through dissociation and increased physiological arousal. This is part of what she describes:

It is like for those four or five years [Pol Pot era] my brain was totally attached to that without forgetting at all you know, for those four or five years...

Sometimes when I awake, I break out in a sweat. Like yesterday, going to class, like there was a suffering within me, like there was a problem, like I was unhappy, and when the teacher spoke to me, when he was done, I stared at his face. I stared just like that, but I had no idea what he was asking, I blanked out for that moment.

...because my brain was thinking about other stories, it's like I wasn't focused on him, but I heard him though. Yesterday, everybody in the

whole class laughed so hard. I kept staring at him when he questioned me, I snapped out of it only when he called my name, but I had no idea what he was lecturing on, I was thinking about who knows where, my brain went to Cambodia actually. When my feelings are unhappy, whatever people say I don't really hear it, it's like I'm recalling those pasts. But within my intention, I don't want to behave like that, I don't want to at all, but I don't know why, it goes off on its own, it drifts on its own. My intention is determined to pull it [my mind] back so those things don't happen again, but I cannot pull it back successfully, I tried in every way, I cannot do it. I don't know why it happens.

... Sometimes, sometimes, there really isn't anything, like there isn't anybody making me upset or stressful at all, it's like me, myself, going off like that without anybody provoking it. Sometimes I keep thinking about my first sister [Sokha] that I often talk about, the one that died, I keep recalling it as if it's right in front of my eyes, like how she was dying, whatever took place then, I keep seeing it exactly like that

...I see her, oh, so real so vividly like when I saw it, although ten years have past, it seems like it had just happened...

Sometimes I dream that I dig through dead bodies, sometimes there are sixty of them in a bunker. I would keep on digging, searching for my sister that was killed at the bottom of the ditch, sobbing, when I wake up, my tears stream down my face as if I was truly crying. I sweat as if I was really working.

Sophiap's psychiatrist had confirmed her diagnosis of posttraumatic stress disorder, however, her internist's response negates these findings. Here she shares how he discounts her suffering:

...I ask my doctor why am I so sick, I'm sick constantly. The doctor then answered that he cannot detect it, but my ailment cannot kill me, it cannot kill me like cancer and stuff. That's how he answered me. And so I responded that the ailment cannot kill me, that may be true, but they can hurt me and make it hard for me to live...

For me, I might have hope with the ACRS (Asian Counseling and Referral Service) counselor [counseling and psychiatric services], but with my regular doctor, I have no hope. He has thrown quite a bit of [unpleasant] words at me. He said you're sick, but you're not sick every day and I should be able to work.

The robotic procedures of the welfare system, and its workers' apparent lack of knowledge about the historic background of Cambodians and posttraumatic stress disorder have also caused Sophiap needless suffering. After repeatedly receiving letters threatening to terminate her aid, she arranged for a personal interview with her case worker, and was told that assistance would not be cut off, however, she still needed to get a job and a letter from her physician identifying her specific illnesses. The physicians' conflicting views of her illness, and a welfare system which communicates general policy without considering the individual's circumstances, exacerbate her trauma and place the burden of proof on her. She described the process as follows:

Welfare calls me to see them almost everyday. If they don't call, they send letters. They keep threatening to cut off assistance for this and that constantly, and that stirs up my mind so much...

Last month, welfare wrote to me to go to work and stuff, they are cutting me off from welfare. And another thing, the doctor doesn't help me very much. So I'm having such a hard time, I worried so much in the last couple of days, that I got sick again.

And the doctor keeps on saying that because I keep thinking that I'm sick, that's why I'm sick. ... And then I said, I don't believe that, it's because I'm in so much pain that's why I say I'm in pain. Sometimes the pain that felt like I was being stabbed all over would go away only for two days, and then it would start again. My head hurts and I have dizzy spells. And my stomach hurts constantly, days and nights. And inside me I feel like I have no energy. I eat normal like other people, but I have no energy, I feel like I'm so sleepy because I don't get much sleep at night because it hurts too much...I keep waking up constantly.

Sophiap reasons that her various illnesses and suffering have complicated origins, but she is not sure that they are directly connected to her experiences during Pol Pot. She said:

I don't know what to think, but my family doctor thinks it has something to do with it [Pol Pot era experiences].

My thoughts are that I must have some kind of illness for me to hurt like that....

... during the Pol Pot regime I was not sick...I...I came to stay at the refugee camp and wasn't sick either. It started for the first time in 1987.

However, she also believes that her suffering is the result of forces beyond the war:

Me, I think this way. I think it's because it's my karma, not cultivating good merit from previous life, maybe I didn't cultivate good merit like others, that's why I'm under going those bad karma now, it could be so...

I have always believed that if I didn't have [bad] karma, I would not have suffered to this extreme, I believe like that.

Attempts at Healing

The major sources of treatment that Sophiap utilized since resettling in the U.S. has been the Western medical system and Kru Khmer. Thus, she received acupuncture, spot-burning, traditional Khmer herbs, and absolution from Khmer Buddhist monks and Kru Khmer, at the same time that she was receiving Western medicines.

None of the traditional Khmer treatments helped relieve Sophiap's pain. And although Western medication helped relieve pain temporarily, it did not help stop recurring nightmares or flashbacks. She says of Western medication:

It doesn't really help, those recurring nightmares, those flashbacks are still there, but it helps for me not to think. I still keep seeing, but I don't think. And when I asked the doctor, the doctor said that that medication is like that, because when I take the medication, I don't think too much, I don't get sick as much. But it's not comfortable for us humans with body, but without marbles to think, it's difficult you know, right?

She concludes, however, that each treatment modality has been helpful to her in some way. She said:

Come to think of it, each plays a different role. Like the Khmer guru helps ease the mental anxiety, and the doctors help give medication to cure me of the pain....

... The one that helps the most are the doctors.

However, regardless of which type of treatment is used, Sophiap says, "It doesn't get worse. It's the same old thing, I'm still sick."

Chanda: A Mother's Story

In 1975, Chanda was 25 years of age. Her extended family consisted of twenty-three people all residing together, in the same village outside of Phnom Penh. Her father was an investigator, and was pursued by the Khmer Rouge as soon as they came to power. He was shot to death after several escape attempts. At the end of the Pol Pot era, the entire family, with the exception of herself and two younger brothers, had either been killed by the Khmer Rouge or died of starvation.

Chanda's family of origin consisted of herself and four siblings. Her older brother died prior to the Pol Pot era in an auto accident, and one of her younger brothers died for lack of medical care in 1975. Both her parents were ethnically

part Chinese and Khmer. Her mother had been married previously; thus, Chanda also had an older step-sister and step-brother who lived with their biological father's family.

Chanda's entire extended family lived together and made their living as various types of merchants, selling rice, groceries and other items. She went to school for six years, and recalls being seventeen or eighteen when she first got married. Chanda was working in a cloth weaving factory when the Khmer Rouge took over the government.

Chanda has been pregnant twelve times: six resulted in miscarriages: one prior to Pol Pot and five during that era; two children that were born during the Pol Pot era died from starvation as infants. She currently has four children ranging from sixteen to eight years of age. Her oldest child, a daughter, was the only one who remains alive from the Pol Pot era. The second child was born in a refugee camp and the last two in the U.S.

Chanda's first husband was executed by the Khmer Rouge just prior to the Vietnamese invasion. Her second husband died of an illness when they were in the refugee camp. Her third husband left with another woman, and she separated from her fourth husband.

Initially, when her family was evacuated from Phnom Penh, they lived in the woods without food or shelter. Because of her family's background they were rationed only one can of rice and a spoon of salt for a month.

Forced Labor, Starvation and Death

Chanda was moved from village to village by the Khmer Rouge group leader in charge of their area. She finally ended up farming in Svay Dangkham. The living and working conditions caused thousands to die; she recalls of that time:

When I first got off the truck, I was made a rice farmer. There were four groups that came to this area. When we first arrived there, there were 19,000 people. Then, by the time the Vietnamese invaded there were only 1,800 people left. They all died. They usually died by the families. [by] Starvation, because some families have eighty people and only one can of rice. And some even had one hundred people. Sometimes there was nothing, we had to drink the water as broth without any rice.

Then when the floods came, we had nothing to eat at all. Living there, you know? And from working and over exhaustion, having nothing to eat. Some months, when there was no rice at all, they would make soup out of rice peel for us to eat.

There were even people who ate their own children. There was a lady who ate her dead baby. Too hungry. If you don't believe me, go see for yourself, and you'll see that this village is full of skeletons.

In our group, at first, the men agreed to farm, but as time went on they all died off....

... Sometimes they were rushed and forced to make seven tons of rice per one acre of land, people were then forced to work all day and night. From seven in the morning until twelve, then from one until five o'clock in the evening. Then would work from seven in the evening until eleven at night, again.

Yes, only two hours for rest! A lot of people would die because of not enough sleep also. There wasn't enough to eat, people's stomachs were big. When there was flooding, there was nothing to eat at all. We would walk around looking for food, even one little plant, we left no leaves on it. We were even eating vegetables that would give us diarrhea. In that village, nothing grew, only morning glory vegetable and sdauw [a bitter vegetable]. It was too much, ... there was nothing and as far as we can see there were no trees around. There was nothing to shelter under, no trees. You had to make your own shelter or else you had nothing....

Young children, ages six, seven had to go around picking up cow dung. They weren't allowed any free time. Living in that village, there was a lot of

hardship. There was never a moment to sleep easy during Pol Pot times. We had to dig irrigation ditches. There was a group of people sent From Svay Reang to dig irrigation ditches, when they were done, they were beaten to death.

They beat them line by line. They were all tied together in a line. Yes, they beat them. We would ride out in wagons in the morning you could smell the stench. These were the people that were accused of being traitors, so they brought them over and killed them. Ooooh...it was scary!

In 1979, three days prior to the Vietnamese invasion, Chanda's first husband was taken away and beaten to death. Pregnant at the time, she gave birth alone and found herself needing to be on-guard that the child would not be taken from her. She describes the first of these situations:

When I gave birth, I did it by myself. When my stomach hurt, I called out for the midwife, I was going crazy. I had to build a fire and boiled water on my own. When the water was about boiled, I went and sat up on the bed. Then the midwife showed up, but by that time, I had already given birth....

It was after I had given birth that there was a Vietnamese person [soldier] that took care of us....

The Vietnamese kept asking me for my baby. He said he would give me ten units of gold. But I wouldn't give up my baby, after all I had been through. I would not trade my child for anything.

Chanda was on her own after her husband's death, and she needed to support her child. During this period she walked from village to village, carrying her baby and following the movement of people headed toward Battambang. She describes herself as having bountiful energy:

Back then, my strength, was like something was helping me, I never ran out of strength. I would go get water for people, wash people's clothes for them, as long as they gave me enough rice for two meals. Then, I kept praying for my life and to take care of my baby's life, to help me live, and I never was sick back then. It was as though something was helping me the entire time, back then.

Along the way Chanda was shown kindness and generosity by several strangers, who shared food. She was given work in exchange for food by a woman who took her in for about five months after seeing she was trustworthy and industrious. Then, she continued following the exodus of people toward Camp Tmeay, where she was reunited with a younger brother, and later met her second husband.

Both families moved to Khao-I-Dang camp when their children became ill and needed medical care. They were advised that medical care would be available at the camp's clinic. There, Chanda's second husband fell ill; he died after they were moved to Srakeo, just prior to the birth of her second child. After the birth of her second child in Thailand, Chanda became totally blind for three months, after warming herself over a charcoal fire, which she believes may have caused the blindness.

Chanda believes that she survived the Pol Pot era because she, "... did good deeds, " in her previous life. Her story also suggests that resourcefulness, strength of character and strong maternal instincts were factors responsible for her survival.

Illness and Suffering

Since 1983, when Chanda resettled in Washington State, she has suffered continuously from various forms of illness, physical pain, constant

coughing, feeling that something was stuck in her throat, allergies, hearing voices and seeing spirits. In one of her first encounters with the health system, she had uncontrollable shaking in reaction to drinking coffee and eating jauf kway [fried bread]. She had to be taken to the hospital on three separate occasions because of this reaction.

Chanda is also allergic to the ingredients in Nyquil and develops a severe rash when she takes it. Unbeknownst to the doctors treating her for coughing up blood, she was prescribed medication containing such ingredients, which resulted in the unpleasant rash.

In 1992, Chanda and her family were robbed at gun point in their home by a group of four robbers who spoke Cambodian, English, Laotian, and Vietnamese. They tore the place apart, physically abused, threatened and terrorized them for close to an hour. Chanda was robbed of ten thousand dollars worth of money and gifts she was planning to take to Cambodia.

After the robbery, Chanda and her children were so frightened of being at home, that they slept at her sponsor's home every night for a year. When they returned to sleeping at home, Chanda began to be sick. She describes occurrences at that time:

... when I was driving, I saw stop lights...red lights, I saw green lights. I looked and didn't see any cars, so I kept driving on. My child yelled, "It's a red light!" When the light was green, I came to a stop. At that time, I thought I was going crazy. When it kept getting worse, I was extremely worried, because everything I owned was all gone....

... it was an illness related to the mind, thinking. I kept thinking that these things that I had collected from a long time ago, was all gone with a blink of an eye. I was thinking that, you know?

Then, I was sick and was unable to drive or anything anymore. I drove and got lost in downtown [laughter]. I was in downtown and asked the police which way to downtown. The police would look at me and shake his head. My child that was in the car was scolding me that it was downtown, but I wasn't able to understand my child anymore. Then, I was sick and began to have a fever. I had fever to the point of losing my consciousness and my children were scared. Then, I took some medicine. I was sick and was hot to the point of confusion. My child made rice soup for me to eat. I was eating rice soup and it seemed like the rice soup was stuck in my throat.

Chanda was taken to the hospital, where x-rays were taken, but the medical people were unable to determine the cause of her problem, nothing showed up in the photos. Her pain persisted, as she describes it:

I went to Harborview Hospital, I told them that I had a fever and things. As soon as I came down with a fever, it was like "a hundred ghosts took over my body". I was sick on that day. Within one hour, it was like I was sick with ten different types of illnesses. I would sit there and I would hear ringing.

Then, I went to the doctors, I told them that this hurt and that hurt, because it really did hurt inside my body. My arm hurt, to this day it hurts where I extend my arm and the pain won't go away. If I don't take pain killers I would "sleep in tears" every night. I have to take it continuously.

Chanda also experienced spirit visitations. She says these spirits keep telling her things and she keeps seeing something from another world. She described these experiences:

In my ear, I would hear somebody telling me things the entire time. And when I went to tell the doctors, they took me and put me in "hand cuffs" and said I was "crazy". And I said, I told them, "That I'm not crazy." But since I was sick, I have this thing, like people are telling me things.

They wear something like a king's crown or a beautiful angel, they tell me things. My eyes were open, you can't see it, but I can see it. I told them, when I was in the hospital, I told them, "He is coming to me again."

The doctor said I was crazy and they put in cuffs and things. I said I wasn't crazy, that people were calling me to go.

They don't come to harm me or anything, they are good people. I would see my grandfather, like from the time of the Republic, like from before. I wasn't asleep, I saw it like it was really there. Then when I went to the hospital, I tell them that I see these things...speaking based on what I saw....

Sometimes, I would see...but it became worse after I was robbed. It's related to "the way of my mind". Because I have sinned in the past and when I've lost everything from my body...these things are related to each other. I don't think about it. I just think that little things like these, as long as I am alive and find away to live it's okay, right?

Chanda's descriptions of her visitations from spirits caused her to be hospitalized for a week. Doctors wanted her to stay there longer, but she was released upon her insistence and intention to make a trip to Cambodia.

Chanda's suffering also manifests itself in severe, uncontrollable anger, which she has unleashed on her children. In the past, she has thrown a knife at her daughter and scarred her face. She says they are too big now, but she still attempts to hit them when she becomes angry or has problems with them.

Attempts To Heal

Chanda links her suffering to her experiences and losses during the Pol Pot era and the robbery of her home here in the U.S. Physical ailments such as her coughing go back to her childhood, and are triggered by things she worries about, depression, not feeling well and stress.

Chanda has utilized many forms of treatment in addition to Western medicine. She has tried, "Kru Khmer and Khmer medicine, Chinese medicine,

anything that was supposed to be good. I went to American doctors, Vietnamese doctors." She has also tried acupuncture, chiropractors, exercise at a fitness center. She finds "everything" helpful toward her healing.

Chanda also performs self-treatment or has the family help her with coining, suction, bleeding, bruising of her neck and drinking herbal potions. She describes some of these practices:

I had heating rub [tiger balm] on my head with bandage wrapped around it for thirty days in a month. The headaches, I had suction done to the forehead for it until it didn't bruise [bruising means it's working, bad air is being taken out].

At first, it helped. But later, it became not as effective.

I do the suction everyday, now it doesn't even turn red anymore. It stopped turning red, so, I would take a razor blade and make a small incision and create a small opening until black blood runs down....

When I slice it like that, dark blood comes out. Headaches. I've tried everything. When I go the doctors and it would hurt so bad, I would do this with my hands. The doctor would ask what I was doing. When he pulled my hand away and saw the bruise there, he would ask if it was hurting again [headaches]. I said it was hurting again. He said I shouldn't be so tense. I when it hurts so bad and the doctor would come and ask about it, I wasn't happy, I would even get into arguments with the doctor. Dr. Jackson, when I go there, I would be loud at the clinic, when it hurts so bad, I became loud at the clinic.

Chanda has had her head shaven regularly, in special Buddhist ceremonies. In 1992, she went to Cambodia and had her head shaved in such a ceremony. As a result, her condition was better for over a year. This ceremony had special significance as she explains:

During Pol Pot times, they took me to beat to death [execution]. I prayed to Buddha and said that if I survived that I would go and shave my head, just so they wouldn't beat me to death. So I wouldn't die and if I was alive,

I would be able to meet up with my aunt and uncle and shave my head and have a ceremony.

Another important aspect of Chanda's life, which she discussed in great detail, is her role as a marriage facilitator and mentor to younger Cambodians. She seemed to have great skill at facilitating relationships. In these situations, Chanda described not receiving benefits, since within certain Asian cultures doing good deeds without expecting benefit in return is part of the Buddhist cultural context of selflessness. Here she describes advice that was given to her about her over-involvement in helping others:

The fortune teller said not to help others too much, if you take on other's responsibilities, you will get punishment in return. And it's true. When I took on other's responsibilities, ten out of ten times, I never received merits, I received punishment in return [implied: receiving grief in return]. But, I never seem to remember [learn].

Sorya: A Story of Spousal Abuse

Sorya grew up in Srouk Boveil, later known as Ampil Pram Dan (Five Tamarind Trees) in Battambang province, a village composed primarily of her own relatives. Her nuclear family consisted of her parents, and nine children: five brothers and four sisters. She describes her family as middle class and doing well financially, until the deaths of her eldest sister during childbirth, and her eldest brother, a monk, due to illness. Sorya described what happened after her sister died:

All the older people in my family were all so upset and they cried a lot and I started to cry too, but I didn't cry long like them, because I was really young so I didn't really know much, what was going on. They were all really

suffering to see what had happened to their sister. ... my mother suffered for months and not even a year went by yet, then one of my older brothers passed away too

Sorya's eldest brother was ill prior to his death, however, the family did not believe that illness actually took him. She explains:

He was sick, his joints were all swollen, that made him very sick, but they didn't believe that, they believed in Krou Khmer, they said that the grandma on my father's side, made my brother sick, and she came back to get him.

I only believed a little, but my parents, sisters, and brothers believed in that. Every time, someone got sick in the family, my parents always tried to pray and setup a ceremony to get rid off the bad spirits.

These losses were a major stress on the family, especially, Sorya's parents. She described how her father reacted:

... my father started to have a lot of emotional suffering. He didn't want to work as hard any more, my parents started to sell some of their property and gold bit by bit. Plus, my parents had to raise my sister's children that even made things more difficult for us. My brother in-law, the father of the 2 children, didn't want anything to do with his children, and he left my family and got married again.

Sorya was born in 1954. At six years of age she started working in the rice fields. At nine, she was sent to school for three years, then returned to work in the fields with her mother. She says of the education in her family:

... we all worked in the rice fields, and the other 3 never went to school. Men got more education than women because they went to the temple to become monks so they could learn. My sister that lives in Cambodia now, she went to school longer than me.

Sorya was the eighth of nine children. She worked the hardest amongst her siblings, but was not recognized for this and often felt blamed by them. She says of her relationship with them:

I could not determine whether my parents loved my brothers or my sisters more than me. I was the one among my siblings that I worked more than them but I got blamed a lot by my parents more than my siblings. At one time, we finished working in the rice fields for the season, we didn't have to live at the rice fields anymore, moved back to my village. I was so upset with my parents, I went back alone to sleep at my thatched hut at the rice fields, I was about 14 years old already [considered mature]. I wanted to commit suicide by hanging myself because I was so afraid of my parents. When I was married, my life was not any better than before, I had many problems. I always liked to do good things [go to the Watt], but God never blessed me. I always received bad luck.

Death, Constant Fear and Starvation

Prior to the take over of Phnom Penh, the Khmer Rouge began entering Sorya's village. She says of this period:

In 1974, the Khmer Rouge started to come into my village to capture people to join them, so they got one of my brothers [seventh in line] and forced him to become a Khmer Rouge, but he didn't want to, he wanted to escape back to his village, so they killed him....

In 1975 when Pol Pot took over the country, they separated me from my parents and they forced me to live with a group of people that were around my age....

My brothers and sisters were all separated and sent away from the village and my parents remained in the village. I had no idea where they sent my brothers and my sisters.

In 1977, I suffered a lot when I lived in Sala Kraw because they killed a lot of people from 1976-1977.

Sometimes, some people in my group wanted to run away but the KR usually knew about that so they called everyone into a group meeting and then they called out those people that wanted to escape. The KR ordered those people to be killed right away. The KR tortured many people because those people tried to escape to Thailand; the KR forced us to

watch because they wanted us to know that we couldn't escape from them. I was even more afraid after I watched that .

... I saw them tortured people in different ways such as they beat them up or put plastic bags to cover their face to suffocate them. I saw them passed out and they told people that the meeting is over and to return to their place. I had no idea what they did with those people.

The Khmer Rouge made Sorya the leader of a rice planting work-group which consisted of nine other individuals. Every so often, they would tell her there was a traitor in the group and they wanted to her to investigate everyone very carefully. The KR gave her ten days to find out who this person was. Her response was:

When I got that news I was very scared and at the same time I was very angry toward the KR. I asked myself a question, if they saw those people talking to the enemy, why didn't they catch those people on the spot on their own? Why did they ask me to catch that person for them. I realized that they always wanted to kill people with no reason. Another reason was that they wanted to kill people from my group, and another reason was that they also wanted to kill me. Every time, I had to go for the meeting, I always had a small knife hidden around my waist. If my time was up, I wanted to make sure that I would kill myself first instead of letting them torture me. During that time, there were many people that killed themselves because they didn't want the KR to torture them. They killed themselves by over dose or hung themselves.... No one knew that I had a knife, if they ever found that I had a knife they would kill me as well.

Sorya believed that she survived because the gods were with her, and her mother's good spirit protected her from all the bad things. But she also knew that she had to be extremely cautious:

During that time, I could not trust anyone because some people would spy on others for the KR so the KR would promote them to become a leader of their group or else....

I was about 22 or 23 years old so I knew and I always was so scared of them but for some young people they didn't know. I never played with

anyone I never talked more than I had to and I was very careful about everything around me. They tried to pick on me by saying that I was very serious about my work. At night, they didn't allow a man and a woman in my group to talk to each other but they would come to watch us through the holes in the walls because when we lit up a kerosene they could see us clearly from the outside but we could not see them from the inside.

The Khmer Rouge cadre forced Sorya to marry in February 1979. In April of the same year, pregnant with her first child, she was separated from her husband. She recalls:

In the morning of April, 1979, the chief of my village ordered my husband to transport some rice to hide them in the woods because they got the news that the Vietnamese soldiers were getting close to their village, but they didn't want to tell the civilians the truth, instead, they told us that they needed to keep the rice in the woods so it would be safe from the fire, most civilians didn't know about their plan. My husband left around 9:00 a.m. in that day, at noon time, there were a lot of people running from all over in my village. When I saw that I was so panicked and scared, I started to run and my mother told me not to go anywhere. The bullets were dropping all over in my village. I saw a lady crying about the chaos in the village, when I saw that I ran out of my village. My younger sister didn't want to run with me. Now, she lives with my mother in Cambodia, so only me that came to Thailand....

In 1979, after I entered into the refugee camp, I had difficult time living in the Refugees camp because I lived with my in-laws. Everyday, they brought people from different places into the refugee camp, I was always at the gate waiting for my husband.

In 1980, word came that Sorya's husband had been killed. She lived for a time with her in-laws, but they were unable to get along. She then went to the camp authorities and requested living quarters with other widows. She describes this period:

We didn't have any money to buy food because I didn't know how to make money, I didn't have my husband to support me, like other people. In 1980, sometimes, we didn't even have enough firewood to prepare our food.

Every ten days, they let people out of the Refugees camp, to find some firewood but they didn't give us enough time, only 20 or 30 minutes at the most. Everyone must returned back to camp when the camp authorities said so, if anyone didn't make it back on time. Those people would get beat very badly by the camp patrollers. In my case, I never got a chance to go out there because I was scared and I had no one to take care my son... I didn't have enough water to use, they provided us with very limited amount of water... I had to wait for a long time to receive a bucket of water. When I went to get in line for the water, I had to leave my son at home, so every so often my neighbor would let me know that my son cried, I had to run back to check on my baby. Sometimes, when I got back to the line someone else took my spot and I could not find my bucket water because some people had stolen it. During that time, many people were stealing from each other. Some people that were very good with stealing, were doing O.K. I never had enough water, firewood, or food to eat. I had such a hard time supporting myself and my son. Sometimes, I thought my son would be better off to die than to stay alive like that. I lived in that refugee camp from October, 1979 until August, 1981

Eventually, she met a cousin in the refugee camp and both were sponsored into the U.S. by an uncle who had escaped in 1975.

New Suffering in the US

The transition into the U.S. was difficult for Sorya. She was depressed about the prospect of entering a new country. Her main concern was being so far away from her family:

The day that I had my name posted to come to the United States, I was so sad and I cried a lot. Other people said to me that, they were very happy to come to the United States and they said to me that I should be happy, instead I cried. I cried because I'll be too far away from my family.

Upon entry into the US, Sorya was actually happy, but that happiness did not last long:

I arrived to the United States in 1981, I felt a little bit better with myself because I started to see a lot of good things about this country. The Welfare Department gave me some money to start my life here. At that time, I did not miss my family as much as I did like when I was in the refugees camp in Thailand. By mid of 1982, I met with a man that wanted to marry with me. I was not to sure that I wanted to be involved in a relationship again but he helped me with many things, for example, he took me to many places that I needed to go. I decided to get married with this man because I wanted someone that I could depend on and he seemed to be the right one for me at that time. Shortly after I married to him, I was very disappointed because I realized that he was not a good person, as I though he would be. He was an alcoholic and he was very mean. He verbally and physically abused me and my children. I really hate one thing about the Cambodian culture is that if a woman got married, she had to stayed with that man regardless of their married relationship. If she wanted to leave that man, people in the Cambodian community would look down on her. In this case, I decided to live with that man for as long as I could because I did not want other Cambodians to look down on me. *It was my karma that I had to marry with him so I had to live with him until the end of my karma.* I had to put up many things with him, when I got into the argument with him or he beat me up I could not report to the authority. Some of my neighbors supported me and some others didn't, they said a lot of bad things about me. At that time, I was forced to keep everything to myself, I put up with many painful and fearful things that he did to abused me and my children during those years.

Sorya had two children with her second husband. On several occasions after the birth of her third child, Sorya took protective shelter at the YMCA . In April 1985, after a "big fight" she returned to the shelter. She shared, "At that time, I made up my mind not to be with him again forever."

That month, Sorya moved to California with her children to live with relatives. A cousin, not understanding the extent of abuse she had suffered, thought it would helpful to send her husband the cost of the trip to be reunited with his family. She recalls:

In the past, he [her husband] was very good at convincing everyone to be on his side. When I told them about many problems that I had with him, my family members in California did not believe me. They usually thought that I was the problem maker instead. He only was there for 11 days, he beat me up so bad that I thought I was going to die. At that time, all my family members started to believe in me after they saw what he did to me.

Sorya's family aided her escape from her husband and did not tell him where she had gone. She returned to Seattle and began divorce proceedings. From that point, she avoided men, hated them and made up her mind not to marry again.

Forgetfulness, Depression, Anger

While in the refugee camp, Sorya describes being confused, disoriented, unable to concentrate, depressed and forgetful. She said, "In 1980, I was so forgetful, I thought I lost my mind, I know things, but I could not think of what I needed to do at a particular time." Her condition was better for a time and worsened after her second marriage.

In 1987, two years after her divorce, Sorya began to feel that her condition was improving. Then in 1991, she received some bad news from Cambodia: her family was suffering from lack of food and poverty. In 1992, she learned that her father and one of her nephews had died. These concerns, in addition to her worries about her sons, caused her to become depressed and agitated.

Then in 1993, in the early phase of developing a relationship with an American man, Sorya became extremely angry and made a suicide attempt, then called an ambulance. She recalled:

I decided to over dose myself because I didn't want to live anymore. They brought me to the hospital and they referred me to the ACRS. The ACRS prescribed these medications to me.

In 1993, this problem happen when I met with my boyfriend. He is a very kind person but I worried too much. I had a hard time believing in him and I got angry very easy. I was never involved with any man since 1985, until I met with him in 1993. After I met with him a few months later, I had mixed feelings about him, I was jealous of him and I was a little bit angry.

He had no idea about my past problems. He found out some of my problems after that incident. I had no idea about my problem, I only knew that I feel angry and hate many things. After I met with my counselor at the ACRS, I started to realize that I have this problem (mental problem).

Sorya's American boyfriend has been good to her children, but her middle son does not like him and conflicts occurred when the child made an ultimatum regarding one of them leaving. Her boyfriend's recent departure left her wondering what was causing her unhappiness:

Sometimes he would travel for a month or so, then he would return. But leaving this time meant we're really breaking up, he took all his belongings. He left because he was upset too. His clothes, his computer that he used to have here, he took them all. After he was gone, I laid here missing him. This is one thought that provokes my blame for God. Why does God punish me so. My first husband was separated, my second one was no good, and this last one can't be considered as a legal husband, but in my heart, I'm with him, he is my husband. But why make it so that I'm separated and can't live with him? What have I committed so wrong from previous life?

Resources Utilized in Coping

Sorya's first contact with psychological help came after her suicide attempt in 1993. Since that time she has continued to receive counseling, psychiatric care and medications for her depression. She says of the medications:

I would say it helps me. It releases my anger and it stops me from thinking too much. But I don't forget totally. Thinking and anger are still there somewhat, though I feel much more relief. When I'm stressed out, I would take the medication, it would stop me.

She finds the help received from the Cambodian counselor and psychiatrist at the counseling agency the most helpful. She shared:

I say medication and the counselors at ACRS are the most helpful.... When they ask about the stories and stuff, the doctor poses the questions about the causes of things and then he would give me medication. But when I share my problems and when it comes to most problem solving, then it's really the Cambodian counselor [that is most helpful], although she doesn't give me medication.

However, in Sorya's attempt to receive treatment for her severe pain from an internist, she felt ignored and her symptoms were discredited. She said of this experience:

...before I would go once a month to have physical therapy. Then later I had a full day of x-rays and then they gave me medication. A whole day, then they called later to say I had no problems. And my doctor, too, called and said I had no problems. So next time when I have pain, I never bother, I don't go again.

Sorya is uncertain about the path to healing, in many ways she feels that God and Buddha have abandoned her, but she also prays to them. The support

she desires from a male companion seems always thwarted. What Sorya feels would most help, she described this way:

Like when I'm angry, I'm totally feeling severe suffering, like I want someone to come to my house this instant to my contentment, I don't have any of that.

If I were to count the normal relations, of course, I would have them, but to have 100% support like I ask for support, [where] they come to my aid right away, to my pleasing, according to my needs and my sufferings, I don't have that.

For now, her most effective sources of help are the psychiatrist and Cambodian counselor at the multi-service agency.

Summary of First Level Findings

The first level of analysis involved considerable reflection on, and familiarity with the narratives of Cambodian Holocaust survivors. The meanings survivors attributed to their experiences were syncretic and dynamic in nature, allowing for blending several different meanings while changing them as needed. The healing processes that were invoked by these survivors were, therefore, also syncretic, and a tribute to their creative resilience.

Survivors' Traumatic Experiences

As the previous analysis of their narratives disclosed, the war experiences of each of the four survivors were extremely devastating and traumatizing. The traumas they experienced included: attempted murder,

beatings, continuous threats of death, forced labor without food or rest, starvation, forced separation from their families, and witnessing executions, torture, and mass killings. Sophiap, Chomreun, Chanda and Sorya remained in constant fear of death, with the knowledge that those individuals the Khmer Rouge led away were never seen again. Stories of rape, torture and failed escapes were commonly heard. Psychologically, the Khmer Rouge created fear and distrust by pitting children against adults, and forcing individuals to spy on each other to garner their favor. The Khmer Rouge forced them to attend "re-education" meetings to reinforce rules and instill fear. To live another day, under the Pol Pot Regime, people had to be resourceful, to steal, lie or cheat, and to eat the inedible.

During the escape from Cambodia to the Thai refugee camps, survivors found themselves in the middle of combat situations, witnessing the gory deaths of loved ones or fellow countrymen, and facing the dangers of robbery, murder, rape, and land-mines. In the refugee camps, they were beaten or helplessly watched as Thai guards killed others. Conditions in the camps were squalid. Food and water were scarce, and shelter was minimal and primitive. Fear of Khmer Rouge operatives continued and many were subjected to the manipulation of opportunists who sought profit and control during the chaos.

It must be emphasized that the constant fear, exhaustion, hunger and moments of sheer terror that plagued these survivors on a daily basis are forever

emblazoned in their minds. Across all cases, survivors reported intense flashbacks and dreams, which are as vivid as the day they happened, and have the same or greater amount of emotional impact.

These survivors were often further traumatized upon entering the U.S. Two of the women in this study experienced further traumatization through physical abuse and violence perpetrated on them. Sorya, who expected a happier life in the U.S., instead led a life of physical and emotional abuse under the domination of her second husband. And when Chanda was robbed in her own home at gun point, the terror she experienced during that incident exacerbated her emotional and physical suffering. Demeaning or insulting encounters which survivors had with the social service, medical and school systems also aggravated their suffering.

Suffering: Illness, Symptoms, Spirits

Cambodian survivors in this study continue to suffer from flash-backs, nightmares, dissociative episodes, headaches, dizziness, extreme physical pain, auditory hallucinations, seeing spirits, coughing, loss of memory, depression, agitation, loss of appetite, insomnia and PTSD symptomatology. Suffering may diminish, but never completely goes away, and seems to recur in full measure when exacerbating circumstances or events trigger the survivor's recall of traumatic times in Cambodia.

Paths to Healing

These individuals have employed various paths to healing (see Table 3 for summary). Chomreun, the most educated of the four, by virtue of traditional societal practices which preferenced males for higher education, conceptualized his suffering as the result of Khmer Rouge disruption of the country and political mismanagement. Chomreun understands that his suffering will never go away until he dies. He formulates that he must, therefore, control it. He has never used Western forms of intervention for treatment of his suffering. His primary resources for the control of suffering were: Buddhist teachings, incantations, coining, hobbies such as gardening, and writing about injustices perpetrated on Cambodians. His world view enables him to link his suffering with a historic moment in time, and connects him to the collective suffering of other Cambodians who have suffered as he has.

Chomreun, thus, appears to be the best adjusted of the survivors in the study. The daily challenges of work, provide an excellent means to preoccupy his mind and ward off war memories. However, the risk of post trauma suffering recurring at a later age remains to be seen, in light of the observed recurrence of PTSD in W.W.II veterans.

All three women in this study managed their suffering through combinations of Western health care and traditional Cambodian treatments. Although they all demonstrated resourcefulness in locating help to relieve their

suffering within the Western system, their educational attainment, age and gender play a critical part in the options available to them in terms of effectively utilizing resources and creating further healing opportunities. For example, because these women came with little or no education and primarily worked in agriculture, it was much more difficult for them find employment in this society in comparison to Chomreun, who already had a great deal of education, knew several languages, was able to retrain himself in this country, and find a job which supports his family well.

In contrast, Sophiap, Chanda and Sorya receive Aid to Families with Dependent Children as their primary source of financial support. All three women received little or no education in Cambodia. Sophiap and Sorya came from farming backgrounds, and Chanda from a family of merchants. None of them understood English upon entering the country, and despite some English as a second language training, their primary language remains Cambodian. Their rudimentary knowledge of English prevents them from participating in complicated transactions. For example, Sorya, who attempts to speak English, is discouraged about her prospects for work and reported these frustrating experiences:

Last week they called and said the hospital needed a receptionist for a month. She said for me to go. I said how could I with my [limited] English... I want to do it, so I told Phala I would go, but I'll volunteer with someone with me. I can't answer the phone seven hours a day by myself. I don't trust myself... I want to be a volunteer because if I do it officially, I would [have to] take full responsibility... Another thing is, I want to work at the

store and stuff. I see people working at the fitting room, giving out numbers, putting clothes away. I want a job like that. I think I could do that, but John said I have to know how to read and write English. Just those price tags, [they] think I can't do that? So if that's the case I will stay on welfare.

I talked ... about a cafeteria job at school. He [another worker] said I have to pass the test or I can't work. I have to know all those foods by name. Forget it then. I want to do volunteer work at school, but they don't want me. What can I do?

The lack of facility in English limits their access to educational, recreational, and economic resources and opportunities within the larger community.

Healing avenues for the women are, therefore, limited to what the welfare system offers and what they can afford on their own. Sophiap, for example, relies primarily on the simultaneous use of Western medicine, traditional healing techniques, Kru Khmer and Buddhist absolution. Although her illness persists, she finds medications most helpful in controlling her pain, but feels that traditional healing aids in alleviating her mental anxiety.

According to Chanda, all forms of treatment aid in her healing. She performs daily blood-letting to relieve her headaches, and bruises her neck for her throat problem, while simultaneously making regular appointments to see her Western doctors. Yet, the duration of her relief from suffering was longest after she participated in a special Buddhist ceremony in Cambodia.

Medication and counseling are currently the most effective treatments for controlling Sorya's depression and agitation. Like Chanda and Sophiap, her

formulation of the healing process is syncretistic, reconciling a combination of differing beliefs.

This reconciliation of differing beliefs was an essential characteristic of all four participants' survival and healing processes. They were able, in this way, to reflexively respond to oppressive systemic structures in Cambodia and the U.S. by reconstructing the conditions of their survival on a moment to moment basis. The use of various beliefs to understand their survival, suffering and healing is of critical importance to their continual healing process.

The narratives also indicate that Western health care providers' lack of knowledge about Cambodian cultural norms impedes survivors' healing processes, discredits survivors' suffering and provides an example of systemic oppression. For example, knowledge about cultural norms regarding spirit invasion would have aided doctors who were working with Chanda to determine, in consultation with her, the most helpful course of action. Determining what kind of spirits they were, what they were saying and what this experience meant to her were important factors in her healing process.

Table 3: Survivor Characteristics and Formulations of Survival, Suffering and Healing

	Chomreun	Sophiap	Chanda	Sorya
Age in 1975 & Gender	30 yrs old male	9 yrs old female	25 yrs old female	21 yrs old female
Level of Education/ status	14 yrs teacher	none orphaned, farming family	6 yrs married/ wked in factory	3 yrs rice farmer
Explanation of Survival	knowledge, Buddhism, protection from spirits, talisman	no formulation	good deeds in previous life	mother's good spirit; her own caution
Forms of post-war suffering	nightmares, flashbacks	gallstones, physical pain, constant illness, suicidal, auditory/visual flashbacks	physical pain, constant illness; suicidal; spirit visitation	depression, nightmares, anger, suicide attempt
Reason for of Suffering	Khmer Rouge	not sure, bad karma	KR, robbery	KR; cursed by God /Buddha; bad karma
PTSD Symptoms	yes	yes	yes	yes
Western Medicine	no	yes	yes	yes
Traditional or other Healing Practices	self-administered incantations, coining	yes/moderate	yes/extensive	yes/minimal
Other Means of Healing	writing	friend who listens	mentor to younger Cambodians	no
Current Status	works as electrical tech	disabled with illness/PTSD	disabled with illness/PTSD	PTSD/ depression

CHAPTER 7: SURVIVAL IN A NEW SYSTEM: SECOND LEVEL ANALYSIS

I have a hard time with my physical body, if it's not one pain it's the other, like throughout my whole body there isn't any part that doesn't have pain. After my head, it's my chest, after my chest it's my bladder, after my bladder it's my stomach, and because of all this, my doctor said my life is too hard and he said that I should go see counseling, that they might be able to help alleviate some [of the pain]. And going to counseling, they say they might help with the burden, but I notice that there isn't any laws [methods]. I'm still sick.

Chanda 1995

Second Level Findings

The Ripples of Oppression

The previous sections documented the events and decision-making processes during the Cold War and traced the genesis of the culturally imperialist policies of the West in Southeast Asia which led to the Cambodian holocaust. The survivors of that holocaust, who participated in this study, experienced the everyday consequences of those imperialist policies at multiple levels. Some of the aftereffects of these policies as well as the strengths Cambodian survivors exhibited, which were revealed through interrogation of their narratives, will be considered here.

At one level, the Pol Pot regime orchestrated the genocide of its identified enemies and the disruption of cultural traditions to purge the newly formed communist society of Western cultural imperialism. These purges had

devastating effects on all Cambodians regardless of their status in society. Small facts were distorted in such a way that anyone might be considered an enemy of the state and targeted for elimination. In the case of Sophiap, who came from a farm family, the erroneous report of a neighbor condemned her entire family to elimination by the Khmer Rouge. In her narrative Sophiap stated:

But later on there was a neighbor who reported that my family used to be big [officials], but the truth was that my family wasn't all that big.

They condemned us. They said our family was of importance, but the truth was my brothers were educated but they lived with others, not us...they [her brothers] would come and visit. My second brother was a soldier...that was true...but my parents and the rest of my family were not any big officials...

They were ordinary farmers but they were well off. When we moved to Svay [Sisophon] we became rich, and then the people recognized our family. They said our family used to be big officials, so they arrested me.

Khmer Rouge policies, which appeared to be aimed at eradicating Western imperialism from its midst, in fact, were extremist and disrupted every aspect of traditional Cambodian life. It must be emphasized, that the survivors interviewed for this study, regardless, of their social status or actual connections with the Lon Nol government or Western imperialism, were evacuated from their villages and the larger cities of Phnom Phen and Battambang, and most often, permanently dislocated from their homes. These Cambodian citizens were forcibly separated from their immediate families, excluded from their normal life activities, and indoctrinated to accept a new set of values.

The Khmer Rouge efforts to indoctrinate Cambodians, however, underestimated the strength of traditional cultural-spiritual values based in Buddhist teachings of oneness with the universe, the lack of duality in conceptualizations, and extending compassion to all living beings. So many times throughout the narratives, the kindness and compassion of strangers shines distinctly as their country's beacon of hope. Chomreun's life, for example, was spared by a stranger who intervened on his behalf when Chomreun was discovered hiding on his roof top by Khmer Rouge soldiers. Chanda was given shelter and food by a woman who befriended her in the aftermath of the Vietnamese invasion. And Sophiap, after being clubbed and taken for dead in a mass killing, described the following help from a stranger:

And so I kept on crawling...through long bladed grass...kept on crawling. And then there was this old man who was assigned to hunt animals for food, he saw me, I told him about all the events...he took me to live on the other side of the mountain...the mountain that I left twice...he took me to a different location of the mountain...

I was almost dead already. He carried me up the mountain, and so I lived there. No one maltreated me anymore, except that I had to work hard and that was it. And ever since that day, I was separated from my family and never saw their faces again.

The survivors in this study experienced numerous forced separations and the death of large numbers of immediate and extended family members because of Pol Pot's economic and ideological policies. This disruption and destruction of large, well established family networks hit at the heart of their functional stability and ability to generate resources. Grief, resulting from the loss of

traditional networks, cultural practices, and daily-life activities, in the familiar environment of village life and within one's group of family and friends, has been expressed in various ways to this researcher. Many survivors did not wish to leave their homeland. Sorya described the loss of her husband and separation from family support in this way:

In the refugee camp, I was emotionally suffering about my life. I thought a lot about my family and relatives back in Cambodia and I also thought a lot about my husband because I was separated from all of them...

... I was so sad because my son was born, with no father. I had a hard time to stay focused or think straight about anything, I had no one to turn to.

I thought about dying because my life was darkness, I couldn't see or tell about my future, I was hopeless. Everyone was happy to come to the United States but I didn't want to come because it would be too far for me from my family.

In this and other segments of her narrative, Sorya expressed her need for familial support which she lacks but longs to have. She yearns for the kind of support that she would not need to ask for because, within the high-context nature of Cambodian culture, her suffering would be immediately recognized by the members of her family and appropriate response given.

Other Effects of Dispersal and Disruption

In 1975, U.S. refugee resettlement policy focused on the dispersal of Southeast Asian refugees, for example, at least 100 refugees were sent to forty-nine states except Alaska. By 1980, the relative isolation of these assignments proved unsatisfactory, and 45 percent of the refugees had made secondary

migrations to areas where they might receive familial, cultural and ethnic support (Hing 1993, 128-130). Two of the survivors described in this study moved here from another state or city to be closer to relatives or Cambodian community resources. This is important to note in light of our understanding about the collective nature of Cambodian healing processes.

Cambodians in America, however, have been resourceful in re-making their communities. After fifteen years, the Cambodian community in Seattle has two Buddhist Temples, and many Cambodians have found their places in the larger community, contributing to the welfare of their people and American society. Nevertheless, the current progress is a mere beginning, and the Cambodian refugee's struggle for various services is on-going. The current disruption of families and loss of networks is a constant reminder of survivors' past trauma, often exacerbated by distressing experiences which refugees encounter on a daily basis. Furthermore, violence instigated by Southeast Asians against their own community is a constant threat to individuals living in low-income areas. For example, the violent robbery that Chanda and her family experienced in their low-income apartment in Seattle exacerbated Chanda's post trauma stress symptoms as well as traumatizing her children.

There are also continued rumors that members of the Khmer Rouge members entered the U.S. as ordinary Cambodian citizens during post war exodus and currently reside in this country. These stories or accounts of

underground Khmer Rouge also pose another level of fear and disruption within Cambodian communities. Chomreun, who resided in several areas before settling away from any concentrated populations of Cambodians, discussed his concerns about documented members of the Khmer Rouge, who work in positions within the American welfare system and use their power to intimidate less educated Cambodians in various ways. He said of the atmosphere in another large city he had lived in:

But all of you Americans don't know the truth. Behind that Cambodian association is the Khmer Rouge. One is a doctor, another two are government officials, and another one is informant of FBI ... ! Four of them are Khmer Rouge, and some Americans told me that, "Oh.. they were former Khmer Rouge before, maybe they've changed now." I say, "No! No way, they've changed!" So, how do they control the community? A lot of them [Cambodians] are still on welfare, you see. When they [KR] know, they insult them. Khmer Rouge or Khmer Kruer Hrm, so they use their hidden power as a informant of the FBI, or at the employment office to treat those people to make them fearful, I heard that! They brought the police and FBI to check on a house even at midnight. At 12 midnight the Khmer Rouge informant brought the FBI to investigate a family on welfare to check on whether the father was hiding in the house or not, because the parents were supposed to be separated. But the wife came out, and said, "No, you don't have the right to check my house during midnight, if you want to know call me in the morning!" They still do that, to make people fearful. So, often, people who don't know anything about the Khmer Rouge have to join them, if they want to be on welfare. It's the truth! Most Americans don't know that! They use their hidden power.

Systemic Effects of Culturally Imperialized Policies

A second level of effects traceable to culturally imperialized U.S. policies can be located in the interactions with systems that refugees must engage in

order to live in this country. Traversing bureaucratic systems to obtain services is difficult work when a language barrier exists, cultural patterns are vastly different, and the individual is concurrently suffering from illness. Within the Western health care system, survivors reported receiving health and mental health care service, that varied in quality, concern, user-friendliness and effectiveness. Survivors found the care provided was helpful and user-friendly when it was respectful and attentive to their cultural needs, and especially when capable, caring translators were provided. At deeper levels, however, these war-traumatized refugees were deterred from their healing efforts by conflicts within and between the systems providing services; and health care providers' lack of knowledge about PTSD and/or the refugee's historic geo-political and cultural contexts.

The psychiatrists, along with social workers at the Asian Counseling and Referral Service (ACRS), who had treated Chanda, Sophiap and Sorya for PTSD and depression, have been trained to understand the disabling effects of severe trauma. The survivors' internists or general practitioners, on the contrary, discredited their suffering by telling them there was no medical basis for their illness. This type of inconsistency is indicative of the specialized training that physicians in the United States receive, which limits their knowledge and practice to specific areas of care. Physicians without psychiatric training tend to treat patients with a primary focus on disease-based illnesses.

The survivors in this study suffering from PTSD were left in a frustrating, confusing position between physicians who fundamentally disagree about the nature of illness and well-being. This confusion also reflects the continuing debate, within the medical profession itself, regarding the separation of mind and body in treatment.

In practice, psychiatrists themselves are divided about how to approach and treat patients in cross-cultural situations. Often, they find themselves compelled to hospitalize individuals who report auditory or visual hallucinations without any other evidence of dysfunction. Physicians lack information about the cultural beliefs and norms of Cambodians, and thus, have not developed appropriate practice protocols. For example, Sophiap and Chanda both had surgeries. Sophiap's gallbladder was removed, and Chanda had a tubal ligation performed. In both cases, the women have had extreme loss of energy and state that after the operations they have never been the same. Knowledge that among some Southeast Asians each body organ is considered to have a soul, and that loss of an organ leaves the body open to harmful spirit invasion would have aided the practitioner to better prepare the patient for the operation. The health care provider would have also been more effective in patient care had he or she consulted with recognized family elders or other respected individuals in the patient's social network regarding ways to anticipate and relieve stress resulting from the patient's cultural beliefs.

Furthermore, war-trauma survivors, like Chanda, Sophiap and Sorya are in an untenable position between two service systems. If the medical system regards them as not disabled, that is, capable of functioning normally, then the welfare system insists that they go to work, insists that they receive training toward that end, and threatens to cut them off from financial aid if they do not comply. The welfare system's focus on getting the survivor back to work without knowledge or regard for their condition aggravates their PTSD symptoms, and appears to turn their humiliation into rage and desperation. This degrading process not only works against their healing, but, once more, places them in a life-threatening situation.

Refugees and other non-dominant, economically and socially oppressed groups, in this country, typically, find themselves in unrecognized, unacknowledged life-threatening situations. Threats to life range from direct violence to more subtle forms as in culturally insensitive and ineffective provision of health care. As Young (1990) states, these threats represent manifestations of the underlying agenda of cultural imperialism, supported by racism and bigotry in this country.

Culturally imperialized practices were continually repeated when doctors, social workers and other health care professionals, who interacted with Chanda, Sophiap and Sorya assessed their reported symptoms only from the Western perspective. Their attempts at treating Chanda, for example, without awareness

of Cambodian health beliefs, spirits and healing practices left Chanda bewildered and at odds with Western treatment. Her spirit visitations, which could have been treated with prayers, absolution or other forms of spiritual care in the context of traditional Cambodian culture, were considered pathological and treated with the use of physical restraints and medication, which Chanda found offensive. She remembers:

After Harborview...they sent me to University Hospital. But before they sent me to University hospital, they cuffed my hands and ankles together. I kept arguing with them, saying, "I'm not crazy, why do you treat me like this." At that time, it was like something was coming again. I said, "Here they come again." They came and said this and that to me. The interpreter interpreted like I said it, from what I could understand. Then, when the doctor came, they made me lay on the bed and they put cuffs on my wrists and cuffed my ankles together. I said, "How come you are putting cuffs on my wrists and ankles? I'm not crazy."

This anecdote also indicates that our professional training lags far behind the needs of the increasingly diverse people using the health and mental health system.

As discussed previously, the United States involvement in the Second Indochinese War and our immigration and refugee policies are prime examples of our historic predisposition toward cultural imperialism. Yet the history of the Second Indochina War remains obscure, and our penchant for cultural imperialism is further evidenced by the fact that social systems within this country have been maintained in ignorance about the historic geo-political contexts of all non-European immigrants. Our public school systems, for

example, focus primarily on Euro-American history. Knowledge about the history of Southeast Asia must be sought independently or at the college level. Cambodian youth in America know little about the history of their culture, or the origins of their parents' refugee status. For example, in discussing the situation of Southeast Asian teenagers in Seattle, a gang interventionist shared that he knew of Cambodian gang members who called themselves "Khmer Rouge" without knowledge of its historic implications or of the impact of their rubric on the parental generation (G. Kurose, personal communication, 1995).

This second level analysis examined the historic and structural consequences of Western culturally imperialized policies relative to Cambodians. First, the effects of these policies as a catalyst to the Pol Pot regime's destruction and disruption of Cambodian life was considered. Second, culturally imperialist policies in the arena of refugee resettlement was considered as a continuation of the historic oppression of early Asian immigrants. And finally, culturally imperialized policies seemingly repeated in the current health and social service systems were analyzed. This examination disclosed the multiple ways in which these policies are experienced in the everyday lives of Cambodian survivors and continue to disrupt their progress to personal and cultural adjustment.

If, as demonstrated here, the reality of systemic cultural imperialism is recognized as our historic legacy, we must also recognize that it has crippled us

all and all of our efforts to assist those whose lives have been harmed by the policies and practices which are both the cause and expression of such imperialism.

CHAPTER 8: SUMMARY AND IMPLICATIONS: SYNTHESIS TOWARD CHANGE

As the introductory section pointed out, the analysis of Cambodian survivor narratives was framed within the context of historic geo-political events surrounding the Cambodian Holocaust. Chapter 2, therefore, provided a rudimentary exploration of culturally imperialist decision-making processes, which contributed to the traumatization and oppression of Southeast Asian refugees. This was followed, in Chapter 3, by an examination of the history of U.S. immigration policy, which attempted to demonstrate how immigration policy has functioned as an extension of foreign policy, and has protracted the oppression of Southeast Asian refugees. These contexts provided a framework for the analysis of survivors' narratives.

The data were analyzed at two levels. At the first level, the personal constructions of survivors' trauma-suffering-healing processes were examined for patterns and central concepts. At the second level, survivors' narratives were interrogated in relation to historic geo-political contexts and Western health care practices in order to reveal the circumstances within which refugee traumatization occurred and refugee oppression perpetuated within Western health and social service systems.

First level findings documented the severity and duration of traumatic experiences encountered by the survivors, as well as the nature and intensity of

their post trauma suffering. Data analysis revealed that survivors utilized syncretic belief systems in their attempts to alleviate suffering. By Western standards, Chomreun, the male survivor, appears to have made a successful adaptation to American culture. Further, he has been coping with his suffering without seeking Western health care. The women survivors, by Western standards, appear to be less successful in their adaptation and coping. However, within the context of traditional Cambodian beliefs, their syncretic healing practices enabled the women to cope with their afflictions on a day to day basis in a relatively successful manner.

The second level of analysis elucidated the ways in which survivors perceived Western health care as effective or ineffective depending on whether service was provided in a manner that was respectful and responsive in culturally appropriate ways. Survivors were frustrated and their post trauma conditions aggravated by welfare and health care practices and policies that were at cross-purposes and continuously threatened their survival in this country.

Implications for Practice

Throughout their narratives Cambodian refugee-survivors expressed their definite preference for services that were accessible, provided translators and was sensitive to their needs and cultural background. The refugee-survivor

narratives provide clear illustrations of practice implications in many areas. The first of these is a strong need for trained, competent language translators in the provision of health care or social services. These translators need a sound understanding of the differences in cultural values regarding family and social customs, health care, a knowledge base in posttraumatic stress disorder, and the ability to advocate and present as accurately as possible the perspectives of the client and service provider. Translator skills need to be updated regularly. Most importantly, the client should be provided with a safe and confidential way to provide evaluatory feedback regarding the translator's reliability and manner of treatment of the client. Several Cambodian survivors have informed this researcher that they were subjected to judgmental statements on the part of translators or perceived inaccurate translations, and were powerless to do anything about it.

Second, individuals and agencies who work with refugees need to be informed of the specific geo-political contexts from which refugees emerged, their socio-cultural traditions, health care and spiritual beliefs, as well as any other pertinent information relating to a particular refugee group. This will enable the service provider to take a history that is sensitive to historical factors and to cultural issues, while remaining alert for cultural signals of trauma and the survivor's expectations of the healing process. A sound understanding of the refugee's cultural and historic background provides the basis for a deeper

understanding of the client's situation, thus, a more informed basis for service planning.

Knowledge and understanding of the refugee family's cultural and historic background also serves as the basis for better rapport and a foundation for building trust and confidence in the service provider. When the service provider takes the time to allow family members to share their experiences, learn where they came from, who they were, what they did in their country of origin and about the things that are important to them, that interaction builds the basis of mutual respect and a viable helping relationship.

These multiple levels of historic and cultural context also prepare the social worker or other service providers with the ability to advocate for and facilitate the refugee's access to services, and the ability to develop service plans that more accurately assess what is workable for refugee clients. When a clear picture, developed over time and in collaboration with multiple sources emerges that provides as much of the refugee's experience and understandings as possible, much improved treatment plans can be made and implemented. This information might include the refugee's educational, socio-economic, and family background, information regarding gender, age and traumatization factors. With this information the service provider is better able to assess the level at which a refugee has the potential to participate in the American work force or whether the client should be recommended for long-term PTSD and/or

other disability support. This information base would also enable service providers to advocate on behalf of a refugee suffering from Posttraumatic Stress Disorder, but unable to express his or her needs due to the effects of PTSD, as well as cultural and language differences.

Third, in matters of health care with Asian refugees, Western service providers need to be open to collaboration and consultation with family elders, trusted family friends or respected community leaders. Conferring in this way with elders and other trusted, respected individuals provides a more fulsome picture of events, chronology and family history, and offers the refugee the collective assurance of his family network.

Fourth, individuals and agencies working with refugees should be knowledgeable regarding Posttraumatic Stress Disorder symptomatology, treatment and prognosis from both Western and non-dominant perspectives. This knowledge base would provide health care and social service providers with the ability to advocate and facilitate services on behalf of refugees afflicted with Posttraumatic Stress Disorder, while educating interdisciplinary colleagues about PTSD. It should be noted that studies previously mentioned studies, and the larger NIMH project which this study is a part of, indicate a large percentage of Cambodian refugees suffer from PTSD, but have not received any Western mental health care. These individuals may not seek mental health services until much later in their lives, or may primarily utilize orthodox medical services.

Finally, culturally effective practice must recognize the policies, political events and histories which were instrumental in creating the power imbalances that led to the persecution and domination of ethnic, racial, gender and other marginalized groups and sub-cultures. Without these macro level perspectives, practitioners are not simply less effective in intervention, research and policy making efforts, they become purveyors of guileful forms of oppression. For example, in this study, survivors talked about intimidating experiences with welfare workers, who, in attempting to enforce government regulations regarding the employment of "able bodied" individuals threatened their survival, and placed them in untenable positions reminiscent of the Pol Pot regime. Intimidating interaction with government authority figures exacerbates the refugee's fear and posttraumatic stress. This apparent lack of knowledge about the historic, cultural or situational contexts from which refugees come, or about PTSD symptomatology and what part it plays in the survivor's inability to work, is one of the ways in which refugee oppression is continued.

Implications for Policy

The possibility of U.S. defeat in Southeast Asia was not a consideration in American political decisions to intervene in the internal affairs of Vietnam, Laos and Cambodia, nor in the decision to initiate and persevere in the Second Indochina War. The need for refugee resettlement programs was never

anticipated and as a result were planned hastily with primary consideration focused on dispersal of an at least temporarily dependent population rather than the successful adaptation of refugees and consideration for the effects of war trauma.

These disorganized, hastily determined policies have also had long-term consequences for the variety of ways in which Southeast Asian refugees are treated by Americans. Within the American psyche, Southeast Asian refugees continue to be thought of as a "problem" disconnected from the causal source of their status; the U.S. policy of active intervention in Southeast Asia during the Cold War. Of course, the full picture or contextual totality involved in the development of national policies is not easily apprehended by Americans; its understanding is obscured by biased, sanitized accounts which are part of the nationalistic tendency of the U.S. as well as other countries.

The important job of shaping national policy in this country has been left, largely, to politicians judged to have the best interests of all citizens in mind. However, as traced in the previous discussions of discriminatory U.S. immigration policies and the history of U.S. involvement in the Second Indochina War, cultural imperialism in the guise of democratic ideology, clearly, has been the underlying force which fueled policy-making directed at the exclusion, or limited the entry, of Asians into the U.S., and can also be linked to the continuance of war in Southeast Asia. Short (1989, 133) in his investigation of

the underlying dynamics of U.S. involvement in Vietnam, found in the 1954 Geneva accord records, that Secretary of State, John F. Dulles, was, "...incapable even of considering the sort of accommodation with China that might have produced a settlement in Vietnam." Some Republican members of the Congress, for example, Senator Knowland, Congressman Walter Judd, and Assistant Secretary of State Walter Robertson were also passionately and intensely hostile toward the Chinese Communists. Short writes:

This would, simply because of the Sino-American experience over the previous five or ten years, account for the violence of their hostility and their willingness to make life as difficult for the Chinese regime as they could and might explain the comparative lack of restraint or caution which seemed to characterize their thinking about Chinese problems (Short, 133).

This complexity which surrounds national policy-making demands that each of us who are in helping and service-providing professions actively pursue larger view perspectives regarding national policies, at multiple levels, in order to better understand the long range ramifications of policies, whether they be foreign or domestic. It calls upon us to critically examine and seek linkages between larger national policies and their implementation at the local level. And to be actively involved in shaping policy that is informed by both practice experience and research findings.

In addition to signaling a urgent need for involvement in policy-making, Cambodian refugee-survivor narratives revealed important implications for policy-making. Social service and health care policies for refugees need to be

coordinated in anticipation of the problems refugees will face in a new culture, with the full picture of the refugee's cultural and situational needs in mind, and informed by the facts surrounding PTSD and its long-term, debilitating effects.

There is need for national policy regarding standards for sponsorship of refugees. It has been reported to this researcher by several refugees that some sponsors (referring to agencies as well as individuals) have used refugees as house servants, or controlled all money given in payment to refugees, in essence keeping them as captive labor. In these instances, refugees were discouraged from obtaining an education and obstacles were created to prevent their learning English.

Social workers and most helping-professionals may find moral high ground in the knowledge that the intensity involved in service to others, and personal survival needs limits the time available to identify and advocate against hidden agendas in policy-making. But in taking this stance are we not managed, in essence, by larger structural forces which have lured us into remaining in the dark while colluding with systemic oppression?

Unless interventionists at all levels acquire a larger-view understanding, which recognizes that mass-traumatization of refugees is merely the end point in a series of geo-political and transhistoric events, brought about by silently condoned national policies, we, in effect, contribute to prolonged traumatization and perpetuate the subjugation of refugee-immigrant populations. Ignorance of

our historic geo-political involvement in creating those events which produced mass trauma decreases the interventionist's sensitivity and perception of U.S. responsibility in aiding our "alien allies" toward healing and adjustment. The resulting shallow commitment to developing and implementing culturally effective healing processes seamlessly perpetuates Western biomedical and Eurocentric social service practice methods; a form of cultural imperialism in the name of altruism.

Implications For Social Work Education

The single most important implication for social work education that can be garnered from this study is the need for continual awareness regarding the complexity of all social phenomena. Understanding the traumatization of Cambodian refugees and providing services which facilitate their survival and healing is not only complex, but requires skill development at multiple levels as evidenced in survivors' narratives. The responsibility for skill and knowledge development lies with practitioners as well as educators. The most urgent call, in this researcher's opinion, is for social work educators to move beyond the limits of Western concepts of practice. The current literature on social work practice fails to meet the practical challenges of providing appropriate services to rapidly changing, diverse communities and makes it imperative that educators

venture into the community to collaborate with those communities social work practitioners purport to serve.

Knowledge about the health practices and belief systems of culturally diverse groups needs to be understood within the context of their traditional cultural expectations as well as from the ever-changing perspective of families adapting to life in this country as ethnic-minorities. There are no simple, all-inclusive explanations for differences in cultural beliefs and daily practices which are mediated by individual life experiences, age, gender and socialization factors. The work of understanding and providing useful services to diverse peoples requires that practitioners exercise patience and skill and a willingness to deal with the intricacies of individual cases. Social work education needs not only to broaden its perspectives, but allow for flexible, creative, collaborative approaches to work with refugees and other minorities.

Implications for Research

Respectful, sincere, informed and paced entry into the Seattle Cambodian community progressively established collaborative bonds between the principal investigator, field coordinator and interviewers recruited from the community, translators, transcribers, informal leaders and other interested community members. These individuals then became our core research team who were trained in research methodology and objectives and had a direct influence on

the type of questions asked, interviewing practices and sample recruitment procedures. This trusting, collaborative relationship in the team was critical in enabling us to assess methodological rigor, cross-cultural reliability in data collection and the need for adjustments in data collection procedures depending on participants' situations.

Communities continually targeted for research have begun to critically question what direct benefits they derive from participating in research. For example, ethnic minority communities in Seattle are angry and frustrated with research efforts which have left them feeling manipulated and no better off. Communities currently expect, and rightfully so, to participate in the research process by providing input into research directions, to approve or disapprove of any research done in their community, and be informed of how the findings of research will be used to benefit the community more directly.

The potential mutual benefits of collaborative research within communities and special interest groups far outweigh concerns regarding time investment, and scientific rigor. The time invested in developing community collaboration is more than doubly returned by the ways in which community members are able to facilitate, mediate or prevent difficult situations. The quality and depth of data obtained through collaborative efforts meet the challenge of methodological reliability and validity, and obviate the myth that collaborative research suffers from lack of scientific rigor.

Conclusion

This study utilized both constructivist and critical social research perspectives in the service of a deeper understanding of Cambodian holocaust survivors' narratives of their traumatization and attempts to heal. The use of both these frameworks in the analyses of narratives proved challenging. However, the potential of the critical social research method for examining the multi-layered elements of social phenomena and its clear agenda to unveil and oppose oppressive social structures must be recognized by social researchers.

Cambodian survivors whose narratives made this study possible faced oppression at multiple levels of their existence. Their experiences span the years of the French occupation, the numerous insurgent group activities against imperialist forces within their own government of the 1940s and 1950s, the Sihanouk and Lon Nol governments, the U.S. interference in and bombings of Cambodia, and the years of the Pol Pot regime. Their survival through the ordeals they described, is miraculous.

The nature of meaning-making for these survivors lies in their day to day constructions of suffering, which in turn also determine the nature of healing efforts that are attempted. What was evidenced in this study was the syncretic nature of Cambodian survivors' constructions of suffering, which catalyzed syncretic, dynamic healing strategies.

The long arm of cultural imperialism was traced from early U.S. interference in Vietnam, into Cambodia, to its direct affect on refugees resettling in this country and their participation in Western service systems. Through it all, the survivors of this study were resourceful and resilient, finding strength in their traditional cultural beliefs and practices, whenever possible, and utilizing to the best of their abilities Western social service and health care systems.

Our moral obligation to Southeast Asian refugees has not ended. As refugees the world over face the dawn of another era, we, in a country that has enjoyed peace within its borders for over a hundred years, must develop and practice the art of self vigilance and reciprocity in learning about, living with and interacting with cultures and ways of being that are different than our own. Like the Cambodians, who have been resourceful in adapting to a new culture and life, we must remain flexible and ready to be syncretic and dynamic in our approach to cultures and people unfamiliar to us.

Finally, peace is not easily maintained, but each of us has responsibility for maintaining that peace. This responsibility need not be fulfilled in the grand strokes of a master international peace-maker, although that too is needed. It is more powerfully realized in purposefulness and mindfulness in all actions. Thich Nhat Hanh writes:

People everywhere saw the Los Angeles policemen beating Rodney King. When I first saw that video on French TV, I felt that I was the one being beaten, and I suffered a lot. I think you must have felt the same. All

of us were beaten at the same time. We were all victims of violence, anger, misunderstanding, and the lack of respect for our human dignity.

But as I looked more deeply, I saw that the policemen beating Rodney King were no different from myself. They were doing it because our society is filled with hatred and violence. Everything is like a bomb ready to explode, and we are all a part of that bomb; we are all co-responsible. We are all the policemen *and* the victim.

In the practice of mindfulness, we nurture the ability to see deeply into the nature of things and people, and the fruit is insight, understanding, and love. Because we have not practiced deeply enough, violence has become the substance of our society. Putting the policemen in jail will not solve this fundamental problem. We accept violence as a way of life and as a way to deal with problems. If we are not mindful --if we do not transform our shared suffering through compassion and deep understanding--then one day our child will be the one who is beaten, or the one doing the beating. It is very much our affair. We have to look at the roots of the problem not just on the surface. (Thich Nhat Hanh 1993, 84-85)

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APPENDIX A: Diagnostic Criteria for Posttraumatic Stress Disorder

Posttraumatic Stress Disorder 309.81

A. The essential feature is the development of characteristic symptoms following exposure to an extreme traumatic stressor involving direct personal experience of an event that involves actual or threatened death or serious injury or threat to one's physical integrity; or witnessing an event that involves death, injury or threat to the physical integrity of another person; or learning about unexpected or violent death, serious harm or threat of death or injury experienced by a family member or other close associate.

The individual's response to the event involves intense fear, helplessness or horror, in children it involves disorganized or agitated behavior.

B. Persistent reexperiencing of the traumatic event in the following ways:

- 1. intrusive recollections of the event**
- 2. recurrent distressing dreams in which the event is replayed**
- 3. dissociative states which last from a few seconds to several hours or days, during which the person believes he/she is experiencing the events of the trauma in the present**
- 4. intense psychological distress or physiological reactivity due to symbolic triggering events.**

C. Persistent avoidance of stimuli associated with the trauma and numbing of general responsiveness manifested in the following ways:

- 1. deliberate efforts to avoid thoughts, feelings, or conversations about the traumatic event**
- 2. avoidance of activities, situations or people who arouse recollections**
- 3. amnesia for important aspects of the traumatic event**
- 4. diminished responsiveness or "psychic numbing" after the event, diminished interest or participation in previously enjoyed activities**
- 5. feeling detached or estranged from other people**
- 6. marked reduction of ability to feel emotions**
- 7. sense of foreshortened future.**

D. Persistent symptoms of increased anxiety or arousal not present before the trauma, which include:

- 1. difficulty staying or falling asleep due to recurrent nightmares of the traumatic event**
- 2. outbursts of anger**
- 3. difficulty concentrating**

- 4. hypervigilance
- 5. exaggerated startle response.

E. The full symptom picture must be present for more than one month

F. The disturbance must cause clinically significant distress or impairment in social, occupational, or other important areas of functioning (American Psychiatric Association 1994, 427- 429).

APPENDIX A-1: Complex Post-Traumatic Stress Disorder

1. A history of subjection to totalitarian control over a prolonged period (months to years). Examples are hostages, prisoners of war, concentration camp survivors, survivors of some religious cults; also those subjected to totalitarian systems in sexual and domestic life, including survivors of domestic battering, childhood physical or sexual abuse, and organized sexual exploitation.

2. Alterations in affect regulation, including

- * persistent dysphoria**
- * chronic suicidal preoccupation**
- * self-injury**
- * explosive or extremely inhibited anger (may alternate)**
- * compulsive or extremely inhibited sexuality (may alternate)**

3. Alterations in consciousness, including

- * amnesia or hypermnesia for traumatic events**
- * transient dissociative episodes**
- * depersonalization/derealization**
- * reliving experiences, either in the form of intrusive post-traumatic stress disorder symptoms or in the form of ruminative preoccupation**

4. Alterations in self-perception, including

- * sense of helplessness or paralysis of initiative**
- * shame, guilt, and self-blame**
- * sense of defilement or stigma**
- * sense of complete difference from others (may include sense of specialness, utter aloneness, belief no other person can understand, or nonhuman identity)**

5. Alterations in perception of perpetrator, including

- * preoccupation with relationship with perpetrator (includes preoccupation with revenge)**
- * unrealistic attribution of total power to perpetrator (caution: victim's assessment of power realities may be more realistic than clinician's)**
- * idealization or paradoxical gratitude**
- * sense of special or supernatural relationship**
- * acceptance of belief system or rationalizations of perpetrator**

6. Alterations in relations with others, including

- * isolation and withdrawal**
- * disruption in intimate relationships**
- * repeated search for rescuer (may alternate with isolation and withdrawal)**
- * persistent distrust**
- * repeated failures of self-protection**

7. Alterations in systems of meaning

- * loss of sustaining faith**
- * sense of hopelessness and despair**

APPENDIX B: HUMAN SUBJECTS REVIEW COMMITTEE APPROVAL

Form UW 13-11 (Rev. 7/94)



UNIVERSITY OF WASHINGTON

CONFIDENTIAL

Human Subjects Division
Grant and Contract Services JM-22

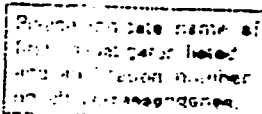
HUMAN SUBJECTS REVIEW COMMITTEE APPLICATION

BOX FOR COMMITTEE USE ONLY	
MASTER <input type="checkbox"/>	COMMITTEE <input type="checkbox"/>
REVIEWER <input type="checkbox"/>	INVESTIGATOR <input checked="" type="checkbox"/>
<u>25-378-C</u> <small>APPLICATION NO.</small>	

Submit nine copies (including one copy with original inked signatures) and all relevant materials (consent forms, questionnaires, instruments, data collection forms, debriefing statement, advertisements, etc.) to the Human Subjects Division, JM-22. Do not leave blanks. Submit one copy of each grant or contract proposal, and one copy of the protocol and investigator's brochure for clinical drug trials. Students should submit one copy of thesis or dissertation proposals. For information and assistance, call 543-0098. Handwritten and/or incomplete forms will be returned.

I. INVESTIGATORS AND ASSOCIATES (Correspondence will be directed to name of first person listed):

NAME	POSITION	DEPARTMENT/DIVISION	MAIL STOP	TEL/FAX Nos.
Paula T. Morelli	Ph.C.	Social Work	JH-30	522-2696 Fax: 525-7983



II. TITLE OF ACTIVITY: TRAUMA AND HEALING: THE CONSTRUCTION OF MEANING AMONG SURVIVORS OF THE CAMBODIAN HOLOCAUST

III. TIME PERIOD FOR INVOLVEMENT OF HUMAN SUBJECTS: FROM 8/1995 TO 7/1996

IV. ELIGIBLE FOR EXPEDITED REVIEW? ☐ YES (SEE MANUAL FOR DEFINITION OF EXPEDITED REVIEW)

V. FUNDING INFORMATION: LIST ALL GRANT AND CONTRACT INFORMATION ON PAGE 2. IF NONE, CHECK HERE ☒

VI. SIGNATURES: The undersigned acknowledge that this application represents an accurate and complete description of the proposed research; that the research will be conducted in compliance with the recommendations of and only after approval has been received from the Human Subjects Review Committee (HSRC); that the principal investigator is responsible for reporting any serious adverse events or problems to the HSRC, for requesting prior HSRC approval for modifications, and for requesting annual review and approval; and that if this research will not be peer-reviewed by a funding agency, it has received intra-mural review for scientific merit.

A. Investigator:	PAULA T. MORELLI	<u>Paula T. Morelli</u>	<u>6/23/95</u>
		<small>TYPED NAME PLUS SIGNATURE</small>	<small>DATE</small>
B. Faculty sponsor (for student):	ANTHONY H. ISHISAKA	<u>Anthony H. Ishisaka</u>	<u>7/3/95</u>
		<small>TYPED NAME PLUS SIGNATURE</small>	<small>DATE</small>
C. Department Chairman:	NANCY HOOYMAN	<u>Nancy R. Hooyman</u>	<u>7/3/95</u>
		<small>TYPED NAME PLUS SIGNATURE</small>	<small>DATE</small>

<u>[Signature]</u> <small>HUMAN SUBJECTS REVIEW COMMITTEE CHAIRMAN'S SIGNATURE</small>	<small>DATE</small> <u>8/13/96</u>
<small>Subject to the following conditions:</small> _____	
<small>Period of approval is one year, from</small> <u>8/13/95</u> <small>through</small> <u>8/13/96</u>	

VALID ONLY AS LONG AS APPROVED PROCEDURES ARE FOLLOWED

APPENDIX B-1: PARTICIPANT INFORMED CONSENT**University of Washington
Consent Form****Trauma and Healing: The Construction of Meaning Among Survivors
of the Cambodian Holocaust**

Investigator: Paula T. Morelli, Ph.C., doctoral student, School of Social Work, 685-2480 or 522-2696.

Investigator's statement:**Purpose and Benefits**

This study will explore the experience of Cambodians, between the ages of 30 and 55, who survived the Cambodian civil war between 1975-1979. Through this research we hope to better understanding how Cambodians survived their experiences, and what helps their adjustment and recovery. Information gained from this study may help Western service providers to develop culturally sensitive services for Cambodians and other refugee groups who have experienced wartime trauma.

Procedures

If you agree to participate in this study, the following will occur: You will be interviewed three times. Each interview will last approximately one and a half to two hours. The interviews will take place at any location that is convenient, maintains your privacy, and is acceptable to you. The interviews will consist of questions about your life, including your family history, experiences during the war and what has helped you deal with those experiences. Some examples of questions are: Of all the things that happened to you during the Pol Pot years (1975-1979) what are the things that you most remember? When you and your family came to America did you or anyone in your family suffer from problems (health, spiritual)? You are free not to answer any questions you do not wish to answer and to stop the interview at any time. Participation is strictly voluntary and you can drop out of the study at any time. Participation in the study will in no way affect any services that you already receive. With your permission, the interviews will be tape recorded.

Risks, Stress or Discomfort

There are some possible risks from being in this study. Answering some of the questions may make you uncomfortable or upset. Talking about the experiences of the Pol Pot years may bring into your awareness anxiety or discomfort about

that experience that you may not have been aware of previously. I can discuss your discomfort with you, or refer you to experienced counselors. I can provide you with the names of counselors should you decide to seek additional help.

Other Information

The information you provide will be handled confidentially. The audio tapes will be used instead of note-taking during the interview to assure accuracy of data collection. The tapes will be transcribed within three months and will be kept indefinitely. You will have the right to review the tape recordings and delete any part of them. The tapes will be locked in a file cabinet, and only the investigator and the transcriber and members of the dissertation committee will have access to it. No identities will be used in any report or on the transcriptions or in any publications resulting from this study.

In appreciation for your participation in this study you will receive fifty dollars for each interview that you participate in, or a maximum of one-hundred fifty dollars for all three interviews.

There are no adverse consequences if you choose not to participate in this study. Participation in research is voluntary. You have the right to decline to participate or to withdraw at any point in this study.

Signature of the Investigator

Date

Participant's statement:

This study described above has been explained to me by Paula T. Morelli, who has offered to answer any questions I may have. She can be reached at 685-2480 or 522-2696 if I have any further questions. I voluntarily consent to participate in this activity. I have had an opportunity to ask questions and understand that future questions I may have about the research or about my rights as a participant will be answered by Paula Morelli, as indicated above.

Signature of Participant

Date

cc: Participant
Investigator's file

APPENDIX C: NIMH STUDY INSTRUMENT

INTERVIEW GUIDE:

CAMBODIAN-AMERICAN HEALTH-SEEKING NARRATIVES

Principal Investigator:

Edwina S. Uehara, Ph.D., University of Washington School of Social Work

Co-Principal Investigator:

David Takeuchi, Ph.D., University of California at Los Angeles, Neuropsychiatric Institute

Field Coordinator:

Paula Morelli, Ph.C., University of Washington School of Social Work

Research Team:

Sorom Anderson

Molly Daggett

Louise Lew

Tom Morelli

Pat Norikane

Sona Pel

Sokha Saing-Fekete

Sopha Sar

Dharamuni Phala Svy

Poly Tieng

**Funded by PHS/NIMH Grant #2 P01 MH44331-07,
National Research Center on Asian American Mental Health
University of California, Los Angeles. Principal Investigator: Stanley Sue, Ph.D.**

INTERVIEW #1: FAMILY LIFE HISTORY NARRATIVE

* The war in Cambodia brought bad times and suffering to many, many people. These things are not easy to talk about. We are very grateful that you and other Cambodian people in Seattle are willing to help us understand what you and your families went through. This information can help Western mental health workers to understand what is helpful and what is not helpful to people when they go through hard times like that. This information can help Cambodian people who have suffered, and also other people who have suffered from war.

* Could you please tell us what life was like for you and your family in Cambodia before the Khmer Rouge came in your area?

Probes:

- Place of origin: Where came from (city or province) in Cambodia
- Family info: Birthplace, age, gender of family members, marital status (who is considered "family"?):
 - mother/father
 - siblings (+ children of sibs)
 - children (+ children)
 - others
- Ethnicity
- Occupation in Cambodia (if relevant); changes in occupation, especially during war/occupation/camps]
- Education: Highest level school completed; other kinds of job training received; ordination into monkhood (when, how long); military service (when, how long)]
- Whereabouts of family: who are in Seattle; other U.S.; other country; Cambodia [*probe*: missing/deceased family members]

* Could you please tell us about your experience of coming to the United States?

Probes:

- Leaving Cambodia: year left; w/whom; who helped/facilitated leaving
- Refugee Camps: Which refugee camp(s) lived in/how long; what was life like in camps [Problems/stressors experienced?]
- Arriving in U.S.: When/where arrived; who sponsored; who arrived with
- * If you don't mind, could you please tell us what happened to you and your family when the Khmer Rouge came into your area?

Probes: For self, family and friends:
 - imprisonment/deaths
 - forced relocation/labor camps
- other stressful events?
 - [if applicable:] experiences of Vietnamese invasion?
- * Of all the things that happened to you during the Pol Pot period, what things do you remember the most?
- * [Debriefing--throughout and at end of session] How are you feeling about what we're talking about today? probe: tired? uncomfortable? Anything want to say/talk about? [//Allow time for discussion of issues/feelings raised by interview//]

ID#: _____

[Screening Form:]

- * If you don't mind, [in addition to what you have just described] we would like to ask if you have experienced, witnessed, or heard of any of the following events, whether in Cambodia or in a refugee camp. If some of these questions are upsetting, please feel free not to answer or to stop at any time:

E=Experienced H= Heard about it W= Witnessed N=No

	In Cambodia?				In Refugee Camp?		
	E	H	W	N	E	H	N
Lack of food or water							
Ill health without access to medical care							
Lack of shelter							
Imprisonment							
Serious injury							
Combat situation							
Brainwashing							
Rape or sexual abuse							
Forced isolation from others							
Being close to death							
Forced separation from family members							
Murder of family or friend							
Unnatural death of family or friend							
Murder of stranger or strangers							
Lost or kidnapped							
Torture (specify)							
Any other situation that was very frightening or you felt your life was in danger							

ID # _____

- * **After you experienced these events, were you ever bothered by any of the following symptoms? (If yes, probe: when first experienced? did symptom bother you for a pretty long period of time--that is, for at least six months in a row or more? If yes, probe: At that time, did the problem bother you: a little, quite a bit, or extremely?)**

	"X" if yes	When ?	"X" if yes	Record number:
	Expe r. symp tom?	Mo., year?	6 mos or mor e?	(1) litt le (2) Qui te a bit (3) Ext rem ely
Re-experiencing traumatic stressors:				
Recurrent thoughts or memories of the most hurtful or terrifying events				
Feeling as though the event is happening again				
Recurrent nightmares				
Symptoms of emotional numbing, avoidance, social dysfunction:				
Feeling detached or withdrawn from people				
Avoiding activities that remind you of the traumatic or hurtful event				
Avoiding thoughts or feelings associated with the traumatic or hurtful experience				

Difficulty performing work or daily tasks				
Inability to remember parts of the most traumatic or hurtful events				
Less interest in daily activities				
Feeling as if you don't have a future				
Unable to feel emotions				
Finding out or being told by other people that you have done something you can't remember				
Feeling as if you are split into two people and one of you is watching what the other is doing				
Symptoms of heightened physiological arousal:				
Feeling jumpy, easily startled				
Difficulty concentrating				
Trouble sleeping				
Feeling irritable or having outbursts of anger				
Feeling on guard				
Sudden emotional or physical reaction when reminded of the most traumatic or hurtful events				
Associated features:				
Loss of appetite				
Feeling that people do not understand what happened to you				
Blaming yourself for things that happened				
Feeling guilty for having survived				
Hopelessness				
Feeling ashamed of the hurtful or traumatic events that have happened to you				
Spending time thinking about why these events happened to you				

Feeling as if you're going crazy				
Feeling that you are the only one who suffered these events				
Feeling others are hostile toward you				
Feeling that you have no one to rely on				
Feeling someone you trusted betrayed you				
Any other specific feelings or happenings?				

INTERVIEW #2: HEALTH-SEEKING NARRATIVES

- * **Was there anything about last session you want to ask about? Anything you want to add or change? Anything you kept thinking about or feeling?**

[Follow up: fill in any gaps in information from family life history narrative interview.]

Since you and your family came to America have you suffered from any health problems that you believe are related to the war? Could you please tell us about [the problem(s)]?

Probes:

- **Name** for this problem(s)? Meaning of name(s)? Positive, negative connotations of name(s)?
- **When first noticed?** By whom? Setting/context?
- **Signs/symptoms:** Specific signs/symptoms?

Probe further. How does problem(s):

- Affect body?
- Affect mind? (thoughts, feelings, heart)?
- Affect relationships with others?

Probe further: Beliefs re:

- Mind and body same or different?
- Mind controls body, or body controls mind?
- **Cause(s) and construction of problem:**

- How related to war experience? Experienced before war?
- What other causes involved?

Probe further. cause attributed to:

- invasion of evil spirit, spirit weakness due to family loss?
- "kam", "guilt"?
- actions in previous life?
- Who/what most influential in shaping beliefs regarding the cause of the problem/illness?
- Causal beliefs changed over time? why? who/what influenced?
- Family's construction of problem: causal construction different/same as respondent? Differences of opinion w/in family?
Probe further.
 - family feels "ashamed"? embarrassed? burdened?]
- Effects of problem(s): Own/family's life? Work life, other effects?
- Changes in problem(s): Since first noticed: worse, better, or stayed same? If so at what points? cause of changes? (← *probe further.* helpful/unhelpful interventions? caregivers? advisors?
- Most troubling thing about problem(s)?
- Exacerbating events/conditions: Most significant events or changes in own/family's life when problem began? Related to/exacerbate problem? How?

* We would like to understand what has happened to you and your family as a result of your experiencing these problems. If you wouldn't mind, we would appreciate hearing about all the things that you and others did to try to make the problem better, as well as all the things that happened that made it better or made it worse. Could you please tell us about that?

Probes:

- Anything else? (meditation, prayer, dietary adjustment, etc.?)

-- Anyone else?

- * friends, neighbors, coworkers
- * American sponsor
- * spirit medium
- * kru khmer
- * monks
- * priests, ministers
- * herbalist/traditional chinese medicine
- * western-style doctors/psychiatrists
- * chiropractor
- * nutritionist
- * ACRS staff/professional mental health specialist
- * druggist or pharmacist

Probes: For each source of care described:

- Type(s) of help/treatment received? How often? When?
How came to know about [source(s) of care]?
- Who suggested/referred? If referred, *probe further:* single or multiple people told you about source? Who first?

Probe further:

- Importance, satisfaction with help received
- Perceived consequences (problem better/worse/same? what was helpful/not so helpful? why? intended/unintended consequences?)

Probes: Received medicine?

[if yes:]

- Name?
- Cost?
- How often did/do you take it? How often supposed to?
- Side effects? (describe)
- Anyone tried/tires to help you remember take meds? Who?
- Anyone who thought/thinks taking meds IS NOT good idea? Suggested shouldn't take? Who?

Probe: *Probes:* Other things/events/conditions made problem worse? better? (e.g., spouse's job loss, moving to a new neighborhood, caring for an elderly parent)

- * **When you experience [problem(s)], what comforts you/helped you to feel better?**

Probes:

- Spiritual beliefs (Buddhist, animist, Christian, etc.)
- Participating in religious ceremonies (transferring merit to ancestors, receiving monk's blessings, etc.)
- Care received/caregivers (probe for details)
- Helping others (details)
- Of all the help received, which most important? why?

- * **When you experienced [the problem], did anyone give you bad advice, cause you to feel worse, or cause additional problems for you?**

Probe: who, when, how caused problems

- * **How is your health now days? Would you say you still experience [the problem] now days?**

Probe: how often experiences the problem(s) now days? How manifested? How characterizes health at this time? Believes problem is solved completely/partially/not at all?

- * **[Debriefing--throughout and at end of session] How are you feeling about what we're talking about today? [*Probe:* tired? uncomfortable? Anything want to say/talk about? //Allow time for discussion of issues/feelings raised by interview//]**

INTERVIEWER: PLEASE REVIEW INTERVIEWS #1 AND #2 FOR ALL PERSONS MENTIONED AS INVOLVED/INFLUENTIAL IN RESPONDENT'S EXPERIENCE OF ILLNESS AND HELPSEEKING, WHETHER INFLUENCE/ACTIONS WERE POSITIVE OR NEGATIVE, WHETHER ACTIONS WERE INTENTIONAL OR UNINTENTIONAL. IF UNSURE, ERR ON SIDE OF INCLUSION. PRIOR TO INTERVIEW #3:

INTERVIEW #3: FAMILY AND SOCIAL NETWORKS

A. Health-Seeking Narratives, Cont'd

- ** Was there anything about last session you want to ask about? Anything you want to add or change?**
- * [Follow up: Fill in any gaps in information from healthseeking narrative interview.]**

B. Family and Social Networks

- * If you don't mind, today we would like to understand more about your family and other people that care for you when you experience the health problem(s) you talked to us about last time.**

We tried to remember all the people you mentioned that were involved in some way in your experience. Here are the people we recalled: [read list of names].

Are there other people that we've forgotten to mention who were also involved? [add to list; *probe*: names to be added/dropped; update list]

- * If you don't mind, we'd like to know a little bit more about your relationship with each of these persons. Can you please tell us about your relationship with [name 1]?**

***Probes:* gender, age, ethnicity; duration of tie; closeness; assistance given to one another; stresses/conflicts).**

- * We would also like to learn about the relationships between the people we have been talking about today. Some of them may be strangers, others may know each other only a little bit, and others may be family members or know each other very well.**

Can you please tell us about the relationship between [name 1] and [name 2]?

Probes: duration of tie; closeness; assistance given to one another; stresses/conflicts).

- * Of all the people we have been talking about today, who has been most active in helping you with [problem(s)]?

Probes:

- How and why helps: in what ways helpful? What motivates person? (e.g., personal qualities, role in family, financial status, etc.).
- "Pro western care" attitudes: trusts western-style treatment to take care of people's problems? relies on western-style treatment for own problems?

- * [For each "influential" member, ask:] Who are the people (name) counts on for help—people with whom she/he discusses important matters or people she/he turns to for help?

Probe:

- Overlap in support network: [For all who are NOT on network list:] respondent also counts on (name) for help?

- * When you think about your experiences with [problem] after all this time, what advice would you give to others who may be experiencing similar problems?

- Best ways to cope with [the problem]?
- Things people should avoid doing?
- Doctors and mental health agencies do to help people who experience similar problems?

- * [Debriefing—throughout and at end of session] How are you feeling about what we're talking about today? [*Probe*: tired? uncomfortable? Anything want to say/talk about? //Allow time for discussion of issues/feelings raised by interview//]

APPENDIX C-1: INTERVIEW GUIDE

Interview Guide

Introduction: The war in Cambodia brought bad times and suffering to everyone. These things are not easy to talk about. We are very grateful that you are willing to help us understand what you and your family went through. This information can help us understand what happened, and to understand what we do that can be helpful and what is not helpful when people go through hard times like that.

If at any time during our talking you want to stop, we can do that. If you want to stop for today, we can come back another time. Or if you would rather not continue talking to us, we will not have any bad feelings about stopping. Nothing bad will happen if you choose to stop the interviewing. If you are okay about talking to us, we will come back to talk 2 more times to hear your whole story. So you can take your time and tell us everything you need to.

Please feel free to use Cambodian terms/words for feelings you have. We want to understand things from your point of view, so it is very helpful for you to use your own words. If you have questions or what I said is not clear please ask me to explain. If I make a mistake in understanding what you said, please let me know. Is there anything you want to ask?

Go over consent form and request signature.
Ask if tape recording is permissible.

Topics to be covered in interviews 1, 2, 3 and if necessary 4:

A. Life History Questions:

– Could you please tell me about the S'rok (district, province) your family came from? (lead to location, family size, clan, ethnicity)

probes:

- were all your family members born there? were you? (lead to age)
- does your family belong to a particular clan? (lead to: family members here in this country)
- how did your family make their living in Cambodia? (lead to education, kind of current work)
- where did you go to school? (monkhood, special education) what was it like?

- are all your family members (sisters, bros) married? how did you meet your spouse? how did your marriage come about? children? (lead to number, gender, ages)
- are many of your family members here with you? (lead to missing members)

B. Civil War Experiences:

– if you don't mind could you tell me how and when you left Cambodia?

probes: what year did you leave? who left with you? what camp were you at?
how long were you there? what was it like?

– If it is all right, I'd appreciate it if you could tell me what happen to you and your family members when Phnom Phen was taken over by the Khmer Rouge?

Please tell me about them one by one.

probes: where did you go? what were the conditions? how did family members react? did anyone get sick, have bad headaches or act different? what kind of help did they get?

– Of all the things that happened to you during the Pol Pot period what are the things that you remember?

probes: what do you think about that? how did you explain that to yourself? help me understand.

–When you think about what happened during the Pol Pot time, how do you think about it/ how do you explain it?

probes: was it because of a bad government?
bad fortune?
help me understand how you think of it.
how do you feel about these events?

C. Healing:

–When you (and your family) came to America after all that happened did you or anyone in your family suffer from problems (health, spiritual)? What did the family do to help? what kinds of help did you get?

probes: was help from Kru Khmer? Buddhist temple? Western services? Other?

what was most helpful? not so helpful?
what beliefs were helpful? not so helpful?

D. Debriefing during and after each session: How are you feeling about what we talked about today/up to this point?

probes: uncomfortable? tired? is there something that is bothering you now? is there something you want to say to me or ask me?

E. Review prior to each session: Was there anything about last session you want to ask about? Anything you want to add or change? How did you feel about last session?

Biographical Note

Paula Toki Tanemura Morelli

Born:

**June 19, 1943
Chicago, Illinois**

Secondary Education:

**McKinley High School
Honolulu, Hawaii
1961**

College Education:

**University of Southern California
Los Angeles, California
B.A. in Social Sciences, 1965
M.S.W. 1968**

**University of California at Fullerton
Fullerton, California
B. A. in Art, 1980**