Psychological Needs in Post-Genocide Cambodia: The Call for Family Therapy Services and the Implications for the "Majority World" Populations

John K. Miller, Ph.D.
Fudan University
Department of Social Work
School of Social Development and Public Policy
Shanghai, China

Jason Platt, Ph.D.
International Center for Therapy and Dialogue
Mexico City, Mexico

Hema Nhong, M.A.
Royal University of Phnom Penh
Psychology Department
Phnom Penh, Cambodia

Address correspondence to John K. Miller; 1010 Wenke Building, Department of Social Work, School of Social Development and Social Sciences, Fudan University, Shanghai, China; Email: jkmillertoo@yahoo.com.

ABSTRACT

During the Khmer Rouge reign in Cambodia from 1975 to1979, approximately one quarter of the country's population lost their lives by starvation, disease, or execution. Most intellectual and academic institutions, including mental health services, were destroyed during this period by the Khmer Rouge regime who saw them as a threat. About 15 years ago mental health services began to be reinitiated in the country, usually in collaboration with Western academics and mental health experts. The call for these services was often in response to the high prevalence of post-traumatic stress disorders and other psychosocial problems. Today mental health issues still receive insufficient attention in Cambodia, mainly stemming from a lack of resources, knowledge about the general topic of mental health, and stigma. This article presents the results of a survey delivered to the first generation of psychology students since the end of the Khmer Rouge regime regarding their impressions of the current mental health needs in Cambodia. Respondents answered questions about the types of problems people bring to Cambodian counselors and therapist, the clinical populations in their work settings, their views of preferred treatment approaches in Cambodia, barriers to service delivery, and types of training needed to address the concerns of the people of Cambodia. The leading requests for the future development of mental health training included the need for training in marriage and family therapy, assessments, and play therapy. Domestic violence, depression, and anxiety/stress were also placed at the top of the mental health issues reported.

Keywords: Cambodia, Khmer Rouge, mental health counseling, barriers to service, clinical service delivery systems, genocide, therapy

The Kingdom of Cambodia (commonly known as “Cambodia” in the West) is a Southeast Asian country with a population of over 16 million people, approximately the size of the US state of Iowa (Worldometers, 2017). Over 10 percent of the population lives in the capitol city of Phnom Penh, with 80% of Cambodians living in rural communities as farmers and manual laborers. The country has only recently emerged from the after-effects of the war in neighboring Vietnam War (1955-1975), and the subsequent Khmer Rouge regime in Cambodia that occurred from 1975-1979.

From the Western perspective, the Vietnam War was waged to staunch the spread of communism in the region. In an effort to cut off supply chains to the Viet Cong Army (VC) and the North Vietnamese Army (NVA), the US began a bombing campaign in neutral Cambodia that escalated from the Nixon to Johnson administrations resulting in more bombs dropped on Cambodia than all those dropped during the entirety of World War II. Many of the bombing raids to Cambodia were on indiscriminate targets within the borders of the country (Brinkley, 2011; Owen & Kiernan, 2006). The civilian casualty estimates as a result of the bombings range from 50,000 to 150,000, traumatizing the civilian population in Cambodia. Ironically while the bombings were intended to prevent a further spread of communism in the region, they unintentionally forced Vietnamese communists deeper into Cambodia and in greater contact with Cambodian Khmer Rouge insurgents who used the bombings as fodder for anti-American propaganda (Owen & Kiernan, 2006).

Near the end of the Vietnam War in 1974, the Khmer Rouge regime began to seize power in Cambodia under the title *Democratic Kampuchea*, with the charismatic leader Pol Pot (Brother Number One) named as Prime Minister (Bureau of East Asian and Pacific Affairs, 2011; Chandler, 1999). During the four years that Pol Pot and his Khmer Rouge government

were in power, the country suffered massive brutality and a complete restructuring of its society. Educational institutions were closed down, class distinctions were abolished, and all types of educated professionals and religious people were systematically tortured and murdered along with their extended families (Hinton, 1998; Miles & Thomas, 2007; Um, 2008). Much of the torture and executions were carried out by young people, many of whom are now themselves parents (Miles & Thomas, 2007). About a quarter of the population of the country died during this period (Heuveline & Poch, 2007). The reign of the Khmer Rouge ended in 1979 when the Vietnamese army overthrew the Khmer Rouge. Yet the Khmer Rouge regime's conflict with the newly formed Cambodian government continued until 1996, resulting in more trauma for the Cambodian population (Bureau of East Asian and Pacific Affairs, 2011; Hsu, Davies, & Hansen, 2004).

The Psychological Residuals of Genocide and Trauma in Cambodia

The legacy of trauma and genocide in Cambodia continues to this day, resulting in elevated levels of psychosocial problems, post-traumatic stress disorders (PTSD), and poverty among the population of the country (Um, 2008; Palmieri, Marshall, & Schell, 2007; Zimmer, Knodel, Kim & Puch, 2006; Hinton, 1998). The survivors of the conflict suffer from an average of 12-16 trauma experiences, including the witnessing of atrocities such as torture, slave labor, imprisonment, and starvation (Miller & Platt, 2018; Kinzie, Fredrickson & Ben, 1984; Mollica, Wyshak, & Lavelle, 1987; Ralmuto, Ann, Hubbard, Groteluschen, & Chhun, 1992).

About half of the children of the Khmer Rouge era have elevated rates of PTSD, anxiety, and depression years after the end of the regime. Follow-up studies show that these negative effects have not faded with time (Sack, Him, and Dickason, 1999). Pham and colleagues (2009)

found that 35% of Cambodians still suffer from some kind of severe psychiatric problem (e.g., psychosis, severe depression, and schizophrenia) and 45% suffer from psychosocial problems (e.g., anxiety, grief, and stunted emotional development). Few question the lasting effects of trauma and genocide among the Cambodian population today (Hinton, 1998; Miles & Thomas, 2007; Miller, 2018).

Post-Genocide Impact on Contemporary Cambodian Families

Although only about a quarter of Cambodians alive today lived through the Khmer Rouge regime, its dark legacy affects the population at large (Dubois et al., 2004; Heuveline & Poch, 2007). The violence and terror experienced during the Khmer Rouge period continues to cast a significant shadow on the culture and contemporary values of Cambodia (Gellately & Kiernan, 2003; Hsu et al., 2004). The country's post-Khmer Rouge history is strongly associated with violence, internal political conflict, and massive trauma (Broadhurst, 2001; de Jong et al., 2001; Hinton, 1998; Johnson & Thompson, 2008). The impact of the Khmer Rouge regime is visible in the pervasive poverty, inequality, and culture of violence present in contemporary Cambodia. The events of the genocide period are likely to have 'affected the parenting abilities of adults who were children during this period, with a consequent effect on their children's physical and emotional health' (Miles & Thomas, 2007, p. 386). In studying survivors of the Holocaust, Sigal (1998) suggested that children of survivors tended to be anxious with difficulty in controlling aggressive impulses. Some researchers maintain that the intergenerational impact of the Khmer Rouge is evident in survivors who perpetuate vulnerability, violence, and abuse against children and spouses (Miller & Platt, 2018; Miles & Thomas, 2007).

Child abuse, violence, and exploitation are of particular concern, in a post-genocide nation with 41% of the population under the age of 15 (Bertrand, 2005; Broadhurst, 2002; Eisenbruch, de Jong, & van de Put, 2004; Miles & Thomas, 2007). A report by the End Child Prostitution, Abuse, and Trafficking in Cambodia (ECPACT-Cambodia) conducted in 2009 found a 49% increase in the number of reported sex trafficking victims from the previous year (109 documented victims in 2009 compared to the report of 78 in 2008). Their findings also indicated that most victims of sex trafficking were females between the ages of 7 and 39 years (with 36.7% under the age of 17), and 76.1% had prior knowledge that they would be engaging in prostitution-related activities. Almost half (47 percent) of the young women in the sex industry reported that they were sold into it by their parents, relatives, or friends to pay for food or for family medical bills (ECPAT-Cambodia, 2009). Cambodian adults, often mothers, have trafficked out their children for forced labor in organized begging rings, soliciting, street vending, and flower selling (Naro, 2009).

While it may seem obvious that there are many direct effects of Cambodia's genocide and war trauma on individuals and families, determining the long term effects on families is a complex undertaking that must take into account the entire reorganization of family and societal life post-genocide (Rousseau, Drapeau & Platt, 1999; Somassundaram, van de Put, Eisenbruch, & de Jong, 1999). Family life was greatly transformed under the paranoia of the Khmer Rouge where professionals, intellectuals, anyone with former connections to government, or those lacking agricultural knowledge were subject to arrest, torture, and eventual execution. Detentions and executions were carried out at institutions such as the Tuol Sleng Security Prison 21 in Phnom Penh, or outside the city at locations such as the Choeung Ek extermination center (commonly referred to as the "killing fields"). Family relationships that were not approved by

the state were banned and communication between family members was punishable by death, although family communication was often impossible given that many families were split up and relocated to forced labor camps (Criddle, 1989; van de Put & van der Veer, 2005). Personal relationships and any displays of affection were discouraged. Cambodian family structures were often completely destroyed by the Khmer Rouge who frequently turned children against their parents by forcing the children to kill their own parents or parents being forced to torture their own children (Criddle, 1989; Rousseau et al., 1999). If an individual was suspected of betraying the state, often the entire family was executed so that the family descendants would not seek retribution against the killers, termed "phchanh phchal" in Khmer (Hinton, 1998)[1].

Mental Health Issues and Educational Needs in Contemporary Cambodia

Despite the recent efforts of the country to reinitiate mental health services in Cambodia, there still exists a need for training programs and resources for the masses (Miller, 2018; van de Put & van der Veer, 2005). The institutions that existed prior to the Khmer Rouge in 1975 were completely destroyed during the conflict. With the assistance of the United Nations, the Cambodian government began to address the need for services as early as 1993, with the creation of a National Health Plan to address basic health needs as well as the elevated need for mental health services (Somasundarm, van de Put, Eisenbruch, & de Jong, 1999; Stockwell, Whiteford, Townsend, & Stewart, 2005).

[1] ***Phchanh phchal*** is a Cambodian cultural concept applicable to the destruction of entire families during the Khmer Rouge regime. The concept literally means "defeat, vanquish in such a manner as to "cause (the opponent to be) afraid and not dare to repeat the same act." This view that one must completely destroy the enemy in a disproportionate way is explored in Hinton's important (1998) anthropological study of the origins of "disproportionate revenge" in Cambodian culture (known as ***kum kum*** in Khmer), and more currently referred to as "a head for an eye" style of retribution (Hinton, 1998). The Khmer Rouge commonly used the metaphor of ***chik***

Western informed “medical model” methods greatly influenced these early efforts to provide mental health services (Solomon, 2015; Stevens & Wedding, 2004; Stockwell et al., 2005). These methods were created in Western cultures, where only about 15% of the global population reside. Many Western methods are individually focused. While some parts of these intervention strategies can be helpful in the Cambodian context, others require modification to fit the family and communally based culture of the Cambodian people. Further, we have found some Western based interventions completely inappropriate for the Cambodian culture (Miller, 2019).

In response to the growing demand for trained mental health professionals, the Royal University of Phnom Penh (RUPP) was the first university to establish a post-Khmer Rouge Department of Psychology in 1994. The program is one of the leading psychology programs in the country. In 2006 the lead author led a Western faculty exchange at the invitation of the faculty and administration of the RUPP, and continued to visit and work with the faculty each year until the present. In 2007, the Psychology Department developed a graduate training program in psychology in collaboration with many local and foreign experts, including the authors. In this endeavor we faced many challenges and complexities. As is true in many Asian cultures, there is no comparable indigenous term for what is referred to commonly as “therapy” or “therapist” in the West. There were few English textbooks initially, and even fewer translations of these texts. Western experts were brought in to offer university-based lectures, translators hired, and student and faculty exchange programs were initiated. Supports were offered to provide opportunities for Cambodian faculty and students to visit Western universities for trainings and the cultural exchange of ideas. Fulbright scholarships for Western scholars to

---

smav trauv chik teang reus or “pull up the grass, dig up the roots” to express the importance of wiping out entire family lines (Gellately & Kiernan, 2003).

live and work in the country were carried out. Ever mindful of the potential for "colonial" effects of these well-meant efforts, the authors operated in constant collaboration with local faculty and administrators. All instructional activities were carried out in consultation and in deference to the requests of the local Cambodian faculty and students. Topics such as trauma, parent-child relationships, domestic violence intervention, substance abuse and addictions intervention, crisis intervention, brief therapy, single session therapy, and family therapy were offered.

In order to better understand the emergent needs of the post-Khmer Rouge society, the authors launched a multi-year survey of students and faculty at RUPP to attempt to shed light on the unique mental health needs of the people. The survey was designed to gain information about their perceptions of their view of the predominant mental health issues, desired approaches to treatment, presenting problems brought to therapy or counseling, and common barriers to treatment.

Methods

The survey population consisted of all full-time senior level undergraduate and graduate students who were enrolled in the Department of Psychology during the winter semesters (N=112). All of the respondents had previously or were currently engaged in conducting some sort of counseling, therapy, or human services work as part of their education or work. The majority of the respondents were between 22 and 25 years old, with a range of 18 years old to 50 years old. Only 10.7% of the respondents were older than age 25, and 33.9% were younger than age 21. The youthfulness of the sample is typical of Cambodia's higher education population, as this is the first generation to return to college since the Khmer Rouge regime. Female students comprised of 47.3% of the respondents, and men represented 52.7%. Approximately 62.5% of

the respondents indicated that they were from an urban city, and 37.5% from a rural area. Many of the students at RUPP are from other provinces from more rural areas of Cambodia.

Procedure

Surveys were developed by the first author and distributed and collected by all three authors. The survey was created in English and translated into Khmer (the language of Cambodia). Respondents could answer in English or in Khmer, with 30% of the respondents answering in English and the remaining 70% answering in Khmer. Khmer surveys were translated into English.

The survey was designed to address the following topics: (1) respondents' opinions regarding the types of problems faced by Cambodians; (2) main individual and child issues currently occurring; (3) type of clinical populations respondents treat in counseling or therapy; (4) mental health work setting of respondents; (5) approaches to treatment currently used by respondents; (6) training services respondents would like to see developed; (7) the main difficulties with Western teachers offering trainings in Cambodia; (8) respondents' opinions regarding the main barriers to service for the people of Cambodia; and (9) demographic information. All the questions on the survey were open-ended, and invited respondents to write in their answers to the questions. Respondents were advised that there were no "correct" responses, and that they were free to answer in any way they chose. They were invited to share openly their opinions regarding the questions asked on the survey.

Data Analysis

The surveys were analyzed using inductive content analysis (Bogdan & Biklen, 1998). The surveys completed in Khmer were translated into English. Each survey was then read one by one, and all responses were marked to create a thematic list of all possible responses from each

question. Then the surveys were re-read to check that nothing was missing. Next, the response lists were collated into subcategories, noting common themes. As a last step, the occurrence of each category was examined, and frequencies were calculated.

Results

The respondents were asked their views of the overall types of problems faced by Cambodian people that would be relevant to therapy and counseling. Domestic violence (*f*=94; 19.4%), depression (*f*=81; 16.7%), stress/anxiety (*f*=76; 15.7%) and child abuse/neglect (*f*=55; 11.3%) were the four main types of problems indicated by the respondents (see Table 1). Other problems indicated include grief/loss, substance abuse, and couple conflict.

Table 1
Overall types of problems faced by Cambodians

Frequency (*f*) and Percent (%)	*F*	%
Domestic violence	94	19.4%
Depression	81	16.7%
Stress/anxiety	76	15.7%
Child abuse/neglect	55	11.3%
Grief/loss	44	9.1%
Substance abuse	42	8.7%
Couple conflict	24	4.9%
Physical pain	21	4.3%
Mental illness	18	3.7%
Parent-child conflict	13	2.7%
Conduct disorder	10	2.1%
Gambling	5	1.0%
Eating disorder	2	0.4%

Respondents were also asked to consider their views of the main individual issues facing people in Cambodia. The five most frequently reported individual therapy issues consisted of depression (*f*=24; 21.1%), stress/anxiety (*f*=24; 21.1%), family conflicts (*f*=12; 10.5%),

relationship issues (*f*=12; 10.5%), and sexual abuse (*f*=12; 10.5%). These five accounted for the majority of individual concerns listed (see Table 2).

Finally, respondents indicated their views of the main therapy issues facing children in Cambodia. Behavioral problems (*f*=30; 29.4%) and domestic violence (*f*=24; 23.5%) were the most frequently reported presenting issues facing children.

Table 2
Main individual therapy issues facing Cambodia

Frequency (*f*) and Percent (%)	*f*	%
Depression	24	21.1%
Stress/anxiety	24	21.1%
Family conflicts	12	10.5%
Relationship issues	12	10.5%
Sexual abuse	12	10.5%
Adjustment disorder	6	5.3%
Behavior disorder	6	5.3%
Conduct disorder	6	5.3%
Drug abuse	6	5.3%
Psychosis	6	5.3%

Main child issues facing Cambodia

Frequency (*f*) and Percent (%)	*f*	%
Behavioral problems	30	29.4%
Domestic violence	24	23.5%
Child sexual abuse	12	11.8%
Intellectual disability	12	11.8%
School problems	12	11.8%
Substance abuse	12	11.8%

All of the participants were engaged in some form of counseling practice, and were asked about the population which they worked with. Individual adults (*f*=37, 30%), children (*f*=26, 21.3%), and families (*f*=24, 19.7%) made up the majority of the populations seen by the sample (see Table 3).

Table 3

Clinical population of respondents (N=112)		
Frequency (*f*) and Percent (%)	*f*	%
Individual adults	37	30.3%
Children	26	21.3%
Families	24	19.7%
Couples	16	13.1%
Adolescents	13	10.7%
Elderly	6	4.9%

Interestingly, few of the respondents indicated that their mental health work settings were traditional office settings (by Western standards). The top three settings included in-home treatment (*f*=28, 26.7%), day treatment center (*f*=21, 20%), and telephone counseling (*f*=16, 15.2%) (see Table 4). This reflection of the currently occurring clinical service delivery modalities indicates the developing nature of counseling in Cambodia and the efforts of therapists to overcome the barriers to service (i.e. stigma, accessibility, and cost).

Table 4
Mental health work setting of respondents (N-112)

Frequency (*f*) and Percent (%)	*f*	%
In-home treatment	28	26.7%
Day treatment center	21	20.0%
Telephone counseling	16	15.2%
Community agency	14	13.3%
In-patient treatment	10	9.5%
Residential treatment center	7	6.7%
Substance abuse treatment center	3	2.9%
Clinic in a church	2	1.9%
Internet counseling	2	1.9%
Private practice	2	1.9%

The three most common approaches to treatment used by the respondents included play therapy, cognitive behavioral therapy, and group therapy (see Table 5). The selection of these approaches seemed largely due to the setting and population being served.

Table 5
Approaches to treatment used by respondents (N=112)

Frequency (*f*) and Percent (%)	*f*	%
Play therapy	49	20.9%
Cognitive therapy	45	19.1%
Group therapy	41	17.4%
Psychodynamic psychotherapy	25	10.6%
Marriage and family therapy	20	8.5%
Art therapy	19	8.1%
Spiritual counseling	9	3.8%
Behavioral therapy	8	3.4%
Interpersonal psychotherapy	4	1.7%
Psychiatry	4	1.7%
Psychoanalysis	4	1.7%
Rational emotive therapy	3	1.3%
Social work	2	0.9%
Acupuncture (and holistic treatment)	1	0.4%
Existential therapy	1	0.4%
Biomedical treatment	0	0.0%

The respondents were asked about the types of mental health trainings they would like to see offered. Marriage and family therapy, mental health assessments, play therapy, and couples therapy were the top four types of trainings requested (see Table 6). This matches somewhat with the type of mental health needs indicated by the respondents, which included intervention for domestic violence, depression, stress/anxiety, and child abuse/neglect.

Table 6
Types of trainings requested by respondents

Frequency (*f*) and Percent (%)	*f*	%
Marriage and family therapy	22	20.4%

Mental health assessments	14	13.0%
Play therapy	14	13.0%
Couples therapy	12	11.1%
Domestic violence	10	9.3%
Parent education	10	9.3%
Substance abuse counseling	9	8.3%
Art therapy	7	6.5%
Hypnosis	4	3.7%
Behavior therapy	3	2.8%
Grief/loss therapy	3	2.8%

Finally, respondents indicated their ideas about the main barriers to services in Cambodia. The leading barriers to service reported included: *clients don't believe therapy or counseling is useful; difficulty finding a qualified therapist or counselor; and not enough therapists to provide services* (see Table 8). These findings are somewhat different from the barriers to services in the West (i.e., stigma, accessibility, and cost) (U.S. Department of Health and Human Services, 1999).

Table 8
Main barriers to services for Cambodians as reported by respondents

Frequency (*f*) and Percent (%)	f	%
Don't believe therapy is useful	81	23.0%
Difficult for clients to easily find qualified therapist/counselor	71	20.2%
Not enough therapists to provide service	66	18.8%
Cost	39	11.1%
Stigma/shame	29	8.2%
Fear of revealing confidential information	24	6.8%
Lack of transportation to get to service	13	3.7%
Finding time to meet with therapist	12	3.4%
Medical issues	10	2.8%
Family members/support system do not support therapy as an option	7	2.0%

Discussion

The World Health Organization's study of mental disorders worldwide listed the most common mental health problems as depression, generalized anxiety disorder, and harmful use of alcohol (Craig and Boardman, 1997). The results from our respondents were somewhat different. Specifically, respondents were asked to consider three areas where problems could occur: (1) overall types of problems faced by Cambodians, (2) main individual issues facing Cambodia, and (3) main child issues facing Cambodia. In all three areas some form of domestic violence or family conflict was indicated as one of the top three problems.

Some anthropologists maintain that the societal effect of genocide has created a "culture of impunity" in Cambodia where those who commit crimes are not held accountable for their acts (Hinton, 1998). This is commonly considered the case for those who committed the atrocities of the Khmer Rouge regime, with very few of the perpetrators ever facing trial or public accountability. Hinton (1998) once described Cambodia's cultural climate as one where perpetrators of violence face no or few consequences for their actions. Such a "culture of impunity" may be isomorphically translated to some family processes. The results of this survey lend some credence to the idea that the violence experienced by the society during the Khmer Rouge regime (and afterwards) has an influence on Cambodian families. This may be especially evident with the high frequency of domestic violence reported by the respondents in this study.

While there is no formal practice of systemic family therapy on a large-scale basis in Cambodia, there are pockets of recognition and isolated practitioners who are increasingly utilizing family therapy and other popular western therapy formats for their work with patients and clients. Many who provide family therapy services operate within an in-home treatment format funded by non-government organizations (NGOs).

As academic and training institutions in Cambodia have shown increasing interest in family theory and practice, family therapy appears to be one of the popular mental health strategies. The results of this study indicate that the population struggles with dilemmas that are often relational in origin. This makes sense, given the historical trauma suffered by families, and the collectivist and family oriented nature of Khmer culture. Cultural examples of family connectedness includes the concept of "filial piety", which runs throughout Cambodian society and is based on a value of showing respect, obedience, and reverence for one's parents and ancestors. Filial piety is a common Asian cultural value that embraces intergenerational connectedness, family influence, and the transmission of ideas down the generational lines (Miller, 2019; Lewis, 2008; Miller & Fang, 2012; Liu, Miller, Zhao, Ma, Wang & Li, 2012).

The economic challenges faced by many Cambodians will require that family therapy models and practices be adapted appropriately for the existing economic realities. Historically, the field of family therapy has had an ambivalent relationship with families who are living in poverty (Frankel & Frankel 2006) and many of the models were initially developed to serve wealthy communities (Platt & Laszloffy, 2012). Still, a number of family therapy models do exist that specifically tune into how societal contexts are connected to mental health, such as Systems-Oriented Family-Centered Approaches, Multilevel Systems Therapy, Community Family Therapy and the New Zealand originating model of Just Therapy (Frankel & Frankel, 2006). In implementing family therapy in Cambodia, these family therapy models may be useful to consider. Additionally, Liberation Psychology, a Latin American originating theory that has a focus on how the macro-system effects mental health, may also be a useful counterbalance to family therapy's tendency to only focus on microsystem of the family (Martin-Baró, 1994; Platt, 2012). Practitioners in Cambodia will also need to consider the way services are delivered, for

example how and where services are delivered may need to be adapted. Potential delivery formats, like single session therapy (Miller, Platt & Conroy, 2018; Bobele & Slive, 2011; Miller, 2012; Miller & Slive, 2004), may provide starting points for altering how services are provided. Research on what family therapy models work best in Cambodia is still an on-going quest. Also, such research would be valuable to disseminate in order to address the fact that Cambodians may not believe therapy or counseling is useful.

The issue of adapting the therapy to the indigenous culture is never more pressing than when dealing with Cambodian clients (Miller, 2019; Frye & D'Avanzo, 1994; Hinton et al., 2003). The Khmer Rouge in Cambodia referred to their reign of terror (between 1975 and 1979) as a "return to the year zero"; and an estimated 2 million Cambodians perished during this time. Although they have suffered the torture of seeing loved ones killed and the pain of dislocation, many Cambodians have no concept of mental illness (Coton, Poly, Hoyois, & Dubois, 2008). They do, however, complain of bodily illnesses (somatic problems) that psychologists frequently attribute to past experiences of trauma (Uehara, Morelli, & Abe-Kim, 2001). Western systemic family therapy provides a good fit for the treatment of some problems in the Cambodian context given the culture's emphasis on the family and filial piety.

Core systemic concepts such as "interconnectedness", "intergenerational process", "wholeness", and "context" views fit well with the culture and history of Cambodia. Yet, what is needed is an adaption of the components of systemic family processes to uniquely fit the Khmer culture. Cultural and religious values or concepts of Cambodia can be integrated into a unique model of family therapy. One way to think about the mental health issues present in Cambodia is that they are not merely individual mental or psychiatric issues, but also social and relational in origin and are also often linked to the macro level issues occurring in community. If this is the

case, what is critical is a need for more formal education and training of therapists and psychologists in Cambodia to address both the individual psychological issues, as well as the intergenerational, family, and community issues that arise in a post-genocide context. This is the challenge for the Western mental health educators who are attempting to help support the rebuilding of the tradition of psychology training in Cambodian universities, as well as a challenge for the next generation of Cambodian mental health providers.

References

Bertrand, D. (2005). The therapeutic role of Khmer mediums (kvu Boramei) in contemporary Cambodia. *Mental Health, Religion, & Culture, 8*(4), 309-327.

Bogdan, R. B., & Biklen, S. K. (1998). *Qualitative research in education: An introduction to theory and methods* (3rd ed.). Needham Heights, MA: Allyn and Bacon.

Brinkley, J. (2011). *Cambodian curse: Modern history of a troubled land*. New York: Perseus Books.

Broadhurst, R. (2002). Lethal violence, crime and state formation in Cambodia. *The Australian and New Zealand Journal of Criminology* 35(1), 1-26.

Bureau of East Asian and Pacific Affairs (January 28, 2011). *Background note: Cambodia*. Retrieved February 19, 2011, from http://www.state.gov/r/pa/ei/bgn/2732.htm.

Cambodia Acid Survivors Charity (2010). *Annual report 2010.* Retrieved January 1, 2012, from http://www.cambodianacidsurvivorscharity.org/Annual%20Report%202010.pdf.

Cambodian Center for Human Rights (May, 2010). *Breaking the silence: Addressing acid attacks in Cambodia.* Retrieved February 20, 2011, from http://www.sithi.org/admin/upload/media/[2010-05-24]1230/Breaking%20the%20Silence%20--%20Addressing%20Acid%20Attacks%20in%20Cambodia.pdf.

Cambodian National Institute of Statistics (2008). *General population census of Cambodia 2008.* Retrieved February 19, 2011, from http://www.nis.gov.kh/nis//census2008//Census.pdf.

Chandler, D. (1999). *Brother number one: A political biography of Pol Pot*. Thailand: Westview Press.

Craig, T., & Boardman, A. (1997). ABC of mental health: Common mental health problems in primary care. *British Medical Journal, 314,* 1609-1612.

Criddle, J. (1989). *To destroy you is no loss: The odyssey of a Cambodian family*. Anchor Press.

Coton, X., Poly, S., Hoyois, P., & Dubois, V. (2008). The healthcare-seeking behavior of schizophrenic patients in Cambodia. *International Journal of Social Psychiatry, 54,* 328-337.

de Jong, J. , I., Komproe, M., Van Ommeren, M., El Masir, M., Araya, N., Khaled, W., van de Put & D., Somasundaram. (2001). Lifetime events and posttraumatic stress disorder in 4 postconflict settings. *Journal of the American Medical Association*, 286, (5), 555-562.

Dubois, V., Hauff, E., Hoyois, P., Roussaux, J., Sunbaunat, K., & Tonglet, R. (2004). Household survey of psychiatric morbidity in Cambodia. *Journal of Social Psychology,* 50(2), 174-185.

End Child Prostitution, Abuse, and Trafficking in Cambodia (2009). *Database report on rape and trafficking in 2009.* Retrieved on February 20, 2011, from http://www.ecpatcambodia.org/documents/database_report/database_report_on_rape_and_trafficking_2009_eng.pdf.

Eisenbruch, M., de Jong, J., & van de Put, W. (2004). Bringing order out of chaos: A culturally competent approach to managing the problems of refugees and victims of organized violence. *Journal of Traumatic Stress, 17*(2), 123-131.

Frankel, H., & Frankel, S. (2006). Family therapy, family practice, and child and family poverty: Historical perspectives and recent developments. Journal of Family Social Work, 10(4), 43-80.

Frye, B., & D'Avanzo, C. (1994). Themes in managing culturally defined illness in the Cambodian refugee family. *Journal of Community Health Nursing, 11*(2), 89-98.

Gellately, R. & Kiernan, B. (2003). *The specter of genocide: Mass murder in historical perspective*. New York: Cambridge University Press.

Golloglya, J., Vatha, S., & Malmberg, A. (2008). Acid attacks in Cambodia: Serious reminders of personal conflicts. *Asian Biomedicine, 2*(4), 329-334.

Heuveline, P., & Poch, B. (2007). The Phoenix population: Demographic crisis and rebound in Cambodia. *Demography, 44*(2), 405-426.

Hinton, A. L. (1998). A head for an eye: Revenge in the Cambodian genocide. *American Ethnologist, 25*(3), 352-377.

Hinton, D., Hsia, C., Um, K., & Otto, M. (2003). Anger-associated panic attacks in Cambodian refugees with PTSD: A multiple baseline examination of clinical data. *Behavior Research & Therapy, 41*(6), 647-654.

Hsu, E., Davies, C., & Hansen, D. (2004). Understanding mental health needs of Southeast Asian refugees: Historical, cultural, and contextual challenges. *Clinical Psychology Review, 24*, 193-213.

Johnson, H. & Thompson, A. (2008). The development and maintenance of post-traumatic stress disorder (PTSD) in civilian adult survivors of war trauma and torture: A review. *Clinical Psychology Review* 28, 36-47.

Kalantry, S., Sital, and Getgen, J. (2011) Combating Acid Violence in Bangladesh, India and Cambodia. *Cornell Legal Studies Research Paper No. 11-24*. Available at SSRN: http://ssrn.com/abstract=1861218

Kinzie, D., Fredrickson, R., Ben, R. (1984). Post-traumatic stress disorder among survivors of Cambodian concentration camps. *American Journal of Psychiatry, 141,* 645-650.

Lewis, D. (2008). Types, meanings and ambivalence in intergenerational exchanges among Cambodian refugee families in the United States. Ageing and Society, Volume 28, Issues 05,. Pp 693-715. Cambridge University Press. DOI: http://dx.doi.org/10.1017/S0144686X08007034

Liu, L., Miller, J. K., Zhao, X., Ma, X, Wang, J., & Li, W. (2012). Systemic family psychotherapy in China: A qualitative analysis of therapy process. *Psychology and Psychotherapy: Theory, Research, and Practice.* doi: 10.1111/j.2044-8341.2012.02075.x

Martin-Baró, I. (1994). *Writings for a liberation psychology*. USA: Harvard University Press.

Miles, G., & Thomas, N. (2007). 'Don't grind an egg against a stone': Children's rights and violence in Cambodian history and culture. *Child Abuse Review, 16,* 383-400.

Miller, J. K. (2018). Plenary Address*: Family therapy in the majority world: The future of international psychotherapy.* International Family Therapy Association Annual Conference (IFTA). Bangkok, Thailand.

Miller, J. K. (2019). *The Ethos and Ethics of Global Family Therapy.* International Family Therapy Association Annual Conference (IFTA). Aberdeen, Scotland.

Miller, J. K., Platt, J. J. & Conroy, K. (2018). *Single Session Therapy in the Majority World: Addressing the Challenge of Service Delivery in Cambodia and the Implications for Other Global Contexts*. In Slive, A., Bobele, M., Hoyt, M. and Rosembaum R. (Eds.) Capturing the Moment: Single Session Therapy. Zeig, Tucker, & Theisen Publishing.

Miller, J. K. & Fang, X. (2012). Marriage and family therapy in the People's Republic of China: Current issues and challenges. *Journal of Family Psychotherapy, 23,* 173-183.

Minas, H. (2009). Mentally ill patients dying in social shelters in Indonesia. *Lancet, 374*(9690), 592-593.

Mollica, R., Wyshak, D., & Lavelle, J. (1987). The psychosocial impact of war, trauma and torture on Southeast Asian refugees. *American Journal of Psychiatry, 144*, 1567-1572.

Naro, N. (2009). *Human trafficking in Cambodia: Reintegration of the Cambodian illegal migrants from Vietnam and Thailand.* Unpublished manuscript. S. Rajaratnam School of International Studies, Singapore. Retrieved on February 20, 2011, from http://www.rsis.edu.sg/publications/WorkingPapers/WP181.pdf.

Owen, T., & Kiernan, B. (October 2006). Bombs over Cambodia. *The Walrus Magazine*, 62-69.

Palmieri, P., Marshall, G., & Schell, T. (2007). Confirmatory factor analysis of posttraumatic stress symptoms in Cambodia refugees. *Journal of Traumatic Stress, 20*(2), 207-216.

Pham, P., Vinck, P., Hean, S., & Stover, E. (2009). *So we will never forget: A population-based survey on attitudes about social reconstruction and the extraordinary chambers in the courts of Cambodia.* Human Rights Center of California Berkeley. Retrieved on February 20, 2011, from http://escholarship.org/uc/item/74x685xm#page-1.

Platt, J.J., & Laszloffy, T.A. (2012) *Critical patriotism: Incorporating nationality into MFT education and training. Journal of Marital and Family Therapy, 1-16,* Retrieved from doi: 10.1111/j.1752-0606.2012.00325.x

Realmuto, G., Ann, C., Hubbard, J., Groteluschen, A., & Chhun, B. (1992). Adolescent survivors of massive childhood trauma in Cambodia: Life events and current systems. *Journal of Traumatic Stress, 5*(4), 589-599.

Reid, K., Vittinghoff, E., & Kushel, M. (2008). Association between the level of housing instability, economic standing and health care access: A meta-regression. *Journal of Healthcare for the Poor and Underserved, 19*(4), 1212-1228.

Rouseau, C., Drapeau, A., & Platt, R. (1999). Family trauma and its association with emotional and behavioral problems and social adjustment in adolescent Cambodian refugees. *Child Abuse & Neglect, 23*(12), 1263-1273.

Sack, W. H., Him, C., & Dickason, D. (1999). Twelve-year follow-up study of Khmer youths who suffered massive war trauma as children. *Journal of the American Academy of Child and Adolescent Psychiatry, 38*(9), 1173-1179.

Sigal, J. (1998). Long term effects of the Holocaust: Empirical evidence for resilience in the first, second, and third generation. *Psychoanalytical Review, 85*, 579-585.

Solomon, A. (2015). *The noonday demon: An atlas of depression*. New York, Scribner Publishing.

Somasundaram, D., van de Put, W., Eisenbruch, M., & de Jong, J. (1999). Starting mental health services in Cambodia. *Social Science & Medicine, 48*, 1029-1046.

Stevens, M. J., & Wedding, D. (Eds.) (2004). *Handbook of international psychology*. New York: Brunner-Routledge.

Stockwell, A., Whiteford, H., Townsend, C., & Stewart, D. (2005). Mental health policy development: Case study of Cambodia. *Australasian Psychiatry, 13*(2), 190-194.

Uehara, E., Morelli, P., & Abe-Kim, J. (2001). Somatic complaint and social suffering among survivors of the Cambodian killing fields. *Journal of Human Behavior in the Social Environment, 3*(3/4), 243-262.

Um, K. (2008). Cambodia: A decade after coup. *Southeast Asia Affairs, 2008*(0), 107-120.

U.S. Department of Health and Human Services. (1999). *Mental Health: A Report of the Surgeon General—Executive Summary*. Rockville, MD: U.S. Department of Health and Human Services, Substance Abuse and Mental Health Services Administration, Center for Mental Health Services, National Institutes of Health, National Institute of Mental Health.

van de Put, W., & van der Veer, G. (2005). Counselling in Cambodia: Cultural competence and contextual costs. *Intervention, 3*(2), 87-96.

Watters, C. (2001). Emerging paradigms in the mental health care of refugees. *Social Science & Medicine, 52,* 1709-1718.

Worldometers. (2017). Department of Economic and Social Affairs, Population Division, World Population Prospects. from www.worldometers.info//.

Yount, K., & Carrera, J. (2006). Domestic violence against married women in Cambodia. *Social Forces, 85*(1), 355-387.

Zimmer, Z., Knodel, J., Kim, K., & Puch, S. (2006). The impact of past conflicts and social disruption on the elderly in Cambodia. *Population and Development Review, 32*(2), 333-360.