

The Prevalence and Characteristics of Psychological Disturbances among War-Affected
Children: Looking to the Voices of Cambodian Children

By

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Millions of children around the globe have been killed, maimed, disabled, or orphaned as a result of armed conflict. Children have been exposed to brutal death, dangerous escape or flight; violence; physical injury; mutilation; rape; starvation; loss of family, friends, community, or home; and other war-related trauma. This exposure can have a significant and long-lasting psychological impact such as the development of PTSD symptoms. The development of psychological disturbances is largely determined by each individual child's set of risk and resiliency factors. Cambodian children, who grew up under the Khmer Rouge, provide an excellent illustration of children who have been affected by war. Their primary accounts shed light on the horrific experiences of children amid armed conflict, the psychological symptoms endured, and the risk and resiliency factors that influenced each child's likelihood for developing psychopathology. These accounts further illuminate the need for developmentally appropriate and culturally competent prevention and intervention methods.

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The Prevalence and Characteristics of Psychological Disturbances among War-Affected
Children: Looking to the Voices of Cambodian Children

Introduction

On June 27, 1944, Herbert Hoover boldly stated, “Older men declare war. But it is youth that must fight and die. And it is youth who must inherit the tribulation, the sorrow, and the triumphs that are the aftermath of war” (as cited in Boothby, Strang, & Wessells, 2006, p. 1). In this statement, Herbert Hoover articulated a concept that society has only begun to understand: the vast and often devastating effects of war on not only children’s physical but particularly their psychological well-being. Wars between 1987 and 1997 have killed 2 million of the world’s children, maimed, injured, or permanently disabled 6 million children, and orphaned or separated from their parents 1 million children (Klot, Machel, & Sowa, 2001). Furthermore, more than 300,000 children under the age of 18 were fighting in conflicts worldwide and accounted for one half of the 27.4 million refugees and additional 30 million internally displaced peoples worldwide (Klot, Machel, & Sowa, 2001). This is particularly telling since the number of refugees in 1974 was only 2.4 million. These horrific statistics are largely due to the changing face of war in today’s world. In World War I, civilians composed 15% of total casualties as compared to the 5% of war-related civilian casualties recorded at the turn of the 20th Century. However, the world began to witness a troubling trend when this percentage of civilian casualties increased to 65% in World War II. Today, the trend has continued and civilians compose 90% of the casualties of war (Klot, Machel, & Sowa, 2001). At least half of these civilian deaths are children

(Klot, Machel, & Sowa, 2001). As Boothby, Strang, and Wessells (2006, p. 1) so poignantly stated, “No longer are wars fought on battlefields by opposing armies. Today the village is the battleground of change, and children caught in the crossfire are now the main victims of war.” In light of this reality, the effect that war has on children’s physical and mental health has just recently become a clinical interest of health care providers in both the public and mental health sectors.

Much of the research that exists is focused on the effects of war on adults and extrapolations have been made to children. This is clearly problematic because it has become increasingly clear that there are distinct differences between the ways that adults and children react to different traumatic situations and environments depending on their stage of development (Shaw, 2003). Furthermore, there is little dispute as to whether or not children exposed to war or war-related trauma are at increased risk for the development of psychopathology resulting from traumatic life experiences including violence, war, and various other trauma (Bramley, Down, Hodes, & O’Shea, 2000). However, the research and interventions proposed still often lack specificity with regards to a child’s stage of development or his or her cultural context. Further research specific to children is essential in order to identify needs specific to children, formulate interventions that are developmentally appropriate, and determine the efficacy of programs currently being used with children. These specific directions of research cannot be undertaken until a solid knowledge base is established that verifies the link between a child’s exposure to war and a heightened demonstration of psychological disturbances throughout the child’s lifetime after the initial war trauma. It is essential to

not only understand this link, but also to understand the specific reactions that children have to war trauma, as well as the risk and resiliency factors that influence whether or not specific children develop psychological disturbances.

Thus, the aim of this paper is to answer the question, “*What are the effects of exposure to war and war-related trauma on the prevalence and characteristics of psychological disturbances among war-affected children?*” In order to answer this question, I will first examine the effects that war and related trauma have on the psychological well-being of children in general. I will then examine the kinds of traumatic events that these children must endure during times of armed conflict, the specific psychological disturbances that can result from exposure to such trauma, and the different risk and resiliency factors that can either put children at further risk or protect them from developing psychopathology or related symptoms. I will then look to Cambodia after the Khmer Rouge period (1975-1979) as a case study to demonstrate these effects. I will pursue many primary accounts of survivors who endured concentration-camp-like situations under this regime in order to illustrate the specific types of trauma that they had to endure as children, the various psychological disturbances revealed by the literature, and the differing risk and resiliency factors of Cambodian children during this time. Finally, I will examine contemporary Cambodia to determine the lasting effects that war and war trauma can have not only on a whole society, but its future generations of children as well. Overall, I hope to further establish the link between exposure to war-related trauma and the development of psychopathology in children, identify specific risk and resiliency factors associated with

this development, and propose global attention and action towards developing interventions for war-affected children that pay specific attention to cultural factors as well as developmental stages within this framework.

Given these areas of focus, it is important to consider the limitations of this paper. First, the current research that exists around war-affected children is relatively incomplete. While many studies have been conducted, longitudinal studies to explore the effects of war on children across time have been lacking (Bramley, Down, Hodes, & O'Shea, 2000). In addition, it is difficult to make conclusions from current research that often lacks baseline data. Children in war-affected countries often are not the focus of research until they have been exposed to war-related trauma. Therefore, it is difficult to interpret research findings in this context where no comparison with pre-existing data can be made. Developing countries may lack the fiscal resources and infrastructure to conduct research and gather accurate data from their populations. Cambodia is no exception. Dubrow, Garbarino, and Kostelny (1991, p. 42) attest to this, "In 1982, after the emergency was over and the first years of recovery were past, per capita Cambodian income stood at \$160. Cambodia was one of the poorest of the world's nations, ranking 195th out of 203 countries whose per capita incomes could be calculated."

Another important limitation is that children's voices will be heard and discussed through adult recollections of their childhoods under the Khmer Rouge. Thus, the accounts will not be directly from children themselves, but rather from adult memories of what they experienced and endured as children. It is important to recognize that age and time have an effect on how these accounts are expressed and articulated.

However, this methodology is utilized for several reasons. First, there are very few studies that have solely addressed children who have experienced war trauma.

Typically, research surrounding war-affected children involves other adults in the children's lives such as parents, teachers, or other significant adults. Second, this lack of child-specific research is largely due to important ethical considerations. Research is often not conducted on war-affected children directly because of the re-traumatizing effect that discussing traumatic events or experiences in depth can have for children (Herman, 1992). In light of the particular vulnerability of this population, often the closest we can come to understanding the effects that war has on children is through looking to adult recollections of their childhood.

Children and War

Prevalence of War-Affected Children Worldwide

At any given time, there are about two dozen armed conflicts ensuing in the world (McCloskey & Southwick, 1996). This has resulted and continues to result in millions of children being killed, maimed, disabled, or orphaned. One can only begin to speculate, therefore, on the number of children who are otherwise affected directly and indirectly by war or war-related trauma. For instance, children living in areas plagued by armed conflict are likely to be exposed to brutal death, dangerous escape or flight; violence; physical injury; mutilation; rape; starvation; loss of family, friends, community, or home; and other war-related trauma (McCloskey & Southwick, 1996). Furthermore, according to Klot, Machel, and Sowa (2001, p. 172), "Not only are large

numbers of children killed and injured, but countless others grow up deprived of their material and emotional needs, including the structures that give meaning to social and cultural life. The entire fabric of their societies, homes, schools, health systems, and religious institutions are torn to pieces.” In light of this reality, the question that surfaces is the implications that these various traumatic events, environmental deficiencies, and violent experiences have on the psychological health of exposed children.

The research conducted thus far has found a clear link between a child’s exposure to war or war-related trauma and the incidence of psychological disturbances such as PTSD, anxiety, depression, developmental disorders, aggression, grief, poor concentration, behavior problems, and somatic symptoms (Davies & Webb, 2000; Flores, 2000; McCloskey & Southwick, 1996; O’Shea, Hodes, Down, & Brameley, 2000; Hermanns, de Jong, & Paardekooper, 1999; Shaw, 2003). While this link has been established, there is a lack of longitudinal studies in this field that makes it difficult to determine whether these psychological disturbances are life-long or tend to dissipate over time. One study by Davies and Webb (2000) looked at war-affected children’s psychological suffering one year after their exposure to war and found that 62.4% of children were still experiencing psychological symptoms and that 35% of children met DSM (Diagnostic and Statistical Manual for Mental Disorders) criteria for mental and/or behavioral disorders. While this study demonstrates the lasting effect that war-related trauma has on the psychological health of children, the question of the incidence, prevalence, and characteristics of these psychological disturbances across time and developmental stages is left unanswered. Furthermore, the methods used to

indicate whether or not psychological disturbances or their symptoms were present or not may not have been specific to children at their stage of development or to their cultural context. In order to answer or at least shed light to some of these issues, it is essential to better understand how childhood is defined, and to understand why children's issues particularly around mental health have been historically neglected.

Childhood Defined

According to the United Nations Convention on the Rights of the Child of 1989 (as cited in Funk, 2005, p. 7), "a child means every human being below the age of eighteen years unless under the law applicable to the child, maturity is attained earlier." According to the same tenets instituted at this convention, "all children have the right to develop physically and mentally, and to be protected from abuse and exploitation" (Funk, 2005, p. 23). Furthermore, "children must be consulted and heard in matters concerning them" (Funk, 2005, p. 24). These defined and declared rights of children instituted by the United Nations in 1989 were groundbreaking in that for the first time children were acknowledged as full human beings, rightfully awarded basic human rights, and given a voice in matters concerning their physical, emotional, and sexual well-being. Burman (1986, as cited in Cairns, 1996, p. 4) added, "until relatively recently women, and children in particular, have been invisible socially and therefore irrelevant to, and apparently immune from, the great events of the world's nations." This is most likely a legacy that until a few hundred years ago virtually all western societies did not really think of children as full members of society or even, some would claim, as proper human beings" (Hareven, 1986, as cited in Cairns, 1996, p. 4). Thus,

the convention was a huge step forward in that it acknowledged that children were human beings; that they had rights that were legally stated, declared, defended, and protected. Dubrow, Garbarino, and Kostelny (1991, p. 10) stated, “As a concept, childhood is one of the major accomplishments of the modern era. Unlike adults who are expected to earn their own keep and pay their own way, modern children have an absolute economic claim on us. If their parents cannot provide for them, the local, state, national, or international community has an obligation to care for them.” It is one thing to identify and institute children’s rights in a global forum, but it is quite another to ensure and enforce that these are being implemented worldwide. Consequently, many of these rights are implemented in theory, but are altogether ignored in practice, particularly in developing countries that lack the infrastructure and fiscal means to uphold the rights of their most vulnerable citizens.

Violations of Children’s Rights

Sadly, it is in these developing countries that most of today’s approximately two dozen armed conflicts are taking place (McCloskey & Southwick, 1996). The countries that are least capable of instituting and protecting the rights of children are the countries being expected to defend these rights within the context of armed conflict. However, a child growing up amid armed conflict and with his or her basic human rights being upheld is an oxymoron. Klot, Machel, and Sowa (2001, p. 32) spoke to this when they stated, “Millions of children are caught up in conflicts in which they are not merely bystanders, but targets. Some fall victim to a general onslaught against civilians; others die as part of a calculated genocide. Still other children suffer the effects of sexual

violence or the multiple deprivations of armed conflict that expose them to hunger or disease. Just as shocking, thousands of young people are cynically exploited as combatants.” War by definition violates every right of a child including the “right to life, the right to be with family and community, the right to health, the right to the development of the personality, and the right to be nurtured and protected” (Klot, Machel, & Sowa, 2001, p. 33). In addition to these blatant violations of the basic rights of childhood, many of today’s current conflicts last the duration of the child’s “childhood,” which means that from their birth to early adulthood these children are at a particularly heightened risk for experiencing multiple and cumulative assaults against their putative rights. This disruption of the child’s “social networks and primary relationships that support children’s physical, emotional, moral, cognitive, and social development in this way, and for this duration, can have profound physical and psychological implications” (Klot, Machel, & Sowa, 2001, p. 178). With the understanding that armed conflicts are persistent globally, the knowledge that civilians and particularly children are at the greatest risk for physical and psychological harm, and the realization that children’s basic human rights are being violated on a daily basis resulting in serious psychological harm, it is vital that a basic understanding of children’s psychopathology and the various risk and resiliency factors associated with it be developed and established within prevention and intervention frameworks.

Post Traumatic Stress Disorder

History of PTSD

Post Traumatic Stress Disorder (PTSD) was not officially recognized as a psychological disorder by the American Psychiatric Association until 1980, when it was legitimated by combat veterans returning from the Vietnam War (Herman, 1992), although its symptoms were being studied as early as the late nineteenth century by Jean-Martin Charcot, Pierre Janet, William James, and Sigmund Freud. However, the disorder they were studying was known at that time as hysteria; therefore, it was considered a psychological disorder unique to women. When they began conducting research on hysterical women, they noticed a clear link between these women's experiences of sexual assault, abuse, and incest during their childhood and their current psychological disturbances. However, within one year of putting forth this thesis, Freud retracted his views entirely because of the implication that sexual assault, abuse, and incest were endemic among the proletariat of Paris and the respectable bourgeois families of France whose daughters he had interviewed. The social conditions were not yet right for the traumatic effects of trauma to be legitimated.

Similar phenomena were observed among soldiers returning from war and research began soon after World War I. The symptoms of these soldiers were often looked upon as weakness, cowardice, and a lack of masculinity. Soldiers were dishonorably discharged and were denied medical treatment. It wasn't until after the Vietnam War and the strengthening of the women's movement in the United States that

PTSD was recognized as an official mental disorder by the American Psychiatric Association (Herman, 1992). At this point these reactions to trauma witnessed among combat veterans and women in domestic life were officially recognized not as a disease of inferior females or weak men, but as a psychological disorder suffered by victims of trauma. However, in light of this relatively recent understanding and discovery, research surrounding PTSD is still incomplete. In particular, developing specificity in relation to children and culture is only recently a focus of this research. Clarke, Sack, and Seeley (1996, as cited in Israel & Wicks-Nelson, 2006, p. 141) acknowledged this when they said, “studies of PTSD in children have lagged behind adult studies (Saigh, 1992; Yule & Williams, 1990, as cited in Israel & Wicks-Nelson, 2006, p. 141), and have usually been carried out on selected samples after acute or “single blow” trauma (Terr, 1991, as cited in Israel & Wicks-Nelson, 2006, p. 141). “The studies of the aftereffects of war trauma on children are only now beginning to appear” (Jenson & Shaw, 1993, as cited in Israel & Wicks-Nelson, 2006, p. 141). However, if effective and ethical prevention and treatment methods and models are to be created and utilized with the vast number of children experiencing PTSD as a result of their exposure to war-related trauma, it is vital that further research concerning children’s PTSD be prioritized.

Diagnosing PTSD

While further research is needed before any clear conclusions can be drawn in regards to how children experience PTSD, existing research conducted on both adults and children can help guide clinicians, public health practitioners, policy makers, and others to make decisions with the best interests of youth in mind. As Cairns (1996, p.

67) articulated, “The children who do suffer sufficiently to be considered clinically ill appear to experience a wide variety of symptoms. Until recently, these have not been thought to form a specific constellation but more recently the whole constellation tends to have been referred to as PTSD. Perhaps the most salient characteristic is that symptoms tend to become worse with time not better.” In order to develop interventions that can prevent this negative outcome among children across time, it is important to understand how PTSD is diagnosed and children’s symptoms.

The first criterion that must be established when diagnosing PTSD is that the child was in fact exposed to a traumatic event that “included a threat of death, serious injury, or physical integrity to the self and of others” (APA, 2000, as cited in Israel & Wicks-Nelson, 2006, p. 141). Trauma within this context is defined as “an event outside everyday experience that would be distressing to almost anyone” (Israel & Wicks-Nelson, 2006, p. 140). Unfortunately, these experiences are not as uncommon as might be thought. The response to this exposure must “involve fear, helplessness, or horror” (APA, 2000, as cited in Israel & Wicks-Nelson, 2006, p. 141). In children this reaction may be expressed as disorganized or agitated behavior (Israel & Wicks-Nelson, 2006, p. 141). This is a particularly salient point given that many children’s inability to recognize and verbally articulate their emotional state, or even the event itself, depends upon their stage of development. It is important, however, to recognize that children are capable of experiencing “intense fear, helplessness, anger, sadness, horror, or denial” (American Academy of Child & Adolescent Psychiatry [AACAP], 1999, p. 1), even if they have difficulty articulating these responses.

The second criterion that must be observed in order to make the diagnosis of PTSD is the re-experiencing of the traumatic event that includes one or more of the following symptoms: “recurrent distressing recollections, recurrent distressing dreams, acting or feeling as if the event were reoccurring, intense distress to cues that symbolize the event, and/or physiological reactivity to cues that symbolize the event” (APA, 2000, as cited in Israel & Wicks-Nelson, 2006, p. 141). In children, the recurrent distressing recollections may be observed as trauma-related play (Israel & Wicks-Nelson, 2006). Terr (1988, as cited by Herman, 1992, p. 38) found that “among twenty children with documented histories of trauma, none of the children could give a verbal description of the events that had occurred before they were two and one-half years old. Nonetheless, these experiences were indelibly encoded in memory. Eighteen of the twenty children showed evidence of traumatic memory in their behavior and their play. They had specific fears related to the traumatic events, and they were able to reenact those events in their play with extraordinary accuracy.” This study shows that despite children’s lack of ability to verbalize their experience(s), the traumatic events that they endured still had lasting psychological effects that were articulated through their play. In addition, the recurrent distressing dreams are quite common among these children and are often dreams about death or nightmares that replay the traumatic event. It is also common for children to believe in omens that predict disastrous future events which often replaces the adult symptom of “physiological reactivity to cues that symbolize the event” (AACAP, 1999, p. 2). These findings and others like them show that traumatic experiences during infancy and young childhood can and do have psychological effects.

The third criterion that must be met in order for the diagnosis of PTSD is the persistent avoidance of trauma-related stimuli and general numbing as evidenced by three or more of the following: “avoidance of trauma-related thoughts, feelings, or conversations, avoidance of activities, places, or people associated with trauma, inability to recall important aspects of the trauma, diminished interest in significant activities, feelings of detachment from others, restricted range of affect, and/or sense of foreshortened future” (APA, 2000, as cited in Israel & Wicks-Nelson, 2006, p. 141). This criterion otherwise known as numbing or dissociation, is expressed in children as emotional numbness, diminished interest in previously enjoyed activities, and the perception that they are going to die at a young age. For instance, they may avoid specific places, activities, or people that remind them of the trauma or they may withdraw from others in general (AACAP, 1999). Additionally, Israel and Wicks-Nelson (2006, p. 142) stated, “Separation difficulties and clingy, dependent behaviors are also common. These behaviors may be exhibited in reluctance to go to school or in a desire to sleep with parent. A sense of vulnerability and loss of faith in the future have also been reported. In adolescence, this loss may interfere with planning for future education and careers; moreover, school performance is reported to suffer.” These withdrawal symptoms of PTSD, therefore, not only affect the youth’s internal sense of self, self-esteem, and his or her connection to others; but they also limit his or her future outcomes because of the youth’s self-perceived lack of a future.

The final criterion that must be met in order to make the diagnosis of PTSD is the persistent symptoms of increased arousal including two or more of the following:

“Sleep difficulties, irritability or angry outbursts, difficulty concentrating, hyper-vigilance, and/or exaggerated startle response” (APA, 2000, as cited by Israel & Wicks-Nelson, 2006, p. 141). This criterion is often observed in children as a constant state of being vigilant, nervousness or having a quick startle response, and/or having psychosomatic symptoms such as stomachaches and headaches (AACAP, 1999). These symptoms can also impede the child’s academic success. He or she is often incapable of concentrating on the material being taught because he or she is instead dealing with the effects of traumatic memory.

Finally, for the diagnosis to be complete, the child or youth must experience all three of the major criteria (re-experiencing, avoidance, and arousal) for more than one month and the disturbance must cause significant interference in key areas of the youth’s functioning (i.e., family, peer, and school relations) (APA, 2000, as cited in Israel & Wicks-Nelson, 2006, p. 141). The child’s symptoms may look different depending on what stage of development the child was in when the traumatic event(s) occurred. For instance, very young children (birth to five years) present with very few PTSD symptoms. This is probably because eight of the PTSD symptoms require a verbal description of one’s feelings and experiences which children of this age are not developmentally capable of doing. Instead, young children may present more generalized fears such as stranger or separation anxiety, avoidance of environments or instances that may or may not be related to the trauma, sleep disturbances, and a preoccupation with words or symbols that may or may not be related to the trauma. Furthermore, children at this stage of development may display post-traumatic play

which demonstrates repetition of themes related to the trauma. Children may lose an already learned developmental skill (i.e., toilet training) because of the experience of the traumatic event (Bernet, 1998). Elementary school-aged children, in contrast, may not experience visual flashbacks or amnesia for aspects of the traumatic experience as adults do, but they may experience “time-skew,” a mis-sequencing of the trauma-related events when recalling the memory, and “omen formation,” believing that there are warning signs that predict the trauma and that if they are alert to these signs they will be able to avoid future trauma. Both of these phenomena seen in elementary school-aged children are less frequent in adults. In addition, school-aged children demonstrate post-traumatic play or reenactment of the trauma in play, drawings, or verbalizations. Post-traumatic play refers to a “literal representation of the trauma” (Bernet, 1998, p. 12) and involves a compulsive repetition of some aspect of the trauma which does not tend to relieve anxiety. For instance, a child exposed to armed conflict may engage in repetitive shooting games where war is acted out through play compulsively. Post-traumatic reenactment, in contrast, is more open-ended and involves “behaviorally recreating aspects of the trauma” (Bernet, 1998, p. 12). For example, a child may carry a weapon (whether it be a stick or actual knife or gun) as a result of having been exposed to war-related violence. When the child reaches adolescence, their PTSD may begin to resemble PTSD in adults. However, adolescents still incorporate traumatic reenactment into their daily lives by including aspects of the trauma into their daily routines as discussed previously. Furthermore, adolescents are more likely than younger children to

show impulsive or aggressive behaviors such as conduct disorder and drug and alcohol abuse (Bernet, 1998; Israel & Wicks-Nelson, 2006).

Despite the numerous criteria that have to be met in order to receive a diagnosis of PTSD, it is notable that the rates of PTSD have been found to be widespread, especially among children that have been exposed to war-related trauma. Fletcher (2003, as cited in Israel & Wicks-Nelson, 2006, p. 142) indicated that about one third of youngsters exposed to traumatic events are diagnosed with PTSD--a rate that is slightly higher than traumatized adult."

While the prevalence of PTSD is quite high among war-affected children, many children do not experience the disorder or its symptoms over long periods of time. Whether or not a child develops PTSD is determined by a wide myriad of specific risk and resiliency factors (Boothby, Strang, & Wessells, 2006, pp. 27-28).

Risk and Resiliency Factors

Risk and Resilience Defined

In order to discuss these factors, it is important to understand the terms risk and resiliency in relation to whether or not one develops psychopathology. According to McWhirter, McWhirter, McWhirter, and McWhirter (2007, p. 6), "At-risk denotes a set of presumed cause-effect dynamics that place an individual child or adolescent in danger of future negative outcomes. At-risk designates a situation that is not necessarily current (although we sometimes use the term in that sense too) but that can be anticipated in the absence of intervention." In other words, at-risk refers to a set of

factors that influence the child or youth's susceptibility to developing psychopathology without appropriate intervention. Furthermore, it is important to understand that risk factors are not associated with causality, but rather they are environmental or internal influences that affect the vulnerability of a particular child or youth to developing psychological disturbances. For example, orphaned children are at a higher risk for developing psychopathology because of their lack of familial support. However, orphan-status does not result in psychopathology; rather it increases the child's vulnerability to developing psychopathology because the child is lacking a key source of support. Risk factors are not casual, but rather influence the child's likelihood of developing psychopathology in the absence of intervention.

Resilience, on the other hand, "refers to those who demonstrate a good outcome in spite of high risk, sustained competence under stress, and recovery from trauma. Essentially, resilience is the capacity to adapt and function successfully despite experiencing chronic stress and adversity. Resilience is not a static trait, but it is influenced by both internal and environmental factors" (McWhirter et al., 2007, p. 109). Again, possessing a certain set of resiliency or protective factors, does not mean that people do not experience or suffer from trauma. Rather, it refers to both environmental and internal factors that the individual possesses that help protect against or lessen that person's susceptibility for experiencing negative outcomes. Resilience or protective factors are not linked with causality, but are merely identified aspects (both internal and external) of that individual's life that lessen that person's probability of developing or

failing to rebound from psychopathology. For instance, what might be a risk factor for one child may be a resiliency factor for another and vice-versa.

Individual Characteristics

A child's individual characteristics play a huge role in whether or not a child is going to experience future negative outcomes after being exposed to war. This is one of the key reasons why the same prevention and intervention strategies do not work for all children. Personality traits that contribute to a child's resiliency include effective verbal communication skills, good social skills, an ability to form positive relationships with others, an internal locus of control, impulse control, a tendency to reflect on life's events, and a positive self-esteem (Flores, Cicchetti, & Rogosch, 2005; Berry, Shillington, Peak, & Hohman, 2000, as cited in McWhirter et al., 2007, p. 111). A well-developed sense of humor, future orientation, and an optimistic tendency promote resilience in children as well (McWhirter et al., 2007). Many of these protective factors promote resiliency in children because they typically contribute to other people having positive perceptions of them. For instance, good verbal communication skills, social skills, and the child's ability to form positive relationships all increase the child's likelihood that he or she will elicit positive attention from his or her family, school, or family, thereby ensuring additional supports for surviving with trauma. In fact, "Children and adolescents who lack connectedness, experience social isolation, or rejection tend to suffer psychological distress and greater mental health problems as adults" (Kupersmidt, Coie, Dodge, 1990; Resnick et al., 1998, as cited in McWhirter et al., 2007, p. 117). Attributes such as a well-developed sense of humor, future

orientation, and an optimistic tendency contribute to the child's resiliency by giving the child a perspective on life that is still positive and hopeful despite the traumatic events that they may have been exposed to. In addition, resiliency equips the child with coping skills that allow the children to direct their emotions concerning the trauma towards a positive course of action. McWhirter et al., (2007, p. 118) added, "Coping skills influence an individual's response to stress, which in turn affects the way that person deals with conflict. Some young people cope with humor and altruism, others by focusing their attention elsewhere. These methods result in a more relaxed and positive view of the situation. When young people are in a positive, relaxed state of mind, they are able to process information more objectively, exercise better judgment, and use common sense. They also demonstrate more effectiveness and competence in solving personal problems."

While possessing those characteristics that promote active and effective responses to experienced war-related trauma can be crucial to a child's recovery, there are many children who either lack these characteristics or are not brought up in an environment that promotes or is capable of fostering the development of active responses to traumatic events. These children, therefore, are at an increased risk for developing psychopathology. La Greca et al. (1996, as referenced in Israel & Wicks-Nelson, 2006, p. 144), "Children who tend to use negative coping strategies (e.g., blaming others, screaming) may be more likely to experience persistent symptoms." Furthermore, children who are passive, withdrawn, or introverted are at an increased risk for experiencing negative outcomes because they tend to be more socially isolated

and thus have fewer outside supports to assist them in processing the traumatic events that they have experienced (McWhirter, 2007). Children who have poor verbal communication, social skills, or who lack the ability to form positive relationships or to elicit positive attention from those around them tend to exhibit more negative outcomes. This has also been shown to be true among children who have an external locus of control, lack of impulse control, little or no hope for the future, or show a tendency towards pessimism. These attributes not only contribute to the child's social isolation, but they also promote coping strategies that are maladaptive and ultimately harmful to the child in the form of limited future expectations as well as the development of psychological disturbances (Israel & Wicks-Nelson, 2006). For instance, at-risk children can adopt maladaptive coping strategies such as denial, distancing, and habituation (Cairns, 1996).

If a child copes with an experienced trauma mal-adaptively he or she may utilize distancing or denial as coping strategies (Cairns, 1996). He or she may refuse to talk about the traumatic event with an adult, but may talk to a doll instead. In addition, he or she may laugh during the traumatic event as a way in which to distance himself or herself from the actual reality of what is occurring (Cairns, 1996). Another coping strategy known as habituation, a tactic in which abnormality has become normality. For example, the horror that is experienced during armed conflict is no longer seen as an experience outside of what is experienced in everyday life, but has rather become so endemic that it is now the reality of the child's day to day life. McWhirter (1988, as cited in Cairns, 1996, p. 57) articulated, "[children] become so accustomed to political

violence that political violence is perceived as normal.” Children who exhibit an external locus of control are clearly more vulnerable to habituation in that they perceive that they have little or no influence on the events occurring outside of them and thus habituate to its terror. In the same way, children who are socially isolated or lack the skills or capabilities to forge social connection stand without role-models who can help them process what they are experiencing not as normal but in fact as abnormal.

Gender

Gender is another individual factor that has been widely debated in the literature in terms of its effect on the probability that a child will develop psychopathology. According to Israel and Wicks-Nelson (2006, p. 142), “Most studies find a higher incidence of PTSD among girls.” While these findings may be prevalent in the existing but limited research base, at least one study conducted by Dawes et al. (1989, as cited in Cairns, 1996, p. 37) has challenged this premise as being far too simplistic. This study “reported a more complicated pattern which involved the interaction of gender and age. This arose because boys had a higher frequency of symptomatic behavior than girls in the youngest age group, while by middle childhood the two were very similar. By adolescence, however, proportionately more girls than boys had PTSD type symptoms.” These findings speak to the effect that societal influences surrounding gender norms and expectations have on whether or not psychological disturbances are exhibited among children of different genders at different age groups. The findings that a boy’s prevalence of PTSD related symptoms declines with age could be correlated with a boy’s tendency to deny or hide his or her trauma-related symptoms because society

tends to be less sympathetic towards male children and thus provides less support or responds negatively to a boy's distress (Cairns, 1996). Older boys may suffer less because of their own or their family's reluctance to disclose PTSD related symptoms because they did not want to appear non-masculine (Cairns, 1996). Overall, despite the contradictory findings in the current research, the idea that females are more susceptible to the effects of war-related trauma has been increasingly attributed to both a male child's and his family's reluctance to disclose his symptoms due to perceived societal shame and society's overall acceptance and support of female children's expression of trauma-related symptoms. It is increasingly evident, therefore, that it is not being female that is a risk factor for psychopathology, but that female distress is culturally supported, a construct which paradoxically supports female psychopathology as a response to trauma.

Age

Another factor that has a definite effect on the way in which children respond to trauma is their age or stage of development. As discussed previously, PTSD manifests itself in different ways and different symptoms are present among children of different age groups. The question that arises, therefore, is whether or not a child's age at the time that the trauma is occurring affects their susceptibility to developing psychopathology. Rutter (1983, as cited in Cairns, 1996, p. 36) addressed this issue when he stated, "Children at different ages may respond to stress in different ways, and different stressors may have a different impact at different ages. However, vulnerability to stress does not seem to increase or decrease markedly at any specific age." However,

this area of research has been much-debated. It was previously thought that infants or very young children were immune from the effects of exposure to war-related trauma. However, increased research efforts being done on early brain development has shown that because the brain adapts to its environment, the brains of children growing up in chronically war-torn or chaotic environments will develop neural pathways dedicated to survival and responding to negative environmental threats, rather than those dedicated to the development of intelligence, emotions, and personality. This is particularly significant considering that the brain reaches 90% of its adult size by the time the child is three years old (Butchart, Furniss, Mian, & Phinney, 2006). Therefore, infants and young children are definitely at risk for the negative effects of war-related trauma despite their inability to verbally articulate their experience as do older children. Dubrow, Garbarino, and Kostelny (1991) stated, "The eventual consequences of early traumatic loss may not be fully evident until many years have passed." While the research seems not to consider age as a factor in a child's development of psychopathology, one factor that does seem to promote either a risk or resilience is the age at which a child becomes separated from his or her family if that is part of their experience. Cairns (1996, p. 65) stated, "age at which a child becomes separated from his or her family is important. Ressler et al. (1988, as cited by Cairns, 1996, p. 65) suggests that the loss of both parents before the age of five is [...] most likely to place a child at risk, if another satisfactory relationship with an adult does not develop."

Family Dynamics

A child's family can also serve as either a risk or protective factor, depending on whether or not the family is a source of support and comfort for the child or a source of abuse and further grief (Herman, 1992). It is important to recognize that *family* is not a structure that must look or be composed a certain way, but rather it is "whatever provides an economic foundation for meeting physical needs, fosters basic skills and competencies, fosters social access, and transmits core cultural knowledge and values" (Boothby, Strang, & Wessells, 2006, p. 57). This concept of family is inclusive of extended family systems as well as non-Western cultures that view children as not solely the responsibility of their biological parents, but rather as the responsibility of the community as a whole. These family systems can be crucial to the war-affected child's resilience. As Israel and Wicks-Nelson (2006, p. 144) stated, "that children survive at all in the heat of war is testimony to their resilience and to the efforts of the adults who care for them: parents, teachers, relatives, friends, and therapists." If families have the capacity to mitigate harmful effects for children, what characteristics help to facilitate this protective process?

According to Ressler et al. (1988, as cited in Cairns, 1996, p. 42), "war acquires comparatively little significance for children so long as it only threatens their lives, disturbs their material comfort, or cuts their food rations. It becomes enormously significant the moment it breaks up family life and uproots the first emotional attachments of the child within the family group." From what we know about how PTSD presents in young children (i.e., attachment disorders), it becomes increasingly

clear how a secure attachment with a primary caregiver even in times of chaos can serve as a protective factor against serious psychological disturbances. In fact, “attachment is perhaps the most important item on the child’s developmental agenda in the first year of life” (Dubrow, Garbarino, & Kostelny, 1991, p. 10). Erik Erickson (1963, as cited in Dubrow, Garbarino, & Kostelny, 1991, p. 10) identified the development of this ‘basic trust’ as the most important challenge during the first year of life. Armed with basic trust the child is ready to face the world secure in the knowledge that people are caring and the world is trustworthy.” However, in order to develop this basic trust, the child must be within a family environment that fosters its development. For instance, “parenting characterized by warmth, affective expression, anticipatory guidance, active teaching of social skills, and involvement reduces risk” (Petit, Bates, & Dodge, 1997, as cited in McWhirter et al., 2007, p. 111) and “increases children’s social competence” (Mize & Petit, 1997, as cited in McWhirter et al., 2007, p. 111). In addition, according to Wolin & Wolin (1993, as cited in McWhirter et al., 2007, p. 111), “Healthy communication patterns often prevail in the homes of resilient youth.” McCubbin & McCubbin, 1988, as cited in McWhirter et al., 2007, p. 111) added, “The parents model such skills such as attending, focusing, and sustaining tasks. Focused, flexible, well-structured, and task-appropriate communication leads to academic and social competence.” Parenting characterized in this way, therefore, creates a safe and secure environment in which the child feel loved and wanted, thereby producing a safe place in which the child can progress developmentally, emotionally, and socially. Furthermore, parental modeling of effective communication promotes the child’s current and future

psychosocial competence thus ensuring that the child will be able to positively thrive in social relations in groups outside of his or her immediate family including school, peer, and societal relations. This is particularly salient considering that “caring relationships increase resiliency” (Laursen & Birmingham, 2003, as cited in McWhirter et al., 2007, p. 110) by providing supports for the child to develop and function normally despite adverse environmental stressors which abound in regions affected by armed conflict.

Parental Reaction

While strong and secure family relations can be crucial to young children developing this “basic trust,” it can also be especially important for older children as well, who look to their parents or related figures for guidance, support, and comfort. Indeed, one protective factor that has been identified throughout the research has been the parent’s maintenance of normal routines, which provides a consistent framework in which children feel relatively safe and secure. As Dubrow, Garbarino, and Kostelny (1991) put it, “If parents could maintain day-to-day care routines and project high morale, their children ha[ve] a foundation of basic trust from which to build as they [seek] to cope with the stresses around them.” On the contrary, if parents do not or cannot maintain these routines that provide a sense of normalcy amid the chaos, the child’s emotional foundation no longer feels safe; thus lapses in development or maladaptive coping strategies can occur in response. In addition, parents who engage with their children in a process of interpreting the events that are occurring around them rather than excluding the children from these types of activities provide an additional protective factor for the child’s psychological well-being (Dubrow, Garbarino, &

Kostelny (1991). In this way, the child is included in conversations that promote processing and interpreting the traumatic events and gives the child a way to incorporate what they are experiencing into the context of their lives. This does not mean that the child is exposed to the wide range of his or her parent's or caregiver's reactions and emotions, but rather that he or she is given the opportunity to talk about and process his or her own experiences, thus preventing the formation of traumatic memory which often lacks understanding or explanation (Herman, 1992). As Cairns (1996, p. 41) stated, "it is not just overtly fearful parents who are likely to be a liability according to Ronstrom (1989). Parents can also transmit fear to their children 'through hidden and mixed messages,' for example, the tendency to be overprotective, or to hold anxious discussions from which children are excluded." Overall, the reactions and responses to traumatic events of those who are primary caregivers for children, are crucial because it is to these that children look to know how to respond and react to these traumatic events as well. Dubrow, Garbarino, and Kostelny (1991, p. 19) put it poignantly when they stated, "Research on children growing up in war zones tells us that children who have experienced a warm, positive relationship with parents can develop a 'working model' of what it means to be a person that can serve to sustain them through hard times. Parents and the quality of their relationships with their children are a key to understanding the psychological health of children who live in war zones."

Orphaned and Separated Children

The reactions and responses of a child's parents can be crucial to how the child processes and attributes meaning to the traumatic experiences they have been exposed to. While this factor affects children growing up in zones of armed conflict who do have parents, orphaned or separated children who have not been so fortunate must grapple with the reality of their traumatic experiences without this support, modeling, or guidance. These children constitute a vulnerable population and are at increased risk for developing psychopathology. Boothby, Strang, and Wessels (2006, p. 64) spoke to this vulnerability when they stated, "Such children are also the most vulnerable to recruitment into armed forces, trafficking into forced labor or prostitution, and other egregious forms of physical, psychological, and sexual abuse. As a result, a comprehensive understanding of developmental, psychological, and protective needs of children in such situations is essential to informing effective policy and programming responses." Furthermore, children who are orphaned or separated from their parents are at increased risk for malnutrition, lack of access to both medical and educational facilities, developmental delay, and abject poverty (Boothby, Strang, & Wessels, 2006). They are also at an increased risk for psychological stress due to a loss of identity or feeling of belonging, a heightened sense of physical or emotional disorientation, and bearing the pressure of sustaining their own survival or the survival of their siblings (Boothby, Strang, & Wessels, 2006). In addition, children who are occupied with meeting the needs of their basic survival are often ill-equipped to seek understanding or processing of the events that they are witnessing or being directly

affected by. They also lack the social, moral, and cultural knowledge that is typically transmitted from parent to child. This adds to their sense of isolation and lack of belonging. Therefore, it is vital that these children receive priority in terms of intervention and prevention efforts as they are extremely vulnerable to having negative outcomes.

Broader Systemic Influences on Resilience and Trauma

Community

The fact that many children growing up in war zones are orphaned or separated from their parents as a result of the chaotic environment or situational circumstances that accompany war, implies that the child's broader community can play a crucial role in supporting their physical, emotional, and psychological well-being despite their adverse circumstances. For example, siblings, grandparents, relatives, teachers, and familiar adults can all provide support that serves as a protective factor for children (Cairns, 1996). Future research needs to focus on this broadened definition of social support in children's lives rather than solely focusing on the parent's and particularly the mother's ability to support her children (Cairns, 1996). This traditional and very stereotypical assumption that mothers are to provide the sole source of emotional support for children neglects the family dynamics in many non-Western contexts where the child's care is the responsibility of the community as a whole and not merely the nuclear family or mother. Even in Western contexts, gender roles are not as rigid as

they once were and thus many children today receive this kind of support from other family members and resources within the community.

The benefits of this support are many. As Dubrow, Garbarino, and Kostelny (1991, p. 27) articulated, “[Children] may come through the challenge of facing danger with an enhanced capacity to see the world with sensitivity and moral astuteness. This can happen if adults [not just parents] help them process their experiences, heal their pain, and help put those painful experiences in a humanistic framework that refuses to dehumanize the enemy and instead encourages the development of empathy.”

In addition to its preventative aspects, this type of support is crucial when children have been traumatized within the context of their community. For instance, they may have been forced to flee their village or city, experienced the destruction of their school, or made to participate in activities such as forced attacks on neighbors or other within their community which rupture any former sense of social bond that the child or youth may have had in his or her community (Boothby, Stran, & Wessells, 2006). They may also have seen family members die or be killed. Community support is necessary to foster the rehabilitation of these children back into their communities despite former forced breaches of trust and security. This level of community support can also depend on how familiar the community is with political violence and how to cope with its effects (Cairns, 1996) as well as how wide-ranging the conflict has been. If the community holds a high level of social capital in which its members trust and support one another, it can play a vital role in supporting war-affected children. On the other hand, if the community is characterized by a low level of social capital, positive or

negative relations within and between families, peer groups; religious and cultural institutions; links with civic and political authorities, and so on, where mistrust and competition reign, or resources are scarce, children may not be able to rely on their communities for this kind of support (Boothby, Strang, & Wessells, 2006). Again, this largely depends on the community's familiarity with armed conflict and how to respond to the chaotic environment it creates. If this social capital is present, however, "in the simplest sense, the community [can be] crucial in offering orphaned and abandoned children a second chance through adoption and foster care, particularly if those new relationships provide children with a chance to 'process' their loss of parents" (Dubrow, Garbarino, & Kostelny, 1991, p. 20). Overall, if a war-affected child has many people and social supports invested in him or her such as family, peer, and community supports, he or she will be less likely to develop a psychological disturbance than a child that lacks these vital supports or protective factors (Kostelny, 2006, as cited by Boothby, Strang, & Wessells, 2006).

Socioeconomic Status and Education

In considering factors such as family dynamics and community support systems, it is essential to explore how factors such as socioeconomic status or the family's degree of poverty affects the degree to which the family or community is able to support their children, not only physically, emotionally, and psychologically, but also in terms of their ability to provide adequate education to war-affected children. Cairns (1996, p. 71) pointed out, "Given the overall correlation between family dysfunction and lower socioeconomic status observed in most societies, the children most vulnerable to the effects

of political violence are likely to be those among the poorer sections of society.” Children living within these poorer sections of society are at increased risk for developing psychopathology because they lack not only fiscal but survival means as well. In fact, “In the worst situations, children’s lives may be affected by such things as lack of shelter, poor diet, and lack of medical services which in turn may lead to increased susceptibility to simple diseases such as diarrhea, respiratory and childhood infections, and to a general increase in the child-mortality rate” (Armenian, 1989; Arroyo & Eth, 1989; as cited by Cairns, 1996, p. 72). In addition, families or communities that are not able to provide the basic necessities for physical health such as food, water, or shelter, are not likely going to be available to meet their children’s emotional and psychological needs as well. Furthermore, in many cases disadvantaged communities are not going to be able to subsidize public services, such as schooling. As a result, war-affected children are often disadvantaged and lose many opportunities available to other children. Those children who are privileged enough to be able to attend school even amid the chaos of war are at significantly lower risk for developing psychological disturbances because they are given the tools to be able “figure things out, to read situations and people, [and] to create alternatives” (Dubrow, Garbarino, & Kostelny, 1991, p. 31). It also helps them to avoid simplistic interpretations of their surroundings that typically result in self-defeating and socially destructive outcomes (Dubrow, Garbarino, & Kostelny, 1991).

Religious Beliefs, Ideology, and Interpretation

Another factor that can act as either a protective or risk factor for children is the religious or ideological framework that the child is surrounded by or participates in and which influences the way that each child interprets the traumatic events occurring around them. As Dubrow, Garbarino, and Kostelny (1991) found, “One aspect of narrative that enables children to survive emotionally in the midst of war-induced trauma is ideological, offering a worldview that makes sense of experience in political, religious, and social terms.” In adults, it has been shown that appraisal, the process whereby the individual evaluates the personal significance of the traumatic event, and the subsequent coping behavior or strategy of thought that is chosen based on the outcome of their appraisal has a significant role in whether or not that individual adult exhibits negative psychological outcomes (Cairns, 1996). This helps to explain why different individuals experiencing the same event often have different accounts or experiences of the event and thus use different coping strategies in response. Although the appraisal process has rarely been considered with children because of their early stages of development and the assumption that they entirely look to parental reactions for guidance on how to interpret traumatic events, it is highly likely that “a child’s primary cognitive appraisal of the positive or negative meaning of a particular life event will determine whether that event is experienced as stressful or not” (Rutter, 1983, as cited by Cairns, 1996, p. 50). Therefore, religious and ideological frameworks that the child is a part of before the traumatic event occurs can serve as protective factors for the child in that they may promote more positive and active responses to trauma that

protects them from the development of negative coping strategies and resulting outcomes.

While “being part of a religious group provides meaning to one’s surroundings and can serve as a coping mechanism and resiliency factor” (Dubrow, Garbarino, & Kostelny, 1991, p. 24), it can also be detrimental if that religious group serves to perpetuate violence. A key factor in determining whether religious frameworks are protective or detrimental depends on whether the ideology promotes dehumanization, demonization, and destruction of the enemy, or teaches compromise, personal integration, and empathy (Cairns, 1996). Religion can be an essential protective factor promoting children’s resiliency if it acts as a source of support for helping children understand, process, and give meaning to their traumatic life experiences. McWhirter (1983, as cited in Cairns, 1996, p. 53) suggested that the Christian churches in Northern Ireland may have had a positive effect on children’s coping. Additionally, Reynolds (1990, as cited in Cairns, 1996, p. 53) recorded the work of spirit healers in Zimbabwe that played a crucial role in the healing of war-affected children. Overall, a child’s interpretation of a traumatic event can be crucial in determining that child’s psychological outcome; thus religious or ideological frameworks can be key components in supporting children’s appropriate and healthy interpretation of the chaotic events surrounding them.

Trauma, War, and Psychopathology

Characteristics of Trauma

While individual, social, and environmental factors are crucial to consider when determining the level of risk and vulnerability of children to developing psychopathology, the characteristics of the traumatic events themselves can be major determinants in children's exhibited psychological responses. The major characteristics of trauma that play a key role in determining the level of risk that the child has for developing psychological disturbances includes the type, degree, and duration of the trauma. According to Boothby, Strang, and Wessells (2006, pp. 4-5), "An understanding of how children are affected by war must begin by clarifying the important distinctions among type, degree, and duration of traumatic events." For instance, research has shown that a child is more likely to develop negative psychological outcomes if he or she witnessed the death or murder of his or her parents as opposed to witnessing or experiencing his or her community being bombed. While both instances may induce a traumatic response, the former is typically much more traumatic for the child because of the personal significance it holds.

While this example provides an illustration of how the type of trauma can be crucial for determining a child's response to traumatic events, another important characteristic of trauma is its degree (Israel & Wicks-Nelson, 2006). A child who witnesses his or her parents be killed or murdered is much more likely to develop psychopathology than a child who witnesses a complete stranger be killed or murdered.

While the child is witnessing the same type of trauma in this instance, the degree is markedly different because one is extremely significant to the child in that he or she is losing someone they love, depend upon, and seek guidance from, while the other is someone who holds little emotional significance for them. While both events are traumatic for the child in light of the fact that they are watching a human life be killed, the differing degree of trauma in this instance affects the child's response greatly.

Finally, the duration of the traumatic event is another attribute of trauma that holds a lot of weight as to not only whether the child will develop psychopathology but also in determining the degree, form, and longevity that the psychological disturbances will have and take. Garmezy (1993, as cited in Israel & Wicks-Nelson, 2006, p. 143) suggested that "prolonged and cumulative stress may be a prime factor in the loss of resilience over time." In other words, if a child has been exposed to a stressor such as murder multiple times as opposed to only once, he or she is more likely to develop a psychological disorder than a child who witnessed murder only once. The same can be said for children living in physically, emotionally, or sexually abusive situations. The longer the abuse occurs, the higher the risk is for the child to develop psychopathology as a result. Boothby, Strang, and Wessells (2006) affirmed this same premise when they stated, "Because war zones present multiple risks to children, their situation cannot be understood in terms of single events such as displacement from home, stepping on a landmine, or the death of a parent. In this respect a risk-accumulation model provides useful insights into the plight of children in conflict and post-conflict situations" (Garbarino & Kostelny, 1996, as cited in Boothby, Strang, & Wessells, 2006, p. 26).

This model asserts that as risks accumulate, the likelihood of damage to children increases exponentially. For example, the accumulation of three or more risks can produce ten times as much damage as a single risk factor (Rutter, 1985).” In light of this, it is important that specific attention be put towards determining the type, degree, and duration of trauma that each individual child has experienced in order to design effective prevention and intervention methods.

Considering the Context of War-Affected Children

As should be clear by now, both characteristics of the child’s context and the traumatic event should be considered when determining whether or not the child is at an increased risk for developing PTSD or related symptoms. However, it is important to remember not to pathologize children when making these kinds of determinations. De Jong (2000, as cited in Boothby, Strang, & Wessells, p. 7) articulated, “Behaviors that could be classified as trauma symptoms should rather be seen as normal responses to abnormal circumstances. This surely must be true by definition where 95 percent of the population is classified as demonstrating post traumatic stress disorder, thus creating a ‘norm’ for this situation.” In other words, the experience of war and war-related trauma is horrific and thus it is obvious that it will negatively affect those who are exposed to its terror. Therefore, it should not be surprising when children develop PTSD or related traumatic symptoms. They are simply coping under adverse, chaotic, and abnormal circumstances. Unfortunately, this hasn’t been so obvious to many looking at war-affected children who label them as “traumatized” and “maladaptive” rather than understanding that their responses are quite normal considering the horrific nature of the

trauma they are experiencing at an extremely vulnerable age. In light of this tendency, those working with or researching war-affected children must seek to support where supports are lacking, as well as view each child's traumatic symptoms as a natural response to war-trauma particularly when supports are absent or minuscule.

Cultural Considerations

While considering the way in which war-affected children are viewed and diagnosed is essential, it is also imperative that one consider each child's cultural context and its values, beliefs, and customs. According to Perrin, Smith and Yule (2000, as cited in Israel & Wicks-Nelson, 2006, p. 143), "The PTSD cluster of symptoms (re-experiencing, avoidance, and arousal) has been reported in youngsters from a variety of different cultures." "The most frequently occurring category of symptoms is probably re-experiencing the event" (Fletcher, 2003, as cited in Israel & Wicks-Nelson, 2006, p. 143)." However, while PTSD symptoms have been found to be present cross-culturally, it is essential to remember that the PTSD diagnosis, the majority of the research thus far, and the prevention and intervention methods and models that have been designed have primarily been based within the adult Western context. Western concepts and characteristics have been attributed to everyone regardless of their cultural frameworks and beliefs. This tendency is detrimental because it disregards and disrespects each person's unique culture; a key source of support that promotes resiliency. Dubrow, Garbarino, and Kostelny (1991) supported this idea when they stated, "the best we can expect from a culture is that it have resources to bring to bear in times of stress and trauma, resources that can help the healing process and stem the tide of situationally

induced evil.” Many children’s responses to trauma are culturally scripted, founded on the beliefs, values, and customs within their culture. Therefore, it is necessary to incorporate culture into understandings of war-affected children’s behavior, development, and psychopathology.

Cultures can provide a rich resource of strength not only to adults but also to children. Service providers should seek to understand the child’s cultural context before making a diagnosis, developing an intervention, or making any assumptions about the child’s behavior. Kostelny (2006, as cited in Boothby, Strang, & Wessells, 2006, p. 19) affirmed this need when she stated, “it is vital to reflect deeply on issues of culture--to probe indigenous understandings of childhood, well-being, and healing practices--and to explore the power relations that lead to the imposition of Western approaches to mental health and intervention. Lack of awareness of these issues leads to violations of the “do no harm” imperative that should lead all humanitarian assistance to war-affected children.” Furthermore, “Imposing Western interventions is an act of “psychological imperialism” that marginalizes local belief systems and undermines cultural ways of dealing with psychosocial stresses” (Anderson, 1996; Dawes, 1997; Wessells, 1999; Wessells & Kostelny, 1996, as cited in Boothby, Strang, & Wessells, 2006, pp. 21-22). This is not to say that Western knowledge and experience has little or no value, but rather that recognizing the power differential that is often at play and the ethically imperative necessity of respecting each cultures beliefs, traditions, and customs is vital. Triandis (2001, as cited in Boothby, Strang, & Wessells, 2006, p. 20) added that, “While Western ideas of childhood view the child as an autonomous entity or as

developing into one, in other countries (including most war zones) children's identities are defined mainly in terms of their social relations and social roles; people have collective identities that honor the good of the group over any individual good." Furthermore, Western definitions of healthy child development include physical, cognitive, social, and emotional competencies while neglecting spiritual competencies which are often crucial aspects of the child's development among many other cultures (Kostelny, 2006, as cited by Boothby, Strang, & Wessells, 2006). Finally, "In many non-Western cultures the somatic symptoms typically associated with PTSD, such as sleep disturbances, intrusive thoughts, and hyper-vigilance, are seen not as the result of experiencing a single traumatic event in the past but as part of current personal, social, and spiritual stresses and problems" (Kostelny, 2006, as cited by Boothby, Strang, & Wessells, 2006, p. 23). In light of these cultural differences in how both childhood and trauma are viewed, it is essential that the child's cultural context is given careful consideration and that his or her beliefs, customs, and traditions be respected and incorporated in interventions. Western methods may still be appropriate, bearing in mind that "while some Western interventions may be of value, they must be carefully tailored to fit the context and integrated with local methods" (Kostelny, 2006, as cited in Boothby, Strang, & Wessells, 2006, p. 25).

The Khmer Rouge

Looking to the Voices of Cambodian Children

Given that both the concepts of childhood and culture have been largely neglected until recently among clinicians, researchers, and providers of humanitarian assistance who are working with populations who have been affected by war, this paper will now look to a specific case study that will examine the effects that war and war-related trauma have on children growing up under the Khmer Rouge, a political faction that took control of Cambodia from 1975-1979.

First, the history and ideology of the Khmer Rouge themselves will be described in order to illustrate the multiple ways in which children's lives were affected by the conflict and quotes from children who survived the Khmer Rouge will be presented so that their voices can describe their experiences. Particular attention will be placed on the reports of PTSD-related symptoms. Finally, this paper will examine contemporary Cambodia in order to describe the long-lasting effects of trauma as well as the concept of transmitted trauma. Overall, this section will aim to paint a specific picture of what children endure during war, the psychological disturbances that they suffer from, the risk and protective factors that influence the development of psychopathology among Cambodian children, the cultural specificity that is needed in order to support healing for Cambodian children, and the lasting effects that trauma can have especially in the absence of developmentally and culturally appropriate interventions.

History of the Khmer Rouge

In 1953, the former French colony of Cambodia became independent under the leaderships of Prince Sihanouk, who was proud of Cambodia's independence and neutrality (Kieinan, 1997, as cited by Maguire, 2005). Throughout his reign from the 1950s to the 1960s, Cambodia was prosperous and self-sufficient; however his government was corrupt and self-serving. As a result, the rich became richer and the poor became poorer, leading to the creation of nationalistic factions who demanded reforms. One of these was a Communist faction known as the Khmer Rouge ("Red Cambodian") or the Revolutionary Army of Democratic Kampuchea. The Khmer Rouge launched an armed struggle against the Cambodian government (Ung, 2000). During the 1960s and early 1970's, Cambodia was drawn into the Vietnam War as the Vietnamese extended the Ho Chi Minh Trail to include areas along the border of and inside Cambodia. As a result of this extension, the United States under the Nixon administration covertly bombed this North Vietnamese refuge and supply route inside Cambodia. In fact, according to Maguire (2005, p. 45), "Between February and July 1973, they dropped more than 250,000 tons of bombs in what the Khmer Rouge leaders would later call the '200 nights of bombing.' In the end, U.S. bombers launched 3,630 raids along the Cambodian border and dropped a total of 15,000 pounds of explosives for every square mile of Cambodian territory." Unfortunately, this bombing did more than target the North Vietnamese supply route. In fact, it killed many Cambodian civilians, revolutionized numerous Cambodian citizens, and pushed the Communist factions deeper inside Cambodia (Kieinan, 1997, as cited by Maguire, 2005). It also

allowed the Khmer Rouge to gain support from many peasants and farmers who were affected by the bombings and injustices of the corrupt government (Ung, 2000). This was also affirmed by Maguire (2005, p. 45) when he commented, "Two facts remain certain, the U.S. bombing campaign pushed the Vietnamese deeper into Cambodian territory [thereby pushing the Khmer Rouge in deeper as well], and most important, turned many uprooted Cambodian peasants into zealous revolutionaries."

The North Vietnamese army then began training the Khmer Rouge, and giving them Chinese and Soviet weaponry, reinforcing their strength, force, and influence within Cambodia (Kieinan, 1997, as cited in Maguire, 2005). In 1970, Prince Sihanouk was overthrown by his top general, Lon Nol. Initially, the Khmer Rouge professed to be patriotic while concurrently exploiting the corruption of the U.S.-backed Lon Nol government. They took villages captive, burned towns, and recruited youths to join their cause (Kieinan, 1997, as cited in Maguire, 2005). It wasn't until July 1st, 1973 that the United States Congress voted to end all bombing in Cambodia by August 15th, 1973. On December 31st, 1973, Congress decided to limit the number of U.S. military personnel in Vietnam to 50. As a result, a massive evacuation of U.S. military and related personnel from both Vietnam and Cambodia began. On April 1st, 1975 the U.S. pulled its embassy staff from Phnom Penh. Sixteen days later, on April 17th, 1975, the Khmer Rouge marched into and took control of Phnom Penh (Kieinan, 1997, as cited in Maguire, 2005).

The simultaneity of the U.S. evacuation and the Khmer Rouge take over is no coincidence. Lon Nol's government was weak and corrupt and could not stand without

U.S support and backing. When the United States pulled out, the Khmer Rouge, which had grown to be a force of about 60,000 guerilla soldiers, defeated the government forces with ease. As Abdulgaffar Peang Meth, the Cambodian diplomat at that time, lamented from his Washington D.C. office, “What hurts, is the way the United States used us. You marched into our country, you promised us aid, you encouraged us to keep fighting, you told us you were our friends, and now you drop us” (Maguire, 2005). Pol Pot, the Khmer Rouge leader, called the U.S. evacuation, “a great event clearly demonstrating to the world that small Cambodia with a small population was extremely brave and could force U.S. imperialism to flee in a most shameful manner” (Maguire, 2005). While this statement obviously reflects Pol Pot’s political agenda, one point is clear. The Cambodian people felt betrayed and used by the United States government while the Khmer Rouge reveled in their victory and subsequent “glorious revolution.”

Khmer Rouge Ideology, Modes, and Methods

When the Khmer Rouge took control of Phnom Penh, they declared that Cambodia was entering “Year Zero.” The primary goal of the Khmer Rouge was to destroy Cambodia’s current hierarchical social, economic, and political culture, which they considered corrupt and Western, and restructure Cambodian society to make it the most egalitarian social order in the world. They used violence and terror to achieve these means, destroying everything that they deemed to be associated with the former government, industrialization, and the Western world (Jackson, 1989). Their first course of action was to empty the cities and towns and resettle the former residents into agricultural communes. These communes not only served agricultural functions but also

served as sites for systematic killing, starvation, and overworking of adults and children alike. Anyone who was identified with the former Lon Nol government was immediately executed as well as anyone who was known or suspected to be educated, wealthy, or of foreign origin. In addition, education, medicine, and material possessions were seen as evil influences from the Western world that corrupted the pure Khmer society that the Khmer Rouge was trying to create. Therefore, possession of these items or skills was punishable by death. “Cambodian society was to become a giant agricultural factory with each person filling a distinct, specific function, like a small part of a machine” (Schanberg, 1980, as cited in Jackson, 1989, p. 192). Anyone who deviated from this ultimate plan was murdered along with his or her family. In the end, out of the 7.3 million Cambodians that were said to be alive on that day, less than 6 million remained alive to welcome the Vietnamese occupiers in late 1978 (Jackson, 1989). However, the estimated deaths have been argued to be much higher. The Research Committee on Pol Pot’s Genocidal Regime conducted a national household survey that found that over 3 million Cambodians lost their lives under the Khmer Rouge (Etcheson, 1999). In fact, “The 1979 U.N. report [...] determined that the violations were ‘the worst to have occurred anywhere in the world since Nazism’” (Hawk, 1989, as cited in Jackson, 1989, p. 213). One Khmer woman referred to the Khmer Rouge period as “over one thousand, three hundred days of hell” (Jackson, 1989). In order to achieve “Year Zero,” the Khmer Rouge targeted specific aspects of Cambodian culture and infrastructure to systematically destroy, and punished affiliation with these systems with death.

Socioeconomic Transformation

The first step that the Khmer Rouge took to achieve “Year Zero” was to empty all cities and towns and resettle these populations on agricultural communes. To evacuate Phnom Penh, the Khmer Rouge told its residents to leave the city. They were also told that they would be allowed to return in three days (Him, 2000). Of course, this was a lie that facilitated the Khmer Rouge’s goal of swiftly diffusing any political sources of resistance. While this exodus was taking place, the Khmer Rouge systematically identified, arrested, and executed officials and military personnel from the Lon Nol government. They also began their purges of those who they perceived as potentially threatening their rule or their return to traditional Khmer society. Skilled workers or those in positions that required education were seen as a threat to the return to “Year Zero” and were therefore killed. However, peasants (“base people” or “old people” as the Khmer Rouge termed them) who had lived in the countryside since before the revolution were rewarded by being allowed to stay in their villages. As Ung (2000) remembered her own experience growing up under the Khmer Rouge, “The base people will train us to be hard workers and teach us to have pride in our country. Only then will we be worthy to call ourselves Khmer.” Initially, the peasants were allowed to live relatively autonomous lives way from the watchful eye of the Khmer Rouge cadres or soldiers. This meant that they could live in their own houses, avoid the rigorous work routines, and eat communally as well as adequately. They were empowered to patrol, give orders to the city people (“new people”), and inform the Khmer Rouge of any suspicious activity. In contrast, the city or new people had no freedom of speech, no

autonomy, were suspected of having no allegiance to the Khmer Rouge and its political ideology. They were also under the constant scrutiny of Khmer Rouge cadres and old people, overworked, starved, and under a constant threat of death and/or torture (Maguire, 2005). The social and economic infrastructure of Cambodia was reversed overnight. Those who used to hold a high position of respect and authority in society were suddenly at the bottom, and those who used to hold a low social position were now at the top.

In order to achieve this socioeconomic transformation, the Khmer Rouge utilized violence and terror to form new patterns of collectivization made possible by work battalions that were operated by the new low-class group, the former city dwellers (Jackson, 1989). The Khmer Rouge's ultimate goal was to make Cambodia economically self-sufficient by maximizing agricultural production. In theory, under the new communal system, the crops and other produced resources were to be distributed equally among the workers in each battalion. However, ultimately everything belonged to the Angkar (the Khmer Rouge "Organization") which not only abolished private ownership, but made the workers subject to its rules. One such rule was that a person was fed the amount that he or she had earned working. Because the Khmer Rouge actually operated within a hierarchical system that had simply been reversed in their favor; the harvest was typically taken away from the workers, resulting in massive malnutrition, starvation, and death (Jackson, 1989). In fact, Jackson (1989, p. 3) reinforced this point when he stated, "Starvation and pestilence stalked the land because the regime's pursuit of complete independence led it to sever access to most aid and

trade, thereby insuring death-dealing shortages of food, pesticides, and modern medicine. Successful communist revolutions emphasize national sovereignty and self-reliance, but no other movement has applied the academic theory of dependency in such a doctrinaire and literal manner, thereby inflicting on Cambodia severe diplomatic isolation, economic devastation, and massive human suffering.” In addition, the Khmer Rouge traded crops to countries such as China in exchange for arms (Jackson, 1989). Thus, in a short period of time, Cambodia became a temporary agrarian commune lacking in most necessities and all civil rights.

Education, Religion, and Western Culture

While being from the city, possessing occupation skills, and having an education were all seen as threats to the Khmer Rouge, anything (including the value of education) that resembling Western culture or its values was targeted, destroyed, and forbidden. As Ouk Villa (cited in Pran, 1997, p. 116) another survivor, recounted, “We never received an education because schools, money, markets, books, postal services, and religions were banned.” Furthermore, as Ung (2000, p. 54) remembered “Anyone can be viewed as a threat to the Angkar--former civil servants, monks, doctors, nurses, artists, teachers, students-- even people who wear glasses, as the soldiers view this as a sign of intelligence.” While many educated Khmer were killed, many learned quickly to deny their identity and intelligence and pretend to be uneducated peasants whose sole skill was farming. For instance, Ung (2000), a survivor, hid her past life, was careful of what she said, talked about, or acted like, and remained highly conscious of the type of language she used in order to avoid death and at best torture. Him (2000) similarly

remembered her family lying about her father's former profession as well as their family's former status in society. She was forbidden from whispering a word about her education, her father's knowledge of medicine, or her home full of delicious food and pretty clothes in Phnom Penh.

In addition to the Khmer Rouge's deliberate attack on the educated and affluent, they also sought to destroy all artifacts and representations of Khmer history and religion. For instance, much of the written documentation of Khmer culture was lost during this period due to deliberate burnings of texts by the Khmer Rouge. In fact, more than half of the pre-existing Khmer language materials written before 1975 are gone (Jackson, 1989). In addition, the Khmer Rouge systematically confiscated personal items like jewelry, watches, photographs, and books, because they represented Western influence on Khmer society. Imports were defined as evil because they allowed foreign countries a way to invade and influence Cambodia, not just physically but culturally (Ung, 2000). In an effort to erase the final vestiges of Western culture, the Khmer Rouge confiscated all the city people's personal clothing and insisted that they all dress the same in simple black uniforms. According to Ung (2000, p. 58), the Khmer Rouge thought that "by wearing the same thing, [they would] rid [the Khmer people] of the corrupt Western creation of vanity."

Finally, Cambodia experienced a huge loss in cultural and religious artifacts with the systematic destruction of pagodas, decapitations of large statues of Buddha, and burnings of ceremonial costumes. (Jackson, 1989). Not only were the three practiced religions in Cambodia (i.e., Cambodian Theravada Buddhism, Islam, and

Christianity) ruthlessly suppressed, but temples were destroyed, monks were killed or forced to break their vows, and ritual activity was forbidden (Jackson, 1989). This deliberate destruction of Cambodian religious institutions was extremely significant in that “Theravada Buddhism had been the state religion and its importance in pre-revolutionary Cambodia can scarcely be overstated” (Jackson, 1989, p. 12). In fact, the temple constituted the center of village life and most young men in Cambodian society entered the monkhood for a period of time (Jackson, 1989). These extreme setbacks in cultural and religious capital were yet another loss that the Cambodian people had to endure without the ability to grieve openly, and yet another loss of support that further contributed to their suffering.

Attack on the Cambodian Family

The family was another aspect of society that was targeted by the Khmer Rouge, ultimately leading to massive human suffering. The Khmer Rouge attempted to divide the family unit through the creation of work teams. Children were frequently separated from their parents and adolescents were typically grouped in mobile working units at a distance from where their parents were located. Husbands and wives were often separated and the extended family functionally ceased to exist. This distance and separation created an environment in which parents no longer held authority over their children (Jackson, 1989). In fact, “Since Angkar is the “dad-mom” of the people, it hence has the responsibility to determine who is part of the family and who is not” (Jackson, 1989, p. 165). This was particularly significant because the extended family was extremely important and close-knit in prewar Cambodian society. Jackson (1989,

pp. 166-167) stated, "In the context of family life, no important decision could be made without submitting the matter and deferring to grandparents, parents or their substitutes (uncles, aunts, elders)." Therefore, children lacking parental figures lacked the crucial guidance, support, and instruction that they otherwise would have received. While the Khmer Rouge provided ideology and strict commands, it did not provide a base for resilient development.

Another way in which the Khmer Rouge attacked Cambodian family life was to control communication and expressions of love within the family unit. For instance, as Becker (2005, as cited in Maguire, 2005, p. 51) pointed out, "the Khmer Rouge were threatened by all expressions of love-- between husband and wife, parents and children, friends and colleagues." Furthermore, Maguire (2005, p. 51) added, "Not only did the Khmer Rouge eliminate family life, they made sex before marriage a capital offense." Both premarital sex and missing one's family were capital offenses because they demonstrated that one held a higher allegiance to a person or family than to Angkar. This suspicion was punishable by death because it was seen as a potential barrier to returning to pure Khmer society. In addition, because Angkar replaced children's parents as well as their elders, the Khmer Rouge demanded that everyone refer to others as "comrade" rather than using traditional titles that indicated respect and status according to age and position within the family unit (Ung, 2000). This was extremely significant to the Cambodian people considering that "first names were nonexistent in the Khmer language, [where] everyone address[ed] each other or themselves as 'child'

or ‘father/mother,’ ‘nephew or niece,’ ‘uncle or aunt,’ ‘grandfather or grandmother,’ ‘older brother or sister,’ ‘younger brother or sister,’ and so on” (Jackson, 1989, p. 165).

Finally, another key way in which the Khmer Rouge sought to divide the family was by teaching its members to spy on one another and other families and to report any suspicious activities or conversations to Angkar. This reporting would result in a reward, whether it was a larger food ration or a more privileged job in the work camp. Often, entire families would be executed together if even one member was found to be treacherous or suspected of disloyalty. Teeda Butt Mam (as cited in Pran, 1997, p. 14), a survivor, remembered, “I wanted to commit suicide but I couldn’t. If I did, I would be labeled ‘the enemy’ because I dared to show my unhappiness with their regime. My death would be followed by my family’s death because they were the family of the enemy.” Ultimately, the Khmer Rouge wanted to create a system in which silence was an absolute rule, for within silence comes absolute obedience and unquestioned authority. Thus, families learned to talk little and never about their emotions, feelings, or deepest thoughts. In risking to do so, one might bring death not only upon oneself, but upon the whole family. Teeda Butt Mam (as cited in Pran, 1997, p. 12) also remembered this reality when she stated, “Later the Khmer Rouge killed the wives and children of the executed men in order to avoid revenge. They encouraged children to find fault with their own parents and to spy on them. They openly showed their intention to destroy the family structure that once held love, faith, comfort, happiness, and companionship.”

The Khmer Rouge and Children

Separated Children and Angkar's New Parental Role

From what is known thus far about the development of PTSD or related symptoms among children as well as the methods that the Khmer Rouge used to create its revolution, there is little doubt that Cambodian children growing up under these conditions were at an increased risk for developing psychopathology. Just the methods and means that the Khmer Rouge used to control the Cambodian people, comprise a list of risk factors, making the affected children more vulnerable to developing negative psychological outcomes. For instance, the deliberate separation of families that was systematically implemented by the Khmer Rouge immediately made children more vulnerable in that they lacked a vital support system that would typically be responsible for their physical care, emotional needs, spiritual and cultural development, and psychological well-being. Furthermore, this separation denied many children the chance to form a strong positive attachment to a caring adult. In addition, the Khmer Rouge's demand for absolute silence among and between families prevented children from being able to express their feelings, emotions, and thoughts both verbally and physically. Since showing emotion or showing any sign of discontent with Angkar was punishable by death, there was no opportunity to engage in the kind of processing of the traumatic event(s) in safe, secure, and supportive environments that serves as not only a protective factor but as an essential element of healing from post-traumatic symptoms (Herman, 1992). Finally, the Khmer Rouge's attack on education, culture, and religion also debilitated crucial outside support systems that otherwise could have been utilized in the

absence of family supports. The Khmer Rouge understood children's needs to consist of food (at times), education in the form of indoctrination, unquestioning submission to Angkar, and shelter (although inadequate and often self-built). Ung (2000, p. 86) even recognized this inconsistency when she poignantly stated, "I remember when we first arrived at Ro Leap [a work camp], the chief told us the Angkar would take care of us and would provide us with everything we need. I guess the Angkar doesn't understand that we need to eat." While identifying these risk factors in the context of the knowledge of the Khmer Rouge ideology can be helpful, it is equally important to understand how children were viewed and treated in the Khmer Rouge period, including the type, degree, and duration of the trauma that they endured, as well as the specific risk and resiliency factors that contributed to whether or not they developed psychopathology.

View and Treatment of Children

While the Khmer Rouge systematically destroyed the outside support networks of Cambodian children, they actually greatly valued children and saw them as the only hope for attaining a pure Khmer society. This was largely because children could be easily taught, influenced, and indoctrinated with the beliefs and ideologies of Angkar. In fact, according to Leng Thirth, the Khmer Rouge Minister of Culture and Social Affairs, "Only children can purely serve the revolution and eliminate reactionism, since they are young, obedient, loyal, and active" (Maguire, 2005, p. 51). Furthermore, Maguire (2005, p. 36) pointed out, "the Khmer Rouge made virtues of inexperience and ignorance, preferring young people, who were, in Mao's phrase, 'poor and blank.'" In

addition to children's malleable quality, they were also seen as pure and untainted because they had not operated under the former government and were being brought up in the Khmer Rouge society free from foreign influences. Jackson (1989, p. 166) stated, "Angkar [...], fulfilling a collective parental role, took diligent care of children—'the future of the nation'-- whose minds aren't tainted like those of their elders."

One must recognize, however, that while the Khmer Rouge valued children for their role in creating their ideal Khmer society, their words and tenets did not always translate into actions. Many children were neglected, abused, and killed. Nevertheless, it is important to realize the parental role that the Khmer Rouge took with children as well as their motives for doing so. Maguire (2005, pp. xvi-xvii) summarized this clearly when he stated, "Adults became so alienated from the regime that young children became the only hope for the Khmer Rouge revolution to reproduce itself. Children were employed as militia, to spy on their families, and as soldiers and executioners. The Khmer Rouge hoped to use children as the basis of a new society without memory."

This new society that was supposed to be composed of these "blank" children meant that the Khmer Rouge had to separate children from the influences of their parents. The influence must be only from Angkar, the new parental figure of the nation. In fact, in the prerevolutionary Khmer language, the word "kruosaa" meant "family," but under the Khmer Rouge, it came to mean "spouse" which excluded children since children belonged not to the family but to Angkar (Pran, 1997). In order to achieve the goal of separation, "those under six years of age were entrusted to the care of [Khmer Rouge] 'grandmothers' who cultivated their revolutionary spirit through the narration of

heroic tales while their mothers were at work. Those six to twelve lived apart from their parents, sleeping in separate quarters--called 'moni-komer'--or else were organized into groups of ten, enlisted in 'mobile troops' and hardly ever had the opportunity to see their parents again" (Jackson, 1989, p. 165). According to one Khmer child who survived under the Khmer Rouge, "At that time, the Khmer Rouge taught us to hate our parents and not to call them 'Pok' and 'Me' because our parents did not deserve to be 'Pok Me.' Only Angkar deserved to be children's parents. We believed what they said, and step by step they slowly made us crazy" (Maguire, 2005, p. 58). According to Pran (1997, pp. xvi-xvii), "Cambodian children were orphaned, deprived of real knowledge of natural parents, and constantly told of how lucky they were to be adopted by their new family."

In order to transmit this information, the Khmer Rouge would send the children to indoctrination sessions, which was the children's only form of education. At these sessions, the children were required to repeat slogans which celebrated Angkar and its "glorious revolution," and were forced to witness violent demonstrations, including the torture and killings of those who dared to defy Angkar in even the slightest manner. Ung (2000, p. 131) remembered one such session at a training camp for child soldiers in which, "The Met Bongs [Khmer Rouge child leaders] pace around the circle of children as if possessed by powerful spirits, their arms shaking furiously at the sky, their lips moving faster and faster as they spit words about the glory of the Angkar and our unbeatable Khmer soldiers." Children were not allowed to show emotion, shock, or even fear at these demonstrations because it was a sign of corruption and disloyalty to

Angkar. Therefore, while the Angkar adopted the parental role of Cambodia's children, the atrocities and brutal murders that children both witnessed and endured speak of a form of parenting that no child should ever have to endure.

Atrocities Committed towards Children

The three most telling atrocities committed against children were overworking, starvation, and murder. Children were the future of the regime, but the children's future under the regime was not so "glorious." The children were placed in work camps in which they often worked from before the sun came up until after it went down. They were required to engage in extremely strenuous physical labor, including building massive canal systems, planting and harvesting rice, and building dikes. This was, of course, all done under the tropical sun with less than adequate clothing (Him, 2000). According to Maguire (2005, p. 52), "Samandara Vuthi Ros described her time in a children's mobile unit as a 'vagrant life, like that of a plant floating in the ocean.' Each child was responsible for building fifty meters of dike or three cubic meters of dam each day. If this quota was not met, his or her food rations would be reduced." This reduction in food rations could be life threatening in light of the fact that these children were being severely overworked and underfed.

Hunger was commonplace among children under the Khmer Rouge regime. As Ung (2000, p. 80) recalled, "It [was] no use thinking about food knowing you will not get any. Still, it is hard to think of anything else. Hunger eats at my sanity."

Furthermore, she says, "I am now always tired. Starvation has done terrible things to

my body.” Children were typically given one bowl of rice mush a day, twice a day if they were lucky. As time progressed, however, the proportion of rice to water in these bowls drastically declined. This resulted not only in the malnourishment and slow starvation of the entire Cambodian population, but it also gravely affected children by stunting their growth and development (Ung, 2000). Hunger also preoccupied the thoughts of children, giving them little room to think of much other than the details of their own meager survival. This is illustrated clearly by Moly Ly (as cited by Pran, 1997, p. 60), who remembered, “My little niece, Viphea, was about two years old. The only words she knew how to speak were, buy, Pa, and Mak which meant in English, ‘steamed rice,’ ‘Dad,’ and ‘Mom.’” Savath Penn (as cited in Pran, 1997, p. 48), another child survivor under the Khmer Rouge, stated, “My body was so thin and weak from lack of adequate nutrition. The other young boys were in the same condition as me. We looked like grandpas to one another. We rarely played or had long conversations because we lacked energy and tried to conserve it for the next day’s work quota.”

Even if the children did not see or recognize the effects that starvation was having on their minds and bodies, all they had to do was look at their friends, family, or fellow “comrades” and they would see it clearly. Ung (2000, p. 87) further illustrated this point when she recounted, “Geak [her younger sister] waves at me again and even attempts to smile, baring her teeth. A wave of heaviness descends upon me. By smiling, she only manages to stretch her skin back even more, and I can see what she will look like when she is dead and her skin dies over her bones.” This heart-wrenching illustration shows the severity to which these children were systematically starved and

the devastating effect that it had not only the children who were suffering its dire effects, but on those children who witnessed the slow death of those they cared for and loved. Many children were forced to risk their lives in order to steal food to keep not only themselves, but their brothers and sister alive. In fact, stealing was an active coping strategy that was at times the only thing that kept children alive. Charles Ok (as cited in Pran, 1997, p. 53), another survivor, affirmed this when he said, “Everyone became a burglar, and if we were caught, death was certain.” Ouk Villa (as cited in Pran, 1997, p. 119) also stated, “I had to become a thief because of my sister’s starvation.” Overall, the Khmer Rouge’s systematic starvation of Cambodia’s children resulted in severe malnutrition, developmental delays, and stunted growth. These would continue to have lasting effects on both the children’s physical and psychological well-being after the war. It also illustrates the initiative that many children took to survive. However, they would feel the guilt and shame for stealing while concurrently feeling the fear and anxiety of getting caught, beaten, and killed for trying to find mere sustenance to survive.

If children survived the grueling work conditions and systematic starvation, it was truly miraculous. However, even though they had survived thus far, they still faced the persistent danger of torture and death. They had to fear not only their own actions being held against them, but the actions of anyone in their family could result in their death. As Maguire (2005, p. 40) articulated, “Because the Khmer Rouge designated whole families as corrupt and traitorous, children were killed along with their parents.” Furthermore, Ung (2000, p. 163) added to this when she remembered that, “it [is] said

that the soldiers often kill children in front of their parents to elicit confessions and names of traitors.” Sarom Prak (as cited in Pran, 1997, p. 70) recounted, “They disfigured the bodies and slashed the throats of young children and babies. The Khmer Rouge tore the babies into pieces.” Again, despite Angkar’s professed regard for children, the reality of their treatment showed quite a different and perhaps rather inconsistent story.

While children were seen as Angkar’s future, certain children could be killed, tortured, or mistreated if they showed any sign of corruption from the “old society.” This might include crying, showing physical affection towards their parents, stealing food to offset their starvation, or expressing any sort of discontent with their lives under the Khmer Rouge. Thus, fear was pervasive and constantly took a toll on their physical, emotional, and psychological health.

The Voices of Cambodian Children

What Children Witnessed under the Khmer Rouge

The chronic fear that Cambodian children experienced under the Khmer Rouge was made more acute by the acts of extreme violence and killing to which they were also exposed. The degree of this trauma was also heightened not when they witnessed their friends or family members die of not only starvation, but torture and murder as well. This element gave the trauma that they were experiencing an extremely strong personal significance, resulting in a heightened risk of developing psychological disturbances. This type of trauma was deliberately inflicted on children by the Khmer

Rouge. Sim Phia (as cited in Maguire, 2005, p. 66), a Khmer child survivor, was working nearby when he saw trucks arrive. He decided to hide behind some coconut trees and watched some Khmer Rouge cadres “take nine children from 10 to 13 years of age out of the trucks. The children’s arms were tied. No matter how much they cried and shouted for help, they were thrown into the pool as prey to the crocodiles.” Another example of deliberate exposure of children to killing was illustrated by another child survivor who remembered the actions of the Khmer Rouge. He declared, “Killing happened every day, in the morning, in the evening--every day. Sometimes they would kill people in front of the Children’s Center. All the children watched. They wanted the children to watch, so they didn’t send them out to the fields. They wanted to provide an example to the children. If they knew a child was a relative of the prisoners, they would kill the child too” (Maguire, 2005).

Another brutal example of what the Cambodians were forced to witness as part of the Khmer Rouge’s indoctrination sessions are horrifically illustrated by Roeun Sam. He was led to a meeting that was led by Angka. The children were forced to sit in front and were told by the Khmer Rouge, “If anyone cries or shows empathy or compassion for this person, they will be punished by receiving the same treatment.” Two prisoners were led out and forced to confess their so-called crime. However, the prisoners cried that this was an injustice and were hit from behind with a shovel, which rained blood on the children sitting in front. A prisoner began to have a seizure and was cut from his breastbone to his stomach with a knife. The Khmer Rouge proceeded to take out his organs, string his liver and bowels on a wire, put this wire on the handlebars of a

bicycle, and cycle away with it in tow (as cited in Pran, 1997, p. 98). This account is truly horrific. It shows the degree to which children were deliberately exposed and desensitized to violence and gruesome murders perpetrated against their own people.

Sometimes the killing was not only in close proximity to children but also directly targeted at their neighbors, friends or family. Youkimmy Chan (as cited in Pran, 1997, p. 21), remembered his experience when he said, “The soldiers cut off the men’s heads, which fell to the ground as their bodies slumped. There was nothing I could do. People were being murdered before my eyes. These were my friends, my neighbors. The rest of us kept walking.” This same youth also witnessed his brothers dig their own graves at gunpoint and subsequently be beaten to death with bamboo rods by Khmer Rouge cadres. Another telling example is Ung’s (2000, pp. 196-197) account of her friend’s death: “I wipe her blood and brains on my pant legs. In a panic, I get up and run after Kim and Chou out of the shelter; away from Pithy. Away from her screaming mother. Away from the sorrow that threatens to take residence in my heart.” Finally, Him (2000, p. 200) explained how she felt when she heard that her mother had been thrown in a well to die while she was still alive. She laments, “Her words sink in. No! The core of my soul screams out from a deep hidden place. My legs carry me away before my brain can comprehend them. Across a dusty path, toward a distant woods, I run as fast as I can, the fingers of anguish squeezing my soul, pumping out pain.” These accounts shed light on the horrific losses that these children endured under the Khmer Rouge. They often lost their friends, siblings, or parents to the most gruesome deaths. Whether they saw them starve to death like Him (2000) did or be deliberately murdered

like Ung (2000), they experienced a loss that no child should have to endure. To summarize, not only did they experience the loss of their closest friends, family members, and parents, they lost them in the most violent and terrifying of manners. Furthermore, they had to endure this terror, grief, and anguish alone. If they showed their sadness, tried to process their grief through talking, or demonstrated any kind of anger towards the Khmer Rouge, their lives were put in danger. In order to survive, they were forced to suppress their grief, anguish, and horrific loss.

A Lost Childhood

Hong A Chork (as cited in Pran, 1997, p. xv) lamented, “My childhood was lost during those years. The Khmer Rouge allowed no time for growing up” Teeda Butt Mam (as cited in Pran, 1997, p. 15) added to this same sentiment when she declared, “We not only lost our identities, but we lost our pride, our senses, our religion, our loved ones, our souls, ourselves.” From what we know about child development, brain formation and crucial development tasks and skills that must be mastered are crucial for positive physical, emotional, and psychological health later on in life. The Khmer Rouge held no regard for this fragile aspect of life. Their goal was not to foster development, but rather to impose upon it their own set of developmental tasks which did not include aspects of attachment, empathy, compassion, social functioning, education, or trust. Savath Penn (as cited in Pran, 1997, pp. 48-49) illustrated this when he said, “Time seemed to be at a standstill. There was no schooling and no prospect for the future. The only things I learned were hatred and revenge for my father and sister’s deaths.” This loss of development, time, and childhood itself was made more acute

through the children's inability to grieve its loss. As Ung (2000) stated, "We have all learned to be silent with our emotions." Overall, this exposure to war-related trauma, loss of development, time, and childhood itself, and the compounding effect of not being able to appropriately grieve or express one's reactions to what has occurred, all lead to an extremely high-risk environment for children. What effect, one wonders then, did these events, factors, and influences have on the prevalence of psychological disturbances for Cambodian children growing up under the Khmer Rouge?

Post Traumatic Stress Disorder in War-Affected Cambodian Children

The Voices of Cambodian Children and PTSD

In light of the horrific experiences that most Cambodian children endured, it is not surprising that PTSD or related symptoms would be endemic at best within the population. Throughout multiple primary accounts by child survivors who lived through the Khmer Rouge period, the PTSD cluster of symptoms (re-experiencing, avoidance, and arousal) are illustrated with frequency and intensity. It is not surprising, then, that one study of children living under the concentration-camp-like conditions of the Khmer Rouge reported that 50% were manifesting symptoms of PTSD four years later (Kinzie et al., 1986, as cited in Dubrow, Garbarino, & Kostelny, 1991, p. 22). Him (2000) found similar results when she assisted in research with Cambodian refugees who had relocated to Portland, Oregon. Among 40 Cambodian high school student research participants who had survived under Pol Pot, 50% were diagnosed with PTSD and an additional 50% who were suffering from some form of depression. Another survey

conducted in California is just as telling. It found that 84% of Cambodian households reported a member under a physician's care, compared to 45% for Vietnamese and 24% for Hmong and Lao populations (Jackson, 1989). Even according to a recent study by de Jong (2001), 28.4% of those Cambodian adults participating in the study demonstrated PTSD symptoms. One must recognize that 25 years had gone by since the Vietnamese occupation and yet over a quarter of the population was still demonstrating PTSD-related symptoms. One has to wonder if these adults were the same children who survived life under the Khmer Rouge, but who still suffered psychologically due to a lack of appropriate and effective interventions. In fact, many adults have spoken of psychological trauma endured as children in their accounts of survival. It is these children's voices that will be brought to life in the following discourse.

Re-experiencing the Event

The characteristic PTSD symptom of re-experiencing the traumatic event is seen throughout the accounts written and described by children who survived under the Khmer Rouge regime. Pran (1997, xiv) supported one of these re-experiencing symptoms with his comment, "for children, sleeping became one of the most terrifying aspects of life." This was true because of the recurrent horrific nightmares that many children experienced. For instance, Ung talked about her repeated nightmare that she was being tracked down and killed by monsters. It is not surprising that her siblings reported having the same dream. Ronnie Yimsut (as cited in Pran, 1997, p. 194), another survivor, lamented, "I still have nightmares about the massacre on that dark December night. It has never completely gone away from my mind and I am still

horrified just thinking about it. Time does not heal such emotional trauma, at least not for me. I have long since learned to live with it. My life must go on.” One young Cambodian boy suffered from similar dreams, although his were about wars. He stated, “I wish I was older so I could go back and fight the war.” In his dreams, “the war never ends” (Foreman, 2003, p. 99). In addition to these horrific and recurrent nightmares, many Cambodian children spoke of feeling as though they were reliving the traumatic event. Khuon Kiv (as cited in Pran, 1997, p. 102), a child survivor who heard the voices and cries of those being executed with shovels, stated, “These voices will haunt me forever. For months, I could hear them every time I fell asleep.” Foreman (2003, p. 99) described a young Cambodian boy who “continued scavenging by digging in the garbage, dumpsters, and hunting small animals, long after his family [had] adopted local customs for obtaining food and clothing.” This behavior demonstrates some children’s reactions of acting in a way that would make one think that the trauma is still occurring. In addition, Him described an observation made by Dickason in the early 1980s after an influx of Cambodian refugee children had come to Portland, Oregon. She states, “Once, on a trip to a high school teacher’s home, a young Cambodian girl was digging in the ground and unearthed a bone. She began to unravel, screaming and running about” (Him, 2000, p. 16). This clearly illustrates an “intense distress to cues that symbolize the traumatic event” (APA, 2000, as cited in Israel & Wicks-Nelson, 2006, p. 141) associated with the re-experiencing aspect of PTSD. Finally, Him (2000, p. 19) discussed her own familiarity with the re-experiencing element when she wrote, “Even on the streets of Portland I look over my shoulder. The Khmer Rouge are a

continent away, and yet they are not. Psychologically they are parasites, like tapeworms that slumber within you, living passively until something stirs them to life.” This demonstrates the serious and long-term effects on daily functioning that re-experiencing symptoms can have on those who have survived traumatic events. The long-lasting effect that these symptoms may have is not surprising given the degree and duration of trauma experienced as well as the absence of interventions during childhood.

Avoidance of Trauma and/or Numbing

The second major criterion of PTSD, avoiding the trauma or numbing, is also seen throughout the accounts of child survivors of the Khmer Rouge regime. Ung (2000, p. 107) described this numbing process, “I simply black out the part of me that feels emotion. It is as if I am alive but not alive.” She also recalled losing her memory for three days after she received the news of her mother’s and younger sister’s deaths. This phenomenon of lost memory is also seen when one asks adults who were children under the Khmer Rouge about what happened to them during that time. Many simply cannot remember (Dubrow, Garbarino, & Kostelny, 1991). Ung (2000) recalled creating a fantasy world to live in when she heard of her sister’s death. She remembered that the pain was too unbearable and thus the fantasy world or dissociative state was an escape from this pain that was too horrific to face and feel. Him (2000, p. 22) remembered feeling a very similar urgency to escape the horror she was experiencing. She stated, “The war crushed my innocent belief in magic as neatly and efficiently as you might smash a cricket beneath your heel. At first I tried to hide inside the magic. It was a refuge against the surreal realities of war.”

In addition to these avoidance strategies and resulting PTSD-related symptoms, somatic symptoms are also commonly reported among those who have been affected by chronic war trauma. Somatic symptoms are physical pains such as stomachaches or headaches that result from psychological trauma. They are much more prevalent forms of psychological expression in non-Western contexts and are therefore often missed or misdiagnosed by practitioners operating within a Western context. In the Western context, mind and body are often divorced areas of study and mental health and physical health have only recently been identified as interconnected (Herman, 1992). However, in many other cultures, this separation does not exist. Therefore, it is not uncommon for psychological symptoms to manifest as physical pains. Throughout the primary accounts of child survivors one sees frequent illustrations of these somatic symptoms. For instance, according to Jackson (1989), Cambodians referred to these symptoms as the “Pol Pot syndrome” which consisted of non-specific pains, insomnia, loss of appetite, palpitations, and difficulties in breathing. Ung (2000, p. 163) described these same physical symptoms when she said, “The pain in my heart hurts so much it becomes physical and attacks my shoulders, back, arms, and neck like hot pins pricking me. Only death will relieve me of it.” Furthermore, Soour Hai Gov (as cited in Mar-Bucknell, 2004, p. 42) spoke of similar symptoms, “Around this time I started having dreadful migraines. They would start with tiny stars embedded in the corners of my eyes, then swell to glaring suns and, finally, begin to hammer in my head so painfully that I was totally unable to do anything but sit and grit my teeth. I tried to keep the peace at home, to stop provoking anger, as the arguments were what brought on the

worst ones.” Somatic symptoms are not only prevalent among Cambodians who lived under the Khmer Rouge, but can seriously impose on their ability to function throughout life.

Increased Arousal

“Something hurts inside me. Rage erupts in my body, making me jump and run out of the hut. I don’t understand the electricity in my body, this panic, this sadness, hatred, emotions that manifest into physical pains” (Ung, 2000, p. 159). This statement both demonstrates the intense frustration of somatic symptoms and also illustrates the last criterion for PTSD, increased arousal. This exaggerated startle response is common among those who have endured war-related trauma and can be extremely detrimental to returning to peaceful society, although it serves as a useful tool in dangerous and chaotic environments. Another aspect of increased arousal that is seen throughout the accounts of survivors is irritability and angry outbursts. Again, Ung (2000, p. 105) described this tendency when she recalled, “It is unfair of the gods to show us beauty when I am in so much pain and anguish. I want to destroy all the beautiful things.” This would not be a typical response from a child who had been spared the traumatic effects of war. Rather, it is the response of a child who has been traumatized and must channel her intolerable pain in some direction, whether it be inward or outward.

Risk and Resiliency Factors for Cambodian Children

Risk, Resiliency, and Cambodian Children

War is easily discussed when one neglects to consider its implications.

Discussions regarding war-affected children often remain in the academic forum while little attention is given to the atrocities they experience and witness. The prevalence of war throughout the world may have a desensitizing effect on the public's perception of what actually happens to children growing up in areas of armed conflict. Accounts of child survivors can be truly revealing, horrifying, and heart-wrenching. However, these accounts make up a mere minority of stories and experiences that could be shared and told by the vast number of children that war affects. Their voices must be heard if we are ever to understand the true effects of war.

The Khmer Rouge controlled Cambodia and its people from 1975 to 1979. In relation to Cambodia's children, this means that many children were born and raised under the terror of this regime. It also means that many children spent four years of their childhood exposed to the effects of strenuous, intensive, and long-term labor and starvation. They witnessed extreme violence and the murder of their people, the destruction of their communities, and the loss of their neighbors, friends, and families. Every child was affected. No one escaped the effects of this pervasive civil war. In light of this, why did some Cambodian children develop PTSD and its symptoms while others did not? Why did some children's PTSD symptoms decrease or disappear after the Khmer Rouge were ousted by the Vietnamese, while others were haunted by

symptoms over the course of their lives? These questions lead our discussion back to the risk and resiliency factors associated with the development of psychopathology.

Individual Characteristics

While every child is different in terms of personality and way of being in the world, there are some specific, individual characteristics that helped aid some children to survive both physically and psychologically. For instance, those children who demonstrated active coping strategies, such as scavenging for or stealing food rather than simply succumbing to the effects of starvation, were not only more likely to survive because of the added nutrition gained, but they were more likely to feel in control of their surroundings and ultimate survival (Him, 2000). As has been demonstrated by the research, a child demonstrating an internal locus of control has a much better chance of avoiding negative psychological outcomes than those children demonstrating an external locus of control. Him (2000) demonstrated this resilient and creative quality when she took the metal clasp from her shirt and turned it into a fishing hook with which she caught the fish that helped sustain her life.

Another crucial element previously discussed that can contribute to each individual child's resiliency is his or her ability to form positive relationships using good verbal communication and social skills. Therefore, children who are more extroverted, optimistic, and able to gain positive attention from those around them are more likely to avoid negative psychological outcomes than children who are introverted, withdraw, impulsively aggressive, or are unable to gain positive attention

and support from those around them. Although this ability was severely limited by the dangerous and watchful eye of the Khmer Rouge, those children who succeeded to make friends with the other children in their brigade gained a vital support when support was lacking from familial and other sources. For instance, Him (2000) formed a friendship with another female child in her brigade. She described how they would stick together on marches, share food that they had scavenged or stolen, and take care of each other when they were sick. Ultimately, they escaped from their work camp by working together on an escape plan which ultimately ensured their survival at that time. Although their companionship and risk-taking threatened their lives, they supported each other through hunger, sickness, and despair (Him, 2000). Him (2000, p. 140) recalled this when she said, “There, we would talk about missing our mothers and about our problems. Together we’ve shared rice crust when one of us gets more than the other.” This close social bond was essential to not only their physical survival, but to their psychological well-being as well.

Him (2000) also describes how she and other children would take great risks quite frequently to go and visit their families. They would often sneak out at night and sacrifice their night’s rest to go and visit their family in distant camps. This points to the importance, consciously or unconsciously recognized by the children engaging in such risks, of the family in not only Cambodian culture but in a child’s life in general. It points to the fact that children in chaotic, war-torn environments need familial supports and attachments in order to function emotionally and psychologically. It also shows that Cambodian children who felt as though they were able to make friendships with their

peers were more likely to demonstrate resilience and survival than those children who lived in isolation and had a perceived lack of control over whether they saw their family. It is virtually needless to say, therefore, that those children who still had a family or friends were at less risk than children who had no supportive interpersonal relationships.

Gender

As has been discussed previously, gender on its own does not affect the child's degree of risk of developing negative psychological outcomes. However, under the Khmer Rouge, being either male or female carried a different set of risk and protective factors. Females, for instance, were at an increased risk for rape and sexual exploitation by Khmer Rouge cadres. Ung (2000), for instance, was afraid for her sister's well-being due to this fear. She remembered the sound of a girl's parents' cries and subsequent sobbing as their daughter was taken by the Khmer Rouge cadres, presumably to be raped. She recalled that many of the girls who were taken either did not return, returned altogether changed, or resorted to suicide in order to escape abduction. In fact, many girls were forced into marriages as a way to ensure that they wouldn't be taken and raped by the soldiers. Furthermore, girls who experienced attempted or completed rape compounded the trauma from this event with the war-related trauma that they were experiencing, thus increasing their risk for development of psychopathology (Herman, 1992).

While being a female was extremely risky in terms of the threat of sexual assault, it also served as a protective factor in another sense. Men were the main targets of murder by the Khmer Rouge. This had much to do with the Khmer Rouge's systematic attempts to weaken the family unit. It also had a lot to do with the fact that in Cambodian traditional society, men possessed higher education, higher status within the community, and higher power positions, especially in government. Therefore, they were the first to be killed in the initial and ongoing purging undertaken by the Khmer Rouge. In fact, according to UNICEF estimates, so many men have been killed in direct fighting and as the result of purges during the Khmer Rouge period that 64 % of the adult population of Cambodia is female (Dubrow, Garbarino, & Kostelny, 1991).

While male children weren't at as much risk as their fathers, they still suffered the effects of a lack of male role-models and were often given the responsibility of head of household after their father's death. Ung (2000, pp. 116-119), illustrated this point when she told of her brother, Kim, who had to take on this role after his father's death. She recalled, "Kim is the man of the house. But in reality he is only a little boy, a little boy who feels helpless and unable to protect his own family." In addition she remembered, "He [Kim] realizes it is his own tears and he lifts up his shirt quickly to wipe his eyes. He misses Pa so much, but he cannot allow himself to think of this now. He has to take care of his family." This added pressure of being put in a position that no child can be expected to fill serves as a further risk factor in terms of vulnerability to developing psychopathology.

Age

As previously discussed, a child's specific age is not a determinant as to whether or not that child will demonstrate psychological disturbances; rather, those disturbances or related symptoms are manifested differently depending on the child's stage of development. The same is true in the Cambodian context. However, one aspect that is important to keep in mind is that the time frame in the child's life in which the Khmer Rouge period fell has a definitive impact as to how war-related trauma was manifested in each child's life. Furthermore, the age of the child determined what the Khmer Rouge expected of them as well as what they were exposed to as a result. For instance, a child who was born and initially raised under the regime may have had developmental delays, stunted growth, and failure to thrive physically, emotionally, and psychologically. They may also have lacked that basic trust that is so crucial during the first years of life due to a lack of primary attachments. After all, "In 1977, all children no longer breastfeeding were taken from their parents and cared for permanently by female members of the Khmer Rouge" (Pran, 1997).

Slightly older children, on the other hand, may manifest the symptoms of the deprivation and trauma through repetitious and habitual traumatized play or other PTSD-related symptoms such as nightmares, irritability and poor concentration, or withdrawal. Ung (2000, p. 149) described these symptoms in her younger sister when she questioned, "How does a five-year-old tell us about her stomach hurting, her heart aching for Pa, and her fading memories of Keav? I know she hurts and feels pain. It is rare when she does not thrash or cry in her sleep. Her eyes look lost." In addition, these

older children were often forced to work long hours with little food as well as attend the political indoctrination sessions described previously. Moly Ly (as cited in Pran, 1997, p. 59), spoke to this when she said, “Every day we were starving yet forced to work harder. Small children who could walk and work (as young as five and six years old) were given jobs. Our sustenance was a small amount of watery rice.”

Older children, who have a conscious understanding of the events taking place and are able to verbalize what they are being exposed to often demonstrate the more typical adult related symptoms of PTSD, such as re-experiencing, avoidance and numbing, and increased arousal. Ung (2000, p. 100) articulated her experience of numbing when she stated, “Hunger and death have numbed our spirits. It is as if we have lost all energy for life.” She also described re-experiencing symptoms when she declared, “Stop thinking or you’ll die. But I cannot stop” (Ung, 2000, p. 106). Although these older children could articulate the symptoms they were experiencing, their verbalizations did not prevent or mitigate the harmful effects. These older children were often recruited into mobile brigades who were responsible for a majority of the strenuous labor, or recruited as child soldiers. As Moly Ly (as cited in Pran, 1997, p. 59) remembered her experience in a mobile brigade, “Our duties included building dikes, digging canals, liquidating the forest by removing roots, chopping logs and branches, and setting old brush on fire. We mixed human remains with soil.”

No matter what the child’s age, the Khmer Rouge severely limited and even punished children’s reactions and even their manifestations of trauma, thereby making most children turn inward until much later. This is particularly telling considering that

nearly half of the Cambodian population is under the age of 15 (United Nations (UNO), 2004, as cited in Funk, 2005). This demographic imbalance is significant because it indicates that children not only compose a very large proportion of Cambodian society, but that an older segment of the population is missing. Today, the large number of Cambodian youth lack the vital supports once found among this lost older generation. Additionally, those people not lost during the Khmer Rouge period are still grappling with the effects of trauma, and are inhibited from providing the full support these youth need.

Family Dynamics

Under the Khmer Rouge, the family was a cultural institution under direct attack. It was separated, persecuted, and systematically destroyed. Many children were separated or orphaned as a result of Angkar's declaration that it, the organization, was the Pa/Mak of Cambodian society. Dubrow, Garbarino, and Kostelny (1991, p. 48) highlight the dangers of separation when they state, "Children who are unaccompanied are at greatest risk. They are doubly at risk not only because of the fact of their loss, but because of its nature, the process of losing. It is a devastation of primary importance to have lost one's parents. But to have 'lost' them as so many in Cambodia have is too much to bear. Children who see their parents killed in front of their eyes--shot, beheaded, disemboweled, drowned, strangled-- are most likely to manifest functional problems, the classic psychiatric problems related to trauma." Those who lost their parents in such violent manners not only have to come to terms with the meaning of this horror, but have to survive in a violent and chaotic world without the support, guidance,

and love that parents are typically expected to provide. However, even those children who were lucky enough to still have their parents and at that close by often mourned the fact that they rarely saw them. Ung (2000, p. 65), laments, "I miss my family and see them only briefly each night when they return exhausted from working hours in the fields." Even if parents were present physically, this did not mean that they had the resources or supports to be able to be emotionally available for their children's needs. In fact, even if they were emotionally available, the Khmer Rouge often frowned on or violently punished any sign of emotion or affection between family members. For example, Sam (as cited in Pran, 1997, p. 75), another survivor, said, "My younger sister wanted to cry when she saw me, but crying was forbidden by Angka. I turned away from my sister so the Khmer Rouge wouldn't see her cry and discover that we were sisters" Teng (as cited in Pran, 1997, p. 158). reaffirmed this point when he said, "If we were caught hugging or talking intimately to our parents, we would get a beating." In this way, the deliberate attack on the family by the Khmer Rouge put children at an increased risk for developing psychological difficulties because it severely limited the degree of support that parents could provide, made talking and physical affection among families often a capital offense, and denied children the secure attachments they needed to develop appropriately within the context of a dangerous world.

In contrast, the family was also a crucial protective factor for many children who were either lucky enough to be kept close to their parents or who risked their lives to go and visit their families in distant work camps. Him (2000, p. 124) recalled the many instances that she snuck away from the children's brigade, sacrificing both food and

sleep, to visit her mother in another camp. She articulated the value of these times when she said, "I'm afraid they will take me away from Mak and never let me come back to her. Lying beside Mak, I'm comforted by her warm presence, her soft breathing as she sleeps. I don't want to go, for now I know I'll really miss her. I know that I need her more than food." She stated later, "To be so near her. To smell her familiar scent. In an instant, I realize the depth of my love for her. I know exactly how much I need my mother. How much my family means to me. To my survival." Cairns (1996) reinforces Him's illustration when he discusses a study done by Kinzie et al. (1986) which found that, "children were less likely to be diagnosed as suffering from PTSD if they [...] lived with a family member or with a foster family." Thus, the family, although severely persecuted, was a strong protective factor for the children who had one; lowering their risk for the development of psychological disturbances.

Parental Reaction

It has been shown that children often look to their parents during traumatic events and environments for guidance as to how to respond emotionally and physically. Their parents' ability, therefore, to maintain normal routines and model proactive and positive coping strategies during traumatic times is crucial to the child's psychological well-being. Under the Khmer Rouge regime, parents had little to no control over their children's routines. In fact, they had little control over their children at all. They virtually lost their parental rights and responsibilities to Angkar. Parents were limited in the amount of support or care that they could show their children and had to be careful in how they modeled their own responses. There was no outlet for verbal processing or

discussion of what was happening. Silence reigned. In light of this, parents and children alike were required to hold their pain, grief, and anger inside. However, despite its concealed quality, the pain still showed on the countenances of those affected by the atrocities of the Khmer Rouge. For instance, Ung (2000, p. 105) recalled, "As if picking up on Ma's pain, Geak [her younger sister] kisses her cheek softly and caresses her hair." While parental reaction is an important risk or protective factor for war-affected children, within the Cambodian context, the available parents responded the best they could with what they had and were allowed to do. The loss of parental guidance was a definite risk factor for Cambodian children growing up during this time.

Broader Systemic Influences on Resilience and Trauma for Cambodian Children

Community

The importance of community supports must not be underestimated as a component in promoting resiliency in children. However, under the Khmer Rouge, many of these community supports were destroyed, along with the Cambodian political infrastructure. The community that existed before the Khmer Rouge was deemed as corrupt and any affiliation with it or its ways was grounds for murder. Teachers, religious leaders, traditional healers, doctors, social workers, and politicians were no longer available to act as alternative supports for children. In fact, most of these community leaders had been murdered or disguised their identities. As Jackson (1989, p. 173) pointed out, "Khmer culture has at least partially disappeared. Because of the tremendous loss of lives during the war years and the Democratic Kampuchea period, many skills known to

[only] certain individuals are lost.” Loss of life and the loss of those who were typically responsible for transmitting key aspects of Cambodian culture meant that parts of the culture itself were lost. Consequently, the cultural framework that once brought children strength and hope had been shattered.

Despite these setbacks, since the war there have been many attempts to rebuild what has been lost in terms of Khmer culture. Many Cambodians have dedicated their lives to reconstructing the institutions, symbols, and knowledge that was sadly lost under the Khmer Rouge. This has promoted their resiliency as well as promoted the resiliency of future generations of children still suffering the effects of the Khmer Rouge regime. Even under the Khmer Rouge, the Cambodian community played a key role in the survival of the nation’s children. Him (2000) often described the generosity of her fellow Cambodians, whether it was a kind word or someone risking their life and well-being to bring her food. Despite overwhelming circumstances, the Cambodian community did the best with what little they had.

Socioeconomic Status and Education

While higher socioeconomic status and a higher education level are typically thought of as protective factors, under the Khmer Rouge they were just the opposite. Those children who were from families who had both money and education were immediately at high risk of severe maltreatment, loss of family members, and death. Furthermore, if they possessed some education themselves, they had to pretend that they were illiterate and unskilled. They had to monitor how they talked, the language that they used, and their identities.

The Khmer Rouge's attack on education had a devastating effect on not only individual children growing up under its rule, but on the entire educational infrastructure of Cambodia. "By 1979, almost all the children were unschooled (and even those who had been to school had largely lost whatever academic skills they may have had)" (Dubrow, Garbarino, & Kostelny, 1991, p. 40). Furthermore, 15,000 of the country's 20,000 teachers had either died or fled the country (Dubrow, Garbarino, & Kostelny, 1991). When more than 5,000 primary schools reopened in 1979, they were faced with the prospect of meeting the needs of a million eight-to fourteen-year olds with no materials and few teachers (Dubrow, Garbarino, & Kostelny, 1991). While this lack of education was a serious risk factor for many coming out of the Khmer Rouge period, the Cambodian people have miraculously recreated the education system despite minimal and inadequate resources. For instance, they split the school day into two shifts in order to accommodate so many students with so little classroom space. Furthermore, they created a cluster system which is made up of 7-10 schools that partner together and share teachers, supplies, and physical as well as human resources. Finally, because transportation was a barrier to many children living in more remote areas, they created "floating schools" in which school travels along with migrant families, ensuring their children an education (Gill & Griffiths, 1996). This tremendous progress points to increasing resiliency among children as well as a restored hope of the future for many who had this hope taken away from them for so long.

Religious Beliefs, Ideology, and Interpretation

Finally, religion is typically seen as a resiliency factor if it promotes empathy, compassion, and positive coping strategies rather than the dehumanization, demonization, and hatred of the enemy (Dubrow, Garbarino, & Kostelny, 1991, p. 23). In addition, religion or political ideology typically provides context and meaning to one's life, thus acting as an additional support. It also forms the way in which those within its framework interpret the events that are occurring around them. This is particularly significant in situations of violence, trauma, and war. Buddhism is the major religion in Cambodia and has acted as a source of support for many Cambodians throughout history, including children. However, this was another institution that was directly targeted and attacked by the Khmer Rouge. Therefore, during that time, a child outwardly affiliated with Buddhism or its tenants was at risk. In fact, many monks were killed during this time and ritualistic or religious practices were forbidden.

However, Buddhism also served as a protective factor for those who found comfort in prayer and the Buddha's teachings amidst their experience of horror. For example, Him (2000, p. 180) explained how her sister, Ry, turned to Buddhism as a source of comfort and support after their sister Avy's death. She recalled, "Avy's death lingers in Ry's mind. Her inability to mourn continues to haunt her. In desperation, she turns to Buddhism, an institution long since destroyed and disdained by the Khmer Rouge. In spite of that, she finds a way to make things right for herself. She remembers reincarnation, the idea that after death we are reborn. She reconciles her internal conflicts this way, as our parents and elders did before the Khmer Rouge's takeover.

She talks to Avy's spirit." Despite the Khmer Rouge's pointed attack on this cherished Cambodian belief system, children still found a way to privately gain support, solace, and guidance from its tenets.

Buddhism continues to be a powerful force in how the Khmer Rouge are viewed even after their demise. "The Buddha taught that 'Blood stains cannot be removed by more blood; resentment cannot be removed by more resentment; resentment can only be removed by forgetting it'" (Maguire, 2005). This statement has extreme significance for how the Cambodian people as a whole have chosen to move forward toward peace and reconciliation rather than justice and revenge. This is illustrated when Chan (as cited in Maguire, 2005, p. 32), a survivor, stated, "Some of them [the Khmer Rouge] have come back, and I would like to see them punished. [He pauses.] But I truly cannot do that because I am a Buddhist-- no revenge." This reaction is particularly crucial in contemporary Cambodia where the former Khmer Rouge walk along the same streets as those they once inflicted multiple atrocities upon. Buddhism, therefore, serves as a supportive and guiding force that directs much of what has been done in regard to the Khmer Rouge since their fall from power in 1979.

Resilience

Another way in which the Cambodian people have demonstrated resiliency has been through altruism. "She [the director of an orphanage in Phnom Penh] told us that over the years the children at the orphanage have spoken of revenge, but revenge not in the sense of killing, but of working to ensure that Pol Potists can never return to power. The orphans are drawn to service in the new government, in the various ministries, or in

the army” (Dubrow, Garbarino, & Kostelny, 1991, p. 47). This trend is promising in that it illustrates a trend of active coping which as has been discussed previously, is directly correlated with resiliency and healing. In fact, despite the devastation inflicted upon Cambodia on multiple levels, its people and especially its children are quite resilient. Dubrow, Garbarino, and Kostelny (1991, p. 48) declare, “Most Khmer children have triumphed over the madness we might expect to find among those who have been subjected to the terror of the Cambodian holocaust. Their very success reinforces our principal hypothesis about the crucial importance of a child’s basic relationships as the foundation for resilience and recovery.” Him (2000, p. 15) articulated her own resilience, demonstrated by her ability to survive the most horrific of conditions, when she said, “I survived starvation, disease, forced labor, and refugee camps. I survived a world of violence and despair. I survived.” Furthermore, she stated, “As a survivor, I want to be worthy of the suffering that I endured as a child. I don’t want to let that pain count for nothing, nor do I want others to endure it.” She found her healing in reaching out to those who had experienced what she had experienced. She wanted to help others because she once had little or no power to do so. This is the story of many Cambodians today who are directing their energy and trauma-related grief, pain, and anger into altruism and rebuilding their culture. In other words, they are committing the ultimate revenge against Pol Pot and the Khmer Rouge by reuniting as families and communities and showing compassion and empathy for those in need.

Consequences for the Future

Transmitted Trauma across Future Generations

Despite the beauty of this resilience, “a traumatized people carries with it a collective narrative that shapes political life and provides the foundation for the messages communicated to children of the next generation” (Dubrow, Garbarino, & Kostelny, 1991, p. 48). As one Cambodian woman put it, “Blessed and cursed with our survival. We have grown silent. A silence born of fear and distrust. A silence born of uncertainty. We live from day to day. We plant no trees. For who will have the pleasure of its shade?” (Bruno, 1989). Furthermore the woman adds, “We live in the shadow of memory. We look back to the time when we were together as family. When we trusted our neighbor. When we spoke without fear. But with each good memory comes the pain of its loss” (Bruno, 1989). In addition she inquires, “How often in the market do we brush against those who tortured us? Who among us has bloody hands? Slipped quietly into life beside us. We are all in search of someone in every crowd, on every train, for the child lost, the husband lost” (Bruno, 1989). These questions and thoughts that still haunt those who survived under the Khmer Rouge do not stop with them. These feelings of loss, despair, fear, mistrust, and silence are all transmitted consciously or subconsciously from generation to generation. This is why community supports for these future generations of children are so crucial. Such ongoing and systematic indoctrination, torture, and killing have serious traumatic effects, not only on the children who experienced them directly, but on their own children in turn. Furthermore, traumatized children as well as adults influence those around them with the effects of

the trauma that they carry with them. If a whole country has been traumatized, its people will transmit aspects of their trauma to the next generation of children. Therefore, it is vital that an effective mental health system be implemented within Cambodia that utilizes effective prevention and intervention methods that are appropriate to Cambodian beliefs, values, and traditions.

Contemporary Mental Health Services

In light of the reality of transmitted trauma, Cambodia's psychological and social supports are still largely lacking. In fact, between 1979 and 1992, there were no mental health services available in Cambodia (Funk, 2005). Even today, the state of the mental health care system and the availability of psychiatrists, psychiatric nurses, neurologists, neurosurgeons, and social workers in Cambodia are limited at best. In fact, Meyers (2007) states, "At the hospital, the medical director explained that most physicians were killed during the genocide, including all of the psychiatrists. There were no psychologists in Cambodia before 1994." Furthermore, it wasn't until 1994 that a children's mental health clinic was opened. In 1995, a mental health training system that targeted the health care system was instituted and has proven successful. There is also a high involvement of Non-governmental organizations (NGOs) within Cambodia who provide both physical and human resources. However, they primarily operate from a Western model and tend to lack cultural specificity as well as competency (de Jong, Eisenbruch, Samasundaram, & van de Put, 1999). Therefore, it is essential that prevention and intervention methods and models be created that not only utilize the

knowledge that is known from within the Western context, but also incorporate and give weight to Cambodian values, beliefs, and traditions.

Community-Based Approach

The psychology department within the Royal University of Phnom Penh (RUPP) has this same vision in mind. It aims to provide “solid educational training in psychology for individuals who want to alleviate the many social and mental health problems particularly relevant to Cambodia” (Lahar, 2004). The department recognizes that there is a high rate of people needing psychological assistance within Cambodia due to its recent traumatic history under the Khmer Rouge, and proposes to help fill the great demand for trained mental health professionals in both the rural and urban settings. Starting in 1993, it developed a 4-year bachelor’s degree which focuses solely on psychology that coincided with international standards. Students not only receive training in areas surrounding mental health, but they also complete practicum hours at organizations within the community addressing specific psychosocial needs in Cambodia (Lahar, 2004). As a result, psychological knowledge and Cambodian-specific services incorporating cultural values, traditions, and beliefs are being united and utilized by these newly trained mental health professionals. Samasundaram and van de Put (1999, p. 276) affirm the effectiveness of this strategy, “The best option for Cambodia, with [limited] structures and resources in mental health other than in the traditional sector, and with 85% of its population living in rural areas, would be to adopt a community-based mental health program founded on a policy of decentralization and integration of services. The aims should be to deliver adequate coverage of the

population and for workers at the community level to provide basic mental healthcare as has been achieved elsewhere.”

The community-based mental health model is particularly appropriate because “In Cambodia, mind cannot be separated from spirit or body, and the individual cannot be separated from the collective. Treating trauma literally takes a village” (Meyers, 2007). For example, village elders or traditional healers can utilize mental health interventions when given the proper training. Mental health treatment can also integrate cultural and religious beliefs by utilizing Buddhist monks in group sessions, meditation, and healing ceremonies (Meyers, 2007). Students graduating in psychology from RUPP play a crucial role in not only providing mental health services themselves, but also in providing training for traditional healers, monks, and others to incorporate their traditional practices and beliefs with effective mental health interventions. If this trend continues, mental health services will be more widely available and culturally appropriate. Silverstein (2007, as cited in Meyers, 2007) commented, “They are very sophisticated in treating trauma in a collective way.”

Although this trend towards community-based mental health seems promising, there is still much work that needs to be done. However, this work by students from RUPP is often limited due to a lack of resources. For example, the psychology department at RUPP has only a small library of approximately 300 books; most of which are outdated and worn. The department also has a computer that was donated by a NGO for faculty and student use. Internet access was just made available due to recent donations (Lahar, 2004). In light of this reality, global attention needs to be placed on

supporting efforts made by war-torn countries to fulfill the mental health needs of their communities.

Conclusion

“While I am writing now, little boys and girls are dying as unknown to us in death as they were in life. But to those who loved them and gave them life, they are not faceless, they are not mere statistics. They are ‘son’ and ‘daughter’” (Dubrow, Garbarino, & Kostelny, 1991, p. xi). War-affected children are a growing population in our world today as war now affects far more civilians than combatants. The effects of war can have severe and lasting traumatic effects that are specific to children. Therefore, it is important to not only know how war affects children specifically, but to also be aware of the different risk and protective factors that are involved in determining whether or not a child is at risk of developing negative psychological outcomes such as PTSD. Once specific risk and protective factors have been identified in relation to the child’s specific cultural context, we can begin to develop effective and culturally competent prevention and intervention methods and models. Ultimately, these models will help reinforce the child’s pre-existing resiliency and help to mitigate any risk factors that the child may have been exposed to. In listening to the voices of Cambodian children, we hear the horrific events that they endured and witnessed, the specific types of traumatic symptoms that they suffered from, and the specific positive and negative factors that affected their level of risk for developing psychopathology. Finally, we hear an inspiring call to action led by the Cambodian people themselves as they break the silence imposed by the Khmer Rouge. As Dubrow, Garbarino, and

Kostelny (1991, p. 152) declare, “But with the children of war, knowing can only be redeemed by doing. Knowing without doing is obscene.” Whatever our place or position in this world, each of us has an obligation to defend the rights of children, especially with the increasing threat of war that violates every notion of what it means to be a child. As Chanrithy Him (2000, pp. 20-21) so eloquently stated, “This may be our greatest test: to recognize the weight of war on children. If thousands upon thousands of children will suffer and are suffering right now in the world, we must be prepared to help them. But it’s folly to look at the future without an eye to the past.”

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