Re-visiting Experiences of Working with Intergenerational Trauma in Cambodia through a CAT Lens

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Drawing from my experiences of working psychologically with second generation Khmer Rouge (KR) survivors through the lens of Cognitive Analytic Therapy (CAT), I will briefly discuss the history of twentieth century Cambodia, literature on the intergenerational transmission of trauma (ITT), and two clinical vignettes illustrating multigenerational legacies of trauma in the context of ITT in Cambodia. As I came to understand these Cambodian individuals and their difficulties, it became apparent that the history of Cambodian genocide also left its mark on them as the offspring of survivors. I examine how distress and intergenerational trauma may be transmitted and filter through to younger generations through the mediating interplay of familial, cultural, and epigenetic factors. Applying the CAT model, I present a map offering a relational way of understanding the processes and mechanisms for how trauma stemming from genocide may have been transmitted from survivors to their children both on a familial and cultural/societal level.

The Khmer Rouge (KR) Regime

The KR in Cambodia were an agrarian communist group led by Pol Pot, inflicting massive human right violations, such as widespread famine, violence, torture, executions, repression, slave labour, starvation and illness on the whole of its nation between 1975 to 1979 (Kiernan, 2001). One of the most brutal of genocidal regimes in the 20th century, nearly one-fifth of Cambodia's population is reported to have died during this period (Chandler, 2008). The unimaginable distress and suffering inflicted on its people from the KR regime has led to a relatively high incidence of poor mental health in the nation.

Research using western diagnostic frameworks has found a high prevalence of Post-Traumatic Stress Disorder (PTSD), depression and anxiety symptoms in KR regime survivors (Sonis et al., 2009). Eisenbruch (1991) argues *"cultural bereavement"* more adequately captures symptoms of distress experienced by Cambodians. The KR regime resulted in incomparable loss of life, physical capital and cultural identity destroying the very fabric of Cambodian life, disrupting the country's social, economic and spiritual trajectory (Kinseth, 2009). Political, religious leaders and citizens who were educated and/or had professional, medical and skilled labour abilities were killed, along with systematic destruction of books, buildings, and places of worship.

Cambodians still struggle to understand how such atrocities could have happened and to cope with their painful legacy (Kinseth, 2009). Many second generation Cambodians have grown up with parents who continue to suffer emotionally from long-standing effects of the KR regime (Field et al., 2011). Cambodian youth have known only a post-genocide, post-conflict society, which has suffered enormously in both psychological and socioeconomic terms[1] (Kinseth, 2009). The younger generation may have endured their own suffering that, though not inflicted by the KR directly, nonetheless takes root in the regime's brutal rule; a complex experience of suffering in which unspoken intergenerational trauma continues to go widely unacknowledged (Kinseth, 2009).

Case Study 1: Channa[2]

Channa, a 29 year old female, self-referred to the Psychological Service with recurrent episodes of depression, anxiety, insomnia, poor concentration and ruminative cycles she described as "thinking too much", a phrase common when Cambodians talk about depression and trauma[3]. She experienced headaches, dizziness, and diminished energy, a familiar somatic and cultural presentation (Hinton et al., 2012; 2013). She described recurrent, disturbing dreams, which culturally are widely believed to relate to the spirits of those who have died violently and are unable to find peace (Agger, 2015).

Channa described her parents as over-bearing and over-involved, a common parental style in Cambodia (Haas, 1990). She recognised this parental over-protectiveness related to their experiences of surviving the KR regime. She knew little of her family's experiences during the KR rein; her only understanding emerged when she expressed dissatisfaction or distress and her Mother would become critically dismissive on account of Channa not knowing how fortunate she was in comparison to what she and her generation had suffered. Channa would feel guilty for displeasing and upsetting her Mother, providing care and reassurance to console her and regain her approval. She spoke of this role-reversal dynamic, becoming a parental child, and having a felt sense of her parents' fragility from early in life.

Case Study 2: Sokha[4]

Sokha, a 21 year old female, was referred to the Service by a non-government organisation (NGO) following Sokha repeatedly presenting to a health clinic complaining of a restricted sensation in her throat creating difficulty speaking and

swallowing, dizziness, chest pain, palpitations, shortness of breath, headaches and a lack of appetite with stomach pain. There was no apparent physical cause to these symptoms. Psychosomatic difficulties are often the presenting affliction among Cambodians with depression and trauma (Cheung, 1993; Hinton, et al., 2013).

Sokha described an impoverished upbringing, often left uncared for, caring for her younger brother from the age of four when her Mother left them to work in the rice fields. She described her Mother as emotionally unavailable, fearful, hypervigilant, often hostile, physically and emotionally abusive and neglectful. Sokha reported no knowledge of her Mother's experiences during the KR regime as this was never spoken of. She recounted the traumatic loss of her Father who was murdered.

Intergenerational Transmission of Trauma (ITT)

Trauma derives from the Greek word for 'wound'. ITT refers to children of trauma survivors as *those who bear the wound without the scar* (Albeck, 1994). This passing down of historical trauma experienced by an older generation to a younger generation, has been found to be especially true for survivors of genocide (Kay, 1998). ITT received attention following World War II (Abrams, 1999) as children of Holocaust survivors were treated for PTSD (Roland-Klien & Dunlop, 2001).

Research has explored ITT through both direct and indirect pathways of transmission: direct referring to trauma resulting from familial experiences in the way survivors deal with their genocide experience and how they communicate this history and their experience of trauma to their children; and indirect whereby trauma results from the experience of growing up with a traumatised parent who may struggle in their parenting (Kellermann, 2001). This suggests people may be susceptible to collective or historical trauma that emerges not necessarily as a result of personal experiences, but rather from witnessing the effects of trauma on others.

More recently a third pathway of transmission has been identified and researched, the field of epigenetics – the study of heritable changes in gene expression that do not involve changes to the underlying DNA sequence (Kellerman, 2013). This entails a change in phenotype without a change in genotype, which affects how cells read genes. This area of research integrates environmental factors, such as parents' child-rearing practices, with genetics adding a psychobiological dimension to the explanation of trauma in subsequent generations of survivors (Kellerman, 2013). Therefore, second-generation Cambodians may have been marked epigenetically with a chemical coating upon their chromosomes, representing a kind of biological memory of what their parents experienced. Any inherited dispositions can be either turned on or off, thus activating either overwhelming anxiety or sufficient coping in the same person at different times, according to certain aggravating and mitigating (environmental) factors (Kellermann, 2009, citation in Kellerman, 2013).

Epigenetics fits with the CAT relational model of self-development:

"CAT is based on a clearly defined and radically social concept of the self. In this view the mature, individual, 'phenotypic' self is formed through a process of development during which an original infant 'genotypic' self, with a set of inherited characteristics and certain evolutionary predispositions interacts reciprocally with care-giver(s) in a given culture and in time psychologically internalises that experience and their 'voices'. These 'voices' are the patterns of relationship established, convey the values of the immediate family and the wider culture and contribute to the formation of a repertoire of reciprocal role patterns embodying action, thinking, feeling and meaning".
Ryle & Kerr, 2002

CAT Reformulation of ITT

CAT therefore offers a useful model in thinking about ITT, acknowledging biological, relational and cultural influences. Yet, little research within the CAT literature relates to ITT, particularly in different cultural contexts. The Multiple Self States Model (MSSM; Pollock et al., 2001; Ryle, 1997) provides a framework for understanding more complex difficulties within CAT. Applied to the community and sociocultural context in Cambodia, the MSSM offers a way of understanding the spectrum of multiplicity in the self on one level, and the nation on a systemic level. Figure 1 is an attempt to *map* the resulting emergence of states, cut-off or fragmented from other Reciprocal Roles [RRs] in the individual and collective repertoire.

Potter (2004) acknowledges distressing states can have history and lineage across time and generations. States once chronically endured or traumatically induced in a previous generation are now dreadfully avoided or unexpectedly re-activated. Parental-derived RRs of *[silencing, withholding]* and *[defensive distancing, controlling]* to child-derived RRs of *[silenced, withheld, unspoken, confusion]* and *[controlled/cut-off, distant, detached]* becomes a way of avoiding pervasive fear, terror and unprocessed trauma stemming from genocidal annihilation.

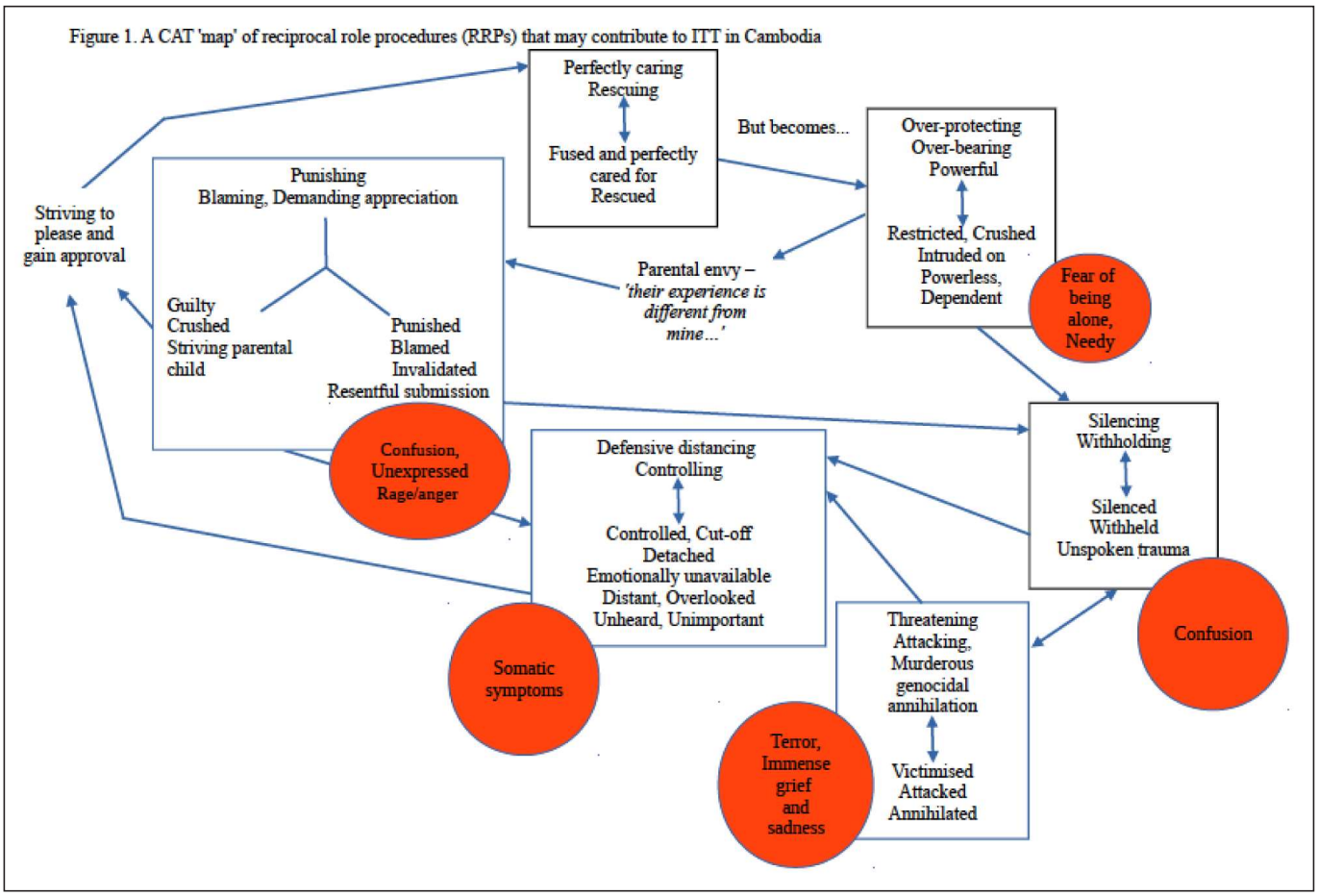
Such detachment from feelings and distress may lead to a culture that carries its unexpressed pain in somatic symptoms (Hinton et al., 2013). From time to time, the tremendous suppressed cultural grief and anger may erupt in problematic ways, such as in the high prevalence of domestic violence and child abuse. Both Channa and Sokha described physically punitive treatment; Cambodians commonly view hitting children as a warranted form of discipline (Gourley, 2009). Sokha described the violence within her community that resulted in the death of her father. Such volatile mood and behaviour could be conceptualised in terms of RRs of *[threatening, attacking murderous genocidal annihiliation] to [victimised, attacked, annihilated].*

Sokha and Channa reported their parents exhibited a pattern of demanding greater appreciation from them due to their relatively advantageous situation. Münyas (2008) described this procedure as the *demonising narratives* survivors tell their children about their experiences living under the KR regime, and used as punishment when youth complain about hard work, act lazy, or leave food. This can induce guilt and emotional invalidation as they are told their lives are better/easier than their parents' lives have been and their problems amount to nothing compared with what their parents lived through. Parental envy may contribute to procedures of *[punishing, demanding appreciation]* to *[punished, emotionally invalidated, guilty and crushed].* This guilt-inducing relational pattern could elicit sympathy (striving parental child procedure - left-side of Figure 1) or exert control as they submitted to their parents' needs to avoid distressing them *[controlling]* to *[controlled, unheard, unimportant].*

Culturally this procedural sequence is seen in attempts to avoid bringing shame on family, but also includes spiritual relationships as offerings are made to spirits to avoid displeasing them to restore karmic balance. Cultural expectations to care for older relatives until the end of life informs an *[ideally caring] – [ideally cared for]* RR with possible disavowal of anger and resentment.

Bakhtin's dialogic conception of the self emphasises the dialogic relationship as a defining feature of the self, with talking, listening, and creating meaning offering the potential to heal (Pollard et al., 2005). Both Channa's and Sokha's parents predominately found refuge in silence, possibly also an attempt to protect their children from the horrors of genocide. Untold stories can of course send as powerful messages as told stories.

Figure 1. A CAT 'map' of reciprocal role procedures (RRPs) that may contribute to ITT in Cambodia



The overt *[silencing]* to *[silenced]* RR apparent in Cambodian family communication styles keeps a RR of *[threatening, attacking, murderous, genocidal annihilation]* to *[victimised, attacked, annihilated]* hidden, and so feelings of terror and un-mourned loss, immense grief and sadness become dissociated and disavowed.

Ways of managing trauma, seen in societal and parental emotional disavowal to avoid the emergence of unmanageable feelings of sadness, grief and anger in relation to their past, could lead to detachment, a lack of emotional expression and so connectivity to their children seen in RRs of *[defensive distancing, controlling']* to *[controlled, cut off, detached, emotionally unavailable, distant, overlooked, unheard, unimportant]*. Avoidance of intense and unmanageable emotions, could therefore hinder opportunities for parents to develop RRs of [containing' to 'contained, held, safe] in relation to their children.

Reflections and Conclusion

My attempt to *map* both the individual and collective Cambodian wounds, was constructed post-working in Cambodia, whilst reflecting on such profound experiences during my CAT practitioner training. It has been moving to revisit my experiences of working with Cambodian people, such as Channa and Sokha, once again acknowledging the Cambodian nation's shared history of grief and traumatisation and the way such a legacy may move from generation to generation.

I was very fortunate to have clinical supervision in Cambodia with a Clinical Psychologist who trained as a CAT practitioner in the UK. In supervision we considered how unspeakable trauma and losses were inferred from parental anxiety, neediness and harshness. Channa's parents oscillated between states in which they were over-bearing and critical or needy of care and support from her. This created immense anxiety within Channa as she struggled to know what was expected, how to respond and led her to internalise criticism and blame. As therapy progressed, we brought what was known of her parent's experiences into dialogue; she recognised her parents whose own families had been destroyed in the KR regime understandably developed an excessive need to shield her from danger. Yet in doing so, they restricted her, leaving her frustrated, anxiously dependent and powerless. I noted my own feelings of powerlessness and frustration in relation to Channa's passivity and desire for me to "*fix*" her, as well as at her familial situation, as I hoped she would challenge her parent's authority and expectations. Supervision helped me consider the cultural context and prevailing style of communication in Cambodian families, including an avoidance of intergenerational conflict, and cultural expectations for younger generations to respect their elders and not challenge their position.

It is difficult to recall my initial impressions of Sokha, perhaps a relational [countertransferential] experience emanating from her early neglect. Sokha presented as anxious, compliant, and appeared thin, helpless and needy as she sobbed and pleaded to be seen twice a week[5]. I felt cold and withholding in response to her request and questioned the need to maintain a boundary of weekly appointments in supervision. Interestingly she elicited strong rescuing reciprocal roles in many, with Western female NGO workers going beyond their role of supporting her; speaking of wanting to take her home and care for her, mirroring my earlier desire to "*fix*" her.

As Sokha's story unfolded, I noticed how I too felt a lump in my throat. It seems her repressed sadness, stuck in her throat, was transferred to me, a shared embodiment of her distress. We began to link her somatic and psychological difficulties to systemic and familial struggles stemming from the traumas and losses of the KR era. Exploring her fear of loneliness, we placed this in the context of early neglect and her experience of leaving her family in the province to live independently and access further education. Her transition from being embedded in a community to leading a more individualistic lifestyle, far removed from traditional collectivist Cambodian way of life, appeared linked to her fear of being alone should she stop breathing and die alone.

Münyas (2008) said: "*Repairing societies' wounds of war and conflict occurs in dialogue with the past*". Therapy can be a way of giving voice to experiences that remain unseen, unspoken and unacknowledged (Fawkes & Fretten, 2016). Bringing Sokha and Channa's legacy of intergenerational trauma and suffering into dialogue, meant a shared understanding emerged not only between them and myself within the therapy dyad, but also between them, their families and collective history. Gaining an observing eye of the disavowal of individual, familial, community, and societal pain, allowed a process of integrating split-off somatic and emotional experiences, and the emergence of adaptive RRs: *[hearing, containing, understanding]* to *[worded pain, heard and contained, felt and understood]*.

Like any CAT map, my attempts to map their experience risks being crude and over-simplified. There is also the risk of colonising the experiences of victims of intergenerational trauma,

particularly when Western psychological *knowledge* is introduced in countries like Cambodia, and can be interpreted by locals as superior to their own knowledge even though it may be quite dissonant with their experience (Agger, 2015). Therefore, I was sensitive to situating their ways of coping in the context of broader Khmer Buddhist practice. Psychological therapy should be rooted in client's own traditions as part of their Zone of Proximal Development (ZPD).

Traditional Cambodian approaches to healing distress centre on Buddhism with most turning to Buddhist monks for advice on how to accept what cannot be changed, manage distress and *calm their mind*, often through Buddhist rituals and meditation, medicinal herbs, spirit possession and various *magical practices* (Agger, 2015). Buddhism values the quality of equanimity; distancing oneself from emotions and disturbing thoughts. We therefore considered such traditions in thinking about alternative ways of relating to both themselves and others, which offered *exits* from maladaptive RRPs:

Channa's EXITS:

"Peace button" - mindful breathing to create spaciousness around distressing experiences,

Self-forgiveness/acceptance, beginning to let go of the need to 'perfectly' appease others,

Loving-kindness meditation to counter her inner critic.

Sokha's EXITS:

Meditation to help reconnect the mind/body/spirit,

Engagement with her local Wat (Buddhist church),

Self-compassion (internalised from the therapy dyad and her relationship with NGO staff) to develop a caring, nurturing response to her history and losses.

I hope this paper demonstrates the possibilities of using CAT as a framework for understanding the ITT through the complex interplay of epigenetic, familial and cultural pathways. The relational tool of mapping can enable us to grasp the complexity of how pervasive, unspoken trauma within families, communities and society, and cultural values and ways of coping, can manifest in self-identity following intergenerational transmission of damaging and traumatic RRPs. My hope is this evokes a reflective, curious stance in examining the impact of culture and also large-scale cultural bereavement and trauma. This is an area, I feel, that warrants further research and reflection.

Footnotes

1. The country's education system, religious identity, economic security, and governance have all been severely compromised as a result of the KR regime (Kinseth, 2009).

2. The client's name has been changed to preserve anonymity.

3. In Khmer: 'kut caraeun', a term that relates to ruminating over upsetting issues, past traumatic events and separation, by death, from loved ones (Hinton et al., 2012).

4. The client's name has been changed to protect anonymity.

5. A cultural expression of distress known as Baksbat (translated as "broken courage"; Chhim, 2012), is seen to relate to a lack of trust in others, submissiveness, feeling fearful, and being deaf and mute. This may have some similarities with Sokha's presentation, particularly as she struggled to speak at times

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Innovations in Writing

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Introduction

For some twenty years, writing has been central to CAT therapy. The reformulation letter written by the therapist, to and for the client, has been a lynchpin of CAT therapy. The reading of a draft of this letter, by the therapist, in session four or five is a moment of drawing together the work of formulation into a reformulation of the client's difficulties. Standard practice has been that clients are invited to amend the reformulation letter, but only at the end of therapy to write their own letter back to the therapist, at the end of therapy, in order to reflect on the therapy and how they may continue the work.

In recent years therapists, under pressure of time in the public sector, and in pursuit of a genuinely collaborative approach, have extended the idea of an exchange of letters from the end stage of therapy (the goodbye letters) to the reformulation stage. Alison Jenaway (2011) has described inviting the client to write a letter back in response to the therapist's reformulation letter. Others have tried writing the reformulation letter with the client in the room.

We would like to contribute to reflection and development of how we traditionally use writing in CAT. Is it helpful? Is it efficient? How else could we use writing to develop and broaden our practice, and add to our therapeutic toolkits?

We describe writing to address unmet childhood needs and how this can open up a dialogue about change Two examples in the process of therapy of writing a memorable sentence either as a 'protective' sentence in the face of difficulty or as a 'blocking' sentence describing a core difficulty. We write of the added therapeutic richness of reading aloud what is written.

What we describe is work in progress. We warmly welcome additions and responses to our work and encourage the reader to try out some of the ideas.

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Blocking or Protecting Sentences

Marie Ann Bernardy

In Goethe's Faust, Mephisto insists that his pupil should write everything down, to which the pupil replies:

> "*You will not need to tell me twice!*
> *I think myself, how much it is of use*
> *Because what one possesses penned in black and white*
> *Can be carried home confidently*"
> (personal translation)

Practising CAT, needs constant adaptation to the needs of our patients. The quote from Goethe's Faust in the voice of Mephistopheles comes as a perfect advice for the therapist and his patient. What is written on paper invites us to go back to, look again, confront with, try to understand, take in and, change our responses. But it also stands *in the moment*: it fixes what has been said by the patient, is listened to, heard and received by the therapist, but not yet perceived by the patient. This writing *in the moment* with the blocking sentence, can be used to overcome "blockages" as the patient sees before him the sentence he has just been uttering, or the sentence he keeps repeating, incapable of moving on. Writing in the moment can also be used for frightening situations where patients can dissociate or experience flashbacks. By writing a "protecting sentence" in the here and now, we can help the person to feel secure,