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## PEER-REVIEWED ARTICLE

### The politics of humanitarian aid: A case study of EMDR in Cambodia

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#### ABSTRACT

The global expansion of psychotherapy through humanitarian aid is a political act. International aid organizations assert power over resource-scarce countries, make critical decisions about who receives care, who provides care, and what modalities are delivered. Once embedded in a country, programs exert influence between international interests, local governance, and the targeted population. This study adds to the limited information on how the humanitarian aid phenomenon is experienced by the practitioners who must navigate these conflicts through a case study of eye movement desensitization and reprocessing (EMDR) in Cambodia. As a non-Western nation with a colonial and autogenocidal history, Cambodia offers a unique perspective for those interested in the concerns and challenges of globalized psychotherapy. As found in this case study, EMDR as humanitarian aid and a mental health movement pushes traumatology while simultaneously necessitating the need for EMDR. Findings suggest that Cambodians working as psychologists become dependent upon and caught between competing aid organizations.

**KEYWORDS:** humanitarian aid; Cambodia; EMDR; global mental health; responsive evaluation

The global expansion of mental health through humanitarian aid is a political act associated with conflicts between international organizations, local governance, and the clinicians and clients in the targeted country. International aid organizations assert power over resource-poor countries in making decisions about who can practice clinical services, who can receive these services, and what types of services are delivered (Kienzler, 2019). Similarly, the therapies promoted through aid organizations can be influenced by people who have developed and who seek to advance particular forms and modalities of therapeutic practice. Such top-down approaches occur when organizations act in lieu of governance rather than with it (Abramowitz, 2015). Tensions at the local level arise as concerns over what treatment is most needed and whose culture is privileged are juxtaposed to a backdrop of low funding and a desire for mental health (Harper Shehadeh et al., 2020).

Humanitarian mental health aid is connected to particular conceptualizations of mental health and treatment, and particular standpoints (Kienzler, 2020). Global endeavors to ameliorate social problems stem from Western academic groups that have eclipsed the World Health Organization's (WHO) goal of multilateralism (Saraceno, 2020). When these attempts come from a non-local context, the representation of human problems, and thus suffering, risk being disconnected from local meanings and ways of being (Saraceno, 2020). Treatments developed in other locations may be incommensurate with the local intended recipients while mechanistically normalizing a Westernized perspective of mental health (Jordan, Anderson, & Hall, 2021). The entrée of humanitarian mental health aid into a culture is guided by the idea that human suffering is universal and requires solutions outside of the culture's abilities (Kienzler, 2019, 2020). In this article, it is suggested that the appearance of humanitarian aid programs creates lasting effects in countries that are complex, risking the loss of local ways of healing while promoting dependence on other nations. Through a case study of eye movement desensitization and reprocessing's (EMDR) international humanitarian mental health response in Cambodia, we explore the nested layers of power and influence on clinicians and clinical services in that country.

## **THE GLOBALISATION OF MENTAL HEALTH AND THE HUMANITARIAN RESPONSE**

While humanitarian actors are beginning to recognise the importance of localized responses to mental health (Kienzler, 2019), many aid programs continue to provide treatments developed in Anglo-European and Anglo-American contexts (Abramowitz & Panter-Brick, 2015). This monocultural lens produces potentially ineffective treatments for the needs of a broader population by neglecting culturally relevant community outcomes (Jordan, Seponski, et al., 2021). Internationally, mental health providers diagnose problems with psychometric assessments and utilize treatment modalities that have been tested and validated in the West, which assumes that the experience of mental health is a universal condition (Jordan,

Seponski, et al., 2021). Such assumptions promote the idea that mental health treatments can be globally applied, in all contexts, and are universally effective. While many argue against hierarchical expansion in the broader sense (Bemme & Kirmayer, 2020), one area of mental health where it is encouraged is within humanitarian aid programs (WHO, 2013b).

Increased globalized responses to mental health stem from growing recognition of the economic burden of mental health disorders that disproportionately affect low- and middle-income countries (LMICs; Becker & Kleinman, 2013). The WHO (2013b) and other international organizations have described humanitarian crises as ‘unparalleled opportunities’ (p. 9) to expand mental health in resource-scarce countries (Kienzler, 2019). Whereas mental health might not be on the agenda in these countries, crises caused by natural and human-caused disasters are thought to simultaneously contribute to, and be a path out of, the global mental health burden by making space for an influx of international aid (Kienzler, 2019). Following an acute crisis, such as war or a natural disaster, to respond to the urgent needs of localities, mental healthcare is enfolded in other medical humanitarian aid rather than delivered as long-term interventions in economic, political, or governmental reforms (Abramowitz & Panter-Brick, 2015). It is assumed that short-term services can be transitioned into ongoing support programs once the acute crisis is resolved (Patel et al., 2018). Given the interest in expanding mental health resources, the rapidly expanding trauma field within crisis response has found commonality with the global mental health and humanitarian aid movements.

## **TRAUMA AND HUMANITARIAN CRISES**

Since the latter part of the 20th century, the terms *stress* and *trauma* have become part of contemporary Western culture in such a way that they are viewed as both natural responses to distressing events and indicative of the need for professional help (Tarvydas et al., 2017). Increased focus on the impact of traumatic events and resulting symptomology has created the belief that victims of humanitarian crises, including human-caused (e.g., war, genocide) and natural (e.g., hurricane, tsunami, wildfire) disasters, should have similar trauma responses regardless of culture, context, or geolocation (American Psychiatric Association, 2013; Bemme & Kirmayer, 2020; Micale, 2017). Painting disasters as mental health emergencies capable of causing long-term and intergenerational psychopathology on a community invites aid organizations into these populations that are presumed to be unprepared to treat such issues (Wilson, 2014). Previously, there was an assumption that survivors of a disaster would heal using their indigenous (to the population) coping mechanisms (Beneduce, 2019). However, due to the assumed universality of acute and post-traumatic stress responses across varying cultures and populations (Lee, 2017), there has been a push to deliver Western-based humanitarian aid as the vehicle for trauma healing (Summerfield 2013; WHO, 2013b).

## HUMANITARIANISM AND EMDR

Humanitarian programs are often funded by individual donations, corporations, and non-governmental organizations (NGOs), and are implemented to ameliorate the costs in human resources that often follow natural and human-caused disasters (Wood & Sullivan, 2015). With support from the WHO (Van Ommeren et al., 2015), humanitarian programs began to deliver psychological assistance to respond to community-wide trauma responses in times of crisis. Simultaneously, arguments emerged for and against the need for, or effectiveness of, mental health interventions in times of crisis, when what appears to be most important is the securement of resources, such as shelter, food, and water (Anderson et al., 2012; Seponski et al., 2014).

EMDR, an increasingly common yet disputed Western mental health treatment (Cuijpers et al., 2020) is one such mental health treatment that foreign aid employs in response to a disaster (Shapiro, 2017). The popularity of EMDR services has been attributed, in part, to ongoing media coverage of EMDR (Shapiro & Forrest, 2016) and its promises of significant results in as little as one session (Kutz et al., 2008). The American Psychiatric Association (2004), Department of Veteran Affairs and Department of Defense (2010), and the WHO (2013a) have endorsed EMDR as a *possibly efficacious* treatment for individuals with post-traumatic stress disorder (PTSD).

The roots of EMDR's humanitarian assistance programs took shape when, in 1995, a crisis team responded to the bombing of the Federal Building in Oklahoma City (Shapiro, 2014). This incident, and the subsequent response, led to the formation of the EMDR Humanitarian Assistance Program (HAP). During times of crisis, the EMDR HAP would approach disasters in the United States of America (USA) with the intention of training local clinicians on how to use EMDR and providing direct clinical care to survivors of acute and post-traumatic stress (Shapiro, 2014). EMDR HAP then began branching into countries that had experienced long-term conflict, war, poverty, and scarcity of resources (Gelbach, 2014). The EMDR HAP created the Trauma Recovery Network to connect local volunteers to community needs as well as to form strong connections to emergency services and educate the public about trauma and its treatability (Alter-Reid et al., 2014). EMDR HAP's international work has slowly reduced as country- or region-specific EMDR humanitarian aid programs have grown (Gelbach, 2014). Due to its humanitarian work, EMDR's global reach has been prolific, especially in Southeast Asian countries (Mehrotra, 2014). In Cambodia, the mental health landscape is centered around trauma and EMDR, as an influx of humanitarian-led EMDR trainings, associations, aid groups, and NGOs have been instituted over the past decade.

## MENTAL HEALTH AND THE CAMBODIAN CONTEXT

Cambodia entered the landscape of humanitarian aid recipients most prominently due to the Khmer Rouge autogenocide (1975–1979) that resulted in the loss of approximately 1.8 million lives through mass killings, starvation, and severe torture (Seponski et al., 2019). Thus, Cambodians are presumed to be inherently at a high risk of trauma, anxiety, depression, and PTSD exceeding the ‘normal’ range (Seponski et al., 2019). While Cambodians express that socioeconomic factors pose the biggest challenge to wellbeing, due to pervasive rates of poverty (Seponski et al., 2014), expatriate practitioners have suggested that the experiences of the Khmer Rouge created a ‘culture of silence’ that thwarted Cambodians’ natural expression of painful memories, maintaining past trauma into the present day (Summerfield, 1998, p. 1580).

Given concerns of the risk of mental health challenges in Cambodia and the unavailability of standardized mental healthcare in the years following the Pol Pot regime and genocide, humanitarian efforts have provided a steady stream of psychotherapists, trainings, and intervention methods from the West (Chhim, 2017). These early and continued humanitarian efforts were driven by expatriate practitioners, who suggested that the events and legacy of the Pol Pot regime were, and continue to be, universally traumatic for the Cambodian population (Eichfeld et al., 2019).

In 2008, the Royal University of Phnom Penh (RUPP) developed the first Master’s of Psychology and Psychotherapy program delivered through a prominent, public university. RUPP has graduated approximately 1,000 bachelor’s and master’s students to work as psychologists throughout the nation (Sonyka, 2016); and approximately one third of the graduated master’s students are working as therapists or are directly involved in mental health treatment (Stackhouse, 2016). The disparity between graduates and employed practitioners is due, in part, to the continued lack of government support for mental health services, as the Ministry of Health spends about 0.02% of the national health fund on mental health services annually (Chhim, 2017; McLaughlin & Wickeri, 2012).

Persons who deliver mental health treatments are typically employed through humanitarian-funded mental health groups and international organizations (Stackhouse, 2016). The modalities used in these practices are often dependent on the mental health models delivered and promoted by the specific needs and interests of the aid groups. It is against this backdrop that EMDR came to Cambodia (Mattheß & Sodemann, 2014). From the years 2010 to 2014, the Trauma-Aid Germany group initiated the Mekong Project to train Cambodian professional and lay counsellors in the basics of trauma and stabilization by providing basic EMDR skills (Mehrotra, 2014).

The purpose of this article is not to critique the whole of humanitarian aid and, more specifically, humanitarian mental health programs. We acknowledge the good that has come out of assistance delivered around the world in times of crisis, in resettlement camps, and

after disasters. However, we do critique the long-term effects of humanitarian programs which create a permanent internationalized presence, as is seen in Cambodia. Our critique is meant to further the conversation about the consequences of framing an entire population as potentially traumatized while living in a 'post-conflict' society (Hughes & Pupavac, 2005). Some suggest that such moves pathologise the country as dysfunctional while positioning international aid as functional. In a way, the Cambodian government becomes absolved from solving the country's issues as NGOs occupy mental health's temporal landscape (Hughes & Pupavac, 2005), which sets up a competitive field with limited resources and dependence for the organization's longevity.

## RESEARCH PURPOSE

As a non-Westernized nation with a colonial history and period of autogenocide, Cambodia offers an important lens for researchers and clinicians interested in pulling apart the concerns and challenges of creating a global mental health field. In 2010, as EMDR was being integrated into Cambodian mental healthcare, Seponski spent a year living, studying, and working in Phnom Penh while on a Fulbright award. During this time, she witnessed massive changes in the political and social climate of Cambodia. In response to RUPP's request, Seponski broadly explored the effectiveness and cultural responsiveness of therapeutic modalities developed in the USA and adopted within the Cambodian context. As the university was the first to incorporate EMDR, the modality became a focus of her responsive evaluation. The current case is a part of our larger study (Seponski et al., 2014, 2020) and presents an analysis of data obtained through interviews and participant observation, which provide a unique look at the effects of introducing EMDR through humanitarian means on a developing psychological field in an LMIC. Minimal research exists on how Cambodians who have been trained as psychologists perceive the practical effects of humanitarian aid. This study adds to the limited information on the humanitarian aid phenomenon and was guided by the following research question: *How do Cambodian psychologists, teachers, and supervisors experience the political landscape of EMDR as a humanitarian mental health program?*

## METHOD: RESPONSIVE EVALUATION

Responsive evaluation (Seponski et al., 2013; Stake, 2004) was employed to generate information and suggestions for the improvement of the training, implementation, and adoption of EMDR (see Seponski et al., 2013 for a detailed description of responsive evaluation methodology). The research process began by engaging with multiple stakeholders to identify the scope of services provided, conceptualize the stakeholders' concerns, and winnow out issues through this engagement. In this process, it became clear that the stakeholders were interested in the implementation of EMDR and its appropriateness for Cambodian therapists and a Cambodian clinical population. A core component of responsive

evaluation is focusing on the unique needs of a unique population and amplifying silenced and marginalized voices. Thus, when conducting an evaluation of a therapeutic approach, the focus is not on assessing whether the therapy is inherently valuable as a model but whether it is valuable to a given population. In the original study (Seponski et al., 2020), common themes emerged relating to the political influence of EMDR—the focus of the current analysis. Thus, in this article, we do not describe how Cambodian clients and therapist students feel about the treatment but how the providers experience the political landscape of humanitarian mental health programs, and EMDR specifically.

## DATA COLLECTION AND PARTICIPANTS

As is common in responsive evaluation, Seponski collected data through multiple qualitative methods including focus groups ( $n = 5$ ), semi-structured interviews ( $n = 21$ ), surveys ( $n = 68$ ), case illustrations ( $n = 10$ ), and case presentations ( $n = 16$ ). She also conducted 11 months of observations, which included observations of EMDR supervision and an EMDR disaster response intervention that occurred during the deadly Koh Pich bridge stampede (Eisenbruch, 2020). The responsive evaluation method encourages data from multiple perspectives. For the current case, stakeholders ( $n = 95$ ) included master's students ( $n = 16$ ) who were enrolled in Cambodia's only public university program in psychology and who trained in EMDR level 1 (as a minimum requirement of their program, some were trained in level 2 optionally); peer supervisors ( $n = 11$ ); therapy workshop participants ( $n = 54$ ); and Koh Pich stampede EMDR crisis response therapists ( $n = 14$ ). We also developed a two-tier cultural advisory board ( $n = 11$ ) of native Cambodians ( $n = 5$ ; level 1) and non-native clinical supervisors ( $n = 6$ ; level 2) from five different countries. Two levels were used for the advisory board to amplify local knowledge (level 1) and decrease the chances of replicating a power structure privileging an external way of knowing (level 2). While all advisory board members were familiar with EMDR, only one level 2 supervisor was formally trained.

For the semi-structured interviews, criterion sampling (Patton, 2002) was employed to obtain a sample of participants that represented a range of experiences and perspectives. Interviews occurred in locations that were convenient for participants, including cafes and classrooms. Interviews were digitally recorded, followed informed consent, and lasted 1–3 hours. Following the individual interviews, five interviewees participated in a focus group (2.5 hours). Throughout this case study, Seponski engaged in participant observation and taught at the university, taking extensive field notes of observations and informal interviews with students and the cultural advisory board. The field notes provided rich field data to triangulate formally gathered data. For further details on participants, supervisors, and methods, see Seponski et al. (2014).

As all authors are US citizens and mental health practitioners, it is important that we situate ourselves in relation to Cambodia and EMDR. Jordan is a critical international health



researcher, who works to unravel the colonizing effects of Westernized mental health practices in indigenous contexts. For the past six years, after an extended research trip to Cambodia, she has continued to collaborate on projects evaluating Cambodia's mental health system. Seponski has been teaching, researching, and collaborating in Cambodia for 13 years, lived in Cambodia for one year, and is EMDR trained. The department of psychology at a university in Cambodia requested her assistance in evaluating the use of EMDR in Cambodia, suggesting she was neutral/unbiased in whether it 'worked' because she was not the one teaching, implementing, or funding it. Kelley lived in Cambodia for three months, has been conducting research on Cambodian mental health for two-and-a-half years, and is EMDR trained. Krpo is new to working with Cambodians and mental health practice but focuses her scholarship and clinical work on improving mental health with refugee populations in the USA.

## ANALYSIS

Consistent with responsive evaluation, data analysis followed the constant comparative method (Strauss & Corbin, 1990). Through open coding, we reviewed data line by line to identify relevant initial codes. During this phase, we grouped together conceptually similar ideas to condense and connect codes in the creation of tentative categories. As categories were identified, we moved to axial coding, positioning topics that were related by similarities in contexts and consequences under main categories to create subcategories. During selective coding (Strauss & Corbin, 1990), the categories and subcategories were unified into a core category with a central theme that responded to the central phenomenon of interest.

## FINDINGS: A COMPLEX POLITICAL CONTEXT

Through our analysis, it became clear that the political context surrounding EMDR directly impacted the implementation and acceptance of modalities in Cambodia. This context was multifactorial in that it intersected with the foreign influence of EMDR at the local level and the interplay between the interests of two competing EMDR organizations (EMDR Institute and EMDR International Association). Our participants described feeling the external pressures associated with these factors, which caused them to question the origins of outside interest in Cambodia. Statements gave accounts of the delicate balance needed to meet the requirements of funders, trainers, and project managers, while simultaneously obtaining the needed education and therapeutic treatments. From tensions highlighted in the data emerged two categories: (1) *the foreign push* and (2) *caught in between EMDR associations*. Throughout this article, pseudonyms are used for participants based on their role (e.g., S: student therapists; CA: cultural advisors). To protect participants' identities and maintain confidentiality, results are often presented in summaries or paraphrased quotes (Pickering & Kara, 2017).



## THE FOREIGN PUSH

The first theme was centered around concerns over why and how EMDR was introduced to Cambodia. Many participants felt this introduction to be a foreign push at the expense of the local wisdom within Cambodia or as an attempt to culturally adapt the method. For a country that has experienced a long history of colonialism, this is a particularly poignant theme expressed from a variety of perspectives.

The overarching concern was evidenced in statements from participants who worried about being used for others' gains. They shared that, as Cambodians, they were at risk of manipulation by foreigners who could profit off them, while their own financial stability and that of Cambodia did not improve. This was especially true when considering how money generated could return to foreign lands. In part, this financing was accrued by the requirements of an EMDR trainer's certification and obtaining grant funding to provide services in the country through NGOs and other entities. They also expressed a fear that Cambodians would be exploited for research and publication purposes. As S9 stated, 'To be honest, the supervisor also runs a business; I think she wants to help, but she asks us to go along'—indicating concern that while the supervisor may care about the needs of Cambodians, her primary interest is her business. Similarly, participants were concerned that the push for EMDR appeared more focused on the model rather than the health of the country.

Participants criticized the foreign push to use EMDR, stating that it was 'foreigners pushing their pet projects.' At the same time, faculty members recognized a sense of desperation for funding and education in Cambodia—a need that made administrators unable to say 'no' to outside support and instead comply with the use of EMDR in their program. To some participants, EMDR appeared to be little more than an integrative and derivative therapy packaged with eye movements. These participants expressed concern about the usefulness of EMDR for the Cambodian population, when students could be learning different modes of therapy that required less funding and had fewer implementation challenges, as expressed by participant CA3:

If EMDR is going to improve their quality of life in any way, that's great, but the time, energy, and money spent to implement EMDR could be used in better ways with a longer lasting effect. If EMDR is someone's project, that's good, but other stuff should be focused on now, especially with the education level and understanding where it is now.

As noted in CA3's statement, many participants questioned the relevance of EMDR for Cambodians over the relevance for stakeholders. In part, the questioning related to concerns over the hard push for implementation without the foreign implementers having first conducted an evaluation or empirical validation.

The frustration with the push for EMDR was best summarized by a participant who noted that while foreigners bring the model, they are insensitive to criticism about it and ultimately

unwilling to make cultural adjustments. Participants expressed concern about the foreigners interested in ‘helping Cambodians’, who did not listen to the locals when they suggested changes relevant for the population; for instance, refusal to translate manuals or adapt scaling and other questions. Participants desired for foreigners to actively engage with persons familiar with Cambodia as cultural brokers. They felt it was important to discuss the methods of integrating EMDR into the curriculum rather than simply insisting on its inclusion. Focus group participants described how EMDR had been demonstrated as successful in other Asian contexts (e.g., China, Indonesia, India), where the protocols were adapted, and technical terms were localized. That locally appropriate measures had been developed in other Asian countries left some participants wondering ‘Why not here?’ and overlooks the between—and within—group differences across Asian cultures and within the Cambodian context.

Similarly, participants questioned the creation of a specifically Cambodian EMDR association. Participant S2 asked, ‘What does it mean to make an EMDR association? Does that mean something to Cambodian people or does that mean something to EMDR?’ The consensus in the focus group was that an EMDR association may be beneficial. Ultimately, however, these participants were concerned that its creation before the development of a general Cambodian Psychological Association would exclude rather than unite. Such an organization might induce therapists to become trained in EMDR simply to belong to an organizing body.

### **CAUGHT IN BETWEEN EMDR ASSOCIATIONS**

Throughout the interviews, participants shared the tensions felt regarding the international political push for EMDR, which was magnified by the disconnection between the EMDR Institute and EMDR International Association (EMDRIA). Per participants’ reports, the politicized conflicts between the two groups and their desire for viability directly impacted the experiences of Cambodian therapists. Participants felt that political tensions revolved around the power associated with grant funding and EMDR accreditation standards, which spilled over into ideas about who should be trained (nurses, students, counsellors, or laypeople).

There was also a general concern about how and who could receive supervision. The certification of the Cambodia-based supervisor as an EMDRIA-recognized trainer, facilitator, and supervisor influenced whether they could also supervise therapists and students of the Trauma-Aid Germany EMDR project (TAG)—the major employers in the area. Neither organization would accept the other’s standards. Participant CA7 described that TAG did not allow EMDRIA supervisors because they were dissatisfied with the training. Concerns included students not having enough theoretical knowledge, a lack of live supervision, and issues arising when personally observing the students’ use of EMDR.

The faculty was equally divided on how they perceived TAG, but most agreed that they were playing with a strong hand and questioned their interests. A few cultural advocates felt strongly that Cambodians were already being trained by EMDRIA, and the introduction of TAG confused matters. Further, they remained concerned about the responsibility of training therapists without a TAG-specific in-country supervisor. The EMDRIA in-country supervisor suggested that they would offer services but was not invited, and often overlooked, for Trauma-Aid Germany/HAP EMDR meetings.

The Cambodian-based supervisor expressed disappointment with the two organizations, citing that their conflict was short-sighted and unfortunate. Attempts to create collaboration between the two groups failed as the groups were non-responsive to attempts, emails, and phone calls. The supervisor worried that TAG's inability to provide an in-country supervisor would mean that the TAG supervisees would contact them, and they could not refuse. However, this supervisor felt that while they wanted to help, they could not manage the additional responsibility of more supervisees.

In response to questions about the tension, CA2 stated, 'Trauma-Aid Germany is going to do what Trauma-Aid Germany wants to do. They've got their minds set on Southeast Asia.' This individual shared that they felt TAG's goal was to expand and become the recognized EMDR provider, rather than to genuinely integrate services. At the same time, almost all participants agreed that the trainings offered by TAG were in-depth and addressed ongoing needs for additional training.

Regardless of the interest group and funders (e.g., EMDRIA and TAG), participants overwhelmingly agreed with focus group members that 'EMDR is trying to show the world that it is the best' and that it was implemented not just for the sake of the locals but for promoting EMDR itself. Students and faculty members expressed concern over the students being put in the middle of EMDR politics. Students noted extreme awkwardness when working with each of the EMDR groups and when talking about one group to the other, as reported on numerous occasions by several students and faculty members. One faculty member noted that students continually expressed discomfort, both directly and indirectly, about being caught in the crossfire between the groups. Being caught in between was highlighted when several of the expatriate clinicians who were working as supervisors reported that they felt forced to leave the country due to the conflict between the associations. The students and teachers felt loyalty to their supervisors and did not know with whom to discuss future projects and translation and whom to involve in the future of EMDR in Cambodia. At the same time, TAG, as the largest employer of mental health projects at the time, offered stable positions and opportunities to work as psychologists. Many participants noted feeling excited about the opportunity to work with TAG and have funding for employment. Yet, they were also very sad to see their supervisors leave and worried about the future of EMDR in Cambodia and the safety of their clients without weekly live supervision.

## DISCUSSION

Throughout this case study, participants depicted how the political influences of therapeutic humanitarian aid occurring at the international level affect local operations and operators. Humanitarian mental health assistance in Cambodia, as in other countries, functions within a dynamic and complex social, political, and economic context (McKinney, 2007). In our study, it became clear that competing aid organizations that received funding from external sources designated the type of therapy utilized and promoted their own needs at the exclusion of others. These actions were taken to the economic benefit of the organization, including inducing therapists to pay for training and ongoing supervision, and for the exposure that occurs when a type of therapy enters a community where it was previously unavailable.

NGOs and other humanitarian aid organizations have their own political agendas (Kienzler & Pedersen, 2012; Mercer, 2002). As seen in our study, the interviewed students and faculty members felt that there were blurred boundaries between the humanitarian mission and economic objectives of the organizations' design and implementation of mental health interventions. These blurred boundaries existed within the organizations themselves, the intersections between the organizations' mission and the country's political climate, and the cultural understandings of both home and host country, and were further blurred by the political agendas of the organizations.

## THE BLURRING OF EMDR'S EFFECTIVENESS

EMDR associations refer to their research as providing evidence of EMDR's effectiveness, citing the WHO's support for its use in humanitarian situations (Van Bennekum, 2013). However, this evidence is frequently contested as having high rates of bias in research design and publishing (Cuijpers et al., 2020). According to the WHO's (2013a) report on treatment, there is no clinical consensus on EMDR's effectiveness. However, the report did suggest that EMDR could possibly be efficacious for persons with PTSD, if provided by trained and supervised therapists with adequate access to resources, including ongoing supervision (WHO, 2013a). Furthermore, it stated that evidence is lacking for EMDR's use by non-specialized persons, who do not have the capacity to make differential diagnoses, and the EMDR training manual requires a master's degree and licensure to practice (WHO, 2013a). From our study, it appears that EMDR's international push into Cambodia has disregarded the WHO's recommendations and EMDR's own training. It was clear throughout the study that the EMDR associations within Cambodia frequently trained non-master's level clinicians, that there was a lack of consistent supervision, and a significant lack of available resources.

## THE PROBLEMATICS OF EMDR'S PUSH

For any aid organization to thrive and survive, the services that it provides must be accepted in the local context and show evidence of positive results (Kienzler, 2019, 2020). In our study, the need for credibility created a dynamic wherein the programs appeared to compete for providers and resources. Students were trained in traumatology and in the use of EMDR, often in conjunction with the organizations. Depending on which aid organization trained the students, they had the possibility of being hired. On the one hand, this provided needed employment to Cambodians; on the other hand, as community members became staff members, it appeared to create local receptivity to the aid interventions simply because of the possibility of gaining employment. Thus, there was a broader local acceptance of the program, which then could signal the success of the program to funders and government organizations. According to similar studies on humanitarian aid and mental health, simply the appearance of support for one approach over another provides legitimacy and interest in that approach (Kienzler, 2019, 2020; Pupavac, 2002). Another problem is that once funding is depleted, there is no method of continued sustainability, and aid organizations may leave to their home countries without infrastructure in place in the host country (Kienzler, 2019).

In the USA and other countries, it is becoming increasingly common for professional ethics to imply that providers should leave a small cultural footprint, adapt to the local culture, and not force their own culture on the communities (Jordan, Anderson, & Hall, 2021; Jordan, Seponski, et al., 2021; Seponski et al., 2013). Yet, when humanitarian programs come to host countries, the interventions run the risk of being culturally inappropriate while increasing the focus on decontextualized suffering (Pupavac, 2002). It is postulated that when aid programs treat mental health problems, they assign an overarching mental health diagnosis to a community that is experiencing normal distress responses during disasters (Pupavac, 2002; Summerfield, 2008, 2013).

Many in the field of EMDR see global trauma as an issue of historic proportions and suggest that EMDR can cure a variety of manifestations of trauma, such as interpersonal violence, while promoting increases in a community's economic, social, and cultural productivity (Gelbach, 2014; Shapiro, 2014). Authors have suggested that millions of people are exposed to traumatic events every year and have no access to treatment (Benjet et al., 2016). Kienzler (2020) described the challenges of mental health humanitarian aid when treatment depends on the clinical population 'fitting' into a diagnostic category—in Cambodia's case, post-traumatic stress. She found that in Kosovo, when international mental health was imported to a resource-scarce context, practitioners reduced complex responses to distress to produce 'diagnosable and treatable patients' (Kienzler, 2020, p. 60). As clients were created, the treatments were necessitated.

In our study, it was clear that the aid programs were aimed at training the providers in EMDR with a focus on trauma, and many interviewees felt that there was no real

consideration of Cambodia's unique context. Instead, they were expected to treat their clients with treatments designed for post-traumatic stress, which required having traumatized clients. As our participants shared, they felt it would be better to have a broader training experience that could enable them to work with multiple clinical issues. Participants routinely expressed concerns that EMDR was not being specifically adapted or evaluated for Cambodians. Consequently, the aid programs risked pathologizing community response to possible trauma, and overlooked the resiliency and traditional methods of healing indigenous to Cambodia (Kienzler, 2020).

Our results align with the WHO (2013a), which suggested that the use of EMDR in diverse situations must proceed with caution, as cultures may interpret the method as inappropriate. Authors have emphasized the importance of cultural consideration of individualistic Western ideals, in which diagnoses such as PTSD are based, as well as treatments that coincide that might not be applicable in collectivist cultures (Jordan et al., 2019; Seponski et al., 2014). In our observations, it did not appear that the EMDR implementers took a culturally informed approach to clinical training and service implementation. Instead, participants described how the aid organizations replicated the dominant power structures that are disempowering to Cambodian therapists.

According to participants, the focus on EMDR specifically was less appealing; rather, what was considered most beneficial would be continued support for, and training of, multiple modalities of mental health treatment. However, there was also clear recognition that with a lack of infrastructure and funding, they were at the mercy of aid organizations. All the participants felt that an important step for all of Cambodia would be the creation of a general psychology association, with a possible EMDR special interest group. Less clear was what the existence of such an association would look like and who the leaders would be, but they desired to help take on that role. If an EMDR association was formed, S8 suggested that doing so in a culturally responsive manner would assist in creating genuine engagement with the modality. Participants' suggestions included engaging students of RUPP as members, providing additional training, offering EMDR workshops led by experts and experienced clinicians, and developing an EMDR research project to investigate applied clinical services in Cambodia.

## **CONCLUSION**

Humanitarian efforts are determined by many factors, including local and national resources. The availability of trained professionals (O'Hanlon & Budosan, 2015) combined with a lack of a coordinated plan of intervention can reduce the impact of aid provided (Dickson & Bangpan, 2018). The global mental health movement promotes the dependence of LMICs on foreign diagnoses for understanding distress and, thus, foreign aid and practices to promote healing (Titchkosky & Aubrecht, 2015). This cycle of distress, diagnosis, and aid furthers the

colonization of LMICs, as the medical movement spreads with the globalization of mental health, often at the expense of considering the impacts and complexities of social inequalities that affect the human condition and the problems that mental healthcare attempts to solve (Titchkosky & Aubrecht, 2015). The conceptualization of what encapsulates a mental health issue as well as a health concern is not singular in nature but is dependent on social and local concepts. When interventions are blindly adopted from one culture to another, we risk neglecting the unique problem-solving and coping skills of the community. Attempts to intervene can devalue the cultural knowledge and resources of a population and impede the normal processing of events that occur. This engages a system whereby distress is medicalized and pathologized without attempting to uncover how such distress might be growth inducing, healing, and community building. As seen in the case study of Cambodia, EMDR, and humanitarian aid, global mental health movements are pushing ideas of PTSD and trauma while simultaneously pushing the application of EMDR. For the country to truly heal from its history of colonization and autogenocide, it must be supported in developing and studying therapies specific to Cambodia. Aid organizations can support these efforts through assisting in training, developing, and evaluating multiple modalities and their ability to culturally respond to social problems.

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## ACKNOWLEDGEMENTS

This work was supported by a Fulbright Program grant sponsored by the Bureau of Educational and Cultural Affairs of the United States Department of State and administered by the Institute of International Education; the University of Georgia Graduate School Deans Award, Social Sciences; and University of Houston—Clear Lake Faculty Support Research Funds.

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