Paper 9

Acquiring expertise on the field of intervention

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Learning the intervention: the case of Cambodia

Cambodia, like Kosovo, has endured a recent history of turmoil. Like Kosovo, these years were not isolated, but exist within the broader setting of more than 500 years of war. The issues or points that we are now considering, genocide and auto-genocide, their context of war and migration both external and internal, are similar to those of my experience in Cambodia. Likewise, they are to be considered not only as a fragment of time but diachronically, over a long period of time.

Beyond these violent situations, both in Cambodia and in Kosovo, lie the existing local systems of belief about suffering, wellness and illness. In either culture, there is a hierarchy of resort in case of need; the people within the community networks to whom others used to turn, still turn or might turn in these difficult times. Any intervention, if it were to be successful, must therefore begin with a knowledge of this existing network, as well as of methods by which we might discover more.

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Moreover, once these local resources have been identified, the knowledge acquired from them must be applied to improve methods of training and research, as well as curriculum, policy, fundraising and collaboration with other groups.

The early intervention, and the concept of cultural bereavement

In 1980, when interventions were first attempted in Cambodia, the South-East Asian refugees had been through a period which is roughly similar to the more recent experience of the Kosovars. There had been large-scale genocide followed by war, and there had been a time since the war had ended. The people still faced civil conflict, unrest, poverty and sickness. There were no local resources: the health system had been decimated and the war had affected other social structures necessary to the normal lives of the Cambodians.

The challenge of working in resettlement countries, which is ours today as it was the challenge of the United States, Canada or Australia then, was to find ways to prepare the mental health system so as to receive these people and to deal with the kind of difficulties they might bring. It thus became apparent that in 1980, the science of psychiatry was not prepared for the problems that were to arise. At that time, Post Traumatic Stress Disorder (PTSD) had not yet been invented. We, as psychiatrists, were still working with the previous taxonomies which had come to us from Switzerland. The whole question of trauma, loss, and so forth were linked to *Heimweh* and *Nostalgie*. These were the disorders first identified in Swiss mercenary soldiers who, dispatched far from home, returned in misery, and this was perhaps the forerunner of the concept “PTSD”.

But there are alternative ways of seeing what we call PTSD. It was apparent that these displaced were searching for an identity. For this reason, most psychiatrists began by looking at acculturation, at how different the refugees were from the people of the host country in language, custom, and so on. There were acculturation scales, and many people would be “rated” as to their distance from the new culture. Beneath this was the notion of alienation: to what extent the resettled felt powerlessness, normlessness, meaninglessness, isolation and self-estrangement.

In retrospect, however, it seems that more important than acculturation was the root of this cultural alienation, the sense of bereavement which was not only individual, but also collective. In this context, 20 years ago, the notion of cultural bereavement was coined. It was the experience and reaction not only in the individual, but also

in groups of people, to the loss not only of their homeland, previous status and social structure but also of the cultural "meaning of life", that erupted into a collective syndrome (Eisenbruch, 1987; Eisenbruch, 1989; Eisenbruch, 1991).

We attempted to understand how this idea of cultural bereavement might be applied to health services and policies (Eisenbruch, 1990). One antidote to the collective suffering was found in ritual. By rediscovering rituals lost after flight from the homeland, people were able to create and revive the attachments that had been lost in time and space. These latter attachments were not only mental or spiritual but also "supernatural".

This last word is seldom acceptable in professional, "unsupernatural" circles, and yet it should be remembered that - regardless of the well-intended body of western expertise - the traditional healers and Buddhist monks would have been the best gatekeepers and health workers.

The traditional Cambodian healers, however, were absent at the time, because the International Committee for Migration (ICM), which then handled these migrations, was not empowered to select their workers. Host countries did not see the importance of recruiting healers and monks, so these tended to remain in the camps like the other refugees. On the other hand, when such people were found and allowed to interact with the other displaced Cambodians, incredible results followed. Rituals were carried out, reparation ceremonies were performed for those who had been left in the homeland, whose bodies had never been found and never buried or cremated. By carrying out these rituals, the Cambodians were able to focus on the future through a healing of their past.

As they learned to cope with the problems, the Cambodians began to accept their experiences. They spoke of the past in ways that worried trauma counsellors of the time, because according to the early benchmarks of the 1980s, refugees should not be encouraged to open up to their stories. It was believed better for victims to seal off their history, to move on, and the counsellors were then unprepared for this new acceptance, which later proved beneficial.

Moving upstream

There were at times five or six thousand, at times ten or 20 thousand people in one part of Australia, Canada or another refuge, and yet it seemed absurd to be spending so much time and effort working with one group when the bulk of the people were in the country from which they had fled; in the homeland that, as a "communist enclave", was cut-off from the West. One could not even fly to Cambodia other than through Vietnam. Around 1989, the strategy of the intervention thus

shifted to a move "upstream", towards the source of conflict. This return to Cambodia was important for its humanitarian aspect, but also for our increased understanding of the problems. A study was begun in this broken homeland, starting with a search for indigenous concepts of mental health.

During this seminar, reference has been made to psychiatry, neuropsychiatry and counselling, as adapted to the culture's notion of mental health and suffering. Traditional healers were discussed as a medium, through which patients might be helped, and comments have been made about whether these special practitioners still exist within this moving target of culture.

Though it is accepted that culture is dynamic, not static, this return to tradition is by no means simply a yearning for "the world we have lost". In Cambodia's communist period, for instance, there were at first no healers to be found on the surface of society, just as in Australia or other "more developed" cities there seemed to be none. The people asked answered mockingly that these were relics of the past. They spoke the voice of the Khmer Rouge, echoed by the drumbeat of the Vietnamese regime that came after that. "Those were primitive beliefs, we do not want to go back to them", they answered, or, "We are an agrarian socialist collective society and these superstitions have no place here anymore." In fact, the healers did exist, but underground. They hid because, had their practice been uncovered, they ran the risk of summary execution. Cambodians would go to them in secret. Their practice was comprehensive, combining technology, systems of diagnosis, explanation, therapeutics and treatment to manage a wide range of mental health and psychosocial problems. It became one of the goals of the action research in Cambodia to learn from their methods.

Piece by piece, working with healers in this clinical-ethnographic approach, we began to understand the grammatical rules of the newly rediscovered logical map of the mind. Our approach was a humble one, in that we had to avoid superimposing western psychiatry, but to start afresh, as the experts were the healers and their patients.

We learned from this approach (and echoes appear in some of the reports from anthropologists in the Kosovo project) that there are ways in which one can divide mental suffering into causal categories: natural or supernatural, self-caused or caused by spirits, caused by recent actions or by those committed in previous lives and so on, which might be understood and accepted by a people not trained in western psychiatry. Elaborate maps of this logic can be drawn from these categories, and choices can be made accordingly (Eisenbruch, 1999; Eisenbruch, 1998; Eisenbruch, 2000). Perhaps this approach can be incorporated as a module into the curriculum of the programme in Kosovo.

Applying "supernatural" methods to the concrete

This general, local means of understanding mental health could then be applied to particular problems. For instance, we might see that the main health issues in countries like Cambodia or Laos are no longer issues of mental health. Ministry officials and Non Governmental Organizations (NGOs) will agree that the main problems reside in HIV/AIDS, in malaria or in lack of hygiene. "Psychosocial issues can wait before we solve vital problems, issues of life or death", they remark. But the life-and-death issues of HIV/AIDS and malaria, however, are riddled with mental health problems. They are there, in questions like "Am I going to die because my husband went to work in the next village and brought me illness?", "Is my child going to die because my husband got AIDS?", "Am I going to die because I have to go to the forest to cut timber to feed my children or because I have to go where there are landmines?", etc. Such are the ubiquitous problems in countries undergoing post-war reconstruction and development, and the mental health questions remain.

It thus becomes necessary to apply the new research approach to these areas, to see if in understanding these problems we could use our new knowledge in other ways. HIV/AIDS, for example, is a problem that is going to face Kosovo. It will arise in East Timor, and, just as it has plagued Cambodia, it will plague Laos. Countries recovering after difficulties will have to face these new problems, and we must ask now how we are to persuade a people that a disease of which they have no understanding could destroy them, as well as how we are to teach them what they can do to stop it.

Training therapists and community development

The experiences outlined here have not been attempted in Kosovo, nor do they draw upon particular "Balkan" expertise. Each professional must decide for themselves whether these few points might be of relevance to this new problem, and to the situations faced in Kosovo.

Returning, full circle, to the subject of Cambodia, it should be added that in the beginning, it was not known whether the healers were helpful or would ever be so. We, as western professionals, only knew what we saw on the field, in our ethnographic work. As we took this information back to Phnom Penh University, we realized that there were no psychologists there. There were paedopsychiatrists, trained in Belgrade, Moscow or other countries, and these were professionals in certain

aspects of psychology that were foreign to ours. They did not see the relevance of our approach, so our methods ended there. We also observed the methods of certain NGOs who came, but we did not work with the Ministry of Health, because it was centrally organized; working from the top of society downwards, and believing in vertical programmes of past eras.

There was another ministry however, the Ministry of Rural Development, which worked from the bottom up and believed in village development. Working in parallel with the outlook of this Ministry, we allowed ourselves to accept a goal of community health and development from which we even, at times, dropped the word "health" altogether, to stay focused in the right direction. It was eventually found that when "psychosocial" approaches, rather than "community" interventions were attempted, they led us away from the core and worked only for fundraising.

We found ourselves, instead, leaving the towns to work in the villages ever further from the provincial capitals, where there were few doctors and no known notion of psychiatry. In these places, where the word for the mentally ill patient in Cambodian could raise mockery and fear rather than sympathy and understanding, we began to work within the categories and languages we learned from the village elders, traditional birth attendants and other people who controlled and shaped behaviour: the decision makers of each village. The people knew the value of their healers because they existed within their lifestyle. They did not see the value of new mental health programmes, because they had never encountered them before.

According to this method, we started to train a group of community workers, who would later train other workers in the usual cascade approach of barefoot community projects. In order to create a programme, we began with the World Health Organization (WHO) and the United Nations High Commissioner for Refugees (UNHCR) manuals for refugees, but rewrote them according to the experiences particular to the field. Our new manuals were based on essential "barefoot mental health knowledge", because it was important that the people at least recognize psychosis, suicide and dangerous behaviour in order to save lives, but this knowledge was then combined with the local information we had gathered. We worked with the healers not as people whom we would train but who would be auxiliary sources of information for the development of our programme. Though they did become part of our group of trainees, they were not taught to be mental health workers, but collaborators (Somasundaram et al., 1997).

The local approach

In conclusion, we must remember that every society has its local beliefs, this should be self-evident. After a period of war, these beliefs are threatened and even more so after the reign of a totalitarian regime which drives them underground. We cannot, of course, resurrect what no longer exists, it cannot be done, but I would think, based on my experience in one country, that it is possible to hunt and find what is important to the people now, in this February of the year 2000.

It may be folklore or dance, it may be songs or melodies, theatre or ritual. We might spend three months working with songs or protective amulets to discover how they affect the way that people deal with landmines or other risks they face. Each people will have its amulets, songs or rituals that allows them to deal with the dangers and risks of their daily lives. By proceeding step by step, learning with the people, we might discover that there are healers in Kosovo. It is no longer enough to arrive with our set questionnaires, our aerial photography and our set hypotheses. We will not help a people by pushing them into fixed theoretical categories, but only through a flexible and understanding "soft" approach that attempts to help them within the world that they had heretofore known.

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