An Elusive Consensus: Mental Health and Psychosocial Support in Disasters and Emergencies Since 1980

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Abstract

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Mental health and psychosocial support (MHPSS) has become an increasingly common form of humanitarian aid in disasters and emergencies, particularly since the publication of the influential *IASC Guidelines* in 2007. Despite increased acceptance of and attention to MHPSS within the humanitarian field, fundamental questions about the logic and practice of MHPSS remain unresolved. Drawing from and contributing to scholarly literature in feminist political geography and science and technology studies, this dissertation investigates the policies, politics, and practice of MHPSS in emergencies through qualitative interviewing, archival research, and content and discourse analysis of standards and guidelines for this form of humanitarian aid. Previous scholarship critiquing the inclusion of mental health and psychosocial interventions within emergency humanitarian response does not adequately account for the central divisions and debates that have characterized the MHPSS field for decades—or for the ontological and

epistemological multiplicity underlying these debates. In contrast with framings of MHPSS as a field that is characterized by professional consensus, I argue that key questions about MHPSS as a domain of expert knowledge and practice remain unresolved. This lack of consensus stems, in part, from a tension between conceptualizations of MHPSS as a standardized, technical practice, and as an intimate and humane form of care. This research adds depth and nuance to critical scholarship on MHPSS in humanitarian emergencies by analyzing three interrelated areas of dissensus within the humanitarian field: trauma and PTSD as objects of expert intervention in disasters and emergencies; the role of medicalized mental health care in humanitarian emergency response; and systems of classification that are foundational to the practice of MHPSS in emergencies.

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List of Abbreviations Used

Abbreviation	Meaning
CFS	Child-friendly space
DSM	Diagnostic and Statistical Manual of Mental Disorders
ECHO	European Community Humanitarian Office
GBV	Gender-based violence
GMH	Global Mental Health
IASC	Inter-Agency Standing Committee
ICD	International Classification of Diseases
ICRC	International Committee of Red Cross and Red Crescent Societies
IHL	International humanitarian law
MENA	Middle East and North Africa
mhGAP	Mental Health Gap Action Programme
MHPSS	Mental health and psychosocial support
MNS	Mental, neurological, and substance-use disorders
MSF	Médecins sans Frontières (Doctors Without Borders)
NGO	Non-governmental organization
OCHA	United Nations Office for the Coordination of Humanitarian Affairs
PFA	Psychological first aid
PTSD	Post-traumatic stress disorder
SGBV	Sexual and gender-based violence
UN	United Nations
UNHCR	United Nations High Commissioner for Refugees
UNICEF	United Nations International Children's Emergency Fund
WaSH	Water, sanitation, and hygiene
WHO	World Health Organization

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Chapter I – Introduction: Unresolved Questions and Conceptual Confusions in the MHPSS Apparatus

Disasters and emergencies—ranging from natural disasters to industrial accidents to violent conflicts to protracted wars—are often understood to cause psychological as well as material damage for the communities they affect. The *New York Times* described Hurricane Maria as “a 72-hour assault on the Puerto Rican psyche” (Dickerson, 2017). The medical humanitarian organization Médecins Sans Frontières (MSF) provided “psychological first aid” as well as “medical first aid” to Mozambicans displaced by civil war in 2021 (Lohmeyer, 2021). A network of psychologists in Ukraine established crisis hotlines in response to the Russian invasion of their country in 2022 (Shilonosova, 2022). Unlike the material destruction and physical injuries that result from disasters and emergencies, however, these impacts on mental health are difficult to locate, difficult to measure, and difficult to see. They are often described as “silent” or “hidden,” and a common metaphor for the mental health effects of disasters and emergencies is that of the “invisible wound” (Mollica, 2008; Tanielian and Jaycox, 2008). Accordingly, addressing mental health poses unique challenges for humanitarian emergency response.

For decades, mental health care in disasters and emergencies has been an exceptionally contested and controversial form of humanitarian aid. Experts in this field have disagreed about which types of mental health care are appropriate to provide, which humanitarian agencies and actors should be responsible for mental health and psychosocial wellbeing, and, ultimately, whether it is appropriate and necessary for mental health care and psychosocial support to be included in humanitarian emergency response at all. Until, approximately, the end of the Cold War, humanitarianism “meant relief and nothing but relief” (Barnett and Weiss, 2011, p. 5): the

proper scope of humanitarian intervention was understood to be limited to meeting immediate needs, divorced from larger social, cultural, and political contexts. Humanitarian aid during this period focused narrowly on what one expert in international disaster management called the "classical refugees' problems" (Lechat, 1986): the need for food, shelter, water, and other basic requirements for ensuring the biological survival of human beings affected by disasters and emergencies. More recently, this assumption that the aim of humanitarian assistance is solely to preserve life has been called into question, with attention to ensuring human rights, dignity, and wellbeing taking on a more prominent role within humanitarian emergency response. Mental health care and psychosocial support have been a key component of this expanded vision of humanitarian aid. Mental health interventions have become a common and widely accepted element of humanitarian emergency response (Jones and Ventevogel, 2021), and current minimum standards for humanitarian intervention specify that mental health and psychosocial support are an essential component of humanitarian aid, and that they should always be made available in emergency settings (Sphere Association, 2018). Questions remain, however, about the nature, function, and objectives of mental health and psychosocial support in disasters and emergencies as a matter of policy and practice.

In this project, I seek to add depth and nuance to the existing scholarly literature on mental health and psychosocial support (MHPSS) in emergencies by investigating a set of interrelated, unresolved questions about trauma and PTSD in disasters and emergencies; the role of medicalized mental health care in humanitarian emergency response; and multiple systems of classification that are foundational to the policies and practice of MHPSS in emergencies. The field of MHPSS is often represented as having reached a *consensus* among competing frameworks, paradigms, and technical approaches toward mental health and psychosocial

support after decades of debate, division, and controversy (e.g. Ager, 2008; van Ommeren, Saxena, and Saraceno, 2005; Ventevogel, 2018). The idea of consensus in the MHPSS field is closely linked to the development of a set of highly influential guidelines, the *Inter-Agency Standing Committee Guidelines on Mental Health and Psychosocial Support in Emergency Settings* (IASC, 2007; hereafter referred to as the *IASC Guidelines*)[1]—and to the adoption of the composite term "MHPSS" itself. The consensus that guided the development of the *IASC Guidelines* was based in a shared understanding among experts from a variety of disciplines and backgrounds that "exposure to extreme stressors is a risk factor for social and mental health problems…[and] emergencies can severely disrupt social structures," including systems for providing mental health care (van Ommeren, Saxena, and Saraceno, 2005, p. 72). This collective belief that the impacts of disasters and emergencies on mental health constitute a social problem that compels remediation by experts lies at the heart of the purported consensus on MHPSS among experts and practitioners in the field. I argue, however, that in several key areas, the field of MHPSS has *not* reached consensus—and that achieving consensus about the nature of trauma, the implications of medicalization in mental health care, and the classification of MHPSS within humanitarian emergency response may not be possible or, perhaps, desirable.

Michel Foucault used the concept of the apparatus (or *dispositif*) to describe a "formation which has as its major function at a given historical moment that of responding to an *urgent need*" (Foucault, 1980, p. 195, emphasis in original). It is just such an apparatus—a constantly evolving "system of relations" (Foucault, 1980, p. 194) among heterogenous discursive and material elements arranged in response to a social problem—that I take as the focus of my analysis in this dissertation. The apparatus is a key (and contested) concept within assemblage

[1] For a detailed description of the development of the *IASC Guidelines*, see Wessells and van Ommeren (2008).

theory, which “emphasise[s] emergence, multiplicity and indeterminacy” in social forms and processes (Anderson and McFarlane, 2011, p. 124). The apparatus can be considered a form of assemblage that regulates and governs (Legg, 2011), but that is contingent and continually in flux. Perhaps fittingly for a set of concepts that are associated with heterogeneity, change, and messiness, the assemblage/apparatus distinction is a matter of considerable academic debate (Legg, 2011), and the two terms lack agreed-upon definitions in the scholarly literature. For the purposes of my analysis, however, MHPSS can be usefully described as an apparatus that brings together standards, bodies of knowledge, ethical imperatives, institutions, and practices from multiple interrelated fields, and that has come into being to produce technical solutions to the problem of mental health and psychosocial wellbeing in disasters and emergencies. This process of “rendering technical”—which “confirms expertise and constitutes the boundary between those who are positioned as trustees…and those who are subject to expert direction”—underlies the production of what Tania Li has called “improvement schemes” such as humanitarianism and international development (Li, 2007, p. 7). To render technical is also to render nonpolitical (Li, 2007)—a particularly salient characteristic in light of the idea of a physical and metaphorical “humanitarian space” that exists outside of politics, ostensibly allowing humanitarian organizations to adhere to the principles of independence and neutrality (Hilhorst and Jansen, 2010). The question of whether (or to what extent) MHPSS is a technical domain of knowledge and practice is a theme that I examine throughout this dissertation, particularly in relation to the medicalization of mental health care.

The MHPSS apparatus came into being in its current form in the mid-2000s, precipitated in part by the perceived mental health consequences of the 2004 tsunami in Southeast Asia (Wessells and van Ommeren, 2008) and emblematized by the publication of the *IASC Guidelines*

in 2007. Yet many of the institutions, bodies of expert knowledge, and standards of practice that make up this apparatus overlap and intersect with several earlier precursor fields that aimed to address the impact of situations of exceptional disruption, displacement, and violence on mental health and psychosocial wellbeing. These include disaster epidemiology, refugee mental health, humanitarian psychiatry, and psychosocial humanitarian aid in war. In order to better understand the contemporary practice of MHPSS, in this project I analyze key texts and archival sources related to these earlier projects in addition to standards and guidelines that are in current use. My analysis draws upon empirical evidence from archival research that I conducted at the World Health Organization (WHO), the United Nations (UN), and the United Nations High Commissioner for Refugees (UNHCR), and a content and discourse analysis of key handbooks, standards, guidelines, and other texts that guide the practice of MHPSS. I also conducted semi-structured interviews with professionals currently working in the MHPSS field to gain insights into how these written standards have been developed by policymakers and put into practice by humanitarian aid workers in disasters and emergencies.

My findings from this research indicate that, contrary to dominant narratives depicting MHPSS as the product of a professional consensus, foundational questions about the practice of MHPSS in emergencies remain unanswered and underexplored. There is an ongoing, unresolved, and possibly unresolvable, tension between a conceptualization of MHPSS as a practice that is technical, specialized, and medicalized on the one hand, and intimate, humane, and intuitive on the other, reflecting ontological and epistemological divisions within the field. A comment from one of the MHPSS professionals whom I interviewed captured this tension aptly: she told me that a set of standards for the treatment of depression had "shown good results," but that "[she] would feel like [she] was in a straitjacket" if she had to use them in the field. While advocating

for a standardized approach to care in general, she resisted having to follow such rigid, routinized, impersonal protocols when providing care herself. In this dissertation, I explore this ambivalence about the conceptualization of MHPSS as a technical practice through an analysis of several interrelated areas of disagreement among experts and professionals in the field. In what follows, I situate my analysis of the nature and implications of this dissensus within theoretical conversations about the politics of humanitarianism; the medicalization of mental health care; and the production of objects of expert intervention through the processes of standardization and classification. I conclude by providing a brief summary of each of the remaining chapters of this dissertation.

Political geographies of humanitarianism, mental health, and "therapeutic governance"

Humanitarianism is a term with multiple, interrelated meanings. It is sometimes used as a general synonym for altruism, or compassion for strangers. Many things that are described as "humanitarian" represent certain types of exceptions to general rules: namely, these are exceptions that are made in response to unusually acute human suffering. Drugs and medical devices not available to the general public might be approved for humanitarian use for extremely ill patients; incarcerated people with terminal illnesses might be granted humanitarian release. The meaning of humanitarianism that is relevant to this dissertation is also associated with states of exception and a concern with the suffering of others. The humanitarian organizations and agencies involved in MHPSS in emergencies are motivated by a commitment "to prevent or alleviate human suffering arising out of disaster or conflict" (Sphere Association, 2018). The logic and rhetoric of humanitarianism is universalizing, and its written standards theoretically apply equally to all populations everywhere. In practice, however, transnational humanitarian organizations and agencies typically operate in countries where local resources are insufficient

for coping with disasters and emergencies. Global inequalities in risk associated with disasters and emergencies profoundly shape where, when, by whom, and under what circumstances these humanitarian actors provide aid.

Humanitarianism is inescapably (geo)political. Existing scholarship in geography and the critical social sciences on the politics of humanitarianism has analyzed its deep links to militarism (McCormack and Gilbert, 2022) and its complex role in both responding to and facilitating violence (Lopez, Bhungalia, and Newhouse, 2015; Weizman, 2011). Simon Reid-Henry (2014) has argued that humanitarianism has come to play a central and “diagnostic” role within political liberalism; according to Didier Fassin, “the humanitarian reason associated with human rights” constitutes the moral foundation of the modern biopolitical state (Fassin, 2013, p. 39). In disasters and emergencies, humanitarian intervention is fundamentally driven by a desire to preserve life; the extension of this mandate beyond ensuring physical survival to a concern with human dignity and holistic wellbeing raises important questions about the biopolitics and geopolitics of humanitarianism, and its implications for the beneficiaries of humanitarian aid (Newhouse, 2015; Redfield, 2005). Mental health and psychosocial support are typically considered to exceed the limits of the narrower vision of humanitarian intervention that is strictly concerned with saving lives. In relation to preventing deaths by suicide, however, mental health care *is* a matter of life and death—a fact that, as I will discuss in the last chapter of this dissertation, humanitarians are forced to contend with in certain extremely fraught ethical and political circumstances.

Just as mental health has traditionally played a peripheral role in humanitarian emergency response, the rich and insightful body of scholarship on the politics of humanitarianism[2] largely

[2] See also Barnett, 2013; Barnett and Weiss, 2011; Fassin, 2012, and Reid-Henry, 2013.

does not focus on the relationship between humanitarian intervention and mental health. There are several suggestive parallels and intersections between the logics of these two fields, however. Humanitarian emergency response and mental health care, in different ways, are driven by an ethical imperative to alleviate human suffering, but also to impose order onto that which is unruly, chaotic, and irrational. “There is no care without control” in humanitarian intervention (Agier, 2011, p. 4), and mental health professionals must sometimes balance compassion with coercion when providing care (Brodwin, 2013). Julian Reid has argued that “the humanitarian emergency…is today conceived as the primary locale for the transformation of ungovernable peoples into governable populations” (Reid, 2010, p. 390), and assigns an unusually central role to mental health in his analysis of the politics of humanitarianism. He writes that “the humanitarian will to govern and transform” the societies in which they intervene is based in the identification of “dysfunctionality” within those societies, and that programs aimed at supporting mental health and “psychosocial survival” are an important means of framing that perceived disfunction (Reid, 2010, p. 400). Vanessa Pupavac (2001, 2002, 2004, 2012) coined the term “therapeutic governance” to describe “psycho-social intervention as a new form of international governance based on social risk management” (Pupavac, 2001, p. 358). Her development of the concept of therapeutic governance has informed the work of Reid (2010) and some other political scientists analyzing the geopolitics of humanitarianism (e.g. Duffield, 2007), but has undergone little critical evaluation in the scholarly literature (though see Rehberg, 2015). Pupavac’s work raises provocative questions about how psychosocial interventions might “pathologize populations” and “colonize minds” (Pupavac, 2004, p. 489). Much of her analysis, however, appears to be empirically based in her readings of reports and handbooks published by humanitarian organizations, with limited information or insights about how psychosocial

interventions actually operate on the ground. At times, her critiques go so far as to suggest that psychosocial programs in wars and other violent conflicts could cause greater psychological damage for the intended beneficiaries of this aid than their experiences of war itself. Pupavac's analysis of psychosocial programs also overlooks important divisions and tensions within MHPSS and its precursor fields, and does not distinguish between medicalized mental health care and forms of psychosocial support that are not based in a biomedical model. Though the distinction between mental health and psychosocial support is complicated and sometimes ill-defined, erasing or ignoring it altogether leads to an excessively reductive view of the field of MHPSS.

The analytical sensibility and conceptual lens that I bring to this project is informed by feminist geopolitics and feminist political geography. This body of scholarship, which extends insights from critical geopolitics and puts otherwise disparate literatures in feminist geography and political geography in conversation with each other, offers a powerful critique of dominant geopolitical epistemologies, reframing what counts as legitimate geopolitical knowledge (and who can produce this knowledge), and calling for attention to multiple forms of violence, both "fast" and "slow," that are effected by war and displacement (Hyndman, 2004, 2019). Feminist geopolitics also brings careful attention to materiality (Dixon, 2015) and to the multiple scales at which geopolitical processes occur, especially the scale of the body (Hyndman, 2019). Feminist theory reveals that "the intimate is inextricable from the global" (Mountz and Hyndman, 2006, p. 448), and the illumination of the *intimate* dimensions of geopolitics (Brickell, 2014; Smith, 2012) is particularly salient to my research in this project. Mental health care and psychosocial support are distinctively intimate forms of humanitarian aid, and its effective provision requires access to private space that is not typically possible in emergency settings. Additionally, the

mental health consequences of rape and other forms of sexual and gender-based violence are positioned as exceptionally important matters of concern within the MHPSS field and its antecedents. (This has manifested in sometimes surprising ways, particularly in relation to the expert perspectives on trauma that I analyze in Chapter III of this dissertation.) I seek to contribute to this body of scholarship by bringing attention to the ways that trauma and mental health more generally have been constructed as objects of expert knowledge and management within the MHPSS apparatus.

Mental health and medicalization

Mental health is hard to talk about: it blurs the boundaries between medical, psychological, cultural, and, at times, spiritual ways of knowing and managing human experience and suffering. Even very basic terms in the field can be confusing: we might talk of mental illnesses, mental disorders, or mental conditions, but rarely of mental disease. (Throughout this dissertation, I use the term "mental disorder," primarily for the sake of consistency.) We often use the term "mental health" to signify its lack. Calls for increased mental health awareness that conflate the term "mental health" with mild or moderate depression, anxiety, and difficulties of everyday living can paradoxically erase the experiences of people with severe mental disorders (Green, 2022). The quotation below by the philosopher Ian Hacking captures some of the complexity and multiplicity associated with understandings of mental health and mental illness:

> "Ludwig Wittgenstein said that in psychology there are experimental methods and conceptual confusion. We have more than that for the mental illnesses. We have the clinical methods of medicine, psychiatry, psychology; we have the innumerable variants of and deviations from psychoanalysis; we have systems of self-help, group help, and counselors including priests and gurus; we have the experimental methods of

> biochemistry, neurology, pathology, and molecular biology; we have the theoretical modeling of cognitive sciences; and we have conceptual confusion.
>
> "Perhaps all our problems will be erased when we have enough objective scientific knowledge. I have another view. We do have a limitless reservoir of ignorance, but we also have conceptual confusions that new knowledge seldom helps relieve." (Hacking, 1998, p. 10)

Hacking argues that these "conceptual confusions" mean that the production of new scientific knowledge will not resolve frictions and conflicts among the multiple domains of knowledge, practice, and belief that circulate through the mental health field. The limitations of biomedical explanations for mental disorders and their treatments, however, do make mental health a particularly ontologically and epistemologically interesting subject of inquiry. Though significant advances in biological understandings of mental health and mental illness have been made, there are persistent uncertainties about the relationship between the biological and the social in relation to mental illness (Kleinman, 1988; Pickersgill, 2011). Contestations of the medicalization of psychological suffering are a major focus of my analysis in this dissertation; the scientific uncertainty about the biological basis of mental health forms an important backdrop for the ambivalence toward medicalized mental health care that I have found to be a durable tendency within the MHPSS field.

The transcultural validity of Western mental health paradigms and practices has been the subject of vigorous and sometimes acrimonious debate, at times producing "a hostile intellectual climate within the international mental health arena" (Cooper, 2016, p. 356). These intellectual debates are certainly salient to mental health in disasters and emergencies, and the applicability of psychiatric diagnosis and treatment in these contexts is further complicated by the fact that "it has been difficult for mental health professionals to determine what constitutes an appropriate

psychological reaction…[to] torture, genocide, and mass rape" (Brennan and Nandy, 2001, p. 152). Distinguishing between what is normal and abnormal is a fundamental component of the medicalization of psychological distress and suffering, but this determination is especially challenging to make in disasters and emergency contexts—which are by definition abnormal circumstances themselves.

Mental health has been a focus of inquiry by multiple intellectual communities within the discipline of Geography, with concepts like therapeutic landscapes (Gesler, 1992, 2005; Williams, 2007) and psychoanalytic geographies (Kingsbury and Pile, 2014) bringing particular attention to cultural and symbolic dimensions of mental illness and wellness. Geographers have explored the relationship between space, place, and mental health, including the ways in which the material landscape affects risks and possibilities for mental health and psychosocial wellbeing (Curtis, 2010), and the lived experiences of people with mental disorders (Parr, 2008). This literature has tended to be strongly focused on the Global North (though see McGeachan and Philo, 2017), and while the geography of asylums, psychiatric hospitals, and other spaces of mental health care has been a significant field of inquiry in the discipline (Philo, 2005), less attention has been paid to the multiple ontologies and epistemologies that circulate within the mental health field itself.

Points of dissensus: objects, standards, classifications

In this dissertation, I explore the *lack* of consensus in the MHPSS field in relation to a set of key objects of expert intervention and systems of standardization and classification. Many of the objects of MHPSS interventions (such as trauma, dignity, resilience, distress, wellbeing) are intangible and difficult to precisely define, measure, and document. They are therefore difficult for experts and practitioners in the field to know and manage. A new object of expert

intervention comes into being when "a heretofore unknown, ignored, or dispersed set of phenomena is transformed" into something that can be "observed and manipulated…and that coheres, at least for a time, as an ontological entity" (Daston, 2000, p. 5). I argue that within MHPSS as a domain of knowledge and practice, key objects of expert intervention, such as trauma, have *not* cohered into ontologically stable entities.

In addition to incoherent objects, inconsistently defined categories are sources of miscommunication and confusion in the field of MHPSS. I examine multiple, sometimes overlapping, systems of classification and standardization that organize and regulate the practice of MHPSS in emergencies. According to Bowker and Star (1999), a *standard* is "any set of agreed-upon rules for the production of (textual or material) objects" (p. 13). They argue that standards and classifications are "two sides of the same coin" (p. 15). The existence of a standard inherently implies a system of classification that, at a minimum, distinguishes between things that do and do not meet the standard; classifications must become standardized in order for them to effectively travel among multiple social worlds, contexts, and communities of knowledge and practice. A system of classification that fails to become standardized is "ad hoc, limited to an individual or a local community, and/or of limited duration" (Bowker and Star, 1999, p. 15). In this way, standards, objects, and classifications are all closely interconnected.

Standardization has played a significant role in the recent histories of both humanitarianism and mental health, through the bureaucratization and professionalization of humanitarian aid (Barnett and Weiss, 2011) and the often-contested process of revising psychiatric diagnostic criteria (Welch et al., 2013). While the production of formal, published standards—most notably in *The Sphere Handbook: Humanitarian Charter and Minimum Standards in Humanitarian Response* (Sphere Association, 2018)—has long been a frequent

topic of discussion, debate, and analysis within the social world of humanitarianism (Stockton, 1999; Walker and Purdin, 2004), classification has not been made as explicit and visible as a matter of concern within humanitarianism. The invisibilized, taken-for-granted nature of systems of classification and the objects of expert intervention that they categorize makes them all the more important for social scientists to pay attention to and think critically about.

Research questions and overview of the dissertation

In this project, I have sought to address the following research questions about mental health and psychosocial support in humanitarian emergencies:

1. How have expert perspectives on trauma and PTSD in the context of disasters and emergencies varied and changed over time?
2. What role does medicalized mental health care play in humanitarian emergency response, relative to other MHPSS interventions?
3. How do systems of standardization and classification affect the practice of MHPSS in disasters and emergencies?

My responses to these questions reveal that, as the title of this dissertation suggests, consensus within the MHPSS field has been elusive in several important areas. I do not attempt to provide concrete, practical solutions to problems in the field, or a path toward neatly resolving the ambiguities, contradictions, and inconsistencies within the MHPSS apparatus that I have identified. Rather, my analysis offers insights about *why* confusion and ambivalence have been so persistent within this domain of expertise and intervention. I also suggest that increased data collection and more precise measurement tools are unlikely to adequately resolve these issues, both because of the practical difficulties involved in empirically studying MHPSS, and because

of the ontological and epistemological multiplicity underlying key points of dissensus within this field.

Several of the MHPSS professionals whom I interviewed told me they were glad that it was no longer necessary to “fight” for MHPSS to be included in humanitarian aid. This struggle for recognition and resources in the not-so-distant past may help explain what is at stake in representations of professional consensus in the MHPSS world. Unsettled questions about the logic, purpose, and practice of MHPSS may foster skepticism among some outsiders to the field. It is *not* my contention, however, that a lack of consensus among policymakers and practitioners should necessarily undermine the legitimacy or value of MHPSS as a form of humanitarian aid. Persistent dissensus can cause miscommunications and confusion in the field, but it may also allow for greater flexibility, openness, and possibility. The intimacy, cultural specificity, and uncategorizability of mental health and psychosocial interventions make it difficult for them to be fully “rendered technical” (Li, 2007)—suggesting a potential for political engagements that might otherwise be foreclosed.

In Chapter II of this dissertation, I discuss the methodology I used to investigate the questions above. In this project, I combined archival research; content analysis of MHPSS guidelines and handbooks; and qualitative interviewing to explore the histories, policies, and practices that have characterized this field. Each mode of observation contributed to my understanding of the MHPSS apparatus, how it has come into being, and how it currently operates. Putting unobtrusive research methods in conversation with data from qualitative interviewing allowed me to take a more nuanced approach to my analysis in this project than would have been possible through either method on its own.

In Chapter III, I address RQ1 through a content analysis of handbooks, guidelines, manuals, and other texts that illuminate the controversial role of trauma and PTSD in professional responses to disasters and emergencies since the 1980s. The question of whether trauma and PTSD compel expert intervention and management in these contexts has been the subject of vigorous debate, and current MHPSS standards do *not* foreground trauma as a problem for humanitarian aid workers to address. My analysis identifies several key points of disagreement among experts about trauma and PTSD in disasters and emergencies—including the medicalization of human suffering; the individual as a unit of analysis in situations of collective violence; and the problem of differentiating normal and abnormal psychological responses to extreme disruption—but I also highlight the heterogeneity of conceptual approaches and interpretations that have circulated among these experts, to avoid being excessively reductive about the nature of the controversy.

In Chapter IV, I address RQ2 by bringing together archival sources and data from the interviews that I conducted to examine the relationship between MHPSS and medicalized mental health care. Several of my interviewees were markedly ambivalent about medicalized mental health interventions and the Global Mental Health "treatment gap" paradigm. I discuss several interrelated sources of this ambivalence, including the challenges of providing this form of care in the contexts in which disasters and emergencies occur, and the potential for medicalized mental health care to cause harm for its intended beneficiaries. The complications and drawbacks to providing medicalized mental health care that my research identifies suggest that it may not be possible or desirable for MHPSS to become a fully standardized, technical practice in disasters and emergencies.

In Chapter V, I address RQ3 by analyzing four fundamental systems of classification that purportedly organize MHPSS interventions: the distinction between "mental health" and "psychosocial support"; the MHPSS intervention pyramid; the humanitarian cluster approach; and the category of the minimum humanitarian response. Inconsistencies in how these systems of classification are put into practice sometimes causes confusion and frustration in the field, but also raise important questions about the nature and appropriate scope of both mental health care and humanitarian emergency response.

In Chapter VI, I conclude this dissertation with reflections on my findings, answers to my research questions, and a discussion of potential directions for future research. I call for further research on how humanitarian actors determine the appropriate scope of aid in ethically and politically complex situations; how the lived experiences of disasters and emergencies—both for aid workers and the beneficiaries of aid—are affected by MHPSS interventions; and whether (or to what extent) sexual violence has been conceptualized as uniquely psychologically damaging by humanitarian aid workers and policymakers.

Chapter II – Methodology: A Mixed-Qualitative Approach to the Study of Humanitarian Aid

In this project, I employed a mixed qualitative methods approach, using four different modes of observation: an online survey; content analysis of handbooks, standards, and guidelines; archival research; and qualitative interviews with employees of humanitarian agencies and organizations currently working in the MHPSS field. In what follows, I describe each mode of observation, evaluating the strengths and limitations of each in the context of the project.

Because this research raises questions about the relationship between policy and practice in relation to MHPSS, participant observation and other ethnographic methods would have offered perspectives that are inaccessible to me as an outsider to this field. Practical and ethical considerations made an ethnographic approach to this research infeasible, however. I also acknowledge that the fact that I did not interact with or seek the perspectives of beneficiaries of humanitarian aid is a potential limitation of this research. For this project, the imposition and intrusion associated with attempting to interview this vulnerable population far outweighed the potential benefits to the research. Despite these limitations, the unobtrusive methods and qualitative interviews that I conducted as part of this project provided key insights into the conceptual basis and practice of MHPSS, and allowed me to answer my research questions.

Online survey

In my research design, I sought the insights and perspectives of professionals currently working in the MHPSS field via two different modes of observation: an anonymous online survey and semi-structured qualitative interviews, with the hope that the former would allow me to access a greater breadth of perspectives, and the latter would provide greater depth.

The survey included questions about respondents' educational and professional backgrounds prior to becoming involved in the MHPSS field; their professional roles and experiences in MHPSS; their perceptions and opinions about the role of MHPSS within humanitarian emergency response; and their experiences using several key MHPSS-related handbooks and guidelines.

I sent a request for participation in my survey via email to approximately 15 medical humanitarian organizations, as well as the UW Global Mental Health listserv, followed by a reminder email two weeks after my initial inquiry. Unfortunately, I received only five responses in total, and the results of the survey were not generalizable. Because the survey did not capture the breadth of experience that a larger sample size would have offered, I did not incorporate data from the survey into my analysis; it proved to be a methodological dead end.

Content analysis

The second mode of observation that I used in this research was content analysis, focusing on several key guidelines, handbooks, and standards for the practice of MHPSS in emergencies. These texts represent some of the most widely known and circulated collections of expert knowledge on MHPSS, and specifically offer guidance for how this expertise should be put into practice. A major limitation of content analysis as a mode of observation lies in the fact that these written policies may or may not align with how MHPSS programs are actually carried out in the field. Combining content analysis with other modes of observation strengthened my research design by adding depth, nuance, and context to my interpretation of these texts.

Content analysis as a method was particularly useful for my analysis of the professional controversy about trauma and PTSD in Chapter III of this dissertation. I analyzed four

handbooks, published between 1980 and 2007, alongside other sources of expert knowledge about mental health and trauma in disasters and emergencies from my archival research.

I knew that it would be essential to include the *IASC Guidelines* (IASC, 2007) in my analysis, because they are so widely known and used in the field that they are closely linked to the term "MHPSS" itself (Rehberg, 2015). Their publication was understood to represent a major moment of consensus in the "young, divided field" of MHPSS in emergencies (Wessells and van Ommeren, 2008, p. 199). As such, the *IASC Guidelines* were an especially important source of data for this project, and I incorporate some discussion of these guidelines in all three empirical chapters of this dissertation.

The second handbook I chose to include in my analysis of trauma and PTSD in Chapter III is a manual for humanitarian aid workers called *Mental Health of Refugees* (WHO/UNHCR, 1996) that I learned about during my archival research at the WHO. I read multiple preliminary drafts of chapters of this manual during my archival research, along with correspondence and other documentation related to its production, which was a joint effort between WHO and UNHCR. As the culmination of a lengthy collaborative project between these two agencies that incorporated contributions from many leading experts in the field, this manual usefully encapsulated the standards of practice for refugee mental health at the time. I analyze the empirically rich data that I collected at the Archives of the WHO alongside the final, published version of the manual.

The third handbook I analyze in Chapter III is a guide and directory for psychosocial humanitarian aid during the civil wars in Bosnia-Herzegovina and Croatia in the 1990s (Agger, 1995). It includes an extensive introduction laying out theoretical concepts that informed the delivery of psychosocial aid at the time, which was the focus of my analysis. This handbook has

been cited in the scholarly literature as a key representation of how trauma was conceptualized within psychosocial aid at the time, and I felt that it was important to include the perspectives it contains in my analysis as well.

Lastly, I selected a handbook for mental health care in disasters that was published before the widespread adoption of the PTSD diagnosis (Cohen and Ahearn, 1980). I included this text mainly as a point of comparison with sources that were published later in the 1980s and 1990s, and to examine how the mental health impacts of disasters were conceptualized as objects of expert intervention before the PTSD diagnosis became a standard psychiatric diagnosis (and source of controversy) within the mental health field.

I supplemented my analysis of these four texts with archival sources dating from the 1980s and 1990s to add depth and nuance to my discuss of how expert perspectives on trauma and PTSD have varied and changed.

Archival research

In addition to my analysis of guidelines, standards, and handbooks, I conducted research at four archives. In August 2018, I traveled to Geneva, Switzerland and spent several weeks doing research at the Archives of the WHO and the UNHCR Archives. In March and April 2019, I traveled to New York City and Washington, D.C. to visit the UN Archives and the National Archives of the United States. Conducting research in formal archives was new to me, and I was not sure what to expect from the process. Ultimately, certain archival sources proved to be invaluable, especially for Chapter III of this dissertation.

I visited the Archives of the WHO first, and they proved to be by far the richest source of archival data for my project of the four sites that I visited. I reviewed a total of 114 files dating from 1963 to 1998, with the vast majority of these dated 1970 or later. Of these, 84 files

contained material with potential relevance to this project, and I ultimately digitized a total of 218 documents. Like the other archives within the UN system that I visited, the WHO Archives does not offer access to files that are less than 20 years old to external researchers—this "gap" made it somewhat challenging to connect the archival data I collected with the current practice of MHPSS in emergencies. The files that I reviewed primarily contained copies of letters and memoranda written by and to WHO officials; internally and externally produced reports; planning documents regarding WHO programs and collaborations; travel reports; and documentation regarding seminars, symposia, workshops, and training courses organized by the WHO or attended by the agency's representatives.

At the UNHCR Archives, I reviewed a total of six files, and digitized 15 documents. Unlike at the WHO Archives, the staff of the UNHCR Archives closely reviews files before allowing researchers to access them. I was not able to access several of the files I had requested because they were found to contain too many individual case files. The contents of the files I was able to access contained less internal correspondence and documentation than I found in the WHO Archives, and a higher proportion of press releases and other material intended for public release that was less relevant to this project and less empirically rich than the data I collected at the WHO Archives.

At the UN Archives, I reviewed 29 files, and digitized a total of 66 documents. The files I reviewed primarily contained correspondence; memoranda; meeting minutes and notes; official statements; press releases; reports; and documentation of symposia and conferences. Though some of the sources that I found provided useful context, they were not ultimately directly relevant to my analysis in this project.

My visit to the United States National Archives was wholly unsuccessful as a data-gathering exercise, but it did provide preliminary training in the complex, securitized, and, for the uninitiated, opaque process of using these archives. There are significantly higher barriers to access, in terms of logistics and expertise, to the U.S. National Archives in comparison with the archives I visited within the U.N. system. If I were to conduct future research at the National Archives, I would need to seek additional mentorship and guidance, and likely allow much more time for archival research there than I did for this project.

Archival data is always second-hand, in the sense that it was not produced with the needs and interests of future researchers in mind, and it often provides a partial, fragmentary view of the systems and institutions it documents. For this project, however, archival research provided valuable insights into the way that expertise about mental health in disasters and emergencies has been produced, disseminated, and legitimated by agencies like the WHO. It also helped me learn about projects and publications relevant to my research questions that I otherwise may not have been aware of, and granted me a perspective, however incomplete, into a social world that I would otherwise have had no access to.

Qualitative interviews

Using a purposive, non-probability sampling strategy, I contacted approximately ten medical humanitarian organizations and international agencies involved with MHPSS in emergencies, using publicly available email addresses, to request interviews with their employees. Unsurprisingly and understandably, since I had no professional or personal connections in the humanitarian field, I received no response to most of my inquiries, and some others declined my request. I was, however, able to schedule two interviews based on these initial contacts, and scheduled three more interviews via snowball sampling after I conducted the

first two. In total, I conducted five semi-structured interviews with professionals whose primary job functions were related to MHPSS in emergencies.

The social world of MHPSS is a relatively small one, and in order to protect the confidentiality of my informants, I cannot provide detailed demographic, biographical, or professional details about them as individuals. (Knowing their employer, job function, and nationality would likely make them individually identifiable.) I refer to my informants by pseudonyms throughout this dissertation, and have not preserved any written records linking their real names with their pseudonyms. Information about their collective background, experience, and expertise, however, provides important context to support the validity of the claims I make based on my interview data.

My informants all had years, and, in some cases, decades, of professional experience in the mental health field, the humanitarian field, or both. None of them were medical professionals per se, but four out of five of them had training and professional experience in non-medicalized mental health fields, such as social work and psychotherapy. Two of them were employed by major international organizations in the UN system, and the other three were employed by branches of one of the world's largest and most influential medical humanitarian organizations. Four of them were based in Northern Europe, and one of them was based in East Africa. All five of them occupied leadership positions, of various types, at the time that I interviewed them. The fact that my informants were all in leadership positions meant that they had valuable insights to share about strategy, planning, and other "big picture" issues in the professional world of MHPSS. I recognize that I may have received very different perspectives from aid workers who were differently positioned in this professional hierarchy, especially local rather than international staff. My informants' professional responsibilities included day-to-day management

of MHPSS programs; providing consultation and technical advising about MHPSS; and higher-level policymaking and advocacy for MHPSS on an international scale. Among the five of them, they had on-the-ground experience with MHPSS in at least a dozen different countries, primarily in Southeast Asia, Sub-Saharan Africa, and the Middle East and North Africa (MENA) regions.

Initially, I had hoped to conduct at least some of my interviews in person, during my research trip to Geneva. However, I was ultimately unable to do so due to a logistical setback related to funding, my own schedule, and Europeans' tendency to be out of the office during the month of August. In the summer of 2018, I had a teaching appointment that ended in late July, and a travel grant from the UW Center for West European Studies that I was required spend out by the end of August. This meant that my travel to Europe needed to take place during a month of the year when Europeans are frequently on holiday, and I found that it would be impossible to schedule face-to-face meetings with professionals in Geneva while I was there. As such, I had more time to conduct archival research than I had initially expected, and all of my interviews were conducted via Skype.

All five of my informants opted not to enable the video feature of our Skype calls. Not being able to see each other's faces may have inhibited non-verbal communication, but it also granted my informants a degree of anonymity; I know their names, but I have never seen any of their faces, and I would not recognize any of them by sight. Because my informants are part of a transnational workforce, they were all very comfortable communicating via Skype in their professional capacities. Due to time-zone differences, I conducted some of my interviews very late at night, and while my bleariness surely meant that I was not as sharp as an interviewer as I otherwise would have been, I otherwise found that conducting interviews remotely worked well for this project. The sound quality of the audio recordings of my interviews was often poor,

however, and the process of transcribing the interviews was laborious. I often had to listen to fragments of the audio many times during the transcription process, and there were occasional breaks in the audio, leading to gaps in some of my transcripts. The arduous transcription process gave me the opportunity to become very familiar with my interview data, which was an asset during the construction of this manuscript.

My interview script included a set of open-ended questions about my informants' professional backgrounds; experiences working in the MHPSS field; and perceptions of "bigger picture" processes and concepts, such as the relationship between humanitarian aid and development. I include a copy of the questions that I asked in the Appendix, along with potential prompting, probing, and clarifying questions. I also asked prompting and probing questions as necessary throughout the interviews. Overall, I found that my informants were quite candid and thoughtful in their answers to my questions, and their participation immensely improved the quality of my research.

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Overall, despite a number of setbacks and disappointments (or learning opportunities?) during this research, my analysis and interpretation of the interview data that I collected and the textual sources that I curated have allowed me to address my research questions about the historical antecedents and contemporary practice of MHPSS in emergencies. I approach this analysis with humility and a commitment to being intellectually honest in my interpretations, always striving to accurately represent my interviewees' remarks and to fairly evaluate my textual sources.

Chapter III – Incoherent Objects: Trauma and PTSD in Disasters and Emergencies, 1980-2007

Does the experience of living through war, natural disasters, and other emergencies cause psychological trauma? Is post-traumatic stress disorder (PTSD) an inevitable consequence of humanitarian emergencies, and one which urgently compels expert intervention? It may seem obvious that trauma and PTSD would be of central concern for the project of MHPSS in disasters and emergencies. However, the answers to these questions—and the basic terms of the questions themselves—have been matters of considerable professional debate for decades. The PTSD diagnosis and trauma-oriented psychological interventions have been at the center of larger debates about whether mental health and psychosocial support projects should be implemented in disasters and emergencies at all (van Ommeren, Saxena, and Saraceno, 2005), and current MHPSS standards do not focus on trauma and PTSD as objects of expert intervention (IASC, 2007). It has often been suggested that additional research and data about the prevalence of the symptoms of PTSD in disasters and emergencies or the effects of trauma-focused psychosocial interventions would offer a resolution to this professional controversy. My findings indicate, however, that additional empirical evidence would be unlikely to bring the competing views about trauma that have characterized the debate into agreement with each other. The professional dissensus about trauma and PTSD in disasters and emergencies stems less from disputes about facts than from incompatible understandings of what trauma is and whether it constitutes a problem to be acted upon by experts in emergency contexts.

In this chapter, I examine the contours of the debate about trauma and PTSD in disasters and emergencies through a discourse and content analysis of several key guidelines, handbooks, reports, and dialogues among experts, written between 1980, when the PTSD diagnosis was first codified, and 2007, when the *IASC Guidelines* were published. In different ways, all of these

texts reflect the existence of an ongoing professional controversy about trauma and PTSD in disasters and emergencies. Some of them accept the idea that disasters and emergencies cause some form of psychological trauma, but reject the use of the PTSD diagnosis in these contexts. Others pointedly avoid the language of trauma and traumatization altogether. While nearly all of them express some degree of hesitation or ambivalence about trauma and PTSD, they offer differing and sometimes incompatible justifications for these reservations. This inconsistency, variability, and ambiguity is a major focus of my analysis of the professional dissensus about trauma and PTSD in disasters and emergencies. From this variation, I trace several key themes through my analysis of these texts: the tension between the scale of the individual and the collective experience of disasters and emergencies; the cross-cultural validity of the PTSD diagnosis; the medicalization of human suffering; the social meanings associated with trauma and PTSD; and the problem of differentiating between normal and abnormal (or pathological) responses to extreme experiences of disruption and violence.

Trauma and PTSD in question

While trauma and PTSD are terms with multiple meanings, some basic definitions provide useful context for understanding these varying interpretations. The American Psychological Association defines trauma as "any disturbing experience that results in significant fear, helplessness, dissociation, confusion, or other disruptive feelings intense enough to have a long-lasting negative effect on a person's attitudes, behavior, and other aspects of functioning" (APA, 2023). Trauma is defined here both by an emotional reaction and a temporality: it must bring about these negative emotions long after the "disturbing experience" itself has concluded. The core characteristics of PTSD, as described in the 11th edition of the *International Classification of Diseases* (WHO, 2019), comprise "re-experiencing the traumatic event in the

present" through flashbacks, nightmares, and intrusive memories; "deliberate avoidance of reminders" of the traumatic event; and hypervigilance, or "persistent perceptions of heightened current threat." The specific diagnostic criteria for PTSD have shifted significantly over time, to a greater extent than most other psychiatric diagnoses (North et al, 2016). These adjustments and revisions, however, do *not* meaningfully figure into the professional debates about trauma and PTSD that I analyze here. PTSD as a construct is called into question in some of the texts that I analyze in this chapter, but these critiques are not based in disputes about the particularities of its diagnostic criteria.

The concept of trauma is ubiquitous in contemporary Western culture. Alongside its proliferation as a "a major signifier of our age" (Fassin and Rechtman, 2009, p. xi), its cultural role has been a frequent subject of critique and skepticism (Pandell, 2022; Sehgal, 2021). Fassin and Rechtman (2009) note that the modern history of trauma is a story about both the changing social meaning of trauma and the emergence of a technical, scientific object. The transformation in societal perceptions of trauma victims that occurred between the late 19th Century and the beginning of the 21st was "not due to more refined diagnostic tools, but rather to a narrowing of the gap between the climate of public opinion and the preoccupations of mental health professionals, between the moral economy and medical theory" (Fassin and Rechtman, 2009, p. 22). This dynamic relationship between "moral economy and medical theory" has made trauma a particularly generative subject of academic inquiry, and critical scholarship about the social meanings and functions of trauma is abundant. Interest in trauma has grown within the discipline of Geography specifically in recent years (see, for example, Blum and Secor, 2014; Loyd, Ehrkamp, and Secor, 2018; and Pain, 2021). Coddington and Micieli-Voutsinas (2017) note that geographers have increasingly employed the concept of trauma to understand the legacies of

violence, and that scholars outside of the discipline of Geography have simultaneously taken up geographic approaches in the study of trauma. My analysis in this chapter contributes to this growing critical literature on the political and cultural dimensions of trauma and PTSD.

Some academic critics of MHPSS and its related and precursor fields are especially critical of what they see as a problematic focus on trauma within these domains. The psychiatrist Derek Summerfield has opposed the global expansion of Western mental health paradigms in general (Summerfield, 2012) and trauma-oriented interventions in disasters and emergencies specifically (Summerfield, 1999). Vanessa Pupavac (2001, 2002, 2004) has placed trauma at the center of her critiques of wartime psychosocial programs, arguing that an emphasis on trauma by humanitarian aid agencies casts the populations affected by war as "dysfunctional" and incapable of self-government (Pupavac, 2002, p. 490). Both Summerfield and Pupavac argue that the PTSD diagnosis represents a cross-culturally invalid "medicalisation of distress" (Summerfield, 1999, p. 1460) that is inappropriate, unnecessary, and even harmful in the context of disasters and emergencies. Changes in the MHPSS field since the early 2000s have undermined the salience of some of these critiques (Rehberg, 2015), but their core assumptions about the construction of trauma as a primary matter of concern for humanitarian actors during the 1980s and 1990s have generally gone unquestioned. According to Wessells and van Ommeren (2008 p. 200), however, in the fifteen years preceding the publication of the *IASC Guidelines* in 2007, MHPSS was "polarized" and "divided"—and differing approaches and orientations toward trauma and PTSD were a major source of this division. This ambivalence toward trauma and PTSD, which I examine throughout this chapter, stands in contrast to overly reductive arguments about the role of trauma in psychosocial humanitarian aid.

Current MHPSS standards—exemplified by the *IASC Guidelines* (IASC, 2007)—do *not* focus on trauma and PTSD as the primary objects of expert intervention in disasters and emergencies. In fact, as I will discuss later in this chapter, trauma is seldom mentioned in these guidelines at all. During the interviews I conducted for this project, trauma was also not emphasized by my informants, and most of them never mentioned it during our conversations. My informant Rafaela did briefly discuss the concept of trauma with me—but only as an example of language and terminology that she found to be problematic and advised against using in emergency settings. Rafaela had told me that miscommunications and a lack of shared definitions of key terms were common challenges in her work managing MHPSS programs in East Africa; when I asked her for an example of this problem, she responded as follows:

> "Oh yeah, I have some examples! The first was the word 'trauma.' Everybody liked the [word] 'trauma' very much….I was leading this meeting, …[and] the partners often referred to children as 'traumatized children.' And that made me a bit curious. So, I tried to ask more, and I realized there was this widespread idea that everybody that had been affected by the conflict was 'traumatized.'….But there were some case studies from other countries showing that people affected by conflict still have good resilience, and still can function well, and not all of them, of course, are traumatized….
>
> "So we agreed on some more appropriate terminology that we would use to indicate stages of being psychosocially affected. We use the term 'distressed' and not 'traumatized,' for instance, to emphasize the resilient part of the person and their capacity to recover."

For Rafaela, the (mis)use of the word "trauma" was the most obvious example of a term that caused misunderstandings among MHPSS actors. Rafaela challenged the assumption that people, and especially children, were consistently "traumatized" by the experience of war and violent conflict, contrasting trauma with resilience. In place of "trauma," Rafaela spoke of "distress" as a

more acceptable way to describe the psychological impact of war. The term "distress" appears frequently in the *IASC Guidelines*, and Rafaela's comments suggest that for her, at least, "distress" is not a synonym for "trauma." Notably, the other aid workers in her story, who presumably were trained and positioned as MHPSS experts to a lesser degree than Rafaela, had no such hesitations about using the language of trauma to describe children who had been affected by war until she corrected them. Presumably, then, her reluctance to describe children as "traumatized" was related to her knowledge, training, and experience as an expert in this form of aid.

Seven expert perspectives on trauma in disasters and emergencies, 1980-2007

My analysis in this chapter provides additional context for the elision of trauma from MHPSS guidelines and the hesitation that the term provokes from experts in this field. I show that trauma and PTSD have a decades-long, yet uneven, history of being perceived as contentious or controversial in disasters and emergencies. In what follows, I analyze how seven texts representing expert perspectives on mental health in disasters and emergencies, address—or, in some cases, notably do *not* address—trauma and PTSD as matters of concern for aid workers, researchers, and policymakers. Published between 1980 and 2007, this set of texts provides an illustrative rather than an exhaustive view of the professional debate about PTSD and trauma-focused mental health care during this period. I recognize that some perspectives are, inevitably, left out of my analysis. Notably, none of the texts I analyze include the voices of the *recipients* of mental health care and psychosocial support in disasters and emergencies, and I make no claims about their experiences. The purpose of this chapter is not to offer an answer to the question of whether disasters and emergencies cause trauma or PTSD, but rather to examine how experts have repeatedly attempted to answer this question in variable and inconsistent ways.

The construction of trauma and PTSD as objects of expert intervention in disasters and emergencies has not produced ontologically stable entities, and this incoherence has prevented different professional communities from arriving at a shared understanding of how and whether they should be addressed.

Instead of organizing my analysis around common themes or trends among the texts, I analyze each of them separately, to focus on the internal logic, idiosyncrasies, and nuances of each of them. Though I discuss the texts in chronological order below, the conceptual evolution that I trace is not a neatly linear trajectory. Trauma as a problem relevant to disasters and emergencies is variously taken for granted, rejected, questioned, and sidestepped. A few of the authors describe trauma as a logical and natural effect of disasters and emergencies, but this is far from a consensus view. On the contrary, most of the texts that I analyze offer some degree of skepticism or ambivalence about trauma and PTSD in disasters and emergencies, and the rationales that they offer for their perspectives vary considerably. The texts vary in terms of the specific types of emergency contexts they are intended for as well: natural disasters, violent conflicts, or both. The authors of all the texts I analyze are positioned as producers of expert knowledge, but their credentials, backgrounds, professional roles, and intended audiences vary, and, for texts published by institutions, the identities of individual authors are not always made apparent. While there are significant differences among these texts, there are also interlinkages among many of them. The WHO report in Section 3 has clear links to several of the other texts I have included in my analysis, for instance; it cites both the published work of Enrico Quarantelli and Cohen and Ahearn's (1980) handbook, and makes reference to the ongoing collaboration between WHO and UNHCR to produce a manual for refugee mental health, the text I analyze in Section 5. I present these seven texts as a loosely linked set of expert opinions, connected by a

shared aim to offer guidance about the provision of a specific type of care in disasters and emergencies settings. The heterogeneity of the texts reflects the inherent heterogeneity of the MHPSS apparatus, which brings together multiple related domains of expertise.

1: Disaster mental health before PTSD – *Handbook for Mental Health Care of Disaster Victims* (1980)

The *Handbook for Mental Health Care of Disaster Victims* was written by two American mental health professionals—from the medical and social work fields, respectively—who had provided mental health care in several natural disasters in Peru, Nicaragua, and the United States in the 1970s (Cohen and Ahearn, 1980, p. xvii). The handbook provides guidance to clinicians and administrators for the design and implementation of mental health care programs in the aftermath of disasters. The authors assume that their audience would have substantial training and expertise in the mental health field, but that readers would not have previous professional experience with disasters. The handbook is *not* intended for use by mental health "nonprofessionals or paraprofessionals" such as community health workers (p. 10), but rather by more specialized clinicians. The authors describe disaster mental health as a specialized form of care that most mental health experts would not have experience planning or providing, but that should be part of disaster preparedness planning everywhere. The manual is not explicitly written with a specific geographic location or type of disaster in mind; its guidance is presumed to be universally applicable.

This handbook was published in 1980, the same year as the *Diagnostic and Statistical Manual of Mental Disorders, Third Edition* (*DSM-III*), which was the first edition of the American psychiatric diagnostic manual that included the PTSD diagnosis. (PTSD would not appear in the *International Classification of Diseases (ICD)* until the publication of its tenth

edition in 1990.) The specific terms "post-traumatic stress disorder" and "PTSD" do not, of course, appear in this text. Because the handbook was written prior to the codification of PTSD as a psychiatric diagnosis, it provides insights into how mental health in disasters was conceptualized as a problem in need of expert intervention before PTSD became a dominant paradigm to be embraced, rejected, or critiqued by mental health professionals.

While PTSD is entirely absent from this text, trauma is largely elided as well. The handbook discusses the psychological impact of disasters primarily in terms of "stress" rather than "trauma," and defines "stress" as "physical and emotional reactive tensions that can emanate from objective events and/or external stimuli" (p. 13). "Stress" is described here as a normal, natural, at least partially biological, transitory, and morally neutral response to the disruptions, losses, and threats associated with disasters. In its introduction to the concept of stress, the handbook emphasizes recent research linking stress responses to specific neurotransmitters and changes in brain chemistry (p. 14). Stress responses are presented as physiological as much as emotional or cognitive phenomena. Because stress is understood to be a *normal* and even rational reaction to disasters, it requires minimal intervention from mental health experts.

This is not to say that the authors of this book overlooked the concept of trauma altogether. For instance, they briefly mention (but do not elaborate on) theorizations of the differences between individual and collective trauma (p. 5), a distinction that experts like Quarantelli (1987) and Agger (1995) would later identify as a central problem with the application of the PTSD concept in disasters and emergencies. Additionally, the handbook mentions "traumatic syndrome," or "posttraumatic neurosis," in a brief discussion of rare, severe psychological reactions to disasters (p. 34). While there appears to be some overlap between

symptoms and behaviors associated with this syndrome and the typical diagnostic criteria for PTSD—such as nightmares and hypervigilance—there is little explanation of how these disorders might be identified or treated by clinicians in the aftermath of disasters. They are not depicted as major concerns for the majority of the population affected by disasters.

"Posttraumatic neurosis" is also an example of psychoanalytic terminology that the handbook occasionally employs. It mentions both "neurosis" and "hysteria" as psychiatric problems that arose in the aftermath of an earthquake in Nicaragua in the 1970s, noting in particular that "young mothers" were the most typical patients presenting these problems (p. 35). Introducing a set of techniques that mental health workers might employ in disasters, the handbook frames the goal of these interventions as "restoring ego functions" or "returning balance to the total ego system" (p. 71). Such psychoanalytic terminology is totally absent from the later texts that I analyze in this chapter, which were published during a period when the language and concepts of psychoanalysis garnered less and less respect and credibility in the mental health field as a whole. While psychoanalytic ideas and techniques are not strongly emphasized in the handbook, their occasional presence here and complete absence elsewhere is an indicator of the ways that dominant ideas about mental health care were changing in the last decades of the 20th Century.

Cohen and Ahearn acknowledge that some experts at the time viewed the mental health impacts of disasters as "a hotly debated issue" (p. 28), and they present this controversy as the product of a lack of sufficient empirical research on the topic. In reviewing the existing literature about "disaster behavior," they call for "continued careful investigation" (p. 28). They also imply that the idea that "there is little or no psychological impact from a natural disaster" is supported by only a small minority of experts in the field, and that the dominant view among members of

their profession holds that disasters do cause mental health problems (p. 29). Their calls for additional research imply that this minor controversy could and should be resolved through the collection and analysis of additional data. The object of study for this future research, however, is identified not as "trauma" but rather in more general terms, as the "emotional consequences" or "psychological impact" of disasters (p. 29).

This handbook provides a snapshot of expert knowledge on disasters and mental health before the introduction of the PTSD diagnosis. References to trauma are sparse, concepts from Freudian psychoanalysis are accepted as valid, and "stress" is described in physiological as well as psychological terms. The authors acknowledge that a minority of dissenting voices within the field challenge the idea that disasters have a negative impact on mental health, but they suggest that the professional debate on this topic can and will be resolved through additional empirical research.

2: A rejection of "the individual trauma approach" – "The Controversy on the Mental Health Consequences of Disaster" (1987)

This text is not a handbook or set of guidelines, but the transcript of a seminar delivered by a well-known expert in disaster mental health and the subsequent discussion among the audience of other experts who attended the talk (Quarantelli, 1987). The transcript provides a record of a conversation among experts behind closed doors, so to speak—the seminar itself and the publication containing its transcript were never intended for the general public, or even for the aid workers who would be providing mental health care in disasters. Instead, the report on "war, disasters, and trauma" (Ursano, 1988) that contained the seminar transcript was likely intended for use by researchers in academic settings, government agencies, and the military. While the seminar was, obviously, not "off the record" as such, its organizer encouraged its

participants to speak informally and conversationally with each other, and their discussion offers insight into the way that these experts talked among themselves about mental health and trauma in disasters; the kinds of questions related to this topic that interested them; and what they saw as significant about its study. The seminar provided an extensive discussion about competing conceptual models and practical approaches to trauma and mental health in disasters.

The seminar in question was presented by Enrico Quarantelli in 1987 at the Uniformed Services University of the Health Sciences (USUHS) in Bethesda, Maryland, and was titled “The controversy on the mental health consequences of disaster” (Quarantelli, 1987, p. 1). The seminar was attended by psychiatrists; clinical, research, and social psychologists; and an anthropologist who studied military psychology. Some of the attendees were employed by USUHS and others worked at the Walter Reed Army Institute of Research. At the time, Quarantelli had been a leading expert on the sociology of disasters for decades (see, for example, Quarantelli, 1960), and had been invited to USUHS to speak as part of an ongoing institutional effort to, as the official who convened the seminar put it, “build data bases on aspects of disasters and traumas” (p. 1). Though USUHS is affiliated with the United States military, and many of the seminar attendees were officers in the armed forces as well as academics, Quarantelli’s research and the seminar he gave at USUHS was focused primarily on disasters that affected civilian populations.

As the title of the seminar suggests, Quarantelli argued that professional opinion about the psychological impact of disasters was divided in significant ways. In the excerpt below, he summarized the two primary opposing views among experts about the impact of disasters on mental health:

> “A minority [of experts] argues that mental health effects [of disasters] are widespread, deep, persistent, long lasting and dysfunctional….. The majority of disaster researchers

> argue that while there are immediate widespread effects, much of the reaction is surface, non-persistent, of short duration, [and] not behaviorally dysfunctional." (Quarantelli, 1987, p. 2).

As I have described in the previous section of this chapter, Cohen and Ahearn's (1980) handbook also depicted expert opinion on this topic as unevenly divided—but unlike Quarantelli, they claimed that a majority of experts believed that the impact of disasters on mental health *was* a significant matter of concern. During his talk, Quarantelli made it clear that he belonged to what he described as the majority group of experts: he argued that at the population level, disasters do *not* effect significant negative mental health outcomes, and that intervention by mental health professionals is not necessarily required during and in the aftermath of disasters.

Quarantelli labeled the two theoretical camps outlined in the excerpt above as the "individual trauma approach" and the "social sponge approach." Hence, expert opinion about trauma in disaster settings was at the center of the controversy that was the subject of the seminar. For Quarantelli, the core characteristics of trauma were its severity, duration, and impact on day-to-day behavior; he understood trauma to be something disabling, and a source of dysfunction and disorder on both the individual and societal level. Quarantelli's overall argument, however, was less about the existence or non-existence of trauma as a psychological reaction to disasters. He was instead concerned with how experts viewed and understood social and interpersonal impacts of disasters. For Quarantelli, trauma was a relevant concept less as a discrete empirical phenomenon and more as an analytic lens through which human experience might be interpreted by experts. Trauma, that is, was not so much a clearly defined object of expert intervention, but a set of assumptions used by experts to justify their interventions. As I will show, the empirical evidence that Quarantelli used to support his argument against the

"individual trauma approach" could just as plausibly be interpreted to reach very different conclusions about the impact of disasters on mental health.

Quarantelli's views about trauma were in large part the product of how he and other researchers conceptualized and operationalized the mental health consequences of disaster. For this group of researchers, negative mental health impacts only merited attention by experts if they produced socially undesirable changes in behavior and functioning. In particular, Quarantelli was interested in the question of whether or not people abandoned their expected social roles during and in the aftermath of disasters. In the passage from his talk that I excerpt below, Quarantelli described the findings of a study evaluating mental health in the town of Xenia, Ohio in the aftermath of a major tornado in 1974. In the "mental health scale" Quarantelli referred to, higher scores signified worse mental health outcomes:

> "Looking at the mental health scale data, there was no doubt that the Xenia population, both at six months and 18 months after the disaster, scored well over the national sample….The Xenia people were way over….You did not even need to conduct statistical tests on the data, the data stood out. You simply had to look at the frequencies.
>
> "We concluded that in Xenia, overall, there were no psychological or serious mental health problems because there were other kinds of data, particularly the behavioral indicators. We had, for example, questions relating to interruptions of work that asked if people took more time off work. We also had questions about family behavior, about the kids in school, and a whole variety of items of that kind….With a few minor exceptions, these indicators showed very little difference six months or 18 months after the disasters….
>
> "If you simply look at the mental health scores, you could say that these people have problems. Obviously, they are 'suffering.' This is part of their psychic make-up. The argument is, 'If this does not have consequences in terms of their everyday life, then I am not going to be terribly worried about it.'" (Quarantelli, 1987, p. 14-15)

The empirical evidence that the Xenia study produced—high rates of self-reported psychological distress, but little evidence of disruptions in social behavior—could reasonably be used to support *either* the "individual trauma" or "social sponge" analysis. However, Quarantelli dismissed as irrelevant the evidence that indicated that the tornado had caused psychological suffering among residents of the town (which, as he himself acknowledged, would potentially support an "individual trauma approach") in favor of the evidence that showed that people affected by the tornado were able to fulfill their responsibilities in work, school, and family life. Quarantelli only conceived of mental health as a problem in need of expert intervention if researchers observed behavioral changes that disrupted the "normal" operations of everyday life. Because the suffering that residents of Xenia reported did not prevent them from, for instance, going to work, Quarantelli did not find it to be scientifically meaningful.

In addition to being informed by his conceptualization of what it meant for a person to have mental health "problems" (as he put it), Quarantelli's argument is contingent upon his working definition of disaster. He acknowledged that the term could be used to refer to a wide range of "collective stressful situations," but that for the purposes of disaster researchers like himself, disasters were categorically distinct from war and conflict[3] (Quarantelli, 1987, p. 7). He further differentiated between "community type disasters" and "non-community type disasters." While both types of disasters are collective experiences—that is, they affect a large group of people rather than isolated individuals—the groups affected by "community type disasters" comprised cohesive, unified communities, whereas "non-community type disasters" affected groups of people with no pre-existing or ongoing social bonds. The examples he provided of "non-community type disasters" were a train derailment in which the passengers lived in many

[3] This distinction is assumed to be less salient in some of the subsequent texts that I analyze in this chapter, which aim to be applicable to both natural disasters and violent conflicts.

different areas and had no social ties with each other, and a group of residents of Darwin, Australia, who left the city in the aftermath of a cyclone and never returned (Quarantelli, 1987, p. 7). Quarantelli's arguments focused instead on "community type disasters," and it was precisely the "community" dimension of these disasters that he claimed had a protective psychological effect; shared suffering promoted collective cohesion and support. This question of how to understand individual-level experiences of collective violence and disruption is an ongoing theme among the texts that I analyze in this chapter, though it is articulated in different ways in different texts. Here, the collective experience of a potentially traumatic event was understood to negate its negative psychosocial impact—despite the fact that, as described above, empirical evidence showed that disasters resulted in worse self-reported mental health outcomes.

Though the concept of trauma was, as I have shown, central to his arguments, Quarantelli never mentioned the PTSD diagnosis during the seminar. One the attendees introduced herself as a psychologist with an interest in "post-traumatic stress disorders" (p. 1), but neither she nor any of the other attendees asked Quarantelli about or otherwise mentioned PTSD during the seminar. Some of the other texts that I analyze in this chapter (such as the refugee mental health manual in Section 5) also do not use the term "PTSD," but *do* include descriptions of symptoms that closely mirror its diagnostic criteria—in effect, they talk about PTSD without naming it. That is not the case in Quarantelli's seminar; he did not specify which symptoms the "mental health scale" used in the Xenia study measured, for instance, but described it as a general-purpose mental health questionnaire. While I cannot fully account for the elision of PTSD from his analysis, he linked the "individual trauma approach" that he is critical of to "a medical view of the phenomena" of the social and psychological impacts of disasters (p. 18). Confusingly, in the context of the rest of his talk, however, Quarantelli defines this "medical view" as "the notion

that there is some objective reality out there that is responsible for the pathologies." He contrasts this with "a social problem view" in which "things are defined in a particular ways [sic] and social problems do not have any objective reality" (p. 18). These comments suggest that Quarantelli was skeptical of medicalized understandings of distress and suffering, but his critiques of medicalization were not cogently or lucidly articulated in this seminar.

Quarantelli's seminar rejected the idea that psychological trauma was an expected outcome in "community type disasters," precisely because they are *collective* experiences; he argued that this shared suffering is psychologically protective. For Quarantelli, the legibility and salience of trauma as an object of expert intervention depended on decisions about which forms of evidence were valid: individual, subjective reports of distress were rendered irrelevant by data about social functioning at the population level. The question of how trauma comes to be knowable by experts, then, was an important dimension of the arguments presented at this seminar.

3: Trauma and PTSD unquestioned – *Psychosocial Consequences of Disasters: Prevention and Management* (1992)

The third text I analyze in this chapter is a report that was published by the World Health Organization in 1992. This report was drafted as part of an effort across UN agencies to improve preparedness for natural disasters, in response to the UN General Assembly's designation of the 1990s as "a decade for natural disaster reduction" (WHO, 1992, p. 5). Though it is not immediately clear whether the report was intended for aid workers, policymakers, UN bureaucrats, or some other audience, its purpose was to offer both general information and practical guidance about what it refers to as "psychosocial interventions" in disasters. As I discuss in Chapter V of this dissertation, the distinction between "psychosocial" and "mental

health" projects is frequently murky, but in the context of this WHO report, the term "psychosocial" encompasses at least some medicalized mental health interventions as well as other forms of care.

Like Quarantelli (1987) and Cohen and Ahearn (1980), the WHO report indicates that at the time it was written, expert opinion varied about whether or not mental health is a significant matter of concern during and after disasters. Consistent with Cohen and Ahearn (1980) but contra Quarantelli (1987), the report suggests that the majority of researchers agreed that disasters *do* cause substantial negative mental health outcomes. The report accounts for the differences in opinion among experts with a critique of the methodology of some of the studies that argued that the mental health impact of disasters is negligible. The WHO report asserts that in these studies, "some of the disasters cited involved little loss of life…[and] poor detection methods were used to find psychological disturbance" (WHO, 1992, p. 15). While the report does not mention Quarantelli by name here, it notes that these studies "can be found especially in some of the sociological literature, mainly from the US" (WHO, 1992, p. 15), a body of scholarship in which Quarantelli's work would almost certainly be included. The authors of the report situated themselves, then, on the opposing side of the professional disagreement about disaster mental health as Quarantelli.

Trauma and PTSD feature prominently as matters of concern and objects of expert intervention in this report; the text of the 39-page document uses the terms "trauma" and "PTSD" 35 times. It identifies the prevention of PTSD as a primary aim of psychosocial interventions (p. 21). Trauma is often taken for granted as the principal problem that psychosocial interventions should address. In a summary of the "psychosocial consequences" of disasters, for instance, trauma is not listed as a separate, standalone category, but it is implied

that “disaster trauma” is the underlying cause of many other issues, up to and including PTSD (pp. 18-20). Disasters are assumed to be fundamentally traumatizing. Elsewhere in the report, however, psychosocial aid workers are advised to explain to people affected by disasters that “natural post-traumatic stress reactions” in these circumstances are “normal and expected, and not…pathological” (p. 26). According to this framing, different types of trauma fall along a spectrum, from the “normal” and “natural” to the abnormal and pathological. The idea of a “normal” reaction based in “stress” echoes Cohen and Ahearn’s (1980) conceptualization of stress as an expected, natural response to the experience of living through a disaster.

The report concludes with a list of seven proposed priorities for future research on mental health in disasters (pp. 38-39). Five of the seven explicitly refer to trauma or PTSD, and the remaining two call for the study of “psychological disorders”—which would surely include PTSD—in non-Western contexts and in relation to social support networks. The experts who composed the report saw trauma and PTSD as being absolutely central to the future of research and practice of psychosocial aid in disasters, but the “physiological determinants,” “diagnostic specificity,” and “main psychotherapeutic and pharmaco-logical [sic] treatment methods” for PTSD are presented not as settled science but as subjects in need of further empirical inquiry (p. 38-39). This list of research priorities also calls for further research on “the experience of facing trauma as an individual, versus the effect of trauma when experienced with others,” a recurring theme among several of the texts I analyze in this chapter.

This report indicates that for the WHO, mental health and psychosocial support were recognized as integral components of disaster preparation during the UN’s “decade for natural disaster reduction.” Though the report acknowledges that some experts disagreed about the scope of the problem of disaster mental health, it does not place trauma at the center of this debate. The

role of trauma and PTSD as the primary objects of expert intervention to be managed through this type of disaster relief is largely taken for granted.

4: Prioritizing trauma, questioning PTSD – *Theory and Practice of Psycho-social Projects Under War Conditions in Bosnia-Herzegovina and Croatia* (1995)

Unlike the other handbooks and manuals that I analyze in this chapter, this book (Agger, 1995) was developed in response to a specific crisis: the wars in Bosnia-Herzegovina and Croatia in the early 1990s, which were ongoing at the time the book was written. Unlike the three texts I have discussed so far, this book focuses on the mental health and psychosocial impact of war rather than natural disasters; all of the texts that I analyze in the remainder of this chapter also address emergencies related to war and other violent conflict, either instead of or in addition to natural disasters. The preface to the book emphasizes that psychosocial aid was a new form of humanitarian assistance, and that the European Community Humanitarian Office (ECHO) had never previously funded this type of work (p. 7). While the book is explicitly oriented toward "psychosocial" rather than "mental health" interventions, the distinction between these two approaches is never clearly articulated.

Though much of the book comprises a directory of ECHO-funded NGOs that provided psychosocial aid in Croatia and Bosnia-Herzegovina, it also includes a more general section about the theoretical foundations of psychosocial support for civilian populations affected by war. The first chapter in particular provides a general framework for psychosocial aid in wars and emergencies. It therefore holds relevance, for the purposes of my analysis, beyond the wars in Bosnia-Herzegovina and Croatia, and is a text that has been frequently cited by scholars who are critical of mental health and psychosocial aid in emergencies (e.g. Pupavac, 2001; Summerfield, 1999).

To an even greater extent than the WHO report from the previous section of this chapter, this text presents trauma as the central problem in which psychosocial aid should intervene. Trauma is framed as an urgent, pervasive problem with far-reaching and long-lasting consequences for populations affected by war and other violent conflict. In the first, 20-page chapter of the book alone—which is the section of the text most relevant to my analysis—the terms "trauma" and "traumatized" appear 73 times, and the terms "PTSD" and "post-traumatic stress disorder" appear four times. (While trauma is strongly foregrounded, then, PTSD is *not* emphasized, for reasons I will discuss.) The book's introduction asserts that "about 700,000 people in [Bosnia-Herzegovina and Croatia] have a severe trauma response condition and are in need of professional help" (Agger 1995, p. 9), a claim that is repeated several times throughout the book. The unmet need for expert intervention for trauma is described as vast and dire; the current level of available assistance is claimed to be "only sufficient to cover less than 1% of the estimated needs for psycho-social assistance to the traumatized" (p. 13).[4] The introduction goes on to claim that a failure to provide this aid "will have a massive impact in the next generations, and can even ignite new wars" (p. 9). The need for psychosocial aid in response to trauma is justified, then, not only in terms of compassion and empathy, but also as a way to prevent future violence perpetrated by the victims of the current war.

The concept of trauma first appears in the book's epigraph, a quotation by the European Commissioner responsible for humanitarian aid, which identifies women and children as "the first victims of war" who are "often deeply traumatised in ways not visible to the naked eye" (p. 4). This linking of trauma—and the need for mental health care more generally—with women and children, and to a lesser extent other "victims of violence and rape"—is pervasive

[4] This framing reflects the logic of the Global Mental Health "treatment gap" paradigm that I discuss in more detail in Chapter IV.

throughout the book, and also appears in several other texts that I analyze in this chapter.[5] While sexual violence is far from the only source of wartime trauma that the book identifies, it is one that is frequently and explicitly named as an impetus for providing psychosocial support for civilians during war. Sexual violence is also, implicitly or explicitly, framed as a problem that affected women and girls almost exclusively; this framing of sexual violence is one way in which trauma (and mental health or psychosocial interventions more broadly) is discursively linked to gender.

The broader framing of trauma as a severe, urgent, yet uncontested problem in this book is complicated by its more detailed discussion of the PTSD diagnosis. As I note above, while "trauma" appears very frequently throughout the introductory section of the book, "PTSD" does not. One key passage about the meanings and limitations of PTSD in emergencies helps to explain the relative scarcity of references to PTSD elsewhere in the text. I excerpt the relevant passage at length below:

> "There is much debate on the part of mental health professionals on the use of [the PTSD] diagnosis in situations of war or organized violence. On the one hand, it is not reasonable to attach such diagnoses to whole populations, as they lose their value as working tools if applied indiscriminately. Moreover, refugees and [the] displaced do not appreciate further stigmatization through such labeling. They are not insane, but are suffering from the war. The careless use of diagnoses can lead to individualization of a problem which is basically political. On the other hand, under-diagnosing by not recognizing the symptoms or their significance may lead to overlooking the suffering of large numbers of people. This failure may support the development of long range chronic reactions." (Agger, 1995, p. 18).

[5] This theme most notably appears in the refugee mental health manual that I discuss in the next section.

In this passage, the idea of a professional controversy or debate about PTSD helps explain why the introductory section of the book does not foreground the PTSD diagnosis in its discussion of trauma.[6] Within this framing of the controversy, the PTSD diagnosis is problematic because of the shared, collective nature of the violence and disruption associated with disasters and emergencies—and PTSD's "individualization" is contrasted with the specifically *political* nature of war and conflict, as though political violence is not experienced at the scale of the individual. Unlike Quarantelli (1987), this text does not explicitly argue that shared suffering in disasters and emergencies has a protective psychological effect at the individual level. Instead, it claims that diagnosing PTSD might be inappropriate in situations of collective violence for a utilitarian reason: psychiatric diagnoses "lose their value as working tools" if they apply to too many members of a population. In this view, the PTSD diagnosis is only salient when applied to exceptional cases; paradoxically, if everyone has PTSD in disasters and emergencies, no one can. Another source of ambivalence toward PTSD in this passage is cultural: the author warns of "stigmatization" associated with PTSD, ironically using the stigmatizing term "insane" in this explanation. This suggests that trauma is not necessarily stigmatized, but the medicalization of trauma through the PTSD diagnosis produces a greater risk of stigmatization for people affected by war and conflict.

This book does not offer a clear prescription for how aid workers should address trauma in the context of this controversy. It advises them to "talk with those who have experienced trauma," to be attentive to symptoms of PTSD, and to "reassure the victims that they are not losing their minds, but rather reacting in a normal and even adaptive way to extreme events" (p.

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[6] I note, however, that in the directory of psychosocial programs that makes up the second section of this book, over one-third of the programs listed (43 out of 117) mention care and treatment for PTSD or post-traumatic stress as either an existing activity or an outstanding need. PTSD was, apparently, a matter of concern in practice for the organizations providing this aid.

18). Like the WHO report I discussed in Section 3, this text assumes that there are “normal” or natural ways for humans to respond to trauma. At the same time, it cautions about the “chronic reactions” (presumably abnormal and pathological in nature) that can result if people affected by disasters and emergencies do not receive appropriate and effective psychosocial aid.

Although this book’s focus on trauma has been interpreted as an indication that psychosocial humanitarian aid “pathologiz[es] populations” (Pupavac, 2004, p. 489), the text itself is cautious about the medicalization of trauma with the PTSD diagnosis in wars and other emergency settings. Certainly, it frames trauma as a pervasive and harmful outcome of war and conflict that compels outside, expert intervention—but the expertise that is needed to address trauma would not necessarily come from within the domain of medicalized mental health care.

5: Selective erasure of trauma – *Mental Health of Refugees* (1996)

In 1996, the World Health Organization (WHO) and United Nations High Commissioner for Refugees (UNHCR) jointly published a field manual for aid workers titled *Mental Health of Refugees* (WHO/UNHCR, 1996). The publication of the manual represented the culmination of a lengthy process; parts of it had been drafted and were under review as early as 1988 (Westermeyer, 1988). During my research at the Archives of the WHO, I analyzed early drafts of some of its chapters, along with correspondence related to its production, and feedback that the authors received from aid workers about preliminary drafts. In this section, I analyze the final, published version of the manual in conjunction with these archival sources that provide insights into the process of its creation.

Although *Mental Health of Refugees* is, like the handbook for mental health care in disasters that I discussed in Section 1, a guide for direct service providers, these two publications were written with very different audiences in mind. Whereas Cohen and Ahearn’s (1980)

handbook was intended for use by medical professionals with specialized mental health training and experience, *Mental Health of Refugees* was created to assist aid workers who had no previous background in medicine or mental health. The introduction notes that the book is written in "simple language," designed to be comprehensible and useful for aid workers who had no prior training or education in mental health care (p. 2), some of whom may not have been native English speakers. The fact that the manual was written for non-specialists, and therefore avoids technical terminology, may partially account for the primary finding of my analysis of the published text: the term "trauma" is virtually absent from the final version of the manual. All references to "trauma" and "PTSD" were edited out of an earlier draft of the chapter on common mental disorders prior to publication. The term "trauma" appears only in the chapter about rape and sexual violence and, once, to describe "traumatic life events" experienced by refugee children (p. 63). Otherwise, trauma is elided entirely.

In contrast with the final version of *Mental Health of Refugees*, an unpublished draft of its chapter on common mental disorders (Mollica, 1990) foregrounds trauma and comments extensively on PTSD. The preliminary draft identifies "trauma (torture) related syndromes" as one of the three most common mental health problems that aid workers could expect to encounter among refugees, along with depression and "behavioral disturbances" caused by head injuries (p. 2). It encourages aid workers to "ask about…trauma events and trauma related symptoms" when conducting initial interviews with refugees (p. 9) and refers to refugees as being potentially "traumatized" several times throughout the chapter. It also includes a section specifically focused on PTSD that both questions the appropriateness of the PTSD diagnosis for refugee populations and provides guidance for the identification and treatment of refugees with PTSD. I excerpt the passage that most directly expresses this doubt about PTSD below:

> “Unfortunately, the term posttraumatic stress disorder does not accurately describe the psychiatric conditions related to trauma for most refugees. First, for most refugees, the violence is never ‘post’, i.e., it is almost always ongoing. Second, the acute and chronic forms of PTSD have not been clearly defined. Third, the validity of PTSD as a disease has not been fully established. Many scientists consider it a form of depression; almost all PTSD researchers consider it a normal human response to violent, life-threatening situations. Finally, those unique cultural and psychological responses associated with torture and trauma are just being described.” (Mollica, 1990, p. 18)

Scientific uncertainty and questions about the “validity” of PTSD—both in general and for refugees specifically—figure prominently in this author’s hesitations about the applicability of PTSD for refugees. Like several other texts I have analyzed in this chapter, the idea of a “normal human response” to trauma recurs here—but this author considers the symptoms of PTSD themselves to be part of this “normal” or “natural” reaction to the violence, danger, and disruption that many refugees would have experienced. This framing of PTSD as a normal response to the abnormal circumstances of war and displacement undermines its salience as a psychiatric diagnosis.

In the published version of *Mental Health of Refugees*, this section on PTSD from the unpublished draft was replaced with a section titled “Mental disorders caused by hurtful and frightening events” (pp. 52-55). Instead of describing the psychologically harmful experiences as “traumatic,” it describes them as “hurtful,” “violent,” “terrifying,” or “frightening.” The terms “trauma” and “PTSD” are never used, yet the list of symptoms that are included closely mirrors the symptoms of PTSD that are listed in the unpublished draft version of the chapter (Mollica, 1990, p. 19). Namely, both versions of this text identify flashbacks; intrusive thoughts or memories; nightmares; insomnia and disturbed sleep; being easily startled; hopelessness; and fear or anxiety as the primary symptoms of concern. This set of symptoms closely aligns with

typical diagnostic criteria for PTSD, but the published version of the manual does not connect them with the PTSD label.

In my archival research at the WHO, I did not come across any direct discussion or explanation of the decision to remove references to trauma and PTSD from the chapter on common mental disorders. It is possible that the erasure of trauma and PTSD from the text was part of the process of removing excessively technical or specialized terminology. However, in the larger context of my analysis in this chapter, it seems equally possible that this decision was informed by the ongoing professional disagreement about the salience of the concept of trauma and the appropriateness of the PTSD diagnosis in disasters and emergencies.

There is one major exception to the omission of trauma from the published version of the manual: its chapter on "Helping victims of rape and their communities" describes various characteristics of "rape trauma" (p. 123), and advises aid workers to pay attention to "signs of post-traumatic stress" (p. 125) in rape victims. In total, this chapter uses the terms "trauma," "traumatic," or "traumatized" eight times. With the exception to one brief reference in the chapter on supporting refugee children, these terms never appear at all. Even the chapter focusing on victims of torture makes no mention of trauma or traumatic stress. Though refugees experience many forms of violence, only sexual violence is associated with trauma in the final version of the manual. Rape and sexual violence are presented as problems that affect women and girls almost exclusively; a brief paragraph acknowledging that "men can be raped too" (p. 125) did not appear in an earlier, unpublished draft of the chapter that I reviewed at the Archives of the WHO (Wali, 1990). The acknowledgement that it is possible for men to be victims of sexual violence reads like an afterthought in the final text because it was, in fact, added as an afterthought. As with the elision of trauma from the rest of the manual, I cannot offer a definitive

explanation for the inclusion of trauma in the chapter about rape and sexual violence. The clear association between trauma, sexual violence, and gender, however, is particularly meaningful because it is a theme both in *Mental Health of Refugees*, and in the book on psychosocial aid in Bosnia-Herzegovina and Croatia that I discussed in Section 4.

In the draft version of this refugee mental health manual, the PTSD diagnosis is represented as being controversial, and possibly inappropriate for refugees and other displaced people. As in several other texts I have analyzed, the idea of a “normal” or “natural” psychological reaction to disasters and emergencies plays a role in the controversy—but, uniquely, the unpublished draft depicts PTSD itself as a “normal” psychological response for refugees. This text also provides an additional example of a discursive link between trauma, gender, and sexual violence.

6: Multiple meanings of PTSD – WHO correspondence (1998)

In this section, I discuss two letters, written by a WHO official to external experts, from the WHO Archives. These sources are somewhat akin to the seminar transcript that I analyzed in Section 2; they are a piece, however fragmentary, of an informal conversation among experts about competing conceptual paradigms and technical approaches to managing mental health care in disaster or emergency settings. Like the handbook I discussed in Section 5 above, the letters that I analyze here focus specifically on the mental health of refugees, as part of the WHO’s ongoing involvement in that area at the time, in collaboration with UNCHR and other organizations and agencies.

In a 1998 letter to an American academic psychiatrist, the WHO’s Coordinator of Mental Health of Refugees offered comments and suggestions related to a mental-health project in post-

conflict Rwanda. The principal comment that the WHO coordinator offered about the program was a critique of the use of the PTSD diagnosis:

> "WHO, as in fact many others working in mental health of refugees and displaced persons [do], uses PTSD as a common language but not necessarily as a working method in terms of research or care, particularly in non-Western countries." (Petevi, 1998a)

In place of the standard diagnostic criteria for PTSD, the coordinator recommended the use of an alternative "trauma questionnaire" that had been developed specifically for use with refugees by a group of experts at Harvard University, and was designed to "remedy the shortcomings of PTSD and of other paradigms." She emphasized that the questionnaire was initially designed for use in Southeast Asia, and would therefore need to be "revalidated" for use in Rwanda. Here, the WHO coordinator rejected the PTSD diagnosis as such for refugees and other displaced persons, but accepted trauma as a primary matter of concern for this population. She advocated for the use of an alternative diagnostic instrument, developed by Western experts on the mental health of refugees. This indicates that she took issue not with trauma as an object of expert intervention, but with the PTSD diagnosis specifically.

What does it mean for PTSD to function as a "common language" but not a "working method"? This distinction, though not explained in the letter, suggests that PTSD was a term with multiple meanings, used by different actors in different ways—and that it was not always defined by formal, written diagnostic criteria. Another letter from later in the same year written by the same WHO official to a different American academic,[7] offers some additional clues about her understanding of the difference between PTSD as "common language" versus "working method." In this second letter, the WHO coordinator recounted a conversation she had had with a

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[7] The recipient of this letter is the author of the chapter on common mental disorders in *Mental Health of Refugees*, the handbook I discussed in the previous section.

representative of the Office of International and Refugee Health at the US Department of Health and Human Services. In the context of what the WHO coordinator described as "the prevailing confusion over mental health" of refugees, she found common ground with the American official, as described in the excerpt below:

> "[The American official and I] had a long discussion, through which I realized very quickly that he has the same conceptual framework as ours, in the sense that he does not believe that the biomedical model and the clinical-mental illness approach (PTSD, psychotherapy, psychiatric treatment, etc.) are the appropriate responses to refugee trauma and suffering." (Petevi, 1998b)

She went on to propose that funding for "individual clinical interventions" for refugees—which presumably would be aligned with the "biomedical model and the clinical-mental illness approach"—be redirected to other programs that were guided by a "community-based model." The inappropriateness of PTSD (and medicalized mental health care more generally) for refugees is associated here, at least in part, with its orientation toward the scale of the individual rather than the collective. Again, the WHO coordinator accepted the idea that trauma was a significant concern for refugees, but rejected PTSD and, more generally, "the clinical-mental illness approach" for this population.

Despite their brevity, these two pieces of correspondence capture several key dimensions of the controversy (or "confusion") among experts that surrounded trauma and PTSD for refugees including a concern with the cultural specificity of PTSD and trauma-based mental health interventions and resistance to the medicalization of "trauma and suffering" among refugees. The description of PTSD as having utility as a "common language" but not a "working method" illuminates the fact that multiple meanings of the term, with differing policy implications, circulated within this community of experts at the time.

7: Sidestepping trauma and PTSD – *IASC Guidelines on Mental Health and Psychosocial Support in Emergency Settings* (2007)

The final text that I analyze in this chapter is the set of MHPSS guidelines published by the Inter-Agency Standing Committee (IASC) in 2007, which have been widely adopted by humanitarian actors for the design and implementation of MHPSS responses in disasters and emergencies. The *IASC Guidelines* are so influential and well-known that they have been interpreted as a representation of the current practice of MHPSS as a whole (Rehberg, 2015), and are closely associated with an emergent "consensus" view of professionals and experts in the MPHSS field (Ventevogel, 2018). As such, these guidelines are a key tool for the reproduction and dissemination of expert knowledge and best practices for MHPSS in emergencies globally. The guidelines are intended to be used by humanitarian actors without specialized mental health training. As I discuss more extensively in Chapters IV and V, the guidelines emphasize forms of humanitarian aid both within and beyond the health sector; medicalized mental health care is not foregrounded in the guidelines as the primary form of care that MHPSS actors should be concerned with.

Overall, the *IASC Guidelines* contain very few references to either "trauma" or "PTSD." The terms "post-traumatic stress disorder" or "PTSD" appear only six times in the 182-page document, excluding references; there are an additional six occurrences of the terms "trauma," "traumatic," or "traumatised." (By comparison, the terms "distress" or "distressed" appear 54 times.) This lack of emphasis on trauma and PTSD may be surprising to outsiders to the MHPSS field; accordingly, one of the "Frequently Asked Questions" at the beginning of the document addresses this directly, posing the question, "Why do the guidelines not focus on traumatic stress and post-traumatic stress disorder (PTSD)?" The guidelines provide the following answer to this question:

> "The types of social and psychological problems that people may experience in emergencies are extremely diverse….An exclusive focus on traumatic stress may lead to neglect of many other key mental health and psychosocial issues. There is a wide range of opinion among agencies and experts on the positive and negative aspects of focusing on traumatic stress. The present guidelines aim to provide a balanced approach of recommended minimum actions in the midst of emergencies. The guidelines include (a) psychological first aid for people in acute trauma-induced distress by a variety of community workers…and (b) care for people with severe mental disorders, including severe PTSD, by trained and supervised health staff only." (IASC 2007, p. 16).

The guidelines do not endorse a clear position among the "wide range of opinions" about PTSD in emergency settings. They acknowledge the existence of some degree of controversy about the diagnosis, but provide no additional information about what the "positive and negative aspects" of prioritizing PTSD in emergencies might be. The guidelines do not necessarily question the validity of PTSD as a diagnosis or claim that it is not a matter of concern in emergencies, but nor do they place it at the center of MHPSS interventions. Finally, this passage indicates that both mental health specialists and those without specific mental health training have roles to play in addressing trauma and its consequences in emergencies.

Another key passage in the guidelines, which describes recommendations for "psychological support for survivors of extreme stressors (also known as traumatic stressors)" (p. 119), offers additional insights into how trauma and PTSD are conceptualized by the authors of the text. According to this section of the guidelines, "[i]n most cases, acute distress will decrease naturally, without outside intervention, over time. However, in a minority of cases, a chronic mood or anxiety disorder (including severe post-traumatic stress disorder) will develop" (p. 119). Here, PTSD is presented as a rare reaction to "extreme stressors," and is contrasted with the normal, "natural" reaction to these stressors that the majority of the population will experience.

In their account of the development of the *IASC Guidelines,* Wessells and van Ommeren (2008) identify PTSD and traumatic stress as one of the most "contentious, complex issues" that the task force responsible for the guidelines were confronted with (p. 212). They acknowledge that expert opinion on PTSD in emergency settings was divided in the late 1990s and early 2000s, but report that members of the task force expressed "little interest in a focus on traumatic stress" (p. 214), based on their collective experience working in disasters and emergencies. Interestingly, the task force was skeptical of certain forms of scholarly knowledge about mental health in emergencies: MHPSS professionals with extensive on-the-ground experience questioned the credibility of "surveys of mental disorders in emergency contexts" that had been "published in prestigious journals" (p. 214). Though the community of experts on the task force were apparently in relative agreement that trauma and PTSD should not be the primary focus of the guidelines, debates about evidence and the production of knowledge about PTSD and other mental disorders in disasters and emergencies continued to be a source of disagreement in the field.

Conclusions

Trauma and PTSD have been a significant focus of dissensus among experts in disaster mental health, refugee mental health, psychosocial humanitarian aid, and MHPSS. Among the seven texts that I have analyzed in this chapter, an unqualified prioritization of trauma as a matter of concern in disasters and emergencies was the exception rather than the rule. I found persistent references to a controversy among experts on the subject of trauma and PTSD in disasters and emergencies, and multiple, sometimes contradictory, characterizations of that controversy. In some cases, the terms "trauma" and "PTSD" themselves are partially or entirely omitted from the texts, sidestepping the potentially contentious nature of these concepts. These

two terms lack fixed, agreed-upon meanings within this body of expert knowledge, with, for instance, PTSD being understood to signify a “common language” but not a “working method” by experts in refugee mental health at the WHO (Petevi, 1998a). These slippages in meaning prevent trauma and PTSD from fully cohering as ontologically stable entities within the MHPSS apparatus, and impede their effective circulation as objects of expert intervention across different communities of knowledge and practice. Ontological disputes about what trauma is and whether PTSD is a valid psychiatric diagnosis in emergency contexts are accompanied by epistemological disconnects, in which the same evidence is taken up to support opposing schools of thought about whether trauma is a problem in need of expert remediation in disasters and emergencies (Quarantelli, 1987). Experts in this field have frequently sought resolution to the controversies about trauma and PTSD through additional empirical research, but the conceptual incompatibilities in which the controversies are based indicate that they cannot be resolved simply by collecting and analyzing sufficient amounts of data.

The *medicalization* of human suffering has been a major source of skepticism toward trauma and PTSD within this controversy among experts. Many of the texts that I analyzed raised concerns about the medical model’s emphasis on the scale of the individual in situations in which violence, suffering, and disruption is, by definition, a shared, collective experience. Concerns about medicalization are closely linked to ideas about stigma and the cultural meanings of trauma and PTSD. Because trauma is frequently linked to dysfunction and vulnerability, describing people as “traumatized” is understood to carry harmful cultural connotations. Medicalization is also conflated with pathologization, or the interpretation of trauma and PTSD as aberrations from a “normal” or “natural” psychological response to disasters and

emergencies—though the question of what, specifically, would constitute a normal reaction to these circumstances remains largely unanswered.

Chapter IV – Ambivalence Toward Standardization: Medicalization and the Mental Health Treatment Gap Paradigm in Disasters and Emergencies

The medicalization of psychological and social suffering through Western mental health paradigms has been a significant source of dissensus within MHPSS and its related fields. Medicalization is the process by which "increasing domains of social experience…come to be interpreted via biomedical categories," and medical interventions are deployed as remedies for social problems (Good, 2010, p. 119). Medicalization can be a means for patients to acquire greater agency, as their suffering becomes legible to experts, but it can also act as a "coercive force turning people into patients in order to control and manage them" (Dumit, 2012, p. 66). Medicalization makes it possible for psychiatric diagnoses to be made and treatments for mental disorders to be administered, but also has the potential to marginalize or delegitimize other forms of care and support for people who are experiencing psychological distress. In the previous chapter of this dissertation, I discussed the role that critiques of medicalization have played in the controversy among experts about trauma and PTSD in disasters and emergencies. In this chapter, I extend my analysis of expert perspectives on the medicalization of human suffering in disasters and emergencies. Specifically, I examine and historically situate a key theme that emerged from the interviews that I conducted with MHPSS professionals: ambivalence about the expansion of medicalized mental health care as a form of humanitarian aid. While my informants recognized some clear benefits associated with this form of care, they also identified significant problems with including it in humanitarian emergency response.

Many of my informants told me that medicalized mental health care was not a major component of their work in emergency settings, and that they did not necessarily wish for it to take on a larger role in MHPSS programming. This was a somewhat surprising perspective to hear from a group of people employed to advocate for, plan, and implement mental health and

psychosocial interventions. Explaining this ambivalence toward mental health care may seem like a simplistic analytical goal, but as I will show, its origins are varied and complex, involving the multiscalar, multidimensional contexts in which MHPSS actors work; potential harms associated with mental health care; and the valorization of multiple forms of expertise within the social and professional world of MHPSS. My informants' perspectives reflect the ontological and epistemological multiplicity of the MHPSS field, in which medicalized and non-medicalized forms of care and knowledge coexist and sometimes conflict with each other. Ambivalence toward medicalization is one element that contributes to a broader tension between MHPSS as a standardized, technical practice and one that is based in humanity, empathy, and interpersonal connection.

In relation to mental health, medicalization is closely linked to pharmaceuticalization, the proliferation of pharmaceutical treatments for mental disorders, and critical scholarship about the globalization of Western mental health care often focuses on the social and cultural impacts of these psychopharmaceuticals (e.g. Applbaum, 2006; Jenkins, 2010). While concerns about the use of psychopharmaceuticals were a notable source of my informants' hesitations about medicalized mental health care, my interpretation of the concept of medicalization in this chapter is not narrowly focused on pharmaceuticals. Rather, I understand medicalization to encompass the introduction of multiple paradigms, practices, and technologies associated with Western mental health care, including, but by no means limited to, the use of psychopharmaceuticals. The expansion of Western mental health care through the process of medicalization is based upon the assumption that "all humans in all societies have essentially the same minds" (Ecks, 2010, p. 108), and thus are susceptible to the same diagnosable mental disorders. This presumed universality of mental health diagnoses and treatments forms the basis of a key paradigm in

Global Mental Health that provides important context for much of my analysis in this chapter: the concept of the mental health "treatment gap."

Medicalization and the treatment gap paradigm in Global Mental Health and MHPSS

The mental health treatment gap is the idea that disparities in the delivery of mental health care worldwide represent an urgent unmet need: a veritable gap that should be closed or narrowed by increasing access to mental health diagnosis and treatment, especially in parts of the world with little to no existing mental health infrastructure. It has become a dominant paradigm in Global Mental Health, providing justification for increased funding and attention for mental health care globally (Lancet Global Mental Health Group, 2007). As described in an influential 2004 paper in the *Bulletin of the World Health Organization,* the treatment gap is defined by "the absolute difference between the true prevalence of a disorder and the treated proportion of individuals affected by the disorder" (Kohn et al., 2004, p. 859). Within this definition, it is mathematically obvious that the numerical value of the treatment gap would be reduced by *either* reducing the prevalence of mental disorders *or* increasing the number of individuals who receive treatment. However, neither this paper nor the wider expert discourse about the treatment gap focus on reducing the prevalence of mental disorders. Instead, the process for narrowing or closing the treatment gap is generally discussed in terms of "scaling up" access to mental health treatment worldwide (e.g. Jordans and Kohrt, 2020). Additionally, the above definition of the treatment gap presumes that mental disorders have a "true prevalence" that precedes the introduction of Western mental health paradigms. The "lack of care" (WHO, 2015, p. 1) for mental health that constitutes the treatment gap provides the central justification for much of the current movement for increased access to mental healthcare worldwide (Lancet Global Mental Health Group, 2007).

Within the world of Global Mental Health, the treatment gap is not solely conceived of as a technical problem to be resolved via the expansion of access to Western mental health care, however. The World Bank (Mnookin, 2016) and the *Lancet* (Patel et al., 2018) have argued that the treatment gap is a significant driver of economic underdevelopment and inequality. Within this discourse linking mental health and economic productivity, the treatment gap is framed as an economic as well as a public health problem. Arthur Kleinman (2009, p. 603) has argued that the suffering of people with untreated mental disorders—not only as a result of the symptoms of their illnesses, but also due to the "appalling, dreadful, [and] inhumane" conditions in which they live and the many forms of violence they experience—represents a "failure of humanity." For Kleinman, there is a powerful moral imperative to close the treatment gap that echoes the moral imperative to alleviate suffering that animates humanitarian intervention (Fassin, 2012; Reid-Henry, 2014). Both humanitarian emergency response and efforts to close the Global Mental Health treatment gap are justified, in part, by a moral obligation to respond to the suffering of distant others.

Kohn et al. (2004) offer several different explanations for why the treatment gap exists, first emphasizing individual-level ignorance and "fail[ure] to seek help" before acknowledging "direct barriers" such as "limited availability or lack of availability of services" as relevant factors (p. 859). This framing is suggestive of the primacy of the individual as the unit of analysis within the treatment gap paradigm, while also assigning more responsibility (and, perhaps, blame) for the existence of the treatment gap to people with mental disorders than to the health systems that deliver mental health care and societal contexts in which those systems are situated. More recent literature (e.g. Patel et al., 2018) places a greater emphasis on structural and systemic factors, and conceptualizes the treatment gap in a more multifaceted way: as a

"care gap," a "quality gap," and a "prevention gap" (Patel et al., p. 1556) rather than something reducible to a single numerical figure. Additionally, Patel et al. (2018) have called for an expansion of the aims of the movement for Global Mental Health beyond narrowing the treatment gap and towards "the improvement of mental health for whole populations" (p. 1553). Though discourses surrounding the treatment gap have become more nuanced over time, the treatment gap paradigm remains a foundational concept for Global Mental Health policies and practices.

The World Health Organization's influential Mental Health Gap Action Programme (mhGAP), which was initiated in 2008, is emblematic of the treatment gap paradigm as it has been translated into policy, and the WHO reports that mhGAP has now been implemented in over 100 countries worldwide (WHO, 2022). The mhGAP model is based on the training and education of general healthcare providers about mental health care; as such, it implicitly understands psychological suffering through a medical lens. The problems that mhGAP seeks to address include neurological disorders such as epilepsy in addition to mental and substance-use disorders, suggesting that mental disorders are conceived of as primarily biological conditions (that is, as diseases of the brain). The *mhGAP Intervention Guide* (WHO, 2016), or *mhGAP-IG*, describes itself as a manual for use by health care workers such as nurses and primary-care physicians who have no special training in mental health care. Though the *mhGAP-IG* frequently emphasizes the important role of psychosocial factors for mental health, it primarily provides guidance for recommended medical interventions, including but not limited to the use of medication to manage and treat mental disorders. While the mhGAP model as a whole is not oriented toward disasters and emergencies, the *mhGAP Humanitarian Intervention Guide* (WHO, 2015), a condensed version of the *mhGAP-IG* adapted for use in humanitarian settings,

has been widely disseminated among humanitarian actors since its publication in 2015. As I will discuss in this chapter, several of my informants mentioned the mhGAP model by name during our interviews, indicating that it is well-known among professionals currently working in this field.

While the concepts of the treatment gap and the goal of scaling-up mental health care have become ubiquitous in Global Mental Health discourses, they have also been critiqued as manifestations of "cultural imperialism" (Miller, 2014, p. 131) that inappropriately pathologize human experience and erase the sociopolitical contexts of human suffering (Mills and Fernando, 2014). Roberts et al. (2022) have argued that the treatment gap for common mental disorders (such as depression and anxiety) is the product of a lack of *demand* for mental health care rather than a shortfall in supply, reflecting a disconnect between the actual desires and needs of people with mental disorders and that which Western mental health care can provide. According to Jansen et al. (2015), the treatment gap paradigm erases the crucially important role of community for mental wellbeing by focusing on the individual rather than the collective and overlooking culturally specific dimensions of mental health and wellness. More fundamentally, the treatment gap paradigm does not account for variations and ambiguities in what "counts" as treatment for mental disorders at all, particularly in the context of substance abuse disorders (Bartlett, Garriott, and Raikhel, 2014) or in relation to the use of traditional and faith healing techniques (Pham et al., 2021). As I will show, these issues of cultural appropriateness, a lack of demand for mental health care, and individual versus community-level interventions were all relevant factors in my interview informants' reservations about the provision of medicalized mental health care in disasters and emergency settings.

A note on sources

In this chapter, I incorporate a discussion of data from my archival research alongside my analysis of the contemporary practice of MHPSS in emergencies. The relationship between my archival sources and interview data is untidy. It would be too simplistic to claim that the problems, conflicts, and concepts that I have observed in my archival sources are directly analogous to the stories that my informants told me in our interview conversations. However, I have found significant echoes and linkages between these two sources of data. Putting them in conversation with each other adds depth and nuance to my analysis, and illustrates the intractability of some of the dilemmas and challenges that MHPSS professionals are confronted with in their work.

One source from the WHO Archives has been particularly salient to my analysis of medicalization in this chapter: a 1993 report written by the French psychiatrist Jean-Pierre Hiegel (1993), titled *Today's psychiatric needs of the Cambodians: A social or a medical answer?*. Hiegel had worked in refugee camps in Southeast Asia since the 1970s, consulting with UNHCR, the ICRC, and assorted NGOs in the area, in addition to the WHO itself. In response to the answer posed by the report's title, he argued that "the psychiatric needs of the Cambodians should be met, for now, at a social and not at a medical level" (Hiegel, 1993, p. 1). Many of the problems with medicalized mental health care that he mentioned in the report resonate with observations that my informants related to me in my interviews: these include the logistical difficulty of providing mental health care during wartime, problems related to maintaining privacy and confidentiality, the lack of existing mental health systems for long-term treatment, and the fact that inappropriate or poorly executed mental health treatment can cause more harm than benefit.

Contrary to his initial emphasis on a "social" approach to mental health, however, at the end of the report, Hiegel proposed a surprising and distinctly *medical* intervention, as described in the excerpt below:

> "The answer in all cases is simple: make one single potent, cheap and easy to use sedative drug available all over the country in every health center. The drug of choice is Chlorpromazine[8]…. It may need years of medical and psychiatric studies to make a correct diagnosis of the exact form of a psychosis, but anyone in the street can recognize that a person is crazy. This opinion, in fact, is usually a valid diagnosis of psychosis. It would be easy to inform any prescriber, even with no medical background, that those who are 'chukot'[9] and present a socially disruptive behavior should receive at first 25 mg of Chlorpromazine 3 times a day and 100 mg before sleep, a dosage which could be rapidly increased if necessary….There are [fewer] risk[s] than with other antipsychotic drugs that the patients develop side effects, such as rigidity and shaking which, if they appear, can be corrected by one antiparkinson drug." (Hiegel, 1993, pp. 10-11)

The indiscriminate distribution of psychopharmaceuticals in humanitarian settings is yet another theme that arose in my interviews, as I will discuss later in this chapter. While Hiegel's report begins with a call for a "social" remedy to the problems created by untreated mental illness in Cambodia, it ends by recommending mass drug administration, an unquestionably biomedical solution—albeit a peculiar and potentially dangerous one. Chlorpromazine, like most antipsychotic medications, is associated with potentially serious side effects, including movement disorders (the "rigidity and shaking" that Hiegel refers to), which can be both debilitating and permanent for some patients (Mayo Clinic, 2022). Hiegel suggested that humanitarian aid workers provide this drug not only to treat psychosis, but also for insomnia

[8] Chlorpromazine is an antipsychotic medication sometimes sold under the brand name Thorazine, and is currently included in the WHO's Model List of Essential Medicines (WHO, 2021, p. 51).

[9] Earlier in the report, Hiegel suggests that 'chukot' is a Khmer term for psychosis, but provides no further detail about its cultural significance or specific clinical presentation.

associated with depression and other common mental disorders. The Hiegel report is illustrative of the doubts and hesitations about medical approaches to addressing mental health in humanitarian settings that experts have harbored for decades. It suggests that addressing the lack of standard Western mental health care in these contexts can be complex for practitioners to navigate—and that they have, at times, struggled to disentangle the medical from the social.

Expert ambivalence about medicalized mental health care in disasters and emergencies

In our interview conversations, my informants Rafaela, Claudia, and Beatrice all told me that they did not think that most people needed mental health care. They referred to the minority of cases that *did* require care from trained mental health specialists as "rare," "bizarre," or "extreme." Instead of a medicalized model of mental health treatment, they advocated for an "integration approach," emphasizing that psychosocial interventions improved mental health without the need for mental health specialists or medical treatments. They described non-medical forms of care as being generally more effective and appropriate in emergency settings than the work of psychiatrists and psychologists. (Many of these non-medicalized interventions were classified as "psychosocial" rather than "mental health" programs, though the distinction between these two categories is not always clearcut. I discuss the relationship between mental health and psychosocial support in greater detail in Chapter V of this dissertation.) My informants used the term *integration* in two different but interrelated ways: to describe the promotion of individual involvement in collective or community projects, and to describe the integration of MHPSS aims and priorities into multiple forms of humanitarian aid. Both senses of integration were understood by my informants as alternatives to an individualistic, medicalized approach to MHPSS.

However, not everyone I interviewed was skeptical of medicalized mental health care or the treatment gap paradigm, as represented by the mhGAP model. My informant Nadia credited mhGAP with helping to increase global awareness of the importance of mental health. Many of my informants mentioned that mental health and psychosocial support had gained significantly broader acceptance and support among humanitarian agencies, organizations, and funders in recent years. As my informant Claudia put it, "You don't have to fight as much [anymore] for PSS[10] to be included" in humanitarian emergency response. Nadia specifically attributed this increase in resources and recognition to the mhGAP model. In the quotation below, she reflected on the mhGAP model and its global impact:

> "Mental health has gained an enormous amount of traction since about probably 2008. It's really picked up…because WHO released the Mental Health Gap [Action] Programme that really enabled governments to understand practically, 'I know I have a problem in my provision of mental health care for my citizens. How can I actually do this better? What's the concrete training that staff need? What are the drugs that they need? What's the supervision program that they need? What are the priority disorders that I need to be focused on?'
>
> "The package that they developed [with mhGAP] has really advanced the integration of mental health into health systems in the country. And then in turn, this has built up the mental health systems in countries where mhGAP has been rolled out over time. For example, mental health has had *much* more success than its other counterparts for non-communicable diseases; it's had much more success than diabetes and cancer and hypertension [in emergency settings]."

In Nadia's view, the mhGAP model made mental health legible to country governments as a clearly defined technical problem that could be solved through education, training, expert

[10] Psychosocial support

management, and the procurement and dissemination of psychotropic medications. She described mental health as being in competition, presumably for limited resources and attention, with other health problems and diseases. The treatment gap paradigm, as described here, silos mental health, and within the mhGAP model, fragments mental health care through its focus on the selection of "priority disorders" that Nadia mentioned in the quotation above. In this way, mhGAP and the treatment gap paradigm differ from the "integration approach" that my other informants advocated for.

The disconnect between the treatment gap paradigm and an "integration approach" to MHPSS may account for some of my informants' reservations about mhGAP and medicalized mental health care. In what follows, I analyze two additional sources of my informants' ambivalence toward medicalized mental health care: the multiscalar, multidimensional contexts in which disasters and emergencies occur; and the potential harms to beneficiaries of humanitarian aid that are associated with mental health care.

The contexts of disasters and emergencies: a source of ambivalence

The mhGAP model is ostensibly designed to accommodate differing needs for mental health care in different geographical contexts. According to the introduction of the *mhGAP Intervention Guide* (*mhGAP-IG*), "it is essential that [the model guide] is adapted to the unique national or local situation. Users may select a subset of the priority conditions or interventions to adapt and implement, depending on the contextual differences in prevalence and availability of resources" (WHO, 2016, p. 3). In addition to the selection of priority conditions and interventions, the guide identifies "language translation and ensuring that the interventions are acceptable in their sociocultural context and suitable for the local health system" (WHO, 2016, p. 3) as key elements in the process of adapting the mhGAP model to local contexts. The mhGAP

model, then, strives to be both universally applicable and context-specific, in a way that produces a "contingent and strategic…universality in relation to mental health" (Mills, 2022, p. 1). The publication of the *mhGAP Humanitarian Intervention Guide* (WHO, 2015), a condensed version of the *mhGAP-IG* tailored for use by humanitarian organizations and agencies, reflects the fact that the contexts of disasters and emergencies require even further adaptation of the general principles and practices that constitute the mhGAP model.

In this section, I analyze the multiscalar contexts of disasters and emergencies that complicate the treatment gap paradigm and the implementation of medicalized mental health care through the mhGAP model and similar approaches. First, I examine a set of problems related to the "staff, space, stuff, and systems" (Farmer, 2014, p. 38) that are necessary for mental health care in disasters and emergencies. The immediate material realities that characterize disaster and emergency settings, as well as the lack of existing mental health infrastructure in the places in which these crises most often occur, both impede the provision of effective mental health treatment. Second, I analyze a story that one my of informants related to me about the implementation of mhGAP in a country that was experiencing a violent conflict. Though my informant viewed the adaptation of the mhGAP model in Syria to be a success, the story she told me involved the ironic elision of war as a relevant context to the delivery of mental health care. By adhering to a set of decisions that were made by the Syrian government before the beginning of the war, this implementation of mhGAP appeared to take for granted that the violence, disruption, and dislocations associated with the conflict did not fundamentally alter the mental health needs of the country's citizens, both within and beyond its borders.

Considerations of "staff, space, and stuff" frequently limit the feasibility of providing mental health services in disasters and emergency settings. My informant Nadia told me that in

emergency contexts, the most challenging aspects of MHPSS work were "practical considerations…[such as], 'How do I get supplies to this particular area? How do I get medication to the clinic? How do I get staff to move around safely?'" She further highlighted the problem of "recruit[ing] staff with the appropriate pre-existing competencies…for them to be able to do the job" as a particularly challenging aspect of the work. This was a common theme in the interviews I conducted; several of my informants described difficulties with recruiting and retaining staff with appropriate mental health qualifications, experience, and training. Trained psychologists and psychiatrists are frequently not available at all in disasters and emergencies, and when these mental health specialists *are* available, they are often international volunteers who do not share a common language with potential patients. A lack of available interpreters makes it impossible for these clinicians to effectively communicate with and provide care for the beneficiaries of humanitarian aid.

The lack of appropriate space (and especially the lack of *private* space) in refugee camps and other emergency settings also acts as a barrier to the delivery of mental health care in these contexts. Because mental health assessments frequently involve the discussion of intimate, sensitive, and personal subjects, effective mental health care requires access to private space in a way that most other forms of humanitarian aid generally do not. In the quotation below, my informant Beatrice mentioned this problem in relation to a mental health program that she had observed and disapproved of:

> "People would come and say, [for example,] 'I can't sleep,' and everybody around is listening! There was no privacy. There was no space….If people came to report SGBV[11], there was no examination….When there's no privacy, and everybody can overhear what everybody else is saying, then you don't report cases of sexual and gender-based

[11] Sexual and gender-based violence

> violence, because you're being overheard by everybody else in the queue standing around you."

The personal, private, and sensitive nature of mental health assessments, particularly in relation to sexual violence, made it impossible for this mental health intervention to function effectively. I return to Beatrice's discussion and criticisms of this particular mental health program later in this chapter. As I will discuss, Beatrice offered several additional critiques of how the program was conducted, but in the quotation above, she identified the basic material conditions in which the mental health program took place as a limiting factor that made it impossible for clinicians to conduct private, confidential mental health evaluations.

My informant Rafaela also identified the material conditions in emergency settings as a barrier to mental health treatment, but focused on the challenges of daily life for the beneficiaries of humanitarian aid rather than the availability of suitable space for the practice of mental health care. Paralleling Roberts et al. (2022)'s attribution of the treatment gap to a lack of demand for mental health care, Rafaela told me that many potential beneficiaries of mental health interventions such as psychotherapy are simply not interested in taking part in these activities. She linked this lack of demand to both the lived realities of day-to-day life in disasters and emergencies, and to the cultural irrelevance of the mhGAP model and Western-style mental health care more generally in non-Western cultural contexts. I quote her at length below:

> "[Humanitarian aid workers] have imposed this model from the Western culture that we have. All of these organizations are Western organizations that bring this [mhGAP] model to other countries and other contexts where they don't necessarily see this support as something that they need, or as something effective. In most cases, actually, there are a lot of dropouts. [People] don't continue with therapy because…I mean, I remember in South Sudan, for instance, in these old, crowded camps—mostly it is women alone with multiple children there to take care of: their own children, plus other children that are

unaccompanied, separated [from their families], or orphans. And these women are the only [adult] in the family or the household.

"They have to wake up very early in the morning to risk their lives to go and fetch water, or get firewood and so on. And then, I mean: they have this hour of therapy every other day, and of course they don't see the value! For them, it's just a further burden in the sense that they already struggle with the time that they have, to be able to just care for the very basic needs of their families and themselves."

According to Rafaela, even when specialized mental health services—in this case, weekly psychotherapy sessions—were available, they were perceived by their intended beneficiaries as having little value in a context in which "very basic needs" for physical survival were not guaranteed.[12] Compared with ensuring that they and their children had access to food and water, talk therapy seemed like a superfluous imposition to the women in the camps where Rafaela had worked.

In addition to immediate, practical concerns related to "staff, space, and stuff," the lack of existing mental health *systems* poses a challenge to the provision of mental health care in disasters and emergencies. Several of my informants emphasized that there were few or no psychiatrists and very little functional mental health infrastructure in many of the countries where they had worked. There were no mental health systems to which they could refer patients for ongoing treatment. Short-term mental health interventions with no referrals for ongoing treatment meant that psychiatric patients would be, as one of my informants put it, "abandoned to themselves." This lack of existing infrastructure—the absence of functioning mental health systems—made even some short-term mental health interventions inadvisable, since effective

[12] In Chapter V of this dissertation, I discuss competing interpretations of how different human needs are ranked and prioritized relative to each other through an analysis of the IASC "intervention pyramid."

mental health treatment typically requires ongoing care over the course of weeks, months, or even years. As I describe in more detail later in this chapter, attempting to provide mental health care without appropriate follow-up and ongoing treatment could cause more harm than benefit for people with mental disorders in disasters and emergencies.

By highlighting the problems with mental health interventions during disasters and emergencies in places without functioning mental health systems, I do not mean to imply that my informants thought that mental health systems were unnecessary in these places. On the contrary, two of my informants noted that the consequences of this lack of access to mental health treatment could be dire for people with severe mental disorders. These consequences included being indefinitely incarcerated or even shackled. According to a Human Rights Watch report (Human Rights Watch, 2020), hundreds of thousands of people with mental disorders in 60 different countries have been chained or confined in very small spaces at least once. This is an enduring problem; I also found references to the shackling of people with mental disorders in my archival research. According to the Hiegel (1993) report, "patients are tied to their beds" in places where psychotropic medications are not available to serve as a "chemical strait-waistcoat" (pp. 7-8).

My informant Claudia also framed the use of psychopharmaceuticals as an alternative to physical confinement for people with severe mental disorders. She told me at first that "not everyone needs mental health support," but clarified her thinking in the quotation below:

> "It's not to say that there's *not* a need for mental health support in many of the contexts where you have the big emergencies. Take South Sudan: you have 11 million people, and you have one psychiatrist. People are put in jail because of mental health conditions. They have no mental health institutions, and nowhere to put people. They are scared of [people with mental health conditions]: scared of what they will do to others, [and] scared of what they will do to themselves. And they end up in a jail, and in a system where there

> is no medication. There are, of course, certain conditions that you cannot treat without medication—there are some chemical conditions that need medication."

According to Claudia, in the absence of access to mental health care, people with severe mental disorders were often imprisoned, and she saw mental health treatment as an alternative to this confinement. In the passage above, she conflated this needed mental health treatment with the use of psychopharmaceutical medications (such as antipsychotics) for the management of severe mental disorders. The phrase "chemical conditions that need medication"[13] reinforces a conceptualization of this subset of mental disorders as biological illnesses in need of medical intervention—in contrast, perhaps, to other forms of psychological distress that could be effectively addressed through non-medicalized, psychosocial interventions.

My informant Beatrice also told me about her experience witnessing people with mental disorders living in extremely inhumane conditions in the absence of effective treatment—but she rejected the idea that medicalized mental health care was the only way that severe mental disorders could be addressed in such contexts. I quote her at length below:

> "In many of the countries where we work, there is no access to mental health care. I've been working in Pakistan, in Sindh [Province]. 32 million [people]. What do you have? Do you have anywhere you can send people who have problems? No, of course not. You don't have anything, and you don't even want to go see the hospitals because they're so horrible….
>
> "In each and every village there would be somebody who would be in chains because they had a mental problem. We made interventions talking to [their families]…about what they could do, how they could handle it, how they could release the person from the

[13] Claudia's choice of words here also echoes the controversial and scientifically dubious "chemical imbalance" model of mental illness.

> chains and have him or her be a member of the community….This is how you would address mental health problems in a community setting."

Instead of describing incarceration in jails or other institutions, Beatrice told me about seeing people with severe mental disorders being confined and physically restrained by members of their families and communities. While she did tell me that some "very, very bizarre and specialized cases" needed to be referred to specialists for treatment, she described psychoeducation—a psychosocial rather than a medical intervention—as being an effective alternative to physical confinement for many people with severe mental disorders. While Claudia saw medication as a necessary tool for allowing people with severe mental disorders to live independently in their communities, Beatrice argued that there were effective non-medical strategies that families and communities could employ in places where treatment by mental health specialists is inaccessible. Both Beatrice and Claudia envisioned a limited role for medicalized mental health care in the places where they worked, and their comments suggest that there is significant diversity of opinion about the appropriate scope of medicalization within the MHPSS field.

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As I have mentioned, the mhGAP model explicitly calls for adaptation to different national contexts, based on differences in the "disease burden" of different mental disorders and the "availability of resources" for different mental health treatments (WHO, 2016, p. 3). In what follows, I discuss a story that my informant Nadia told me about the implementation of the mhGAP model in Syria, and how this country-specific adaptation was put into practice during the Syrian Civil War. Nadia's story suggests that in practice, the mhGAP model does not account for or adapt to the changing contexts of war and displacement.

In our interview conversation, Nadia described the Syrian adaptation of mhGAP in terms of the selection of "priority disorders." The *mhGAP-IG* is largely organized around a set of "priority MNS [mental, neurological, and substance-use] conditions"[14] (WHO, 2016, p. 2) and it emphasizes the selection of a subset of these conditions on the basis of known prevalence and treatment availability as an important step (and, possibly, the *most* important step) in the process of adapting the general model to specific local circumstances. Nadia's emphasis on the selection of priority disorders in our conversation, then, mirrored the emphasis that the *mhGAP-IG* places on this specific aspect of local adaptation. She considered mhGAP in Syria to be a success story of how the model could be adapted to address country-specific needs, and how humanitarian agencies could tailor their MHPSS interventions in different national contexts during and after violent conflicts. I quote her at length below:

> "mhGAP was just beginning to be rolled out in Syria [in 2010 to 2011]—so, just before the conflict started. I was working there at the time, and we had discussions with the government as to which mental health disorders they wanted to prioritize. There's thirteen [priority disorders in the mhGAP model], and [the Syrian government] chose five out of the thirteen. Then, when the conflict started and humanitarian funding was coming in, agencies were able to get funding to also do mhGAP in the refugee-hosting countries around Syria, as well as within Syria. Agencies that had a presence in Syria…were able to say, 'Okay, what are the five priority disorders?' And they were then able to do the

[14] The set of priority conditions that are included in version 2.0 of the *mhGAP Intervention Guide* (WHO, 2016) comprises the following:

- depression;
- psychoses;
- epilepsy;
- child & adolescent mental & behavioral disorders;
- dementia;
- disorders due to substance use;
- self-harm/suicide;
- and "other significant mental health complaints."

I note that these conditions do not directly correspond with specific diagnostic codes from either the DSM or ICD. They represent categories of mental health and neurological problems rather than specific psychiatric diagnoses.

trainings for the doctors working on the Syrian refugee population on the same five disorders, because it's the same population group: it doesn't matter whether it's a Syrian in Turkey, or in Lebanon, or in Iraq, or a Syrian in Syria. They're [all] Syrian.

"Those agencies were able to come together…and they said, 'Okay, this is what the Syrian government has got as their top five priorities. This is what we need to be training on when we're doing mhGAP trainings for refugee populations and for health clinics providing services to refugees.' Which was quite a strategic move! That's an example of a system-building approach as well, because a lot of the doctors that were working with the refugee populations are also Syrian psychiatrists themselves that had left the country. So, you would hope that when—or *if* they go back, they are also equipped with the same knowledge of the same disorders and can fit back into the system again somehow."

In the passage above, Nadia equated the process of adapting the mhGAP model to the Syrian context with Syrian government officials' selection of five priority disorders; knowledge of how to treat these five disorders became synonymous with the ability to offer appropriate and effective mental health care to Syrian patients, by virtue of their nationality.

According to Nadia's story, the appropriateness of the Syrian adaptation of mhGAP was unchanged by the onset of war, suggesting that the conflict had little or no impact on population-level mental health care needs in Syria.[15] Furthermore, even Syrian refugees who had fled the country due to the conflict were assumed to have the same mental health needs as Syrians who had remained in their home country. In Nadia's words, "it doesn't matter whether it's a Syrian in Turkey, or in Lebanon, or in Iraq, or a Syrian in Syria. They're [all] Syrian." The changed geographical context and lived experience of being displaced as a refugee "doesn't matter," with regard to the provision of mental health care. Despite the fact that country-level adaptations of

[15] The inference that war does not meaningfully affect mental health at the population level is particularly suggestive in light of the controversy surrounding trauma and PTSD in disasters and emergencies that I analyze in Chapter III of this dissertation.

the mhGAP model are informed by a recognition of the importance of context for mental health care, the story that Nadia told me about mhGAP during the Syrian Civil War was characterized by a curious *inattention* to the context of the war—or even the drastically changed social contexts associated with becoming a refugee. The decisions that the Syrian government had made about mhGAP during peacetime were assumed to be equally relevant during the war—a conflict in which the Syrian government itself was a primary combatant.

In this section, I have examined multiple ways in which the contexts of disasters and emergencies pose challenges to the expansion of medicalized mental health care to narrow the treatment gap. Logistical concerns, such as a lack of trained mental health specialists and appropriate spaces for mental health evaluations, present the most obvious of these. However, Nadia's story about the Syrian mental health system during the Syrian Civil War suggests an insensitivity within the mhGAP model to the changed contexts associated with violent conflict and other emergency contexts.

Aid as harm: a source of ambivalence

A second major theme that helps explain my informants' ambivalence about medicalized mental health care is the capacity for mental health interventions to cause harm for their intended beneficiaries. The central activities of Western mental health care—the diagnosis and treatment of mental disorders—are fraught with potential harms; some of these harms are specific to the context of humanitarian emergency response. There is a multidimensional relationship between MHPSS and perceived and actual harms to the beneficiaries of humanitarian aid. Humanitarian assistance itself has a long history of causing harm, and one function of MHPSS is to guard against the potential harms that can arise from other forms of aid. Similarly, the history of psychiatry has been punctuated with practices that are now widely considered to be harmful—

such as the early 20th-century "fever cure" (Shorter, 1997, p. 192), or the inclusion of homosexuality as a diagnosable mental disorder in the *DSM-II* until 1973 (Drescher, 2015)—and this potential for mental health care to cause harm also informs the practice of MHPSS in emergencies. The distinction between helping and harming in these contexts is sometimes unclear, and several of my informants described difficulties in navigating this ambiguity. Their reservations about the potential harms of MHPSS interventions included concerns about interference with cultural practices and beliefs; the use (and misuse) of psychopharmaceuticals; and disrespectful or inappropriate behavior by humanitarian aid workers. In what follows, I provide historical context and framing about the perceived harms of humanitarian aid in relation to mental health and examine the ways that this relationship between aid and harm is reflected in the *IASC Guidelines* (IASC, 2007). I then analyze the multiple forms of harm associated with MHPSS aid that my informants expressed concerns about during our interview conversations.

The core ethical imperatives that drive humanitarian intervention include both *beneficence* (doing good) and *non-maleficence* (not causing harm). Recognition of harmful unintended consequences of humanitarian intervention has been a central feature of debates about the fundamental identity and appropriate role and scope of humanitarianism for decades (Barnett and Weiss, 2011). According to Barnett (2005), an increasing awareness of fact that humanitarian aid could cause more harm than good was a key factor that drove the increasing institutionalization and standardization of humanitarianism in the 1990s. One notable outcome of this process was the creation of the Sphere Project in 1997, which led to the drafting of a widely adopted set of standards and principles that guide humanitarian response (Sphere Association, 2018).

One function of mental health and psychosocial support in disasters and emergencies has been to mitigate the harmful effects of humanitarian aid itself. A 1986 letter between two WHO officials involved in refugee mental health, for example, contained the following remark in relation to the management of fleas and lice in refugee camps:

> "Agencies in Ethiopia were shaving the heads of people in the camps. Could it be emphasised that this is not (or is it?) advocated, particularly for an already traumatised population?" (Simmonds, 1986)

As early as the 1980s, then, the field of refugee mental health involved identifying and intervening in ostensibly well-intentioned actions by humanitarian aid agencies that had the potential to increase distress and suffering for refugees.

Concerns about the potential harms of mental health care *itself* in disasters and emergencies have also circulated among experts for decades. In the 1987 seminar on the mental health impact of disasters that I analyzed in Chapter III, Enrico Quarantelli claimed that most psychosocial problems that arose during and after disasters were "not agent-generated as much as…response-generated" (Quarantelli, 1987, p. 4)—that is, they were not the result of the disaster itself, but instead were unintended consequences of actions by the organizations and agencies responding to the disaster. In the report from the WHO Archives I discussed earlier in this chapter, Jean-Pierre Hiegel (1993) wrote that,

> "There may be fields where it is better to do even very imperfect things than nothing at all. This is not the case in psychiatry, because imperfect things quickly turn into hell or, at least, into a situation where the patients do not really get help and just become more unhappy than they were." (pp. 6-7)

According to Hiegel, the potential harms of his field of practice were so great, that it was often better, when working with refugees, for psychiatrists to abstain from attempting to treat potential

patients at all—though, as I previously noted, his recommendation that antipsychotic medication be widely administered in refugee camps, including by non-experts, was itself potentially harmful.

The evolution of currently recommended MHPSS interventions has been shaped in part by the recognition that previous standards of care were potentially harmful. Changing attitudes toward the practice of psychological debriefing provides an instructive example of this tendency. Psychological debriefing (also referred to as critical incident debriefing) is an approach to mental health treatment in the aftermath of disasters and other highly stressful experiences that became popular in the 1990s; debriefing was replaced by other forms of psychosocial support after research found that debriefing not only failed to prevent the onset of PTSD, but in some cases led worse mental health outcomes than control groups (e.g. Rose et al., 2002). The practice of psychological first aid (PFA), a widely adopted form of psychosocial support in disasters and emergencies, is described as "an alternative to psychological debriefing" in a PFA guide for field workers (WHO, 2011, p. ii). PFA is a distinctly non-medicalized form of care; it is described as "a humane, supportive response to a fellow human being who is suffering" (WHO, 2011, p. 53), one of the aims of which is "not to cause harm" (p. ii). The replacement of debriefing with PFA represents a move away from a potentially harmful medicalized intervention in favor of an approach centered on communication, comfort, and facilitating access to needed services and resources.

The *IASC Guidelines* (IASC, 2007) repeatedly make reference to potential harms associated with humanitarian aid. They warn that medical care that involves "disrespectful treatment or poor communication threatens dignity, deters people from seeking health care, and undermines adherence to treatment regimes, including for life-threatening diseases" (p. 116).

They warn that providers of food aid and nutritional support must be attentive to "interactions between psychosocial well-being and food/nutritional security" because "[i]gnoring these interactions causes harm, resulting for example in programmes that require people to queue up for long hours to receive food, treat recipients as dehumanised, passive consumers, or create the conditions for violence in and around food deliveries" (p. 168). They note that site planning and shelter provision can result in "overcrowding and the lack of privacy commonly found in camps and other settings," which negatively impact mental health and psychosocial wellbeing (p. 174). Finally, the guidelines note that access to water and sanitation "can either improve or harm mental health and psychosocial wellbeing" because, for instance, "poorly lit, unlocked latrines have become sites of gender-based violence, including rape…and conflict at water sources has become a significant source of distress" in some emergencies (p. 179). The *IASC Guidelines* establish MHPSS principles and objectives for multiple sectors of humanitarian aid,[16] and one purpose of this inter-sectoral focus is the prevention of different sources of harm to the beneficiaries of aid.

During the interviews that I conducted, my informants discussed several different potential sources of harm that could result from MHPSS interventions. Their comments reveal the complexities of translating written policies for MHPSS into practice in emergency settings, and they identified medicalized mental health care as a type of intervention that is particularly fraught with potentially harmful unintended consequences.

My informant Arsène identified the relationship between MHPSS interventions and culture as a potential source of harm related to this work, and stressed the importance of avoiding harm as a foundational principle in the field:

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[16] I discuss the relationship between MHPSS and the humanitarian sectoral model (or "cluster approach") in more detail in Chapter V.

> "We don't want to change the lifestyle of the people, but you do want to show them…the positives and the negatives of what they do. Because if you try to change the community, then that would be causing more harm. As you know, usually in MHPSS, we work with the principle of 'no harm.' You don't want to cause harm."

In practice, Arsène told me that balancing respect for cultural practices with the desire to provide appropriate aid could be complicated. In the quotation below, he gave me an example of how he navigated this dilemma:

> "If a community believes that talking to their pastor or talking to their priest will help them, then our main role would be to talk to that priest and train [him in] the technical bit of psychosocial support…. But, for instance, you'll get a community that doesn't go to the hospital because that's what their church and their religion tells them. When you come into such a situation, we want to, kind of, twist the mindset of these people and show them that, yes, your religion is good, and it's good to believe in what you believe. However, in terms of the practical bits, you need to see a doctor. It's something like that."

Another situation in which Arsène discussed a need for MHPSS aid workers to intervene in cultural practices involved gender equity in education:

> "For instance, there is a community that you might be working in, and they don't believe in education. They don't believe in taking their girls to school…. We want to take care of them, especially the girl child. We have adolescent psychosocial activities which are inclined to the adolescent age. But at the same time, we want to come up with an activity or a process whereby [the community] will accept the need of going to school later."

In these examples, the desire to not "change the lifestyle" of the beneficiaries of humanitarian aid came into conflict with the harms that would result from avoiding necessary medical care or preventing girls from accessing education. The *IASC Guidelines* call for aid workers to exercise "ethical sensitivity" (IASC, 2007, p. 107) in navigating situations like the ones that Arsène described to me. The guidelines call for humanitarian aid workers to build connections with local

spiritual and religious leaders in order to improve the cultural appropriateness of humanitarian aid—but they note that "some spiritual, cultural, and religious practices cause harm" and that aid workers must "maintain a critical perspective, supporting cultural, religious, and spiritual practices only if they fit with human rights standards" (IASC, 2007, p. 107). The *IASC Guidelines* also note that while collaboration with traditional healers is encouraged, "some traditional healing practices are harmful. They may, for example, include the provision of false information, beatings, prolonged fasting, cutting, prolonged physical restraint or social cleansing rituals that involve the expulsion of 'witches' from the community" (pp. 136-137). According to MHPSS principles, if cultural beliefs themselves cause harm, it is appropriate and even necessary for aid workers to intervene in and attempt to alter existing cultural practices and beliefs.

In other interviews, my informants linked their concerns about the potential harms associated with MHPSS to the use of psychopharmaceuticals. My informant Rafaela directly linked her reservations about pharmaceutical treatments for mental disorders to the mhGAP model and the treatment gap paradigm that it represents. I quote her at length below:

> "I really want to express a concern about this mhGAP model, because in my experience, I've seen it applied in a very, very wide way, with very poor supervision. Sometimes very inappropriate diagnoses [are] made because people don't have appropriate training or appropriate supervision. They do these diagnoses of psychosis, or whatever, without knowing exactly what they're doing, and administering very heavy medications, psychotropics, without follow-up…. Then, the patient is completely abandoned to themselves.
>
> "We're still pushing for this model without really being aware of the heavy consequences when such a model is not implemented in a very qualitative [high-quality] and very supervised and good, appropriate way.

> "So, what I mean is that if I open a CFS[17] and I do it with poor quality, I can really make further harm to a child, which is really quite dangerous and really worrisome. But…if I start to administer psychotropics and I have no qualifications to do so…the harm, of course, is even more. That's something that scared me in the past. I've seen it, and it was quite a shock, to be honest."

Rafaela associated the mhGAP model with medicalized mental health interventions, and especially with the use of psychotropic medications. She suggested that mhGAP protocols are, in practice, often implemented in a haphazard and unskilled way, and while she noted that many forms of aid (such as the creation of a child-friendly space in a refugee camp) have the potential to cause harm if implemented poorly, she characterized the inappropriate use of psychotropic medications as being uniquely dangerous. Rafaela did not reject Western mental health care or the use of medication to treat mental disorders in general; rather, she identified the unique harms that aid workers could cause when they attempted to provide this form of care without appropriate expertise in disasters and emergency contexts.

My informant Beatrice echoed Rafaela's concerns about poorly implemented mental health programs, especially in relation to psychotropic medications. In the quotation below, she expanded on her discussion of the mental health program that she was critical of that I mentioned in the previous section of this chapter:

> "There was another medical team that worked [with] us. In my intervention, putting psychosocially trained people [in] was criticized because it was seen that the other team was there, but they had *no clue* what they were doing. It was just an old guy handing out pharmaceuticals—it was pills like they were candy! The intervention was horrible, and I couldn't stop it. If somebody goes out as a medical doctor, and just sits [there], and doesn't see the patients, but prescribes pills…. It was a mess! It was a joke.

[17] Child-friendly space

> "I could put other measures in place in my team, because I had trained them, and I knew them, and I'd been with them. And they knew the standards—they knew how to behave, and they knew how to be respectful."

At first, Beatrice mentioned the reckless distribution of psychopharmaceuticals as the most salient indicator that the mental health intervention was inappropriate and potentially harmful. In her description of her own team's competence, she did not discuss their superior understanding of appropriate prescription practices for psychopharmaceuticals, however, despite the fact that they were also medical professionals. Instead, she emphasized that her staff "knew how to behave" and "knew how to be respectful." In fact, she equated "knowing the standards," or possessing valuable expert knowledge, with this appropriate and respectful conduct. The expertise that she most valued in her team was associated with a capacity for respectful and inoffensive behavior rather than knowledge of specific diagnostic criteria or dosage guidelines for medications. The kinds of care that she prioritized are more reminiscent of the humane, compassionate, non-specialized care associated with psychological first aid than of standardized, medicalized mental health care.

Conclusions

Contrary to the set of assumptions associated with the Global Mental Health treatment gap paradigm, my informants generally did not advocate for an increase in the use of medical treatments for mental disorders as part of MHPSS humanitarian aid. They recognized that practical considerations made it difficult to implement medicalized mental health interventions in disasters and emergency contexts, but also expressed concerns that Western mental health care was culturally inappropriate in some of the places where they worked. Potential harms associated with mental health care (especially the inappropriate use of psychopharmaceuticals) also

contributed to my informants' equivocal attitudes toward biomedical responses to distress and suffering in humanitarian settings. Resistance to medicalization reflects an ongoing tension between MHPSS as a standardized, technical practice versus a form of care that is humane, compassionate, and sensitive to context. Several of my informants' concerns about medicalized mental health care were echoed in some of my archival sources, suggesting that this is a durable problem within MHPSS and its antecedent fields, without easy or obvious solutions. Alternatives to medicalized mental health care in disasters and emergencies—like psychoeducation for the families of people with severe mental disorders, or even simply training aid workers to "be respectful," as my informant Beatrice put it—are promising possibilities for addressing mental health and psychosocial wellbeing in disasters and emergencies. To an even greater extent than mental health interventions, however, these approaches to MHPSS are difficult to standardize, classify, and, in some cases, even describe.

Chapter V – Inconsistent Categories: Classifying MHPSS in Disasters and Emergencies

In this chapter, I analyze several systems of classification that are fundamental to the practice of mental health and psychosocial support in emergencies. For each of these classification systems, ostensibly straightforward categories become difficult to interpret and enact in practice, and category-defining boundaries become cloudy and imprecise. These problems of classification cause confusion and miscommunication in the field; they also illuminate fundamental challenges in precisely and consistently defining the appropriate scope of both mental health care and humanitarian emergency response. They are emblematic of the "conceptual fuzziness" (Miller et al., 2021, p. 1) that plagues MHPSS as a field of practice. Furthermore, I argue that they are illustrative of a fundamental and unresolved tension within the field between a concern with *integration* and an opposing tendency toward *fragmentation*. I explore these tendencies through four interrelated classification systems that are crucially important within the MHPSS apparatus: the distinction between "mental health" and "psychosocial support"; the relative prioritization of different forms of humanitarian aid, as organized in the MHPSS "intervention pyramid"; the role of MHPSS within the humanitarian "cluster approach"; and the definition of a minimum humanitarian response.

The systems of classification that I analyze in this chapter are manifestations of the "epistemology of the grid," which Dixon and Jones (1998) describe as "a procedure for locating and segmenting a complex, relational, and dynamic social reality" (p. 251). A grid attempts to impose rigid, static boundaries on social phenomena that are inherently amorphous and fluid. In the case of the intervention pyramid and the cluster approach, this ordering and segmentation of the social world is represented visually, through simple diagrams that reinforce the logic of the grid. In both cases, the *meanings* associated with (superficially straightforward) visual

representations of these systems of classification are subject to multiple, competing interpretations in practice. For each of the four classification systems in this chapter, significant disconnects, slippages, and ambiguities emerge when the abstract tidiness of the grid collides with the messiness of the social world of MHPSS.

Bowker and Star (1999) define classification as the "spatial, temporal, or spatio-temporal segmentation of the world," and classification systems as "set[s] of boxes (metaphorical or literal) into which things can be put to then do some kind work—bureaucratic or knowledge production" (p. 10). This work that classification systems do in the world has significant consequences; classifications "give advantage or they give suffering" (Bowker and Star, 1999, p. 6). Classification systems, mundane and esoteric alike, are important to pay attention to and think critically about because of the often invisibilized, taken-for-granted nature of their impact on the social world. While many scholars have critically analyzed psychiatric diagnosis as a classification system with wide-ranging social consequences (e.g. Hacking, 1998; Kleinman, 1988; Metzl, 2009), in this chapter I focus instead on how mental health itself is categorized within several intersecting systems of classification.

Processes of classification plays a crucial role in initiating, organizing, and regulating emergency humanitarian response; these systems of classification are subject to frequent rethinking and revision, which both reflects and contributes to a complicated, messy social reality in the humanitarian field. Prior to 2018, for instance, the United Nations Office for the Coordination of Humanitarian Affairs (OCHA) and the Inter-Agency Standing Committee (IASC) used the Level 3 (or L3) designation to identify the most urgent and severe humanitarian emergencies which "require[d] system-wide mobilization" (IASC Working Group, 2012). In 2018, this system was replaced with a process called a Humanitarian System-Wide Scale-Up

activation (or "Scale-Up"); the change was prompted by a perceived need to "reinforce focused collective and time-bound emergency procedures" by limiting the Scale-Up activation to six months, with the possibility of a single three-month extension (IASC, 2018, p. 1). Categories such as the L3 emergency or the Scale-Up activation determine where, when, for how long, and what forms of aid are available in disasters and emergencies. The classification systems themselves and their frequent replacement or modification have a direct impact on where humanitarian aid is delivered, to whom, and for how long.

The categories of "disaster" and "emergency" themselves have been subject to ongoing expert discussion for decades. An illustrative 1994 report from WHO's Department of Emergency and Humanitarian Action (EHA) defines disaster as "failure to cope with an emergency," taking the view that "*emergencies are inevitable* rather than exceptional" (emphasis in original), but that disasters can be avoided with appropriate planning and preparation (WHO, 1994). Disasters are distinguished here from emergencies primarily in terms of how effectively humans respond to them. The classification of different *types* of disaster has also been a matter of significant concern for experts in the field. At a 1990 meeting of the EuroActDIS[18] Working Group, the first order of business was to classify disasters, using a "three-dimensional" typology in which disasters are either "military [or] non-military; natural or unnatural; and acute, chronic or intermittent" (Schüffel, 1990). The working group furthermore created a scale to rank different "degrees of disaster," consisting of the following categories: major accidents; catastrophes; "actual disasters"; cataclysms; and calamities. A final category for "apocalyptical experiences" was considered, but ultimately eliminated by the Working Group. Presumably, no humanitarian aid agency would be capable of ameliorating the apocalypse; there was no place

[18] Concerted European Action on Coping with Disasters.

within this system of classification for a category of disaster in which expert knowledge had no utility. None of the above categories were explicitly defined in the meeting minutes, nor was there a discussion of how operational and financial requirements might differ among these different categories of disaster. The work of creating an epistemological grid was viewed as an important task for the Working Group, even in the absence of an explicit discussion of the practical implications of the grid.

The *IASC Guidelines* (IASC, 2007) identify both “armed conflicts and natural disasters” (p. 17) as examples of emergency contexts in which the guidelines should be used. Many humanitarian organizations routinely provide aid in both of these types of emergencies. Fassin and Pandolfi (2010) have argued that placing both types of emergency in the same broad category (i.e. that which compels humanitarian intervention) conflates natural disasters and human conflicts, producing “a form of naturalization—or depoliticization—of war” (p. 13). The coming into being of the category of the “complex emergency” or “complex humanitarian emergency” in the 1990s marked an important development in the humanitarian field and in the global political order more broadly (see, for example, Dillon and Reid, 2000). In my archival research, I noticed an uptick in references to “technological disasters” as scenarios for experts to plan for in the years following the Bhopal chemical leak in 1984 and the Chernobyl nuclear accident in 1986. The specific logics of classification that organize humanitarian emergency response have varied over time and will doubtless continue to do so—but the impulse to produce, revise, debate, and pontificate upon systems of classification seems to be a constant within the field of humanitarianism.

The production of *standards* has also been a frequent subject of discussion, revision, and debate within the field of humanitarian emergency response, most notably through the drafting of

the *Sphere Handbook* (2018) in the late 1990s. Classification (the twin process of standardization, according to Bowker and Star (1999)) has seemed to attract less overt attention within the social and professional world of MHPSS. In what follows, I analyze four interrelated systems of classification that are foundational to the practice of MHPSS in emergencies. The first two (the distinction between mental health and psychosocial support, and the IASC intervention pyramid) are largely internal to the MHPSS apparatus; the third and fourth (the humanitarian cluster approach and the minimum humanitarian response) concern the role of MHPSS within humanitarian emergency response more broadly. As part of my analysis, I evaluate each system of classification according to the three basic properties of classification systems identified by Bowker and Star (1999). First, a classification system must be organized according to "consistent, unique classificatory principles" (p. 11). Secondly, the categories created in accordance with these principles must be mutually exclusive: none of the elements organized by the system can belong to more than one category. Finally, these categories must be exhaustive, with the system "provid[ing] total coverage of the world it describes" (p. 11). Bowker and Star acknowledge that these fundamental requirements for a classification system to be consistent and for its categories to be both exclusive and exhaustive are seldom, if ever, fully met in practice. The fact that these four classification systems all fail to meet Bowker and Star's criteria is less noteworthy than the specifics of *how* they do so.

Classifying "mental health" and "psychosocial support"

In this section, I discuss the relationship between the two components of the composite term "mental health and psychosocial support," and examine the "conceptual fuzziness" (Miller et al., 2021, p. 1) that arises from the use of the term itself and the multiple conceptual frameworks it represents. Though the term "MHPSS" is widely used in the humanitarian field,

the definitions of and distinction between "mental health" and "psychosocial support" are not always clearly articulated. In their "call for greater conceptual clarity" in the MHPSS field, for instance, Miller et al. (2021, p. 1) eschew the labels of "mental health" and "psychosocial support" in favor of "clinical" and "social-environmental" to describe the two major approaches in the field, though it is questionable whether these alternative terms are clearer or more accurate descriptors than "mental health" and "psychosocial support." None of the MHPSS professionals whom I interviewed rejected the terms "mental health" and "psychosocial support" per se, they told me that in practice, the distinction between the two categories was sometimes unclear, and terms like "psychosocial support" could be "vague," "unhelpful," and "distancing for people" in practice. The problem of differentiating between mental health and psychosocial support is further complicated by the fact that the category of psychosocial support is very difficult for some humanitarian actors to define or explain at all. Even those who explicitly identify themselves as being providers of psychosocial support are sometimes unable to communicate what they have done in practice to deliver this form of humanitarian aid.

The *IASC Guidelines* (IASC, 2007) define "mental health and psychosocial support" as "any type of local or outside support that aims to protect or promote psychosocial well-being and/or prevent or treat mental disorder," and explain that the two terms "are closely related and overlap" but "reflect different, yet complementary, approaches" (p. 1). The guidelines further note that MHPSS-related terminology varies across humanitarian agencies and organizations, and claim that "the composite term *mental health and psychosocial support (MHPSS)* serves to unite as broad a group of actors as possible and underscores the need for diverse, complementary approaches in providing appropriate supports" (pp. 1-2, emphasis in original). The adoption of the composite term aims to bring together multiple theoretical and practical orientations toward

this area of humanitarian aid, and the *IASC Guidelines* and the MHPSS term they introduced are often associated with professional consensus within the field (e.g. van Ommeren, Saxena, and Saraceno, 2005). The explanation of the term *mental health and psychosocial support* in the *IASC Guidelines*, however, notes that "exact definitions of these terms vary between and within aid organizations, disciplines, and countries" (IASC, 2007, p. 16), and does not offer an explicit definition of the terms, allowing for variable definitions to coexist in the field without sanctioning any of them more than the others.

While the *IASC Guidelines* are, of course, about both mental health and psychosocial support, the section of the document that is specific to health services comprises only 32 pages of the 182-page[19] text. Because the guidelines do not clearly differentiate between mental health and psychosocial support, this does not necessarily imply that mental health is less important than psychosocial support, but it is indicative of a relative deprioritization of *medicalized* mental health care. Other handbooks and guidelines for MHPSS in emergencies similarly avoid drawing a clear distinction between mental health and psychosocial support. The *mhGAP Humanitarian Intervention Guide* (*mhGAP-HIG*), which is intended for use by physicians and other health care workers, advises that clinicians offer some form of psychosocial support as part of the basic management plan for nearly all[20] of the conditions included in the guide—often as the first or second step that should be taken in a treatment plan (WHO, 2015). Within the written policies that guide MHPSS in emergencies, then, mental health and psychosocial support are not represented as completely separate, exclusive categories, but the relationship between them is not clearly defined or explained.

[19] Excluding references.
[20] The only exception is epilepsy, a neurological disorder.

As I discussed in Chapter IV of this dissertation, several of my informants deemphasized the role of medicalized mental health care in their work during our interview conversations, in favor of psychosocial interventions or an "integration approach." When I asked them directly about the relationship between mental health and psychosocial support, several of my informants were equivocal about the distinction. In the quotation below, my informant Nadia told me at first that mental health and psychosocial support were two ends of a "spectrum," and then that the two terms were used by different actors to describe identical activities:

> "It's meant to be on a spectrum, or a continuum, so it's a bit arbitrary as to where you put the line and say, 'this is mental health,' and 'this is psychosocial support.' They shouldn't be contradictory....It's just a question of language. Some agencies talk about mental health promotion, [and] other agencies talk about psychosocial activities—even though they can be literally doing the same thing in the same context."

For Nadia, there was not necessarily a clear-cut distinction between mental health and psychosocial support—though they did lie on opposing ends of a continuum, suggesting that they were substantively different in some way. However, the two categories were not always exclusive in practice: certain activities could be classified as either mental health or psychosocial support by different actors, even in the same place at the same time.

My informant Arsène also described mental health and psychosocial support as distinct but interrelated projects, telling me that:

> "[Mental health and psychosocial support] kind of work hand-in-hand with one another. But I can say that when you look at the psychosocial support activities, they all kind of work towards improving mental health."

Even though Arsène did not view the psychosocial support work that he oversaw as being a form of mental health care, he understood the purpose of the work in terms of its impact on mental

health. This suggests that mental health and psychosocial support might be considered two different means to the same end.

My informant Claudia drew a distinction between mental health and psychosocial support based on a bureaucratic divide between the health and protection sectors of humanitarian emergency response.[21] For Claudia, although "mental health and psychosocial support" is presented in the guidelines as a single project, the health sector was responsible for mental health interventions, and the protection sector was responsible for psychosocial support. She described her thinking in the quotation below:

> "[Mental health and psychosocial support] are separate projects in a way, because much of mental health is under the health sector. And a lot of psychosocial support interventions, I'd say, are falling under the protection cluster. So, when you, for example, look at child-friendly spaces, that would be under UNICEF, under child protection. Whereas mental health and the whole medical treatment is under a hospital often, so under the health sector. Which, in my personal opinion, is completely nonsense because it's all interlinked. But the whole humanitarian field from my experience, is sectorial. It's silo thinking. There's not very much holistic thinking. And I truly do believe that we need to look at a person, an individual, as a holistic being."

In addition to linking two systems of classification together (the distinction between mental health and psychosocial support, and the humanitarian cluster approach), Claudia offered a critique of a tendency toward fragmentary, "silo thinking" in the humanitarian field. She contrasted this "silo thinking" with "holistic thinking," marking a tension between fragmentation and integration within humanitarianism. This is not simply a bureaucratic problem, but a manifestation of epistemological and ontological multiplicity within the humanitarian field. It is

[21] I return to the positioning of MHPSS within the humanitarian cluster approach, in which different technical areas of humanitarian aid are organized into different sectors in a later section of this chapter.

not clear, however, what the implications of "look[ing] at a person…as a holistic being" would be in practical terms for humanitarian emergency response.

During our conversation, Claudia also told me that defining the category of psychosocial support was a problem that she had encountered in the field. She said that frequently, humanitarian organizations would claim to have carried out psychosocial programming, but fail to meet minimum standards for this care or provide adequate documentation of their activities. When I asked her to tell me about a time that this had happened, she hesitated. In the quotation below, she explained why it was difficult to provide a specific example of how this problem plays out:

> "It's really difficult to say, because you would see that [the organizations] put in the report that they 'did psychosocial,' but nobody can explain to you what they've done….The easiest for me to say would be recreational activities, or playing with kids. If you justify it and you're able to explain it, and if you're able to link your play activities with child development, then it's perfectly psychosocial, right? The problem here is that a lot of organizations or programs are saying, 'We're doing psychosocial,' and when you ask them what they've done—they can't really say what they've done…. Some [of them] would say that [just] talking to a person is psychosocial. Which I am not necessarily agreeing with."

According to Claudia, some organizations categorize a very broad range of activities as "psychosocial support," up to and including "just talking to a person."[22] She also identified a problem with humanitarian organizations who represented themselves as "doing psychosocial," but failing to narrate, document, and explain this work in a way that is legible and legitimate to other humanitarian actors (and presumably to outsiders to the humanitarian field as well). They

[22] Claudia's example of "talking to a person" as an invalid approach to psychosocial support seems particularly ironic here. The process of psychiatric diagnosis and many forms of mental health treatment are essentially highly specialized techniques for "talking to a person." Many of the guidelines for providing psychological first aid (PFA) comprise strategies for supportive, caring verbal communication (WHO, 2011).

adopted MHPSS as a nomenclature, but not a conceptually coherent system of classification. The work of psychosocial support is difficult to define precisely, and for Claudia, certain activities qualify as psychosocial based more on how they are documented, justified, and explained than on what is actually done. An activity would become a form of psychosocial support only when appropriately documented and justified.

I note that Claudia did not necessarily think that there was fundamental disagreement in the field about what, essentially, psychosocial support is. She instead attributed the problem of defining psychosocial support to a failure in the MHPSS field to consistently document psychosocial support and measure its effects. She told me that a major challenge in the field was "getting good data," or "documenting the changes that stem from [psychosocial] programs," which in turn made it difficult to identify effective psychosocial support in practice. In the quotation below, she attributed this problem, in part, to the forms of training and expertise that MHPSS actors tended to bring to their work:

> "There is a limitation within, I think, the educational background and the courses available for psychosocial delegates and mental health specialists. Like, psychiatrists, psychologists: we're not really asked in our education to measure things."

For Claudia, being able to "measure things" and link them conceptually to theories about child development and other psychosocial concepts would promote better communication and coherence among MHPSS actors. Her belief in the power of "good data" to overcome confusion and miscommunication in relation to psychosocial support echoes the persistent desire for additional evidence about trauma and PTSD in disasters and emergencies that has characterized the professional controversy on this subject, as I discuss in Chapter III of this dissertation.

Within the MHPSS field, the categories of "mental health" and "psychosocial support" are not clearly and consistently defined, either in theory or in practice. Furthermore, they are not

always exclusive of each other: certain activities can be considered to belong to both categories, sometimes leading to confusion in the field. Because the category of psychosocial support is so broad and flexible, it is likely that this system of classification is exhaustive; I did not find any evidence that there were elements of the MHPSS apparatus that would not fall within either of these categories and be excluded from the classification system.

Organizing MHPSS through the IASC intervention pyramid

One of the hallmarks of the influential *IASC Guidelines* (IASC, 2007) for MHPSS in emergencies is a system of classification that many of my informants called "the pyramid" (Figure 1). The intervention pyramid is represented in the guidelines with a diagram organizing different types of MHPSS interventions into "layers," with basic and universal needs (food, shelter, physical security) at the base of the pyramid, and specialized psychiatric services at the top. The form of the IASC pyramid bears a cursory resemblance to Maslow's (1943) well-known hierarchy of human needs, which is often visualized in the form of a pyramid as well. Although Maslow's methodology in developing this theory has been called into question (e.g. Wahba and Bridwell, 1976), Maslow's hierarchy has inspired a significant body of academic scholarship, and has found enthusiastic reception in the realms of popular psychology, marketing, and business. Similarly, the IASC pyramid has gained traction in the MHPSS field by purporting to organize, categorize, and (perhaps) rank the conditions necessary for ensuring human health and wellbeing. In this section, I analyze the IASC intervention pyramid as a classification system comprising different categories of humanitarian aid, and the multiple, contradictory ways that this relatively simple diagram is interpreted in practice in the field.

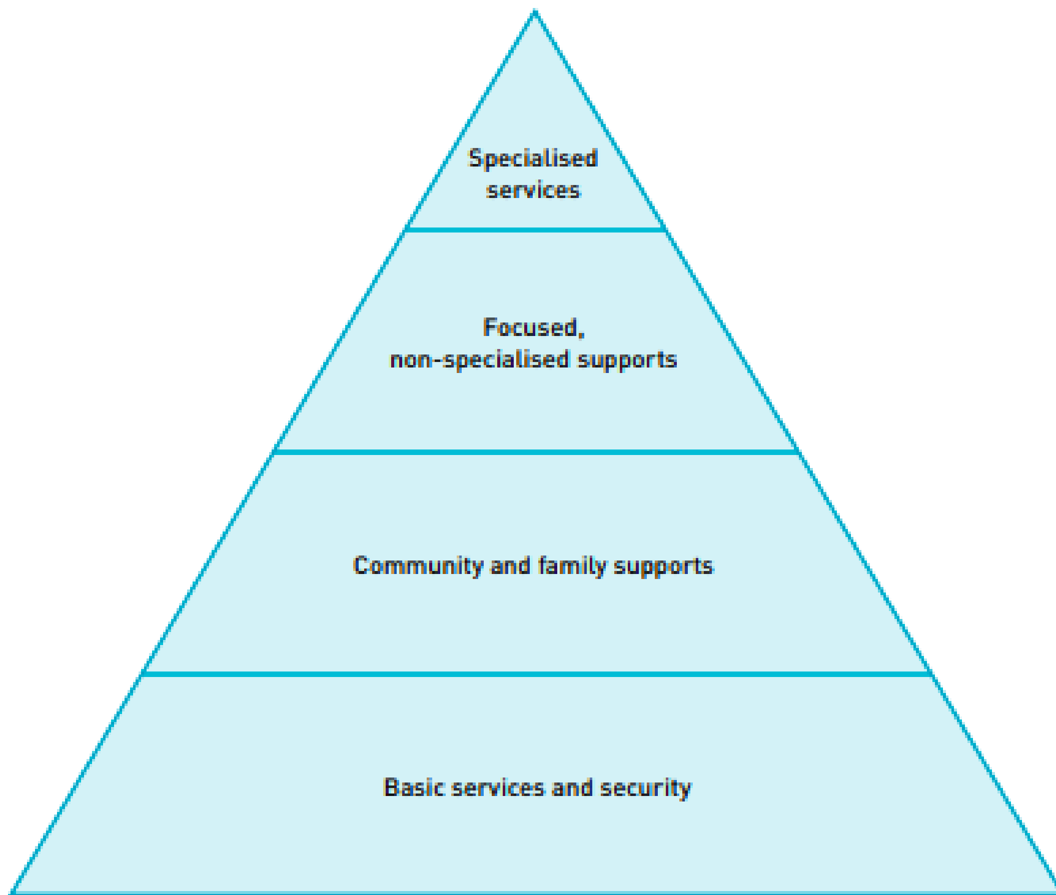

Figure 1: IASC intervention pyramid (IASC, 2007, p. 12)

Many of my informants mentioned the pyramid during our interview conversations, an indication of how well-known the diagram has become in relation to MHPSS. In the quotation below, my informant Nadia noted that while the IASC guidelines have been widely disseminated among MHPSS actors, their details were less well known:

> "People don't know [the guidelines] in details. They probably know about the pyramid in the guidelines. They don't, probably, even know the content of the pyramid, but they can say to you, 'There's a pyramid in the guidelines,' and they know the name of it."

According to Nadia, the intervention pyramid was emblematic of the *IASC Guidelines* and the approach to MHPSS that they represent. As such, the intervention pyramid is an important

representation of how different types of MHPSS interventions are categorized. My findings suggest, however, that there is disagreement in the field about what the intervention pyramid means for the practice of MHPSS in emergencies.

The bottom layer of the pyramid represents "basic services and security"—namely food, water, sanitation, shelter, physical security, and primary health care—which the *IASC Guidelines* emphasize "should be established in participatory, safe and socially appropriate ways that protect local people's dignity, strengthen local social supports, and mobilise community networks" (IASC, 2007, pp. 11-12). The form of aid represented by the second layer of the pyramid (labeled as "community and family supports" in the diagram) consists of "help in accessing community and family supports" to allow people to "maintain their mental health and psychosocial well-being" (IASC, 2007, p. 12). The examples listed in the guidelines include both psychoeducation (such as "mass communication on constructive coping methods") and the reunification of families and communities who had been separated as a result of disasters and emergencies. The third layer of the pyramid ("focused, non-specialised supports") represents "focused individual, family or group interventions by trained and supervised workers (but [sic] who may not have had years of training in specialised care)," which includes "basic mental health care by primary health care workers" (IASC, 2007, p. 12). The term "non-specialized" here excludes mental health specialists in particular; other forms of training and expertise *are* necessary for the MHPSS interventions that fall into this category. Finally, the top layer of the pyramid ("specialised services") represents medicalized mental health care, as provided by psychologists and psychiatrists.

The *IASC Guidelines* state that "[a]ll layers of the pyramid are important and should ideally be implemented concurrently" (IASC, 2007, p. 11). They imply that the size of each layer

of the diagram is intended to correspond with the share of the total population who will require each type of intervention in emergencies; since each successive layer is a smaller piece of the pyramid, the forms of aid they represent are necessary for a smaller subset of the population. The visual logic of the diagram, however, strongly implies a hierarchy, in which some interventions are more important (or should be implemented sooner) than others. The interviews I conducted confirmed that many MHPSS actors think of the intervention pyramid as a hierarchy—but my informants offered differing interpretations of the diagram and disagreed about the validity of the pyramid's ostensible ranking of different forms of humanitarian aid.

According to my informant Rafaela, many MHPSS actors prioritize the kinds of specialized interventions from the top layer of the pyramid that, according to her interpretation of the guidelines, should be implemented only after basic needs for food, water, shelter, and security have been met. She identified this impulse to offer medicalized mental health care at the expense of providing other forms of aid as a reason why mental health programs often failed to garner enthusiasm from the populations that they were intended to serve:

> "In most cases the population is really [not keen]...to participate, [and] to be actively engaged in these [mental health] programs….And, I would say, rightly so, because these people are struggling with their survival, they don't have enough food, and they don't have enough water, or the right clothes….If you look at the guidelines, that is, of course, the foundation of the pyramid. We do know that's the basics but still—we struggle to make it happen….
>
> "There is this tendency to address the wellbeing of the affected population the other way around. Instead of going from the bottom to the top of the pyramid--you know, basic services, basic needs, and then moving upward--there is a tendency to do it the other way around. At first people think, 'Oh, we need a psychiatrist, we need a psychologist, because people are traumatized, they are heavily affected! We don't know what to do.'

> So, people start to not even provide the very basic psychosocial support they could already have, but they want first to jump to the specialized services, and then perhaps [go] downward. And then [they realize] that, still, the very basic needs haven't been addressed! This is something that really needs to be improved, I think, and we are still struggling with that."

In Rafaela's view, the layers of the pyramid represent a temporal order of operations: "basic needs" from the bottom layer should be addressed first in emergency contexts, and specialized mental health care should be attended to only after food, water, and other physical needs have been met. According to her reasoning, if MHPSS actors provided different forms of humanitarian aid in a more appropriate order, their work would be more effective and they would find more enthusiasm and acceptance from the intended beneficiaries of this aid.

My informant Beatrice, however, challenged the idea that basic needs should always be addressed before interventions from higher levels of the pyramid are implemented. When I asked her whether she thought that there was more recognition of the need for MHPSS work in emergencies, for instance, she told me that,

> "On one level, there's much more recognition…. At the same time, [MHPSS] can still be under-prioritized, because water and other things are seen as more important. But if you think of a migrant landing, they're not needing shelter, they're not needing food. The first thing they will say when they land in Greece after crossing is, 'Where can I get my phone charged? How can I get in contact with my close ones? Do you have IT? Is there Wi-Fi here?'. Which are all psychosocial needs for relating to the people that are most important to us. So, understanding that shift in how you deliver services—that you always need to think about, 'What is it that people need on a psychosocial level?'—is yet to come [in the humanitarian sector].
>
> "'Where's my family? Did my wife survive?' That's more important than food and shelter, right in the first place. Because we're connected."

To Beatrice, contact and connection with family and loved ones (or what would be termed "community and family supports" in the pyramid") are more urgent needs than the ones that are categorized in the base layer of the pyramid. Like Rafaela, however, her comments framed the intervention pyramid as a hierarchy, in which some forms of aid should be prioritized before others. Though they disagreed about which needs should be attended to first, neither of them held the view that all layers of the pyramid "should ideally be implemented concurrently" (IASC, 2007, p. 11), as specified by the *IASC Guidelines*.

The classification system represented by the intervention pyramid comprises a set of categories that do seem to be exclusive and exhaustive in practice. However, my findings indicate that there are inconsistencies in the field relating to prioritization of different categories of MHPSS intervention. In contrast to the written policy that all four categories of aid are of equal value, and none should be prioritized above another, my informants offered differing interpretations of which needs are more urgent for humanitarian aid workers to address in disasters and emergencies.

Classifying MHPSS through the humanitarian cluster approach

A previous section of this chapter included a quotation from my informant Claudia in which she described mental health and psychosocial support as two separate projects, since they fell under the health sector and protection sector, respectively. Her comments pertained to the distinction between the categories of mental health and psychosocial support, but also related to a second system of classification: the categorization of different forms of humanitarian emergency assistance as a whole. Since 2005, humanitarian emergency response has been organized within the UN system via the "cluster approach" (visualized in Figure 2 below), in which different *sectors* (or "discrete technical area[s] of humanitarian action" (OCHA, 2014))

are assigned to one of eleven different *clusters,* or groups of humanitarian agencies and organizations with relevant capacity and expertise within that sector. Each cluster is led by one or more UN or non-UN agency, as indicated in Figure 2. In this section, I analyze the relationship of MHPSS to the cluster approach. The aims and activities associated with MHPSS do not fit neatly into this model, sometimes causing confusion and tension among humanitarian actors in the field. The *IASC Guidelines* (IASC, 2007) contain recommendations across multiple humanitarian sectors, and while the term "MHPSS" is most closely associated with the health sector, some of its processes and goals are shared by the humanitarian protection sector. MHPSS represents a domain of humanitarian emergency response in which the categories of *health* and *protection* are not consistently defined, nor are they entirely exclusive of each other.

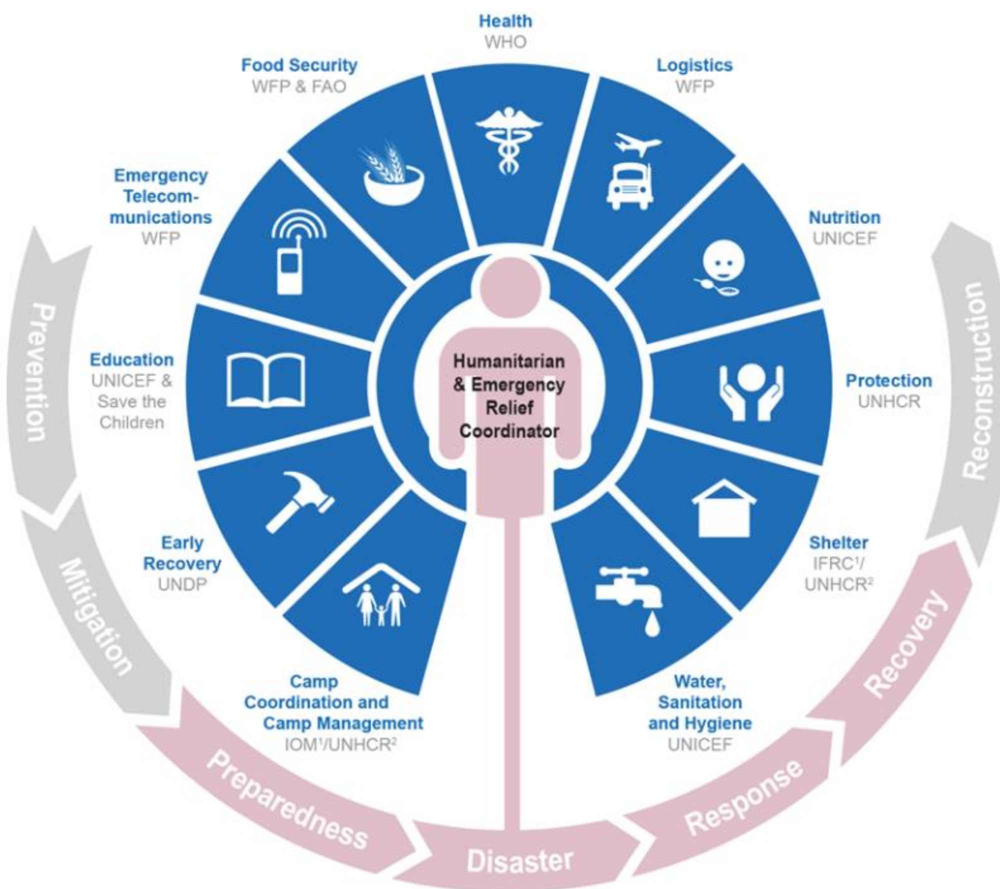

Figure 2: Diagram of the Humanitarian Cluster Approach (OCHA, 2020)

The *IASC Guidelines* (IASC, 2007) are intended for use by actors across all sectors of humanitarian aid, not only within the health sector. The inter-sectoral nature of the guidelines reflects "increasing inter-agency consensus that psychosocial concerns involve all sectors of humanitarian work, because the manner in which aid is implemented…affects psychosocial well-being" (IASC, 2007, p. 16). The guidelines contain sections that directly relate to eight out of the eleven areas of humanitarian aid designated by the cluster approach (IASC, 2007, p. 18).:

- Camp Coordination and Camp Management;
- Early Recovery;
- Education;
- Food Security;
- Health;
- Protection;
- Shelter;
- and Water, Sanitation, and Hygiene (WaSH).

These eight clusters are led by a total of nine different agencies and organizations. (Some clusters have more than one lead agency, and some agencies are designated as the leads of multiple clusters.) Furthermore, the *IASC Guidelines* recommend that "in any large emergency, one intersectoral, inter-agency mental health and psychosocial support coordination group should be established and should aim to secure compliance with guidelines" (IASC, 2007, p. 19). The guidelines envision MHPSS as being enacted by an array of many different organizations, involving complex relationships of responsibility, communication, and coordination. Though MHPSS involves many different sectors of humanitarian emergency response, my informants identified two of them as being primarily responsible for MHPSS in practice: the health sector and the protection sector.

While the concept of humanitarian protection is sometimes understood in terms of physical security, it is more often defined in terms of human rights. The IASC has defined humanitarian protection as "all activities aimed at obtaining full respect for the rights of individuals in accordance with the letter and the spirit of the relevant bodies of law (i.e. HR [human rights] law, IHL [international humanitarian law], refugee law)" (IASC, 1999, p. 4). UNHCR is the agency assigned to lead the protection sector within the cluster approach; it has been deeply involved in and concerned with the mental health of refugees since at least the 1980s, sometimes in concert with the WHO, and sometimes independently. UNHCR continues to incorporate MHPSS into its work (UNHCR, 2022), and has published its own guidelines on MHPSS for refugees (UNHCR, 2013). Several of my informants identified the relationship between the health and protection sectors as a source of confusion, miscommunication, and even contentiousness in the field of MHPSS in emergencies.

My informant Nadia characterized some interactions among agencies from different sectors as "turf wars" over MHPSS with "a lot of confusion over terminology." She told me that even when humanitarian agencies and organizations agree about what forms of aid should be available in emergencies and how it should be delivered, they use different terminology and understand themselves to be doing different work. In the quotation below, she described the confusion that could arise in relation to what she referred to as "psychosocial mainstreaming," or "ensuring that humanitarian response is done in a way that ensures people's safety and dignity" across different sectors of humanitarian aid:

> "These are things we [in MHPSS] would say would be a psychosocial approach….[But] those recommendations are *exactly the same* as what comes out in the GBV—gender-based violence—guidelines. And it's exactly the same as what comes out in protection industry guidelines. And protection actors want to own it and say, 'No, this is a protection

approach.' GBV people say, 'No, this is a GBV approach,' and then psychosocial people say, 'No, it's a psychosocial approach.' And if the recommendations are *literally* identical, and yet there's three different types of actors potentially training different populations within one country on the same emergency…it just gets really confusing.

"'Protection' and 'psychosocial' are very nebulous terms, anyway. I don't understand why we haven't just said, 'This is good humanitarian programming.'….[That was] the whole point of the *Sphere* standards, by the way. That was the beauty of them: they stripped out a lot of jargon, and just said, 'This is good programming.'"

When I asked Nadia for clarification about the difference between a "protection approach" and a "psychosocial approach," she laughed, and told me that although the two sectors generally comprised two different groups of people who understand themselves to be engaged in different forms of work, "the outcomes and the methodology and the emphasis [are] exactly the same. And the recommendations are literally the same, so you can have the same checklists." In this way, health and protection are not fully *exclusive* categories within the categorization system of the humanitarian cluster approach. Furthermore, the confusion about these different ways of classifying MHPSS within humanitarian emergency response, according to Nadia, impeded the delivery of "good humanitarian programming" as defined by standards like the *Sphere Handbook* (Sphere Association, 2018).

My informant Beatrice also told me that the problem of classifying MHPSS within either the health sector or the protection sector caused confusion in the field. Despite the similarities and overlap between guidelines and standards for MHPSS and protection actors, Beatrice drew a sharp contrast between how these two groups approach humanitarian aid in practice. In her experience, "psychosocial support" and "humanitarian protection" are not simply two different labels that describe the same thing. She described protection as a more rigid, legalistic approach

to humanitarian aid. I include a lengthy exchange from our conversation below, in which Beatrice told me about the difficulty of clearly categorizing MHPSS as health or protection, and offered a critique of the approach that she saw protection actors bring to their work:

> ***Beatrice:*** "In [my organization] we are placed under health, so we're seen as part of health…and the protection activities are placed in another department. So, I think that this may go for other organizations as well, that finding out where you belong can be challenging, because a lot of what you do [in] psychosocial support *is* protective. Creating protective environments, teaching children about rights. Referring people who come with SGBV [sexual and gender-based violence] complaints, supporting them if they come to report SGBV complaints, for instance. But protection is seen as something else, and protection is more—that's more of the box-ticking exercise sometimes…. It can be difficult to be seen as somebody who is in protection when you're in mental health and psychosocial support. I think that's how I wanted to phrase it."
>
> ***Maggie:*** "I guess I'm not quite sure what falls into the category of protection."
>
> ***B:*** "Yeah, that's complicated too, because it sits in another department, and nowadays protection is mostly called Protection, Gender, and Inclusion, and can also be called Protection, Gender, Inclusion, and Community Engagement—which is what we do in psychosocial support!"
>
> "Recently, there was a meeting with all the emergency response units that had been in Bangladesh, and what the team leaders all said was that they had been really happy with the psychosocial people at the hospital, because it helped them with the patients…."
>
> "But sometimes they experienced that people coming from Protection, Gender, and Inclusion…will come with a checklist and say, 'Why didn't you do that? Why don't you have material in all languages? Why don't you…?' So, it was a different approach. It didn't feel like help. It felt more like, 'Why is there no ramp up to the bathroom?' I mean, you're in Bangladesh, you don't fucking have ramps up to all [the] toilets! So it was more like that kind of approach….[In this field], if you go by checklist, you will lose touch.

> And this is what I see happening, because of people engaged in Protection, Gender, and Inclusion having more of a policymaker background.
>
> ***M:*** "So, it's a more legalistic way of—"
>
> ***B:*** "Exactly, exactly."

For Beatrice, the category of humanitarian protection was not clearly defined, and the distinction between protection and psychosocial support was not always a meaningful one. Her frustrations with the protection sector were not limited to bureaucratic (mis)classifications, however. She saw the approach taken by individuals and organizations from the protection sector to be unhelpful, legalistic, and in some cases misaligned with the material realities of places where humanitarian agencies tend to work. Specifically, she criticized the tendency of protection actors to "go by checklist" or approach humanitarian aid as "a box-ticking exercise." Like the critique of "silo thinking" within humanitarianism that I discussed earlier in this chapter, Beatrice's comments reflect the multifaceted tension between fragmentation and integration that pervades MHPSS and humanitarian emergency response more broadly.

MHPSS and the category of the minimum humanitarian response

The system of classification that I analyze in this section is a bit different than the other three I have discussed thus far. The two categories that constitute this system of classification are that of the minimum humanitarian response and the comprehensive humanitarian response, but it is not the distinction between these categories as such that is difficult to translate into practice. Rather, my findings suggest that defining the minimum humanitarian response, specifically, is more challenging in certain practical, ethical, and political circumstances than the written guidelines for MHPSS would indicate.

The *IASC Guidelines* (IASC, 2007) and the *Sphere Handbook* (Sphere Association, 2018) are explicitly identified as guidelines and standards, respectively, for a *minimum* humanitarian response. The concept of a minimum response is central to the core purpose and logic of these two documents and the programs and projects that they are concerned with. The *IASC Guidelines* define the concept of a minimum response as follows:

> "[M]inimum responses…are essential, high-priority responses that should be implemented as soon as possible in an emergency…. [They] are the first things that ought to be done; they are the essential first steps that lay the foundation for the more comprehensive efforts that may be needed" (IASC 2007, p. 5).

Throughout the *IASC Guidelines,* the bulk of the text is given over to detailing requirements for a minimum response, including only brief bulleted lists of the necessary elements for a *comprehensive* response.[23] One of the original designers of the *Sphere Handbook* (2018) has linked the concept of a minimum response to human rights; in a 1999 speech about standards and accountability in the humanitarian aid industry, he claimed that "[be]cause Sphere took a rights-based approach, the standards are, necessarily, defined as 'minimum' rather than 'optimal' or 'best practices'." (Stockton, 1999). A minimum response, then, is that which should be provided to everyone in all emergency situations. According to the *IASC Guidelines* and other published standards, guides, and recommendations, the core activities associated with MHPSS make up an integral component of a minimum humanitarian response in disasters and emergencies.

Previously in this dissertation, I have included quotations from my interviews in which my informants questioned the relevance of mental health interventions like psychotherapy in

[23] . For example, "Provide access to care for people with severe mental disorders" is listed as a component of a minimum response (and elaborated upon in greater detail in the guidelines), and "Conduct regular assessments of the accessibility and quality of mental health care" is listed as a component of a comprehensive response (IASC, 2007, p. 27).

contexts in which “people are struggling with their survival” and “very basic needs.” While my informants did not explicitly frame these comments in terms of the concept of a minimum response, they do imply that MHPSS is in some cases superfluous to a more basic humanitarian imperative to ensure survival. Eyal Weizman has defined the concept of the “humanitarian minimum” as the provision of the “minimum possible level [of food, energy, and other necessities] in an attempt to govern people by reducing them to the limit of bare physical existence” (Weizman 2011, p. 5). Weizman quotes the former director of Médecins Sans Frontières (MSF), Rony Brauman, as espousing a view of humanitarian responsibility that is narrowly focused on physical survival:

> “[W]e take care of the bodies. We as aid workers try to maintain life….I would, on the contrary, feel very uncomfortable if we were trying to do more—to control or penetrate people’s minds. What people ask us, what they expect from us, is to help them survive. For the rest, they can manage by themselves.” (Weizman 2011, p. 54).

Brauman here indicates that caring for minds, as well as bodies, would be an inappropriate overreach on the part of humanitarian aid workers. In the anthropologist Peter Redfield’s ethnographic study of MSF, Redfield also includes a quotation from an MSF official framing mental health as secondary to the core aims of medical humanitarianism:

> “[T]he first three days [after a catastrophe] are all about life saving….[But] by week three or four, you’ll have more therapists than patients….Yes, there is a need for mental health, mental health is important. But it’s not life-saving in the direct sense.” (Redfield, 2011, p. 212)

Both of these quotations are illustrative of a view of mental health care as extraneous to the central mission of humanitarian emergency response to save lives-at-risk. Despite the fact that the people whom I interviewed are advocates of MHPSS, some of their comments mirrored this

idea that mental health care falls outside of the minimum level of humanitarian aid that is needed to ensure survival.

Between these two conceptualizations—the guidelines' framing of MHPSS as part of a minimum response, and some humanitarian aid workers' framing of MHPSS as extraneous to the humanitarian minimum—my informant Nadia offered a different perspective on the relationship between MHPSS interventions and the humanitarian imperative to preserve life. According to Nadia, in certain ethically complex circumstances, MHPSS actors choose to limit the interventions they are involved in to those that "maintain life." I quote her at length below:

> "With the increased emphasis on donor governments towards migration and immigration detention, and limiting migration flows, we're seeing a lot of requests for psychosocial activities to make a very harsh environment somehow better. So, to make a migration or an immigration detention facility…somehow nicer inside, by painting the walls and by doing activities for the detainees. But it's still ultimately within a very abusive environment, or within an environment where [detainees] may not have all their rights respected, and they're not necessarily having their legal due process done.
>
> "So what can you feasibly expect from a psychosocial activity?… [What is a] positive outcome in such a context? When the environment itself is the problem, it doesn't matter how many psychosocial activities you do…. I know that some agencies have had big ethical discussions about, 'Do we intervene? Do we say, "Yes, we will work in such settings"?'….
>
> "Some agencies have just made a judgement call and said, "We're not going to take part in these activities…. We're not going to take funding to do activities in such places because…there should be a human rights approach to all of our work." And then there becomes this fine line, and this continuum where you can say that if somebody is attempting suicide in an immigrant detention facility, or a person is committing suicide in a particular camp, there is a duty to intervene and to support that person from a healthcare perspective, or a mental health perspective, but maybe not [to do] communal

> psychosocial activities in the center. So it just becomes a bit of a fine line and a judgement call…. [There are] more ethical dilemmas around this type of work…which have become more prominent, and there's a lot more discussions that I sit in on and take part in than I did a few years ago on this issue. It tended to be a bit more traditional aid in the past."

According to Nadia, aid workers have increasingly been confronted with politically and ethically fraught circumstances in which they are asked to provide mental health care and psychosocial support. In these contexts, the relationship between MHPSS and a minimum humanitarian response is reframed when aid workers choose to only implement MHPSS interventions that would prevent deaths by suicide. In these circumstances, mental health care *is* lifesaving, and not extraneous to efforts to ensure survival in emergency settings. Furthermore, Nadia's comments introduce a new perspective on distinction between mental health and psychosocial support; in certain extreme contexts, a commitment to human rights and a "duty to intervene" compels humanitarian actors to provide mental health care, but not psychosocial support.

Bowker and Star's (1999) three properties are somewhat more difficult to apply to this classification system than to the others I have discussed in this chapter. Certainly, my findings suggest that there are inconsistencies in practice in terms of which MHPSS activities are considered to be part of a minimum humanitarian response and which do not fall into that category. It is less meaningful to evaluate this system of classification in terms of exclusivity and exhaustiveness, since my analysis is primarily concerned with the definition of a single category. The problems with determining when, where, and under what circumstances there is an ethical imperative for humanitarian actors to provide mental health care and psychosocial support reveal an additional dimension of complexity to the tension in the humanitarian field between saving lives-at-risk and defending human dignity (Redfield, 2005).

Conclusions

The systems of classification that I have analyzed in this chapter vary in their contents, purposes, and impacts within the MHPSS apparatus. In different ways, they each reveal tensions and ambiguities about what MHPSS is, who is responsible for it, and how it should be practiced. The stakes of these classification problems range from miscommunications in the field, to bureaucratic infighting, to matters of life and death, in the case of mental health care for people who are at risk of dying by suicide. Most systems of classification fail, in one way or another, to accurately and consistently describe the social phenomena that they aim to organize. The ways that they fall short can help explain practical difficulties (like the problem of documenting and measuring the impact of psychosocial programs) and illuminate more fundamental questions, such as the conceptualization of MHPSS as an integrated, holistic form of care rather than a rigid, technical practice that is reducible to a set of checklists.

Inconsistent definitions of fundamental categories—including psychosocial support, humanitarian protection, and the minimum humanitarian response—are indications of the difficulties of enacting stable systems of classification to organize and manage the practice of MHPSS in emergencies. While one of my informants suggested that a simpler system of classification—namely, focusing on defining "good humanitarian programming" with less jargon and fewer labels—would produce less confusion in the field, the incompatibility between epistemological grids and the messiness and ambiguity of social reality suggests that this simpler approach would have its own shortcomings as well.

Chapter VI – Conclusion: Causes and Consequences of Persistent Dissensus

In the archival research that I conducted at the WHO, UNHCR, and the UN Headquarters for this project, I observed that the perception that disasters and emergencies are increasing in frequency and severity has been remarkably durable and pervasive since at least the late 20th century. The causes of this seemingly perpetually rising risk have varied over time. In the 1960s and 1970s, decolonization was sometimes identified as a source of increased violent conflict, as though colonialism had been a source of stability rather than a profoundly violent and destructive project itself. The Bhopal chemical leak in 1984 and the Chernobyl disaster in 1986 contributed to a growing concern about industrial and "technological" disasters in the 1980s. The end of the Cold War was associated with the emergence of the category of the "complex humanitarian emergency" in the 1990s. The idea that we are living in an era characterized by an increasing risk of disasters and emergencies worldwide is no less prevalent today. Climate change makes many types of natural disaster more frequent and more severe; some of the most dire climate models make the "apocalyptical experiences" that were discarded from the EuroActDIS typology of disasters that I mentioned in Chapter V of this dissertation seem unnervingly plausible. The COVID-19 pandemic was a unique and unprecedented humanitarian emergency in its temporality and spatiality, the political, economic, and public-health effects of which continue to unfold as I write this. Both of these crises have had significant consequences for mental health and psychosocial wellbeing. The MHPSS apparatus will no doubt continue to evolve as the societal conditions producing the problem that it aims to address continue to change.

My analysis of the MHPSS apparatus suggests that previous scholarship that interprets the inclusion of mental health and psychosocial programs within humanitarian aid as a harmful form of "therapeutic governance" (Pupavac, 2001) does not adequately account for persistent

contradictions, ambiguities, and multiplicity within MHPSS and the humanitarian field more broadly. I argue that mental health in disasters and emergencies is a generative empirical focus for feminist political geography, particularly in relation to the concept of intimate geopolitics. I also suggest that human geographers and other critical social scientists pay careful attention to seemingly straightforward systems of classification and standardization, and to the objects of expert intervention that they produce, in other domains of expert knowledge and practice. Epistemologies of the grid (Dixon and Jones, 1998) inevitably fail to fully align with the messiness and instability of social forms and processes, but analyzing the specific ways that they fall short can offer key insights about the social worlds that these epistemological grids purport to organize.

Informed by insights from feminist political geography and science and technology studies, I have explored three interrelated research questions about the policy, politics, and practice of MHPSS in disasters and emergencies in this dissertation. I argue that the persistent dissensus that surrounds this form of humanitarian aid is, in part, the product of unresolved questions about whether it is (or should be) a domain of skilled, standardized, technical intervention. My interviewees criticized "silo thinking" and "going by checklist" as approaches to MHPSS, but the tendency to categorize and classify (and to revise, rethink, and rename existing categories) has deep roots in the humanitarian sector. The imperative to standardize and render MHPSS technical may also be informed by a need for institutional legibility and legitimacy within humanitarianism and with the donors who fund humanitarian agencies and organizations. The connection between "rendering technical" and depoliticization (Li, 2007), however, suggests that the ambivalences toward standardization within the MHPSS may be associated with political possibilities within humanitarianism.

In what follows, I summarize my answers to my research questions, and conclude with several proposed areas for future research building on my findings from this project.

1. How have expert perspectives on trauma and PTSD in the context of disasters and emergencies varied and changed over time?

Trauma and PTSD have been highly contentious objects of expert intervention in disasters and emergencies since at least the 1980s. My findings suggest that in the 1990s, some humanitarian agencies embraced the idea that preventing and treating trauma and PTSD were matters of urgent concern, but that this was not a consensus view in the humanitarian field. Even some organizations that explicitly prioritized trauma were ambivalent about the medicalization of trauma through the PTSD diagnosis, especially in non-Western contexts. The meaning of individual suffering in situations of collective violence and disruption has been an additional source of expert dissensus about trauma and PTSD. Much of the controversy about trauma and PTSD is related to their unsettled status as objects of expert intervention—they do not cohere as standardized ontological entities with consistent definitions.

2. What role does medicalized mental health care play in humanitarian emergency response, relative to other MHPSS interventions?

In many disasters and emergency contexts, providing medicalized mental health care is simply not logistically feasible. Psychologists and psychiatrists who share a common language with the beneficiaries of humanitarian aid are rarely available to provide this care, the lack of private space makes it impossible for conversations about intimate, personal subjects to not be overheard, and the lack of mental health care systems in the places where disasters and emergencies often occur means that patients cannot be given referrals for ongoing care. Concerns

about unintended harms associated with mental health care also limit support for medicalized mental health interventions within the MHPSS field. The medicalization of suffering plays a key role in expert discourses about trauma and PTSD, and ambivalence toward medicalization also figures into difficulties with classifying MHPSS within either the health or protection sectors of humanitarian emergency response.

3. How do systems of standardization and classification affect the practice of MHPSS in disasters and emergencies?

Inconsistently defined categories are a pervasive source of confusion within the MHPSS field. Medicalization is itself deeply connected to multiple systems of classification; simply determining what does and does not constitute health care is a form of classification, and the production and application of diagnostic categories and different treatment approaches are important (and often contested) systems of classification related to mental health. The PTSD diagnosis, as mentioned above, is an especially contentious category within the MHPSS apparatus. Analyzing systems of classification related to MHPSS reveals conceptual confusions and disconnects within the humanitarian field, but also helps illuminate some of the ethical and political complexities that humanitarian agencies and organizations must negotiate in practice.

Directions for future research

The findings of my research indicate that the ostensibly straightforward category of the minimum humanitarian response, described in detail in written guidelines like the *Sphere Handbook* (Sphere Association, 2018), is sometimes very difficult to consistently enact in practice. The ethical dilemmas about providing MHPSS in inhumane migrant detention centers that my informant Nadia told me about are a revealing example of this. Further inquiry about

how humanitarian actors interpret the category of the minimum response in similarly challenging circumstances would be a generative starting point for future research. Much has been written about the relationship between humanitarianism and human rights, but further investigation into how humanitarian aid workers interpret and enact human rights principles when confronted with such dilemmas would usefully extend this body of scholarship.

A major limitation of this project is its lack of direct perspectives and experiences from the beneficiaries of humanitarian aid. Additional research interviewing or surveying participants in MHPSS programs would help remedy this. Future research about how lived experiences of disasters and emergencies are affected by MHPSS interventions should also include perspectives from people who *declined* to participate in these interventions, since my findings suggest that many beneficiaries of humanitarian aid are reluctant to engage with MHPSS programming. Studying the experiences of humanitarian aid workers who directly provide mental health care and psychosocial support in disasters and emergencies would also be a promising direction for research building on my findings from this project.

Lastly, I call for additional research about the relationship between sexual violence and humanitarian emergency response. The discursive link between trauma, gender, and sexual violence in guidelines and standards for mental health in emergencies merits further inquiry. To what extent has sexual violence been conceptualized as uniquely psychologically damaging by humanitarian aid workers and policymakers, and what are the implications of discourses about trauma and sexual violence within this social world? Some of the archival data that I reviewed for this project also suggests that investigating the problem of sexual abuse *by* humanitarian aid workers (and how this problem has been conceptualized and managed within humanitarianism) would be an important line of inquiry for this research.

Appendix – Interview Script

1. How did you come to work in the MHPSS field?
    a. What drew you to this work?
    b. What was your professional experience prior to your current role?
2. What is your current professional role?
    a. What are the most common mental disorders and other problems experienced by the populations you work with?
    b. What kinds of treatments, interventions, and programs are typically available in the places where you work?
    c. What do you do on a typical day at work?
3. What aspects of your work do you find to be the most challenging, and what do you find to be the most rewarding about the work that you do?
    a. Can you describe a time when a challenge came up, and how you dealt with it?
4. What are the most significant changes that have you noticed in the MHPSS field over the course of your career?
    a. This might include: places where you have worked; the needs of the populations that you serve; the resources that are available; the types of collaborations that are formed; or how MHPSS is prioritized institutionally.
5. Do you anticipate additional changes in the MHPSS field in the future?
6. Are there other changes that you would like to see in the MHPSS field in the future?
7. Can you tell me about the distinction between "mental health" and "psychosocial support"?
    a. What is the relationship between "mental health" and "psychosocial support" within the MHPSS field?

8. I am interested in knowing more about the relationship between short-term humanitarian relief and longer-term development goals. Does MHPSS address both of these?
    a. What do you see as the long-term implications of the work that you do?
9. How do cultural differences affect the practice of MHPSS?
    a. Are religious or spiritual practices incorporated into your work?
10. Is there anything else you think I should know about MHPSS that I haven't asked about?

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