

Humanitarian intervention and cultural translation: a review of the *IASC Guidelines on Mental Health and Psychosocial Support in Emergency Settings*

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In this article, we place the Inter-Agency Standing Committee (IASC) Guidelines on Mental Health and Psychosocial Support in Emergency Settings' within the historical context of trauma healing and humanitarian intervention. The IASC taskforce has done important work by bringing to the fore the cultural and local experiences of suffering in humanitarian intervention. The guidelines' recognition of suffering and social repair as a holistic experience is a significant boon to applied understandings of populations in crisis. Our critique of the guidelines addresses some aspects of the practical application of mental health and psychosocial care. We highlight (1) the framing of 'culture', and (2) the institutional cultures and structural hierarchies of humanitarian intervention. The article concludes with recommendations for integrating a blend of mental health, psychosocial care, and humanitarian intervention into the humanitarian established order.

Keywords: culture, guidelines, human rights, humanitarian intervention, Inter-Agency Standing Committee (IASC), mental health and psychosocial support (MHPSS), power

Introduction

The history of large scale mental health interventions is, at best, morally ambiguous. For

more than a century, psychiatric, mental health and psychosocial interventions have been called on to do the sinister work of social control in areas of violence and uncertainty. Examples that come readily to mind include: the deployment of psychoanalysis as a therapeutic intervention to retain soldiers suffering from combat stress during World Wars I & II and the Vietnam War (Barker, 1991); the use of psychiatry as an instrument of political repression in Stalin's Russia and Nazi Germany (Miller, 1998; Proctor, 1988), and the use of psychosocial rehabilitation as a mode of colonial control (e.g., Algeria, the Mau Mau rebellion in Kenya (Elkins, 2005; Fassin, 2000)).

The *IASC Guidelines on Mental Health and Psychosocial Intervention in Emergencies* emerged, in part, to address these and other potential threats to populations who were receiving untried, untested, and unmonitored mental health and psychosocial support (MHPSS) in the aftermath of wars and disasters. When, in the post Cold War period, humanitarian organizations took a psychosocial turn towards addressing the suffering of refugee and post war populations, the premises of ethnopsychiatry gained new respectability and importance. Hundreds of nongovernmental organizations (NGOs) working in

crisis situations sought to heal individual and collective trauma by conducting psychosocial interventions, treating posttraumatic stress disorder (PTSD), anxiety and depression, as well as facilitating the social reintegration of displaced social groups.

Within the humanitarian community, mental health and psychosocial intervention were believed to provide accessible and actionable programmes which could rebind the troubled social ties that hold society together, and enable collective healing on a mass scale. These interventions followed from the premise that (1) mental health is a human right, and (2) that *'the cycle of violence'* – or the presumption of intergenerational transmission of communal violence – could not be repaired without healing the *'social fabric'*. As a result, a new level of attention and resources was dedicated to mental health care. In Bosnia, Rwanda and other 1990's *'hot spots'*, humanitarian organizations deployed public health principles and humanitarian projects to provide trauma healing to the *'most vulnerable populations'*, including: children, women, the elderly, ex combatants, and refugees. Some of these initiatives were conservative, like psychoeducation programs advocating empathic listening skills. Others were radical or experimental, like Freudian analyses, hypnotherapies, or psychotropic (medicinal) treatment. These efforts were supported by a new wave of psychiatric epidemiological statistics on PTSD, anxiety, and depression, by new research on training and cultural validity, and by new forays into activities like psychoeducation and preventive mental health care.

However, criticisms of psychosocial intervention emerged which challenged the legitimacy of early and existing mental health and psychosocial support (MHPSS) projects, and undermined future opportunities for financial support. As the *'Do's/Don'ts'* section of the

guidelines suggest, serious ethical, cultural, and managerial issues have compromised some programmes. In Bosnia, for example, the World Health Organization identified more than 100 mental health and trauma healing projects operating without coordination. Other organizations are colloquially reported to have fielded staff with insufficient training, minimum standards, and without cultural and contextual frameworks (see dispute between Agger et al., 1995 and Summerfield, 1996). Foreign experts misdiagnosed clinical PTSD among populations to whom the concept had no meaning or relevance to their experiences of suffering, committing abundant cultural and diagnostic fallacies (see endnotes for a definition of category fallacy)¹ (Kleinman, 1977, 1988).

Authorities and donors presumed at one time, that everyone who had been exposed to war suffered debilitating trauma required psychotherapeutic interventions, and gave little attention to individual and cultural resilience. The experimental nature of some programmes also came under fire. Furthermore, inadequate MHPSS monitoring and evaluation lead to uncertainty among colleagues, donors, and beneficiaries about what, exactly, MHPSS services were, and what they were achieving. Consequently, within a decade, the funding and legitimacy of emergency mental health care programmes became mired in paralyzing debates.

The new *IASC Guidelines on Mental Health and Psychosocial Support in Emergency Settings* constitute a remarkable feat for the international mental health care community. It reflects a breakthrough in professional reflexivity, and grapples with the moral, medical, and cultural issues at the heart of the humanitarian engagement in mental health and collective healing. This capacity for non-doctrinaire self critique was made possible by literally dozens of organizations, and

hundreds of practitioner and academic contributors. They provided additional feedback, criticism, and commentary to the IASC Working Group about the practice of providing mental health care in emergencies. This document makes major strides in resolving debates regarding the over generalized assumptions about the ubiquity and uniformity of traumatic experience, problems of cultural relevance, and complications of structural vulnerability, as well as the question of what constitutes MHPSS (Kleinman & Desjarlais, 1995; Marsella, 1996; Pupavac, 2001; Summerfield, 1999).

The guidelines address key issues that have compromised MHPSS service delivery in the past. These include: inter-agency coordination, cultural awareness and relevance, technical competency, the role of human rights, and the need for a holistic, contextualized framework for understanding suffering and resiliency. However, in addressing many of the moral, cultural, and medical issues in emergency mental health and psychosocial support, some of the more practical aspects of the praxis of care are omitted. In the remainder of this article, we highlight two aspects of praxis central to care: (1) the framing of culture in the guidelines and in humanitarian/MHPSS practice, and (2) the institutional cultures and structural hierarchies of humanitarian intervention. Throughout the text, we challenge some of the guidelines' implicit assumptions about culture and humanitarian authority in mental health and psychosocial service by using examples² from our ethnographic research.

The guidelines and cultural translation

The *IASC Guidelines on Mental Health and Psychosocial Support in Emergency Settings* attempt to place culture within the interpretation and treatment of mental illness in crises.

Woven throughout the guidelines is an expansive understanding of the nature of suffering. Central suppositions of the text include the irreducible distinctiveness of sufferer's medical and moral experiences, and the need for paradigms of care that take into account cultural meaning and local experience. The guidelines are particularly strong as a statement of local prerogative and as a rejection of 'victim' models. However, they also portray culture as an entity, rather than a dynamic social process. Culture is not recognized as a fluid process of repeated formation, in which both patients and healers experience the grounds of transformation as shifting and emergent. Instead, culture is represented as an entity that is static, fixed, and immutable.

In the guidelines, local mental health and psychosocial workers play an important role in managing the culture 'problem'. Through 'local staff', local cultures and contexts can be learned, integrated, instrumentalized and redeployed selectively in NGO projects and activities. The problem with this however, is that for local staff and participants of emergency mental health programmes, culture is experienced as a process that leads to unknown and uncertain outcomes. In turn these outcomes are constrained by the structured hierarchies of power, authority, and resources – particularly in transitional and emergency contexts.

A typical example would be Diarra, a 25 year old, high school educated man raised in his country's capital, who finds work in a trauma healing and ex combatant rehabilitation NGO as a psychosocial agent (PSA) in a refugee camp. Diarra may be called on to interpret the beliefs of distantly known ethnic groups and tribes from his own country. He performs this task, despite his own lack of knowledge and his own negative attitude towards his

illiterate compatriots, in order to strengthen his reputation to his supervisors, advance through the organization, and retain his salary. However, as he understands little of their cultural practices and rituals, he 'washes' them in his interpretations to his employers, meaning he sanitizes, strips of meaning, importance, and relevance, because he is embarrassed by their ignorance.

By calling for the identification and recruitment of local staff and volunteers who understand the local culture (section 4:1), responsibility for cultural competence and cultural sensitivity is placed on local staff who routinely find themselves caught in the crosshairs of structural privilege and subjugation *vis à vis* their international employers. They are tasked with deploying their local knowledge when it is appropriate, expedient, and ethical for their international organizations to have them do so (i.e., not in contravention of international human rights principles or standards, section 3:1–3). However, their '*local knowledge*' does not furnish sufficient grounds for dissent with those choices. Paradoxically, their status as local authorities is subjugated to the standards of the organization, rather than the community, when a conflict of interest does occur. They are therefore torn between vague, distant, and poorly defined international ethical guidelines, and the immediate demands of their local moral worlds (Kleinman, 1999)³. Furthermore, the mandate to '*enforce staff codes of conduct and ethical guidelines*' (section 4:2) offers international organizations a punitive method for enforcing conformity to international human rights principles. While this mechanism grants NGOs the capacity to condemn serious infractions like sexual exploitation and abuse (SEA), it also creates a hierarchy of knowledge that staff convey to their employers. This is a selective

representation of '*the local*,' and their interactions with the local, which is stripped of much of its moral complexity.

Diarra's colleague, Fatou, a (female) psychosocial counsellor for a Gender Based Violence (GBV) project, can be called on to regulate a dispute in which the senior wife of a polygamous family routinely beats her junior wife. Fatou's ability to intervene in this case is compromised by the way in which her organization frames GBV as a man's crime. Moreover, she is invited to regulate issues between the two wives over which she technically has no jurisdiction, including which wife can use the other's cooking pots, and when. She therefore reassigns custody of one of the wives' children (an apparent cause of the co wives' arguments) to herself, and she employs that child as a cook and a housekeeper. Her organization has no knowledge of her improvisational intervention; nor would they approve of her meddling in an issue that is beyond their mandate. Her intervention is widely appreciated and applauded in the community, however, and she masks her resolution of the conflict from her expatriate supervisors. The guidelines offer little in the way of practical solutions to everyday trans national dilemmas involving institutional structure, institutional culture, capacity, and prioritization.

Guidelines for mental health and psychosocial praxis must take into account the structural and cultural hierarchies of humanitarian institutions. The uncertainties bred by these gaps in practical knowledge and expertise is borne by the targeted beneficiaries, and by the local counsellors and educators who are cast as cultural and medical interpreters of information and experience. Local workers and counsellors are responsible for the delivery of a specific type of service – an intervention; which requires an action, an encounter, and a measurable

output. In order to justify their existence, staffing, and continued funding, NGOs must conduct activities that can be accounted for to beneficiaries. These activities may include any of a wide range of social actions, social relations, and social encounters, and will bear labels that are familiar and recognizable to international donors and transplanted expatriate managers (examples are listed throughout the guidelines, and often in the pages of *Intervention*). Achieving these ends often requires resources (especially transportation, training, and information/referral), which are tied to the vague imperative to achieve the moral and psychosocial transformation of post conflict and post disaster societies.

The guidelines and humanitarian contexts

Humanitarian culture is a constitutive feature of mental health and psychosocial service delivery. The shift to the local advocated by the guidelines (section 5) is commendable; but it does not recognize the structural inequalities that shape the conditions of humanitarian intervention itself. Humanitarian organizations - through employment and through beneficiary status - offer access to cash salaries, t-shirts, preferential classifications (i.e. ex combatant/veteran, rape victim) that may have material, moral, or institutional benefits. Both Diarra and Fatou have vested interests in retaining their NGO jobs. Their access to the world of refugee camp management gives them an insight into when food distributions will occur. They can radio friends and relatives in other camps or towns. They have NGO colleagues in medical and educational facilities that can prioritize their friends and family in a long queue. Two of the most prevalent and powerful benefits of NGO affiliation are access to global flows of infor-

mation (through HQ internet stations, for example), and access to international institutions' individual attention and support, through which they can access hierarchically distributed resources which can transform the conditions of their lives. Diarra and Fatou may well parlay their NGO jobs into positions of NGO seniority; from which they may be able to move into reconstituted state ministries after repatriation, or even into UN jobs, through personal recommendations from expatriate bosses.

Humanitarian interventions often occur in contexts in which the state has failed or has been rendered ineffective. The challenges confronted *'on the ground'* by mental health and psychosocial workers are often directly linked to problems of mandate for mental health and psychosocial support. Organizations providing MHPSS may find themselves operating in environments in which they lack institutional or governmental mandates, terms of reference, international recognition, and adequate pathways towards securing inter-agency coordination. Their advocates may lack legal, institutional and moral leverage to mobilize action on mental health issues, to advocate for national mental health policies, or to gain budgetary recognition for mental illness and psychosocial distress. UN agencies and government ministries can withhold mandates until it is clear that international institutions will fully fund and support specific programmes, salaried staff, and developed organizational structures. Without institutional ownership and formal mandates, coordination is likely to be poorly done, or not accomplished at all.

'Diarra and his boss, an American man, routinely attend coordination meetings to promote mental health and psychosocial services, along with other local and foreign staff working on MHPSS issues. Little happens at these

coordination meetings, other than long, endlessly unresolved debates over the accreditation of local staff for trauma healing work. However, Diarra's colleagues are unable to obtain a mandate for mental health care from the UN Health Cluster. This results in the inadequate and indirect oversight of mental health care policy when the Ministry of Health is reconstituted after repatriation. Fatou's boss never comes to these meetings, because GBV organizations have obtained a clear inter-agency mandate, and have been integrated into both Health and Protection Clusters. Two years later, Diarra's agency has lost 75% of its funding, but Fatou's organization has been institutionalized as a long term provider of state sponsored women's protection services. Diarra is thinking about emigrating to the United States, or looking for a job as a driver or construction worker, because he can't get a new job in the non-existent social welfare sector.

In contrast to the coordination body recommended by the guidelines (section 1), which strongly resembles the institutionalized hierarchy of a state bureaucracy, local coordination efforts more closely resemble a many-headed hydra. Fatou's agency can't support Diarra's agency, because of clear budgetary restrictions and because mental health has not been recognized as a priority in the restoration of governance. The guidelines advocate the development of a mandate for mental health care *'from below'*, but typically, humanitarian and government authorities ultimately determine the emergence of a mandate, the support and development of a bureaucracy that sustains MHPSS services over the long term. When psychiatric, mental health and psychosocial interventions become *'bottom of the bucket'* elective forms of aid, donors, UN authorities, and government officials respond; *'there are so many pressing needs. You can't expect us to do everything.'* This disingen-

uous response is a clear symptom of the problem of legitimacy endemic to MHPSS services in humanitarian contexts⁴. Unfortunately, the IASC recommendations for inter-agency and governmental coordination of MHPSS activities (as recommended in section 1:1) do little to clear up the problems of institutional mandate and programmatic legitimacy.

Finally, the guidelines recommend the delivery of all forms of MHPSS aid, including: psychiatric care, trauma treatment, psychoeducation, targeted counselling (e.g., to rape victims and ex combatants), and the inclusion of a psychosocial framework in other aspects of humanitarian service provision. However, it also seeks to repair the kind of fragmentation seen in Bosnia. While these recommendations are valid reflections of the praxis of care already occurring in emergency contexts, they are contradictory and encourage the very sort of fragmentation that the guidelines seek to discourage.

The international donor organization supporting Diarra and Fatou's organizations noticed that mental health care was being provided by both organizations, but in the face of a diminishing budget, as the crisis receded, the donor representative was forced to make hard choices. Fatou's organization provided a targeted form of psychosocial care that was poorly integrated with other mental health and psychosocial activities, but was well integrated into the new state bureaucracy, so he decided to continue funding that organization. Diarra's organization, however, was poorly integrated into the new bureaucracy, despite his organization's leadership in mental health and psychosocial coordination. By funding Fatou's organization and discontinuing funding to Diarra's, the donor discontinued support for the strongest link to institutional memory and grassroots, partner based institutional

coordination among NGOs working in mental health and psychosocial services.

In conclusion, the institutional cultures of humanitarian organizations have little procedural capacity for tolerating and managing this kind of contradiction. Minimum standards should establish which types of care *must* be present in all humanitarian crises; or one risks the loss of mental health and psychosocial care from newly emerging contexts of suffering.

Conclusion and recommendations

At present, the status of mental health care as a human right remains unresolved, and attendant instabilities in the provision of care are a result. Though mental health and psychosocial language figures prominently in white papers and reports, the actual provision of mental health and psychosocial care has dramatically declined.⁵ It is crucial that the paradigms of MHPSS care and services be understood within the structural and cultural contexts of violence, transition, and transitional governance in which they occur. We therefore offer the following recommendations:

- (1) We recommend that the IASC formulate a clear statement about the status of psychiatric care, mental health counselling, and psychosocial intervention as a human right in emergency settings. The problem of mandate needs to be resolved. Although mental health has been recognized as a human right in several international documents, this recognition has failed to extend itself to humanitarian contexts. A standing global coordination body should be constituted to work with donors across crises to ensure that staff, material and resources are committed to MHPSS
- (2) We vitally need to have an open discussion concerning the premise of *'First, Do No Harm'* in mental health and psychosocial intervention. Thanks to these guidelines, international and local mental health professionals have a set of moral and procedural parameters for creating future MHPSS services. (*'What kinds of interventions are acceptable when the ideal advanced by the IASC is not attainable?'* *'What are the worst practices in MHPSS interventions, and what are their consequences?'* *'What is happening in interactions in which the highest principles of care are not being achieved?'*) Answering these questions will go far to restore legitimacy to mental health and psychosocial care in emergencies.
- (3) A comprehensive ethnographic and comparative examination of MHPSS interventions must be conducted to assess the nature of the interaction between the intervention, the beneficiary population, and local staff. A careful study must be made of: the net social and cultural impact of MHPSS interventions (beyond individual therapeutic outcomes) in emergency settings; the institutional, structural, and

cultural dynamics in which they are taking place; and the contribution of MHPSS services to the creation of a paradigm of care with broad social implications for collective healing.

As anthropologists evaluating the utility of the guidelines, we believe that complex understandings of power and culture must be integrated into an understanding of the guidelines' relevance to the provision of care in the 'field.' Psychosocial interventions in emergency settings operate at two levels simultaneously: (1) the local engagement between MHPSS practitioners and beneficiary populations, and (2) the global engagement between humanitarian organizations and local employees and beneficiaries involved in the provision of services. These latter ethnographic conditions constitute the structural background out of which the dynamics of suffering and healing as a mode of inter-subjective experience emerge (Kleinman, 1999).

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¹ In *Rethinking Psychiatry* (1988) Kleinman describes category fallacy thus: ‘*The reification of one culture’s diagnostic categories and their projection onto patients in another culture, where those categories lack coherence and their validity has not been established, is a category fallacy (p. 14-15)*’. Category fallacies occur when observed symptoms of suffering are associated with a diagnostic label that has little meaning or relevance in the context of cultural meaning that shapes the sufferer’s subjective experience.

² These examples are composite narratives drawn from numerous ethnographic informants during research conducted in Guinea and Liberia between 2003-2008. The authors recognize and salute many local mental health workers’ commitments to alleviating suffering, providing high quality care – often at great personal sacrifice. These examples are provided to serve the rhetorical purpose of illustrating counter examples.

³ The consequences of this whitewashing dynamic are pervasive in psychosocial interventions. In the fieldwork of one of the authors (SA) in Liberia, local psychosocial educators often proposed formulaic psychosocial education projects to their superiors. However, when they conducted trainings in rural areas, psychosocial workers were often confronted with a host of local dilemmas concerning family structure, property distribution, land use, and social mores. Staff members

often adjudicated these issues on the strength of their status as NGO representatives (sometimes fabricating precedents, legal procedures, and bureaucratic practices in the process), and returned to their home offices in the capital, where they never mentioned the altered character of their interventions.

⁴ There are many possible reasons for local and international leaders’ disinterest in mental health issues. These may include, but are not limited to: (1) the relative paucity of material resources which can be exploited in the delivery of services, (2) the relative scale of ‘needs’ in emergencies (shelter before protection, food before mental health), (3) the problems of mandate, (4) the ‘untraditional,’ or semi legitimate status of MHPSS interventions, or the relative coolness of international donors to MHPSS activities.

⁵ Paul Stubbs noticed a downward trend in funding for mental health interventions in Bosnia and Croatia in 1996 (Stubbs, 2005). One of the authors, S.A., noted a continued decline in funding for stand-alone mental health and psychosocial interventions during fieldwork in Liberia from 2005-2008.

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