Defining *mental health* and *psychosocial* in the Inter-Agency Standing Committee Guidelines: constructive criticisms from psychiatry and anthropology

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The development of the Inter-Agency Standing Committee Guidelines heralded an international achievement by gathering mental health and psychosocial professionals to evolve common minimum responses during emergencies. However, one continuing contentious issue has been the definitions of mental health and psychosocial support. The absence of these formal and agreed definitions may well interfere with coordinating minimum responses. This paper explores theoretical differences in these fields, and presents alternative definitions and solutions through a review of the psychiatric and anthropological literature.

Keywords: cultural psychiatry, global mental health, IASC Guidelines, mental health, psychosocial support

Introduction: the *Inter-Agency Standing Committee Guidelines* within the backdrop of global mental health

Over the past decade, greater awareness has developed on the impact of mental disorders on general mortalities and basic disparities in psychiatric treatment. For example, effective mental health treatments may take many forms, but do not always reach those most in need due to stigma and the dearth of providers, researchers, culturally matched services, and international resources (Satcher, 2001). Mental illness constitutes 14% of the global burden of disease, though this statistic underestimates the impact of mental illness on physical morbidities, emphasising the need to integrate health planning, policy, provision, and prevention (Prince et al., 2007), especially since mental disorders are commonly clustered with physical ailments (Miller, 2006).

In 2007, the Inter-Agency Standing Committee (IASC) an inter-agency forum for coordination, policy development and decision making involving crucial UN and non UN humanitarian partners (established in 1992 at the request of the United Nations General Assembly) released guidelines to emphasise that mental health and psychosocial wellbeing are the responsibilities of all humanitarian workers, not just psychologists and psychiatrists (Duarte, 2007). The *IASC Guidelines* marked a milestone in forging political consensus around the psychosocial sector, a controversial area given the heterogeneous disciplines servicing crisis populations (Ager, 2008).

However, concerns have been raised about the assumptions governing the movement

for global mental health. In imposing their biomedical diagnoses and treatments, Western practitioners often ignore local health beliefs and practices (Summerfield, 2008). In addition, humanitarian agencies frequently make local staff accountable to international nongovernmental organisations (INGOs) providing services, not to their local communities (Abramowitz & Kleinman, 2008). This paper reviews how definitions of mental health and the psychosocial sector in the *IASC Guidelines* may impact service delivery. This appraisal seeks to build on existing recommendations for better coordination among diverse professionals with varied theoretical orientations.

The definition of 'psychosocial' may be too expansive in the IASC Guidelines

One fundamental complication is that the *Guidelines* do not explicate the definitions and differences between *mental health* and *psychosocial support*. Since this phrase recurs throughout them, its definition merits attention, given its bearing on minimum responses. The *Guidelines* view this sector broadly:

> *'The composite term 'mental health and psychosocial support' is used in this document to describe any type of local or outside support that aims to protect or promote psychological well-being and/or prevent or treat mental disorder'* (The Inter-Agency Standing Committee, 2007:1).

This statement may be so vague as to permit any well intentioned intervention, despite its consequences. The term *'psychosocial'* has been criticised for lacking a simple definition that is easily comprehensible to donors, recipients, practitioners, and governments (van Ommeren, Morris & Saxena, 2006). The term *'psychosocial'* tends to be used in three ways: as a less stigmatised synonym for *'mental health'*, as social activities typically subsumed within the development sector, and as a community's capacity to leverage resources in adversity (Ager, Strang & Wessells, 2006). These various definitions have even led to calls to end the psychosocial sector as its indeterminate relationship between the psychological and social aspects of wellbeing produces disagreements among field workers (Williamson & Robinson, 2006). Subsequently, the *Guidelines* opted for the phrase *mental health and psychosocial support* to promote inclusion and practicality rather than consensus (Wessells & van Ommeren, 2008).

Furthermore, the *IASC Guidelines* may complicate treatment of mental disorders under the phrase *mental health and psychosocial support* by using the qualification *'and/or'*. They include this caveat:

> *'Although the terms "mental health" and "psychosocial support" are closely related and overlap, for many aid workers they reflect different, yet complementary, approaches. Aid agencies outside the health sector tend to speak of "supporting psychosocial wellbeing." Health sector agencies tend to speak of "mental health," yet historically they have also used the terms "psychosocial rehabilitation" and "psychosocial treatment" to describe nonbiological interventions for people with mental disorders. Exact definitions of these terms vary between and within aid organisations, disciplines, and countries'* (The Inter-Agency Standing Committee, 2007:1).

Ambiguity in delineating the differences between the mental health and psychosocial sectors can fracture management within emergencies. For example, mental health

professionals start with the individual as the unit of analysis and incorporate social factors by attending to the individual's psychological interaction with the environment (Rehman et al., 2007; Pratt, 2003), the integration of the mentally ill within society (Bachrach, 1992), and the match between psychological and environmental interventions (King & Ollendick, 2006). Conversely, psychosocial employees start with the community as the unit of analysis and then narrow the analysis down to the individual by examining the social influences on behaviour (Nicolai, 2003), locating disorders within a political context (Losi, 2000), and expanding social networks (Jones, 2000). Diverse perspectives on the psychosocial sector can frustrate standardised treatments (Tiedje, 2003; Dagnan, 2007), confound research methodologies with variables defined differently (Dodrill et al., 1984; Goldstein, 1996; Egan et al., 2008), and disorganise relief logistics (Galappatti, 2003). Consequently, the *Guidelines* may reinforce divisions among mental health and psychosocial workers who differ in opinion over the need for formal psychological and psychiatric responses in emergency settings (Yule, 2008). Hence, unclear boundaries of the mental health and psychosocial sectors may hinder collaboration if field workers distrust each other.

This lack of specificity ensures multiple interpretations. Gilbert (2009) has commented on how many Jordanian counsellors use psychological terms without shared definitions. In my own work in India, Pakistan, and Jordan, local workers trained in North America or Europe could not translate the term *'psychosocial'* into Hindi, Urdu, or Arabic for monolingual populations because theories from other fields such as religion or political science prevail regarding the individual's relationship to society. Academic translations then arise, which do not circulate among the general public. We therefore encounter a situation where the psychosocial sector, already contested within the IASC, finds translational difficulties in cultures where there may be little experience with mental health and psychosocial activities. In this regard, even though the *Guidelines* encourage using local languages to enlist underrepresented and less powerful groups in inter-sectoral responses (The Inter-Agency Standing Committee, 2007:34), such attempts at cultural sensitivity may ironically showcase power differentials in how emergencies are conceptualised among international versus local staff.

Recommendations

Straightforward, uncomplicated definitions may improve cooperation among interdisciplinary stakeholders and present differences based on professional orientation.

Mental health can be defined as *'the promotion of psychological wellness, emotional stability, and optimal daily functioning for an individual within social and cultural contexts.'*

Mental disorder could then be defined as *'the presence of thoughts, emotions and behaviours experienced by an individual that cause significant distress and impair social and occupational functioning within a cultural context.'* These definitions underscore the individual as the unit of analysis while providing direct reference points by which all workers can refer to mental health professionals in cases of uncertainty.

Psychosocial support could be defined as *'the social, political, cultural, and economic materials and mechanisms essential for an individual's health that promote safety and security within the community.'* This definition emphasises society dimensions essential to the individual's wellbeing. The term *materials* alludes to

concrete resources such as shelter, education, sanitation, and nutrition, which can be tangibly measured, whereas *mechanisms* refers to aspects of community building that defy easy measurement, such as social cohesion and empowerment that may improve health.

A sense of the differences between *mental health* and *psychosocial support* may enable workers to better cooperate in the field and recognise when professional differences might arise. These definitions could be viewed as a foundation for future deliberations among IASC members.

In conclusion, the *IASC Guidelines* represent a historic partnership among many disparate bodies. Application of the *Guidelines* has revealed facets that work well, and others which could benefit from improvement. This paper has concentrated on defining *'mental health'* and *'psychosocial support'* not to create division, but to stress how these sectors can operate in a complementary way for minimum responses.

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