REFUGEE STUDIES CENTRE

WORKING PAPER SERIES NO. 98

Revisiting therapeutic governance

The politics of mental health and psychosocial programmes in humanitarian settings

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March 2014

Refugee Studies Centre
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Working Paper Series

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List of abbreviations

DSM	Diagnostic and Statistical Manual of Mental Disorders
IASC	Inter-Agency Standing Committee
MHPSS	Mental health and psychosocial support
PTSD	Post-traumatic stress disorder

1 Introduction

Suffering is a well-acknowledged part of the human experience; sadness, pain and despair have been subjects of academic analysis, religious explanation and scientific inquiry for centuries. Humanitarian assistance in natural disasters, conflict and instances of forced migration is naturally linked to this suffering, as it "sees the preservation of life and the alleviation of suffering as the highest value of action" (Fassin 2007 in Barnett 2011:12). In the last thirty years, humanitarian programmes have increasingly sought to preserve not only physical life and health, but also to address psychological needs and promote social well-being (Ager 1993; Miller and Rasco 2004; van Ommeren et al. 2005). This growing prioritisation of psychological issues in humanitarian settings can be seen in the development of new types of assistance efforts, described by the umbrella term "mental health and psychosocial" (MHPSS) programmes. Such programmes have taken many forms, including the deployment of psychiatrists to emergencies, promotion of trauma counselling, establishment of supportive spaces for children and longer-term community development and peace-building initiatives.

Despite this proliferation, mental health and psychosocial programmes have been widely criticised, and the MHPSS field marked by intense debate. Psychological needs can be challenging to assess and programme impact difficult to measure (Tol et al. 2012). Frequently grounded in Western understandings of mental health and well-being, the cross-cultural relevance of MHPSS programmes has also been questioned (Ager 1993; Angel et al. 2001). These programmes have sometimes presumed higher levels of distress in populations than is later identified (Silove 1999; Summerfield 2001), and have been accused of leading to an uncritical importation of psychological concepts into research and academic inquiry (Malkki 1995). The validity of psychological concepts upon which psychosocial programmes often rest has also been challenged, including the idea of "trauma" as an explanation for the presence of particular types of psychological stress and its closely associated diagnosis of post-traumatic stress disorder (PTSD) (Bracken and Petty 1998; Kleber et al. 1992; Summerfield 1999; Young 1995).[1]

Several tensions have existed in the discourse of psychosocial programmes, leading to seemingly intractable debate: whether knowledge gained from one cultural context was generalisable or unique; whether programmes should prioritise technical psychological knowledge or indigenous healing strategies; and whether interventions should be targeted to particular "vulnerable" groups or designed to provide societal-level community-based supports (Ager 1997). In addition, competition has existed between professionals from different disciplines, roughly divided between those emphasising mental health supports (typically psychologists, psychiatrists and other mental health professionals), and those preferring social interventions (typically social workers, child protection experts and other paraprofessionals) (Wessells and van Ommeren 2008; Ager 2008). Building on these criticisms and debates, Vanessa Pupavac (2001:358) has argued that mental health and psychosocial programmes constitute therapeutic governance, or a means of control by which humanitarian actors (acting on behalf of "Western" interests) seek to manage global social

[1] Kleber et al. (1995) and Marsella et al. (1996) in Ingleby (2005:10-11) provide a succinct review of doubts about the universality and relevance of PTSD with reference to psychosocial programmes. Kienzler (2008) also reviews literature regarding discourses on and debates over PTSD and trauma. Howell (2012) discusses the evolving political use of PTSD in psychosocial programmes within humanitarianism.

risk. Psychosocial programming is thus seen as depoliticising and dehumanising, relying on the problematic homogenisation and pathologisation of communities' needs and their responses to "traumatic" events (Pupavac 2006b).

These critiques have influenced both policy and practice. Practitioners and academics have proposed alternative models for conceptualising mental health and psychosocial needs, attempting to resolve the cross-cultural irrelevance of interventions and the inappropriate pathologisation of affected communities (e.g. Psychosocial Working Group 2002; Ager et al. 2005). At a global level, the Inter-Agency Standing Committee (IASC), a forum for international coordination of UN and non-UN humanitarian agencies, established a task force to develop guidelines on MHPSS in emergencies. The resulting *IASC Guidelines on Mental Health and Psychosocial Support in Emergency Settings* (hereafter IASC guidelines) (IASC 2007) prescribed minimum standards for psychosocial interventions and established guidelines for interagency coordination (van Ommeren et al. 2007). Additional resources were subsequently developed (e.g. WHO 2012), and the Mental Health and Psychosocial Support (MHPSS) Network was established as a "global platform […] for sharing resources and for building knowledge related to mental health and psychosocial support" (MHPSS Network 2013: Paragraph 1).

However, whilst these developments have been said to represent a "breakthrough in professional reflexivity" (Abramowitz and Kleinman 2008:220), further reflection on the political implications of MHPSS is warranted (*Ibid*; de Jong et al. 2008; Wessells and van Ommeren 2008). The IASC guidelines have been described as marking significant "consensus" in the field, but are focused on practice rather than theoretical or political analysis (van Ommeren et al. 2005; Ager 2008). Thus, significant questions remain: Where does current practice position itself with regard to the field's historical debates? What type of knowledge is given preference? What assumptions underpin current thinking? This inquiry is particularly urgent because inappropriately designed MHPSS interventions have the ability to do harm through undermining local coping strategies, encouraging vulnerability, and reinforcing unequal power dynamics in humanitarianism (Wessells 2009). MHPSS sits at the intersection of several fields frequently claiming to have universal, objective knowledge: the "Western" biomedical paradigm of pathology and disease, the humanitarian system's allegiance to "neutrality" and the powerful moral claim to address suffering. This increases the need for critical analysis to highlight underlying political dynamics. In addition, psychological concepts have increasingly been used to represent suffering; it has been argued that "trauma is displacing hunger in the West's conceptualisation of the impact of wars and disasters" (Pupavac 2001:358). The effect of this psychological paradigm is particularly important in the field of refugee studies, which has often uncritically absorbed "psychologising modes of knowledge and therapeutic forms of relationship" into programmes and academic inquiry (Malkki 1995:510).

This paper explores the political implications of current MHPSS programmes by analysing and evaluating Pupavac's theory of therapeutic governance and applying it to current practice, as represented by the IASC guidelines. Pupavac's theory is useful because it interrogates not only cultural considerations but also control, power and the political implications of MHPSS. However, this paper will also assess the critical utility of Pupavac's theory by examining its strengths, weaknesses, assumptions and theoretical claims. Therefore, this study both refines Pupavac's critique and reflects on the current state of MHPSS programming by revisiting the concept and application of therapeutic governance.

In particular, this paper addresses three research questions: First, what is therapeutic governance and what is its critique of psychosocial programmes? Second, what is the critical utility of therapeutic governance? And third, to what extent does current practice, as represented by the IASC guidelines, constitute therapeutic governance?

Methods and methodology

This evaluation uses a constructivist approach, seeking to uncover implicit assumptions, first in Pupavac's theorisation of psychosocial programmes, and second, in current MHPSS practice. This allows for analysis of the way that mental health and psychosocial programmes construct and regulate particular subject positions, which are more or less empowered as political actors. Though my intention is not to provide policy recommendations, this discussion will raise points for further reflection in the field. The first and second research questions are addressed through analysis and evaluation of Pupavac's body of work (2001; 2002; 2004a; 2004b; 2006a; 2006b; 2008; 2012) and other scholarship on which the critique mental health and psychosocial programming relies (e.g. Bracken 2002; Duffield 2001b; Summerfield 1999; Young 1995). In this analysis I assimilate and distil Pupavac's critique of psychosocial programmes into a four-fold framework: homogenisation, pathologisation, control and depoliticisation.

To answer the third research question, I undertake textual analysis of the IASC guidelines and apply this four-fold framework to evaluate the state of current programming. Constituting the field's current "best practice", the guidelines prescribe minimum responses that should be implemented in all emergencies. They have been adopted and endorsed by all UN and non-UN humanitarian actors and guide current programming and thinking. Therefore, this approach assumes that the guidelines are representative of current practice, and that analysing the language, assertions and underlying assumptions will reveal some aspects of current thinking in the field (Gee 2011).

This analysis is naturally limited to the IASC guidelines themselves and related secondary literature, which provides only a partial examination of "current practice". Indeed, practice encompasses a wide range of programmes, staff, funding sources, recipient communities and historical and political contexts. However, this study provides two novel contributions to the field of mental health and psychosocial programmes in humanitarian settings: a "snapshot" of the field's current theoretical positioning, and an analytical framework for analysing programming in discreet settings.

Whilst there is no shortage of literature exploring the normative value and practical implementation of MHPSS programmes, less is available on the current state of theoretical debates. Partly the result of a proliferation of references to theoretical critiques in the early 2000s, the field has responded in recent years by building consensus regarding practical and programmatic aspects rather than dwelling on intractable philosophical differences. This paper contributes to filling this gap by analysing the extent to which Pupavac's critique is still relevant to practice.

In addition, rather than contributing to the largely "unproductive" theoretical debate which led to the prioritisation of more practical concerns (Ager 2008), this paper revisits and refines Pupavac's critique itself, and offers a new framework for re-evaluating the politics and theoretical positioning of current programming. My assimilation and structuring of Pupavac's body of work and the concept of therapeutic governance applied to mental health and

psychosocial interventions in humanitarian settings contributes to this analysis of the way that people are governed, for good or ill, through the deployment of particular concepts (Howell 2012). Therefore, this study also fills a gap by refining Pupavac's critique in light of current practice, making it more relevant to on-going practice.

Terminology

Inherent in my use of Pupavac's critique, and my own constructivist methodology, is the belief that language and labelling affect reality. This leads to interrogation of particular language and terms. For example, for the purposes of this discussion, I am assuming that trauma is a useful concept for describing distressful events, but my use of the term does not imply that I uncritically accept its widespread use, nor that I accept all associated concepts such as PTSD; when it is necessary to interrogate the term further, I will do so.

Similarly, terms such as "emergency", "disaster" and "humanitarian settings" will be used throughout the paper to describe "situations arising from armed conflicts and natural disasters in which large segments of populations are at *acute* risk of dying, immense suffering and/or losing their dignity" (IASC 2007:17). This is the commonly-held definition in the MHPSS field, and is a convenient way to quickly describe settings where psychosocial programmes are frequently deployed. However, each of these terms is underpinned by assumptions, and I will identify and engage with these assumptions when relevant to the debate.

In addition, these terms encompass a wide range of circumstances, from natural disasters to conflict to situations of forced migration. Each comes with different political, historical and practical implications, and although current guidelines in the MHPSS field are applicable to many of these situations, the degree to which they constitute therapeutic governance may depend on the particular context. This paper will focus mainly on experiences of conflict, war, or human-induced natural disasters (e.g. food crises), rather than natural disasters such as hurricanes. It will focus on humanitarian interventions in developing countries, though MHPSS principles may also be applied in industrialised contexts.

Outline

The paper is divided into three main sections. In the first, I synthesise Pupavac's theorisation of psychosocial programmes, assimilating her body of work related to therapeutic governance as well as literature employing her critique. I argue that therapeutic governance is a value-neutral concept, but that when applied to psychosocial programmes by Pupavac, it illuminates programmes as being homogenising, pathologising, controlling and depoliticising. Though based on analysis of Pupavac's work, this four-fold framework is my own invention and will guide subsequent discussion.

Next I evaluate the critical utility of Pupavac's theory. I analyse its theoretical perspectives and implicit assumptions, arguing that it is weakened by its positions regarding culture, agency, vulnerability and PTSD. This discussion establishes the limitations of applying Pupavac's critique, highlights its most salient aspects and stresses the importance of a critical application of theory.

Finally, I return to my four-fold framework and apply it to current MHPSS programming as represented by the IASC guidelines, bearing in mind throughout the limitations of the theory described in the second section. This analysis demonstrates that current MHPSS

programming expressly avoids problematic homogenisation and pathologisation, and has made progress toward mitigating control and depoliticisation. In this way, the current relevance of Pupavac's critique is significantly undermined. However, this discussion also demonstrates the need to evaluate the implementation of MHPSS guidelines as well as the IASC guidelines themselves. In this way, the four-fold framework based on Pupavac's critique retains utility. Therefore, although therapeutic governance remains a useful lens through which to examine MHPSS programmes in discreet settings, the political nature of mental health and psychosocial support should primarily be analysed as part of broader international humanitarian governance rather than *therapeutic* governance in particular.

2 Analysing therapeutic governance and psychosocial programming

Before evaluating and mobilising Pupavac's critique to analyse current practice, it is first necessary to define therapeutic governance and outline Pupavac's use of the concept to critique mental health and psychosocial interventions. This critique considers programmes to be problematic due to their homogenising, pathologising, controlling and depoliticising nature. I have devised this four-fold framework based on analysis of Pupavac's body of work and related literature, which will be referenced throughout. This discussion frames the subsequent evaluation and application of Pupavac's critique.

Defining therapeutic governance

Therapeutic governance is defined as a "new form of international governance based on social risk management" (Pupavac 2001:258) that "makes a link between psychological well-being and security, and seeks to foster personalities able to cope with risk and insecurity" (Pupavac 2005:161-162). It suggests that guarding and encouraging psychological health is an aspect of good governance rather than a private matter of personal concern (*Ibid*:162) resulting from the widespread dissemination of psychological knowledge and concepts into contemporary society. This type of governance is underpinned by the assumptions that humans have a psychological nature, that this psychological state can be more or less "healthy", that particular ("therapeutic") methods can improve psychological dysfunction, and that it is in society's best interest to encourage and protect psychological well-being. Therapeutic governance has also been called "*international* therapeutic governance", to describe the attempted management of risk through psychological methods at the global as well as the national level (Pupavac 2001). Pupavac sees therapeutic governance as having originated in the "Anglo-American" cultural context, and spreading globally through the hegemonic power of the "West" over the "non-West" in contemporary global society (Pupavac 2001).

The concept of therapeutic governance is also related to Michel Foucault's conceptualisation of "governmentality" (Foucault 1991). For Foucault, government possesses no inherent essence that determines its practices; rather, the particular practices mobilised to govern, or to "observe, monitor, shape and control the behaviour of individuals," establishes its nature (Gordon 1991:3-4). Governance is thus an art, activity or practice, which can be "thinkable and practicable both to its practitioners and to those upon whom it [is] practised" (Gordon 1991:3). Therapeutic governance can therefore be described as the art of governing through the methods of "psychosocial expertise and the wide dispersal and social absorption of psychological knowledge" (McKinney 2007:484). According to Foucault, the "art of

governance" has increasingly utilised these types of "biopolitical" methods as a dispersed form of power by which subjects "regulate themselves". He largely abstains from value judgements about this type of governance (Gordon 1991), and Pupavac's therapeutic governance could similarly allow for discussion of its positive, negative and value-neutral effects.

Psychosocial programmes as therapeutic governance

Pupavac uses the concept of therapeutic governance to critique psychosocial interventions in humanitarian programming, concluding that they are tools by which recipient communities are homogenised, pathologised, controlled and depoliticised. Psychosocial programmes are a manifestation of therapeutic governance, as they mobilise psychological postulations about the effect of war on individuals and communities. Justification for psychosocial considerations in humanitarian intervention is based on the assumption that exposure to "traumatic" events can cause psychological dysfunction in individuals and that "unresolved traumatic experiences [in societies] are likely to ignite new hatred and new wars" (Agger et al. 1995 in Summerfield 1999:1457; Pupavac 2001). The following four categories further describe these arguments and their underlying theoretical positioning.

Homogenisation

First, Pupavac contends that psychosocial programmes both rely on and contribute to problematic labelling of recipients of aid. A review of tools used to measure the psychosocial needs of refugees has remarked that legal definitions such as "refugee" or "internally displaced person" are not always useful for identifying levels of distress and psychological needs of populations (Hollifield et al. 2002:618). Though this is certainly true, Pupavac's critique argues further that definitions used to design and implement psychosocial programmes are inherently problematic, as they simplify and homogenise individuals' and individual communities' unique experiences.

Pupavac challenges the conceptualisation of war-affected populations in recent history as "traumatised *en masse* and in need of therapeutic interventions" (2004b:491), arguing that individual needs should not be aggregated to the societal level and that the humanitarian community should not assume that all people experience traumatic events in the same way. Furthermore, she challenges the prioritisation within psychosocial programming of assisting "vulnerable" groups such as women or children (2002): though women or children may face unique challenges, she says, one must not assume that one type of vulnerability equates to psychological vulnerability, or exclude other groups (such as men who may have been disproportionately exposed to violence as a result of frequently being involved in combat in war) (Pupavac 2002; Summerfield 1999). Assuming that disaster or conflict-affected individuals may require therapeutic interventions, or that particular sub-groups are necessarily more likely to require psychological assistance, *enables* psychosocial programmes, and allows those programmes to reinforce the same labels upon which they rely.

Concern with labelling is not specific to Pupavac's critique of psychosocial programmes: there has been widespread reflection on the effects of labelling within refugee studies and humanitarianism more broadly. Discussing the labelling of refugees in Cyprus, Zetter (1991:39) argued that even labels used to prioritise needs and assign responsibility to assistance providers could create "alienating distinctions" which can be harmful. Analysing the metaphorical language used within the field of forced migration not only to describe, but also to conceptualise relevant concepts, Turton (2003:2) has similarly argued that language and labels determine "the way we think about, and therefore act towards, migrants."

Pupavac's critique draws on this type of analysis, challenging the labels assigned to recipients of psychosocial programmes.

Pathologisation

Second, Pupavac criticises not only the use of labels, but also the particular labels employed by psychosocial programmes. She argues that psychosocial programmes rely on the pathologisation of aid recipients, or the equation of traumatisation with dysfunction and abnormality (Pupavac 2002; 2006b). For Pupavac, this pathologisation is caused by the field's uncritical reliance on two interrelated concepts: first, the diagnosis of PTSD, and second, "Western cultural norms" that favour a particular understanding of response to stress and trauma.

PTSD, defined by the *American Psychiatric Association's Diagnostic and Statistical Manual of Mental Disorders* (DSM) in 1980, was said to be characterised by three symptoms: the "re-experiencing" of a traumatic event through intrusive thoughts, dreams or feeling as if a past event is occurring in the present; a "numbness" to the outside world following a traumatic event and feeling less interested or detached from significant activities or relationships; and behaviour such as hyper vigilance, insomnia or memory impairment that begin only after the traumatic event occurs (DSM-III 1980 in Joseph et al. 1997). These symptoms must be directly related distress that would be likely to produce significant symptoms of stress in nearly anyone, suggesting that the traumatic event must be both significant and universally defined as capable of producing distress (*Ibid*).

This claim to universality and cross-cultural applicability of PTSD has prompted significant debate within the field of psychosocial programming and more broadly in psychology, psychiatry and anthropology. Critics, including Pupavac, emphasise that it must be viewed in light of the broader political context in which it originated. A frequently cited analysis of the origins of PTSD, for instance, argues that though there is evidence of distress following "traumatic" events throughout history, PTSD emerged as a way to justify providing assistance to struggling veterans returning to the United States from Vietnam (Young 1995). Thus, even if it is a meaningful category for explaining some individuals' responses to trauma, it cannot be separated from the political purpose that it serves within a particular context. Since 1980, the definition of PTSD has evolved; in 1994 it was expanded to include reactions to witnessing, not only experiencing, traumatic events (DSM-IV in Howell 2012). In addition, it has been noted that PTSD is often assigned to entire populations, even though this broad interpretation is not included in the diagnosis' definition itself (Ingleby 2005).

Pupavac's critique also questions psychosocial programmes' association with "Western cultural norms" and the function that particular types of therapeutic interventions serve within Western society (Pupavac 2001; 2002; 2004b; 2012). For Pupavac, PTSD is the "archetypal syndrome of the emotionally vulnerable individual" (Bracken 2002 in Pupavac 2004b:492), prioritising the therapeutic processing of emotions over alternative ways of responding to suffering. PTSD is therefore regarded as a desirable label to help explain and identify "solutions" for the ill effects of experiencing trauma. She argues that modern "Western" culture has an individualised conception of the self: valuing individual feelings, lacking ties to a broader community or communal identity, framing social issues within emotional terms, and disposed to introspection (Pupavac 2004b:492-494). Furthermore, returning to the concept of therapeutic governance, the "West" maintains that it is morally responsible and a matter of good governance to promote these types of therapeutic responses

to daily life. Contrasting these norms with "non-Western" norms of beneficiaries of humanitarian programmes, Pupavac warns that psychosocial programmes falsely assume that emotional processing with therapeutic support is a universally held value.

Control

Third, Pupavac suggests that this pathologisation is not solely an unintended consequence of the exportation of PTSD and "Western cultural norms", but rather an imposition of a "Western" framework for the purposes of promoting the "West's" own interests: thus moving beyond critique of psychosocial programming simply as culturally irrelevant. Instead, Pupavac makes two assertions: first, therapeutic interventions undermine community-based responses to violence and suffering, and second, they perpetuate and enable Western power (Pupavac 2002; 2004b, 2012.

Pupavac suggests that psychosocial programmes displace alternative responses to violence and suffering that may be held in "non-Western" cultural contexts (2004b). For example, psychosocial programmes could be seen as problematising feelings of anger that might be felt following traumatic experiences, in favour of emotional processing with therapists in order to attempt to "get through the anger". Though it could be argued that anger is an inherently negative emotion, and always beneficial to resolve before it leads a person to inappropriate or harmful behaviour toward others, Pupavac questions this assumption. Rather, it may be in a person or community's best interest to be angry, if that anger leads to obtaining justice for the wronged party. In this way, psychosocial programmes are seen as an instrument for broader "social risk management" (Pupavac 2001:359). Legitimised by the pathologisation which places moral responsibility on outsiders to recognise and assist "traumatised" (i.e. dysfunctional) individuals (Fassin and Rechtman 2009), the West is seen as promoting psychosocial interventions to destabilise pre-existing coping mechanisms that may threaten Western interests.

Pupavac's critique also suggests that psychosocial programmes serve Western interests beyond risk aversion. Psychosocial interventions have historically served funders' interests by relying on Western staff and returning programme funding to Western economies (van Ommeren et al. 2005). Pupavac also suggests that psychosocial considerations help the West "bring back the human face" to its humanitarian activities after being seen as abetting rather than resolving conflict in Rwanda, Kosovo and elsewhere in the 1990s (Pupavac 2004b:497). Within such humanitarian activities, psychosocial considerations based on homogenisation and pathologisation perpetuate the perception that humanitarians are "experts" having relative knowledge and therefore power over recipients of aid (Williamson and Robinson 2006).

Depoliticisation

Finally, Pupavac argues that the result of this desire for control, exerted through homogenisation and pathologisation, is the delegitimising of recipients as political actors (Pupavac 2002). This depoliticisation applies at both the individual and community level, and is the result of two types of power: first, the dispersed regulation of therapeutic governance, and second, a more overt type of control which seeks to maintain historical geopolitical power balance.

Pupavac first argues that the methods of therapeutic governance lead to an implicit constraint of recipients' right to political autonomy. Therapeutic governance restricts the range of

acceptable responses and behaviours at the disposal of the "governed". Seeing oneself as vulnerable, weak and in need of therapeutic interventions may erode self-determination and the willingness to make demands of the community, state or humanitarian actors. This may also legitimise the assumption of "sick roles", or the position in society of being less able to make decisions independently and being seen as in need of outside support (Parsons 1951 in Pupavac 2006, 2006b). Though therapeutic methods could offer some relief of distress through acknowledgement of injustice or suffering, they may perpetuate power imbalances between implementer and recipient of assistance (McKinney 2007). Pupavac has called this constraint of political autonomy the "reduction of politics to administration" (Pupavac 2001:358-359). In other words, it is the management of unpredictable responses to trauma through the deployment of therapeutic interventions, such as those used by psychosocial programmes, which have the potential to avert attention from what people may cite as the root cause of their distress, as well as the solutions they would naturally seek to that distress (Summerfield 2008).

Second, depoliticisation results from the "West's" explicit exertion of control and desire to maintain relative geopolitical power. Pupavac suggests, for instance, that "treating war as a psychological dysfunctionalism" during the Cold War "was viewed by the South as an attempt to delegitimise national liberation movements against colonial rule" (Pupavac 2001:359). Even in a post-Cold War environment, psychosocial programmes are seen justifying "Western" interference in "non-Western" politics (Pupavac 2004b). State and international governments are able to intervene, even militarily, by conceiving of violence as being related to a "cycle of trauma" and appealing on moral grounds to conduct what would otherwise be considered amoral actions (Pupavac 2002). Therefore, not only individuals but also states and other sovereign governments lose their right to political autonomy through the depoliticisation resulting from psychosocial programmes.

3 Evaluating the critique of psychosocial programming

Having described Pupavac's concept of therapeutic governance and its critique of psychosocial programmes, I will now reflect on the utility of this critique. I will argue that its strength is its constructivist methodology, which in the Foucaultian tradition allows for analysis of the ways that "professional communities […] construct subject positions" which are then regulated (Laqueur 2010:1). In this case, Pupavac's disciplinary distance from psychology, traumatology and humanitarian practice allows for reflection on the "professional community" responsible for mental health and psychosocial programme design and implementation, as well as that community's construction of the "subject" receiving assistance. I will demonstrate that the critique is fundamentally weakened by its implicit assumptions regarding culture, agency, vulnerability and PTSD, though it retains critical utility in its discussion of therapeutic methods, power and humanitarianism more broadly. Therefore, though Pupavac's critique retains some usefulness, it must only be applied with these limitations in mind.

The professional community and constructed subject

Pupavac's critique suggests that the professional community administering mental health and psychosocial programmes constructs depoliticised, pathologised subjects in need of outside

intervention. The professional community consists of psychologists, psychiatrists, mental health workers and program administrators familiar with Western psychology and operating within humanitarian settings. It is most often affiliated with large, international humanitarian organisations, and receives funding from North American and European states, which Pupavac refers to broadly as the "West". Its work is underpinned theoretically by research conducted at academic institutions in the same region. For Pupavac, this professional community is inseparable from the broader humanitarian field that has become introspective and vulnerable following humanitarian failures in the 1990s, using psychosocial programmes to regain moral legitimacy (Pupavac 2004b; Pupavac 2006b). Whereas humanitarian workers once thought of themselves as "Western saviours", she argues that humanitarians have had their sense of confidence and purpose challenged by physical, ethical and political attacks on their mission (2006b:25). In response to this, the professional community has adopted the same therapeutic methods employed in programming to analyse themselves, resulting in introspection, self-doubt and vulnerability.

For Pupavac, the professional community is therefore empowered by Western funding and knowledge and sees itself as assisting people through therapeutic interventions. She argues that psychosocial programmes have been used in an attempt to "remoralise" the humanitarian mission through addressing not only the physical needs but also psychological needs of aid recipients (Pupavac 2004b). Whereas material assistance may be extorted or used to perpetuate conflict, addressing immaterial issues inside the body may have seemed a less politically risky option. In keeping with classic humanitarian principles, it could be considered "neutral", even in situations where other types of assistance could have been more closely aligned with supporting one political actor over another. Aid recipients are in turn constructed as a subject benefitting from outside assistance, which serves the political aim of the humanitarian community to justify its existence and actions. With regard to culture, recipients of psychosocial programmes are seen as having entirely different "non-Western" cultural paradigms from the "Western" professional community. Though Pupavac does not argue that the professional community considers the subject's culture to be inferior, her discussion presumes that subjects are seen as benefitting from the adoption of therapeutic methods, even if those therapeutic interventions originate and are situated within a "Western" cultural framework.

Strengths of Pupavac's critique

Therapeutic methods

As stated, the strength of Pupavac's critique relies on its ability to illuminate the political aspects of MHPSS services. The concept of therapeutic governance provides a useful framework for analysing the particular methods prioritised by such programmes, including introspection, self-examination, a preference for individual processing, and the deployment of psychological and psychiatric professional staff. It also highlights the assumption that "dysfunction" can be improved through "therapeutic" methods and it usefully queries the assumptions inherent in concepts that have become commonplace and promoted in programming. It is possible that vulnerability could be perpetuated through encouraging people to talk about their problems, and particularly if people are convinced that they have an ailment that cannot be remedied without outside, "professional" intervention. Applied to psychosocial programming, therapeutic governance is an accessible lens through which to consider practical assumptions made not only by psychologists or within the mental health profession but also by humanitarians who have absorbed psychological knowledge and seek to

administer humanitarian or specifically psychosocial interventions. It would also provide a useful lens through which to research the particular coping methods employed by communities receiving assistance.

This perspective is particularly important in the field of refugee studies, in which both metaphors (e.g. refugee "flows") and disease markers (e.g. "traumatised") are often used uncritically and without reference to the social effects of such labels. Reflecting on refugee-related research initiatives, Malkki has noted for instance that "psychologizing modes of knowledge and therapeutic forms of relationship" have been widely accepted, and "too often been uncritically imported into the disciplinary toolkit of sociocultural anthropology or sociology" (Malkki 1995:510). Pupavac's critique should therefore be considered not only by practitioners of psychosocial programmes themselves, but also by researchers and implementers of non-psychological programmes seeking to understand what are heterogeneous and culturally influenced experiences of conflict, disaster and displacement.

Power

The critique is also useful in its discussion of the overt power expressed through the design and delivery of psychosocial programmes. The political and financial interests of humanitarian implementers clearly bind programmes' ability to respond to local realities, thus restricting recipients' ability to define the content and form of the assistance they receive. Homogenisation and pathologisation are reminiscent of similar critiques of humanitarianism as striving to maintain unequal power relationships between humanitarian actors and recipients of aid (Harrell-Bond 2002:56; Donini 2012; Duffield 2001a).

Pupavac's critique helpfully notes that even programmes attempting to provide culturally sensitive and participatory services are constrained by funding systems. In a context of shrinking humanitarian budgets and an increased emphasis on demonstrating measurable outcomes, programmes may need to rely on biomedical concepts and tools despite recognising their limitations. Such constraints are highlighted by Pupavac's analysis of humanitarian action in Kosovo, where psychosocial programmes continued to be implemented despite the community's lack of prioritisation of psychological needs (Pupavac 2002). Noting significant discrepancy between funding proposals and practice on the ground, Pupavac notes, "although [community-based] studies make some very pointed criticisms about the nature of psychosocial programs in the region, often their proposals reinforce the therapeutic paradigm and suggest an expansion of the scope of psychosocial work" (Ibid: 500).

Analysing a United States-based programme for survivors of torture and trauma, McKinney (2007:498) similarly argues that despite attempting to adopt culturally sensitive methods in its work with refugees and survivors of trauma, "to survive as a viable program, the [programme] had to demonstrate to its funders that it was providing psychological services to traumatized clients and that staff were clinically competent to deliver these services." Thus, concern about the extent to which local communities are empowered to offer alternative understandings of health and well-being is warranted. Pupavac's critique highlights this well, and could be used to query the extent to which psychosocial interventions perpetuate problematic therapeutic governance in discreet contexts.

Humanitarianism

These political dynamics are more striking when considering psychosocial programmes as part of what has been recently named "humanitarian intervention", referring to the increasing relationship between military and humanitarian actors (Chandler 2001; Chomsky 1999). Distinct from the aforementioned allegation of "demoralised humanitarianism", Pupavac has recently challenged the growing association between psychosocial programmes and the promotion of democracy and longer-term peace building initiatives (Pupavac 2012). Therapeutic methods mobilised through psychosocial programmes could conceivably aid humanitarians' attempted management of global risk, particularly with increased securitisation and militarisation of aid (Duffield 2001a, b).

In addition, the increasing acceptance of therapeutic governance has been convincingly analysed as "signalling moral progress" (Fassin and Rechtman 2009:3), as it is politically advantageous to acknowledge and attempt to address persons' psychological states. The popular discourse of "trauma" in media and in fundraising efforts persists, giving psychosocial programmes distinct legitimacy. When paired with humanitarian intervention and the promotion of particular values through humanitarian action, this legitimacy gains further importance. Conceiving of populations as having "suffered" and being "traumatised" could further justify military humanitarian interventions, adding further geopolitical significance to psychosocial programmes in humanitarianism than their simple goal of relieving suffering.

Limitations of Pupavac's critique

However, despite the utility of Pupavac's critique for analysing the politics of psychosocial programmes, her argument is limited by assumptions regarding the nature of culture, agency, vulnerability, and the diagnosis of PTSD. Though these limitations do not undermine the full usefulness of Pupavac's critique, they do suggest that it be applied to psychosocial programmes with caution. It also justifies further examination of the relevance of the critique to current programming in light of progress in the MHPSS field in recent years, as I will do in the following section.

Culture

The concept of therapeutic governance relies on the existence of "Western cultural norms", which are considered by Pupavac to be a static and discreet set of values and practices, easily able to be exported and imposed upon "non-Western" culture. Though there may indeed be characteristics of broadly "Western" culture, this assumption is flawed on two counts. First, it assumes that that "Western" and "non-Western" cultures are homogenous and exist wholly separate from one another. It neglects the heterogeneity of "Western" and "non-Western" culture as well as the "dynamic nature" of culture in general (Ingleby 2005:19, referencing Geertz 1973 and Barth 1969), and oversimplifies what generalisations can be made. Second, Pupavac's characterisation also ignores the contact that broadly "Western" and "non-Western" cultures may already have with one another, and particularly within humanitarian programming. It ignores the fact that pre-existing community-based support systems could be undermined through humanitarian emergencies, conflict and displacement, and that groups may already be experiencing significant stress and cultural change. Though psychosocial programmes may too frequently assume that a therapeutic paradigm is universally relevant, it is equally unwise to homogenise culture and assume its cross-cultural irrelevance.

Agency

In addition, even if the homogenous and separate "West" and "non-West" are accepted, it is not clear that the recent dispersal of psychological knowledge and therapeutic methods has necessarily displaced pre-existing, non-therapeutic coping mechanisms such as religious or community networks, as Pupavac claims. Calling the counselling profession "a 'new priestly class' [which has displaced] religious leaders as the guardians of [Western] society" (Nolen 1998 in Pupavac 2004b:495), Pupavac contrasts the therapeutic approach with a "stiff upper lip" mentality that discourages public acknowledgement of emotional vulnerability. She argues that this has coincided with a general decline in moral, political or communal convictions (Pupavac 2004b), and a heightened focus on an individual's functioning rather than role within a larger communal system.

Though therapeutic methods and professionals with therapeutic knowledge have certainly become more familiar, these assertions ignore the possibility that previous paradigms also contained what could be considered "therapeutic" methods even if previously called something else. In addition, though people may be increasingly accepting of therapeutic interventions and support from psychological and psychiatric professionals, it is unclear that the content and substance of these exchanges is vastly different from previously sought supports. The importation of therapeutic methods does not necessarily equate to a lack of convictions, even if some shift in the framing and expression of those convictions could logically follow from a shift toward a psychological paradigm. Furthermore, in assuming that these norms are easily and necessarily exportable, Pupavac ignores the agency of individuals to resist therapeutic methods or to adapt particular methods to supplement pre-existing coping strategies. Though it may be possible that certain "Western cultural norms" exist, and may be disseminated globally, their exportation is not inevitable. Despite challenging the propensity of humanitarians to ignore individuals' resilience and capacity to cope with stress, Pupavac's critique also implies a lack of individual agency.

Vulnerability

Pupavac's discussion of the implications of these "Western cultural norms" also neglects the possibility of their usefulness, at both the individual and corporate level, by assuming that introspection and an increased focus on an individual necessarily leads to a sense of vulnerability. Though introspection and a sense of self-doubt may be correlated, there is little evidence of a causal relationship. Further investigation on the implications of introspection would strengthen Pupavac's critique; it is possible that introspection may actually be a positive characteristic of both individuals and societies, prompting more appropriate and considered actions and behaviours.

Similarly, the connection between introspection, vulnerability and demoralisation within the humanitarian field warrants further analysis. Whilst it is clear that humanitarians have increasingly analysed the effectiveness and legitimacy of programmes and even the principles upon which their action is frequently based (Macrae 1998; Rieff 2002; Terry 2002; Vaux 2001), it is unconvincing that this analysis has necessarily led to demoralisation requiring the adoption of new types of programmes, as Pupavac argues. It also assumes a homogenous type of "Western" humanitarianism, which does not account for the varied motivations and ideological positions of humanitarian actors. A more nuanced discussion of the relationship between humanitarian introspection and psychosocial programmes is provided by Ager, Strang and Abebe (2005); citing Harrell-Bond's 1986 critique of humanitarian aid, they argue that psychosocial considerations can be seen as a legitimate and community-led response to

the tendency of humanitarian programmes to neglect inherent strengths and resources of aid recipients, including unseen cultural and psychological resources. Though Pupavac may have appropriately associated humanitarianism's introspection with its increased care for more than just economic or physical needs, her claim to demoralisation as an intervening response to that introspection is limited. It neglects the possibility that psychosocial programmes may actually aid humanitarian programmes to avoid being homogenising, pathologising, controlling and depoliticising. Thus, with regard to both recipients of aid and humanitarian actors, Pupavac's automatic equation of introspection and vulnerability is flawed.

Construction of post-traumatic stress disorder

The critique also uncritically adopts a particular understanding of the nature of health and of the diagnosis of PTSD in particular. Value is placed on "looking beyond the epidemiological literature" and exploring the social influences and power dynamics at work within the psychosocial field (Pupavac 2004b:491). This methodology does effectively allow for the discussion of social factors that have led to the overuse of the PTSD diagnosis (Pupavac 2001, 2002, 2004b). However, Pupavac's understanding of PTSD as a "crisis of meaning" contains assumptions regarding the nature of health and effects of culture on the conceptualisation of wellness (including Summerfield, Bracken and Young). It relies on a clear but undefended position regarding the extent to which culture affects construction, expression and treatment of disease, implying that cultural and social factors alone shape illness categories. It suggests that illnesses are not discovered but invented, and that the validity of mental health research is dubious in light of the subjective nature of mental health itself (Summerfield 2008:992). While this perspective is important in a field that has sometimes simplified or ignored cultural differences (Ibid: 993), long-standing disagreement about the nature of health is ignored. It also neglects recent literature suggesting some cross-cultural applicability of PTSD (Friedman et al. 2010; Kienzler 2008; North et al. 2005).

It is not possible to fully interrogate the complexity of the application of PTSD, which has been debated thoroughly and still lacks broad agreement; indeed, the May 2013 publication of the new *Diagnostic and Statistical Manual* (DSM-V) prompted heated debate about the nature of psychiatric diagnoses (e.g. British Psychological Society 2012), including the cultural value of PTSD in particular (Hinton and Lewis-Fernández 2011). However, Pupavac's critique is weakened by her neglect of this debate and the complexity of the cross-cultural meaning of trauma and PTSD. Furthermore, the critique insinuates that symptoms are in some way fictitious – "that those claiming to suffer from it are not 'really' ill" or in need of support (Ingleby 2005:21). Whether or not this is an intended implication, the lack of acknowledgement of diverse views of PTSD and illness limits the relevance of the critique to practice, and the extent to which the diagnosis may retain some value for individuals experiencing the symptoms that it describes.

Reflections for the application of theory

Pupavac's critique of psychosocial programmes using the concept of therapeutic governance is complex and multi-faceted, pointing to on-going debates about the nature of health, culture, humanitarianism and human reactions to suffering and distress. Though several aspects of Pupavac's critique require significant reassessment, it retains utility as a framework through which to consider programmes' political implications and position within broader humanitarian dynamics. Particularly important is the suggestion that depoliticisation may occur through the deployment of therapeutic methods inherent in psychosocial programmes. This raises several practical and theoretical questions. Can psychosocial programmes

acknowledge the multi-dimensional and individual effects of experiencing distressing events? Would it be possible to use psychosocial programmes as a way to invite participation and better understand a community's own resources and coping strategies? Would acknowledging the limits of psychosocial knowledge free the field to identify areas in which psychological considerations increase a community's access to economic or political self-determination? These questions have underpinned on-going development of the psychosocial field and justify the application of Pupavac's critique to current practice.

4 Applying the critique to current practice: the IASC Guidelines on Mental Health and Psychosocial Support in Emergency Settings

Having analysed and evaluated Pupavac's critique of psychosocial programming, I will now consider its relevance to current practice by examining the *Inter-Agency Standing Committee*[2] *Guidelines on Mental Health and Psychosocial Support in Emergency Settings* (IASC 2007). This document represents a notable consensus in the field and continues to inform current programming. I will undertake textual analysis of this document and will refer to secondary literature and subsequent guidance documents when applicable. First, I describe relevant history and the process of the creation of the IASC guidelines. Then I return to the framework of homogenisation, pathologisation, control and depoliticisation and examine the current applicability of therapeutic governance and Pupavac's critique. This will allow for reflection back to the professional community and subject position constructed through current programmes. Though I will argue that psychosocial programming does constitute a type of international therapeutic governance, I will demonstrate that Pupavac's critique has largely been addressed by the guidelines, which avoid homogenisation and pathologisation, and promote control and depoliticisation only through their broader relationship with humanitarian programming. However, this discussion will also highlight the complexity of practically implementing the guidelines and the importance of broader humanitarian politics on the consideration of psychosocial interventions. For these two concerns, the four-fold critique based on Pupavac's work retains utility.

Current MHPSS practice

The IASC guidelines were developed to address on-going debates in the field, promote coordination between humanitarian actors, and ensure that programmes "do no harm" (IASC 2007; Ager 2008; Wessells and van Ommeren 2008; de Jong et al. 2008). As the foreword to the guidelines explains:

[2] The Inter-Agency Standing Committee (IASC), established by the United Nations General Assembly, "is an inter-agency forum for coordination, policy development and decision-making by the executive heads of key humanitarian agencies (UN agencies, Red Cross and Red Crescent societies, and consortia of non-government humanitarian organisations)" (IASC 2007:19). Prior to its guidelines on mental health and psychosocial support in emergencies, the IASC had produced similar guidance on the implementation of HIV/AIDS interventions (IASC 2003) and gender-based violence interventions (IASC 2005) in humanitarian settings.

> *A significant gap […] has been the absence of a multi-sectoral, inter-agency framework that enables effective coordination, identifies useful practices, flags potentially harmful practices and clarifies how different approaches to mental health and psychosocial support complement one another. (2007:iii)*

The IASC Reference Group on MHPSS and an online forum for collaboration provide on-going guidance and coordination on the implementation of the guidelines and current best practice.[3]

Prior to this document, there was no internationally agreed-upon standard or guidance for the provision of psychosocial interventions. The first edition of the Sphere Project's *Humanitarian Charter and Minimum Standards in Humanitarian Response* (1998; 2000) did not include instruction on mental or social support "because of perceived expert disagreement" (Buzzard 2002 in van Ommeren et al. 2005)[4]. Mental health professionals expressed concern that debate in the field was leading humanitarians to believe that they must choose between providing biomedical, trauma-focused care, or no mental health care at all (Silove et al. 2000; Wessells and van Ommeren 2008). Competition and disagreement between actors and disciplines was widespread (Ager 2008; Ingleby 2005). In addition, humanitarian reform of the mid-2000s included the reorganisation of programmes into "clusters", each with its own programmatic focus and leadership mechanisms. As mental and social support encompassed a broad range of activities, it was not clear where such activities would sit within the new framework.

Recognising these practical challenges and entrenched theoretical debates, development of the guidelines was therefore focused on practice rather than theory (Ager 2008; Wessells and Van Ommeren 2008). Discussing the noteworthy achievement of reaching consensus through the IASC guidelines, a leading psychosocial practitioner has written:

> *In the first few years of this century seemingly every academic paper and dissertation regarding work in this field felt it necessary to cite […] the conceptual critique of false assumptions of psychosocial programmes provided by Summerfield and colleagues (e.g. Summerfield 1999). The entry point for discussion was the theoretical and political construction of psychosocial work, rather than details of its practice.* (Ager 2008: 262)

In contrast, the development of the guidelines was practice-led, focused on *how* to conduct MHPSS programmes well, rather than on *if* MHPSS interventions are warranted in the first place. This allowed participation from a wide range of actors including NGOs, universities, academics, researchers and officials from ministries of health (IASC 2007:iv-vi).

However, at the same time, some consensus regarding theoretical aspects was also growing. A 2005 literature review and survey designed to gauge expert opinion revealed agreement on basic points, including that exposure to stress is a risk factor for social and mental health problems, and that emergencies can weaken pre-existing social and individual supports (van Ommeren et al. 2005:72). An updated Sphere Handbook (2004; 2011) included guidance on

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[3] The IASC Reference Group is tasked with following up on the implementation of the 2007 guidelines. See IASC Reference Group: http://www.humanitarianinfo.org/iasc/pageloader.aspx?page=content-subsidi-tf_mhps-default

addressing the "mental and social aspects of health". Even vocal opponents of psychosocial programmes acknowledged the field's improved cultural sensitivity and acknowledgement of social and not only mental aspects of health (Summerfield 2005). It was agreed that PTSD is often over-reported (Silove 2005) and that it is important to recognise and assist communities to reengage in culturally relevant supportive structures and activities (van Ommeren et al. 2005). This theoretical convergence encouraged political will for development of the guidelines.

Similar to Pupavac's conception of the "professional community", the creation of the IASC guidelines was also led by experts in psychology, psychiatry and mental health. However, in its specific separating of "mental health" and "psychosocial" programmes, the IASC guidelines introduced an additional resource: implementers of specifically social interventions. As suggested by Pupavac's critique, the professional community continues to include humanitarian actors tasked with managing mental health and psychosocial programmes. However, rather than introspective and demoralised, it sees itself as having obtained a "breakthrough in professional reflexivity" (Abramowitz and Kleinman 2008:220) and an important political achievement in light of longstanding, "unproductive" controversy (Ager 2008:261). There was agreement that mental health and social aspects of health should be considered distinctly, rather than social aspects being subsumed by mental health concerns through the *psychosocial* label (Williams and Robinson 2006; Ager et al. 2006). Furthermore, it was agreed that mental health professionals are not always best suited to design and implement social supportive programming (van Ommeren et al. 2005). Actors able to support communities to access social supports were therefore enveloped into the professional community. These may include teachers, civic leaders, or religious officials.

MHPSS as international therapeutic governance

There are three facets of international therapeutic governance to discuss with regard to this document. First, does it promote a *therapeutic* understanding of suffering? That is, does it see the experience of distressful events as leading to social or psychological challenges that benefit from therapeutic assistance? Do the guidelines discuss or seem to contribute to a dispersed psychological knowledge described by Pupavac? Second, are these "therapeutic methods" tools for *governance,* or the management of global risk? Is there evidence of risk aversion in the conceptualisation of suffering and appropriate mental health and psychosocial interventions? Third, is this governance *international* in nature? Is a binary "West" and "non-West" implied, and is there evidence of the "West" seeking to avert its own risk by intervening in the "non-West"?

On all counts, the guidelines can indeed be seen as constituting therapeutic governance. First, their existence hinges on a therapeutic understanding, which assumes that humanitarian programmes should consider the social and psychological effects of conflict and disaster, as well as the recognition that psychological tools may provide useful assistance. With the guidelines, MHPSS is the responsibility of all humanitarian workers rather than just within the purview of psychologists and psychiatrists. Though professionals from around the world participated in the creation of the guidelines (IASC 2007:v,vi), terms such as "psychosocial" are now institutionalised and their use encouraged, rather than just assumed by the global humanitarian community. This is true despite the fact that such terms are often unfamiliar cross-culturally and do not have a direct translation into many languages (Aggarwal 2011). This therapeutic approach is retained even when local healing strategies are promoted. Describing mental health and psychosocial impact of emergencies, the guidelines begin with a

section called "Problems" (IASC 2007:2-3), stating, "emergencies create a wide range of problems experienced at the individual, family, community and societal levels" (*Ibid*:2). Individual, community-based, religious and economic resources are also listed, with the instruction that "it is important to know the nature of local resources, whether they are helpful or harmful, and the extent to which affected people can access them" (*Ibid*:5). This implies a therapeutic paradigm, suggesting that problems can be alleviated through the proper identification and promotion of appropriate interventions.

In addition, the guidelines constitute part of the governing function of the broader international humanitarian community. Having emerged as one of several IASC guidelines and in a context of humanitarian reform, the "focus of the guidelines is on implementing minimum responses […] that should be implemented as soon as possible […] they are the essential first steps" (IASC 2007:5). The existence of guidelines implies a standard to which actors are expected to conform, and "minimum standards" represent actions that must be implemented in all emergencies. An element of risk aversion is therefore implied; the humanitarian community seeks to discourage deviation from "best practice" through the declaration of clear consensus and the establishment of specific standards and expectations for service providers. Even if services providers do not conform to the guidelines perfectly or in all cases, they still represent best practice and establish norms of behaviour.

Finally, this therapeutic governance is indeed occurring within an international context. Though "Western" and "non-Western" is not included in the guidelines, allegiance to a particular (and generally "Western") geopolitical position is insinuated. As the introduction to the guidelines states:

> *The psychological and social impacts of emergencies may be acute in the short term, but they can also undermine the long-term mental health and psychosocial well-being of the affected population.* These impacts may threaten peace, human rights, and development. *One of the priorities in emergencies is thus to protect and improve people's mental health and psychosocial well-being.* (IASC 2007:1, emphasis added).

This emphasis on peace, human rights and development reflects particular values often associated with the "West" as defined by Pupavac. It is not clear in the guidelines whether the desire to promote peace, human rights and development is for the benefit of the "West" through risk aversion, or whether it is based on the assumption that these are universal aspirations. However, psychosocial programmes have previously been criticised for making this uncritical assumption of universality (Summerfield 2005), and the guidelines do suggest that peace, human rights and development are desirable. Whilst local coping strategies, traditional healers and culturally specific strategies are supported, the document implies that those methods are means to an end of promoting peace, human rights and development. It is not acknowledged that communities may not prioritise these things, instead favouring communal responses that are not peaceful or do not promote development. In this way, the guidelines do contribute to a type of international therapeutic governance, which sees peace, security, development and human rights as desirable.

However, this international therapeutic governance is not necessarily problematic. Whilst association of the guidelines with broader humanitarianism and arguably "Western" concepts could warrant discussion, further examination of the content of the guidelines themselves is necessary. It is therefore helpful to return to the framework developed in the first section to

consider the normative implications of the promotion of international therapeutic governance through MHPSS practice as defined by the guidelines. This will reveal the limited contemporary relevance of Pupavac's critique, demonstrating that the guidelines do not homogenise or pathologise, and promote control and depoliticisation only in as much as they are connected to broader humanitarian political dynamics. However, it will also highlight the importance of examining the implementation of particular programmes, and for this, Pupavac's critique retains critical utility.

Homogenisation

The IASC guidelines make clear that the homogenisation of populations is problematic. The document devotes its first four pages to acknowledging the varied and individual experiences of distress, and its foundational conceptual framework indicates that individuals within a community may require different types and levels of assistance (IASC 2007:1-4, 12). Individuals' resources as well as their challenges are mentioned specifically (*Ibid:*4-5), and it is stated that challenges may be experienced at the individual, family, community or social level (*Ibid:*2). Responding to the uncritical characterisation of particular groups as particularly "vulnerable", the guidelines maintain that assumptions should be tested. "At-risk" groups should not be assumed to be passive or requiring particular uniform assistance (*Ibid:*4). All sub-groups of a population could potentially be at-risk, including: women; men; children; the elderly; the poor; refugees and irregular migrants; those exposed to particular types of traumatic events (e.g. torture, losing family members); those with pre-existing vulnerabilities; the socially marginalised; and those at risk of human rights violations or persecution (*Ibid:*3-4). These clarifications mitigate some of the homogenisation that has historically characterised MHPSS practice and highlight the need for detailed awareness and understanding about the cultural context in which programming operates.

However, it is unclear whether the guidelines equip practitioners to develop the skills necessary to gain, evaluate and incorporate cultural knowledge into programming. These are skills developed through practice, education and experience, rather than absorbed immediately through reviewing the guidelines. For instance, on a page of "do's and don'ts", it is stated: "Do: Learn about and, where appropriate, use local cultural practices to support local people; Don't: assume that all local cultural practices are helpful or that all local people are supportive of particular practices" (*Ibid:*15). Though it is outside the scope of any one document to instruct practitioners to navigate cultural differences effectively, the guidelines assume that implementers have this knowledge. The extent to which programming will remain homogenising, therefore, may be heavily dependent on the skills of individual staff.

In addition, as noted by Abramowitz and Kleinman, the guidelines tend to consider culture as a static entity "rather than a dynamic social process" (2008:221), referencing particularly the guidelines' instruction to utilise "local staff" to mitigate cultural insensitivity (Action Sheet 4.1, IASC 2007:71-75). The guidelines instruct recruiters to "aim to hire staff who have knowledge of, and insight into, the local culture and appropriate modes of behaviour […] and who have a thorough understanding of social and cultural responses to the emergency situation" (*Ibid*:73). Though appropriately warning against employing too many international staff, promoting outside knowledge and power imbalances, this recommendation minimises the heterogeneity of culture generally and of "local staff" in particular. It homogenises not only individuals affected by distressful events, but also the nature of culture and the difference between "Western" and "non-Western" contexts. Pupavac's critique of MHPSS being homogenising thus holds when considering the guidelines' understanding of an entirely

"other" cultural identity existing in local populations. However, this tendency to homogenise and simplify culture is also similar to Pupavac's own characterisation of "Western cultural norms" as being identifiable, understandable and applicable entities. It is also similar to Pupavac's neglect of the impact of humanitarian interaction on "local culture" and cultural exchange and fluidity that may occur.

Thus, the IASC guidelines have thoroughly addressed the tendency of psychosocial programmes to homogenise. In practice this will depend on the ability of practitioners to avoid generalisations and recognise groups most "at-risk" within a particular context, yet the guidelines dedicate extensive attention to addressing the critique of homogenisation and problematic assumptions and labelling. A respect for local culture is evident. However, the guidelines create a new label of "local culture," which itself represents a type of homogenisation, and highlights the need for implementing staff to be open to the complexity and dynamic nature of culture itself.

Pathologisation

Returning to the particular labels applied by MHPSS programming, the guidelines also avoid many of the field's previous pathologising tendencies. Reference to PTSD is limited, and "trauma-specific" interventions are not supported uncritically. Instead, explicitly citing the "wide range of opinion among agencies and experts on the positive and negative aspects of focusing on traumatic stress", the guidelines advocate a two-fold response: first, "psychological first aid" for people in acute distress delivered by community workers, and second, care for those with severe mental disorders by trained and supervised health staff (IASC 2007:18). Whilst "psychological first aid" does not include clinical psychiatric intervention[4], the second category still allows for identification and treatment of those suffering from PTSD. This formal distancing from PTSD and trauma interventions, combined with recent research into the cross-cultural applicability of the diagnosis, marks significant progress in the field toward a culturally sensitive understanding of the illness. Furthermore, the guidelines help to avoid pathologisation by highlighting the potential needs of those with severe mental illness (Figure 1, IASC 2007:12). This separates "pathology" from the identification of "at-risk" groups and implies that there may be non-pathological reactions to suffering. It also frees practitioners to justify their work regardless of whether a particular diagnosis is made, and without relying on overused and perhaps inappropriate diagnostic categories. Yet at the same time it allows for people with serious conditions, whether PTSD or another issue, to be identified and prioritised.

The guidelines also explicitly recognise local culture and the likely variability of responses to stress. This eases some concern regarding the imposition of "Western" cultural norms that assume an individualistic and therapeutic paradigm. "Non-Western" coping mechanisms are given explicit support. MHPSS programmes are encouraged to facilitate populations' access to spiritual, religious, family or community-based supports (Action Sheet 5.3, IASC 2007:106-109). A recent evaluation of an MHPSS programme in Haiti, based on such principles, suggests that when local culture is considered and prioritised, a psychological framework can

[4] Psychological first aid (PFA) is distinct from the widely criticised psychological debriefing programmes previously promoted in humanitarian settings. Instead, it is "a humane, supportive response to a fellow human being who is suffering and who may need support […] it does not necessarily involve a discussion of the event that caused the distress" (IASC 2007:119). See also Ruzek et al. 2007; WHO 2011a.

supplement, rather than displace, pre-existing coping strategies (James et al. 2012). The authors of the evaluation hypothesised that people may be able to "shift between potentially contradictory cognitive styles associated with different cultures from moment to moment, according to cues in the environment" (Oyserman and Lee 2008 in *Ibid*:114), and that individuals less able to employ a variety of coping strategies may actually be more prone to anxiety and depression (Fresco et al. 2006 in *Ibid*:114). When tested through examination of the culturally sensitive mental health and psychosocial programme, which involved the participation of local healers and relied on spiritually meaningful concepts, this hypothesis was supported. Western biomedical concepts sometimes provided a framework for participants to identify and explain symptoms, including somatic and other "non-Western" ailments, but activities took place within a non-biomedical context. Even language promoted "relief for the spirit" rather than "therapy". This suggests that conceptual frameworks aimed at blending biomedical concepts and local culture may indeed be possible, and that pathologisation is therefore avoidable.

In addition, the IASC guidelines imply that recipients have a right to be protected from inappropriate interventions. A core value of the guidelines is the humanitarian principle of "do no harm", which recognises that humanitarian interventions can sometimes cause further suffering and barriers to recovery despite their mission to assist. Principles for avoiding harm through MHPSS interventions include: participating in coordination to minimise duplication and gaps in response; being open to evaluation and external review; developing cultural sensitivity; and staying updated on best practices as the evidence base develops (IASC 2007:10). Implicit in this guidance is that "harm" is not necessarily caused by Western psychological tools, but rather by the inappropriate use of those tools. It is also assumed that absorbing and disseminating values of human rights, participation and transparency will mitigate "harm". Though these assumptions could be tested further, the acknowledgement of harm is a significant response to the critique of psychosocial programming as pathologising.

Similar to the discussion of homogenisation, analysis of the guidelines does reveal some areas for further inquiry regarding pathologisation. For instance, the guidelines include relatively little information about how best to acquire and interpret population-level quantitative data (Cardozo 2008). Pre- and post- programme evaluations are not uniformly required, and qualitative assessments, literature reviews and key-informant interviews are prioritised (*Ibid*). On one hand, this reluctance to advocate a particular data collection method or interpretive framework could be seen as a response to pathologisation and an attempt to avoid preferencing particular measurement tools and data collection methods. On the other hand, it is possible that in trying to avoid pathologisation, a lack of quantifiable data could cause programme implementers to fall back on assumptions about the nature of communities' responses to distress. Therefore, as with homogenisation, the guidelines are only effective if they are implemented thoroughly in practice. However, despite these challenges, they do present a holistic response to the historical tendency toward problematic pathologisation.

Control

Whereas homogenisation and pathologisation refer to the labels and assumptions underpinning MHPSS, the concept of "control" is a lens through which the motivations of MHPSS can be analysed. Analysis of the guidelines reveals two elements of control: first, a prioritisation of "Western" knowledge and second, ambiguous categories of "minimum standards" and "emergency". Though the guidelines make a clear effort to address inherent power dynamics, these three aspects may perpetuate control. However, this control is

remarkably similar to broader issues of control within humanitarianism, rather than dynamics specific to psychosocial programming in particular. Therefore, Pupavac's concept of "control" is only relevant to current practice, based on analysis of the IASC guidelines, to the extent that psychosocial programmes are linked to humanitarianism.

First, the guidelines prioritise "Western" knowledge. However, unlike in Pupavac's original critique, this prioritisation is not related to psychosocial knowledge in particular, but rather to Western-led measurement, grant and funding procedures. Explaining the importance of specific, measurable, achievable, relevant and time-bound (known as "SMART") indicators in the design and measurement of programmes, the guidelines state that "although process and satisfaction indicators are useful tools for learning from experience, outcome indicators provide the strongest data for informed action" (IASC 2007:47). The importance of demonstrating results is noted, and it is stated that the preferred measurement type is one that demonstrates "whether the intervention has caused […] change" (*Ibid*). Community participation in these monitoring and evaluation methods is lauded, yet the need to deliver clear and measurable results is prioritised. In addition to an end in itself, participation is therefore also a means for achieving this end. This is reminiscent of similar interrogations of the concept of participation (Cooke and Kothari 2001, Wallace 2007), and serves as a reminder that participation is itself can be used as a political tool. In addition to the use of particular measurement techniques and indicators, outside "expert" knowledge is given preference as programmes must filter data into this "measured" framework. A review of UNHCR's MHPSS programmes in Ethiopia has noted difficulty finding local staff who are trained in and familiar with the guidelines (Schilperoord et al. 2008). Published in 2008, these reflections are perhaps outdated; as the guidelines have been further disseminated, it is possible that more country-level staff have gained greater understanding. Yet the observation is important – it is not only the particular terms or concepts that may be foreign at the local level, but also the funding and reporting systems that enable MHPSS programming. This constitutes a type of control in as much as programmes must conform to largely "Western", or at least outside, knowledge in order to gain funding and legitimacy.

It is unclear whether this control is an intentional tool of MHPSS programmes to maintain historical power imbalance and exert control to serve Western interests or avert global risk, as theorised by Pupavac. There is little evidence that the content of the guidelines promotes or enables this type of global risk management. This is partly a limitation inherent in the methodology of analysing a particular set of guidelines; some political factors will not be evident, and it is impossible to fully theorise the motivations of MHPSS through textual analysis.

Second, despite the guidelines' emphasis on minimum response in emergencies (Wessells and van Ommeren 2008), they still include extensive, though general, guidance on implementing "comprehensive response". The second chapter of the guidelines contains a "Matrix of Interventions", which includes guidance on emergency preparedness, minimum response and comprehensive response related to MHPSS issues. Comprehensive response is described as "most often implemented during the stabilised phase and early reconstruction period following an emergency" (IASC 2007:21). Agency implementation of the guidelines corroborates the observation that they are applicable beyond the "emergency phase"; UNHCR, for instance, has attempted to integrate the guidelines into all programming, ranging from sexual and gender-based violence assistance initiatives, community development support, livelihood programmes, shelter provision and other sectors (Shilperood

et al. 2008). Given the clear inclusion of post-emergency phase concerns, it is worth considering how the concept of "emergency" serves the professional community leading the MHPSS field. The desire for consensus likely influenced this focus, as practitioners more readily agreed upon appropriate immediate responses rather than longer-term interventions. Yet, it is also possible that the concept of "emergency" legitimises the guidelines in general by implying moral responsibility (Fassin and Rechtman 2009), and an environment in which exceptional means are justified and control can be exerted (Agamben 1998; Calhoun 2010; Pupavac 2012). In addition, a discourse of "emergency" could perpetuate the belief that programmes are most valuable in the short-term, and less justifiable past the emergency phase. Though this may encourage funders to exercise appropriate caution before deploying long-term psychological programmes based on homogenising and pathologising assumptions, it may also make acquiring funding for longer-term support more difficult. It has been noted that funders tend to prefer interventions in early phases of emergencies, before longer-term mental health concerns appear, and when only a minority of people will actually require specialised care (Silove 2005). Focusing on emergencies could similarly detract attention from providing care for those with pre-existing mental health concerns or for providing longer-term interventions based on what consensus has been reached.

Together, these three aspects of the guidelines suggest that Western control could be enabled and perpetuated through therapeutic governance inherent in MHPSS. Though this review does not prove *geopolitical* risk management as described by Pupavac, a degree of risk aversion and control is clear with regard to outside knowledge and the discourse of "emergency".. It is thus possible that control is continuing to be exercised despite some mitigation of the field's homogenisation and pathologisation.

Depoliticisation

Central to Pupavac's critique is the concept of depoliticisation, or the delegitimising of recipient communities as political actors. The lack of homogenisation and pathologisation implied in the guidelines undermines this claim of depoliticisation. However, the potential maintenance of some types of control prompts further evaluation. The guidelines make little reference to the political identity of recipients of aid, other than advocating for their participation in services and the incorporation of "non-Western" cultural coping mechanisms. As previously discussed, the guidelines do warn against power imbalances implicit in a therapeutic exchange, such as those cited by Pupavac and others (i.e. increasing vulnerability and self-doubt through the use of particular therapeutic methods).

In addition, the guidelines promote the realisation of protections and other basic needs. Recipients are seen as benefitting from interventions, but also as possessing significant resources and "sufficient resilience to participate in relief and reconstruction efforts" (IASC 2007:5). Information is included on promoting mental health and psychosocial well-being through social protection (IASC 2007:56), legal protection (*Ibid:*64-69), community support (*Ibid:*93-115), health services (*Ibid:*116-147), education (*Ibid:*148-156) and the humanitarian relief effort itself (*Ibid:*157-162). While this incorporation of psychosocial considerations into other programming is constitutive of therapeutic governance and a dispersed psychological knowledge, it also may empower communities to express concerns throughout many aspects of daily life. This is inherently empowering, rather than restricting, as psychological knowledge can augment knowledge in each of these realms and, theoretically, promote wellness across sectors. Especially important is the acknowledgement that lack of information about humanitarian assistance itself can create psychological distress. This is noted

throughout the guidelines (Action Sheet 8.1, *Ibid*: 157-162). Subsequently, published guidance has followed this trend and has aimed to recognise non-psychological factors along with mental and social considerations when assessing needs in humanitarian sectors (e.g. WHO 2011b). Therefore, though psychological knowledge is still disseminated, the breath of particular therapeutic methods employed and the inclusion of non-psychological needs empowers individuals and communities to express political identity.

However, returning to the question of geopolitical or international risk aversion and resulting depoliticisation, the nature of humanitarianism is again relevant. In addition to giving preference to "Western" knowledge, the guidelines construct MHPSS programmes as able to achieve "neutrality". They are assumed to be devoid of political entanglements and conflicts of interest associated with supporting particular geopolitical agendas. When discussing the potential for services to do harm, the guidelines instruct managers to "[develop] an understanding of, and consistently [reflect] on, universal human rights [and] power relations between outsiders and emergency-affected people" (IASC 2007:10), yet this is limited to the power dynamics present in MHPSS intervention itself rather than the global humanitarian system. The guidelines warn against supporting foreign psychological "experts" from intervening unless they have extensive cross-cultural experience, have been explicitly invited by host governments and are affiliated with or supported by an international organisation (IASC 2007:73-74). Yet no similar concern is expressed about the intentions of humanitarians in general. The guidelines' focus on identifying and solidifying the psychological evidence base, though an accomplishment, does not indicate the motivation of programme implementers or the political perspectives from which they develop and support programming (de Jong et al. 2008). It fails to acknowledge the ways that psychosocial programmes can be used not only to justify exerting control over affected populations, but also to restrict political self-determination in the interest of humanitarians.

The achievability and desirability of neutrality in humanitarian action has been widely debated (Duffield et al. 2001a; Harroff-Tavel 1989; Minear 1999; Slim 1997). Though some organisations still strive for neutrality, or refraining from political or ideological disputes so that all actors will trust and allow humanitarian support (Harroff-Tavel 1989), the ability of humanitarians to operate is based on political compromise (Slim 1997). In addition, psychosocial programmes have been analysed as tools for promoting strategic interventions; Singh (2010) argues, for instance, that psychosocial programming has aligned well with longer-term reconstruction efforts that have characterised the United States' involvement in Afghanistan (Donini et al. 2004; Duffield et al. 2001b). Reminiscent of Pupavac's critique, Singh argues, "under a security-aid framework, psychosocial work is considered restorative humanitarian aid […] achieved by linking psychosocial intervention with reconstruction goals" (Singh 2010:8). If humanitarianism is seen as implying "some degree of unilateral interference, objectionable or not, of one or more states in the affairs of another" (Kienzler and Pedersen 2012), then psychosocial programmes and other specific tools may also constitute this inherently political interference. This could indeed lead to the depoliticisation of individuals as argued by Pupavac.

However, based on the content of the IASC guidelines, if programmes are indeed implemented in line with stated standards, recipients of aid should be empowered politically to express both immediate needs and long-term desires. Sigh's evaluation of the use of psychosocial programmes in Afghanistan concludes, for instance, with the following statement:

> *Psychosocial programmes that emphasise a community's vulnerability may be disempowering. These programmes can have worth and value, however, if they allow communities to identify and address their mental health and social needs on their own terms. Support of local capacity must thus go beyond rhetoric to true engagement with local actors. (2010:9)*

Again, the degree to which psychosocial programmes are depoliticising depends on their implementation within a particular political context. The guidelines' lack of acknowledgement of this political dimension of humanitarianism perhaps implicitly perpetuates this depoliticising tendency; however, if applied properly, the content of the guidelines does prescribe meaningful participation and community involvement as suggested by Singh. Therefore, this discussion suggests the further need to analyse programmes in discreet political contexts. Pupavac's critique is severely undermined by the empowerment supported by the guidelines; however, in practice her critique remains relevant, particularly in light of the increasing relationship between security objectives and humanitarianism globally.

5 Conclusion

The history of mental health and psychosocial programming in humanitarian settings is fraught with theoretical and practical debate. It has coincided with the widespread dissemination of "therapeutic" methods and psychological knowledge as well as inquiry into the mental health and well-being of survivors of conflict and natural disasters, refugees and other forced migrants. The field's historical connection to predominantly "Western" psychological and psychiatric knowledge and cross-cultural context has raised questions about the suitability and potentially problematic effects of the implementation of such programmes. There is no shortage of literature debating the normative value and practical implementation of such programmes. The fields of anthropology, psychology, psychiatry and forced migration have all contributed to this literature. However, the political implications of programming are important to consider on an on-going basis. Vanessa Pupavac's critique, building on several other authors' work and incorporating many of the predominant criticisms of MHPSS, provides a useful framework for such analysis.

In this paper I defined international therapeutic governance and described Pupavac's critique of psychosocial programming as being homogenising, pathologising, controlling and depoliticising. Assimilating and synthesising Pupavac's critique, I created this four-fold evaluative framework and then analysed its critical utility. With its limitations in mind, I then mobilised it to analyse current practice as represented by the 2007 *IASC Guidelines on Mental Health and Psychosocial Support*. This discussion highlighted the significant progress that has been made by the MHPSS field toward a culturally appropriate and empowering model of psychosocial programming within humanitarian interventions. It demonstrated that the "professional community" implementing psychosocial programmes has attempted to use therapeutic methods and "Western" knowledge critically. However, it also showed that individual programmes would benefit from situation-specific evaluation to assess the degree to which this international therapeutic governance is problematic. Whilst homogenisation and pathologisation have been addressed by the IASC guidelines, there remains the potential for psychosocial programmes to contribute to the controlling and depoliticising nature of broader humanitarian governance.

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