Global Mental Health in South Lebanon: Psychoeducation, Translation, and Culture

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Abstract: In this article I examine the unintended consequences of global mental health reform in postwar South Lebanon. I follow the integration of mental health in primary health care centers. Three key tensions emerge: First, integrating mental health led to separating mental health from socioeconomic conditions. Second, culture was simultaneously conceived as a barrier to therapy and a local context requiring adaptation. Third, the use of personality disorders as psychological interpretations of social life resulted in psychologizing gender and class. The article contributes to growing ethnographic research on global mental health and calls for attention to structural competence in similar settings.

Second language abstract:

في هذا المقال، استكشف العواقب غير المقصودة لإصلاحات الصحة النفسية العالمية في جنوب لبنان بعد الحرب. أتتبع دمج الصحة النفسية في مراكز الرعاية الصحية الأولية. تظهر هنا ثلاث مضاعفات رئيسية: أولاً، أدى دمج الصحة النفسية إلى فصلها عن الظروف الاجتماعية والاقتصادية المحيطة بها. ثانياً، تم تصوير مفهوم الثقافة كحاجز أمام العلاج النفسي، حيث يتطلب تكييفات وترجمة. ثالثاً، أدى استخدام تشخيصات اضطرابات الشخصية كتفسيرات نفسية للحياة الاجتماعية إلى نسبة الجنس والطبقية. يساهم المقال إلى البحوث الإثنوغرافية المتقدمة حول الصحة النفسية العالمية ويدعو إلى الاهتمام بال كيفية الهيكلية للصحة النفسية في بيئات معينة.

Keywords: Lebanon, Global Mental Health, Psychologization, Ethnography, Culture, Humanitarian Psychiatry

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In a remote health center in South Lebanon, the nurse and social worker, Thorayya, sat with her supervisor Sara and a psychologist to discuss her new training as a mental health care provider. It was the summer of 2012 and the psychologist, Samer, was visiting from Beirut to follow up on Thorayya’s training. The center belonged to a local non-governmental organization (NGO) with a long-standing history in health services in the south. Now partnering with an international humanitarian organization, where Samer worked, the center was preparing to implement global mental health standards of care.

Thorayya presented the mental health cases that she had managed since Samer’s last visit. The first case was a young woman who needed a neurological test to determine if she had epilepsy. Thorayya found the case too delicate to diagnose. She did not think the woman had any developmental issues because she was able to take her medication on her own, yet she was unable to provide a clear psychological assessment. Samer proposed that she should refer the woman for more tests, while continuing to do home visits to get a clearer sense of her improvement and diagnosis.

The next case was a young unmarried man from a nearby village: “He takes pills”, said Thorayya. “He does not leave his house. His hair looks strange, and his house is strange. There was a plate of potatoes in the living room that looked like it was 20-days old. He is dirty, always smoking hookah – maybe he puts drugs in it. I did four home visits and each time he was in bed, sleeping.” Sensing that this is a complex case, Samer suggested that the diagnosis might be addiction or antisocial personality disorder, as defined by the Diagnostic Statistical Manual (DSM), one of the manuals he used to train mental health providers.
The third case was Abbas, a middle-aged married man. The center’s doctor had ruled out all physical causes for his distress and referred him to Thorayya to assess his mental health. Abbas was usually a calm person who did not get agitated or anxious, but now he felt “a heaviness in his head” and was afraid that he might have high blood pressure. Thorayya presented a few details that might lead her towards the right diagnosis: the man carried the blood pressure machine with him everywhere; his wife said he used to be happier and light-spirited; his food intake is normal, but he once lost ten kilograms in three months. “He told me he feels normal, but that life has its problems”, she added. “He might have obsessive tendencies [...] His sleep is normal but that could be because he is so exhausted. He said that he has heaviness in his head, so it could also be a problem in focusing or paying attention.”

Dissatisfied with Thorayya’s messy assessment of the case, Samer asked her to return to the patient’s main complaint: his obsession with his blood pressure. He then recommended obsessive compulsive disorder or some features of obsessive compulsive personality disorder as possible diagnoses, proposing that Thorayya reviews his symptoms in the DSM and asks the man about them in his next appointment.

The last case was Mariam, a forty-year-old woman who had been on antidepressant and anti-anxiety medication for a few years. Thorayya noted that Mariam became this way after her brother was “martyred” during the July War in 2006. Thorayya was more confident about this case. “I can tell you she has chronic depression”, she said, “her only worry now is how to get off her medication.” Samer, however, wanted to make sure that the diagnosis was indeed depression. He asked Thorayya and Sara whether they noticed symptoms of histrionic personality disorder – a personality disorder typically diagnosed for women characterized by attention
seeking behavior and intense emotionality. He suggested that they should check whether her doctor also suspected she has this personality disorder and prescribed these medications for that reason. Finding the diagnosis plausible, Thorayya and Sara added that there has been some gossip about May’s husband cheating on her. All these factors, Samer agreed, could be clues for them to diagnose her properly.

Global Mental Health in Postwar Lebanon: Psychoeducation and Psychologization

In this article, I explore the unintended consequences of global mental health reforms in post-conflict societies like Lebanon, tracing their impact on psy-professions, culture, and the psychologization of everyday life. Global mental health reforms were in full force at the time of my research in 2012, six years after the July War in 2006. Based on an ethnographic study on the psychoeducation of experts and communities, I trace how these postwar policies were implemented and negotiated in health clinics of the South, a region that has experienced multiple conflicts and was host to several refugee communities. I argue that considering global mental health projects in ethnographic praxis allows us to analyze the frictions between these projects and the contexts in which they unfold (Tsing 2004). These frictions highlight the transformations and challenges on the professional and sociocultural levels that emerge in these sites. They call for more attention to the role of the national/local psy-disciplines in the making of global mental health, drawing implications on the importance of cultural and structural competence in postwar situations.

Global mental health reforms in Lebanon led to a process of psychologization of life and social relations after the war. The cases that Thorayya presented provide a glimpse into this landscape of psychologization, where a heaviness in the head, marital infidelity, bizarre behaviors, and martyrdom were now scrutinized as potential indicators of psychopathology and psychological disorders. Scholars have distinguished between psychologization,
psychiatrization and psychopathologization as intersecting but distinct processes in global mental health. For example, Mills (2015) defines psychiatrization and psychologization as two genres of medicalisation, whereas psychopathologization is the process that enables something to become medicalised. Yet these processes are epistemically distinct. Psychiatrization is a process that turns specific aspects of life into objects of psychiatric scrutiny (Beeker et al. 2021). Psychologization stems from a different theoretical tradition that primarily examines society’s growing interest in solving social problems with therapeutic solutions (Beeker et al. 2021; Madsen 2018).

I rely in this article on the concept of psychologization to investigate the global projects of turning postwar social and economic conditions, cultural difference and experiences of structural violence, into psychic injuries that require therapeutic treatment. In recent years, humanitarian psychiatry and the Movement for Global Mental Health (GMH) sought to intervene on mental health systems in many societies of the world, psychologizing suffering and violence in conflict sites (Fassin & Rechtman 2009), and recommending a set of initiatives to “scale up” mental health services in low and middle-income countries (Lancet Global Mental Health Group 2007). In Lebanon, the 2006 July War lasted for 34 days and caused mass destruction and thousands of casualties. The war provoked an unprecedented humanitarian intervention including psychological care. This intervention also allowed for the circulation of “humanitarian goods” (Redfield 2012): an assemblage of aid commodities that included anything from blankets and relief kits to humanitarian guidelines and psychological manuals such as Psychological First Aid, and Debriefing.

By the end of the war, Lebanon became a field of “intense recovery and rehabilitation programs, with multiple donors pursuing varied political and aid agendas” (Hidalgo & Lopez Claros 2008, 106). Humanitarian psychiatry turned into an institutionalized expertise that was adopted by mental health policies and aid agendas. Moving from emergency to development,
health organizations like International Medical Corps (IMC) aimed to build more sustainable and equitable mental health systems in Lebanon by engaging local experts and institutions (Hijazi 2015). Postwar mental health reform was a result of converging efforts between NGO and state actors, as well as Lebanese psychiatrists and psychologists. It included plans such as the integration of mental health into primary health care and the launching of the Lebanese national strategy on mental health by the Ministry of Public Health (MOPH 2015; El Chammay et.al 2016). These initiatives were part of a global trend in mental health policy recommended by the World Health Organization (WHO) and the Movement for GMH for societies whose access to mental health services was seen as both urgent and difficult (Jain & Orr 2016).

The integration of mental health into primary health care in Lebanon included the training of healthcare providers on basic competence in identifying, managing and referring people with mental health issues (Hizaji et al. 2011). The training Thorayya received was part of this postwar mental health reform. Developed by IMC to fit the local context, it was based on the Mental Health Gap Action Programme (MhGap), a WHO program that aims to increase access to mental health services (WHO 2008). Following the ethical guidelines of the Inter-Agency Standing Committee (IASC) for mental health and psychological support (De Jong et al. 2008), the training was conceived as a form of community-based service that can provide a less medicalized form of mental health care, while compensating for the limited number of experts (Hijazi 2015).

In addition to mental health care, Thorayya’s new role included the psychoeducation of postwar and refugee communities. As part of her new job, she held mental health awareness sessions for the center’s visitors, where she would leave brochures about depression at the front desk and start informal conversations on mental health with families waiting to get their children vaccinated. Much like the training of local practitioners, mental
health education sought to teach these communities how to tease out “what is psychological” in their family dynamics, personality traits, social interactions, economic conditions, and gender roles. As women were the primary participants in these sessions, their lifestyles – from the TV shows they watched, and the ways they raised their children to their relationships with their husbands – were discussed as potential indicators of psychopathology.

In this article I illuminate three key tensions that emerged during the implementation of global mental health reform in postwar South Lebanon. First, the goal of integrating mental health in primary healthcare unintentionally led to the separation and disconnection of mental health care from the practitioner’s overall job. I trace this tension along with other challenges that social workers and nurses like Thorayya faced in their new job role, as they struggled to set apart mental health from the overall health, economic and social care that they provide for their communities. Second, mental health awareness sessions showed a tension over “culture”, as it was simultaneously treated by Lebanese psychologists as both an obstacle for therapy and a local context that requires translation and adaptation. Mental health practitioners relied on social rather than psychological interventions – albeit in different styles – to counter cultural resistance to therapy. This view of cultural difference as enabling pathology seems to be a common assumption among Lebanese mental health practitioners implementing postwar mental health reform (Kerbage et al 2020).

Third, the trainings and sessions I describe here illustrate how the move to make mental health more accessible, community-based and less medicalised has resulted in a process of psychologization of everyday life, particularly of gender and class. I explore this process of psychologization through one example: the use of personality disorders in the trainings of practitioners and in mental health awareness sessions. I argue that these forms of gendered and classed psychologization highlight the importance of structural competence
(Metzl & Hansen 2014) – the attention to the structural rather than the cultural conditions of mental illness – in global mental health.

Methodology and Context
This article is based on 29-months of ethnographic research in Lebanon conducted between 2008 to 2013, during which I did a total of 25 semi-structured interviews with experts, researchers, and recipients of mental health programs. My ethnography can best be described as multi-sited (Marcus 1995), tracing the circulation of psychological classifications, manuals and programs in organizations and clinics in various regions in Lebanon. I conducted participant observation in eight local and global organizations and I also worked for eight months at a mental health clinic in South Lebanon. In most of the places where I gained permission to do research, I volunteered in different tasks, from doing qualitative assessments of programs, writing reports, to giving English lessons and taking minutes of meetings. My positionality as a mental health practitioner and researcher allowed me to be attuned to the practices and politics of care embedded in this profession. Many times, however, this double positionality also led to an ease of access and quick acceptance of my presence by the experts, which led me to anxiously declare and remind them, throughout my research stay, that I was indeed a researcher who would be writing about the activities taking place at the center, and not only a practitioner. Balancing these two identities and positionalities have pushed me to reflect on the ethics of writing about and through an easily accessible site, even when one is “studying up” (Nader 1972) and focusing on expert knowledge production in the NGO mental health sector. It also continues to inform my ethnographic writing on mental health care.

In addition to spending time with experts and practitioners, I spoke with members of beneficiary communities who visited the centers about their experiences with the mental
health programs. My observations focused more on group activities than individual therapy sessions, so as to not intrude on the privacy and confidentiality of the recipients of mental health programs. Oral consent for participation and observation of the activities was requested and received whenever necessary, recipients have been anonymised, with any identifying information withheld. The analysis conducted in this article is informed by the totality of the conducted ethnography.

Mental health in Lebanon has a rich history in engaging with European and American-based research and practice since the beginning of the twentieth century (Kazarian 2016; Khoury & Tabbara 2012). The organization of Lebanese mental health services was influenced by global agendas since the establishment of WHO’s Eastern Mediterranean Regional Office (EMRO) in 1949. The Lebanese Civil War (1975-1990) along with subsequent Israeli military operations led to a special humanitarian interest in mental health services directed towards the psychological effects of war³. After the end of the civil war in 1990, neoliberal policies of privatizations were implemented in various national sectors including healthcare, leading to the disintegration of public social welfare institutions, and an expansion in local and international NGOs (Cammett 2014).

Prior to the plans to integrate mental health in primary healthcare and the launch of the National Strategy, there was no official policy for mental health in Lebanon. Mental health services have mostly been expensive, centering around private clinics and hospitals. At the time of my research, the ministry of Public Health (MOPH) provided some public coverage for psychiatric inpatient hospitalisation and for some psychotropic medication, but not outpatient services. Migrant workers and refugees had the most difficulty accessing mental health services.

Usually aimed at modernizing mental health policies, global mental health reform in Lebanon has primarily targeted the accumulated and on-going psychological effects of
violence, while building a more stable infrastructure for mental health that can actively respond to future conflict and be accessible to all classes and communities. After the July War, mental health initiatives targeted Lebanon as a site of perpetual conflict, where communities were seen as more at risk of developing psychological disorders because of a mixture of intersecting factors, such as social stigma, lack of mental health knowledge and accumulated experiences of war and violence (Hijazi et al. 2011; El Khoury et al. 2020). Lebanon also became host to new asylum seekers and refugees from Iraq, Syria, Palestine, and Sudan, all seen as requiring psychological care (Moghnieh 2017). Training service providers on mental health competence became an affordable and sustainable approach to meet the pressing needs of both refugee and host communities (Hijazi 2015).

As a Lebanese researcher, my interest in global mental health began when I briefly volunteered as a psychologist and volunteer relief worker during the July War in 2006, and later observed the standardization and NGO-ization of mental health. When I started my research in 2011, many things had drastically changed. Revolutions and uprisings had erupted in Tunisia, Egypt and Libya, and, later on, Syria, against oppressive regimes, economic conditions and social injustice. In Lebanon, the price of food and other items seemed to have doubled since my absence. Global non-governmental organizations, now long settled in Beirut and cities like Tyre in South Lebanon, had reshaped the employment market and politics. I was surprised by the new NGO lingo and politics of activism I encountered, as social movements seemed to have been replaced by a form of NGO-ization of social causes in Lebanon. Many of the psychologists and social workers I knew now had jobs with NGOs, were well versed in concepts like “action plan” and “capacity building” and were engaged in activities such as training, conflict resolution, psychological assessment, and therapy.

This NGO-ization was both new and familiar, as its rise has historically followed various episodes of violent unrests in Lebanon – especially after the Lebanese Civil War
(Karam 2006). Yet, the scale of the humanitarian governance in Lebanon after the July War was massive, drastically shaping economies, technologies, and language of Lebanese civil society. It was predominantly governed by global organizations who, by establishing local partnerships, reshaped local organizations’ agendas and influenced their expertise. Soon all organizations adopted concepts and programs in line with humanitarian trends, donor states’ foreign policies and human right conventions.

Lebanon seemed to be a place where crises and violence never leave, but also a “humanitarian space” (Paulmann 2013) that welcomes global organizations and agendas. As a site of recurrent conflict, a host country for refugees, and a place where global organizations can establish themselves with ease, Lebanon was a site of experimentation for multiple humanitarian technologies, programs and tools, especially in peripheral regions perceived by aid workers as kham (crude and untamed), a wild land amenable and receptive to all kinds of interventions and programs (Moghnieh 2013). This included the use of biometrics as a new technology for asylum registration (Jacobsen 2017), and the experimental piloting of Karim, an artificially intelligent chatbot designed to provide therapy for refugees in North Lebanon (Solon 2016). In this amenable and experimental site, the piloting and testing of global mental health reform in Lebanon served to institutionalise a more stable and affordable service that can benefit peripheral and refugee communities.

**The Challenges of Doing Mental Health Care**

After discussing the cases described in my opening vignette, Samer followed up with Thorayya and Sara on the use of the General Assessment Functioning (GAF) scale. Part of the DSM-IV-TR, the scale was a survey that measures the overall functioning of individuals as a determinant of mental health. As Samer went over the scale, he explained that the answers to the questions must only be psychological. If the visitors complained about a
physical problem hindering their functioning, then they should stop filling the scale.

The GAF scale was one of the tools now used to standardize the detection of mental illness at the center, following global definitions of mental health. Adapted by IMC to fit the Arab-Lebanese culture, the scale guided nurses and social workers like Thorayya to detect psychological stressors in patients’ mundane practices, assess their psychological distresses, and refer them to a specialist. Through these mental health tools, the psychoeducation of Thorayya taught her how to see the psychological in a 20-day-old plate of potatoes, in people’s bizarre and non-normative behaviors and lifestyles. “Seeing the psychological”, I suggest, is analogous to the Foucauldian concept of “the clinical gaze”, a mode of knowing and perceiving disease that is commensurable, observable, and treatable by biomedicine (Foucault 1996). Similarly, Thorayya’s training was to equip her with a psychological gaze that contained the diagnostic know-how of psychologists and psychiatrists.

Yet, what new professional authority did social workers and nurses gain from these trainings? What were the challenges they faced? And what kind of care was possible in this new process of integrating and translating mental health?

Thorayya’s gaze – her professional ability to diagnose and separate mental illness from other diseases – had in fact a peripheral kind of professional authority. The training and case management was run by a supervision unit, composed of an IMC representative, a psychiatrist, a psychologist, and a social worker (Hijazi 2015). The unit oversaw the implementation of the training and provided refresher follow-ups upon need. While the training provided knowledge on mental health detection, management and referral for social workers and nurses, the hierarchy between the professions remained undisturbed. This was played out in the work of translation that each profession undertook in these processes. For example, the supervisory unit functioned as a “community engaged brokerage” (Poltorak 2016: 743), engaging in multiple levels of cultural translations and adaptations of global
mental health, ranging from 1) adapting scales to local contexts (like the GAF), 2) translating psychiatric classifications to other health professions and communities and 3) implementing these adaptive forms in practice.

Thorayya’s new job role fell primarily within this third practical and less conceptual level and remained that of an implementer of an already set intervention. Like many of the social workers trained under global mental health, she had come to be considered as a gatekeeper of mental health: the practitioner most able to narrow the mental health gap between service providers and communities seeking care. She does that by detecting the psychological distress typically overlooked in medical screenings and assessments and ignored by communities themselves (WHO 2008). Her job role includes properly diagnosing and referring patients sent to her by the center’s doctor when they continue visiting the center without improvement, have a seemingly mental health complaint, or have received no clear medical diagnosis. Moreover, Thorayya now engaged in community outreach in nearby villages to detect cases of mental illness among refugee and vulnerable communities.

However, many of the social workers employed in the health centers that I visited commented that what this mental health training taught them was something they had always been doing as part of their job. They just did not call it “mental health work” and did not separate it from their overall social work. Now, with their new job title, they had the authority and knowledge to name it as such by checking a list of psychological disorders from the DSM, or by using the GAF scale. However, many of them were now struggling to distinguish between psychological and physical complaints and to consider the former as a separate kind of labor and care. This was clear in the difficulties Thorayya faced with her case management, as she struggled to separate mental illness from the overall health, economic and social conditions of the community with whom she worked. Thorayya was also many times unsuccessful in finding clear mental health cases. For example, she had administered
the GAF scale to nine random visitors, but she did not find anyone with a low psychological functioning. Sara reflected on this difficulty in detecting mental health cases by pointing to the other priorities that preoccupy those living in the harsh economic conditions of the south. “How can you talk about mental health when you don’t have money?” she said to me, commenting on life in the postwar south, where slow violence and the toxic ruins of war have produced new challenges for agriculture, livelihoods, and economies (Touhouliotis 2018), reshaping what is normal and pathological. Sara questioned the kind of care she was providing for her community when she had to separate mental health from these new conditions of living in the postwar.

Other social workers I spoke with also experienced this new job role as an added form of labor, instead of it being integrated into the overall primary health care setting. This is in line with other ethnographic research that demonstrated how the responsibility of implementing the integration of mental health fell heavily and unequally on professions like social workers and nurses (Burgess 2016). For example, Thorayya now dedicated one day a week to “psychological work”, something many social workers found hard to accomplish. In another instance, a social worker employed at a clinic told me that she found it difficult to separate her work on the mental health of the Palestinian refugees, the main beneficiaries of the clinic, from their other economic and social needs. With their daily and overloaded schedules, social workers questioned the reason why they should separate mental health care from everything else they did, many times speaking about their own mental health issues and well-being, as a result of life’s increasing pressures.

Finally, the mental health training led professionals to over-pathologizing daily activities of communities in the South, as was evident in Thorayya’s presentation of her cases. IMC was indeed sensitive to the issue of over-medicalization, and the supervision unit tried to incorporate a spirit of community-based mental health that was less reliant on
doctors’ drug prescription than on a referral system that can best suit the patient. However, in using global and standardized psychological scales and definitions, practitioners many times ended up looking for symptoms of pathology and distress in social and domestic practices in the south, thereby unintentionally engaging in a scrutiny of everyday life. For example, one nurse, under Sara’s guidance, administered the GAF scale to a married woman living in the south for over ten years. When asked how she took care of her family, the woman began defending herself and her love for her children, stating that she certainly does not have any problem or difficulty in cooking. When she was asked how she took care of herself, the woman mentioned that she liked to wash her hands and clean the house. At the end of the interview, the nurses tried to reach a consensus, using the GAF scale, on what might be wrong in her daily functioning. They also reviewed the WHO’s definitions of mental illness: was this woman’s daily functioning compatible with these definitions? They both noted that the woman had talked a bit much about cleaning her hands, which they speculated might be a symptom of obsessive compulsive disorder. They reluctantly registered this as a possible marker of mental dis-functioning.

**Becoming aware of your problems: Translating and Overcoming Culture**

The training of health professionals in South Lebanon was accompanied by mental health education of postwar communities. I participated in many of these formal and informal mental health awareness sessions, or *jalseit taw’iyeh nafsiyyeh* during my research. They targeted communities living in regions peripheral to the capital Beirut, where access to mental health information and services was easier. The participants were usually a mixture of postwar aid Lebanese and refugee communities from Syria, Iraq, and Palestine, and almost always women. These groups were thought to be most vulnerable to mental illness because of their experiences with violence and displacement on one hand, and the social stigma against
mental illness that was thought to be more pressing in regions like South Lebanon on the other. Now an integral component of global mental health reform, awareness sessions were designed to introduce basic mental health knowledge, counter social stigma, and prevent illness by encouraging communities to seek mental health care.

Samer was one of the psychologists who ran some of these sessions in the south. Every other week, women from nearby villages attended mental health sessions at a health center belonging to another local partner organization. Some of the women were invited by the center’s social worker in her weekly home visits, while other social workers from the center would join occasionally. One of them, a seven-month pregnant woman in her twenties, would eagerly note down information from the discussions, which mostly focused on healthy ways of raising children and maintaining good family dynamics. The women attending saw these sessions as providing practical tips for a better and healthier lifestyle for their families. First and foremost, they attended as mothers, asking questions concerning child education and development, and how to bring up successful children who can excel in school and secure good employment.

By using the psychological disorders of the DSM, Samer introduced mental health analysis and interpretation into these women’s social realities, motherhood style and family dynamics, inviting them to become psychologically aware of their emotions, behaviors, and habits. Reflecting on his current work as a humanitarian psychologist, Samer felt that the psychologist usually meets the patient halfway in the clinic, as the latter already has some form of awareness of the mental health issue he is facing. Like many Lebanese psychologists engaged in the new economies of humanitarian psychiatry, he had his own private clinic in Beirut while he worked with non-governmental organizations in different regions in Lebanon. Yet, he was now encountering new challenges in the humanitarian field that were not familiar to him from the boundaries of his clinic, like people’s lack of knowledge of
mental health. Most importantly, the communities he was treating did not resemble the urbanized patients that usually frequented his clinic, who mostly came from higher socioeconomic classes. These new communities had many other pressing needs than individual psychotherapy. Samer was therefore unable to act as therapist without relying on other skills such as “case management”, something he felt was the job of a social worker. Furthermore, Samer saw these communities as resistant to therapy. This was, in his opinion, caused by a mixture of factors, including social stigma and a conservative culture that many times was also a source of their own illness. Mental health awareness sessions became tools that allowed him to directly address what he thought were inaccurate, archaic, and conservative beliefs on mental illness.

Under these new conditions, Samer adopted what he called “social therapy”. Broadly speaking, this involved focusing on psychologizing the social, rather than the individual psyche, to instil psychological insight into one’s problems. Understanding this insight as a pre-requisite to individual psychotherapy, Samer used social therapy to advocate for what he perceived was a more modern and healthier way of life. As various topics were raised in the sessions, from television shows to child pedagogy and family life, Samer focused on the relations and connections between the psychological-interior and the social-exterior, drawing links that he observed were usually already present in patients seeking therapy in his clinic.

Social therapy was one of the translation techniques that Lebanese psychologists adopted under humanitarian psychiatry. It enabled them to translate global mental health into new contexts and settings. These techniques mediated psychologists’ own professional transition from the boundaries of the clinics to the humanitarian field, where they encountered new patients from other economic and cultural backgrounds. Interviews with other Lebanese psychologists reveal similar techniques and understandings of culture as an obstacle for therapy that requires translation. For example, Leila, a psychologist trained in
Europe and Lebanon found herself unprepared when she started providing mental health care for Iraqi refugees as part of her new NGO job. While they spoke Arabic, the same language as Lebanese use, Leila felt that Iraqi culture was more conservative than the open-minded Lebanese. This led her to adopt a non-clinical kind of intervention when working with refugees, terming it “outreach therapy”: going outside the clinic to families’ houses and assessing their basic needs, while providing them with subtle mental health support that would not invoke social stigma. Like Samer, Leila found this community to be different than the patients that she was taught to treat. Having been trained in group, couple, and analytic therapy, Leila was not able to administer her usual therapeutic techniques and found herself doing things that were not part of the profession of psychologist, such as trying to help her patients find a job and register their children in schools – things that a social worker would usually do.

Within this form of therapeutic translation, techniques like “social therapy” and “outreach therapy” were many times adopted as a direct intervention on culture. Lebanese psychologists used these techniques differently. For example, Samer tried to overcome cultural barriers by adopting an exaggerated and provocative tone during the awareness sessions, disregarding information that the women provided about health, culture, and well-being and placing it in direct contradiction with the scientific knowledge of the DSM. His style was intentionally provocative and challenging, placing psychiatric science in direct confrontation with religion and culture, and many times privileging a Eurocentric translation of global mental health definitions over that of the local context and setting. He drew an exaggerated image of the south as a conservative and regressive place, to instil mental health education and knowledge in the participants.

On the other hand, Leila felt she was adopting a more humanitarian than psychological approach to her intervention. She spoke of therapy as an added bonus to
someone’s practices of care, but impossible to do properly for people who lack basic economic and social needs. She tried to overcome what she described as a “cultural shock” experienced by Iraqi refugees, coupled with severe economic and social transformations in their new situation as refugees, by fully embracing her role as a social worker. Cultural conservatism coupled with harsh structural conditions, were for her the main obstacles towards achieving therapy, as she was not able to only address the psychological, but had to look at the entire package, as she put it.

By encouraging new communities to do self-work (Zhang 2018), Lebanese psychologists faced a double bind in adapting global scales to the cultural context, while also approaching culture as an obstacle for therapy. Regardless of their therapeutic style, Leila and Samer’s views on culture were part of a recurrent discourse adopted by mental health practitioners I encountered in different sites during my research. They are in line with the recent findings of a study conducted by psychiatrists and anthropologists on the experiences of Lebanese mental health practitioners with new patients such as Syrian refugees, in the context of the emerging mental health reform (Kerbage et al 2020; Marranconi & Kerbage 2017). Out of the 60 interviewed, 56 practitioners saw that the Syrian culture was the main obstacle for psychotherapy, defining their culture as “traditional” in contrast to the culture of “modern” psychiatry (Kerbage et al 2020), and describing their backgrounds in terms of ignorance, illiteracy, and lack of education (Marranconi & Kerbage 2017). Forty-five out of 60 practitioners also understood mental health awareness sessions as a form of response to the “ignorance of Syrians due to their culture” (Kerbage et al 2020: 6).

**Personality Disorders, Gender, and the Making of Postwar Therapeutic self**

In this last section, I analyze the use of personality disorders in the training – as shown in the introductory vignette – and the mental health sessions, drawing implications on the
psychologization of postwar life in Lebanon. While the use of personality disorders cannot be
generalized as a common trend, I contextualize it here as an example of the many techniques
that mental health practitioners adopted to implement global mental health reform in postwar
Lebanon.

While Samer lectured about other disorders such as anxiety-related disorders and
depression in the group sessions, he many times relied on personality disorders to interpret
the social and cultural landscape of south Lebanon. In one of the sessions, he pointed to the
difference between normal feelings of sadness that some of the women said they were
experiencing, and the clinical condition of depression. He used histrionic personality
disorder to explain to the women that their expressions of sadness were in fact an
exaggerated cultural practice, not a clinical condition of depression. Similar to how the case
of Mariam’s “chronic depression” in the vignette – linked by the practitioners to the
martyrdom of her brother and the possible cheating of her husband – was classified as an
aspect of histrionic personality disorder, Samer explained that the true cause of the women’s
distress was not depression, but distressful emotions enabled by an overly emotive Arab
culture and traditions. He described this emotive culture as enabling hysterical-like emotions
in rituals and customs, such as funerals, protests and watching soap opera TV shows. In
another session, Samer employed histrionic personality disorder and paranoid personality
disorder to describe marital relations that can produce pathology. He used these disorders to
re-articulate traditional and conservative forms of marital relations and show the relationship
between conservative pedagogy in the household and mental illness. Paranoid personality
disorder was used to describe a suspicious and jealous husband who forbids his wife from
leaving the house and from socializing.

Postwar mental health reform in Lebanon was a humanitarian project that allowed for
a process of individuation through which practitioners and communities became aware of
themselves and their surroundings in psychological terms. I read the use of personality disorders as a diagnostic tool that enabled this process. Personality disorders offered psychological interpretations and narrations of gender, self, and society in the south. Through this form of psychologization, Abbas’s life problems became potential aspects of an obsessive compulsive personality disorder. Mariam’s inability to overcome the loss of her martyred brother and her husband’s infidelity become a possible feature of histrionic personality disorder. Likewise, paranoid and antisocial personality disorders became interpretations of types of men that indicated unhealthy marital and family relationships.

Personality disorders were also one of the psychological interpretations that helped re-imagine the kind of person psychologists were more accustomed to treat in the clinic: a patient with a certain self-awareness and self-understanding, who was able to read her feelings, environment, family and culture through psychological lenses. In one of the last sessions I attended, the group of women finally reached what Samer called a “group catharsis”, becoming therapeutic communities who were able to speak of their distress and problems in psychological terms. The women shared stories about their fathers and their own childhoods, drawing from the pool of psychological knowledge they learned to analyze their feelings of neglect, violence, and abandonment. They stopped speaking about their children and families and started talking about themselves and their own suffering in psychological terms, thus turning into therapeutic subjects.

Yet, the reliance on personality disorders in the psychoeducation of professionals and communities served to vernacularize psychiatric knowledge as an intervention on social and gender relations. They sought to carve a self-aware subject (Zhang 2018; Marranconi & Kerbage 2017) with middle class desires and emotions (Matza 2012), a therapeutic subject that typically frequents Beirut’s mental health clinics.

Commonly used in Lebanese psychiatric practice, personality disorders have been
criticized for perpetuating patriarchal stereotypes of normativity, as women significantly outnumber men in diagnoses such as histrionic personality disorders (Russell 2007). Yet when I inquired about the reasons behind the dominant use of these disorders in the training and awareness sessions, other practitioners involved in the training did not find this to be unusual or problematic. After finishing my research, I also held an academic presentation on the overuse of histrionic personality disorder and psychological interpretations of hysteria more broadly in Lebanon for resident psychiatrists. No one found the focus on histrionic personality disorder to be problematic and cited the DSM as a valid reference for these disorders.

Global Mental Health in Lebanon: Ethnographic Implications

In this article I traced the unintended tensions that emerged from specific sites undergoing global mental health reform in postwar South Lebanon. The reforms that I observed in 2012 were part of a pilot program that later informed other mental health initiatives across the country, including the National Strategy for Mental Health (MOPH 2015).

Three contributions emerge from this ethnographic study with implications for mental health research and practice. First, mental health practitioners, especially social workers and nurses, felt that the integration of mental health led to a division in their care practices where mental health labor was separated from the overall form of social, economic and health work that they usually do. This not only created a burden on their professional work, but many times made it hard to see and treat something as “only psychological” without connecting it to the overall structural conditions. I read their commentaries as a critique of these mental health reforms that carry an individual-based approach to mental health, yet does not have an integrative plan to address structural and accumulative conditions of inequalities and violence in post-conflict sites like Lebanon.
Second, culture emerged as a contested site between various mental health practitioners. Humanitarian psychologists relied on techniques such as social and outreach therapy to establish therapeutic relationships with patient communities from new cultural and economic backgrounds. Leaving the boundedness of their clinics and the typical (upper) middle-class patients that frequent them, they saw culture as both a site that requires translation and adaptation to global mental health and an obstacle for therapy and psychological education. Many of the social workers and nurses I spoke with, however, did not see culture to be the most important obstacle for mental health, but rather the act of separating this form of care from the overall socioeconomic pressures – something that Leila might partly agree with. These practitioners, who were natives of the peripheral regions where they worked and had long-standing ties with the communities, many times gestured towards the structural conditions that define mental illness and stigma, rather than culture.

Third, this article examined the process of psychologization in postwar Lebanon. I argued that psychologization is a productive angle through which we can examine the making of new therapeutic selves in Lebanon, at the backdrop of neoliberal policies that emerged after the Lebanese Civil War, and the political and moral economies around therapy institutionalised by humanitarian psychiatry after the July War in 2006. As the ethnographic examples portrayed, psychologization of postwar life targeted specific gendered and classed ways of living in the south. Overly emotional women in funerals, jealous and possessive husbands, watching soap opera TV and child raising activities were all examples of a conservative culture that itself required intervention and therapy. The psychologization of these gendered and classed activities served to turn postwar communities into therapeutic subjects with middle class values, desires and lifestyles that were more aligned with what Lebanese psychologists and psychiatrists were most familiar with in the clinic.

The role of culture and the psychologization of everyday life have been critiqued and
addressed by other researchers in global mental health (e.g. Wenceslau 2021; Mills & Davar 2016; Kirmayer & Pedersen 2014). In the context of Lebanon, I read the double understanding of cultural difference, and the process of psychologization that ensued, as indicative of the shifting roles of local practitioners, who were now encountering unfamiliar patients with new needs and demands. I argue that understanding the role of culture in global mental health is about understanding the changing nature of Lebanese psychological disciplines that have historically psychiatrized middle and upper middle-class patients. The role of culture in global mental health should then be read within the context of the new circulating economies of humanitarianism and therapy in Lebanon that changed the professional landscape and the patient communities they typically see. Similarly, the psychologization of postwar life in South Lebanon became a professional tool that helped practitioners turn postwar communities outside of the clinic into familiar, therapeutic and treatable subjects.

Recently, scholars have called for more interdisciplinary and genealogical research on global mental health (Bemme & Kirmayer 2020; Lovel et al 2019; Jain & Orr 2016). The case of global mental health reform in Lebanon contributes to these initiatives by adopting an ethnographic approach to understand the impact of global mental health in low and middle-income societies (Jain & Orr 2016). Rather than assessing the efficiency of global mental health, this approach uncovered the kinds of expert and social knowledge making about selves and others that these reforms can enable in local sites. It takes into account the role of the historical context of localized psy-disciplines in the making of global mental health. As such, this ethnographic case calls for more attention to the role of cultural difference in global mental health reform (Davis 2014). It highlights the importance of what Metzl and Hansen (2014) termed as “structural competence” in health practice: the ability to recognize the structures that define illness, stigma and the therapeutic relationship, and rearticulating
cultural formations within structural terms.

Attending to the effects of structural conditions of inequality and violence on mental health seems to be an urgent call in the case of Lebanon today. At the time of writing this article, the collapse of the Lebanese economic system, the explosion of Beirut’s port and the COVID pandemic have radically affected people’s livelihoods and the entire health infrastructure, putting an estimated 82 percent of the population in “multidimensional poverty”, and migrant communities in even more vulnerable conditions (Farran 2021). This has left many in dire need for mental health services, at a time when an estimated 400 physicians and nurses have emigrated due to the severe economic condition (Shallal et al 2021).

Living in unstable, severe and uncertain times, where one’s livelihoods and everyday activities have radically been severed, have raised an important reminder of how mental health is intimately tied to structural conditions of violence brought forth by a history of accumulated inequalities and injustices. As Lebanese mental health professionals like Kerbage & Bejjani (2021) have powerfully articulated, there is a crucial need today for a mental health response that addresses this collective form of suffering and need for justice, rather than treating mental health only as an individual psychic problem.
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Blashfield et. al (2012) and Mullins-Sweatt et.al. (2011) have pointed out the stereotypical and gender-biased assumptions used in the diagnosis of histrionic personality disorder, arguing that the diagnosis is over-diagnosed in women and rarely used with men.

I conducted my dissertation research between 2011 and 2013, and conducted explorative research in the summer of 2008, 2009 and 2010.

This special humanitarian interest in Lebanon was present before the Lebanese Civil War following Al Nakba (the ethnic cleansing and expelling of Palestinians in 1948) and the displacement of an estimated 400 thousand Palestinians into Lebanon. The massacres of Tall El Zaatar (1976) and Sabra and Shatila Palestinian refugee camps (1982) also provoked a grassroots, collective and political interest in attending to the psychological effects of violence.

Iraqi communities became a humanitarian priority in 2008 with an estimated 20,000 to 50,000 refugee arriving to Lebanon. The Syrian Refugee Crisis in 2011 led to the displacement of an estimated 1.5 million Syrians and Palestinians. By 2018, Sudanese refugees constituted 4 per cent of all persons of concern to UNHCR in Lebanon (Janmyr 2022).

While there were grassroots organizations that established mental health services for Palestinian refugees, the overall psycho-profession in Lebanon has traditionally relied on the middle-class patient.

The DSM IV-TR defines histrionic personality disorder as a pervasive pattern of excessive emotionality and attention seeking. It is characterized by symptoms such as inappropriate sexual behavior, rapidly shifting and shallow expression of emotions, exaggerated expression of emotion and being the center of attention.

The DSM-IV-TR defines paranoid personality disorder as a pervasive distrust and suspiciousness of others. It is characterized by symptoms such as recurrent suspicions of others without sufficient basis, preoccupation with unjustified doubts and bearing grudges, among others.

The Lebanese Psychiatric Society conducted an online questionnaire with its members in September 2021. Out of the 62 respondents, 39% had migrated or were actively looking for employment abroad and 27% were considering this option (Cherro & El-Khoury 2022).
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