ALTERNATIVES HUMANITAIRES
HUMANITARIAN ALTERNATIVES

17th Issue – July 2021
p.77-93

Mental health and psychosocial support in humanitarian interventions: critical analysis of the Inter-Agency Standing Committee guidelines

Camilo Coral • Expert in clinical and community psychology

As the main mechanism for facilitating inter-agency decision-making in complex emergencies and natural disasters, the Inter-Agency Standing Committee has focused on the topic of mental health. The author here focuses his specialist's gaze on these directives which largely condition the practices of the actors.

Mental health and psychosocial support (MHPSS) has become one of the most crucial areas in humanitarian interventions. Nowadays, almost every region of the world where international non-governmental organisations (NGOs) work has or will have an MHPSS intervention. To support that work, in 2007 the Inter-Agency Standing Committee (IASC) issued guidelines[1] that intended to establish an operational framework based on practices from the field and specialised advisors working on MHPSS. The idea was that the guidelines should inform the whole life cycle of an MHPSS intervention, from assessment to evaluation.

The elaboration of such guidelines was an interesting and pertinent initiative, but one that needed a formal space where MHPSS actors could systematically discuss and review the formulations presented. This has not been the case. Moreover, the guidelines have turned from being operational recommendations to an imperative framework that has to be rigorously followed. This is evidence that, in the humanitarian world, the sense of urgency often prevails over critical reflection and analysis, which are perceived as non-imperative actions for managerial and field teams and are instead to be addressed by external evaluators. However, these external evaluations are focused on the assessment of outcomes delivery thus rarely involving the review of conceptual fundamentals on which interventions have been formulated. Without pretending to be exhaustive, this article reviews these guidelines from a systemic perspective with the aim of exposing crucial flaws in their formulation and approach and calls for a systematic review of the guidelines by MHPSS teams and organisations.

Essentially, the root cause of these flaws is an eclectic[2] interpretation of mental health and the functioning of the psychic structure. This forcibly creates inconsistencies regarding the conceptual framework of mental health and, more importantly, leads to a reductionist understanding of the conceptual construct of the psychosocial. As a result, all aspects related to the design, implementation and monitoring of MHPSS, as presented in the guidelines, present highly contradictory approaches, mechanisms and activities. This impacts MHPSS work in the field by pushing psychosocial workers and MHPSS managers to implement the same formulas of intervention ("problem management Plus" [PM+][3], stress management, support groups, psychoeducation, psychological first aid, etc.) regardless of the context.

[1] Inter-Agency Standing Committee, *IASC Guidelines on Mental Health and Psychosocial Support in Emergency Settings*, 2007, https://www.who.int/mental_health/emergencies/guidelines_iasc_mental_health_psychosocial_june_2007.pdf

[2] By this I mean picking from what appears to be the best from multiple theories and methods. However, this selection happens without clear conventions or rules demonstrating how or which theories should be combined.

[3] See for instance, World Health Organization, *Problem management Plus (PM+) Individual psychological help for adults impaired by distress in communities exposed to adversity*, WHO generic field-trial version 1.1, WHO, 2018, https://apps.who.int/iris/bitstream/handle/10665/206417/WHO_MSD_MER_16.2_eng.pdf?sequence=1&isAllowed=y

Three main flaws can be identified in the guidelines: the fusion of natural crises and armed conflicts; the distinction between special support and community support, the latter then reflecting the subordination of the concept of mental health to an essentially Western and biomedical approach.

The mistake of fusing people's psychology in natural crises and armed conflicts

This is perhaps the most significant flaw of the guidelines because the majority of MHPSS interventions that are implemented in the world take place in conflict or post-conflict societies. Therefore, before intervening, it is crucial to clearly understand the difference in the psychological dynamics developed by populations living in armed conflict or post-conflict contexts and those developed in the aftermath of natural disasters. In regard to this, the guidelines do not address these differences.

The psychological impacts of such different contexts are equalised and the psychological dynamics of people living in armed conflicts and people affected by natural disasters are reduced to a schematic model of intervention, reflected in the famous IASC pyramid. That equalisation and reduction make it impossible to clearly distinguish the factors that play an active role in shaping the emotional and cognitive reaction of people in those two distinct contexts. By fusing armed conflict and natural disaster under the umbrella of crisis or emergency, the guidelines magically make the very complexity of those situations disappear, thus eliminating the socio-political essence of armed conflicts and the natural essence of disasters. As a result, MHPSS teams can easily end up applying pre-conceived formulas of psychosocial interventions presented in technical manuals, falling in the inertia of "one size fits all". This is largely considered among NGOs as something to be avoided.

Three main factors make armed conflict or post-conflict contexts very different from natural crises: intentionality, time and space[4]. These factors are substantial to all psychological processes underlying the mental health status of a population. Intentionality, time and space in armed conflict contexts play a very different emotional role and they are not at all equivalent to the emotional charge of natural disaster contexts such as tsunamis or cyclical famines. While an armed conflict is an intentional and well-structured action targeting different population sectors, natural disasters are, in essence, a neutral disturbance suffered by an entire population. Undoubtedly, there are economic, social, cultural and environmental characteristics of the population that protect or increase the psychological impact suffered by people during a natural disaster However, in terms of intentionality, time and space, a natural disaster makes no distinction. It is inherently neutral, and therefore the psychological mechanisms impacted are equivalent in all groups of the population affected.

In natural disasters, the absence of intentionality means that people do not need to deal with a third party that forces them to constantly re-symbolise their social, cultural or economic role. This statement should not be understood as if there were no differences in the psychological impacts suffered by poor and wealthy populations. What is stated here is that in natural disasters the *Self* has not been intentionally transformed; a natural disaster does not make a population its ally or its enemy.

Similarly, natural disasters are mostly restricted in time and space. This means that populations can delineate their psychological perception according to those two factors. This allows a population to clearly identify what happened, where it happened and when it happened – essential elements that trigger the psychological mechanisms of a resilient response.

On the contrary, in armed conflicts, intentionality, time and space are actively modified and managed by armed actors. Since in conflicts one of the main objectives of armed actors is to intentionally harm a population, these factors are at the core of any military strategy. Intentionality creates two perceptual dimensions from which populations build their notion of the *Other* (social and individual) that are most of the time expressed as either victim or perpetrator. Thus, the level of psychological impact and the

[4] Mao Tse-tung, *On Protracted War*, Foreign Languages Press, 1967; US Army, *Field Manual (FM) 3-0, Operations*, Department of the Army, 2008; Carl Von Clausewitz, *On War*, Princeton University Press, 2008.

psychological mechanisms mobilised will vary depending on which perspective people have adopted in the midst of the armed conflict.

This brings us to the well-known conflict cycle, divided populations that are mutually accused of being victims or perpetrators. The individual identity assumed will depend on the level of psychological and social identification that people (individuals or communities) have developed with the political or religious precepts of armed actors. From that point on, their self-identification will be reinforced by their participation in the various levels of armed actions: combat, intelligence, logistics, political, financial support, etc.

Another way that intentionality is expressed lies in the reasons argued by armed actors to justify their actions against civil populations: supporters of the enemy, belonging to a different ethnic group, living in a disputed territory, religious beliefs. Intentionality takes away the neutrality of populations and imposes over them imaginary or factual roles that turn communities into the other side of the conflict: the enemy. Even if communities are not actively participating in the conflict, armed actors perceive the targeted population as a threat that needs to be eliminated or dominated. In other words, armed actors are actively shaping the emotional space where social, family and personal relations are created and nurtured, thereby diminishing the very essence of any psychological stability or stable mental health.

In addition to the dynamics previously mentioned, armed actors usually develop a psychological warfare component in their strategies. The main goal of this component is to target the psychology of people directly in order to deactivate the psychological adaptation of the population to the conflict. In this way, armed actors ensure that people will not develop resilience and build actions of human rights protection and peacebuilding. The psychological warfare component allows armed actors to maintain their disturbance power on the emotional state of the population. Thus, people living in contexts of armed conflict or armed instability in post-conflict settings, are continuously forced to re-symbolise and re-structure their Selves.

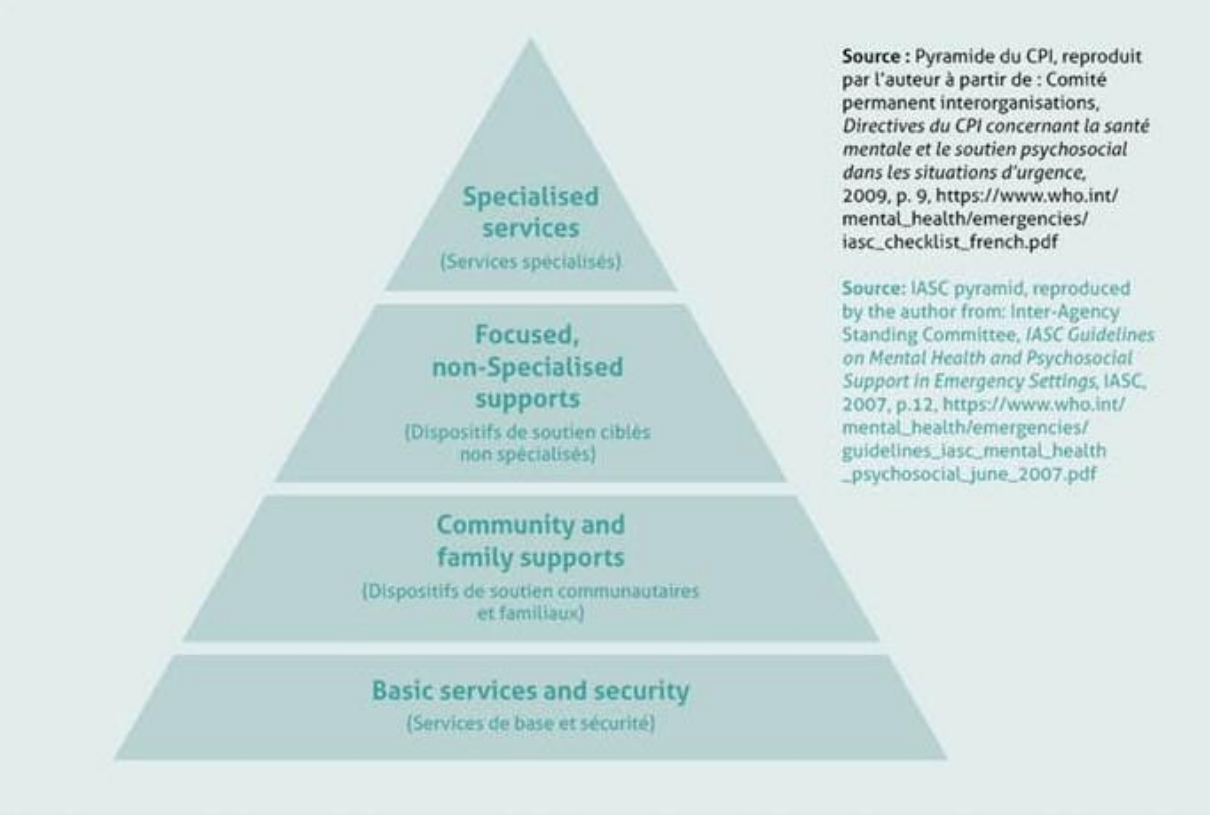
In conflict and post-conflict contexts, the psychological roles of the two other components, time and space, also differ from their roles played in natural disasters. In armed conflicts, once again, time and space are not stable. Conflicts can last for more than fifty years with a successive transformation of the same armed group that goes from regular armies, militias, warlords, ethnic fighters and criminal bands. Entire generations are involved, sometimes actively, other times as victims, but always in a succession of social roles that force populations to develop parallel moral and ethical values, which ends up creating heavy cognitive dissonances and extreme contradictory personality traits.

In armed conflict contexts, space is also always changing. Depending on the armed activity, the living and productive spaces can be turned into a threat that have to be left or avoided. Thus, people flee their homes, fields, towns or cities. In the best of cases, they stay but must live with the risk of armed clashes, kidnapping and extortion. In these circumstances, people cannot perceive their space as a refuge where they can lead a normal life. A safe and stable space is a key psychological factor in developing a solid sense of identity, belonging and community. Without that, people and communities are not able to develop and sustain their mental health. The standard approaches of MHPSS recommended in the guidelines clearly contradicts the social determinants of mental health.

The misinterpretation of specialised support and community support

The second flaw of IASC's guidelines is represented by the pyramidal structure of mental health interventions proposed in the guidelines. That pyramid has become the standard model to interpret the impacts that emergencies have on the mental health of a population as well as the model to formulate MHPSS interventions on.

17th Issue – July 2021
p.77-93



The subordination of the concept of mental health to an essentially Western and biomedical approach

The levels of the pyramid are essentially an industrialised Western interpretation of mental health: a view based on the individualistic dimension of mental health and the predominance of biomedical and pathological approaches.

While mental health is certainly a matter of the individual, it is a cognitive and emotional state determined not by the individual but by the dialectical relationships among policies, communities, groups and individuals. Mental health's nucleus is in the interaction of these elements. Like atoms, which are not just the addition of neutrons and protons but the permanent exchange of energy between those elements, mental health can only be understood taking into consideration the permanent interaction of all social and personal determinants. Thus, mental health can neither be explained nor approached from how it is expressed in a person but rather in how the entire system evolves as a whole.

However, IASC's pyramid stresses a view of mental health that establishes a predominance of the person above all other factors. Even though the guidelines point to the importance of social and community relations, at the centre of the explanations given is always the individual. It is as if the entire system revolved around the person in some kind of geocentrism[5] of mental health. In this sense, it is comprehensible why the guidelines reserve the classification of specialised support to the clinical dimension of mental health, support that must be carried out by clinical psychologists and psychiatrists.

The problem with this hierarchy of support for mental health lies in the view that specialised services are only those provided by doctors or psychologists trained in clinical approaches for a small portion of the population. By contrast, supports such as "family tracing and reunification, assisted mourning and

[5] Geocentrism is the ancient theory that stated that Earth was the centre of the universe.

communal healing ceremonies, mass communication on constructive coping methods, supportive parenting programmes, formal and non-formal educational activities, livelihood activities and the activation of social networks, such as women's groups and youth clubs"[6] are seen as non-specialised, thereby diminishing the importance of mental health recovery and the necessary rigour, systematic inquiry and science behind these types of support.

If the guidelines had been formulated outside of the individualistic and biomedical approach, it would have left vital space to clearly state that community interventions, formulated and led by experts, are the first and most important front to help repair and prevent mental health issues.

Creating collective processes that rebuild the sense of identity, belonging and trust among a community is the basis on which positive emotional responses are developed. These processes last far beyond the timeline of an emergency. Depending on the intensity and scope of the natural disaster or armed conflict, community interventions can last for years. The importance of community interventions can also be evaluated based on the effectiveness of individual mental health interventions. These interventions lose their effectiveness if the individual has to deal daily with a chaotic community submerged in aggressive dynamics or disrupted values of solidarity and peace. This kind of context will quickly overcome all outputs achieved during any kind of individual mental health intervention. In this regard, all interventions suggested in the guidelines only encourage the reinforcement of individual coping mechanisms, as if individuals should make an abstraction of their community context.

Additionally, one of the most important aspects regarding community interventions is that these interventions allow for the "treatment" of large groups of people by transforming the social determinants of mental health. That transformation will ensure that individual changes will be developed and sustained in positive ways. To intervene on the social determinants of mental health is another specialised form of action.

In summary, the relationship between the individual and the community is vital in both the socioemotional constitution of the individual and the constitution and consolidation of the community. This relationship is interactive in nature and not interdependent. It is important to stress this difference, because when we consider the relationship as interdependent, we assume that the individual and the community are entities with separate identities that coexist for different purposes. In contrast, the notion of interaction infers that the community and the individual are inseparable. First of all, insertion into the community requires an individual to possess a social identity that allows them to enter into social relationships and this insertion provides the individual with the ability to embrace the relationships of the community. Secondly, the conditions of the community are transferred into the inner substance of the individual and transform the latter's identity. In this way, a social unit is a produced result and not a mere coexistence of individuals within a community. This unit is based not on the individual but on a social *Self*.

The previous arguments demonstrate that formulating interventions and providing support at a community scale are acutely complex operations that require highly specialised support coming from areas other than clinical psychology or psychiatry. To assume things differently is to ignore the complexity of the construction of our *Self* and how a healthy *Self* can be developed. Sadly, IASCS's guidelines dismiss the importance of social sciences in the understanding of mental health and reduces this phenomenon to the mere biological and pathological subtract of it.

Knowledge and practice evolve thanks to clear boundaries among approaches and intervention models. Working with an eclectic view of concepts, approaches and theories that in the end contradict each other, does not contribute to the consolidation of a clear intervention framework.

Because of these contradictions presented in the IASC's guidelines, their implementation without critical reflection or analysis creates an incoherent ensemble of activities, conceptual interpretations and indicators that jeopardise the recovery or the sustaining of mental health.

[6] As suggested in the guidelines at the level of community and family supports.

NGOs should not systematically promote the implementation of MHPSS IASC guidelines among their MHPSS teams. By doing so, NGOs are dismissing the diversity of interpretations and approaches on mental health and psychosocial support that comes from the rich academic and theoretical discussions in clinical and social community psychology and from the contributions of sociology, anthropology and other social sciences.

By encouraging discussion, MHPSS teams could become more creative and, by working in collaboration with researchers, ultimately build a framework that specifically characterises their NGO's interpretation of mental health. Open discussions based on systematic reviews of the NGO's MHPSS interventions allow teams to reflect on critical elements that compose mental health, of particular importance, the political and ideological content of psychological theories and methodologies. Every NGO should be able to evolve in its own constructs to create a clear MHPSS intervention framework. Only then will NGOs finally be able to recognise the boundaries of MHPSS interventions and increase their accountability.

In our work we are bound by the principle of "Do No Harm". The systematic and mechanical implementation of IASC's guidelines impedes the development of open discussions about what kind of MHPSS interventions are designed, how they are implemented in the field in reality and which mental health indicators are being used. Without a profound review of that evidence, we cannot be held accountable. Discussing and questioning what is assumed to be true will bring us closer to doing no harm.

Biography • Camilo Coral

Expert (Postgraduate Diploma in Rural Development, Master of Science in Public Health) in clinical and community psychology with twenty years of experience working with international organisations in conflict and post-conflict countries of Africa and Latin America. He has formulated and led several psychosocial interventions to support victims of armed conflicts in contexts of extreme poverty and marginality. In community psychology, his areas of interest are rehabilitation of collective dynamics, resilience building, change of attitudes and social cognition. In the clinical field, he has gained extensive psychotherapeutic experience in helping victims to overcome the emotional impacts produced by systematic rape, torture, massacres, forced recruitment, displacement, threats and armed confrontations. He is a strong advocate for the prevention and promotion approach in mental health as well as for healthy cities. In this regard, he developed the *Handbook on the Action-Reflection-Action methodology applied in homelessness interventions* (2018, **https://infopech.org/hc-content/uploads/2018/11/Itine%C4%9Brance-ang-web.pdf**).

Camilo Coral, "Mental health and psychosocial support in humanitarian interventions: critical analysis of the Inter-Agency Standing Committee guidelines", *Humanitarian Alternatives*, no. 17, July 2021, p.77-93,
https://alternatives-humanitaires.org/en/2021/07/20/mental-health-and-psychosocial-support-in-humanitarian-interventions-critical-analysis-of-the-inter-agency-standing-committee-guidelines/
ISBN of the article (PDF): 978-2-37704-836-6