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Coloniality and intersectionality in mental health: a rallying call

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The mental health and psychosocial support sector has largely fallen under the thumb of neoliberal logic by declining its concepts and standards. Carried away by a double movement of standardisation and expansion, it must integrate other methods and practices that enable individuals to recover.

In many parts of the world, the mental healthcare pathway is a veritable *métissage* (hybridisation) of therapeutic methods, in the sense that François Laplantine and Alexis Nouss [1] give to this French term: the product of a structure that assembles and interweaves various elements by transforming them, without dismantling them. Community mental health centres, psychiatric institutions, traditional healers, soothsayers or various therapies embedded in religious practices (Muslim cults, Catholic exorcisms, Pentecostal prayer camps, etc.), associations of people demanding the right to live without pharmacological treatment, liberal professionals practising so-called "brief and progressive" psychotherapies, etc.: there is a myriad of care-giving, cultural and social levers in the environment of people with mental health disorders. [2] In this context, international non-governmental organisations (INGOs) have to rethink how they can design their humanitarian response, in particular by improving the way they work with local actors, civil society organisations and local public institutions. In the field of mental health, as in others, these partners are expressing an increasing desire for autonomy in the management of the actions that concern them. Since the 2016 World Humanitarian Summit, INGOs have referred to this need for a transformation of partnership posture as the "agenda for the localisation of humanitarian aid".

Localisation versus specific features

In the "Mental health and psychosocial support" sector (commonly referred to by its acronym MHPSS), the issue of the "localisation of aid" is not an easy one to address. This is a common view: for the last twenty years, the problems encountered in the field of mental health are not just specific psychiatric or psychological problems – they also relate to the general problems that permeate all levels of social life.

[1] François Laplantine and Alexis Nouss, *Le métissage*, Téraèdre, Coll. Réédition, 2011.
[2] Marie Viviane Goupougouni Leni's current doctoral research involves analysing the psychosocial rehabilitation processes in the various forms of traditional Togolese therapies.

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MHPSS practices addressing these problems thus become a theatre for innovation, a veritable laboratory of humanitarian alternatives where local initiatives are tested in different places. These practices fall within the classic framework of the prevention or care of mental disorders. Yet we increasingly find them in social cohesion and other projects: peacekeeping, preparation for climate disasters, violence based on gender, age, disability, etc. The activities deployed are just as varied. Under the framework of so-called "community mental health" projects, for example, INGOs support many groups of people who want to "take care of themselves" by sharing their individual concerns and implementing projects for and with their community. These are often income-generating projects, such as setting up fruit and vegetable plantations, internet cafés or theatre companies. By monitoring the projects implemented by the people they support, these INGOs seek to address the dissociative processes of trauma[3] and to activate recovery and awareness processes (work on grief and loss, managing emotions, forgiveness and reconciliation, guilt, shame, life projects, individual and community resources, etc.). These mental health practices are tested by many mobile teams, sometimes composed of non-specialists as the presence of psychiatrists/psychologists is rather rare in the intervention countries.

The risk of limitless expansion

By placing a diversity of disorders, practices and actors under its banner, MHPSS has thus become everyone's business but, paradoxically, no-one's responsibility. The agenda for the localisation of humanitarian aid then comes up against a major stumbling block that is currently permeating the MHPSS sector: its expansion. With no clear position on the issue of MHPSS actors and the localisation of aid, there is a great risk of seeing an expansive approach to mental health emerge, one without limits, without a nucleus or target population, turning human beings into a resource, and which would largely be focused on individual responsibility. The concepts of well-being, happiness and resilience – widely acclaimed by INGOs in recent years – have become the achievement-oriented vectors of such an expansion.

Thinking about the issue of localisation thus allows us to take a fresh look at the MHPSS sector's "actors". Who are they? Who bears the social responsibility for defining what constitutes the well-being or good mental health of an individual or community? The ministry of health, or social affairs, justice, the interior? Or scientists who promote evidence-based research, which is sometimes funded by large pharmaceutical companies and sometimes by large development-aid agencies? Or specialists, psychiatrists and psychologists who are still all too often "hemmed in" by their standard clinical theories? Or the people concerned (but concerned by what?), traditional therapists and soothsayers, members of the clergy running specialist centres, prophets in charge of places of prayer and healing, activists from human-rights organisations?

[3] Traumatic dissociation is the psyche's defence mechanism when confronted with an extreme traumatic event. It leads to an absence of desire, amnesia, loss of feeling, identity disorders, intrusions (flashbacks, voices etc.).

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The coloniality of mental health

To understand the political significance of this expansion of mental health, it seems essential to us today to consider the concept of "coloniality" as addressed by Anibal Quijano.[4] Through this concept, the author describes an epistemic process that organises all our relationships with the world. Coloniality refers to a power regime that has generally outlived colonialism and which creates new social and cultural identities by categorising and classifying the population through a filter that prioritises the value of human lives. We can, for example, observe power regimes associated with coloniality in mental health in the way in which some populations find themselves stigmatised and discriminated against: those who are "schizophrenic", "autistic", "suicidal", "drug addicts", "bipolar", etc. We also find it in the way in which each society organises the rules concerning the deprivation of freedom and rights or in which each society deals with the deterioration of discernment in the most psychically fragile people.

Mental health discourses and practices are not neutral. They carry biases specific to our processes of appropriating and (re)producing knowledge of which humanitarians can be the messengers, often in good faith and unwittingly. We can see how many of these discourses and practices particularly convey an imaginary world peculiar to neo-liberal capitalism. In this imaginary world, the person concerned by a disorder or, by extension, the "beneficiary" of a humanitarian aid project, must take responsibility for themselves (for their mental health, their rights, their social inclusion, etc.). To do this, we seek to transform them into stakeholders of their own project and journey and into their own sovereign/governor who is efficient, autonomous, etc. Anibal Quijano clearly demonstrates how modern rational cosmology is closely linked to predatory colonial cosmology: he speaks of the "cosmology of occupation". As they are constantly creating projects/programmes and are involved in existing ones that have no ontological stability, humanitarian "messengers" convey a "projective" anthropology of being to the world. This is valid both for humanitarian operations, which are scattered over as many territories as there are projects with their own timeframe, and for the many technical, positioning, knowledge-capitalisation and training documents that litter the hard drives of "programme managers". Humanitarian action as a whole operates within the framework of the "cité par projets" [city by projects] described by Boltanski and Chiapello.[5] The MHPSS sector is organised by this projective anthropology while, in addition, a certain number of the activities it proposes aim to align individual subjectivities to this way of thinking about the world (pragmatic, operative thinking, waiting for efficiency in the short term, self-management, etc.).

The coloniality of mental health can thus be revealed in the codification of symptoms and the creation of new pathologies more adapted to pharmacological and medical treatments which reinforce certain powers and social inequalities (pharmaceutical companies, affluent social classes who can "afford" to pay for access to treatment where there is no universal health coverage, etc.). We can also see it in processes designed to transform

[4] Aníbal Quijano, "Coloniality and Modernity/Rationality", *Cultural Studies*, vol. 21, no. 2–3, 2007, pp. 168–178.
[5] Luc Boltanski et Ève Chiapello, *Le nouvel esprit du capitalisme*, Gallimard, 1999.

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personal relationships with the body, feelings, emotions and needs, especially through so-called low-intensity therapies (mindfulness meditation, psychological first aid, etc.). A true economy of happiness develops where that happiness is transformed into a desirable object that we seek to measure, a happiness that conveys the trio of positivism, performativity and neo-liberal normativity. The coloniality of mental health can be seen through a form of cultural oppression by psychological theories that localise only the causes of psychological disorders within the person, ignoring the socio-political conditions in which individuals live and which may also be the cause of such distress. In so doing, this coloniality redefines what is real and what is not.

This perspective challenges humanitarian aid practices in MHPSS. Will a six-session programme of cognitive behavioural therapy (CBT) designed specifically to target intrusive thoughts really work for an Eritrean woman who does not know how she will feed her family in the coming weeks? Will antidepressant treatment as part of a targeted care protocol eradicate the racially motivated trauma experienced by Rohingya women in Cox's Bazar, Bangladesh? Does the psychological well-being felt after a series of EMDR[6] sessions for women and girls who are victims of sexual violence help to boost their protection and safety in their society? Does a four-session programme of mindfulness meditation help young men arriving at the French border overcome the administrative traps into which they fall when seeking to obtain a "status" after crossing deserts, oceans and mountains?

Intersectionality in mental health

A decolonial approach to mental health consists of letting those who are experiencing a disorder decide, with the community to which they belong, what they deem to be suffering or good mental health (in their own words and with their own emotions and beliefs), rather than letting psychiatry and psychology textbooks decide for them. It involves creating a space to discuss these people's experiences and the solutions that can be generated collectively to ease their plight.[7] It involves freeing the histories, cultures and the very structure of the teachings and other knowledge-producing systems that have been abused and exploited by colonialism. This approach allows us to question again the conditions that allow our MHPSS practices to help achieve more liveable lives.8 To do this, we believe that it is becoming necessary to introduce an intersectional policy and method into humanitarian aid practices.

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[6] Eye Movement Desensitisation and Reprocessing. EMDR is a type of psychotherapeutic intervention recognised by the WHO as effective in the treatment of post-traumatic stress disorder.

[7] For further information about this, see the excellent documentary *Les cornes de la vache* (The horns of the cow) directed by François Bierry, which tells the story of village communities in Rwanda that practise a so-called restorative justice, which encourages the involvement, as far as possible, of all the parties concerned by a specific offence, and which *"seeks to identify and deal collectively with suffering, needs and obligations, so as to heal and repair as much as possible."* See also Howard Zehr, *The Little Book of Restorative Justice*, Intercourse, Good Books, 2002.

[8] Judith Butler et Frédéric Worms, *Le vivable et l'invivable*, PUF, 2021.

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The concept of intersectionality[9] was coined by African-American feminist lawyer Kimberlé Williams Crenshaw in an investigation into the violence suffered by women of colour in the under-privileged classes in the United States. This concept has since made it possible to broaden the fight against the oppression of "self", against the stifling of freedoms by totalitarian institutions or authoritarian democracy, against the control of the body, the inner self, desires and life choices. In MHPSS, mobilising intersectional methodology allows us to:

- examine the social relationships of gender, race, class and ethno-racial categorisations that permeate our practices
- make knowledge biases and power relations visible in terms of knowledge production
- gain a better understanding of the state of health of human beings as they intermingle with social, political, economic, etc., environments
- invite citizens to deliberate both on the definition of what constitutes a mental health disorder and on possible ways of dealing with the ordeal of suffering from such disorders
- call for the effective application of universalist notions in terms of rights.

The MHPSS approaches developed in humanitarian contexts could learn a great deal from the "liberation psychology"[10] founded in the 1980s by Salvadoran activist and psychologist Ignacio Martín-Baró. This approach highlights the fact that suffering emerges from individuals' experiences and stories of oppression. Such individuals are not seen as patients but as potential social actors in their desire for freedom who value their own heritage, creativity and experience, rather than being forced to adopt a Eurocentric and individualistic idea of relationships with other people and therapy.[11] Liberation psychology targets the social, cultural and political causes of distress through collective and transformative social action. As Rwandan psychology professor Simon Gasibirege points out,[12] "any community has within it the specific local resources to react to an attack on mental health. […] Reconstruction of mental health for a community [thus] goes through an appropriate activation of its structures for communication and solidarity".[13]

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[9] Intersectionality is a method of highlighting the situation of people who suffer simultaneously from several forms of domination or discrimination such as racism, sexism, classism, ableism, homophobia, transphobia, etc. For further information about this, see Myriam Boussahba, Emmanuelle Delanoë and Sandeep Bakshi, *Qu'est-ce que l'intersectionnalité ? Dominations plurielles : sexe, classe et race*, Payot, 2021.

[10] Steve Melluish, "Liberation Psychology", *Clinical Psychology Bite-Size*, no. 50, 7 June 2017, https://criticalvaluesbasedpracticenetwork.co.uk/liberation-psychology

[11] Sanah Ahsan, "Holding up the mirror: deconstructing whiteness in clinical psychology", *The Journal of Critical Psychology, Counselling and Psychotherapy*, vol. 20, no. 3, pp. 45–55.

[12] Simon Gasibirege, « Approche Communautaire en Santé Mentale, Les Guides de la Santé Mentale Communautaire », Programme de Santé Mentale Communautaire (PSMC), Université nationale du Rwanda, p. 19, 1998.

[13] For further study, see the documentary produced by Guillaume Pégon and Elodie Finel in Rwanda with *Handicap International* in 2012 entitled *Réunir les solitudes*, https://www.youtube.com/watch?v=9qw2PRWr3Y0 Or see the knowledge-capitalisation document produced by *Médecins du Monde* and Ibuka directed by Amélie Mutarabayire-Schafer, *Soutien psychologique des rescapés du génocide des Tutsis au Rwanda* in 2010.

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Human rights as a driving force in mental health

Addressing these issues directly in MHPSS projects seems unavoidable, provided that one's relationship with the law and ethics is re-examined. Over the past forty years, a new right to a liveable life has been asserted for individuals and communities (women, LGBTQI, people with disabilities, people who are at risk, mentally ill or formerly colonised) endowed with the power and capability to improve how they love and live and transcend their assignment to the status of victim. This "capability" shift has since been tested in many humanitarian interventions in the wake of the civil rights struggles of the 1960s. It must be said, however, that these multiple historical struggles have been more or less driven by the capitalist powers, with the sequence of pioneering struggles during the years of combat ending at the very moment that the so-called defence of human rights was being raised to the level of universal principles, repeated ad nauseam against a backdrop of problematic, if not a lack of, application in real life.

The neo-liberal shift has admittedly been prolific in the production of standards, codes, international conventions and codicils to be signed one country at a time, but to what real effect beyond the declarative? The path beyond the so-called principled ethics spouted by the Western narrative is narrow. Let's take an example. In some forms of traditional therapy, the patient's obedience to his "master" (sometimes to the point of flagellation) may be part of the "care" system. When the patient's community becomes aware of the fact that the (physically or pharmacologically) shackled person has rights, invoking human rights can then have a tangible meaning, with particular regard to the practice of paying attention to others and their situation – what we now call an ethics of care.[14] The universal nature of rights is then posited not from above but *in situ*, without challenging the value of traditional therapies, prayer camps or other unorthodox forms of care. This is precisely what we can also call decoloniality. It then becomes relevant for the actors involved in the field to equip the law (in terms of advocacy or jurisprudence) to develop MHPSS practices that are more mindful of situations of oppression that are both cumulative (intersectionality) and abusive (abuse of power). For example, the diversity of concepts such as "assisted decision", "substitute decision" or "informed consent" that are widely used in mental health may, in fact, be part of a search for a more culturally appropriate use, in more process-oriented terms, of the capacity/incapacity pairing.

As the new "capacity" frameworks in mental health refer to human rights, they can be emancipatory provided that they are backed up by in situ counter-powers from communities with a shared destiny that learn to "work with" this new legal matter, for example by forcing those stakeholders who have signed agreements to honour their commitments. Along the way, civil societies learn to manipulate mental health law so that it becomes a mobilising force to make lives more liveable. Working with emerging emancipatory and liberating movements from civil society, through citizen-mobilisation activities or community-based mutual aid in MHPSS for example, is therefore one of the

[14] Patricia Paperman et Sandra Laugier (dir.), *Le souci des autres. Éthique et politique du care*, Éditions de l'École des hautes études en sciences sociales, 2005.

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major challenges that INGOs can address when operationalising the agenda for the localisation of humanitarian aid.

Translated from the French by Derek Scoins

Biographies

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Christian Laval • Holder of a Doctorate in Sociology and a Master's degree in Mental Health, Christian Laval is a social science researcher. He co-founded the *Observatoire national sur la santé mentale et les vulnérabilités sociales* of which he was deputy director for fourteen years, and the journal *Rhizome*, which he led for four years. He was also the national coordinator of the qualitative component of evaluative research on the national programme *Un chez-soi d'abord*. He has published numerous articles and books on these issues. He has also been involved with *Médecins du Monde* for over twenty years where he has encountered and supported international mental health and psychosocial support programmes. In this capacity, he currently sits on the *Commission nationale consultative des droits de l'Homme*.

Marie Viviane Goupougouni Leni • Holder of a Master's degree in Mental Health, Marie Viviane Goupougouni Leni has been working in the field of mental health for twenty-five years and is a PhD student in psychopathology at the *Ecole Doctorale Multidisciplinaire, Espaces Cultures et Développement* of the University of Abomey-Calavi in Benin. She is a founder member of the association *Vie Libérée* in Togo, an NGO created for and with mental health service users whose aim is the social reintegration of its members. As an International Certified Addiction Professional (ICAP), her current field of research is the psychosocial rehabilitation of people dependent on psychoactive substances in Togo. In addition to her interest in the prevention of the sexual abuse of minors within the Catholic Church, she has given courses in social psychiatry to Master's students in mental health, and to students at the *Ecole Nationale de Formation Sociale* in Lomé, Togo. Sister Leni is a nun at the *Institut des Soeurs Hospitalières de Notre-Dame de Compassion* in Togo.

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