Humanitarian Psychology in War and Postwar Lebanon:
Violence, Therapy and Suffering

by

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DEDICATION

To my grandmother, Nahla Fahed Jaber. And to the spirits of Ahmad Jaber and Bassem Chit, who haunt this work in different ways.

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Chapter I

"The forsaken sufferers of mental diseases": An introduction to violence, humanitarian psychological aid and suffering in Lebanon

I. Introduction

In the summer of 1860, fights erupted between Druze and Christian Maronite communities of Mount Lebanon ─ an autonomous area in the province of Syria governed by Ottoman rule. The clashes started when Christian peasants revolted over the feudal system mostly run by Druze; both long-term residents of Mount Lebanon (Fawwaz 1995; Taraboulsi 2008). Violence soon escalated into massacres directed towards Christian Maronites (Taraboulsi 2008). French newspapers like *Le Moniteur*, *Le Constitutionnel*, and *Le Siècle* reported on the massacres, recounting Mount Lebanon as a region essentially hostile to Christianity in an attempt to arouse sympathetic feelings from the French public (Rodogno 2012, 94; Makdisi 2000; Bass 2008). As the attacks and killings moved to the coastal cities of Jaffa, Acre, Sidon, Tyre, Tripoli, Beirut, and Damascus, European consuls in Syria released several reports describing the massacres and the number of Christians killed and slaughtered[1].

[1] Rodogno (2012:99) quotes British Colonel Charles Henry Churchill's eyewitness account of the "pure butchery" taking place in Sidon: "300 bodies soon strewed the sea-beach and the gardens round about. The shrieks of the women and children rent the air. Some were slain; numbers violated. The young girls were hurried off by a mingled horde of Mohammedans and Metualis, who mysteriously appeared and pounced upon them like vultures on their quarry. The Druzes scorned to touch such offal. Several Catholic convents and nunneries….were invaded, robbed and pillaged with similar treachery. The nuns were turned out nearly naked into the fields, and in some instances suffered personal violence. The monks who failed in secreting themselves or escaping were pitilessly slaughtered; some spread in derision at the foot of their altars" (from Churchil, Charles Henry. The Druzes and the Maronites under Turkish Rule from 1840 to 1860 [London, 1862] Reading: Garnet, 1994)

"Les Massacres of Syria" were discussed in the French Parliament by the Catholic Deputies, who presented petitions from the Maronites of Lebanon and Christians of Damascus demanding a military intervention to save and protect them (Rodogno 2012, 97). By mid-June 1860, European ambassadors at Constantinople decided to intervene "in the interest of humanity" (Rodogno 2012, 101). An international commission ─ the first of its kind─ was assembled by France, Britain, Austria, Russia and Prussia "for the future peace of Syria" (Bass 2008, 186-190; Makdisi 2008, 166)[2]. Edouard-Antoine de Thouvenel, the French foreign minister and former ambassador to the Ottoman Empire, sent a telegraph to the current ambassador Marquis de Lavalette, warning him of "the regrets and sympathies which the victims of these deplorable events will awake throughout Europe", and stressing that the intervention originated "(...) neither from political disagreements nor from rivalries of influence; humanity demands a prompt intervention and urgent arrangements" (Bass 2008, 170). In his turn, Le Marquis de Lavalette instructed the commander of the frigate Zénobie that his duty was "avant tout une tâche d'humanité" (before anything a touch of humanity) as French and British ships were dispatched to the coast of Syria to form rescue operations for the local Christian refugees, and to evacuate European nationals (Rodogno 2012, 99).

On January 1861, Napoleon III explained that "a re-organization" of Mount Lebanon and other districts in Syria must be accomplished for the "oeuvre d'humanité" (the work of humanity) to be achieved (Rodogno 2012, 107). Rescue operations continued throughout the summer, turning into a long-term plan to protect Christian communities in the Levant. The European re-organization of Ottoman Syria consisted of solving immediate problems like "the

[2] The goal of the commission was " to oversee the execution of severe and impartial justice" for the guilty, to secure reparations for the Christians for their losses, and to suggest political reforms to ensure "the future order and security in Syria" (Bass 2008, 190).

refugee question" (Rodogno 2012, 109) by managing the distribution of aid[3], designing a resettlement plans for the displaced and overseeing a system of punishment and accountability for the perpetrators of the killings (Rodogno 2012, 111). This re-organization also included a series of political and social reforms to prevent future clashes and massacres, as a "humanitarian resolution" was needed for "the Lebanon question" to be resolved (Rodogno 2012, 113).

First designed to save the Ottoman Christians, the European humanitarian intervention transformed into a full-on political, social and cultural reorganization of 'Ottoman Lebanon'[4], in the name of preventing future violence and clashes between communities[5]. The 1860 massacres allowed for an expansion of missions and charitable groups that went on to do work beyond rescuing, like education, religion and health, as well as psychiatric services (Rogan 2002). While missions were already present in Syria, they greatly increased in number in the aftermath of the massacres, reshaping political economy and cultural landscape. One could clearly sense these transformations in 19th century Beirut:

> *"Dress, food, furniture, architecture: everything that defined the city [Beirut] and its inhabitants was obviously changed. The 1860 crisis, if nothing else, had galvanized Ottoman and Western interest in Beirut and Mount Lebanon and prompted an outpouring of Western Christian sympathy for the Christian victims of the massacres. New missionary societies and charitable agencies from Germany and Great Britain arrived to assist refuges and orphans, marking a new, expanded phase of Protestant missionary work in the region"* (Makdisi 2008, 168)[6].

[3] On the corruption and embezzlements of aid in 19th century Syria, Rodogno (2012, 109) writes: "the twenty-first-century reader will not be surprised to note that not all aid destined for Lebanon and Syria found its way to the refugees, and that relief committees publically denounced all sorts of embezzlements. For instance, as far as catholic relief is concerned, it seems that only 10 percent of the relief earmarked for nuns and Jesuits monks reached them, with widows and orphans receiving less than 1 percent of what charities in France has sent them".
[4] Rodogno (2012) uses the term 'Ottoman Lebanon' or "Lebanon" loosely to refer to the 19th century territory currently known as Lebanon.
[5] After the 1860 massacres, Mount Lebanon gained the right for self-governance within the Ottoman Empire.
[6] Also see Thompson 2000, 30; Owen 1981, 150-180.

Stirred by a global feeling of empathy and kinship to the Christians of Syria, missions engaged in emergency and development work, as "charitable contributions from European countries flowed in, [and] an Anglo-American committee was formed for the management of funds" (Maitland-Kirwan 1930,16). One example was the British Syria Mission, one of the largest missions in Syria at the time that was founded as a direct response to the 1860 massacres (Maitland-Kirwan 1930). Once established, it remained in Lebanon focusing on building schools and educational reforms (Maitland-Kirwan 1930).

Theopilus Waldmeier, a Swiss Quaker missionary, joined the British Syria Mission in 1868, settling outside Beirut to run schools[7] in 1874 (Rogan 2002, 114). In 1896, he relinquished his position to promote a new project for European funders which he deemed essential for the region: establishing a psychiatric asylum hospital for the insane. Pleading for funds for the hospital from European philanthropists and politicians, Waldmeier reported on how the insane ─ Christians and Muslims ─ were cruelly and violently treated in the Levant (Waldmeier 1897; Rogan 2002). In his appeal for funds, Waldmeier drew from modern forms of European humanitarianism and humanity by highlighting "the urgent needs of the totally forsaken sufferers from mental diseases", stressing the importance of a humane and scientific treatment:

> *"As I have been for 38 years a missionary in the East, first in Abyssinia, and afterwards in Syria, I have had abundant opportunities for studying the needs of these countries. I speak especially now about the urgent need of Syria, and feel constrained to bring it before the public. I am sure that this pressing need will find many helping hands and hearts for poor suffering humanity."*
> (Waldmeier 1897, 7)

Waldmeier's hospital, the Lebanon Hospital for the Insane, was established in Asfouriyeh city next to Beirut in 1900, and became familiarly known as Asfouriyeh hospital in Lebanon

[7] The boys' school became the famous Broummana high school that is still functioning today.

(Lebanon Hospital for the Insane 1901). The institution grew to become an exemplary modern psychiatric hospital frequented by people from Malta, Greece, Persia and the Levant.

European humanitarianism in 19th century 'Ottoman Lebanon' was centered on modern notions of humanity and on a humanitarian impulse to act in the face of massacre. It was considered one of the first modern humanitarian military interventions (Pandolfi 2003; Rodogno 2012, Makdisi 2008; Simms & Trim 2011) [8]. The intervention was justified not based on colonial or imperial quests, but rather on a shared notion humanity and a moral imperative to save the Christians of Syria (Barnett & Weiss 2008; Fassin 2007). A new international system emerged within this geopolitical context. It centered on 'the right to intervene' (Pandolfi 2003) against massacre, as an exceptional form of violence that threatens humanity as a whole (Rodogno 2012; Bass 2008; Simms & Trim 2011). Foreign interventions relied on aid and funds from different countries as the nature of the intervention extended beyond emergency to provide development and rehabilitation for all communities of Syria. This enabled a humanitarian-missionary space for re-organizing the 'needs' of the population through education, religious conversion, medical and psychiatric sciences. The emergence of a humanitarian market in 19th century Lebanon ─ aid, funds, missionaries, ex-pats, experts, military, corruption, locals aiding the missions─ turned Syria into an intervention site that included various reforms in the aftermath of the massacres. Reforming violence became a pressing need in this 'post-massacre' place, as Waldmeier's project sought to build a humane and psychiatric institution to provide modern treatment for the mentally diseased: a project of modernization against violence.

[8] "Soldiers, you are starting for Syria, and France greets with happiness an expedition that has but one object, that of effecting the triumph of the rights of justice and humanity. You are not, indeed, going to make war on any particular Power, but you are going to aid the Sultan to recall to their allegiance subjects blinded by an antiquated fanaticism" Excerpts from Napoléon III's speech to two regiments and a squadron of Hussars sailing to Syria on august 7th 1860 (Bass 2008, 155).

Lebanon represents a rich site for studying humanitarian projects of psychologization and governance of violence and suffering. As the vignette shows, the Asfourieyh hospital was made possible by the 1860 massacres and the European humanitarian intervention. While the 1860 massacres were considered Lebanon's first civil war, the second Lebanese civil war (1975-1990), the continual wars with Israel and its 18 years of occupation have also all led to multiple forms of humanitarian investments in developing and psychologizing Lebanon. War in Lebanon was accompanied by substantial humanitarian aid and reconstruction that evolved since the 1980s to include psychological aid.

However, it is important to note here that the European presence in Ottoman Syria did not begin with the 19th century humanitarian military intervention, but far preceded it as part of Europe's geopolitical interests in Syria. Khalil Al-Khuri's satirical novel, published one year before the 1860 massacres by Dar Al Akhbar and entitled "*Way: Idhan Lastu bi Ifranji*" or *"Alas! I am not a foreigner"* gives us an insight into cosmopolitan Beirut society in the first half of the 19th century, the social anxieties and desires arising from the influx of foreign travelers (and residents) and from the influence of European culture on Beirutis, who appear as both contesting and desiring, resisting and appropriating, lifestyles and objects of modernity:

> *"[9]The Frenchman, or the Englishman, who departs at the beginning of the month from the Boulevards or Regents' streets and arrives to Beirut by the middle of it, provided he does not pass by Malta or the Greek Islands-- and this is easy to do if he ships himself in one of Liverpool's steamers with spools of undyed cloth and yarn-- feels upon arrival to Beirut that he has entered into a great play that mocks people from the East, West, north and South. This is because our guest sees many speaking his language and wearing his clothes, while they can't differentiate between a pair of pantalon (French pants) and the (letter) A of his language. And he sees some using things that belong to the people of the West in a comical way that calls for laughter (…). And if our*

[9] This is my own adapted translation as the novel has not yet been translated to English.

guest has a head over his shoulder- and we say that because many Europeans who come here leave their heads at home, replacing it with mountains of pride and conversion- he would undoubtedly be very surprised when he sees Khawaja[10] Chahine Al Faroudi on the beach shore wearing what barely can be called clothing, rolled up in a white sheet with tails sticking out, what they call a "redingote"[11] in some countries, with one hand holding a baton as if it was a boat paddle, with his hair dripping of oil, and in his mouth a chimney- what they call a cigarette (…), and he (Khawaja Chahine) is met by another one wearing the same clothes (..) and their tongues –not in the habit of uttering correct sentences from the languages of our world- are mercilessly butchering all linguistic codes formed in Paris or London, so he (the western guest) feels that they are performing in a theatrical play where they are making fun of European habits and languages." (Al-Khuri 2009)

This powerful satirical introduction in Al-Khuri's novel sets the scene in 19th century Beirut where the European traveler 'encounters'[12] Beirutis who are already appropriating and playfully enacting different objects of modernity from the North, West, East and South. Foreign interventions in Lebanon have been described as a "colonial encounter" (Makdisi 2000), or as predicating an orientalist relationship (Said 1979). I rely on Al-Khuri's novel (2009) to argue that this relationship cannot be summarized as just an imperial 'encounter', or as constituted only by an orientalist gaze that predicates the other's subjectivity and identity. As the novel shows, Lebanon can be thought of as a peripheral modern site that identifies with the center while simultaneously being positioned on the periphery. It is a site versatile enough to incorporate, contest and playfully enact projects of modernity. What becomes at stake is less a tension between indigenous and global knowledge — after all the only person in shock here was the European traveler himself — than a glocal exchange and negotiation of projects of modernity (Lakoff 2006; Tsing 2005). Beyond modern/traditional and indigenous/western binaries that

[10] Khawaja is an honorific title.
[11] The redingote is a type of French coat.
[12] It is only the European who is encountering the Beirutis here.

usually frame arguments on governance of (mental) health in local sites, Lebanon serves as a case for a 'glocal' site of expertise that can provide a complex account of the debates on and challenges of projects like humanitarianism and psychologization.

The humanitarian component of foreign interventions in Lebanon has been largely unexplored in its own right. While one may argue, and rightly so, that humanitarianism can be read as part of projects of imperialism, or as just a different form of colonialism, a humanitarian encounter predicates specific moral, expert, and material practices of subjectification. It produces distinct forms of knowledge and understandings of violence and suffering. One must study humanitarian encounters and interventions in terms of their own moral, material and political effects (Feldman & Ticktin 2010)**.**

This dissertation is an ethnographic study of humanitarian psychology, violence and suffering in contemporary Lebanon. Humanitarian psychology is a form of humanitarian expertise that employs psychiatric diagnoses, therapies, psychological aid packages and trainings to psychologize suffering and violence in conflict and post-conflict sites. It operates along war/postwar and emergency/development binaries, identifying and treating different forms of violence and suffering in each case. Drawing on four ethnographic case studies, this dissertation examines the processes and techniques of psychologizing suffering in Lebanon following different examples of humanitarian psychological interventions on war and violence. It explores the various forms of contestations and appropriations that these humanitarian interventions have encountered. It also traces the ways in which suffering, both as articulation and subject position, is contingent on the specificities and temporalities of violence, as well as the shifting ecologies of (psychological) aid in Lebanon.

The first case study focuses on the humanitarian trouble of finding trauma and PTSD in Lebanon following the Israeli invasion of Lebanon in 1982 and the July War in 2006. These wars provoked a wide-scale humanitarian mobilization to treat traumatized communities in Lebanon. Through ethnographic and historical research, I look at the humanitarian trouble in finding signs of war trauma from Israeli wars in Lebanon. I show how experiences of *soumoud* (resistance and steadfastness) and the political investments in trauma, as an instrument of war-making rather than an individual psychological injury of war, challenged humanitarian trauma model. The non-therapeutic subjects who emerged in the face of violence and war in Lebanon saw their suffering as a form of resistance to Israeli occupation and war, while trauma and PTSD in Israel was seen to be the result of an unjust and immoral war. Local humanitarian psychologists spoke of the absence of trauma in terms of a defiant and resistant "field" of living-in violence, where experiencing violence was part of the condition of possibility of living in Lebanon. The story of Bilal, who had the rare opportunity of witnessing the ends of the July War as a liminal site between war and postwar, and his own suffering entangled with the experiences of multiple episodes of violence, complicates the story of suffering from war in Lebanon beyond a trauma/resistance binary.

After the July War in 2006, humanitarian psychology expanded as part of the humanitarian reconstruction of self and place in postwar Lebanon. The second ethnographic case study follows this process of psychologization in postwar South Lebanon, focusing on the psychological training and education of both local practitioners and aid communities. Practitioners like Thorayya, Sara and Sana, and aid communities like Lebanese, Palestinian and Iraqi refugees, all learned how to see the pressures of life in South Lebanon as distinct psychological symptoms of potential disorders. Both psychological training and education relied on the use of personality

disorders— like histrionic, antisocial and obsessive compulsive personalities — as diagnoses of ways of living in the south after the war. While humanitarian psychologists encountered non-traumatized subjects who were resistant to therapy during the July War, the process of psychologization after the war saw this resistance as a product of 'tradition' and 'stigma'. Personality disorders were used as diagnostic tools to locate psychological distress and pathology in archaic pedagogical formations of certain types of persons. They offered psychological explanations and narrations of self and society, as a way to produce a therapeutic subject that can be reformed in individual psychotherapy.

The third ethnographic case study follows the emergence of new therapies that echoed the process of postwar psychologization discussed previously. It focuses on therapies designed to target domestic violence in Lebanon as a product of psychological life pressures experienced by angry men, rather than a product of structural and patriarchal inequalities. In this case study, I follow how new therapies of angry masculinity, and the research studies that informed them, were contested and challenged by both context and people, as they turned domestic violence in a psychological injury of masculinity itself. Therapeutic masculinity blurred the distinction between aggressors and victims of domestic violence, turning men into vulnerable humanitarian subjects in need of psychological assistance. It also produced knowledge about domestic violence as a product of an archaic pedagogy, turning it to an individual psychological problem detached from its patriarchal, political and structural context.

By the end of 2012, new aid communities like Iraqi and Syrian refugees arrived to Lebanon fleeing war, violence and torture. The Syrian refugee crisis in particular brought with it new conditions of aid and suffering, where trauma once again became the focus of humanitarian psychology, but as intimately tied to a refugee status and access to aid. The fourth case study

traces the shift in aid politics and trauma from the July War to the Syrian refugee crisis. It explores how the new conditions of aid transformed narratives of suffering in Lebanon, where aid communities now competed for their suffering to be recognized. I encountered these new realities of aid in a training on Psychological First Aid for humanitarian workers assisting Syrian displaced in Akkar, East of Lebanon. I then observed how a new political economy of trauma, and an abrupt shift in aid priorities emerged with the Syrian refugee crisis, affecting different aid communities in Lebanon, and creating hierarchies for suffering.

Through these four case studies, this dissertation traces the various aid ecologies that constitute and make specific kinds of suffering subjects possible, or, in certain cases absent, like the humanitarian trouble in finding trauma in Israeli wars. Each case study shows a particular formation of aid, resources, care economies and therapeutics that produced specific aid relations and understandings of violence in Lebanon. As this dissertation will show, suffering was directly contingent on these aid ecologies and the changing nature and pace of violence. The diagnostic landscape in Lebanon, from trauma to personality disorders, to trauma again as the condition of victimhood for refugees, also emerged and shifted based on the intersection between aid and violence, creating new forms and narratives of suffering in Lebanon.

My study of the humanitarian psychologization of violence in Lebanon uncovers the debates and tensions on violence, psychologization and the politics of suffering. Throughout my research, I looked at how experts and communities negotiated globally classified disorders, like PTSD and Histrionic personality disorders, and the process of psychologizing violence as a whole. I followed how therapies and policies were contested, challenged and debated in mental health clinics, NGO service centers, in trainings and during mental health awareness sessions. Psychologization in Lebanon was informed by global and standardized mental health policies,

manuals and programs like the Diagnostic Statistical Manual (DSM), WHO's Mental Health Gap (MhGap) and the Inter-Agency Standing Committee on Mental Health and Psychological Support in emergency settings (IASC's MHPS).

Global humanitarian organizations, partnering with local organizations in Lebanon, employed psychological interventions to treat war trauma, and, then after the war, to treat life pressures, violence against women, displacement and 'the refugee experience'. I look at all these interventions together to construct a critique of the knowledge practices of violence emerging from humanitarian psychology, and the ways through which violence was located around new forms of psychic injuries in Lebanon.

II. The chapters

In the next three sections, I provide a brief account of the contemporary history of war, violence and intervention in Lebanon, then move to position my study in the literature by focusing on the relation between violence, intervention and subject. Lastly, I introduce the design and challenges of the study. Chapter two provides an overview of the history, models, and critiques of humanitarian psychology: a moral, scientific and material mode of intervention that emerged in the late 1980s as a reflection of a new humanitarian identity and a moral imperative to intervene psychologically in war and disaster. This review helps us understand how humanitarian psychology became part and parcel of humanitarian intervention in Lebanon, especially in response to the July War.

In chapters three to six, I provide four ethnographic case studies on the implications of humanitarian psychologization of violence on suffering in Lebanon. Chapter three focuses on the humanitarian trouble in finding war trauma following the Israeli invasion in 1982 and the July War in 2006. I start by narrate the humanitarian trouble in finding trauma from the difficulties I

encountered in finding trauma at the beginning of my research in a health clinic in Khiam village in South Lebanon. I unpack the public, political and intellectual debates emerging around the 'absence' of trauma in both 1982 and 2006 wars. I introduce the non-traumatized subjects that humanitarian psychologists encountered in Lebanon. Finally, the story of Bilal shows the complexity of suffering from Israeli wars beyond a trauma/resistance binary.

In Chapter four, I describe the extensive process of psychologization in South Lebanon after the July War, where both local experts and communities were learning how to detect the psychological in everyday life. The July War enabled an unprecedented form of psychologization of violence that became institutionalized under global humanitarian policies, guidelines and programs. War trauma ceased to be of interest to humanitarian psychologists who sought to diagnose the pathologies of everyday life by using personality disorders like histrionic, obsessive compulsive and antisocial personality disorders.

With this expansion of the psychological into everyday life, new therapies emerged that treated domestic violence as a product of psychological life pressures experienced by angry men. Chapter Five follows the making of these therapies in the form of a national research study implemented in the city of Tyre to measure the relationship between masculinity, violence and religion in Lebanon. I follow the difficulties and challenges faced by the study as its principals were challenged by both context and people.

Finally, chapter six introduces the new realities of aid and violence as the Syrian refugee crisis drastically shifted aid and resources, transforming the politics and narratives around suffering. Following a training on Psychological First Aid for humanitarian workers assisting Syrian refugees in Akkar East of Lebanon, I look at how the training quickly escalated into a debate on how to detect authentic psychic wounds of violence required to file a refugee claim. At

the heart of these debates emerged a new reality of aid in postwar Lebanon, where trauma became linked to a refugee status, aid and a promise of a new life. New narratives of suffering developed, where Syrian, Iraqi, Palestinian and Sudanese refugees competed for material acknowledgement of their suffering. Even the war-affected Lebanese who previously challenged and contested war trauma, now seem to recall war and violence in terms of psychological suffering.

III. A brief history of violence, war and humanitarian intervention in contemporary Lebanon (1954-2013)

Lebanon's history of violence provoked worldwide condemnation from the international community, soliciting multiple humanitarian interventions. Providing a consensual narrative of this history remains a complex and controversial practice in the absence of a national discourse on war, commemoration and violence (Volk 2010; Haugbolle 2010). The history of violence and war in Lebanon is commonly recounted in terms of episodic events that oscillate between war and postwar. I have preserved these classifications of violence here, as they inform the timing and nature of humanitarian interventions in terms of emergency and development (Calhoun 2010; Redfield 2008). Within each classification however, I highlight how war and postwar periods were constantly interrupted in Lebanon, where violence was livable and peaceful postwar periods were suspended by outbursts of violence. Classifying the beginnings and ends of violence in Lebanon is a confusing and almost useless exercise. The first Israeli war on Lebanon in 1982 occurred during the civil war, which lasted for 17 years. The first Postwar Lebanon denotes the period of reconstruction following the civil war in 1990s, while the second postwar period categorizes the series of reconstruction that occurred after the July War. Also, both postwar periods witnessed many instances of violence including an Israeli military operation in

South Lebanon in 1996. In all four case studies, I use the term "postwar" to refer to the period of reconstruction following the July War in 2006.

Analytically speaking, 'the war' was used in many instances by people I spoke with to describe the civil war, the first Israeli war in 1982 and the July War all together. This becomes most visible in Chapter Three where *al-harb* (the war) and *al a'dath* (the events) were evoked to sometimes talk about a general condition of war. It also appears in the story of Bilal (see chapter three) who kept talking about the civil war when I asked him about the July War. In this sense, the conflation of wars and episodes of violence, sometimes combining them all into one, was both factual and analytical.

Wars in Lebanon have enabled new kinds of reorganization and reconstruction of self and place through humanitarian interventions. Psychologization was a main process of re-organizing and re-assembling postwar Lebanon, although literature on postwar reconstruction of Lebanon barely addresses the rise of international psychological aid that accompanied different reconstruction initiatives (Sawalha 2010; Khalaf 1993; Khalaf & Khoury 1993 Beyhum 1995; Beyhum et al. 1995; Corm 1996; Volk 2010; Haugbolle 2010).

Post-independence Lebanon: political, cultural and economic growth (1943-1975)

Lebanon's post-independence period after the French Mandate rule is commonly described in terms of an economic and political growth (Makdisi 2004, 11). Economic liberalism and laissez faire policies enabled a rise in financial stability. The role of the state was confined to support the private sector initiatives (Makdisi 2004, 28; Cammett 2014), although welfare state reforms led to the forming of a national social welfare program: the National Social Security Fund (NSSF) in 1965. NSSF was "one of the most important sources of healthcare financing in

Lebanon" (Cammett 2014, 43) designed to provide medical, maternity and disability insurance among other things.

Lebanon's post-independence phase was interrupted by 'small civil conflicts' like the 1958 "events"[13] and by labor protests of workers and unions preceding the Lebanese civil war (Taraboulsi 2008). Al Nakba[14] in 1948 caused the displacement of an estimated 400.000 Palestinian refugees into Lebanon, with no right to return to Palestine[15]. Palestinian refugees remained in Lebanon, with no right to work, own property and acquire Lebanese citizenship (Abdulrahim & Khawaja 2011). The Palestinian armed liberation movement emerged from Lebanon in 1968, causing multiple Israeli aggressions[16] (Taraboulsi 2008, 263).

The Lebanese Civil War (1975-1990)

The Lebanese civil war was considerably represented in Lebanese and Western media, film and literature. Commonly known as *Al a'dath* (the events) to signal its protracted on-and-off nature, the civil war lasted for 17 years. The war raged periodically with brief moments of respite. A reported 184, 0000 were killed, 100,000 displaced, 17,000 disappeared and about 80, 0000 fled abroad (Volk 2010). The physical damage to the infrastructure was estimated to be 18 billion $ (Volk 2010, 105; Blanford 2006, 41). The loss of the social fabric, and the emergence of a civil war economy (Makdisi 2004, 81-82; Picard 1996, 251; Kingston 2013, 47) transformed the geography and materiality of the everyday, as journalists, bomb detonators, snipers, barricade

[13] The 1958 events, also termed as "the 1958 civil war" and the "1958 revolution", were a reflection of the tense situation in the Middle East during the Cold War, which translated into violence and (failed) attempts by the Syrian Social Nationalist Party to topple the Lebanese government (See Elizabeth Picard 1996).
[14] Al Nakba, literally means the catastrophe, is a term that denotes the displacement and expulsion of Palestinians form their towns and villages following the declaration of the state of Israel in Palestine in 1948.
[15] Following the Nakba, a special agency was established- The United Nationals Refugee and Works Agency (UNRWA) -to carry out relief and works programs for Palestinian refugees.
[16] In 1968, Israel bombed Beirut's airport destroying 13 planes.

warriors, shelters, checkpoints, armed militias, IDs and booby trapped cars became part of everyday reality of living in Lebanon (Makhlouf 1988).

In the summer of 1982, Israel conducted the 'Operations of Peace for Galile', or what came to be known as 'the Israeli invasion of Lebanon'. The invasion was framed by Israel as a Just War (O'brien 1991) that aimed at rescuing Lebanon from Palestinian rebels and fractions. 1982 was the deadliest single year in the history of the civil war. The death toll was estimated around 17,000 and 30,000 were wounded. Around one million became displaced and the infrastructural damage from the war was estimated to be around 2 billion dollars (Volk 2010, 222).

The siege of Beirut during the Israeli invasion prevented humanitarian access. Locally organized rescue operations were mobilized to conduct medical services and aid for the wounded and the displaced (Saoudi 1986; Beydoun 2012). Massacres in Tel El Zaatar[17] and Sabra and Chatila[18] Palestinian refugee camps also elicited similar local rescue and relief organization, as well as international condemnation. The International Committee for the Red Cross was the main provider of assistance throughout the civil war, while local organizations like the Lebanese Red Cross, Amel, Al Najdeh Populaire, Mouvement Social, Beit Atfal Al Soumoud, among others, were the main local providers of emergency aid and relief, focusing mainly on medical assistance and aid distribution. Many of these Lebanese and Palestinian NGOs were founded as a direct response to the massacres committed during the civil war and the Israeli invasion. After the withdrawal of Israeli army from Beirut in 1983, multiple Arab states like Saudi Arabia,

[17] In 1976 military members of the Lebanese Forces entered the Palestinian refugee camp in Tal Al Zaatar, massacring an estimated 1,500 refugees.

[18] On 16 September 1982, different Lebanese militias, coordinating with the Israeli army, committed a three day massacre in Sabra and Chatila refugee camp. The estimated number of murdered Palestinian refugees is still unknown, varying from 300 to 3000.

Kuwait, Algeria and United Arab Emirates- and Turkey- provided aid, while Arab Red Crescent organizations distributed relief[19].

The civil war weakened the state national welfare project, leading to the disintegration of public social welfare institutions[20]. The collapse of the Lebanese public health infrastructure during the civil war was met by an expansion of local and international NGOs (Cammett 2014). Major public health initiatives like vaccinations, maternal and child care practices after the Israeli invasion were "donor-driven and often administered by international NGOs rather than state agencies" (Cammett 2014, 45), like UNICEF and Oxfam.

The civil war was momentarily interrupted when Israel withdrew from Beirut in 1983[21]. The civil war was thought to be over. A new Lebanese government was formed and initiated a series of reconstruction projects[22], while trying to impose peace and order on the different fighting fractions (Makdisi 2004, 67; WHO 1983). While reconstruction plans for Lebanon were suggested as early as 1977, Lebanon oscillated between bursts of violence on a "semblance of normality"[23]. These reconstruction initiatives, especially Downtown Beirut (Gavin & Ramez 1996), informed the ends and beginnings of the war/postwar while civil conflict persisted until the 1990 following the Taif Agreement[24] between all fighting fractions.

[19] Conversation with Leila jaber, 2015.
[20] The role of the non-state social provisions increased, where each sectarian group established its own social welfare program (Cammett 2014)
[21] But kept occupying parts of South Lebanon after the invasion.
[22] Some were successful, others were not.
[23] "A semblance of normality returned to Lebanon over the following months. In January 1977, banks re-opened for the first time in 10 months, foreign diplomats returned, reconstruction aid poured in, and the government announced the establishment of the Council for Development and Reconstruction to repair and upgrade the war-damaged infrastructure. But the return of stability was pricked by occasional bursts of violence, including car bombs and assassination attempts." (Blanford 2006, 20-21).
[24] The Taif Agreement was an agreement reached among the different militias to end the civil war.

Postwar Lebanon (1990 to 2005)

Massive economic, financial, political and social reconstruction began after the Taif agreement in what came to be known as "postwar Lebanon"[25] (Makdisi 2004). The newly appointed Prime Minister Rafik Hariri oversaw reforms like privatization, while relying on international aid, loans, and investments from the Lebanese diaspora (Makdisi 2004, 65-68; Blanfod 2006, 47). Horizon 2000, Hariri's 10 year reconstruction plan, led to private contracts to fix telephone lines, highways, construct a new power plant and build a new airport (Blanford 2006, 4). With reforms and reconstruction underway, the political governance of Lebanon remained controlled by Syrian authorities since the civil war[26].

The fall of the Soviet Union and the rise of globalization marked a new series of foreign policies towards the Middle East that led to an increasing form of NGO-ization of social movements, as part of democratizing the Middle East and influencing social change (Jad 2004; Brynen et al 1995). There was a general increase in the number of civil and non-governmental associations after the war, and a rise in 'civil society' and 'advocacy-style' associations[27] (Karam 2006, 316; Ibn Nafisa 2005, 311). The rise of non-governmental organization replaced the role of the state in governing the health of the population, with NGOs accounting for more than 80% of health clinics and dispensaries by the late 1990s[28] (Ammar 2003).

[25] A rapid form of liberalization took place through the expansion of the private sector, financial international aid and investments from International Monetary Fund and other state donors like France (Makdisi 2004).
[26] While the Syrian regime launched a military intervention in Lebanon during the civil war, it remained there and kept controlling and influencing Lebanese politics and decision making.
[27] The growth in private health services increased in postwar Lebanon, while state healthcare became concentrated in secondary and tertiary care, targeting the most marginalized communities (Cammett 2004).
[28] A new process of NGOization can be detected in Lebanon in the 1990s. It is here that we can notice a rise in psychologization of violence, where certain communities became constituted as war-stricken subjects that require therapy. The handicapped, the disappeared, women, children and the tortured, all emerged as the victims of war and violence.

Many violent events disrupted the 'peaceful' reconstruction of postwar Lebanon, among them the 16 day Israeli military operation "Grapes of Wrath" in 1996 that caused 165 dead, 400 wounded and the displacement of around 400,000 person (Volk 2010). Qana village became at the center of international attention when on April 18 1996, Israeli forces targeted and bombed a UN compound in Qana staffed with hundreds of civilians who sought refuge from surrounding villages. More than 100 civilian were killed and around 100 wounded (Volk 2010, 117).

Israeli forces withdrew from the south in May 2000, marking the liberation of Lebanon from 18 years of Israeli occupation. The *Khiam Detention Center* ─ a prison established by the Israel army during the occupation in the village of Khiam[29] ─ was dismantled and all the prisoners liberated by local villagers. The *Khiam Detention Center* became a focus of humanitarian psychological intervention after the liberation. Psychological programs for the detainees were deemed a humanitarian priority, most of them tortured and detained for years. It aimed at reintegrating the liberated prisoners into society after healing their trauma.

On February 14th 2005 Lebanon's Prime Minister Rafik Hariri was assassinated (Charara 2007) in a massive explosion in Beirut, evoking memories of the civil war violence (Haugbolle 2010). The Syrian regime was accused of the assassination, and subsequently, Syrian military troops withdrew from Lebanon, creating a political schism between two opposing alliances:

[29] The *Khiam Detention Center*, or *Mo'takal al Khiam,* was originally established as a military barrack by the French Mandate forces in Khiam, as a strategic place that overseas Mount Al Sheikh, the Palestinian-Lebanese and Lebanese-Syrian borders (Shuraym 2011). It was turned into a detention center in 1985 by the Israel Defense Forces (IDF) and a Lebanese militia, 'the Lebanese southern Army', who mostly ran the detention under direct orders from the IDF during the occupation (Shyraym 2011). Many Lebanese and Palestinian locals from different villages in the occupied South were detained and tortured, and some remained there until the liberation of South Lebanon in 2000. After the war, Hezbollah turned the detention center into an exhibition, displaying the types of torture and illegal detention techniques used by the 'Lebanese Southern Army'. The detention center was bombed by Israeli military planes during the July War. The ICRC was the only humanitarian organization allowed entry into the detention center in 1995 (Shuraym 2011).

March 8th (pro-Syria alliance) and March 14th (against Syria). The assassination of Rafik Hariri was followed by a series of political assassinations by car bombs targeting proponents of March 14th, who accused the Syrian regime of committing these assassinations, while the opposing pro-Syrian alliance in March 8th accused Israel.

The July War in 2006 (*Harb Tammuz)*

The July War started on July 12th 2006 and lasted for 34 days. It caused massive infrastructural damage and causalities. Around 1.200 were killed, 4,400 injured and one million person displaced. Around 100,000 were trapped in South Lebanon with no food, water or medicine; 107,000 houses were destroyed and the damage to the infrastructure was estimated to be around $3.5 billion (Hidalgo & Augusto 2007, 103).

Israeli military committed "the second Qana massacre" in day 18th of the war, where Israeli aircrafts killed 27 families. A few days before the ceasefire went into effect, Israeli dumped around one million cluster bomb in South Lebanon, extending the effects of the war into the postwar phase (Vasiliki 2015). Illegal war weapons and techniques like cluster bombs and the "Dahiyeh Doctrine"[30], as well as unconfirmed claims of phosphoric weapons, were all used in the war.

The July War caused an unprecedented scale of humanitarian intervention in Lebanon, with an emphasis on the importance of treating psychological war trauma side by side with other forms of humanitarian emergency aid. It evoked a wide-scale humanitarian intervention in Lebanon when the United Nations emergency relief coordinator called for immediate

[30] The Dahiyeh doctrine (Dahiyeh means suburbs) was a new military strategy used during the July War, targeting civilians and civilian urban infrastructures for the purpose of causing civilian suffering and rebellion against the opponent party. The Dahiyeh doctrine lead to the complete destruction of neighborhoods and entire areas in the surbubs, and of villages like Ben Jbeil in south Lebanon.

humanitarian assistance, declaring Lebanon a site for humanitarian aid emergency (United Nations Department of Public Information 2006). UN agencies and the ICRC issued first emergency appeals, calling for immediate relief operations (Relief Web 2006). The humanitarian response was massive, exceeding 514 million dollars after the United Nations' flash appeal[31] for emergency intervention. United States, Saudi Arabia, the European Union, Italy, United Arab Emirates, Qatar and Kuwait were the main state donors (Hidalgo & Augusto 2007, 102).

This unprecedented humanitarian relief included psychological aid and emergency trauma interventions. This was the product of intersecting factors reflecting the new identity, politics and ethics of humanitarian action on one hand, and a universal acknowledgment of the importance of treating psychological injuries during war, on the other. Announcing a humanitarian emergency meant the mobilization of different UN agencies, INGOs, and funds from Western and non-western donor societies, each with its own political criteria on how, and to whom, aid should be provided (Hidalgo & Augusto 2007). It also meant the circulation of "humanitarian goods" (Redfield 2012) like aid packages, blankets, guidelines, manuals, programs and relief kits. Statistics, needs assessments and generating data on the nature of the emergency were also of primary importance (Chit 2007). Finally, the massive mobilization of global humanitarian assistance in response to the July War was based on the belief that the

[31] "On 24 July 2006, the European Commission (EC) has already adopted a first emergency Decision of EUR 10,000,000 to address the most urgent humanitarian needs of the populations affected by the conflict in Lebanon and refugees having fled to neighbouring countries. However, after two weeks of war, the coping mechanisms of the population of Lebanon are rapidly depleting. Skyrocketing prices and fuel shortages are signals of a standstill economic life. Especially the estimated 700,000 - 800,000 internally displaced people are in dire need of access to safe shelter, food, water and medical care. Accordingly, the United Nations (UN) have launched a Flash Appeal on 24 July 2006, appealing for US$ 150,000,000 to meet the needs of approximately 800,000 people over the next three months. Funds will enable the UN agencies and their implementing partners to carry out programmes to provide assistance and protection for the civilians caught in the Lebanese conflict. With this second emergency Decision, the EC will provide further funds to respond to the growing needs including against the UN appeal published on 24 July. This will help to address the urgent humanitarian needs of displaced and war-affected populations of Lebanon." (EC 2006)

displacement crisis was to last longer than it actually did. The internal displacement of around one million Lebanese from South Lebanon and the suburbs of Beirut was believed to require long-term humanitarian assistance especially after Israel dropped more than one million cluster bombs in the south a few days before the ceasefire[32].

To some extent, the July War was imagined as a destructive force that depleted the country from all resources and expertise (Moghnieh July 2015). But in reality, local aid initiatives were already underway with the first days of war, offering food and non-food items for the displaced, as well as medical and psychological support when needed (Moghnieh June 2015; July 2015; Chit 2007). Similar to Israel's invasion of Lebanon in 1982 and the 1996's Operation of Grapes of Wrath, Lebanese and Palestinian local experts, students, activists, doctors and community members joined forces and organized a communal aid response to the July War. They mobilized a global solidarity campaign and in many instances replaced and activated the role of the state in responding to the war (Moghnieh June 2015). Local forms of aid grew during the war under the name of *Samidoun* (meaning steadfast and resistant), a collective form of relief that provided aid, health and mental health care for the displaced (Chit 2007; Moghnieh June 2015). International humanitarian assistance arrived late by the end of the War. The intervention and dispersal of funds were slow as donors acted on political interests (Moghnieh August 2015; Hidalgo & Augusto 2007, 105).

A new postwar period of reconstruction

After the July War, Lebanon became a field for "intense recovery and rehabilitation programs, with multiple donors pursuing varied political and aid agencies" (Hidalgo & Augusto

[32] However, politicians and leaders encouraged everyone to return to their villages the same day of the ceasefire, to preventing a lengthy crisis.

2007). A period of reconstruction, aid, and NGO-ization occurred after the July War, as many international humanitarian organizations opened offices in Lebanon, while local NGOs were formed and quickly funded. The Nahr Al Bared conflict[33] in 2007 (Moghnieh October 2015) also contributed to a new pouring of humanitarian funds and aid, reanimating the humanitarian market that was winding down after the war. Furthermore, the incoming Iraqi refugees in 2008, and then Syrians refugees in 2012, moved the focus on refugees as primary aid communities. These different crises brought new kinds of diagnosable subjects for psychologists like the refugees and the marginalized. Accompanying reconstruction initiatives, humanitarian psychology became an institutionalized expert intervention linked to global agendas **(**Moghnieh July 2015). It first focused on treating trauma in war-affected communities, then moved to develop mental health services and assessments. The post-July War period was interrupted by civil street conflict in 2008, and the return of political assassinations in 2012, increasing in pace and scale in 2013, and unfolding in 2014 into a series of suicide bombing targeting civilians[34].

IV-Theoretical positioning of the dissertation: violence, intervention and suffering

This section provides an overview of the theoretical literature on violence, intervention and suffering, using Lebanon as a case study. I seek to locate the different ways in which humanitarian psychology treats violence as a psychological injury, and turns certain communities into therapeutic aid subjects with a certain awareness of their suffering as psychological.

Violence

[33] "The Nahr al-Bared clashes took place between May 20th and early September 2007, where the Lebanese Armed Forces (LAF) battled Fatah al-Islam militants residing in Nahr al-Bared Palestinian refugee camp. These three months of combat led to the destruction of the refugee camp, officially hosting more than 31,000 Palestinians. Internal displacement, reconstruction and rebuilding of the camp became urgent humanitarian issues that required assistance. A plethora of funds, programs and organizations poured into the camp for emergency assistance". (Moghnieh October 2015).

[34] See infographics on suicide bombing in Lebanon since 2013 https://mostlyoff.files.wordpress.com/2014/03/suicide_bombing_lebanon_jan_feb_20141.png (Achkar 2014).

Violence has been studied as a phenomenon that emerges at the end of politics, as residing outside of the political (Arendt 1970; Nordstorm 2004; Sheper-Hughes 1992). Recently scholars and ethnographers have emphasized the inter-subjective aspect of violence as an ethnographic site that opens the domain of the political and intensifies it (Thiranagama 2011). Violence should be studied not only for its destructive effects, but as a social project that is transformative of relations, politics, subjects and spaces ─ a project that shapes and makes certain persons possible. Ethnographies of violence must trace "the reconfiguration of the social fields within which culturally scripted life projects are enabled" and investigate the social and political possibilities that emerge from it (Thiranagama 2011, 14).

Likewise, recent literature on war focused on its productive effects, and on how war makes societies and economies, challenging temporal binaries of war/postwar and war/peace (Heydemann 2000; Nelson 2009; Mcgovern 2011; MESA conference panel on economies of war in the Middle East, 2014; Thiranagama Sharika 2011). In turn, humanitarian interventions have turned wars into emergencies and crises, extending sites of violence into 'postwar' and 'post-conflict' sites, where development, reconstruction and governance of self and place became a possibility (Ticktin & Feldman 2010).

The increasing interest in writing about and studying violence in Lebanon has in many ways reinforced academic and journalistic stereotypes of Lebanon as a site of violence that is simultaneously accessible and impenetrable, welcoming and incomprehensibly unyielding (Fisk 2001); as an object of research that resists analysis and understanding. Some literature on the Lebanese Civil War approached violence as a one-entity phenomenon, a derivate symptom of unequal socioeconomic rights that quickly lost any political identity, and forced a return backwards to "tribalism" and incivility (Khalaf 2002; Charara 2009; 2007; Volk 2010). These

converging accounts of violence helped stage certain debates on Lebanon as a site always oscillating between a modern past ─ as "the Switzerland of the East"[35] ─ and its uncivil violent present (Ghassem-Fachandi 2009, 119). Through this scholarship, the Lebanese Civil War was read as a rupture from politics and modernity, where violence was conceived as an abrupt event that disrupts civil living and the social order.

Other work on Lebanon focused on exploring narratives of violence (Gilsenan 2011) and on how the everyday experience of violence has the capacity to intensify the meaning of social relations and transforming political subjectivities (Makhlouf 1988; Saoudi 1986; Tar Kovacks 1998). Much less known literature produced during the civil war, notably Makhlouf's *Beyrouth ou la fascination du mort* (1988), and the diary of Fatiha Saoudi during the Israeli invasion of Lebanon (1986), had in common an interest and need to ethnographically capture the temporality of civil war and make sense of the politics of living in violence in Lebanon. They both present a thick description of the landscape of the civil war, where Lebanon became a theater of cruelty and terror (Makhlouf 1988) and a site for political and activist subjectivities (Saoudi 1986).

Furthermore, Tar Kovacks's (1998) important work on the proliferation of rumors in the civil war shows how rumors become discursive techniques through which Lebanese manage to live in violence and assess its level of terror and livability. Through studying rumors as discursive readings of violence, Tar Kovacs (1998) goes beyond violence's resistance to analysis to study how unbearable things become bearable and re-situated within the discursive conditions of possibility of social reality, in an attempt to understand how Lebanese made sense and lived in violence and terror.

[35] "The Switzerland of the East" is an expression used to describe the republic of Lebanon before the civil war, as a way to distinguish it from other Arab countries and to denote its liberal politics and affinity with European culture.

This literature provides insights into processes through which normality was socially produced during the civil war. It approaches violence as a force that disturbs and transforms city, neighborhood, family and subject (Makhlouf 1988; Saoudi 1986, Tar Kovacks 1998). It grapples with the changing geography of violence as everyday practice, while also addressing the phenomenological transformations that occur as one becomes puzzled by the sight of violence in everyday life, a detached witness to bombs and dead bodies, an activist resisting the destruction and violence, and then becoming violent herself.

More recent anthropological literature focused on the temporality and the constant anticipation of violence in Lebanon, where it ceases to be an extraordinary event and becomes entangled in people's experience of the everyday and the mundane (Hermez 2011; 2012). Drawing from ethnographic research and interviews with former militia fighters, political activists and family members, this work tries to locate the mundane places in which violence emerges in the everyday (Hermez 2012) and the different forms of activist and political subjectivities emergent out of war and conflict in Lebanon (Hermez 2011). Other ethnographic work focused on the cultural and national production of civil war memory in Lebanon, attempting to unravel the historical narratives around the civil war (Haugbolle 2010), the ways in which urban reconstruction and reorganization of postwar Beirut reshaped memory and collective commemoration (Sawalha 2010), and the politics of remembrance embedded in public memorials of violence and martyrdom in Lebanon (Volk 2010). Finally, the work of Vasiliki Toholioutis (2015) looked at how cluster bombs, dropped by Israel in South Lebanon during the July War in 2006, work to make war durable and productive, challenging normative accounts of war/peace and the notion of the postwar Lebanon, and showing how the durability of war in everyday life challenges notions of recovery from violence in Lebanon.

Intervention: humanitarianism and psychologization

Humanitarianism has only recently become an object of study for anthropology as a political and moral global institution (Fassin & Pandolfi 2010; Feldman and Ticktin 2010; Minn 2007; Allan 2014; Wilson & Brown 2009; Bornstein & Redfield 2010). Earlier work in anthropology addressed issues of displacement and the refugee experience at the intersection of aid (Malkki 1995; 1996; De Waal 1997; Ong 2003), violence against humanity like genocide (Mamdani 2001) and the anti-politics of international developmental aid (Ferguson 1990). More research on transnational institutions like non-governmental organizations and global aid emerged as ethnographic research began tracing traveling global phenomena, becoming multi-sited (Marcus 1995; Bornstein 2005; Ferguson 2002; 2006; Ong 2001; Feher 2007).

Anthropology of humanitarianism drew heavily from discussions on "life" made by Arendt (1998), then taken on by Agamben (1998; 2005) to conceptualize states of exceptions and emergencies, as sites for governing refugees (Fassin & Pandolfi 2010). These Zones of in-distinction (Agamben 2005) and spaces at the margins of the state (Das & Poole 2004) have created kinds of lives that are difficult to represent and account for. These discussions were used to understand the exceptional category of the refugee within the humanitarian governance of disaster and conflict (Redfield 2005; 2006; 2013; Fassin & Pandolfi 2010).

Foucault's concepts of biopower and biopolitics (1980; 2003) also influenced how anthropologists studied the making of new subjects by global life technologies and aid, like the making of "biological citizenship" in Ukraine's welfare state (Petryna 2002), and the emergence of "therapeutic citizenship" as a product of global pharmaceuticals circulating in different societies (Petryna, Lakoff & Kleinman 2006; Nguyen 2005; 2010; Biehl 2005; 2006; Bornstein & Redfield 2010, 153; Yang 2015); while other cases revealed an epistemic resistance to the

premises lying behind these life technologies (Lakoff 2004). This literature mainly focused on the constitution of "citizenship" by welfare states through different global life technologies, like AIDS, psychotherapy and biological indicators of radiation.

However, the governance of life through humanitarianism is based on global networks of aid "without borders" (Redfield 2013; Ticktin 2011). This complicates and produces new kinds of citizenships, and particular form of aid subjects rather than citizens positioned in relation to the state, especially with the rise of transnational (Gupta & Ferguson 2002) and humanitarian governance (Pandolfi 2003, 2008; Feldman 2008; Malkki 2007).

Global life technologies and interventions can also be thought of as ontologically producing subjects as part of a complex network of circulating objects, bodies and technologies (Latour 2005; Mol 2003; Raffles 2002). Life technologies become "immutable mobiles" (Latour 1987) when incorporated as humanitarian technologies and deployed in emergencies and development around the world **(**Redfield 2012) ─ not necessarily as a project of citizenship but of making particular forms of governed humanitarian subjects (Redfield 2005, 2006; Ticktin 2006). Trauma and PTSD, as a universal form of suffering from violence worldwide, have become one example of these life technologies for humanitarianism (Good et all 2008; Daset al 2000; 2001) that constituted a condition for victimhood (Fassin & Rechtman 2010) and a political economy for suffering in post-conflict sites (James 2004; 2010).

In Lebanon, anthropological work on humanitarianism has been scarce. The work of Etsella Carpi (2015) explored how humanitarianism transfigured social space in Beirut's suburbs as a response to the July War, and in Akkar as a response the Syrian refugee influx onto Lebanon. Nikolas Kosmatopoulos (2014a, 2014b) looked at the techno-politics of international

crisis in Lebanon as they unfolded in peace expertise, and in the birth of the conflict-resolution NGO workshops that addressed the making of peace in Lebanon and the Middle East.

Trauma as model for humanitarian psychology

Individuals and collective experiences of war have been conceptualized in terms of a trauma model that dominated 20th century psychiatric, academic and humanitarian representations of suffering (Fassin & Rechtman 2010; Butler 2009). This model of suffering offers specific ways for understanding violence as a sudden event that disrupts and ruptures the everyday life (Das 2007; Hacking 1995).

Originally an object of psychoanalytic science that first emerged to describe soldiers' nonphysical suffering during wars in the late 19th century (Hacking 1995), trauma was incorporated into biomedical psychiatry after the Vietnam war as PTSD (Young 1998), thereby uprooting it from its psychoanalytic origins (Metzl 2005) and turning it into a cluster of symptoms within the American Diagnostic Statistical Manual (DSM) (Young 2008).

The introduction of PTSD within the DSM intersected with the humanitarian's growing interest in incorporating psychological treatments and programs into their emergency action in the early 1980s (Barnett & Weiss 2008; Fassin 2009). With its incorporation into humanitarian action, trauma became a global and mobile model through which suffering from war is recognizable across cultures and societies. The trauma model proposed new kinds of forgetting and remembering violence that were conceived of as internal-psychological properties of individuals (Young 1996; Young 1995). It became a form of psychological injury to the soul that contributed to the construction of new forms of disordered subjectivities (Hacking 1998).

The extension of traumatic logic from a shock to the body to a wound of the soul depended on the 19th century sciences of memory that allowed "an entry into the soul" (Hacking 1995).

Both memory and the self began to be understood as mutually constituted, where recalling a violent event wounds the self by the very action of remembering (Hacking 1995). The traumatized self became a complex state of consciousness that could be known, measured and understood through memory. The memoro-politics of the 19th century privileged a new kind of memory located within the individual and directed outwards to practitioners, lawyers and humanitarians as a condition of victimhood (Hacking 1995; Fassin & Rechtman 2010). Unlike arguments that find political activism responsible for this new form of remembering (Young 1995), it is the replacement of morality with a more scientific, tangible and objective trace that made the politics of individual memory possible (Hacking 1995). Morality now had a material and psychological effect on the mind that can be treated and recognized.

Through this theoretical framework, Hacking (1995) goes beyond a social constructionist critique to address the ways in which psychological diagnoses and classifications *became* real at a particular time[36] and shaped the way we experience violence and psychic pain. Different factors, like memoro-politics, came together around the psychologization of trauma (Hacking 1995). These "ecological niches" constitute the conditions of possibility of trauma, which became defined by memory, the event, and the type of violence produced by the 19th century industrial revolution (Hacking 1998).

Notions of morality and political witnessing that accompanied trauma resonate with the changing nature of humanitarian identity, especially with the emergence of *Medecins Sans Frontiers* in the late seventies, protesting the International Red Cross's principals of neutrality

[36] For example, the invention of the 19th century railroad "created the accident" (Hacking 1995, 185) and informed the materiality and temporality of violence, both in terms of insurance compensation and the idea that the everyday life can be ruptured by an event. The railroad drew the modern materiality of "western" violence and produced subjects with specific demands and pains that called for accountability and categorization.

during conflicts, and calling for a position of witnessing as an ethical principle of humanitarian action (Redfield 2006). Trauma became the quintessential object of witnessing violence, suffering and human rights violations; a model for universal human suffering adopted by humanitarianism (Fassin & Rechtman 2010).

The humanitarian trauma model has been best summarized best by Derek Summerfield (1999) who identifies seven assumptions behind international psychological trauma programs: 1) experiences of war and atrocity cause 'traumatization'; 2) violence and war produce a universal human response that is captured by Western psychology; 3) war-traumatized victims required professional help from experts; 4) victims of violence become better through "talk therapy" and if they 'work through' their experiences; 5) there are vulnerable groups and individuals (women, children and refugee) who need to be specifically targeted for psychological help; 6) war represents a mental health emergency; and 7) humanitarian workers are themselves overwhelmed and may themselves be traumatized.

Beyond trauma: violence in the everyday and hierarchies of suffering

Trauma has become a universally recognized frame of reference through which suffering and precariousness from violence can be framed, recognized and read (Butler 2004; 2009). Representations like the humanitarian trauma model narrate which kind of life is ontologically representable as precarious and which lives are left socially unmarked (Butler 2004; 2009; Fassin & Rechtman 2010). In "*precarious life*" (2004), Butler argues that the 9-11 events have produced new political awareness of injurability and aggression, creating dominant forms of representations of the suffering of others that call into question forms of life worth living and death worth grieving (Butler 2004, xv).

Butler (2009) seeks to locate the different frames and cultural modes that regulate affect, sentiment and ethical responses to violence. Reactions to violence are based on specific dominant narratives that frame which kinds of suffering and vulnerability could be heard and represented (Butler 2009, 1). The humanitarian trauma model has become just that, where life is framed through specific forms of institutional power like psychiatric practices (Butler 2009). The humanitarian trauma model therefore becomes a frame of recognition that allows for the recognition and identification of psychological precariousness, while other forms of lives remain unrepresented (Butler 2009, 5).

Scholars have attempted to propose an alternative framework for suffering to the trauma model that honors communal experiences of violence (Das 2007; Kleinman, Das & Lock 1997). This form of scholarship questions the temporality of violence as a ruptured event by providing a complex discussion of the event in the everyday where "the event attaches itself with its tentacles into everyday life and folds itself into the recesses of the ordinary" (Das 2007, 1). This temporality disrupts psychiatric and humanitarians models of trauma by relocating violence into the everyday. Contrary to the humanitarian trauma model's precepts, the subject here is not separate from the everyday, experiencing and reflecting on the eventful, but emerges from it. This proposes a theoretical and methodological framework that attempts to look at the experiences of inhabiting marginal and fragmented sites of violence (Das 2007). In this framework, violence is both eventful and ordinary. Just like violence is attached to the ordinary, sentiments of fear and terror are also linked to the everyday life, as a constant state of fear and

anticipation of violence. Violence in the everyday becomes a violence that is not actualized but always anticipated and expected[37].

Theoretical positioning of the dissertation

First, humanitarian organizations have implemented different psychological programs and interventions during wars that vary from psychological first aid (Reyes et. al 2006; Ruzek et al 2007), debriefing (Raphael &Wooding 2004), to more clinical and psychiatric interventions that relied on global psychiatric diagnostics like the DSM (Breslau 2004). I refer to all trauma interventions in this dissertation as the humanitarian trauma model because, as diverse as they are in form, they all share at their core common assumptions and understandings of war as a shocking event that produces psychological trauma. The humanitarian trauma model assumes that war produces psychic injuries and requires expert intervention. I take trauma, whether defined and framed by psychiatry, psychology and humanitarianism as Post-traumatic Stress Disorder (PTSD), or evoked in popular Lebanese culture and discourse[38], as an elusive thing that takes on various material, political and ideological values for different actors and communities in Lebanon. The multiple faces of trauma in Lebanon, sometimes intersecting, other times clashing, provides us with an understanding of the contemporary politics of suffering from violence in Lebanon.

Second, this dissertation seeks to explore the kinds of subjects that are made by humanitarian psychology as a project of reforming and reshaping people exposed to violence and

[37] Violence in this framework is not necessarily tied to a separate event but to the experience of unknowability of a world one used to inhabit (Pertryna 2002). This unknowability is found in the ordinary, like witchcraft accusations or rumors that interrupt the ordinary (Das 2007). It does not become an extraordinary event, or an "accident" (Hacking 1995).

[38] There is no word for trauma in Lebanon. *Sadma* is the closest word, which is equivalent to shock. In certain social circles, the word "trauma" is sometimes evoked when one is attempting to express psychological distress.

war. I look at humanitarian psychology as a discipline and practice that aims at turning people into therapeutic aid subjects. In that sense, I understand psychologization as the humanitarian process of employing psychological expertise and techniques to turn aid communities' experiences of violence— and their social conditions— into internal and individual psychic injuries. Yang (2014, 2015) speaks of psychologization in China as a discursive tool of the state that reduces social issues like unemployment into their psychological and moral traits, while downplaying the structural forces at place. I see psychologization in Lebanon more in terms of a humanitarian project-—not of citizenship-—and try to investigate the material process of individuation through which communities became constituted as therapeutic aid subjects; or challenged this constitution.

Anthropological theories of the subject has been central to the work of medical anthropology in recent years, especially in terms of lived experiences of suffering and healing (Good 2010). Medical anthropology has recently focused on theorizing 'subjectivity' as an "essential individuality" and a form of "inner life processes and affective states" that is made and reshaped by different apparatuses of power and life technologies (Biehl & Moran-Thomas 2009: 270; Biehl et al 2007; Good et al 2008). Analytical concepts like subjectivity seem to precondition and honor an internal and individuated affective state, on which projects like humanitarian psychology can intervene and reshape. This dissertation seeks to de-emphasize the importance of inner affective and reflexive experiences by looking at the ways in which specific kinds of ontological subjects or subject positions (traumatized, suffering, non-suffering, resistant, activist, therapeutic) are formed and made by practices and technologies of humanitarian psychology. By ontological subjects, I mean studying the making of a subject beyond privileging a mind/body binary or a discursive articulation of subjectivity.

Third, I rely on Anna Tsing's notion of "sticky engagements" (2005) to understand how universal projects, like humanitarian psychology, are deployed in Lebanon. Most of the humanitarian programs implemented in Lebanon were done by global humanitarian organizations in partnership with local and long-standing non-governmental organizations in Lebanon. This 'partnership' of course was never equal, where local organizations served as implementers for global programs. However these global therapies- dependent on a network of technologies, actors, experts and objects- were themselves reconfigured in glocal sites like Lebanon.

Fourth, recent anthropological literature on transnational governance have addressed how global NGOs, corporations and international actors have participated in weakening the state. Similar to Feldman & Ticktin (2010), I argue that arguments on the decline of the state have been overstated, especially in a place like Lebanon[39]. This dissertation seeks to move away from non-governmental/governmental binaries by being methodologically faithful to following the project of humanitarian psychology and unraveling its own assumptions. In this sense, I argue that state institutions in Lebanon were considered to be similar to local non-governmental organizations, as implementing partners of global humanitarian psychology. While psychological services were mainly provided in NGOs, local governmental health clinics were also used as implementing partners for global humanitarian organizations.

[39] This was informed by lengthy discussions in the workshop on "Beyond State Failure: New Anthropological Perspectives on the Everyday State in Lebanon'(July 14-16, 2014) at the American University, Beirut, Lebanon, organized by Michelle Obeid (U. Manchester) and. Sami Hermez (American U.).

IV-Research project: background, design and challenges

Background

My research project was directly informed by the experiences I had in Lebanon, while briefly volunteering as a psychologist during the July War in 2006, and working in public health department at the American University of Beirut on ameliorating the mental health of Palestinian refugee youth in 2007. Both experiences informed my inquiry into the condition of trauma, humanitarianism and suffering from war and violence.

Like many people I know in my generation who were children of the Lebanese civil war, I learned early on how to live in violence, anticipate it and assess its risk. I could tell a dangerous militiaman[40] from one I could negotiate, joke with, challenge, and even yell at. I knew- although poorly in comparison to boys- how to distinguish between the different kinds of bombing, shelling and gunfire, and associate them to specific types of guns, planes and rockets.

And later on, I learned how to prepare for war and upcoming violence: buy more food, especially cigarettes and bread- since they would be the first to disappear from the market- withdraw money before the banks before they closed, identify which room in the house to hide in (the room with more walls and fewer windows), buy candles and check the radio. I learned to crack open the windows and balcony doors so that the pressure from the shelling doesn't break the glass. I never saw my parents lose their nerves during the civil war or in any of the other succeeding wars.

My parents were not representative of all Lebanese's ways of living in violence but still, they reflect how some people lived and survived the war. One time by the end of the civil war,

[40] Militiamen of the civil war belonged to different fighting sectarian and political fractions and groups and, depending on the neighborhood, they controlled neighborhoods and micro-governed them.

we went swimming outside Beirut during the summer, and the shelling started while we were in the pool. All the families ran to dry up and leave, but my father insisted that we stay, teaching us, while shouting over the intermittent sound of the shelling, how to read the sound of bombing. He urged us to continue swimming since the sound of the shelling indicated that the bombing was directed at another area, so it was still safe to swim. The swimming pool's owner finally had to come and ask us to leave. These earlier experiences informed my understanding of war as an event that one can prepare for, assess its risks, and live through.

In the July War, I first heard of trauma and PTSD from my mother who was a social worker at the Lebanese Red Cross. She came back home angry one day, after working a 12 hour shift, and talked about how her emergency work was interrupted by Red Cross youth asking if they could give her what resembled a debriefing intervention so that she could be de-traumatized. My mom scolded them to leave and continued her work. She was surprised, why did she need to be traumatized? She had a job and she was doing it, as she did during the civil war, and other episodes of violence. Trauma and PTSD were not alien concepts for my mother or me. I had learned about trauma and PTSD from my psychology classes at the American University of Beirut. But they somehow seemed out of context for us both.

I briefly volunteered as a psychologist with *Samidoun*, a local aid group formed by activists, students, political groups and experts to provide aid and relief during the July War. I went to the Sanayeh garden in Beirut to play with the children, where some of the displaced war families from the south and the suburbs of Beirut stayed, like they did during the Israeli invasion of Lebanon in 1982. PTSD surveys, sometimes psychotropic medications and plans to install a psychiatric clinic within the garden were being suggested as interventions then[41]. My friend and I

[41] Interview with Ola Ataya, psychologist, 2014.

organized some games that we could play with the children. As we were leaving, a four year old girl who had been playing with us, held my shirt, asking me to lean towards her and whispered: "My brother was injured. He got shot in the head and he went to the hospital and then we came here". She smiled at me then ran off. The war however was not a time for suffering but for resisting and standing firm in the face of Israeli aggressions and violence. *Samidoun*- meaning staying steadfast and strong- was both the name of the group I briefly volunteered with and a way to survive the July War in 2006. Standing steadfast in the face of violence, when war is out to destroy you.

My friend Diana's whole neighborhood in the suburbs of Beirut was destroyed. Her building and home were in rubbles. At the end of the war, Diana's family recuperated all what they were able to save: a whiskey bottle and a photo album of a trip Diana, some friends and I took to Ladikiyeh in Syria one summer. Diana was deeply upset about losing her house, but she was not necessarily traumatized. Losing her house was part of things she expected to happen in Israeli wars. And standing steadfast in the face of destruction and violence meant that she had survived the war.

I kept in touch with Diana, and with my cousin as we all left to resume our studies abroad after the war. We spoke of how our experiences of being abroad were similar and distressing. We resented the looks of sympathy and concern coming from "the foreigners", the way their voices changed when they asked about the war and the response they expected. We acted nonchalantly and told them that we were not affected and they were shocked by our attitude. I felt isolated and depressed after the war in the US. I would mistake the sounds of trains for the sounds of military planes and I was tired of constantly being pushed to talk about the war as an unfathomable and shocking event. It was not until I came back home five months after the war, that I felt better. I

drove to the south, where the destruction in most areas had already disappeared ─ now replaced by reconstruction plans and empty spaces where a building, a neighborhood or a gas station used to be. One night, I sat with my friends, drinking and jokingly remembering all what happened during the war. Our fears, that day when Israelis captured the wrong Hassan Nasrallah (Secretary General of Hezbollah), raiding a man's house in Baalbeck with the same name; that day when the news reported that an "unidentified flying object" (UFO) was going to hit Beirut. We all laughed hysterically and drank. I remember that night as a night of healing, as a reassurance that I have survived and that I am still human.

Diana's home and neighborhood, like most people living in the south and the suburbs of Beirut, were rebuilt at an incredibly fast pace after the war. The reconstruction attempted to preserve the same urban landscape as before the war, although Hezbollah declared that the suburbs of Beirut "will return more beautiful than it was". When I drove to the suburbs to pick up Diana from her house after the war, I had a hard time remembering where her house was. The whole neighborhood was the same, yet, everything was just slightly different. The uncanny feeling of revisiting a place that is both familiar and not at all the same was how I experienced the process of reconstructing Lebanon in the aftermath of war.

I returned to Lebanon a year later to work at the public health department at the American University of Beirut in 2007. By then, multiple global humanitarian organizations had settled in Lebanon to start emergency and development work. Psychological care, both clinical and psychosocial, became part and parcel of any humanitarian work, as academic and public health research started focusing more on trauma in Lebanon. At that time, I was asked by at least three researchers to assist them in research concerning trauma and the mental health of children

and women in South Lebanon and the suburbs of Beirut. Humanitarian psychological care also became a target for other vulnerable communities like Palestinian refugees[42].

I joined the public health department at AUB as a research assistant working on designing a mental health prevention program for Palestinian refugee youth in Lebanon. The program, later called *Qaderoon* or 'We Are Capable', aimed at enhancing the mental health of Palestinian refugee youth by equipping them with a set of psychological skills and resources as prevention from mental distress. Communication, problem solving and self-esteem skills were included in the program I helped design. The community-based program was supervised, assessed and implemented by various public health faculty in the department, in collaboration with a coalition of Palestinian NGOs and some activists from the Palestinian camps in Beirut[43]. A pre-test and a post-test were conducted to assess the efficiency of the program. The results of the assessment showed that the mental health of refugee youth were negatively affected by the program. The results were statistically significant.

The program itself was very popular within community leaders and families. However the results showed negative effect on the mental health of Palestinian youth[44]. It created debates in the department of public health over the usefulness of similar psychological programs in settings like a refugee camp, where people have been living most of their lives in dire conditions without proper installations or any chance for employment or a good life. Many explanations were given to why the program failed: 1) the Palestinian refugee youth were more than aware of

[42] The discourse and narratives around trauma for Palestinians hold a specific historical and political meaning. Many of the psychological programs in Palestinian camps far preceded the July War and some were a direct result of the Sabra and Chatila Massacre. However, after the July War, psychological programs became institutionalized following global humanitarian policies and programs.
[43] Interview with Sawsan Abdulrahim, 2013.
[44] Interview with Rima Afifi, 2013.

their own situation in Lebanon; 2) they might have felt abandoned when the program ended; 3) there was something inherently wrong with the intervention itself, which might not have been not be the best tool to address mental health in refugee settings; 4) there was not enough time for the intervention to actually work; 5) and finally that children and youth mental health interventions were not enough without an in-depth intervention on family as a whole[45]. In an interview with Prof. Rima Afifi, one of the leading public health faculty on *Qaderoon,* she reflected on the work done on mental health in Lebanon in general, and on the complexity of intervening in violence in Lebanon: On one hand, one cannot just get stuck on the structural forms of violence and not intervene, but then again when one intervenes, one must understand the complexity and historicity of the violence that encloses places like Palestinian camps[46].

Qaderoon was a small program administered by the public health department. However, the debates that emerged around it (Nakkash et.al 2012; Afifi et al November 2010; Afifi et al 2010; Afifi 2008) are worth noting, especially the question of whether these programs do more harm than good when short-term mental health interventions are implemented in a structural and perpetual violent a context. What does it mean to give a refugee child communication and self-esteem skills as solutions for structural barriers? Prof. Sawsan Abdulrahim who also worked on *Qaderoon* remembered two incidences that made her reflect on the usefulness or ability of these programs to transform people who live in dire structural contexts:

> *"I remember two incidences. [One was] a child who came [to the program] whose mother was Sri Lankan[47] and father Palestinian. He was going to UNRWA school but the racism and stigma directed towards the child made me think that this [the program] is not what will make him feel better (…) The*

[45] Interview with Rima Afifi, 2013.
[46] Interview with Rima Afifi, 2013.
[47] Sir Lanka constitutes one of the main countries of origin for foreign domestic migrant workers in Lebanon (Jureidini & Moukarbel 2004; Jureidini 2009).

other time there was a child who (…) started Qaderoon, he was working at the mechanic shop and he was always spaced out and not very responsive and I thought no matter what you do, the fact that he is working at age 11 in the mechanic shop is what determines his self-esteem and mental health (…)[48]"

Despite building a community-based intervention and despite the good intentions and expertise of all involved in the program, including the community itself, the program failed in the face of structural barriers. Participating in *Qaderoon* made me become more sensitive in deconstructing not only the 'efficiency' and 'effectiveness' of similar programs in the face of structural inequalities, but becoming attentive to the different ways in which these programs become contested by the field of violence itself. I became interested in studying the expert knowledge production that accompany these programs, and the technologies and techniques they rely on, following how they become contested even when they were desired and demanded by the communities.

Dissertation Research (2012-2013)

By the time I returned home in 2012 to start my dissertation research on humanitarian mental health programs and trauma in the aftermath of the July War, many things had drastically changed. Revolutions and uprisings in Tunisia and Egypt, and later on in Syria, had erupted over oppressive regimes, economic conditions, and social justice. In Lebanon, the price of food and products seem to have doubled during the time I spent studying in the United States. Global non-governmental organizations, now long settled in Beirut, and in other cities like Tyre in South Lebanon, had reshaped employment market, politics and activism. Most people from my background now had NGO jobs, were well versed in concepts like "action plan" and "capacity building", and were either constantly undergoing "trainings", or giving them. Many of the

[48] Interview with Dr Sawan Abdulrahim, 2013.

psychology Master's students I knew were now NGO workers, doing different things from conflict resolution to psychological assessment and therapy.

This "NGO-ization" was both new and familiar, as similar scholars and activists have pointed out the rise in NGO-ization following various episodes of violent unrest in Lebanon— especially after the civil war (Karam 2005; 2006)[49]. This rise also followed major shifts in foreign aid policies, like post 9/11's American policy of "democratization" in the Middle East that resulted in an outpouring of foreign funds to enhance and ameliorate civil society[50]. After the July War, the scale of the humanitarian governance in Lebanon was massive, drastically shaping the economies, technologies and language of Lebanese civil society (Moghnieh June 2015). Moreover, it was predominantly governed by global humanitarian organizations who, by establishing 'local partnerships' with long-standing organizations, reshaped the latter's agenda, and influenced their professionalization and expertise (Moghnieh July 2015). Soon all organizations spoke the language of global humanitarian concepts, strategies and manuals and followed global humanitarian trends, donor states' foreign policies and human right conventions. NGO work became a professional program in the Lebanese public university where students could now earn a degree to become an 'NGO workers'.

At the time of my research in 2012, most of the emergency global humanitarian organizations working on trauma had left for Tunisia and Libya, which became areas of interests because of the uprisings. Many of them would shortly return with the Syrian refugee crisis[51] to resettle in Lebanon again. Lebanon seemed like the place where crises and violence never leave,

[49] interview with Ghassan Makarem, 2015.
[50] Interview with Ghassan Makarem, 2015.
[51] Medecins Du Monde closed their office Lebanon in 2010, after working in Naher Al Bared, and resettled in Libya in 2011, re-centering their services in Jordan and Palestine. They returned to resettle in Lebanon in 2012 with the emergence of the Syrian crisis (Interview with Federico Dessi, Medecins Du Monde, September 11th 2012).

but also a safe enough site to host a "humanitarian space" (Paulmann 2013). The Syrian refugee crisis, because of its enormity and scale, reshaped humanitarian focus and re-activated a massive humanitarian market, bringing forth new debates on trauma and suffering from violence in Lebanon.

By then, psychological manuals, trainings, therapies and techniques were in full swing. Trauma and PTSD transferred from an epidemiology of war to a disorder of the refugee, as humanitarian psychological care extended its work in South Lebanon to focus on rehabilitating mental health within primary healthcare. This mental health rehabilitation worked as a preventive strategy against future war and violence in the south[52].

This dissertation can best be described as a multi-sited ethnography that followed its object of study as it circulated in different locations. I started my research by locating local non-governmental organizations that were providing mental health services in South Lebanon, and began doing research in health centers of Amel, a local NGO with a history of social service and aid Lebanon. I chose the city of Tyre since it was selected by global humanitarian organizations in the south for emergency and development work after the July War. The mental health services provided by Amel were funded and designed by International Medical Corps (IMC), a global humanitarian nonprofit organization that provides health and mental healthcare for different communities worldwide[53]. The 'local partnership' between IMC and Amel allowed me to easily access and research other organizations partnering with IMC, like ABAAD, Imam Sadr Foundation and others.

[52] Interview with Mohamad Bassam, coordinator of psychological programs in Imam Sadr Foundation, 2012.
[53] See IMC website https://internationalmedicalcorps.org/ .

My ethnography took me to different sites, studying humanitarian psychiatric tools, manuals, therapies and diagnostics employed by organizations like IMC as they traveled to treat and govern different aid communities in Lebanon. I followed psychologists as they trained humanitarian workers on techniques of psychological assessment and diagnosis, implemented group therapies and awareness campaigns and held debriefing sessions to discuss psychiatric cases. I did participant observation and research with more than eight local and global organizations[54]**.** The amount of time I spent in each organization varied depending on my research. Aid communities varied from war-affected communities, to Palestinian, Iraqi, Syrian and Sudanese refugees, and sometimes an indefinite community of what was conceived by organizations and psychologists to be "marginalized people".

I started out this project with the aim of building a critique of humanitarianism and global mental health in Lebanon, gradually deciding to "study up" by focusing on the expert knowledge production and negotiations that occurred in non-governmental sites in Lebanon. I was surprised by the new NGO lingo and politics of activism I saw when I returned to Lebanon in 2012, as social movements were replaced by a form of NGO-ization of social causes. My aim was to follow how therapies and policies were contested, challenged, sometimes appropriated and debated[55].

For most of the organizations I did research with, I offered to volunteer for different tasks, from conducting a full-qualitative assessment of programs, writing reports, to taking minutes of meetings. The only form of collaborative research I was comfortable doing was

[54] Handicap International, Restart center for Rehabilitation of Victims of Torture and Trauma, International Medical Corps, Amel association, Imam Sadr Foundation, Beit Atfal Al Soumoud.

[55] The overall activities I followed were: weekly case studies meetings, psychological awareness sessions, group therapy sessions, trainings for different experts on psychological assessments and new psychological humanitarian manuals, conferences, social worker's visits, public forums, workshops and research studies.

working as a social work volunteer at a psychiatric clinic in a Palestinian refugee camp in South Lebanon. I spent eight months there in a clinic that treats Palestinian refugee children suffering from various developmental and congenital problems. I worked with the Palestinian social workers on different tasks, taught English once a week and attended weekly meetings to discuss cases and different therapies conducted there from psychiatric consultation, psychotherapy, occupational therapy and psychomotor skills.

While my stay at the clinic constituted a significant part of my research, and while it informs the dissertation, I have not written about it extensively or as a case study for many reasons. One of them being that collaborative research in this case ended up making me feel inadequate in representing the situation in the Palestinian camps just for the sake of studying an expertise like humanitarian psychology. Emergent research in Lebanon has also pointed out the over-researched Palestinian refugee communities in Lebanon across disciplines, thereby raising concerns on the impact that this research actually has on the lives and social relations of these communities, as well as its accountability for refugee social change (Sukarieh & Tannock 2012)[56].

[56] A rich scholarship on Palestinian refugees in Lebanon has already produced various and significant amount of contributions in postcolonial studies, anthropology, international law, gender, refugee studies, and have highlighted the problems and ethics of engagement with and researching vulnerable communities like Palestinian refugees. Ethnographic research on the everyday life of Palestinian refugees in the camp has focused more on the experience and the everyday materiality of living in refugee camps (Sayigh 1994), the power of oral history in shaping and producing Palestinian national identities and history (Sayigh 1994; 1997; Peteet 1991); gender practices and ideologies as an complex expression of political activism, agency and inter-subjective transformations (Sayigh 1997; 1998; 2007; Peteet 1991;1997), commemorative and narrating practices of history and nation as political strategies of resistance, (Allan 2014; Khalili 2007), the historicity of commemorative practice, from heroism to marTyredom, as mnemonic frames of political action and resistance, NGO human rights discourse and Islamism (Khalili 2007; 2008), aid and refugee subjectivity (Peteet 2005; Laleh 2007), and politics of citizenship (Knudsen 2009).

Discrimination in the field

In a week-long capacity building workshop for Lebanese police officers against torture in prisons, I sat down during lunch break with two police officers, a Lebanese feminist academic and a Palestinian UN representative who were both lecturing at the conference. The feminist academic gave a lecture on the situation of women in Lebanese prisons while the UN representative lectured about human rights regulations against torture. During lunch, the feminist scholar, in an attempt to make conversation, started commenting on an incident that occurred a week ago in Akkar East of Lebanon, where many Syrian refugees had settled in tents. Ever since the beginning of the Syrian's displacement to Lebanon, the Lebanese government had refused to provide any kind of housing infrastructure other than tents, despite pleas from international organizations. It was winter and a storm had just flooded refugee tents in Akkar, where a less-than-a-year-old baby drowned.

Commenting on this incident, the feminist scholar's narrative went something like this: "How can this happen? Is this possible?! What kind of mother would neglect her baby this way? This is appalling! Some people have no understanding of motherhood and how to take care of their children. I am disgusted and angry at these people, they have kids and then throw them away! How can she let go of her baby like that?" The police officers kept quiet, giving room for "experts" to discuss. The UN representative suggested, with a lot concern, that they needed to form awareness campaigns to target the Syrian refugees in Akkar "on these issues". It was one of these rare moments where I was completely taken aback, probably because I never thought a conversation between a UN representative and a feminist academic could carry with it so much discrimination and disregard to the suffering of refugees. It went unchallenged as a valid anecdote that shows the important of humanitarian intervention on the victims themselves, rather

than the Lebanese state. The absence of any reflection on the structural violence that Lebanese government imposes on the refugees, and the 'blaming of the mother' by the feminist scholar, revealed a deep level of othering embedded in the humanitarian psychological workshops and trainings I attended.

…

In a monthly supervision session held to provide psychological support for therapists and psychologists working on torture cases for refugees, the therapist managing the session encouraged the psychologists, all Lebanese, to talk about distressing and disturbing details or events they found in their Syrian and Iraqi refugee clients. While all of them kept quiet, she took the lead showing them how to let go of their own psychological burden after hearing about and dealing with severe torture cases. She stood up and started imitating, in an exaggerated and loud voice, accents and dialects of the refugees who call her "*khalti"* (an Arabic word for aunt) instead of *"tante"* (what French-educated Lebanese would use) or "doctor. Each therapist started making fun their clients' class, level of intelligence, level of manipulating the therapist, lack of trust, language and dialect.

…

In the summer of 2012, Sudanese refugees and asylum seekers started a hunger strike outside of the United Nations Higher Commission for Refugees (UNHCR)'s headquarters in Beirut, protesting UNHCR's racist treatment and the slow and almost suspended process of gaining refugee status and resettlement in a host country. Some of them had been in Lebanon since the 1990s. Sudanese strikers spoke of being treated like "children" by UNHCR staff and officers (Faramarziha, Gaspais & Moghnieh 2015). They would laugh and make fun of their accent and speak to them "as if they were children".

The invisible and forgotten refugees of Lebanon started a hunger strike to be recognized as refugees and treated as humans with basic rights. 50 days into the hunger strike, on August 4th 2012, Sudanese protesters were arrested outside of UNHCR office and detained in prisons (Faramarziha, Gaspais & Moghnieh 2015). They were told that they would be released provided they sign a paper not to protest again (Faramarziha, Gaspais & Moghnieh 2015). Three years later, in the summer of 2015, the battle for the rights of Sudanese for refugee status was still ongoing, with growing accusations of racist mistreatment and discrimination by UNHCR Lebanon[57]. An open sit-in protest spontaneously took place at the end of July 2015 outside of UNHCR headquarters in Beirut. After three years, many of their refugee and resettlement files were still closed and left unprocessed, and the resettlement process were either suspended or very slow to take place. One protester said "when we ask for the reasons, UNHCR says "we don't know why" (Faramarziha, Gaspais & Moghnieh 2015).

…

These are some examples of various forms of othering and racism I observed in my research. While some of these 'encounters' appear in some of the chapters, I struggled to make sense of them and, more importantly, to figure out how to deal with them when they occurred in sessions, meetings and trainings. How to sit in one session after another, silently observing different forms of discrimination by humanitarian psychologists and workers who were supposed to be doing "more good than harm", and providing psychological care for distressed refugees? While many of these humanitarian psychologists and workers were implementing global humanitarian policies, or working for foreign organization, they were mostly Lebanese locals.

[57] Sudanese refugees also went on strike in Jordan. Their struggle reflects the hierarchies of lives that "crisis" produces: which refugee is more valuable and why.

This essentialist othering I observed is the product of everyday discrimination that refugees had to deal with in Lebanon (Moghnieh 2014). It is not a coincidence that during the protests against corruption and garbage crisis in August 2015, the Minister of Interior Nouhad Al Machnouk, repeatedly stated that among the 'instigators' arrested in the protests were "Sudanese and Syrians", as a way to discredit the protests. Both black bodies -- and I use black as a category foremost implicated in the national dream of what it means to be Lebanese (as a national project that oscillates between Arab and European affinities) and the racialized ideologies of the state vis-à-vis its residents-- are managed and governed in Lebanon in the everyday (Nayel & Moghnieh 2015). They were similarly managed and governed by humanitarian psychology when implemented in local settings.

While some of the organizations I worked with were far more problematic than others, these forms of othering reigned high in many therapy sessions and trainings I attended, and I began to see them as institutionalized the more time I spent in various clinics. I began to think of humanitarian psychology in Lebanon as a discipline that was grounded in nationalist ideologies that make practitioners contribute to the exclusion of the same communities they want to help and heal (Briggs & Briggs 2003). What kind of project did humanitarian psychology in Lebanon hope to accomplish? What kind of subject did it aim to sculpt? On the other hand, the UNHCR's discrimination towards the Sudanese asylum seekers was telling of the institutional forms of bureaucratic, and everyday racial profiling of refugees. A racism that humanitarian organizations and agencies produce by evoking hierarchies of humanity, a current ethical and political dilemma of humanitarianism (Feldman & Ticktin 2010, 238; Ticktin 2006).

V. Conclusion

Drawing from Europe's first modern humanitarian intervention in 19th century Ottoman Syria in response to the 1860 massacres of Mount Lebanon, this chapter introduced the entanglements of violence, intervention and suffering in Lebanon, a cosmopolitan site of glocal reconstructions and exchanges, where psychiatric science became central to the humanitarian project of " re-organizing Lebanon" in the aftermath of violence. I first showed how Europe's military intervention was a humanitarian intervention launched "in the name of humanity" and "against massacre". Psychiatric reforms in the late 19th century were part of this re-organization that went beyond massacre to reform and reconfigure both self and place along psychological lines. It served to make a modern "post-violence subject" who was precarious towards violence. Unlike the immediate act of saving from massacre, the postwar self became a humanitarian project of modernization against violence. This chapter introduced the dissertation as a study of humanitarian psychology and suffering in war and postwar Lebanon. It is a multi-sited ethnography of humanitarian psychology, focusing on the humanitarian response to the July War in 2006. Humanitarian psychology is a form of humanitarian expertise that employs psychiatric diagnoses, therapies, psychological aid packages and trainings to psychologize suffering and violence in conflict sites. The third section provided a short history of war, violence and intervention in contemporary Lebanon. The fourth section introduced the theoretical positioning of the dissertation, focusing on anthropological literature of violence, intervention and the subject. Finally, the last section introduced the background, challenges and design of the study.

Chapter II

Humanitarian Psychology: History, Models and Challenges

« Right from the start of the humanitarian operation, the doctors reports' mentioned signs of psychological problems amongst the affected population, especially amongst the children. An MDM study noted, though the semiology was not clearly defined, that 70% of the children in the affected zone presented serious signs of trauma. Reports from psychologists and psychiatrists sent by MSF in the field at the time confirmed this. It quickly transpired that the psychological therapy administered on a one-off basis was insufficient. The Armenians asked MSF to consider setting up a healthcare facility that could provide longer term healthcare for children and their families that had been victims of the earthquake. But what kind of arrangement could we set up in this particular context? That's how I was asked to set up a healthcare facility that was able to respond to such an acute situation and to the specific needs of the Armenian people. (…) This was the first time MSF had decided to mount an operation to provide treatment for psychological problems. This need was dictated by the amount of psychological distress found in the field»[58].

Marie-Rose Moro, in Psychiatrie humanitaire en ex-Yougosalvie et en Arménie – PUF publications, December 1995

I. Introduction

The incorporation of psychological interventions within humanitarianism in the late 1980s mirrored the transformations in the identity, politics and ethics of humanitarian action. It brought forth implications on how humanitarian workers and practitioners understood war and sought to treat its effects. The humanitarian preoccupation with civilians' psychological wounds in conflict and war intersected with the incorporation of Post-traumatic Stress Disorder (PTSD)

[58] Quoted in MSF newsletter, Magazine 'Freud in the Field' 2006.

into the Diagnostic Statistical Manual (DSM) III by the early 80s (Young 1998). This enabled a psychiatric validation of trauma as PTSD, turning it into a universal disorder that can account for nonphysical suffering from violence (Young 1998, Summerfield 1999; Breslau 2004). It went in line with increasing demands for a universal and global recognition of the psychological suffering of communities affected by war, genocide and conflict, and for the need of a proper humanitarian intervention that attends to these kinds of injuries (Humphrey 2002; Agosin 2001).

Humanitarian psychology is a form of humanitarian expertise that employs psychiatric diagnoses, therapies, care, and trainings to psychologize suffering and violence in conflict and post-conflict sites (Jacobs 2007; Fassin & Rechtman 2009). Trauma was at the heart of these interventions. As Fassin & Rechtman (2009) argued, "the human being suffering from trauma (...) became the very embodiment of our common humanity" (33). Trauma became the universal model of suffering from violence, "a suffering without borders, and a suffering that knows no cultural barriers" (Fassin & Recthman 2009, 239). While humanitarian psychiatry has also been evoked as a term to describe these different programs, I use the term humanitarian psychology to refer to this overall moral, social, material and scientific mode of intervention.

In this chapter, I provide an overview of the history, models and critiques of humanitarian psychology, by drawing from multiple sources in psychology, anthropology and humanitarianism. By becoming a global moral practice, humanitarianism's universal principles are so integrated in people's everyday lives that they become "common sense" (Geertz 1983), taken for granted as natural ethics and norms. A review of the literature reveals the embedded tension between the universalism of humanitarianism and its culturally specific idiosyncrasies.

Section two addresses the history of humanitarian psychology, which includes an overall discussion of the changing identity of humanitarianism and the incorporation of psychological

programs into humanitarian action. Section three reviews the different models used by humanitarian psychology that includes: Psychological First Aid, Debriefing, The Mental Health Gap, the Clinical model, the Psychosocial Model, and the mental health guidelines formed by the Inter-agency Standing Committee on Mental Health and Psychological Support. Section four lists the different challenges faced by these interventions. The last section addresses the emergence of humanitarian psychology in Lebanon as a response to the July War, and the challenges faced by humanitarian psychologists in attending to the suffering of new aid communities.

II. History of humanitarian psychology

It wasn't until recently that suffering, painful memories and difficulties in adjusting during war and conflict were recognized as psychological reactions that require professional intervention (Reyes 2006; Martz 2010). After the fall of the Soviet Union and the outbreak of civil wars in Eastern Europe in the early 1990s, humanitarian organizations began incorporating psychological interventions as part of their international relief strategy (Rieff 2002; Summerfield 1999; Reyes 2006; Jacobs 2007). The Rwandan genocide, more than any other event, shattered humanitarianism's confidence in its own principles and interventions (Lewy 2012; Kuperman 2001) and provoked severe criticisms of humanitarian organizations' neutrality in genocides and massacres (Barnett & Weiss 2008; Reyes 2006; Jacobs 2007).

In the post-Cold War period, two new transformations in humanitarian action were noticeable. The first was the growing willingness of humanitarianism to extend relief to different emergencies around the world simultaneously (Barnett & Weiss 2008). Improvement in technology, increasing number of relief organizations, and globalization, contributed in enhancing the humanitarian capacity to provide war and disaster victims with aid and relief

(Barnett & Weiss 2008). The second trend reflected the increasing threats that now accompanied humanitarian action in 'complex emergencies'[59] (Barnett & Weiss 2008; De Jong et al 2008; Jessen-Petersen 2002; Holtz et. al 2002). Humanitarian organizations "have been generally ill-equipped for what they have found" (Barnett & Weiss 2008, 2) since more demanding conflicts and emergencies emerged after the cold war (Almedon & Summerfield 2004). Humanitarian workers no longer felt safe as the mounting threats to their lives required new and complex decisions. This included deciding when to call for a military intervention, when to side with the state, when to provide aid unconditionally, and who should be identified as a war victim. Faced with new challenges and situations, the idealized image of humanitarianism drastically changed, where "the moral necessity of humanitarian action was no longer self-evident" (Barnett & Weiss 2008, 2).

By the end of 1980s, the United Nations started playing a more proactive and engaged role in managing conflict that ranged from peace keeping, emergency interventions to development work (Agger 2001). This meant "a whole new agenda for the United Nations and international peace work, which also included working with a new "tool box" of interventions that could facilitate peace building and conflict intervention" (Agger 2001, 306). This extended role of humanitarianism was followed by increasing involvement of aid donors in funding emergency and development work. As a result, humanitarian interventions now ranged from relief to development work that included "soft areas", like the promotion of human rights and

[59] It is not a coincidence that the term "complex humanitarian emergency" was coined toward the end of 1980s in Mozambique, where the UN, with the support of the government, provided assistance outside of the framework of its standard country agreements (Calhoun 2008,83). Humanitarian organizations saw conflicts and disasters becoming more "complex" than they were before traditional humanitarian action was insufficient to meet the needs of complex crises and emergencies.

democracy (Agger 2001). Today, humanitarian work can include anything from development, democratic promotion, recording violations of human right, to post-conflict peace building; all activities that are highly political and ideological (Barnett & Weiss 2008; Feldman & Titckin 2010).

It is in this context that psychological interventions, especially trauma, became a fundamental part of humanitarian aid. Psychological assistance began to flow on a larger scale during the civil war in Yugoslavia to target affected communities as part of humanitarian emergency aid and relief (Agger 2001). This particular conflict initiated a new form of humanitarian intervention that focused on trauma relief. The unique nature of the Yugoslavian War made relief agencies develop new models for interventions, while keeping with the European mental health practice which was well developed at the time. Humanitarian relief included individualized psychological assistance for the first time (Agger 2001; Jacobs 2007). While psychological programs have been implemented since the 1950s for refugees in Western host countries like the United States and France (Rechtman 1997; Atlani & Rousseau 2000), what was special about these humanitarian interventions is that they were large-scale emergency projects implemented *as aid* during the conflict itself. The same way in which a humanitarian relief worker needs to mend the physical wounds of victims, he must now also attend to the psychological wounds as well.

Principles and assumptions

One of the assumptions of humanitarian psychology is that people of all ages and places have similar reactions to violence that intrude on their everyday life and security (Reyes 2006). However, people with specific physical and psychological vulnerabilities end up exhibiting a longer and more dysfunctional reaction (Summerfield 1999; Reyes 2006). A consistent goal of

both psychology and humanitarianism is to allow individuals the chance to go back to what they knew and experienced as a normal life before disasters and conflicts happened. Psychological interventions were believed to provide the "accessible and actionable" support that could help rebuild social ties in war and disaster, and their aftermaths (Abramowitz & Kleinman 2008). The premises of these interventions relied on: 1) the idea that mental health is a human right and 2) the idea that violence cannot be repaired "without healing the social fabric" (Abramowitz & Kleinman 2008). By repairing the individual self psychologically, social ties and the social fabric were mended.

Moreover, the growing sense of urgency for psychological humanitarian assistance in sites of conflict was in line with the increasing attention and concern regarding sexual violence in wars like Yugoslavia (Agger 2001; Titckin 2011; Agosin 2001) and sexual violence experienced by refugees (Atlani & Rousseau 2000). This initiated urgent calls for immediate and quick humanitarian interventions. The rationale behind these psychological interventions came from the assumption that rape and sexual violence produced a traumatic experience that needed to be immediately treated through therapy (Atlani & Rousseau 2000; Agosin 2001). Through these paradigms, sexually abused individuals were viewed as victims burdened by PTSD, regardless of their social and cultural backgrounds and of the political context in which the rape occurred (Ticktin 2011). The act of rape and sexual violence became universal generic acts, almost always understood in terms of a "traumatic event" (Ticktin, 2011) much like being injured during war, hearing bombs, or having your house destroyed during an earthquake (Friedman et al 2007). Although there are many important differences between types of disasters and emergencies- from living under perpetual violence to events like suicide bombing-

humanitarian psychology considers the psychological impact on survivors and the communities as mostly similar (Reyes 2006).

New humanitarian Identity

Any historical account and definition of humanitarian psychology must take into account the challenges it takes to define the boundaries of humanitarianism itself, especially after the post-cold war period (Barnett & Weiss 2008; Calhoun 2008). Defining humanitarianism has been historically contingent, making it hard to represent this institution's ethics and politics as a whole (Feldman & Titckin 2010; Paulmann 2013). The first attempts to institutionalize humanitarianism in the 19th century identified several key issues that distinguished this institution from others (Barnett & Weiss 2008). Humanitarianism was defined as a set of affective morality acquired by social agents who were motivated to save others by providing unconditional aid (Feldman & Titckin 2010; Barnett & Weiss 2008).

Institutions like the United Nations and the International Committee of the Red Cross (ICRC) have traditionally been responsible for directing and managing international disasters (Barron 2004). Until the late 1980s, the ICRC's main principles of humanitarian action— like impartiality independence and neutrality— were the unchallenged and standard principles for all humanitarian industries (Barnett & Weiss 2008). Humanitarianism meant relief and nothing else, despite some organizations— like Save the Children, CARE and Oxfam— that prioritized reconstruction and development, adding activities that were not considered neutral then (Barnett & Weiss 2008).

The postwar period represented an important rupture from the defining moral imperative behind neutral humanitarian action, as aid organizations like *Medecins Sans Frontieres*[60] (MSF)

[60] While MSF emerged as a humanitarian organization in the 1970s as an alternative form of humanitarianism that challenged neutrality principle, the post-cold war period witnessed many of these ruptures and new challenges for humanitarian identity and principals.

(Redfield 2006; 2013) and later *Medecins du Monde* (MDM), attempted to chart new directions for humanitarian action, departing from the principle of neutrality to the principal of "witnessing" and then "the right to intervene" (Barnett 2011; Pandolfi 2003), which allowed for humanitarian military intervention in the name of human rights (Rieff 2002, 85). Other organizations increasingly sought to include 'outcome', 'indicators' and 'evidence-based interventions' as main characteristics of humanitarianism, especially after the publicized failures of many aid organizations in identifying and solving problems in Rwanda and Bosnia in the 1990s (Barnett & Weiss 2008). By relying on evidence-based practices and programs, humanitarianism sought to validate and standardize its interventions, a practice that was hard to accomplish especially in emergency relief intervention (Reyes 2007; Cadrozo 2008). Humanitarian action was no longer deemed good by principle. It was turning into an accountable and scientific institution whose morality could be measured and validated. These trends placed humanitarian action in new and complex situations, where its principles, politics and morality were challenged and questioned (Barnett & Weiss 2008).

Funding was another issue that drastically transformed the identity of humanitarianism in the postwar era. There are today more organizations, donor states, relief agencies and corporations dedicated to humanitarian relief than ever before (Fearon 2008). This development renders the boundaries of humanitarianism blurry, where long-standing humanitarian organizations are now funded by private agencies, states, and other sources of funding, which again challenges humanitarian principles of neutrality and aid (Fearon 2008; Feldman & Titckin 2010; Summerfield 1999).

The incorporation of psychology and psychiatry into humanitarian relief was a way to address the complexity of emergencies and conflicts. It helped create a new humanitarian identity that was

not restricted to saving biological lives but reached out to heal and restore communities' suffering. Humanitarian psychology made it difficult to be neutral in the face of genocides and violence, where trauma became an object of witnessing violence and human rights violations (Fassin & Rechtman 2010). The incorporation of a Euro-American centered discipline of psychology and psychiatry into humanitarian action also challenged the apolitical commitment of humanitarianism, its universalism and internationalism

Psychological interventions

By the early 1980s, international manuals for refugee mental health made no mention of trauma (Summerfield 1999). But as soon as western mental health professionals became involved in humanitarian missions, trauma programs became more attractive to humanitarian agencies and organizations (Reyes 2006; Summerfield 1999). With the incorporation of psychological interventions into humanitarianism, trauma became a central humanitarian concept and an integral part of any emergency. War was turned into "a mental health emergency" that caused an urgent epidemic of trauma (Summerfield 1999).

War-ravaged countries and communities were also assumed to be traumatized even in the absence of visible symptoms of trauma .Victims were deemed to be either hiding their symptoms because of stigma, or their symptoms were manifesting differently because of culture. Psychological interventions traditionally targeted "vulnerable" or "special needs" populations— a group of people defined as in need of assistance by developmental characteristics like gender, race and occupational roles (like relief workers, military personnel, journalists) (Reyes 2006). Women and girls in particular became the main focus of psychological interventions (Agger 2001; Ticktin 2011; Agosin 2001). Children were also a primary target for psychological interventions (Summerfield 2000).

Trauma and psychological suffering became core problems to be treated in 'complex' and severe kinds of violence like genocide in Rwanda and civil war in Yugoslavia (Reyes 2006; Barnett & Weiss 2008; De Jong et al 2008; Jessen-Petersen 2002; Cardozo 2002). This recognition of psychological suffering soon turned into large-scale psychological interventions that could be packaged and sent out to different disasters and emergencies. While the consensus recently shifted more towards psychosocial and community-based interventions (Petevi, Revel & Jacobs 2000), PTSD and trauma still remain the most popular form of intervention in humanitarian emergencies (Reyes 2006).

III. Models of humanitarian psychology

In this section, I review the different models of psychological interventions designed by humanitarian organizations, or incorporated from psychiatry or psychology. This includes 1) Debriefing, 2) Psychological First Aid, 3) mental health gap 4) the clinical model, 5) the psychosocial model, and 6) the IASC guidelines for mental health. All these models circulated and were implemented in Lebanon one time or another following the July War.

Debriefing (Raphael &Wooding 2004; Reyes 2006)

Debriefing has captured the popular imagination of what a humanitarian psychological emergency intervention is supposed to be. Debriefing grew out of the war experiences of military experts was influenced by talk therapy, FBI debriefing, concepts of crises interventions, preventive approaches in mental health and an overall awareness and understanding of the importance of psychological injury (Raphael & Wooding 2004). The concepts of Shell-Shock, Combat fatigue symptom and PTSD, which grew out of soldiers' experiences during the First and Second World War, also contributed to a general understanding of the psychological impact of war and violence.

Debriefing aims to extract the trauma by encouraging victims to talking about their experiences of violence. It assumes that narrating the trauma will heal the victims from the burden of PTSD. The most popular form of psychological debriefing is the Critical Incident Stress Debriefing (CISD). While this model was not necessarily designed for emergency and conflict settings, it is commonly used for civilians, military soldiers and humanitarian personnel. However, recent studies have declared this model to be inefficient and sometimes detrimental to the mental health status of survivors of violence.

Psychological First Aid/Psychological Support Program (Reyes 2006; Pairojkul et al 2010; Ruzek et al 2007)

The most prominent humanitarian relief agencies today tend to promote Psychological Support Programs[61] (PSP) and Psychological First Aid (PFA) - rather than Debriefing or specialized clinical interventions- for vulnerable populations during emergencies (Pairojkul et al 2010). The psychological First Aid (PFA) and Psychological Support Program (PSP) are preventive psychological programs for emergencies and conflict. Both rely on similar premises and assumptions but were modeled somewhat differently. The PFA is a disaster response program that aims to support survivors' immediate mental health needs in the aftermath of disaster and conflict. The program was designed by the National Child Traumatic Stress Network

[61] It is worth noting that the terminology in the field of humanitarian psychological intervention seems to vary significantly on what "psychological support" means and covers in terms of services. "Psychological support" has been categorized as a) a disaster psychology issue, which involved services provided by mental health practitioners b) a Psychological first aid issue, which involved services of support provided by family, friends, and neighbors (i.e. the community) but not necessarily professionals (Simons et al 2005). "Psychological support" also refers to "strategies for helping meet the psychological needs of ordinary people in extraordinary events" (Simons et al 2005).

and the National Center for PTSD[62]. This form of intervention relies on the assumption that a first aid program must cater to the immediate psychological needs of survivors of conflict.

These forms of psychosocial interventions are implemented informally and are contingent on the provision of essential services (medical, nutritional, sanitation) and the level of threat, to people's lives during emergencies. PFA was created as a form of care that addresses 1) challenges in implementing psychological support (as encountered with the debriefing model), 2) deciding on the proper time to administer a trauma intervention (Anderson, 2005), and 3) categorizing aid priorities. PFA recognizes that psychological functioning is critical to survival, but that there are more urgent primary needs that need attending during emergencies.

The Psychological Support Program (PSP) was created out of a mutual collaboration between the Danish Red Cross and the International Federation of the Red Cross (IFRC)[63]. This program works towards the immediate relief of trauma in survivors, while acknowledging the difficulties in defining who is a survivor during conflict. PSP is designed to be implemented anywhere following a disaster or conflict. Like the PFA model, the immediacy of this model is crucial since it relies on the assumption that traumatization is a psychological wound that needs to be attended to immediately, like a physical wound. Therefore, PSP is designed for simple implementation in the fastest time possible[64]. Unlike debriefing, PFA nor PSP do not directly

[62] The model was first promoted as a way to provide psychological relief for military personnel, when expert intervention was impossible or impractical (Blain, Hoch & Ryan; 1944). But it soon became recommended for use in wartime and disasters (Reyes 2006).

[63] It is the official psychosocial humanitarian program adopted by the Red Cross and Red Crescent national societies around the world.

[64] The model offers itself as a psychological relief program in conflict and war stricken countries that aims to instill "a psychological sense of safety", arguing that any f psychological intervention in disasters cannot blindly adopt clinical interventions designed for traumatized individuals, like cognitive behavioral therapy (CBT) and detach them from the context they emerged from.

attend to trauma, but work on psychologically supporting the victim to alleviate the effect of trauma.

*The Mental Health Gap Action Program (MhGAP) (*World Health Organization 2008)

Unlike emergency psychological interventions like Debriefing and PSP/PFA, the Mental Health Gap (MhGap) program was designed by World Health Organization in 2002 to encourage the involvement of organizations and governments in developing mental health services in countries where resources are scarce (WHO 2008). The program aims at reducing the prevalence of mental and substance use disorders worldwide by reducing the gap between what is urgently needed and available resources, as most of the people burdened with these disorders have no access to psychological care (WHO 2008). In this sense, MhGap is a developmental and long-term program (WHO 2008). WHO provides an intervention package that can be adopted in different countries based on context and need. MhGap aims to integrate mental health as a part of primary healthcare services. Violence, war and conflict are seen as events that increase the prevalence of psychological disorders and weaken health care infrastructures and facilities.

The clinical model (Reyes 2006; Breslau 2004; Saul 2009)

Clinical and therapy models are often provided in emergencies but in conjunction with general health or medical services. They are implemented either on a short-term or a long-term basis, usually relying on Euro-American schools of psychology, and diagnostics like the DSM-sometimes adapting them to fit with the cultural context. This model is often found to be costly and time consuming by humanitarian organizations, and not too efficient during emergencies.

The Psychosocial Model (Reyes 2006)

The psychosocial program targets the personal resilience of individual survivors of conflict and the community's rehabilitation as a whole. The building of personal resilience model

is found to be less stigmatizing than the clinical model since it privileges resilience over pathology. Approaches like mass education and awareness on trauma and mental illness are preventive approaches in this model. The social rehabilitation model consists of providing "healing" activities in public schools (from craft, drama groups, to sewing and computers) whose therapeutic purpose is to emphasize group support, confidence building and relaxation through safe, acceptable and productive activities. In this model, mental health is blended, or maybe even hidden, with social welfare programs, thereby thought to be less stigmatizing for the community[65].

The Inter-Agency Standing Committee's mental health and psychological support guidelines (Reyes 2006; Horn et al 2008; cordozo 2008; Abramawitz & Kleinman 2008; De Jong et al 2008)

Despite the growing effort in humanitarian organizations to practice evidence-based standards, international mental health operations in disasters seem to be the least organized (Barron 2004)[66]. The new Inter-Agency Standing committee[67] (IASC) for mental health's guidelines was formed partly as a response to criticisms around the efficiency of humanitarian interventions[68]. In 2007, international humanitarian agencies agreed on a new set of guidelines that address the mental health needs of populations in emergencies.

[65] There is, however, little assessment of the therapeutic effectiveness of such a model.
[66] The WHO for example identified around 100 uncoordinated mental health and trauma healing programs in Bosnia (Abramowitz & Kleinman 2008).
[67] The inter-agency standing committee (IASC) "is a unique inter-agency forum for coordination, policy development and decision-making involving the key United Nations and non-UN humanitarian partners". The IASC was established in June 1992 in response to United Nations General Assembly Resolution 46/182 on the strengthening of humanitarian assistance.
[68] The Inter-Agency Standing Committee Task Force on Mental Health and Psychosocial Support contains the following agencies: Action Contre la Faim (ACF), Church of Sweden, Global Psycho-Social Initiative (GPSI), InterAction (through: American Red Cross (ARC), Christian Children's Fund (CCF), International Catholic Migration Commission (ICMC), International Medical Corps (IMC), International Rescue Committee (IRC), Mercy Corps, Save the ChildrenUSA (SC-USA)), Inter-Agency Network for Education in Emergencies (INEE), International Council of Voluntary Agencies (ICVA) (through: Action Aid International, CARE Austria, HealthNet-TPO, MÈdicos del Mundo (MdM-Spain), Medicins Sans Frontiers Holland,(MSF-Holland), Oxfam GB, Refugees Education Trust (RET), Save the

The Inter-Agency Standing Committee (IASC) guidelines on Mental Health and Psychological Support (MHPSS) in emergency settings were formed to enable humanitarian actors to coordinate multiple responses for treating mental health in an emergencies[69]. The guidelines contain a list of Dos and Don'ts collected from previous experiences of humanitarians in the field. This list reveals the ethical, cultural and managerial challenges that have emerged when applying psychological programs (Abramowitz & Kleinman 2008). The purpose of the guidelines is to allow humanitarian actors and communities to plan, coordinate and establish a set of inter-sectoral responses to improve people's mental health during emergencies[70]. The core principles of IASC guidelines on MHPSS are: 1) promoting human rights and equity and protecting individuals from human rights violations; 2) maximizing the participation of local affected populations in the humanitarian response; 3) do no harm[71]; 4) building available resources and capacities; 5) relying on an integrated support system[72] and 6) developing a multi-

Children UK (SC-UK)),International Federation of Red Cross and Red Crescent Societies (IFRC), International Organization for Migration (IOM), Office for the Coordination of Humanitarian Affairs (OCHA),Queen Margaret University, Institute of International Health and Development (IIHD), Regional Psychosocial Support Initiative for Children (REPSSI), Terre des hommes (Tdh), United Nations Children's Fund (UNICEF), United Nations High Commissioner for Refugees (UNHCR), United Nations Population Fund (UNFPA), United National Relief and Works Agency (UNRWA), World Food Programme (WFP), World Health Organization (WHO), World Vision International (IASC guidelines).

[69] The United Nations Populations Fund (UNFPA) has been involved in the development of the IASC guidelines on MHPSS and has adopted these guidelines as part of its institutional policy document, while sharing it with the different organizations they coordinate with.

[70] Mental health and psychological support intervention, as provided by the IASC guidelines, are not all-standing interventions but are incorporated within every form of aid sector as a comprehensive approach to mental health. The guidelines also specifically describe the necessary steps for psychological support, starting with forming a MHPSS group that can coordinate with the government and the NGOs during emergency and- while relying on the existing resources- can also provide psychological support.

[71] IASC is well aware of the unintentional harm that mental health programs can cause, especially that there are no a lot of scientific evidence for their effectiveness (IASC 2007). These guidelines seek to reduce harm through: participation in coordination groups; insisting on evaluations; designing interventions on the basis of "sufficient information"; developing culturally sensitive instruments and competence

[72] Like existing communal support mechanisms, formal/nonformal school systems, general healthcare, general mental healthcare, social services, etc.

layered support that serve the needs of the population and covers issues of security, food, community support, non-specialized and specialized services (IASC 2007).

IV. Challenges of humanitarian psychology

Implementing different psychosocial interventions in emergency and post-emergency settings has presented multiple challenges.

First, the IASC guidelines addressed key challenges of humanitarian psychology like problems in 1) coordination 2) cultural awareness and translation 3) technical competence 4) the role of human rights 5) the need for a holistic comprehensive treatment, 6) inadequate monitoring and evaluation, 7) over-diagnosis, especially PTSD, 8) un-attending to resilience. The literature also focuses on challenges faced by the psychologists themselves when they are implementing psychotherapy in humanitarian emergencies (Thomsen & Bjenrgaard 2009).

Second, the departure of humanitarian organizations from long-standing humanitarian principles have caused violations of the "do no harm" principle, jeopardizing what humanitarianism represented (Wessells 2006; Anderson 1999; Rieff 2001). Implementing psychosocial interventions predicates a sense of trust and security between the interveners and local communities. But when these communities view humanitarian workers as spies and "arms of government", talk therapy becomes an impossible and dangerous practice (Wessells 2006). In addition, humanitarian workers, no longer perceived as heroes and altruists, are themselves at heightened risk when local communities identify them as part of a military intervention (Wessells 2006).

Third, the changes in the nature of humanitarian action have further complicated the ethics of intervention. Humanitarian workers are now more than ever accused of sacrificing their humanitarian principles, of having a political agenda and interfering in the politics of the

countries in which they seek to aid (Rieff 2001; Reyes 2006). As a result, the casualty rates of humanitarian personnel skyrocketed and many NGOs withdrew from sites of emergencies because of lack of protection (Reyes 2006). The symbol of the Red Cross became a target for kidnapping and assault. Providing culturally appropriate, efficient and long-standing psychological interventions in these situations thus became problematic and difficult. As a result of these ethical challenges, humanitarian psychological interventions became less interested in communal approaches to treatment and e more focused on immediate, fast and clinically based interventions.

Fourth, ethical issues emerged in the relationship between mental health humanitarian professionals and aid communities (Crosby & Grodin 2007; Joshi, Dalton & O'donnell 2008). Some of the issues raised were: 1)differential power relationship; 2)being treated by a western-based trauma diagnosis and intervention; 3) issues of informed consent; 4) confidentiality of the patient; 5) hospitalization decisions; 6) assessment of professionals' motives and treatments; 7) cultural translation of western diagnoses and treatments; 8) the value of religious and cultural practices and norms; 9) the ability to ensure sufferers' autonomy and independence in treatment; and 10) cross-cultural concerns (Crosby & Gordin 2007; Joshi et.al 2008; Aubé 2011).

Fifth, another challenge of humanitarian psychology is the mental health of the humanitarian workers themselves. The militarization of humanitarian action has become a common feature of conflicts in many parts of the world (Hammond 2008). This contributed to blurring the distinction between humanitarian workers as idealized aid-providers and social actors participating in the conflict. In this new context, humanitarian workers became another form of "vulnerable" populations whose mental health required attention by psychological programs during emergencies (Holmgren et al 2003; Holtz et al 2002). A number of studies have

conducted surveys to study the prevalence of psychological stress, psychological symptoms, and mental well-being among international and local humanitarian staff workers in emergency setting (Jessen-Petersen 2002; Putman et al 2001; Berk 1998; Holtz et al 2001; Cordozo 2002; Putman et al 2009; Bierens De Han 1998; Filot 2006; De Hann 2008; Ehrenreich & Elliot 2004; Ehrenreich 2006)[73]. These studies suggest a need for an organizational and institutional awareness of the psychological vulnerability of the humanitarian worker during emergencies, in order to better prepare the personnel for humanitarian service[74] (Ericksson et al 2009; Ehrenreich & Elliott 2004; Putnam et al 2009).

Critique of global trauma programs

Derek Summerfield's (1998; 2000, 2004) critiques of trauma programs and international psychological interventions in emergencies are the most prominent critiques in the literature. In *A critique of seven assumptions behind psychological trauma programs* (1999), Summerfield discusses the rise of psychological therapies and the global medicalization of war and suffering. He argues that PTSD turned war into a technical problem with short-term solutions, thereby reframing our understandings of war and suffering (Summerfield 1999). Summerfield questions

[73] The forms of psychological interventions used for humanitarian workers vary but are designed separately from interventions for civilians and communities in war (Bierens De Hann 1998). Emotional debriefing in groups seems to be the favorite form of intervention for the ICRD stress management unit (1998). This form of intervention is used because it is immediate and serves to de-traumatize staff, although evidence-based research has argued against its usefulness (Bierens De Hann 1998). Other forms of interventions and treatment seem to be less reliant on the PTSD and trauma model but focus more on philosophical and lexical approach to reconstructing meaning in one's life (Filot 2006). When psychological interventions were adopted, special roles and recommendations were provided for the psychologists (Filot 2006). In summary, the humanitarian workers seem to be perceived as a special population, as innocent and vulnerable as children who experience violence in a different way than others and who are in need for specialized therapy.

[74] Overall results from different surveys showed that humanitarian workers are exposed to traumatic events for a number of reasons like, the idealist set of morality that normally surrounds a humanitarian workers' ethics; the lack of familial and communal network for the international or expatriate humanitarian worker; the changed perception of the humanitarian worker from a hero to skeptical entrepreneur (Cordozo 2002); and the type of job that requires constant exposure to traumatic events, narratives, stories and settings (Ehrenreich &Elliot 2004; Ehrenreich 2005; Holmgrem et al 2003).

the different assumptions that lie behind psychological trauma programs, one of them being that victims would do better if they "talked through" their problems. He views PTSD as a socially constructed disorder, a product of political and medical categories that serves for the recognition of suffering and a compensation for victimhood, especially in places where there is a material gain from being a victim (Summerfield 1999).

In another article entitled *Childhood, war, refugeedom and 'trauma': three core questions for mental health professionals* (2000), Summerfield looks at the encounter between the child refuge and the mental health professional to generate critical questions for mental health professionals. By looking at the encounter itself, Summerfield attempts to highlight the disparity of power in the clinical encounter and the type of expert knowledge produced by this encounter. Through this encounter, the refugee child's experience is appropriated by the clinician and is reduced to medical trauma (Summerfield 2000). This form of critique focuses on the process of de-politicization of violence that happens through the trauma discourse, where suffering becomes individualized and turned into a biological, context-independent pathology[75] (Summerfield 2000).

V. Introducing Humanitarian psychology in the July War: the new challenges of Lebanese psychologists

After the July War, humanitarian psychology became institutionalized as part of the evolving humanitarian presence in postwar Lebanon. While emergency trauma programs were administered in response to the war, they either eventually transformed into psychological

[75] Almedon & Summerfield (2004) discuss the increase of the professional interest in mental well-being in the last two decades, especially around PTSD and trauma. The medicalization of emergencies has brought new forms of techniques, a repertoire of humanitarian "things" and experts, from manuals, workshops, portfolio to lawyers, psychologists and programs. Time alone is no longer enough to heal the psychological wounds of war (Almedon & Summerfield 2004).

development work or they were implemented to address other humanitarian crises in Lebanon. International non-governmental organizations opened offices, created jobs, provided funding, trained local practitioners, and established partnerships with local NGOs. Local partnerships allowed for the circulation of standardized psychological global guidelines, programs and manuals, where organizations were now bounded to global forms of expertise and economies of aid and care. Manuals (like the Mental Health Gap, Psychological First Aid, and Debriefing), standards for coordination (like the inter-agency guidelines for mental health and psychological support) and assessment trainings following diagnostic tools like the DSM circulated between experts as technologies of humanitarian psychology.

Raising awareness and psychological education became strategies integral to any kind of humanitarian developmental program in Lebanon, transforming emergency trauma programs into long-term ones. While the focus had been on training experts on emergency psychological assistance, a plan was set to develop mental health services that could serve as prevention for future wars (OCHA 2006). Training local practitioners on mental health assessment and diagnosis served to institutionalize humanitarian psychology in postwar Lebanon.

With this institutionalization, the profession of psychology transformed, as psychologists were asked to leave their clinics and reach out to communities seen in need of psychological care. No longer was psychotherapy an intervention for middle and upper middle class patients- as was the case in Lebanon before 2006[76]- while the poor were more like to be incarcerated in psychiatric hospitals (Khoury & Tabbarah 2012). After the July War, mental health became a

[76] Before the July War, seeking psychotherapy would cost around 100.000 Lebanese Pound for one session (the equivalent of 75 American Dollars), while there were very few options for much cheaper mental health services, like the outpatient clinic at the American University Hospital. However, these cheap services meant that the patients' cases were attended by intern doctors and psychologists like myself.

human right issue. Humanitarian psychology made psychology and psychiatry accessible to people who have not had access to these services before, like 'marginalized' communities in the south and east Lebanon, refugees, and women suffering from domestic violence. This was also done on a larger scale, where psychologists were making more money working with NGOs and serving humanitarian aid communities than in clinics. Psychologists became trainers, teaching psychological expertise to a wide range of practitioners like social workers, nurses and doctors[77].

The new challenges of humanitarian psychologists in Lebanon

"I can't look at them the same way" said Leila, "I have to attend to each of them differently". Having been a humanitarian psychologist with International Medical Corps (IMC) for a number of years, Leila's training as a psychotherapist did not prepare her to the kind of work and treatment she was providing for Iraqi refugees in Lebanon. Like most Lebanese psychologists, Leila was trained in Lebanon and Europe on administering psychotherapy in the clinic. Working with INGOs however has pushed her to do something she called "outreach psychotherapy": going to families' houses and assessing their basic needs while providing them with psychological support and treatment. "They did not know it was psychotherapy" she added.

When a community center for Iraqi refugees opened in Beirut, and with more awareness and outreach from social workers, Iraqi families started coming into the center, Leila continued to do things that she considered to be not part of the profession of psychology: trying to help refugees get a job, coordinating meetings between them; things that usually a social worker would do: "It is not possible to do actual psychotherapy with Iraqi refugees since they lack the basic structural way of living" she added, explaining Maslow's hierarchy of needs to me, a tool many of the psychologists and humanitarian workers now use to identify aid priorities.

[77] And sometimes to experts identified as providers of care like policemen and judges.

Iraqi refugees arrived to Lebanon fleeing different forms of violence (sectarian violence, state violence, regime oppression, massacres, US war on Iraq). They became a humanitarian priority in 2008 as reports (O'donell &Newland 2008; International Crisis Group 2008) declared the need for humanitarian assistance for an estimated 20,000 to 50,000 refugee in Lebanon (IOM 2008). High levels of psychological distress was detected for Iraqi refugees who have witnessed assassination of relatives, massacres, kidnapping, torture and rape (IOM 2008; Hijazi et al 2011), many showing psychological disorders[78] (Hijazi et al 2011).

The community Leila was working with was quite different from typical patients she was trained to encounter in psychotherapy. The terrifying violence Iraqi refugees have experienced, their displacement and loss of belonging, the cultural shock they faced when they arrive to Lebanon— "like those African tribes who are shocked at the sight of a white person" — the dire economic situation, the loss of their rights and class; all these experiences produce a special kind of distress. The 'refugee experience'— understood as a mixture of violence, economic situation and environmental stressors— was seen as producing psychological disorders and pathology and was therefore in need for psychological treatments.

Even if Iraqis speak the same language as Lebanese, Leila felt that they still experienced a culture shock in Lebanon, a more open-minded society. Leila understood the refugee experience of Iraqis as producing violence within the family itself, making men more violent towards their wives and children when facing the changing traditions and gender roles. "Some of them come with terror in their eyes, then they disappear. They don't want to talk. Other come and talk and they feel better", she added.

[78] Terre des hommes-Lausanne (Tdh-L), who were providing psychosocial support and counselling to Iraqi refugees in Lebanon, found that of the 83 clients who sought psychosocial services, the majority suffered from emotional disorders (92.7%) followed by behavioral disorders (55.4%) and sleeping disorders (48.2%) (Le Roch et al 2010)

Samer, another humanitarian psychologist who works with IMC, explained his experience as a humanitarian psychologist along similar lines. Like many young and established Lebanese psychologists, both Leila and Samer sustain a clinical practice in Beirut and also travel around the country on several psychological programs and consultancy positions, to provide individual and group therapy for Iraqi, Syrian and Palestinian refugees, and sometimes Lebanese marginalized communities. Occasionally, they are asked to come out on morning TV shows to address different psychological topics from autism to child development and psychological disorders. This is part of an earlier trend in hosting psychologists as public speakers of society and health.

Besides their practice and work with humanitarian organizations, Samer engages in research, conduct empirical studies on the humanitarian communities he works with. Working with IMC since the July War, part of his job is to train practitioners and humanitarian workers on assessing, detecting and referring psychological disorders. I followed Samer's in his work extensively in my research. At the beginning of his work with IMC, Samer found himself dealing with problems he was not equipped to handle as a psychologist trained in cognitive behavioral therapy (CBT).

I asked Samer about the difference between practicing psychotherapy as a humanitarian psychologist and as a clinician. Usually, Samer reflected, the psychologist is meeting the patient halfway in the clinic, as the latter has some form of awareness and understanding of the problem she is facing: "I don't have a hard time in Beirut (in my practice), one comes (to the clinic) and knows what his problem is, even if he sometimes does not have psychological insight". But when working outside the clinic in a region like South Lebanon, there are many challenges for

therapy as "there are certain beliefs here [in the south] in things like *arwah* (spirits) and *Cha'waza* (sorcery)".

The communities Samer was supposed to treat had many other pressing needs than individual psychotherapy. This frustrated him in his work as he did not know how to efficiently intervene as a therapist. Samer found himself in an unfamiliar place, unable to act as therapist without relying on other skills like social work[79]. When he first started working with Palestinian refugees, he changed the way he was practicing psychotherapy. He came to realize how culture can have a severe influence on one's psychological state, citing as an example how the individual intelligence (IQ) of Palestinian refugees can be severely transformed and affected by "refugee culture".

This is where awareness sessions become crucial and useful for the work of humanitarian psychologists like Leila and Samer. They aim to address the inaccuracy of certain belief systems through highlighting psychological knowledge. Samer stressed that "usually one's *tathkif al nafsi* (psychological acculturation) is achieved by the person herself". But here in the south, and when working with Iraqi and Palestinian refugees in general, Samer found himself doing something different than psychotherapy. He called it "social therapy", where he focuses on psychologizing the social rather than the individual-psyche, in order to instill psychological education as a pre-requisite to individual psychotherapy. Samer does that through focusing on the different relations and connections between the psychological-interior and the social-exterior, links that are normally already present within individuals who seek therapy: "Is the lack of psychological

[79] He kept insisting that he was not trained to know "case management", something he felt was the job of a social worker.

awareness a result of poor socio-economic status", he reflected rhetorically, "or is it the other way around? In this society, there are no consistent studies on this issue".

VI. Conclusion

Based on practitioner, humanitarian and anthropological literature, this chapter provided an overview of the history, models and challenges of humanitarian psychology: a moral, scientific and material mode of intervention that emerged in the late 1980s as a reflection of the new humanitarian identity, and the moral imperative to psychologically intervene in emergencies. This chapter provided an overview of the changing humanitarian identity that allowed for the fusion between humanitarianism and psychology. It gave a review of the models used in humanitarian psychology, most of which were implemented in Lebanon. The last two sections addressed the challenges of humanitarian psychology in general then introduced the emergence of humanitarian psychology as a mode of intervention after the July War in Lebanon, presenting the new challenges faced by humanitarian psychologists in Lebanon.

Chapter III

Humanitarian Therapies of War: Trauma and the Politics of Suffering in Israeli Wars (1982-2006)[80]

I. Introduction

In a public speech delivered during Ashura in 2009[81] and aired by multiple television channels, Sayed Hassan Nasrallah, Hezbollah's secretary general, addressed the role of "global organizations [that were] studying the psychological effects of war in South Lebanon, but found only resilient people"[82]. For Nasrallah, humanitarian organizations that arrived in the south by the end of the July War were unable to detect clear signs of trauma, leading them to conclude that they were facing "a special and unique phenomenon in history"[83]. Nasrallah then declared that military resistance to Israel would not be shaken by war. He rhetorically read the 'unique' and exceptional absence of war trauma as a clear sign of winning the war, at a time when heated debates were still raging on which side had won.

[80] A version of this chapter was published here http://cskc.daleel-madani.org/paper/humanitarian-therapeutics-war-and-politics-trauma-and-violence-lebanon (Moghnieh January 2015).
[81] Ashura, the commemoration of the martyrdom of Imam Hussein by Shi'a muslims, is a religious mourning practice that took on different socio-political and ideological meanings after the July War. This commemorative mourning practice also served as a psychological healing place where crying and expressing grief and pain as a community was acceptable.
[82] Al Masih ne'ma lil nas: Nasrallah yatawakaf 'an al kalam wa yadmyadma', Tayyar.org, Arabic, December 27th 2009, http://www.tayyar.org/Tayyar/ArchivedNews/PoliticalNews/ar-LB/2010/1/28/hasan-%20nassrallah-98024470.htm [last accessed on March 18th 2016].
[83] Same citation as above.

In doing so, Nasrallah relocated trauma from a psychological and individual embodiment of terror and violence, into a strategic tool of war itself, utilizing its absence to mark victory and heroism, and show the enemy's weakness and vulnerability. In earlier speeches prior to Ashura, Nasrallah addressed the fundamental role of psychological warfare during the July War. Indeed, psychological warfare was a major part of the war, where terrifying the enemy and breaking its morale was seen as an important weapon. For example, the use of the Dahiyeh doctrine – a new military strategy that targets civilians and civilian urban infrastructures for the purpose of causing civilian suffering and local rebellion against the opponent party – was a form of psychological warfare that aimed at shaking the morale of Hezbollah's supporters. Trauma became a crucial actor in war making, as endurance and resilience during war – which meant controlling one's fear and psychological state of mind- became tools of resistance employed against Israel.

Three years later, as I started my dissertation research, I sat in the office of the chair of Psychology department at the Lebanese University in Beirut asking my first official research questions on war trauma in Lebanon. Dr. Elham El Hage, both an academic and a psychologist, worked with many international humanitarian organizations on psychological and trauma-focused interventions, particularly in South Lebanon. As a humanitarian psychologist, she worked with 'l'Association pour la protection de l'enfant de la guerre' (the Association for the Protection of the Child from War) after the Qana massacre in 1996 and with Medecins Du Monde, targeting people who have been victims of torture in the *Khiam Detention Center* during Israeli occupation (see chapter one). In 2006, she also worked with War Child and the 'Movement for Peace, Disarmament and Liberty' (MPDL) on psychological projects for children combining psychotherapy with recreation in different schools in the south.

I asked Dr. El Hage whether she had encountered many cases of trauma or, broadly defined cases of psychological shock. Her response complicated my simple yes or no question by evoking the different epistemic ways of seeing psychological suffering in sites inhabited by war and violence. Once again, an absence of trauma was evoked in the face of the plethora of humanitarian interventions that were deployed to find trauma for different war affected communities:

> *"There is a book that a fellow psychologist published. He did a study on PTSD and he found its prevalence to be 25%. I am surprised at his findings. Since the liberation (of Lebanon from Israeli occupation) until the 2006 war, I would say that there is around 2% of PTSD. I doubt his numbers. At first glance, one might see PTSD symptoms, and, in a survey one might answer the questions in a certain way but when you dig deeper you will see that there is no trauma. In our work, we can know who is prepared for war and who is not. (...) We did an assessment study (in 2006) and we found that people were immunized (against war). The psychologist working in the field knows that this is not trauma. People have different ways of dealing with war."*

Above all, Dr. El Hage evoked a certain contradiction in finding trauma as a universal form of suffering, by citing disputed prevalence rates and different ways of seeing experiences of violence that signaled an embedded politics of suffering particular to the context of Lebanon.

This chapter addresses the humanitarian difficulty in finding trauma following Israeli wars in Lebanon, while PTSD cases were easily detectable in Israeli soldiers and civilians. The difficulty faced by humanitarian experts in finding war trauma during the July War in 2006 can be traced back to the Israeli invasion of Lebanon in 1982, where humanitarian experts had similar trouble locating population traumatized by war. Debates around the absence of trauma emerged in both wars to explain the nature of war and the politics of suffering in Lebanon. I seek to problematize this humanitarian trouble by showing the multiple meanings and values that this

elusive, discursive and scientific thing called trauma took on for different stakeholders and communities in Lebanon.

I approach the absence of trauma in Lebanon not through the lens of social constructionism – simply examining how trauma manifests differently across cultures– but by reading this absence as ideologically and materially produced in relation to Israeli wars. Hence, this chapter is not about whether or not there actually was trauma in Lebanon in 2006 and 1982. I do not think that this question can be separated from the political and ideological life that trauma immediately takes on when it is evoked as a discursive concept and as an object of science circulating in everyday life. I am more interested in understanding why it was so important to find trauma in the first place, or, in many cases, to find an absence of trauma. Why did some experts, politicians and people feel that the lack of recognizable suffering after war was very problematic, while others found it to be a unique phenomenon that reflected victory, and illustrated, yet again, Lebanese resilience?

This humanitarian difficulty in locating trauma can be identified through different registers. I first consider this difficulty through my own ethnographic trouble in starting my research on trauma in a health clinic in Khiam village in the South Lebanon, in 2012. I then look at the difficulty in finding trauma in the July War and the debates that emerged around suffering from war. Dr. El Hage's insights and critiques of trauma were shared in various tones by other local practitioners I met. The third section introduces the problems faced by humanitarian psychologists in finding trauma in 1982 and the debates that emerged around it. In the fourth section, I analyze the debates on trauma and war by looking at the different theories of subjects and suffering embedded in them. Debates on suffering from war in Lebanon following the 1982 invasion and the July War relied on the assumption that war trauma is a psychic manifestation of

suffering that naturally emerges during war. Its absence led to representations of Lebanese as indifferent and resilient to war, as well as uncivil subjects incapable of articulating a modern and individual form of suffering. I unpack these claims of 'exceptionalism' by showing the different theories of violence and suffering behind these debates. I introduce the non-traumatized subjects encountered by humanitarian psychologists— like the liberated prisoners of the *Khiam Detention Center* (see chapter one), whose suffering resisted psychotherapy and psychologization. I argue that subjects took on a position of *soumoud* (steadfastness and resistance), suffering from Israeli war and violence in ways that were not traumatic. The last section introduces the story of Bilal, a narrative that further complicates both accounts of trauma from and resistance to Israeli war and occupation.

II. Absence: violence, psychological aid and the trouble of finding trauma in a Khiam clinic (2012)

I began my research on trauma in the village of Khiam in South Lebanon; a village with considerable exposure to both Israeli violence and subsequent humanitarian psychological aid. Khiam's history of violence – in the form of Israeli war, massacre and occupation – is no different from many villages in the south, except the *Khiam Detention center* established by the Israeli Defense Army (IDF) in the Khiam village during the Israeli occupation (see chapter one). For my ethnographic site, I chose a health clinic belonging to a local NGO, Amel Organization, with an established history of aid in the south and collaborations with global humanitarian organizations like Medecins Du Monde[84].

[84] Amel was established in 1978 during the civil war as a response to the massacre of Tall Al Zaatar by Kamel Mohanna, after finishing his medical degree in France. The organization would later become a common local partner for international humanitarian intervention**.** Mohanna's close friendship with Bernard Kouchner- whom he met while studying medicine in France- developed into a close partnership between *Medecins du Monde and Amel*.

Amel's clinic in Khiam, founded in late 2000, offered primary health care services that ranged from gynecology to physiotherapy[85]. It has since been one of the main clinics in the south frequented by global humanitarian organizations; like the United Nations Development Program (UNDP), Medecins du Monde, and Medico International. Psychological interventions became a main service in the Khiam clinic especially after the liberation of Lebanon in 2000, where psychological services mostly centered on the ex-detainees of the *Khiam detention center*. During the July War in 2006, Amel, partnering with *Medico International*, started a series of psychological programs in the clinic for war affected communities. These programs were then extended until the end of 2008 to focus on the psychosocial support of mothers and children in South Lebanon, while continuing to provide psychological rehabilitation for the liberated detainees.

The clinic was a big two-floor house with an outside garden. It was located at the center of the village square, unavoidable to anyone entering the village. The first floor consisted of a big waiting room and staff offices, while the second floor had small consultation rooms. Badly damaged during the July War, the center was fully renovated and repaired by the time I arrived to start my research.

Throughout the clinic, posters on health and mental health hung on walls and a variety of health brochures were left in the waiting room. Different subtle signs indicated the psychological nature of the clinic. A big plaque, hanged at the entrance, read "Amel's psycho-physiological center", while a barely visible and smaller plaque placed inside the clinic referred to the clinic as Amel's "Center for the Treatment and Integration of Detainees". The little plaque, and the many others that surrounded it, were all engraved with the names of different global humanitarian

[85] The clinic became fully equipped to receive visitors in 2001 with the support of the Japanese Embassy.

programs that passed through the clinic. They showed the history of global humanitarian assistance and their marks in the south. While these plaques filled the wall of the staircase, the clinic itself, almost too big for its own services, seemed almost empty.

The subtle signaling of the psychological, weaved into the clinic's title of medical services – and safely rephrased as 'integration', and overall assistance to detainees – is a result of the merging of psychological interventions and medical practice in the south, as a way to avoid community' resistance to therapy. Amel's mental health program manager, a young French woman who first joined the organization as an intern, identified Amel's Khiam clinic to me as a good site for my research on trauma**.** She was quick to point out that psychological therapies had 'infiltrated' into social and medical services as many people, like the prisoners of the *Khiam Detention Center*, "would not admit they were suffering from psychological problems"[86]. This was a recurrent problem; in her words, it became increasingly "hard to define and measure what is psychological, and what is not"[87].

In the Khiam clinic, I met Sana, the social worker who had been working intermittently with Amel for more than 30 years. Sana was managing appointments for dental services offered in the clinic – showing people into the dentist's office and collecting nominal fees on their way out. My first encounter with Sana was rather awkward. I told her about my research and we agreed I would visit the clinic to observe psychological services. However, Sana was at a loss, she didn't know what exactly I would be observing that would count as psychological. She suggested that I come back on Wednesdays to observe the weekly reproductive health awareness

[86] Interview with Amel's mental health coordination, 2013.
[87] Interview with Amel's mental health coordination, 2013.

sessions she conducts with women from the village. Next week's topic was going to be about *gender*. Maybe this counted as a psychological topic I would be interested in?

Sana took me on a tour to show me the different projects implemented in the center. At the far end of the lobby she showed me the 'project room', where different handmade projects were made to use in health awareness sessions. She showed me a breast prosthesis, a fake breast "to teach breastfeeding" and a house of "good food", where different kinds of food items like rice and pasta were glued on a wooden platform– used to exhibit good eating practices. Confused over the purpose of the tour, and concerned that Sana might not have understood the purpose of my research, I tried to reiterate my project to her once again, asking her to remember the psychological interventions done in the clinic after the July War. Sana smiled and said in a matter-of-fact tone:

> *"The doctors came and did activities here for the children, but no one was affected. We got used to it, war became a habit for us. They did plays for the children, they brought them broken and torn dolls, so that they can express themselves and the war, but no one was affected. It became a habit since we have all been displaced from this village (because of wars) seven times already. (Eventually) the doctors said that they themselves needed treatment".*

After the war, psychologists focused on children as the most psychologically affected groups. Through fun activities and plays, they tried to heal children from trauma caused by war. Sana's commentary took on an ironic tone. The doctors themselves said that they were going to need treatment, since none of the children responded with distress to the sight of torn dolls, symbolizing injured bodies and psyches. Although Sana did not identify these doctors, their programs were part of the many psychological programs that passed through the clinic for the July War.

Remembering the infamous *Khiam Detention Center* and the clinic's plaque that spoke of the treatment and rehabilitation of the prisoners exposed to torture and illegal detainment at the hands of the Israeli forces, I anxiously asked Sana about this program:

> *"There were programs, but the prisoners did not like them, they said "How do they want to integrate us? Do we need integration? Now, they (the international organizations) found work for everyone, and if they found jobs in Ogero (the electricity company), then they gave it to them."*

"Are there any more mental health programs here"? I pushed again.

> *"No, now it is over. They forgot, I am sure that they forgot. It is like when someone dies, with time you forget (…) they say everything gets stronger with time, except for pain, it becomes weaker".*

I never exactly learned who 'they' were, nor what particular violent experience they had forgotten. Perhaps Sana was referring to the detainees and their experience of torture. Perhaps she was referring to the experience of July War and the unaffected children. Perhaps she referred to all these experiences together, to the practice of forgetting and carrying on, after Israeli war and violence.

Dr. El Hage's experience with treating detainees of the *Khiam Detention Center* in Amel corroborated Sana's account. As one of the psychologists who worked on the psychological program for the detainees at the time, Dr. El Hage was taken aback by the lack of detainee participation:

> *"During the liberation we worked in a medical center. We introduced psychotherapy in medical treatment. The center was a medical one that had numerous specialties and with them we snuck in psychotherapy. This way there was less '"stigma"' (in English). But, to be honest, we were surprised (…) the prisoners were considered heroes by the family and society, so they did not come to us to ask for psychological help. It was not hard for them to return to society. We focused on the middle cases and we started going to them and knocking at their doors to do psychotherapy at home. And you know that*

normally in psychology, ethically speaking, the psychologist is not allowed to follow the patient. The patient must come with his own free will to us. But then, this is what we did so we could treat them"

Reflecting on her experience as a psychologist in these programs, Dr. El Hage had ethical concerns regarding the psychological programs for the detainees. She felt that the program failed in providing psychological care:

"My assessment then was negative. The European Union and the Medecins du monde came and they wanted to do psychotherapy. But what is the use of psychotherapy if one has nothing to eat and has no job or future? So the project was a failure. We insisted that they (MDM) give them workshops on vocational training. So they did, and they also gave them loans and rehabilitation to work in hotel services."

What started off as a psychological war and torture program that focused on unearthing and treating individual trauma and psychological distress ended up being a vocational program to help the ex-detainees secure a job and a future. For Dr. El Hage, stand-alone psychological programs were not successful because they neglected the economic factors essential for an integration into society and for a psychological healthy life. This became an ethical issue: How can she, as a humanitarian psychologist, work with patients on therapeutic recovery when they have no future, no jobs or economic income?

'A'dath' (events): the temporality of violence and suffering in Khiam

On my second visit to the center one morning, I waited for Sana outside her office to finish her paperwork. It was a cold February morning and there were no services provided at the clinic. The woman responsible for cleaning the center –a local from Khiam– was smoking a cigarette outside and asked if I wanted to join her for a smoke. I explained that I was trying to quit. She nodded in sympathy. She had quit smoking five years ago but she started again. "I have

been in a bad psychological place, you know, because of *al-a'dath* (The events), then I lost my father as well, so I started smoking again. Now, I just smoke to pass the time".

I wondered which "events" the woman was referring to. Was it the civil war events, regularly called *al a'dath* to refer to the intermittent nature of the civil war? Or the experience of being displaced seven times because of Israeli aggressions? Was she referring to the July War itself, as a series of violent events? She must have been referring to the July War, I concluded, since it is the only event that occurred around five years ago.

In her office, Sana was dealing with a few villagers who came asking for medications and health advice. She asked me again what I needed to do exactly, still confused by how to help and guide me. I presented my research project to her again and she said, "Look, you are the one who should categorize what things are psychological in my work and what is not. For me, this is my work and I do it spontaneously. But you have to categorize it and tell me so I would know what things I am doing are psychological and what things are not". Both of us were having a hard time figuring out what was "psychological" about the clinic. She was having a hard time knowing what psychological 'things' to show me, and I was having a difficult time seeing them.

I went outside to the garden to find most of the staff there, including a young doctor who was on duty in the clinic. As the sun rose above the village around 10 am, we sat in the garden while the nurses and the doctor joked around, stealing each other's pens and playfully teasing each other. Coffee was served and they started chatting about life in the village. One of the nurses spoke of a man who had lost three of his wives consecutively during "the events". It seemed that two of them were killed by different episodes of violence, and he divorced the third one. *Al a'dath* were evoked to talk about a conglomeration of wars as a series of events, to signal a condition of permanent war. Interrupting the fun and games and the gossip session about the

locals, the doctor sipped his coffee slowly and said, "The war is coming. But when…that is the question. But the war is coming."

We all fell silent for a few seconds, staring at the rising sun and the landscape overlooking the garden, as if we were trying to see traces of the new and upcoming war that seemed so inevitable here in the south. The future, always impregnated with a new war… Then we continued joking, talking and sipping coffee. Shortly after, I left the clinic, having found no traces of trauma, no sign of the psychological.

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At the time of my research in 2012, many of the global humanitarian organizations that attended to psychological interventions during the July War in Lebanon had relocated their mission to countries like Libya and Tunisia when revolutions erupted. But this recent relocation does not explain the whole story of absence. My surprise at how difficult it was to detect the psychological, and the constant need to extract it from social workers and nurses in a clinic equipped to provide mental health assistance was not unique. In 2006, many humanitarian organizations faced similar difficulties while trying to implement their psychological programs for war-affected communities.

International Medical Corps (IMC) arrived in Lebanon in 2006 to provide psychological assistance in the form of clinical diagnosis and treatment of war trauma. Its regional officer[88] spoke of how the organization had to quickly change strategies when they found that the humanitarian trauma model was useless in capturing people's own lived experiences of war and loss. She argued that the Lebanese did not experience the war as traumatic but rather as an expected and anticipated event. IMC's war trauma therapies were quickly transformed into

[88] Interview with IMC regional officer 2013.

interventions that worked on facilitating processes of grief and loss that focused more on psychosocial activities, and on integrating mental health in primary health care facilities in Lebanon.

As my short time at the Khiam clinic had shown, accumulative experiences of war, violence and displacement by local practitioners– who themselves had lived through occupation, invasion and war– did not produce a solid frame of suffering (Butler 2009) that could be recognized by humanitarian psychologists. Instead, trying to find trauma by using pieces of torn and broken dolls elicited a humorous and somewhat ironic reaction from Sana as she remembered how these programs did not, and could not, capture children's experiences of war.

Sana's commentary on the 'doctors' who went mad in the face of an absence of suffering signals their inability to fathom a way of living entangled with war. Past and future Israeli violence overshadowed the clinic and the mundane conversations during my visit. The different episodes of violence experienced in Khiam were regularly spoken of as a series of perpetual "events". They were seemingly unfinished incidents of violence, entangled with the everyday.

Sana's description of war as habitual is indicative of this temporal experience of war and violence in the south, not as a sudden and unfathomable event, but as a recurrent and anticipated event that one can be ready for and "immunized" against, as Dr. El Hage mentioned. This temporality disrupts psychiatric and humanitarians models of trauma by relocating violence into the everyday life (Das 2007; Kleinman, Das & Lock 1997). As Sana suggested, being displaced more than seven times from her village from different wars has turned one's suffering into something other than traumatic.

III. The humanitarian trouble in finding trauma in the July War (2006): challenges and debates

In this section, I continue to recount the trouble of finding trauma. I retell the story of an absence of trauma by exposing the different expert debates emerging around experiences of suffering from the July War. A reading of these debates helps us uncover the politics of trauma as an object of science with specific assumptions about the nature of violence.

As part of the humanitarian relief provided in 2006, many global humanitarian organizations like the International Medical Corps and Red Cross Federation arrived to Lebanon to provide trauma-related therapies and interventions. The World Health Organization (WHO) called the Lebanese ministry of health to mobilize local psychiatrists and psychologists and open psychiatric hospitals and facilities to receive traumatized communities – especially children. These interventions mostly focused on clinical therapies of 'war trauma' that shared the same principals as the humanitarian trauma model (see chapter one).

While WHO called for action in anticipation of a mental health war epidemic, the hospitals and mental health centers remained relatively empty, and PTSD cases did not pour into the clinics as expected[89]. Despite the mobilization of experts, the massive destruction of infrastructure and targeting of civilians, the displacement of over 1 million people and widespread injuries during the war (Human Right Watch 2007), finding traumatized subjects proved much more difficult than originally anticipated. In fact, the search for 'war trauma' in Lebanon became a daunting task as humanitarian workers and experts tried to implement different trauma-related interventions. Debates over four key concerns emerged as a result: the most appropriate mental health model to use during war; contradictory prevalence rates of

[89] Conversation with psychiatrist Sami Abou Rish, 2015.

trauma; the difference between finding trauma in the clinic and finding it in the field, and finally, trauma as warfare versus as a sign of modernity.

Clinical or communal model of mental health?

In response to the July War, volunteers were loosely formed under *Samidoun* (steadfast and resistant) to provide aid during the July War[90]. A group of volunteers, composed of social workers, psychologists, activists, students, theater majors, animators and independent volunteers with various other skills, and also provided psychological and mental health support as part of their broader work (Moghnieh June 2015). Psychosocial activities, like entertainment and games for the children and art therapy, were organically implemented starting the first days of the war, based on each volunteer's skills and resources.

These volunteer-based experiences of psychological support, carried out while simultaneously providing forms of aid, were later discussed in meetings held during the war at the Lebanese Ministry of Social Affairs with different mental health professionals, psychiatrists, psychologists and psychoanalysts. In these meetings, debates emerged to discuss which approaches to adopt in addressing the mental health of displaced families and how best to intervene during war. Following WHO definitions of mental health, and its call for intervention of trauma, some psychiatrists and psychologists argued for the importance of diagnosing and treating PTSD with medications, and suggested that mobile psychiatric clinics could be set in places that hosted displaced families in Beirut, like schools and gardens[91]. Others disapproved of the use of the clinical trauma model and advocated for a more culturally-based and community

[90] Samidoun was "a grassroots relief collective and platform encompassing multiple and divergent forms of relief, initiatives, expertise and volunteerism, that engaged in aid provision during the July War" (Moghnieh June 2015; Chit 2007).

[91] Interview with Ola Ataya, 2015.

form of intervention that can best capture what Dr. Anissa el Amine – a Lebanese psychoanalyst who took part in the debates– referred to as the "*al-mou'ash*"[92] or 'the lived experience' of (living in and anticipating) Israeli war and violence. This type of community-based mental health was thought to be more relevant than a blind adoption of global clinical interventions. At the heart of these debates was a critique that PTSD and the humanitarian trauma model do not capture the experience of suffering from war.

Contradictory prevalence rates: the science of surveys and the field experience

Following the humanitarian interest in the psychological effects of the July War, studies found drastically different prevalence rates of PTSD and trauma (Karam et al 2006; Karam et al 2008; Farhood et al 2006; Tanios et al 2008; Shaar 2013; Al Amin, 2008). Some humanitarian workers and psychologists commented on the wide and conflicting range of these prevalence rates, ranging from 2% to 30%. These rates confused humanitarian workers in terms of identifying whether there was a trauma epidemic in Lebanon, and whether trauma was the best model to use in this context[93].

Dr. El Hage's account of her own field experience complicated the story of trauma in Lebanon – detected through surveys and by ticking separate symptoms. She understood war as an event one could be immunized against, expect and anticipate. Similarly to Sana's description of war as habitual, as something one can get used to, Dr. El Hage defined the task of a field psychologist (a psychologist assessing mental illness in the field) in terms of the ability to see beyond surface symptoms and prevalence rates.

[92] Interview with Dr. Anissa Al Amine, 2014.
[93] Interview with Regional officer of IMC, 2013.

I read her statement – that the psychologist working in the field can distinguish between trauma and other more complex expressions of suffering – not just as a simple challenge to what diagnostic measures like trauma surveys can tell us about the state of suffering of war-affected communities, but also as a commentary on the praxis of being in the field and the ability to *see* the complexity of suffering beyond clinical symptomatology**.** A locally-rooted practitioner can tell who is psychologically prepared for war and who is not, regardless of whether these people manifested separate symptoms from a trauma checklist or an assessment survey.

PTSD or depression during war?

In-depth interviews with leading Lebanese researchers on PTSD, have also revealed a trend that PTSD was rarely diagnosed in the clinic during the war. The recorded prevalence rate were mainly found when using surveys or symptom checklists administered to samples of the general population. Leading trauma experts in Lebanon, some of which have found the highest PTSD prevalence rates in their studies, seem to agree that a psychologist rarely sees trauma or PTSD cases in the clinic during war, but what one sees is a significant increase in depression symptoms with people who visit the clinic for help during war:

> *"Let me tell you we have problems in assessing trauma because PTSD, I always say, is a western concept. […] [T]he psychologists that you see and everybody, I mean we don't see them in the clinic. I mean, I am a clinician, I have two days of clinical every week. Nobody comes and says I have [trauma]. I remember [traumatic events], you know? Unless they are very depressed."*[94]

> *"We don't see PTSD in the clinic. But we see depression during war."*[95]

[94] Interview with Leila Farhood, 2013.
[95] Interview with Elie karam, 2013.

What does it mean when PTSD cannot be found in a clinic but only in "the field"? What are the implications of finding increasing cases of depression during wars and conflicts, rather than trauma? First, one must be wary of drawing decisive conclusions from these interviews without a clear understanding of the role of class, gender, and age in those who seek mental health guidance in clinics in Lebanon. Still, keeping in mind the importance of class analysis in this context, finding depression cases in the clinic during war is indicative of how certain social segments of Lebanese communities experience and react to war in ways that produce depression, and not trauma.

The humanitarian trauma model is predicated on the assumption that war is an unexpected violence that disrupts the everyday and produces symptoms like nightmares, distressing flashbacks of violent events, and a constant feeling of fear, helplessness and horror. However, depression as a result of war suggests a condition of being disinterested and melancholic. Becoming depressed during war meant that it was experienced as a form of repetitive and permanent violence with no control over its occurrence. The temporality of violence was experienced in Lebanon is the core issue here. Finding depression and not PTSD in the clinic reveals a different temporal experience of war, not as an abrupt and shocking event, but as repetitive and seemingly permanent. Again, a different kind of suffering is experienced than was assumed by the humanitarian trauma model.

Trauma as warfare and a sign of modernity

Expert debates on trauma and PTSD were soon read by different groups and actors as implying a general absence of suffering. This 'absence' of trauma was claimed as a unique phenomenon in history by Hezbollah – the main military player in the July War – who employed it to mark victory and resistance to Israel, as was evident in Nasrallah's Ashura speech quoted

above. However, at the end of the July War, Hezbollah was accused by its political opponents from the March 14th coalition of encouraging a "culture of death" among its Lebanese Shi'a constituencies. These communities were seen as not properly expressing grief and shock at the death of their loved ones, but rather rejoicing in their martyrdom (Chaib 2011). Their 'culture' was said to revolve around death, normalizing it and sometimes even expressing joy at its occurrence. At that time, the March 14 coalition launched a political campaign countering Hezbollah's "death ideology" by propagating a culture of life with the slogan being "I Love Life"[96].

The absence of trauma was fundamental for these accusations to be viable. At their core, these accusations hold assumptions about what constitutes a modern way of suffering from war and narrating it in its aftermath. The absence of a visible way of suffering during the July War indexed a "culture of death" that was perceived as non-modern and uncivilized, as Lebanese Shi'a were seen to be unable to celebrate life[97]. Nasrallah read the absence of a collective and visible trauma as a natural and somewhat divine phenomenon of heroism and victory. However the same inability to enact a globally recognized frame of suffering (Butler 2009)–such as trauma– was employed in Lebanese politics to index a deficient and uncivilized culture of death.

This alleged 'absence' of psychological suffering from the war, however, was not the result of moral and divine victory, a manifestation of some Shi'a culture of death, or of an inherent Lebanese resilience. In fact, during the war, Hezbollah worked quite hard on maintaining the morale of war-affected communities. It prevented collective psychological breakdown by

[96] **http://seikaly.blogspot.com/2008/12/political-campaigns-in-lebanon-i-love.html.**

[97] The same accusations of "death culture" are constantly employed against Hamas in Gaza in popular media and political analysis. See for example "Israel Vs the culture of Death", The Times Of Israel, Michelle Cohen, English, July 11th 2014, http://blogs.timesofisrael.com/israel-vs-the-culture-of-death/ , [last accessed on March 18th 2016].

providing communities with multiple social, medical and health services, some even mobilized within hours of the arrival of the displaced, where "the relief body of Hezbollah succeeded in centralizing all humanitarian aid within days" (Nuwayhid et al 2011, 513). For example, sport activities for children and prayer sessions for adults were organized in the displacement centers, while there was immediate mobilization to support mothers who lost children in the war (Nuwayhid et al 2011). In addition to the aid organized by Hezbollah, community forms of aid like that of *Samidoun* provided important forms of support for the displaced communities that worked as protection against psychological breakdown. Finally, the rapid return of the displaced to their villages and hometowns at the same day of the ceasefire[98], and the accelerated process of reconstruction of bridges, houses and neighborhoods, all played a phenomenal role in creating a form of communal resistance against trauma (Nuwayhid et al 2011).

For Hezbollah, the presence of trauma among these communities would mean that the war itself was lost. With the war coming to an end, deciding on who exactly won the war became the main topic in media and political analyses. Nasrallah utilized the absence of trauma to mark victory, and show the enemy's weakness and vulnerability. On the other hand, multiple forms of traumatization were being detected in Israeli soldiers, medical personnel and civilians in general**.** Israeli soldiers were returning home, clearly expressing symptoms of traumatization from the war[99]. Trauma and PTSD cases have been easily detected, diagnosed and treated in Israel in 2006

[98] "in a matter of days, the number of IDPs in displacement centers dwindled from 750,000 and 1 million to a few thousand" (Nuwayhid et al 2011)

[99] I quote here only a few studies conducted on trauma in Israel: Menachem Ben-Ezra, Yuval Palgi, Nir Essar, "Impact of war stress on posttraumatic stress symptoms in hospital personnel", *General Hospital Psychiatry*, Vol.29, No.4, 2007, pp.264-266; Menachem Ben-Ezra, "Late effect of the Second Lebanon War: Level of exposure and rates of comorbidity of posttraumatic stress symptoms and depressive symptoms among Israelis from Northern and Center Israel", *The European Journal of Psychiatry*, Vol. 24, No.3, 2010; and Lebanese media reporting on Israeli war trauma: Al Isra'iliyyoun wa sadmat al harb, AlAkhbar, Arabic, July 16th, 2011 http://www.al-akhbar.com/node/16743 [Last accessed on March 18 2016].

(Ben-Ezra, Palgi & Essar 2007; Bem-Ezta 2010), with trauma becoming central to a discourse on victimhood and suffering from war for Israeli soldiers (Al-Akhbar 2011). The striking contradiction between an alleged absence of trauma from war in Lebanon and a dominating and recognizable form of suffering in Israel is telling of the different political and economic values that trauma can acquire in specific contexts (James 2010)**.** In this sense trauma became part of warfare itself. War trauma, or more specifically its absence in Lebanon, was deployed in the psychological warfare between Israel and Hezbollah, the main military player in the July War, and utilized by Hezbollah's political opponents in Lebanon to make cultural claims in national politics on the proper "modern" ways of suffering from wars.

IV. The humanitarian trouble of finding trauma in the Israeli invasion of Lebanon (1982): challenges and debates

Similar difficulties in finding and detecting trauma were experienced during Israel's invasion of Lebanon in 1982, where debates also emerged on the nature of suffering from war and violence.

Israel's invasion of Lebanon in 1982 ended with the partial occupation of the south, and the defeat and subsequent departure of Palestinian fractions from Lebanon. While Israel withdrew from Beirut, facing fierce military resistance, it maintained its occupation of parts of the south. This marked a new balance of power and a temporary suspension of the civil war, allowing for a swift yet brief period of recovery and reconstruction (CDR 1988). Lebanon thus became a postwar site for rehabilitation and reconstruction, where humanitarian interventions from WHO, UNICEF and Oxfam sought to reform health and mental health institutions (CDR 1988; Picard 1996; Cammett 2014).

Following the invasion, WHO advised the Lebanese Ministry of Health to invite an international team of seven professionals to conduct a need assessment survey on the health status of the Lebanese population. This initiative was part of a need to re-organize the health sector in Lebanon that had been considerably destroyed by the Israeli war[100] (WHO 1983; Zurayk & Armenian 1984). Among the international experts, E. Mansell Pattison, an American psychiatrist, was invited to assess the mental well-being of the affected population.

Pattison was established psychiatrist in the United States, with both humanitarian and anthropological interests in other cultures[101]. In 1980, he became the newly appointed Chairman of the Department of Psychiatry at the Medical College of Georgia (MCG), where he started recruiting faculty who were compatible with his interdisciplinary approach on mental health and culture. In the first published edition on *PTSD Research Quarterly* (1990), Patrick A. Boudewyns, a psychiatrist and colleague of Pattison at MCG, wrote about the *Augusta War Trauma*, a project established to "effectively treat multifaceted mental disorders as PTSD" (Boudewyns 1990). The goal of this project was to identify and develop resources for combat veterans suffering from disorders through the use of innovative research programs at both the VA and MCG centers[102]. Pattison seems to have been the one to provide a niche for the project before he abruptly passed away shortly after the program started[103]. It is probably because of this

[100] Lebanon's hospital for the insane for example, introduced in Chapter One, remained functional until it was shelled during the Israeli invasion in 1992, while psychiatric residents were released due to shortage of food, electricity and lack of safety. Many other hospitals were either hit during the invasion or were lacking basic infrastructure.

[101] Pattison was described as comprising "an unusual combination of intellectual curiosity, academic integrity, research skills and human compassion" (Cox 1969).

[102] The objectives of this "special treatment" unit on PTSD was: "Toward a better understanding of the personal aftermath of war and the development of effective treatment for the psychological casualties of combat" (Boudewyns 1990).

[103] Boudewyns concludes by reciting the future research projects that the center is to test and work on within the biopsychological philosophy implanted and encouraged by Pattison: exploring a diagnostic predictor of PTSD and

position that he was invited to Lebanon to assess the mental health of the population and their level of traumatization from war.

In the psychological study (1984) he published about his findings in Lebanon, Pattison wrote:

> *"I fully expected to find a war-devastating population, with obvious evidence of war trauma. Much to my surprise, this was not the case. The Lebanese population, both Christian and Moslem, were relieved, cheerful, energetic, enthusiastic, basically rebuilding their country. It was like a country of buzzing worker bees. I did not find obvious cases of psychic traumatization, and only with difficulty did I unearth indication of indirect effects of war on psychological well-being" (Pattison 1984:35)*

While Pattison (1984) concluded unequivocally that there were no signs of traumatization or mental illness caused by the war, local Lebanese psychologists were much more perplexed at the changing landscape of suffering from war and violence in Lebanon and struggled to provide a psychological narrative about it. In a group interview conducted by Makhlouf (1988) in the mid-1980s at the American University of Beirut, Lebanese psychologists agreed that "what is happening in Lebanon is inexplicable", while one Lebanese psychologist said: "the war (civil war) has made people insane or criminals, but it has also allowed some to discover hidden qualities in themselves". Psychologists noted how categories of normality and pathology were much harder to separate during war and violence (Makhlouf 1988, 35). The choice of inviting international mental health experts rather than relying on the local expertise of psychiatrists and psychologists to assess the psychological distress of the population from the Israeli war in 1982, reveals an earlier desire to reform health and mental health care based on global humanitarian policies and standards.

testing a new and promising desensitization/exposure technique for the treatment of intrusive memories and thoughts: Shapiro's EMDR. The center also plans to work on longitudinal studies of life course of PTSD.

No trauma from war: the resilience of the Lebanese people

Mansell Pattison found himself "impressed by the resilience of the Lebanese people" as he declared in an interview for an article in The Beeper –the Medical College of Georgia (MCG)'s newsletter – entitled *visit to Lebanon leaves impression on MCG psychiatrist: years of war have not dampened spirits of Lebanese people* (1983). He related what he described as an impressive and surprising lack of psychological distress –after eight years of civil war and Israeli invasion – to the historical nature of Lebanon as "the gateway to the Middle East" (The Beeper, 1983). For Pattison, the geo-political nature of Lebanon attracted numerous occupations and wars from Eastern and Western forces, where, over the years, Lebanese "schemed to survive that process" (The Beeper 1983). Pattison related the Lebanese 'absence' of suffering to a historical narrative of Lebanon as a country prone to violence and invasion. Instead of finding "post-traumatic neurosis", Pattison found all Lebanese to be "jubilant to have the PLO removed from their country" (The Beeper 1983), a proud people who have "maintained their national identity, spirit and purpose, regardless of who has occupied their land" (The Beeper 1983)[104]. He compared the experience of US soldiers in Vietnam with that of the Lebanese fighters. He did not see "the Vietnam vet syndrome" in Lebanon, which he found to be the result of meaningless fighting, whereas the Lebanese soldiers were considered heroes.

By the end of his research study, Pattison reflected on the nature of war itself as an experience:

> *"Upon reflection and discussion with colleagues about my observation, I find that I myself, as well as other psychiatrists, have a bias that war is bad.*

[104] The only problems he found were health-oriented, like alcoholism, drug abuse and diseases resulting from bad sanitation and "influx of foreigners" like syphilis, diphtheria and tuberculosis. While these diseases occurred because of the destruction of the health facilities during Israeli invasion, for Pattison it was the PLO who occupied these facilities and used them as military units, thereby participating in their destruction.

> *Therefore, we assume that the psychological consequences of war are bad. In fact, we frame our assessments in terms of degrees of bad effects. However, from a solely technical scientific perspective, we must also consider that a war experience may have no necessary adverse psychological effect, and we must consider the possibility that a war experience might have overall positive psychological consequences for some people in some contexts (…). My experience in Lebanon has prodded me to re-examine the potential for bias in the psychiatric assessment of the effects of war" (Pattison 1984, 37)*

Pattison provided an alternative reading of the effects of war that are not always detrimental but could be experienced otherwise. Unlike the Vietnam War experience, Pattison argued that the Israeli invasion of Lebanon actually had positive psychological consequences for people in Lebanon. However, the Israeli invasion of Lebanon in 1982, like the July War, was experienced as severely traumatizing in Israel by both experts and in popular discourse around war. Zahaya Solomon's research on the prevalence of PTSD disorder during war is a clear example of an established discourse and expert discipline on trauma in Israel. In a series of studies on the psychological effects of the Israeli invasion of Lebanon, Solomon studied the traumatic manifestations of the war in Israeli veterans; symptoms that could still be detected at least three years after the war. A follow up study with the Israeli veterans twenty years after the end of the 1982 war also found similar and significant relations between negative physical health and PTSD diagnoses (Solomon 1987; 1989; 2006; 2009; 2010).

War and the anguish of the intellectuals

Pattison's findings have been addressed and critiqued by Samir Khalaf, a Lebanese intellectual and sociologist from the American University of Beirut. In two separate publications (1985; 2002), Khalaf accused Pattison of only addressing Lebanese suffering on the surface. He insisted on a deeper exploration of Lebanese suffering from war by highlighting the silenced and oppressed suffering of middle and upper class Lebanese**.** In a paper entitled *the Anguish of*

Lebanese Intellectuals (1985), Khalaf recounted the decline of the neighborhood of Ras Beirut from civil war and Israeli invasion – a place he described as bringing together the cosmopolitan, liberal and intellectual elite of both the city and the region at large. The influx of displaced Shi'as, Palestinians, Kurds and Syrians communities into Beirut "traumatized by fear and violence and raging with bitterness and pent-up frustrations" have disrupted life in Ras Beirut (Khalaf 1985).

Khalaf (1985) found Pattison's description of the Lebanese national resilience to war neither reassuring nor flattering, especially that Pattison failed to see "the latent and unrecognized sources of pathology" caused by the civil war in Lebanese society. For Khalaf, there is some truth to this resilience. However, he saw it as a kind of resilience that turns people into minimalist humans, caring only for their survival and becoming unable to maintain a good quality of life both intellectually and emotionally. This form of resilience made people "become less" (Khalaf 1985). For Khalaf, exploring this form of resilience can provide an insight on how violence persists. He argued that if communities stopped coping and collapsed psychologically, then the violence will stop (Khalaf 1985). This form of resilience normalizes violence, making it part of everyday life: "the more adept they become at adjusting, or coping with, the cruelties of strife, the more opportunities the war had to reproduce and sustain itself" (Khalaf 2002, 234).

For Khalaf, the incivility and terror behind violence in Lebanon comes from the fact that it became normal and everyday routine; it became "*a'dath*" – normalized forms of events– to such an extent that war and fear were now seen as part of the country's ethos and mythology (Khalaf 2002, 237). Violence became "a way of life", the only way in which the Lebanese could

make an assertion about "their damaged identities" (Khalaf 2002, 237)[105]. The fact that the war was experienced as a habit was what became traumatic to Khalaf. In that sense, normalizing war as events allowed both for civilians to learn how to live with it and for fighters to turn cold and indifferent towards the violence they were committing. All this creates an inability to concretely identify suffering and heal from it:

> *"In this regard, it might be argued that Palestinians, Jews, Armenians, Kurds, Corsicans, Ulster Catholics, Basques, Serbs, Croats, and other victims of collective suffering are perhaps more privileged. They can, at least, identify and mobilize their outrage against those who might be held accountable for their suffering. The Lebanese are still unable, as a result, to vindicate their collective grievance. They have been hegemonized by fear, terror and grief, but remain divided and powerless in identifying and copying with the sources of their anguish" (Khalaf 2002, 243)*

Suffering for Khalaf becomes part of the intellectual and emotional work that makes one a human being. Remaining in a continuous survival mode and silencing one's suffering, on the other hand, threatens one's own humanity. For Khalaf, the silenced sufferers from war were the intellectual elites of Beirut[106]. The ideological destruction of Ras Beirut, and the suffering of the alienated[107]Lebanese liberal intellectuals constituted a form of silenced trauma that was not captured by Pattison.

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[105] Other effects of the war was "postwar barbarism" manifested in the unleashing of desires and emotions and behaviors outside of "conventional and civilized constraints", from driving, to bargaining and commerce and cheating to smoking in public space. These feelings and desires have been exacerbated by the pathos of a postwar mentality. Also the war has caused a return to "re-tribalization" manifested in a return to the family, community and sect/confession (Khalaf 2002).

[106] Based on a survey he designed and collected in 1983 for more than 900 heads of households of "middle and upper-middle class professionals, semi-professionals, businessmen, bankers, university and college professors, and instructors, government employees, journalists, and the like", Khalaf found "different forms of traumatization" (2002).

[107] Khalaf describes four expressions of these distressful symptoms that summarizes the suffering of the Lebanese Beiruti liberal (1985):

"1. A chronic state of mourning and grief provoked by an irretrievable loss. The loss is all-embracing. They could be lamenting the death of a loved one or friend, lost opportunity, wasted years, or more regrettable the loss of a way of life that might not be restored or recaptured.

V. War, Trauma and Resistance: Non-therapeutic subjects and suffering in Israeli wars and occupation (1982, 2006)

As soon as the ceasefire went into effect on the morning of August 14th 2006, Al Manar TV, Hezbollah's media channel, opened their phone lines for people to call and congratulate the party for the victory. Calls poured in from all around Lebanon, especially in regions heavily bombarded by Israel. The callers talked about how they lost their loved ones, their homes and entire neighborhoods; as well as how they fled to Beirut**.** People used an expression that was very common at the time to describe how their loss as "*fida ijr al sayyed*", a sacrifice worth doing for Sayed Hassan Nasrallah, Hezbollah's Secretary General. I watched the TV channel, listening to people calling and congratulating, while I packed my luggage to return back to the United States. The airport was still closed, so I was taking a taxi to Damascus airport and then flying to Chicago, where I was finishing my Master's degree.

I suddenly stopped packing to listen to a woman caller who was, for a change, angry: "I have lost seven children, I lost all my children in this war!!" The anchorman was taken aback. He rapidly tried to console the woman and tell her that her children were in heaven, and that everyone lost their loved ones. But she was inconsolable: "No, I lost seven of my children. The woman who just called before said she lost only five. And you called her *'Umm Al Chouhada'* or the mother of all martyrs. I am the mother of martyrs, not her. I lost all my children". The

2. A crushing sense of defeat for being diminished and trivialized. The same spirited individuals who led active and creative lives, sustained by genuine devotion to an open and liberal community, are being robbed of a heritage and denied a role. Their earlier exuberance and expansive vision has been whittled away. Their intellectual horizons have also been progressively shrinking. Much of their creative energy is now consumed by obsessive and futile concerns of personal survival.

3. They are also baffled and bewildered. They can neither understand nor predict the outcome of vital events. Nor can they participate, as they once did, in the cardinal decision, much less control the mundane exigencies of daily life.

4. Finally, they continue to re-experience a pervasive sense of impotence and powerlessness. They are entrapped and suffer all the indignities of captivity. They are, after all, reduced to hostages, listless and disinherited refugees in their own homes. Like other victims of captivity, they are unable to restructure their environment or rearrange themselves, nor can they exist".

anchorman, confused, tried to explain that all mothers who lost their children in the war are mothers of the martyrs, but the woman was still angry: "No. I lost seven children, she lost five. I lost all my children. I am "*Umm Al Chouhada*". At the end, the anchorman surrendered, calling her, and her alone, the mother of all martyrs.

How does one cope, understand and make sense of Israeli wars, loss and the future in Lebanon? In this section, I introduce different non-traumatized subjects that humanitarian psychologists have encountered during Israeli war and violence in Lebanon. These subjects were non-therapeutic, resistant to therapy and psychologization. Their suffering was left unrecognized by the humanitarian trauma model. This led to debates that oscillated between binaries of trauma/resilience and suffering/resistance. I unpack the different theorization of suffering from war embedded in these debates between experts, intellectuals and politicians. The debates that emerged in 1982 and 2006 carried specific justifications for and condemnations of the non-traumatized subjects formed by these wars.

The clinic and the field

First, experts debated the difference between finding trauma in clinics and finding it in the field during war. The clinic and the field represented two sites where violence and suffering were differently enacted. The clinic was a controlled laboratory that isolated war from its ideological and material context, enabling an individualized enactment of suffering through psychiatric diagnoses like trauma and PTSD. The field, on the other hand, is complex and raw, layered with past violence and constant anticipation of new wars. In the field, Israel's first and second war on Lebanon all became one, experienced as a war that keeps repeating and recurring, as a seemingly permanent state of war.

The field is a reflection of what Dr. Anissa al-Amine referred to as "*Al-Mou'ash"*, or the lived and the experienced, in all its complexity and messiness. Not only was trauma hard to excavate as a psychological disorder in the field, but for many of these experts it was simply not there. Experts made a fine distinction between finding trauma in clinics and finding it in the field. Finding the psychological in the field required the work of disentangling it from the everyday. While diagnosing psychological disorders was normally much more contained in the clinic, the work of identifying traumatized subjects in the field was far more daunting and complex.

However, as experts have suggested, it was quite rare for patients to come to the clinic with PTSD symptoms during war. Depression was the condition most prominent in the clinics during war. Trauma and PTSD only appeared as 'contradictory prevalence rates' in Lebanon when experts used checklist symptoms as measures- like nightmares, difficulty in sleeping and flashbacks. Field subjects were accustomed war, "immunized" from it as Dr. Al Hage has observed. They might be depressed from its re-occurence and almost habitual nature but, they were not necessarily traumatized by it. [108].

The clinic-field debates seem at the heart of the new profession of humanitarian psychology, where psychologists were required to reach out for war-affected communities in the field to uncover their psychological suffering as separate from economic and social conditions.

[108] Reaching out to the field to find trauma cases have raised a number of ethical questions and concerns for psychologists working with humanitarian organizations, rather than waiting in their clinics for individuals to arrive voluntarily. Now turning humanitarians, psychologists spoke of how they would infiltrate psychological treatment into different medical services in health clinics in order to implement psychotherapy without resistance from the community**.** They expressed concerns over the ethical boundaries of their discipline, since normally, a patient comes voluntarily to seek treatment, and not the other way around. Stigma is constantly evoked as the main reason of why people chose not to see a psychologist or psychiatrist in Lebanon and this argument is used to justify the different ways humanitarian psychologists apply to find and treat patients.

While this work of separating the psychological is usually performed by the patient himself in the clinic (See Samer in Chapter Two), seeking trauma in the field was far messier. As Dr. El Hage mentioned, a psychologist who "knows the field" knows that what she is finding with clinical scales and measures "is not trauma", but another kind of suffering.

What kind of alternative model of suffering can best capture the "*mou'ash*"[109] or 'the lived' experiences of war as "events" that return, where one is "in a perpetual waiting position" preparing for the next war to happen? (Haugbolle 2010). The cleaning lady at Khiam clinic used a term that was ordinarily used to describe the civil war to speak of the July War. She remembered the war as "events", as a series of occurrences that marked her life, driving her back to smoking- especially after her father passed away. As both eventful and ordinary, Israeli wars fall within the conditions of possibility of living in South Lebanon. Sana talked about war as a habit, as something people get used to, forget with time, and then move on with their life. While Dr. El Hage spoke of war as something one becomes psychologically immunized to. War was also a hunting reality in the south. It creeped into conversations and jokes.

Second, the case of the humanitarian psychological interventions designed for the Khiam detainees showed the importance of securing an economic livelihood for the detainees after their liberation, rather than solely focusing on their psychological injuries from torture and detainment. Seeking economic justice and rehabilitation were more important than a clinical diagnosis and treatment that prioritizes the psychological as the only form of suffering from war. In that sense, being traumatized from war was countered by a desire to resume what Israeli war and violence had suspended; to regain economic and social status, rebuild businesses, jobs and one's home. This resonates with experiences in the July War. In the documentary *Remnants of a*

[109] Interview with Dr. Anissa Al Amine, 2014; Interview with Ola Ataya, 2014

War (2009), Jawad Metni followed the lives of Southern Lebanese who had started working as de-miners with global NGOs to help clear the fields from cluster bombs thrown by Israel at the last days of the war. The people depicted in the documentary spoke of their suffering from war in economic terms. They spoke of their infertile lands, of losing their houses and businesses in the south while they took on a new NGO job made possible by the July War, in the hope of ameliorating their economic status.

Soumoud: Psychological resistance and trauma as warfare

But, beside the importance of economic reintegration to regaining mental health, in what ways were the Khiam detainees who suffered illegal detention and torture-- ranging from electrification, beating, hunger and thirst, water boarding, isolated confinement, psychological torture (Shuraym 2011, 54- 56) and free-style wrestling[110] – not traumatized?

Since the liberation of Lebanon there have been many autobiographies and testimonies recorded by the liberated Khiam prisoners[111]. The excellent anthropological study conducted by one of the liberated prisoners Jalal Shyraym (2011) gives us a deep insight into the different lived experiences of prisoners in the detention center, the torture methods used, and the ways in which prisoners survived under these conditions. Perhaps one of the most heartbreaking accounts was that of the goldsmith from Khiam village who built the detention center without knowing its use, then later ended up there as a prisoner:

[110] "Saturday was one of the ugliest nights (...) I was tied to a pole then and when the "free wrestling show" (an American show) started the police (South Lebanon Army) left me and went to watch it. When the program ended they returned and started beating me in artistic ways inspired by the show. One of them jumped and kicked me in the face and said: "this is how Chris () does it." The other one grabbed me and squeezed my head and said: "this is how Kevin does it.." they would sometimes bring out prisoners from their cells and beat them in ways they had seen on television (Shuraym 2011, 20).

[111] Notably Suha Bechara's autobiography *Resistance: My life for Lebanon (2003)* on her detention in khiam, and her account of other women prisoners Kifah and Hanann; Documentaries like *Khiam* and *The land of women* also feature testimonies and stories of liberated prisoners.

"I was working at the end of 1984 as a goldsmith in Khiam. Someone came to ask us to make iron doors, half of it closed iron, and the other had iron with (…) an opening. We were told that these doors were for the Khiam barrack. (…) when we went there to install the doors we noticed that the interior organization resembles that of a prison/detention so we said "god knows who will end up in these dungeons" Liberated prisoner liberated Riad Kalash (Shyraym 2011:16)

Living and surviving in the Khiam detention camp also meant embodying new ways of living, like how to walk in a cell:

"An incident happened to me after two months of being arrested I had only walked in them to the interrogation room and back. And I had been in a communal cell for around 20 days. I would see the guys walking in the room back and forth, and the room was no more than two meters wide and 2.2 meters long. We were four people so we would take turns in that two would walk and two would sit down. And we managed to walk for long distances this way, between 8 and 10 kilometers a day. The first time I tried to walk I got dizzy after taking a few steps. The others asked me: what is wrong? I said: I don't know but I got dizzy from walking, although I am an athlete and a soccer player. Someone said laughing: "Walking here is different from walking outside. (…) don't take big steps because you'll get through the room in two or three steps. And you'll have to turn left or right at the wall to go back in the same direction, and you will repeat the same thing, so you will get dizzy". He then taught me "the right way to walk" inside the cell: take small steps, don't turn left or right at the wall and don't return linearly but that I should turn around and go back on the same way I came (…) one thinks that he is an athlete, then comes a times when he needs to be taught how to walk. For every place has its own condition and situation" (Shuraym 2011)

Learning to live, walk in the cell, smoke cigarettes and survive a prison like the Khiam detention center was a meaningful practice related to resisting Israel's intention to destroy the morale of the detainees, something they were very much aware of. Resisting a psychological breakdown literally meant resisting Israel:

"Israel has established the detention camp intentionally and with a plan in mind so they would torture people with thirst and hunger and cold and heat, and all these ways that make the detainee go away and talk about what he has been through so that people will become frightened and say: "We have nothing

to do with the resistance" Especially when he goes out (of the detention) in a difficult condition and one can see torture marks so that people would see him and become afraid. This is the purpose of this detention center. But in reality, things backfired and helped to make people stick together and be willful."
Sharif Atweh, liberated detainee (Shuraym 2011, 117)

For the Khiam detainees, fear was a natural emotion in war that should be controlled to be resistant in the face of Israel. A similar experience is described in Ali Beydoun's autobiography of the Israeli invasion of Lebanon in 1982 entitled *Bayrout Nas wa Moukawama* (Beirut: People and Resistance), where he quotes one Lebanese fighter "Abou Jawdeh"'s description of the war:

"(..) Of course fear is a human condition and everyone gets afraid. But we have a rightful cause and they are mercenaries. We dream of martyrdom and the dream of freedom and this fear goes both way and whoever initiates is the one who breaks the obstacle of fear and is victorious" (Baydun 2012, 47*)*

Breaking one's psychological morale was perceived as an important powerful weapon. In this way trauma became a tool of war itself rather than an individual expression of suffering. Resisting the war meant not being traumatized by it, not allowing it to destroy your will to survive or your ability to overcome it.

Maintaining a position of resistance towards war, a position of *soumoud* –of staying steadfast and resistant– was also intimately linked to local forms of aid organized in the 1982 and 2006 war to assist the displaced and wounded. Local aid collectives and initiatives like Samidoun) in 2006 (Chit 2007, and in 1982 as described in Fathia Saoudi's autobiography (1986), have understood that aid was first and foremost "a political act of solidarity and steadfastness" (Moghnieh June 2015), where "liberation could be achieved through intervention and aid" (Saoudi 1986). The different activists and professionals I interviewed about their volunteer work during the July War spoke of the inter-subjective and political transformations

they experienced while engaging in aid and relief (Moghnieh July 2015). Local forms of aid and solidarity during war, including the work Hezbollah, were in themselves forms of psychological resistance to war.

In that sense, an understanding of the politics of suffering from war in Lebanon cannot be read outside its direct relationship to Israel. Trauma was employed as a war weapon used in the psychological warfare between Hezbollah and Israel. In Israel, Lebanon itself as an unconquerable site became 'a trauma', as Israeli politicians, journalists and army military experts started discussing "the Lebanon Trauma" that both the military and the nation had to overcome after the July War. The same term was also evoked to describe the Israeli invasion of Lebanon in 1982 in popular Israeli discourse. But "the Lebanon trauma" was not just a political rhetoric expressing the failure of the Israeli military machine in Lebanon**.** Trauma was clearly at the heart of Israel and Lebanon's understandings of war and suffering. It enabled a sort of an underlying subversive dialogue of power that oscillated between psychological absence of trauma in war and psychological shock over its unbearable atrocity, between heroism and victimhood. Underlying this dialogue are different political and cultural claims from the Lebanese side, over what it means to suffer vis-à-vis Israeli aggressions and wars. While traumatized Israeli soldiers were victims in the eyes of the Israeli state, claiming compensation and protesting an immoral war, being traumatized-- as a discourse between Lebanon and Israel-- carried within it gendered notions of being an emasculated fighter fighting for ethically wrong reasons.

For example, during the 2006 war, the Hezbollah television channel Al Manar would repeatedly show footage of Israeli soldiers crying and running away from the battlefield. Expressions like "when Israel bombs us we do not hide in shelters like Israelis, we go to the balcony and watch" were constantly evoked during the war. Years after the end of the war,

newspapers like Al Akbar would report on the trauma and PTSD cases that Israeli soldiers were suffering from the nightmares they had about the village of Bent Jbeil; a village that witnessed some of the most vicious fighting during the war. Hezbollah fighters, on the other hand, reported experiencing the war as divine, many of them recounting religious visions they experienced while fighting. On the Israeli side, the lack of visible suffering from war in Lebanon was evoked to de-humanize the fighters and signal a non-civilized and non-modern Islamic culture "as a culture of death".

Hierarchies of suffering from war

Finally, the Pattison-Khalaf debate revealed different theorization on the hierarchies of suffering that the absence of trauma had produced. Fascinated by not finding traumatized Lebanese from the 1982 war, Pattison drew a picture of the Lebanese as essentially resilient and indifferent to war. War became an ahistorical cultural experience that Lebanese had to learn to survive through years of exposure. Pattison imagined Lebanese as ontologically different subjects who do not suffer in the face of violence but experience it as a form of social and cultural phenomena. His description was in line with other representations of Lebanese as non-suffering subjects experiencing war as a practice of everyday life. This disregarded the possibility of other forms of suffering that were not necessarily traumatic.

Khalaf rejected Pattison's essentialist description of Lebanese resilience on the basis that it adopts a dominant and collective discourse on suffering that neglects the silenced suffering of intellectual and upper middle class Beirutis. Trauma for Khalaf was both an intellectual and psychological sensitivity to war, a quintessential marker for modernity and civility. A proof that the Lebanese were still human beings who could still feel and communicate their suffering to others**.** Trauma was an expression of the individualist liberal Lebanese. The absence of trauma

marked the death of the intellectual and of the upper middle class, now replaced by collective experiences of normalized violence, like that of Palestinians and Shia communities. What Pattison calls resilience, was the direct effect of the normalization of violence and war for Khalaf.

VI. Beyond trauma/resilience: The story of Bilal and the complexity of suffering from Israel

Bilal is a delicate and sensitive man in his thirties. At the time of the interview, he worked with a global humanitarian organization on the cases of disappeared Lebanese during the civil war, whose fate was still unknown. Like many people I know in Beirut, Bilal was preoccupied and almost obsessed with war and violence. Sipping his tea in a café in Hamra in the middle of the afternoon, he reflected on the nature of war and violence, recalling numerous conversation he had with ex-veterans of the civil war about their first killings, and the techniques they used to dehumanize people they killed during the civil war.

I had asked to interview Bilal to find out more about his experience with the July War. He, like many people I knew at the time, worked as a fixer[112] for foreign journalists covering the war, traveling with them sometimes to areas that were heavily bombarded. During our conversation, I continuously had to ask Bilal whether he was talking about the Lebanese Civil War or the July War when he spoke about *Al harb* (the war). Bilal kept going back to the civil war – a war he never experienced directly but only suffered its remnants while growing up – when he spoke of his experience of the July War.

"Look", he said, "the experience of war is interesting in Lebanon. Either you heard of it, have lived in its remnants, have lived through it and 'seen' it, or you have seen only very little of

[112] A fixer is someone who is hired by foreign journalists to arrange and fix a story (interviews, theme, context, translation).

it." Bilal went back to the civil war as a reference to understand his own experience of the July War, the first war he had lived through and "seen" as an adult. But sometimes during our conversation, *al harb* took on all these events of violence together. Bilal's experience of the civil war was indirect and tangential as a child. It was an experience of remnants: feeling afraid without knowing why. Being silenced by his family when he asked them who killed his family relative. Being punished by his mother for playing with an unexploded bomb in his house's backyard and. He had two vivid memories of the war as a child: going up to the rooftop of his house with his family to watch the city of Tripoli being bombed, while his mother tried to convince him that these were fireworks celebrating "Eid" (a festive religious holiday); and watching bodies of dead and wounded fighters being carried into his village.

The experience of planes bombing Beirut and the south of Lebanon in 2006 reminded Bilal of his fear as a child of being killed in an airstrike by a pilot he would never able to reason with nor see. He didn't think the bombing in 2006 would affect him this much. But it did:

> *"When we (the journalists and him) were going out of Dahiyeh once, the planes started shelling. You first hear the rumbling of planes, and then you see them. Or, it is more like you sense the planes through the rumbling. Then they bomb. This was my first experience of the F16 Jets. You feel helpless. People became agitated when something massive like this would happen, as much as you are psychologically prepared for it. The police officers were screaming at people, the same people who only yesterday were hailing and being defiant (of the war), now they panicked. I started thinking that all structures were collapsing (…)"*

Bilal worked as a fixer during the war- arranging stories, connections, interviews and sites to visit for foreign journalists. He was conflicted about getting paid while people were dying. But he also felt that this job would help him deal with the war "with some sort of sanity". Somehow seeing, witnessing and representing war sites made them less frightening and more meaningful.

For Bilal, dealing with the fear he had from the bombing, the war, and from losing his family members meant that he felt compelled to place himself in war zones in order to "get used to it".

When the ceasefire went into effect, Bilal traveled with the journalists to the south. They were among the first to arrive there, with the Lebanese army and the civil defense opening roads ahead and warning them of cluster bombs Israel has dumped that day. On the first day of the ceasefire, the south was a liminal space, both a war zone and a postwar place to-be-reconstructed. Gunshots were heard everywhere. Fighters were still walking around, looking alert with their guns now hidden underneath their clothes. An Israeli military group was still in the premises, trying to negotiate a safe exit. The military group opened fire to prevent fighters from stealing its parachutes. The smell of death was everywhere. Some wounded were still there and gangrene cases were visible. Skinny fighters, weak and dehydrated– still visibly tense from the hours and days they spent fighting– were walking around. Some of them were pulling out a dead and smelly cow, while others were carrying a man wounded in his face by a cluster bomb. Israeli tanks were moving and retreating.

At the Bent Jbeil[113] hospital, the view resembled that of a Kurosawa movie. There was a hospital staff member who looked like he hasn't slept in ages. He was chasing cats with a broom so they wouldn't eat the dead bodies stacked inside, waiting to be buried. In another village, an old lady was walking aimlessly, confused and lost. She was asking everyone she saw where the municipality was, probably looking for her family or for a way to get to Beirut[114]. The war had invaded everything.

[113] A village in the south.
[114] During the war, traveling from the south to Beirut became was very risky and highly expensive.

The war zone, in its liminality, was described by Bilal as completely absurd and surreal. Lebanese Fighters and Israeli soldiers, they all suddenly seem alike: "Everyone was the same, everyone had a very real reason to fight, but at the same time, they were both living in illusion". A man with clear political and idealist positions against Israel, Bilal's moral clarity and idealism disappeared in the war zone, at the ends of war:

> *"You see the similarity. Destroyed machines, bodies & houses. Something strange happened when we arrived there. Fighters were on their cellphones saying "it is over", others went to get a haircut and a shave. One fighter came up to us and started boasting about the war. Another one said: "Come with me, I want to show you something. These are things that belonged to a dead Israeli soldier, we were trying to take him out of the tank but we couldn't". The guy brought the Israeli soldier's wallet, cellphone and other personal belonging. Every minute, the soldier's cellphone would start ringing and the fighter would turn off the call. "I bet it is his wife" he said. He opened his wallet to show us his ID, then he took out a letter. It was obvious that the Israeli soldier left a letter to his daughter. Many of the fighters knew Hebrew. So he started reading. As jovial and happy and excited he was that the war was over, his face now dropped and he took a picture of his own daughter and showed it to us: "this is my daughter, she might be a year older or younger than his own. It could have been me instead." I felt that the fighter-friends were uncomfortable with him speaking this way (especially with journalists present), because I felt that there was a motive to show themselves as heroes, to show the war as a committed fight (against Israel). One of the fighters told him "salleh ala el nabbe ("pray to the prophet" an expression used to calm someone down). It is okay, you were just doing your duty. You were protecting your land and your own existence". He calmed down after a while. (...) they also found a vodka bottle in the tank: "He needs vodka to come to Lebanon and handle 33 days of war" they said. It was not about a conviction, but more of a personal challenge. "I fight you with nothing" another fighter said."*

No one mentioned Hezbollah or 'divine victory' that day, they didn't talk "like that", reflected Bilal. They would just talk about mundane things: "look at this tree. It got burned in the last two days of the war". Fighters spoke in details about small things: The tree. The tank. How one found his brother in the hospital. How they tried to convince an old lady that they couldn't

get her son's dead body out of the war zone. There was nothing ideological or rhetorical about their speeches. They offered Bilal and the journalists some food, as if everything was normal, trying to maintain an etiquette of hospitality. Bilal found that absurd. If you gave them a mirror, he said, they would laugh at themselves. They all looked terrible. The fighters, still uncomfortable with their friend's identification with the dead Israeli soldier, helped him remember the meaning of his fighting, and the reason behind it. In this liminal space- no longer a battle scene and not yet a scene of the mundane –meaning collapsed.

Bilal and the journalists came back to the same place a week after, to cover the collective funeral of those martyred during the war. The discourse, and the scene, were completely different: Hezbollah flags were everywhere. Pictures of dead fighters as martyrs. People were being told not to cry or show too much sorrow because "you will burn the dead with your tears". The mood was drastically different. It was now about 'resistance' and 'defiance' of Israel. There was no space anymore to talk about losses or resemblances that Bilal had the rare occasion to witness in the liminal battleground. Now it was more like 'everything in life has a price', 'divine victory', 'dignity', 'martyrdom' and geopolitical expressions like "the Western ambitions in the Middle East", 'we need to see the bigger picture' and 'everything will be rebuilt again'. "You could sense this dichotomy then" Bilal said. "The dichotomy of them and us".

***

The war remained with Bilal after the ceasefire ended. Its aftermath persisted. He became more tense and anxious. He felt like he lost, but he didn't actually lose anything. What was the point of fighting for a cause? He began thinking that there was no difference between dying in war and people dying everyday. Is it just a matter of scale and intensity? Does it really make a difference? He felt that everyone defends the small details of their life. In the absence of

ideology, they all are just fighting for small details. What does it mean to die for a small detail, he wondered, versus for a greater cause? And which of them makes more sense? For someone who had idealistic and strong political convictions, things became too meaningless for Bilal. He started drinking more than usual. He used to think of himself as an ethical person. After the war, he found himself doing things more impulsively, doing things he felt like doing without thinking too much about whether they were right or wrong.

VII. Conclusion

This chapter addressed the humanitarian trouble of finding trauma in Lebanon following the Israeli invasion in 1982 and the July War. I started by recounting my difficulty as a researcher in finding trauma as I began research in the Khiam village in south Lebanon, where social workers like Sana and psychologists like Dr. El Hage have worked on numerous psychological programs targeting Israeli war and violence. The temporality of violence and suffering in Khiam – a village that witnessed many episodes of Israeli violence and hosted the *Khiam Detention Camp* during the Israeli occupation of South Lebanon– was experienced as set of events that were repetitive and seemingly permanent, as people learned to become immunized and prepared for the next war to start.

The next two sections summarized the different expert, intellectual and political debates emerging around trauma and suffering from Israel wars in 1982 and 2006. During the July War, experts debated the appropriate model of mental health that would best account for suffering during war in Lebanon, critiquing the humanitarian trauma model. Contradictory prevalence rates of PTSD also confused the experts, signaling a trouble in finding trauma that did not seem highly prevalent in the clinic, where depression seemed to be the most prominent diagnosis given during war. This 'absence' of trauma provoked political debates after the July War that relocated

trauma as an instrument of war against Israel and as a sign of modern and civilized suffering. Similarly, humanitarian psychologists were not able to find trauma from the Israeli invasion of Lebanon in 1982. Debates rose then about the natural resilience of Lebanese people, the nature of war and the silenced suffering of liberal Lebanese intellectuals whose mode of life has been invaded by uncivil war and normalized suffering.

The next section unpacked these debates and introduced the non-therapeutic subjects and forms of suffering encountered by humanitarian psychologists in Israeli wars and violence. These subjects had a position of *Soumoud* (of steadfastness and resistance) towards Israel, where being traumatized meant that the war was lost. An understanding of the politics of trauma in Lebanon cannot be found outside of its relationship to Israel. Finally, the story of Bilal complicates the debates and discourse around violence in Lebanon that oscillated between trauma/resistance binaries, where other modes of suffering are left unrepresented.

Chapter IV

After trauma: Life Pressures, Personality Disorders and the Making of Postwar Therapeutic Self in South Lebanon

I. Introduction

In a small health center in the south, Samer (the humanitarian psychologist featured in Chapter Two) sat with the nurse, Thorayya, and her supervisor, Sarah, to follow up on their new training and job roles as mental health care providers. Thorayya brought her notes and started presenting the psychological cases she had tried diagnosing since Samer's last visit. She had to psychologically assess all the cases that the doctor could not medically diagnose in her center. It was a Saturday morning and the center was somewhat empty. I had met Samer and Sarah in Tyre, a city at the coast of South Lebanon, a few hours before, to join them in their biweekly follow-up visits to nurses working in Imam Sadr Foundation's centers scattered in villages in the south. Imam Sadr Foundation (ISF) is a local organization founded in the 1960s to support and help underprivileged communities in the south through literacy, education and health services.

The first case Thorayya presented was a young girl, Salam, who was in need of a neurological test to determine if she had "retardation or epilepsy". The tests were hard to find in the south, except in expensive, private hospitals. Thorayya did not know where to refer Salam.

Samer gave her some options while insisting that she needed to take ownership of the patient: "This is your patient. You should be able to locate centers and experts around here that can provide these services. Jabal Amel hospital[115] can be an option, as well as the state hospital, now funded by Medecins du Monde. You might find these tests there. What do *you* think is wrong with her?" he added.

"I think she is in a very delicate situation"

"What does that mean?"

"I don't think she is retarded. She is capable of taking her medication (for epilepsy) on her own….What shall I do?"

Samer proposed an alternative option to the tests: "Do home visits and raise awareness on the importance of the medication she is taking, and then after months of follow-ups and monitoring, see if she is still having these crises".

The next case was Hussein**,** a young unmarried man from the village nearby. Thorayya and Sarah had both done multiple home visits to assess his situation.

"What do you think he has?"

"He seemed retarded. He takes pills. He does not go out of 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 a drug in it. I did four visits to see him and he was always in his bed, sleeping." Said Thorayya.

"Let's do a case study with him and videotape him. Tell him, 'there are people who want to interview you'. We did that in other centers. He is probably suffering from addiction and has an

[115] A private hospital.

antisocial personality disorder[116]." Said Samer. "In case he refuses to be videotaped, then tell him to come to the center".

The third case she presented was Abbas, a middle-aged married man whose doctor ruled out all medical causes and referred him back to Thorayya:

> *"The doctor told me: sit down with him and ask him about his overall mood. Abbas said that he was calm and does not get nervous or agitated. I asked him to be more specific. He said "I feel a heaviness in my head, I am afraid that I might have (high) blood pressure". He carries the blood pressure machine with him everywhere he goes to take his blood pressure. His wife said that he was much lighter and happier before. He told me he feels normal, but that life has its problems. His food is also normal. In Africa, where he went to work a few years ago, he lost 10 kilos in 3 months. In Lebanon, the doctor gave him medication and he felt better right away. He might have Obsessive Compulsion, but I left the diagnosis up to the doctor. His sleep is fine but it could be so because he is exhausted. He said that he has heaviness in his head, so it could be a problem in focusing or paying attention. Nothing serious".*

Dissatisfied with her all-over-the-place psychological assessment of the case, Samer tried to guide Thorayya in a less chaotic way: "you are seeing depression but there is no depression. Always look at the patient's main complaint. The complaint was about his blood pressure and obsession, so ask him and focus on that".

[116] The DSM IV-R defines the symptoms of antisocial Personality disorder the following way:
A. There is a pervasive pattern of disregard for and violation of the rights of others occurring since age 15 years, as indicated by three (or more) of the following:
(1) failure to conform to social norms with respect to lawful behaviors as indicated by repeatedly performing acts that are grounds for arrest
(2) deceitfulness, as indicated by repeated lying, use of aliases, or conning others for personal profit or pleasure
(3) impulsivity or failure to plan ahead
(4) irritability and aggressiveness, as indicated by repeated physical fights or assaults
(5) reckless disregard for safety of self or others
(6) consistent irresponsibility, as indicated by repeated failure to sustain consistent work behavior or honor financial obligations
(7) lack of remorse, as indicated by being indifferent to or rationalizing having hurt, mistreated, or stolen from another
B. The individual is at least age 18 years.
C. There is evidence of Conduct Disorder with onset before age 15 years.
D. The occurrence of antisocial behavior is not exclusively during the course of Schizophrenia or a Manic Episode.

"What are the symptoms of Obsessive Compulsive Disorder again?" Asked Thorayya as she tried to remember.

"Repetitive ideation and behaviors. It is probably obsessive compulsive disorder or some features of obsessive compulsive personality disorder[117]. When you see him next, ask him about these symptoms (…)"

"I feel like he has it [obsessive compulsion], but I did not know how to ask"

"You need to first rule out panic attack, anxiety and fear, before asking about his obsessions. Let's see him together next time and you'll see how to ask the questions"

"I did not ask him about delusions and things like that. I don't know if this was right or wrong".

"Don't ask me if it is right or wrong. Just don't get sidetracked from the main complaint".

The last case was May, a forty year old woman. Thorayya said that May was suffering from "chronic depression" and has been on anti-depression and anti-anxiety medications like Cypralex and Zoloft for five years: "She became this way when her brother became a martyr a few years ago". Thorayya was much more certain about this case, probably because of the

[117] A pervasive pattern of preoccupation with orderliness, perfectionism, and mental and interpersonal control, at the expense of flexibility, openness, and efficiency, beginning by early adulthood and present in a variety of contexts, as indicated by four (or more) of the following:
(1) is preoccupied with details, rules, lists, order, organization, or schedules to the extent that the major point of the activity is lost
(2) shows perfectionism that interferes with task completion (e.g., is unable to complete a project because his or her own overly strict standards are not met)
(3) is excessively devoted to work and productivity to the exclusion of leisure activities and friendships (not accounted for by obvious economic necessity)
(4) is over conscientious, scrupulous, and inflexible about matters of morality, ethics, or values (not accounted for by cultural or religious identification)
(5) is unable to discard worn-out or worthless objects even when they have no sentimental value
(6) is reluctant to delegate tasks or to work with others unless they submit to exactly his or her way of doing things
(7) adopts a miserly spending style toward both self and others; money is viewed as something to be hoarded for future catastrophes
(8) shows rigidity and stubbornness.

psychotropic medications May was taking, and of the direct cause of her distress- her martyred brother probably killed during the July War. “I can tell you she has chronic depression”, she added, “Her only worry now is how to get off her medication”.

But Samer wanted to make sure the diagnosis was not something else: “Did you both see her as Histrionic (exhibiting symptoms of hysteria)?” He asked them to check her medication and see if the doctor proscribed them because he also suspected she had Histrionic personality disorder[118]. There also seemed to be some gossip in the village about her husband cheating on her. Samer took this case as a chance to explain to the nurses how studies have found a correlation between histrionic personality disorder and hysterectomy, elaborating on the disorder. All these factors could be clues for them to diagnose her properly.

***

The cases Thorayya presented revealed the new landscape of psychologization of suffering after the war, where a heaviness in the head, life’s problems, bizarre behaviors and martyrdom were now all equated as psychological pressures of living in the south. By the end of the July War, humanitarian psychology changed strategies from emergency to development. It focused on reconstructing mental health institutions, training experts on psychological assessment and providing psychological education for communities**.** This psychological

[118] DSM IV-R defines the symptoms of Histrionic personality disorder the following way:
A pervasive pattern of excessive emotionality and attention seeking, beginning by early adulthood and present in a variety of contexts, as indicated by five (or more) of the following:
(1) is uncomfortable in situations in which he or she is not the center of attention
(2) interaction with others is often characterized by inappropriate sexually seductive or provocative behavior
(3) displays rapidly shifting and shallow expression of emotions
(4) consistently uses physical appearance to draw attention to self
(5) has a style of speech that is excessively impressionistic and lacking in detail
(6) shows self-dramatization, theatricality, and exaggerated expression of emotion
(7) is suggestible, i.e., easily influenced by others or circumstances
(8) considers relationships to be more intimate than they actually are.

reconstruction accompanied massive projects of rebuilding war-torn areas and infrastructures, and developing health services, economies and policies in postwar Lebanon.

Thorayya's new job role, as a psychiatric nurse, was part of Imam Sadr Foundation's psychiatric education program for nurses set up after the July War in 2007. The program provided nurses with psychological skills to prevent the outbreak of psychological disorders in areas like the south that lacked accessible resources and services to psychological care. Partnering with IMC, ISF started integrating mental health in its primary healthcare centers – a project in line with WHO's mental health Gap policy and recommendations (see chapter two; Hijazi et al 2011). ISF's psychiatric nursing program, and the Mental Health Gap**,** were examples of the humanitarian projects of psychological development s in the south after the war. They aimed at attending to the psychological needs of postwar communities by institutionalizing a global standardized assessment of mental health – something that was lacking during the July War[119]. WHO's program on integration of mental health into primary health centers was later adopted by the Lebanese Ministry of Health as a national project in 2015.

The city of Tyre in South Lebanon, once a hub for global humanitarian organizations providing emergency assistance during the war, now became a main site for development work and psychological reconstruction, implemented by local partner organizations. Trainings of local practitioners were accompanied by awareness sessions designed for communities thought to be most vulnerable to mental illness. Thorayya held awareness sessions for the center's visitors, where- similar to how psychological care was "infiltrated" into Amel's health centers during the treatment of Khiam detainees (see chapter three) - she would slip in brochures on depression and hold discussions on mental illness while families were waiting to get their child vaccinated. I

[119] Interview with Mohammad Bassam, ISF, 2014.

observed many of these psychological awareness sessions, or *jalseit taw'iyeh nafsiyyeh,* in the south after the war. They usually focused on raising awareness on the threats of psychological disorders and the importance of mental health and psychological care in everyday life. Much like the trainings of local practitioners, awareness sessions sought to teach postwar communities how to see the psychological in their family dynamics, personality types, society, economic conditions and gender roles. As women were the primary participants of these sessions, their lifestyles, from the television shows they watched, the way they raised their children, to their relationship with their husband, were all discussed as potential indicators for psychological distress.

This chapter follows the psychologization of life in postwar South Lebanon, as the humanitarian focus turned from diagnosing and treating trauma to psychologizing the pressures of living in the aftermath of war. As this chapter will show, trainings and psychological education of practitioners and communities mainly relied on personality disorders like histrionic, antisocial and obsessive-compulsive personality types**.** The traumatic effects of the war ceased to be of interest to humanitarian psychologists. The expansion and proliferation of psychologization went beyond war trauma to look at life pressures and daily functioning as producing psychological injuries. Humanitarian psychology shifted focus from war as an event that injures one's way of living to life itself as containing psychological distress. In that sense it became an intervention of the field itself- what Dr. El Hage and Dr. Al Amine spoke of as "the lived experience" or *al mou'ash*, which was resistant to trauma and psychologization during the July War (see chapter three).

I argue that postwar psychological training, and education, relied on personality disorders to enable a new kind of therapeutic person with a psychological awareness of herself and

surroundings. While humanitarian psychologists encountered non-traumatized subjects who were resistant to therapy during the July War, the process of psychologization after the war saw this resistance as a product of 'conservative pedagogy' and 'stigma'. Postwar psychologization aimed at reconfiguring new selves, meanings, desires, values, tastes and behaviors in line with humanitarian and psychological definitions of the human. It expanded in the south as part of rebuilding both self (in terms of therapeutic communities and experts), and place (in terms of mental health facilities, institutions, services, measures and diagnostics).

First, I look at how practitioners like Thorayya were trained to see life pressures in South Lebanon as psychological symptoms of potential personality disorders, and the difficulties they faced in their new job roles. I then follow the psychological education sessions led by Samer in Amel center in Tyre, as part of psychological services provided by IMC to different communities in South Lebanon after the war. Personality disorders prevailed in the psychological training and education of practitioners and communities. I address how personality disorders were used by Samer as part of psychologizing life and living in the south. In the last section, I show how this form of psychologization worked on overcoming forms of resistance to therapy, understood in terms of stigma and a conservative form of pedagogy.

II. It's all psychological now!: Trainings of practitioners and the challenges of seeing the psychological in everyday life

Psychological trainings of nurses and social workers aimed to teach them how to see "what's psychological" in everyday life pressures and how to detect psychological symptoms of possible disorders. Like many of the nurses and social workers employed by local NGOs in the south, Thorayya was now considered to be the gatekeeper of mental health (Booth 2004), the practitioner most able to "narrow the mental health gap" between health providers and

communities seeking care, by detecting the psychological distress almost always left out in medical screenings and assessments. Now seen as one of the focal points of mental healthcare, nurses and social workers were undergoing training, and enrolling in psychiatric programs, which taught them how to detect symptoms of psychological disorders. These techniques followed global diagnostics like the Diagnostic Statistical Manual (DSM) and WHO definitions of mental health.

Thorayya's new role was to see psychological stressors in patients' mundane practices, assess their psychological distress separately from their physical complaints, and refer them to a specialist. She was learning to see what is psychological in a 20 day old plate of potatoes, in what she kept calling a general condition of "retardation", and in people's bizarre and non-normative behaviors and lifestyles. Histrionic, obsessive compulsive and antisocial personality disorders, or at least some of their features as Samer remarked, became familiar diagnoses replacing PTSD and trauma after the war in the south. These diagnoses- heavily gendered in nature- were used to interpret different types of men and women, and train nurses and social workers in detecting specific behaviors and complaints as symptoms of pathological personalities.

I followed similar trainings for social workers and nurses on psychological assessment, case management, and on how to administer global scales and measures. Even Sana, the social worker I met in Khiam clinic (see chapter three) - who was confused over what part of her job was considered psychological- had undergone a training on detecting psychological disorders after the July War. These trainings were neither restricted to South Lebanon nor to nurses and social workers. They extended to all healthcare providers and were at one point part of capacity building workshops for any expert providing some form of care for vulnerable communities. For

example, judges, policemen, and forensic detectives received some form of psychological training on how to detect psychological distress and provide support for prisoners, refugees and victims of domestic violence.

In many instances, local practitioners told me that what these trainings taught them was something they had always been doing as part of their social work and nursing jobs. They just did not know that this was called 'psychological'. Now with their new job role, they had the authority and knowledge to name it as such by following a list of psychological disorders from the DSM. They were able to distinguish between psychological and physical complaints, and to consider the former as a separate form of labor and care. These training sites, where humanitarian psychologists like Samer pointed out the many ways the psychological might be residing in patient stories and complaints, were quite different from the trouble I went through to find the psychological in the Khiam clinic when looking for trauma (see chapter three). Now, the psychological was everywhere, easily namable and commensurable.

Still, nurses and social workers I spoke with faced some difficulties diagnosing what is psychological in the ways of living in the south**.** As part of her new job, Thorayya now dedicated one day a week to do psychological labor, something local practitioners found difficult to accomplish. With their daily and overloaded schedule, why did they need to separate psychology from anything else they did? Much like how psychology 'infiltrated' the Khiam clinic to treat the detainees, Thorayya needed to work carefully on detecting psychological symptoms in her center because "who is going to say 'I have a psychological problem'?". People who come to the center with their complaints were not really going to separate the psychological from physical complaints. And when Thorayya asked people about their mental health, they always denied there was a specific "psychological situation" they were experiencing.

The General Assessment Function scale (GAF): diagnosing and caring for the psychological pressures of the everyday

At the end of the case management meeting, Samer discussed a pilot study that Thorayya and Sarah were helping in administrating in ISF centers. The pilot study was to measure the validity of the General Assessment Functioning (GAF) scale- a scale that was part of the DSM-IV, used by clinicians to assess the overall functioning of individuals in everyday life as a predictor of psychological distress. Thorayya and Sarah were administering the scale to assess its validity as it was adapted by IMC to fit the Arabic-Lebanese culture.

Samer went over the scale's questions, explaining the best way to administer it: "The answers to the questions on the functioning scale must only be psychological, if they (visitors) have a physical problem then you stop filling the scale. It must only be answered with psychological complaints, not physical ones". They looked over the questions that measured the psychological functioning of individuals, practicing how to ask them in a 'purely psychological way'. Thorayya asked: "Can I say: 'when you are not in physical pain, how do you normally feel'?" "I wouldn't ask it this way". Said Samer. "I would rather say, 'does the psychological situation affect your condition?'" Sarah, looking at the questions of the scale asked: "Isn't it better to talk about life pressures here?" Samer answered: "No. These are psychological pressures".

Global scales like the GAF scale were one example of global measures and tools nurses and social workers relied on to learn how to see the psychological pressures of living in the south. They guided them to notice the ways people took care of themselves and families. GAF measured daily functioning based on a scale from 1 to 4, where 4 was "often cannot do it" and 1 was "did not face difficulty". Adapted to fit the 'culture', GAF contained different adapted

questions for men and women. Thorayya and Sarah administered the scale to ISF center visitors, asking them whether they had difficulty keeping themselves clean (shaving for men, makeup for women), exercising and eating healthily; caring for their family (providing money and attending to household repairs for men, preparing meals and cleaning house for women) and engaging socially in their community. Everyday life activities – from economics, cooking and raising children to taking a walk and exercising – were all indicators of psychological pathologies[120].

Nurses and social workers however were having a hard time finding psychological-only cases and separating psychological pressures from overall structural pressures of living in the south: "how can I talk about what is psychological when I don't have money?" Sarah told me, as she reflected on her new job, putting herself in the place of the villagers who struggled to earn money during different agricultural seasons in the south. Talking about what is psychological seemed almost a luxury to her, especially when she had to measure how people provided psychological care for themselves and their families. After all, who has time to take care of herself, take a walk, exercise and eat well?

I observed how another nurse- with the guidance of Sarah- administered the GAF scale to a married woman who has been living in the south since she got married ten years ago. The woman was French but spoke perfect Arabic with a southern accent. Asking her about how she took care of herself and her family, the woman started defending herself and her love for her children: "Of course I don't have any problem or difficulty in cooking. I love my children!"

[120] Thorayya had administered the GAF scale to nine random people who visited her center, but she did not find anyone with a psychologically functioning problem. Samer said there was something wrong with not finding any psychological cases. Out of the nine people who filled out the scale, at least four should have scored significantly as having a negative psychological functioning because "rationally speaking, the people who are coming with a physical problem and complaint, are not happy and are sad".

When they asked her how she took care of herself, the woman mentioned that she liked to clean her hands and clean the house. She spoke extensively about the proper ways of raising children, being a good wife and mother. At the end of the interview, the nurses tried to find consensus on what was psychologically pathological in her daily functioning. They reviewed the WHO's definition of mental illness. Was this woman's daily functioning compatible to the definition? They both noted that the women talked about cleaning her hands. That might be a symptom of obsessive compulsive personality disorder. They noted that as a marker of pathology in the scale.

Local practitioners scrutinized practices of care in the south for psychological symptoms of pathology and distress. While nurses like Thorayya and Sarah had a difficult time separating what was psychological from the ways of living in the south after the war, they relied on global measures and diagnostics to assess potential psychological disorders in the community.

III. *Jalseit Taw'iyeh nafsiyyeh*: psychological awareness sessions of vulnerable women communities in Tyre

In the lobby of a health center in Tyre belonging to Amel organization, I went to the basement to greet a group of women already sitting in plastic chairs assembled in a semi-circle, chatting with each other while coffee was being served. Every other week, these women from nearby villages and neighborhoods participated in psychological awareness sessions provided by Amel's center as part of wider psychological services targeting Iraqi refugees and marginalized Lebanese communities. I recognized some faces from last week's session. The others had either just been invited by Mounira, Amel's social worker, or were occasional visitors. Sometimes the social workers from the center would also join the session. One of them, a seven month pregnant woman in her twenties eagerly took notes on the psychological information discussed, much of

which focused on proper ways of raising children and building psychologically healthy family dynamics.

Jalseit Taw'iya nafsiyyeh or mental health awareness sessions had become an important part of humanitarian mental health services for communities after the war. Amel, like Imam Sadr Foundation, was a local partner of IMC in the south. The Tyre center offered psychological services that were primarily directed at Iraqi refugees, who became a target of humanitarian psychology in Lebanon by 2008 (see chapter one). However, the mental health awareness sessions were predominantly attended by Lebanese women- some of whom were married to Iraqi refugees. While IMC's programs were directed at Iraqi refugees at Amel center, Mounira had lobbied for including Amel's traditional aid communities, the Lebanese, as beneficiaries for these mental health services. The conflation in categories of humanitarian vulnerability in non-emergency situations – in who was deserving of psychological care and who constituted a humanitarian subject in need for therapy – was a result of the sharp changes and relocations of funds and priorities following changing humanitarian policies and crises in the Middle East. In many ways, this conflation resulted in the serving of therapies for a generally constituted category of the marginalized in the south, determined across economic and cultural boundaries[121].

At 10 am, Samer walked into the room, leaned on a conference table facing the women, and started off the session. Samer conducted both individual psychotherapy and ran the awareness sessions in the center. Today's topic was about teenagers, a topic the women themselves had chosen. Using the DSM, Samer introduced psychological analysis and

[121] This was not uncommon in South Lebanon, a result of shifting funds and donor policies who insist on a purification of categories and emergencies that in practice was usually hard to accomplish.

interpretation into these women's social realities and family dynamics, pushing them to become aware of their emotions, behaviors and habits in psychological ways**.** In these sessions, Samer's style was provocative and challenging, while different topics were raised that ranged from TV shows, child pedagogy and family life.

The women who participated came from different religious and social backgrounds. This became more apparent when they engaged in debates on what constituted a psychologically healthy lifestyle for them and their family. I accompanied Mounira on her home visits for the women whom these awareness sessions targeted. In these visits, Mounira was responsible for detecting cases of psychological distress. A native from Tyre with solid ties to the community she serviced, Mounira relied on her social work expertise and training to decide who to invite to Amel center to benefit from the mental health services and awareness sessions. She was also required to first target Iraqi families settled in the south after their displacement, and let them know about the services at Amel's.

While we were doing home visits, Mounira told me that Iraqis have two faces. While they show their social and normal face in public, in reality they came from a traditional, old-fashioned and conservative culture. All this needs to be taken into consideration when assessing psychological distress. Mounira's talk about two-faced Iraqis was a warning for me not to take things at face value. After all, I was accompanying her on home visits for the first time, and there were plenty of things I was not trained to see. Her warning came right after I expressed my admiration for the Lebanese wife of an Iraqi man we were just visiting. The family was a middle-aged couple and the husband had just had heart surgery that IMC helped pay for. We were there checking up on his health and chatting about the expensive private healthcare in South Lebanon.

His house, unlike the other houses we visited, showed signs of wealth in the form of African commodities: elephant horns, a stuffed eagle and a snake used as decoration. These things indicated that the couple have lived and worked 'in Africa' before coming to Lebanon, making good money. He called his wife to join us. She came in late in her dirty work clothes; as she worked as a car mechanic in the south. She went to change her clothes, and came back with "African tea", a delicacy they were honoring us with.

A married woman mechanic was not someone you meet every day. I expressed my admiration for the woman once we stepped outside, and how strong and amazing she seemed. But Mounira disagreed: "I see it differently. I don't agree with you. She is completely dominant in this relationship. And this is not healthy because the husband also has to have his role in the house. She seems to have completely taken over". Mounira's remark about two-faced Iraqis came in this context, as she seemed worried about the shifting gender roles of this relationship. The wife dominated and assumed a manly role as the breadwinner, while the husband stayed at home. This became even more pressing for Iraqis who were conservative and traditional. For Mounira, this was a psychologically unhealthy relationship that could predict unbalanced family dynamics. This was especially true for marital relationships constituted upon a traditional and conservative form of pedagogy of gender roles, as was the case with Iraqi culture. Mounira's comment on Iraqis' two faces meant that they came from a conservative culture that informed their behaviors and reactions, even if they acted otherwise**.**

We covered around five houses in different villages during our visit, chatting about humanitarian interventions conducted during the July War while driving. In one visit, we went to a house to congratulate a family on the birth of a new baby boy. We sat in the living room with all the women, eating chocolate and *Moghleh,* a festive sweet to celebrate new born babies. The

mother came out to greet us, looking tired and still recovering. By the end of the visit, Mounira sat next to a woman- in her late twenties- and they both whispered quietly.

"Did you see her face? Did you see her eye?" Mounira asked me after the visit was over and we were back in the car. "She just had a divorce from an Iraqi man who used to beat her, that's why her eye is like that". I had not noticed anything wrong with her eye. Mounira kept pointing out the violence and the psychological to me as we went through these home visits. These signs produced a form of psychological assessment I was not able to catch by myself. Contrary to my visit to Sana in Khiam center looking for trauma, the psychological was visible and detectable in Iraqi personality traits, family gender roles, a slightly deformed eye and other forms of life pressures.

These were the women in need of psychological education and awareness sessions. Mounira tried to recruit them, but I never saw the woman-mechanic show up to attend a session. Some of the women did, along with others who were excited to get a chance to ask questions to a psychologist on how to live well and have a psychologically healthy family. Some listened, while others asked specific questions and challenged Samer's clear cut and sharp lecturing. They asked questions about the number of times a mother should hug her child a day, whether it was good or bad for them to take naps in the afternoon, what kind of TV shows they should let their children watch and for how long. First and foremost, women attended as mothers, asking questions concerning child education, development and pedagogy, and, most importantly, how to have a child who does well in school, and succeeds in life.

Throughout the sessions, I sat with the women facing Samer, as seemingly part of the group but distinctly outside it, as someone who was already aware of her psychological positioning in the world. I sense this complicity with Samer's exaggerated and provocative tone,

dismissing information the women provided about health, culture and well-being that he placed in direct contradiction with psychological knowledge he was providing, sometimes laughing at certain questions or arguments while looking at me for approval. I took notes on the session, recording verbatim the entire discussion.

IV. Personality disorders: psychologizing self and pathologizing living in post war South Lebanon

While research is somewhat consistent on the validity of most psychiatric diagnoses, personality disorders[122] are generally critiqued as being the most controversial, linked with qualities of degeneracy, un-treatability and conflict [123](Crews & Moran & Bhuga 2007). Personality disorders[124] are especially critiqued for emphasizing a patriarchal "male view" of normativity, where women significantly outnumber men in diagnoses like histrionic personality disorders[125] (Russell 1995).

Through psychological training and education, both practitioners and communities learned about different psychological disorders, and how they related to living in South Lebanon after the war. In both cases, Samer extensively used personality disorders to show how specific personality types, behaviors and lifestyles could be symptomatic of psychological distress that he thought prevailed in the ways of living in the South (see chapter two). While he lectured about

[122]Personality disorders have been assigned a separate axis in the DSM-IV, meaning that the patient's personality was diagnosed separately from the principal disorder or any other medical condition, life stressor or level of functioning he might be manifesting. For example, a patient can be found to have generalized anxiety disorder on one axis, a severed level of daily functioning on the other, and an obsessive compulsive personality disorder. In the new DSM V, only one axis is used that describes one diagnosis.

[123] These types of disorders were found to generally intersect with non-normative types of persons usually seen by state institutions as criminals or as non-reformed, non-conformist subjects (Crews & Moran & Bhuga 2007). Moreover, "Antisocial and conduct disorders" were seen as interpretations of threatening types of people from lower classes (Kessler et al 1994), frequently used as a way to control and regulate violence in society.

[124] The DSM-IV (APA 1994) defines personality disorders as "an enduring pattern of inner experience and behavior that deviates markedly from the expectations of the individual's culture".

[125] Critiques of personality disorders highlighted how they take place in specific gendered cultural contexts, as they tend to be diagnoses of the self- a culturally informed construct varying across cultures (Crews, Moran & Bhuga 2007).

other disorders like Anxiety-related disorders and depression, he predominantly relied on personality disorders to interpret the social and cultural landscape of South Lebanon. In one of the sessions for example, Samer pointed out the difference between feelings of sadness some women said they were experiencing and the clinical condition of depression. He used hysteria as a disorder of an exaggerated emotive cultural practice that Lebanese and Arab women engage in, to make this distinction:

> *"In Lebanon, we speak wrongly of depression, depression mean Za'alan (sad) here. As I mentioned to you before, the Lebanese are a hysterical people, they love to make a lot of emotional reactions. For example, if you observe a wedding, you will see that the mother is too happy. We think it is okay, what is the problem of being happy? [But] also observe women in funerals, and the people in demonstrations and protests. We [psychologists] call this thing a collective hysteria. I am going to give an example that does not come from the West, because you always say that I talk about the West. In the Gulf countries, they do not express themselves and their feelings there in the same way. (…) Don't be upset with me, but women in Lebanon are hysterics, if you compare them with other women abroad. I mean (…), usually in the Arab world women are hysterics, they express too many emotions. One tends to confuse hysteria with depression (...) Men are usually not hysterics".*

Similar to reading what Thorayya called May's "chronic depression"- from the martyrdom of her brother and the possible cheating husband- as an aspect of histrionic personality disorder, Samer explained that the true cause of the women's distress was not depression but hysterical emotions as a result of overly emotive cultural practices. Overly emotive women in funerals and weddings, in protests and demonstrations, and as a result of prolonged grief over martyred family members and cheating husbands, were all the product of pathological cultural expressions of how women should show emotion in public.

Watching melodramatic Arabic, Turkish and Indian soap operas were also seen as provoking hysterical reactions and encouraging a histrionic-style personality disorder. In discussing which

television shows to watch and which to avoid, Samer asked the women, all adamant watchers of TV soap opera series to stop watching them- along with the news – because they illicit violence and hysterical emotions: "no news or soap opera shows! While driving to Tyre today I saw a car accident and one person had blood all over him. This is how you get affected by violence" **(**implying that what we see on television has a similar effect than actual encounters of violence**)**. He continued to say:

> *"Television can produce sadness which can produce a disorder (depression), which then turns into a cycle. You judge and assess and know what you want. You are watching a series that has hysterical people in it, one heroine is an idiot and there is violence and shootings. They know (the people who do these soap operas) how to capture you (your senses). Why does these series mean so much to you? I don't get it. (…)….these Turkish series are an antidote for depression…so that you won't collapse all together. Your children are watching you. The mother (in Lebanon) cooks then watches television. If you sit and watch TV for two and a half hours, then they will too."*

Erasing violent events, affects and behaviors became a focus of these sessions. Watching too many soap operas could produce psychological distress because of the overly emotive feelings they produce.

In another session, Samer used histrionic personality disorder and paranoid personality disorder[126] to explain marital and familial relations that could produce pathology. Samer

[126] DSM IV-R defines the symptoms of paranoid Personality disorders the following way:
A. A pervasive distrust and suspiciousness of others such that their motives are interpreted as malevolent, beginning by early adulthood and present in a variety of contexts, as indicated by four (or more) of the following:
(1) suspects, without sufficient basis, that others are exploiting, harming, or deceiving him or her
(2) is preoccupied with unjustified doubts about the loyalty or trustworthiness of friends or associates
(3) is reluctant to confide in others because of unwarranted fear that the information will be used maliciously against him or her
(4) reads hidden demeaning or threatening meanings into benign remarks or events
(5) persistently bears grudges, i.e., is unforgiving of insults, injuries, or slights
(6) perceives attacks on his or her character or reputation that are not apparent to others and is quick to react angrily or to counterattack
(7) has recurrent suspicions, without justification, regarding fidelity of spouse or sexual partner

rearticulated traditional and conservative forms of marital relations using personality disorders to show the relation between conservative forms of pedagogy in the household and pathology:

> *"A paranoid personality is someone who is normally suspicious of everything and forbids you from going out to certain places and talking to people. They are normally men. There are a lot of histrionic personalities here, the majority of them are women, and they normally are attracted to paranoid personalities who doubt the other's behavior and are very stubborn. Women normally suffer a lot from paranoid personality men types who lock in a room and forbid them to talk to anyone."*

Samer uses paranoid personality disorder to describe a suspicious and jealous husband that forbids his wife from leaving the house and socializing. A conservative husband with a paranoid-style personality is the result of traditional and conservative forms of pedagogical education. While there is a biological trait for personalities, Samer explained that personality disorders are mainly informed by culture and pedagogy. Normally women who are stuck in these kinds of relationships with paranoid types, become hysterical themselves as they feel that they could not escape the marriage because the husband might become violent. Similar to Mounira's theory of the two-faced Iraqis- that conservative personality traits could produce pathological marital relations- personality disorders were employed to show how marital and family relationships could be predictors of psychological distress.

In several sessions I attended, Samer described women in Lebanon as hysterical, as a way to make the group aware of the pathological emotions they expressed publically, and to advance a more moderate emotional reaction. While I felt very uncomfortable with Samer's constant depiction of Lebanese women as hysterical, I originally thought that Samer might be using

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B. Does not occur exclusively during the course of Schizophrenia, a Mood Disorder With Psychotic Features, or another Psychotic Disorder and is not due to the direct physiological effects of a general medical condition.

hysteria as allegory of some sort to push the women to talk differently about their emotions in the sessions. But Samer said that he was using hysteria as a clinical diagnosis, not an allegory, arguing that hysteria is prominent in the Middle East and citing the DSM as a diagnostic that includes personality disorders like histrionic. In subsequent conversations with other psychiatrists in Lebanon on hysteria and personality disorders, no one found that Samer was overly using diagnoses of personality disorders, stating that these were clinical conditions approved by the DSM and are used in Lebanon according to these standards.

V. From resistant subjects to resistant culture: personality disorders and the making of a therapeutic self in postwar Lebanon

In their search for war trauma and PTSD, humanitarian psychologists encountered many non-traumatized subjects whose suffering from Israeli wars and occupation was resistant to psychotherapy and the humanitarian understanding of war as a psychological injury. Humanitarian psychologists drew specific distinctions between finding trauma in the clinic and finding it in the field—in the lived experience of the everyday (see chapter four). In both these sites, trauma was absent and only appeared as 'conflicting prevalence rates' through surveys and symptom checklists. Non-traumatized subjects, as the last chapter showed, overcame and survived the war with *soumoud,* the condition of steadfastness and resistance.

After the war, humanitarian psychologists shifted their focus from trauma to psychologizing the pressures of living in postwar Lebanon. Psychologization of life pressures became an intervention of the field itself-- of the lived experience of the everyday-- as personality disorders replaced trauma as diagnostic tools to train and educate local practitioners and community members alike on seeing the psychological in family dynamics, personality types, gender roles, practices of grieving and loss, motherhood, and life pressures. Unlike trauma

that triggered a psychological injury from violence, personality disorders focused on individual psychological pathologies embedded in the person herself, manifesting in her behaviors, emotions and interaction with others. While the psychological in the form of trauma was hard to find in Lebanon during the war, the psychological was now seen everywhere- in old potatoes, bizarre behaviors, self-possessive husbands, washing rituals and in the pressures of living in the south all together.

Through this form of psychologization, Abbas's life problems which first started when he traveled to 'Africa' became potential aspects of an obsessive compulsive personality disorder, Mariam's inability to overcome the loss of her martyred brother become a possible feature of histrionic personality disorder- a pathology that many Lebanese and Arab women shared as a result of a traditional pedagogy and a conglomeration of taste, relationships and lifestyle that encouraged hysterical emotions. Likewise, paranoid personality disorders and antisocial personality disorders became interpretations of types of husbands and men that indicated pathological marital and familial relationships. Personality disorders work to turn the problems of living in South Lebanon after the war, with all its economic, social, familial and gendered complexity, into an individual and psychological pathology of the person.

In this form of psychologization of life in postwar South Lebanon, 'culture' and 'stigma' were often evoked to describe the field as a resistant site for psychology and psychotherapy. Many psychologists spoke of 'stigma' as a main obstacle for psychotherapy and psychologization, especially in regions like the south, which was marginalized and lacked accessible health and mental health services. In this sense, psychological education (whether training or awareness sessions) was a form of intervention that served two purposes: it first aimed at overcoming communities' resistance to therapy, as was experienced by many

psychologists trying to diagnose trauma and PTSD. This resistance was understood as a result of fear from stigma in the south, where having a mental illness was considered a mark of disgrace in the community. Humanitarian psychologists spoke numerous times of the ways in which their work was halted by 'stigma' that prevented individuals from seeking therapy and speaking of their distress in psychological terms.

Second, this form of psychologization served to counter social, cultural and religious archaic beliefs around mental illness in the south as a product of "spirits and sorcery" (see chapter three) by introducing psychological science. Humanitarian psychologists built an exaggerated image of the postwar south as a raw and traditional place where sciences of psychology were largely unknown and resisted. The process of psychologization aimed at countering forms of resistance to psychotherapy embedded in people's personality attitudes and belief systems seen as a product of an archaic and conservative pedagogy and culture. The local social workers and nurses I spoke with like Thorayya however, did not articulate this resistance as a product of a conservative and archaic tradition, but of a difficulty in separating the psychological aspect of social and economic life pressures.

Psychological training and education of practitioners and communities relied on personality disorders to reconfigure the ways of living, and socializing, by uncovering the psychological and pathological in one's everyday life. They helped produce a kind of person psychologists were more used to treating in the clinic, a patient with a certain psychological self-awareness and self-understanding, who was able to read her feelings, environment, family and culture through a psychological lens. Personality disorders like histrionic and antisocial personality disorders offered psychological explanations and narrations of self and society in South Lebanon, as a way to produce a therapeutic subject with a specific form of awareness and

vulnerability that could be treated in individual psychotherapy. The making of the humanitarian psychological subject enabled her to lead a better ethical life, have a better future for herself and her children. It enabled the making of a new kind of therapeutic person who possessed psychological knowledge and awareness of herself.

This form of psychologization attempted to deal with some of the struggles humanitarian psychologists had when treating new aid communities who lacking psychological acculturation and were resistant to treatment (see chapter two). But how did the use of personality disorders contribute to the making of therapeutic subjects? By discussing and teaching histrionic and paranoid personality disorders in psychological awareness sessions for example, and using them to interpret specific marital relationships, women participating in the sessions eventually started talking less about their role as "mothers" and started opening up about their problems with their husbands, discussing marital life and private affairs, albeit by talking about them in psychological terms as personality disorders. Questions like "What should a woman do if her husband has a paranoid personality disorder?" And "What if a woman has a son who is always controlling her daughter?" initiated conversations Samer saw as having therapeutic value in these group sessions because they touched upon topics these women have resisted raising so far, and where he thought the women's problems resided.

Eventually, around the last session I attended, the women group reached what Samer called a group catharsis, becoming therapeutic communities who were able to speak of their distress and problems psychologically. Samer was very excited as the women started sharing stories about their fathers and their childhood, drawing from the pool of psychological knowledge he has been lecturing about to analyze their feelings of neglect, violence and abandonment as children. For Samer, this was one of the main purpose of these sessions as the

women stopped speaking of their own children and started talking about themselves and their own suffering in psychological terms.

Practitioners like Thorayya, Miriam and other social workers and nurses also became aware of their own psychological problems. By the end of the psychological awareness sessions, Mounira told me that she was going back to college to get a psychology degree. She was interested more than ever in psychology, now that she could see all the subtle ways in which people's lives can produce psychological illness. Many times during my encounters and visits with social workers and nurses, I saw how they started psychologizing their families and their own problems. For example, by the end of our visit to Imam Sadr Foundation's health center in the south, Thorayya spoke extensively about her own struggle with mental health: "we give a psychological diagnosis and support to others, but who gives us, the nurses, psychological support?" Samer became quiet as she told him of the psychological life pressures she was under. He suggested that she does some self-care like exercise to improve her mental health.

The psychologization after the war was a psychologization of the field itself, of the lived experience manifested in social and cultural practices, behaviors, affects, ideas, pressures and lifestyles. It sought to reconfigure new meanings desires, tastes and behaviors along psychological lines, bringing a new form of consciousness and making a therapeutic subject that welcomes and desires therapy.

While the war became a site of resistance, where trauma was hard to find and treat, the postwar became a site for overcoming the field's resistance to therapy through psychological reconstruction of self and place. The project of humanitarian psychology moved beyond war trauma to assess and map the pressures of living in South Lebanon as psychological distresses and disorders. The lack of mental health institutions, infrastructures and practitioners in the south

during the July War was now addressed in the form of extensive trainings and integration of mental health within primary health care facilities.

Psychologization of life in postwar south was part of a wider trend of incorporating mental health within primary health care institutions in Lebanon. This form of psychologization that IMC made possible through its partnership with Amel and Imam Sadr Foundation was considered as a form of pilot study to test the efficiency and practicality of such a project. At the time of my research, the training of local practitioners on psychological assessment was not restricted to South Lebanon but was implemented in Beirut and in other areas in Lebanon like the city of Tripoli in the north and Akkar in the Eastern district. By the end of 2015, the incorporation of mental health within primary healthcare facilities became a national program as the Lebanese ministry of health adopted a national mental health and substance abuse strategy in line with the WHO regional framework and recommendation. The process of psychologization that took place in South Lebanon informed this strategy that began to be implemented this year in various healthcare centers in Lebanon.

VI. Conclusion

After the war, massive psychological trainings, assessments and rehabilitation of institutions and practitioners in South Lebanon were under way. In contrast to the humanitarian trouble of finding the psychological and trauma, the psychological was everywhere in postwar Lebanon. Local practitioners were learning how to assess and identify psychological distress and disorders in different health centers. They were learning to read and see what is psychological in one's environment, behavior, feelings and stories and in detecting potential psychological disorders in non-normative behaviors and lifestyles. While social workers and nurses had some difficulty finding what is psychological, trainings of local practitioners were accompanied by

awareness campaigns and sessions designed for communities thought to be most vulnerable to mental illness.

War trauma ceased to be an interest of humanitarian psychologists who sought to map out the psychological and the pathological in everyday life in the south. The expansion of psychology through humanitarian organizations went beyond violence to look at life pressures as psychological. In that sense it was an intervention on the field itself, of the lived experience.

This chapter followed how both experts and communities learned, through diagnostic training and psychological education, to see life's pressures, personality types and behaviors. As psychological symptoms. Histrionic, obsessive compulsive and antisocial personality disorders, become familiar diagnoses replacing PTSD and trauma after the war in South Lebanon. This form of psychologization worked on overcoming resistance to psychotherapy by enabling new forms of therapeutic subjects who understand their personality, behavior and sociality in psychological terms.

Chapter V

Therapeutic masculinity and domestic violence in postwar Lebanon

I. Introduction

"*Marhaba, men wein*?" (Hello, where are you from?), the psychologist Salma asked me, smiling politely after Mounira introduced me by name. I was taken aback by the inappropriate taboo question often used to identify one's religious sect in Lebanon by locating her place of birth. It seemed that Salma recognized my last name, a known Shia Muslim name from the south, and wanted to be certain if I was Muslim or Christian. Today, the basement room where I usually attended Samer's psychological awareness sessions in Amel center in Tyre has been occupied for a different purpose. Salma came from Beirut to run a focus group for a research study on domestic violence and masculinity. She was only interested in recruiting Christian women today, as the study explored the relationship between masculinity and domestic violence in distinct Christian and Muslim residents.

I did not know how to answer her question. I introduced myself as a researcher, not to be confused with 'ordinary women residents of Tyre', one of the groups the study targeted. The study was a product of a partnership between International Medical Corps (IMC) and ABAAD, a local women advocacy NGO located in Beirut and founded in 2011, to target domestic violence in Lebanon. IMC's partnership with Amel organization (see chapter four) meant that ABAAD's programs could be implemented by using Amel's aid communities in the south. Tyre was also a good site for these focus groups since it is home to both Christians and Muslims.

Earlier that year, ABAAD had launched a national campaign introducing a new therapy: a counseling center for men who suffer from anger problems. Through giant billboards covering Lebanon's highways from north to south, and in television commercials, the organization introduced the 'men center' as a counseling service for men suffering from uncontrollable anger in response to daily life and work pressures- an anger that had the potential turn into domestic violence against women.

The campaign was called '*Mest'edeen Nesma Haki'*, translated by ABAAD as 'We are willing- and here- to listen", to emphasize the simplicity of talk therapy. The TV commercial introduced four men: a *service* (communal shared taxi) driver stuck behind a vegetable cart; honking and shouting for the seller to come and move it; a doctor in his clinic overwhelmed with work, receiving a call from his wife and screaming at her; a vegetable seller in his shop throwing a tomato box on the ground angrily; and an electrician trying to fix a problem with entangled cables then violently picks up the ladder. All four men then go into their homes slamming the door behind them, implying domestic violence.

In the TV commercial, we hear a narrative that cuts across the four stories, using popular expressions and metaphors normally evoked to express anger:

> *"Have things become too much to handle? Is your blood pressure high? Are you 'mcarraz' (suffering from a crisis of anger)? Are you always 'electrified'? Don't take it out on others. Don't take it out on your family. We are here to listen".*

Figure V.1 An angry vegetable seller. Poster reads:
"Do you feel like you are going into a crisis (of anger)? Don't take it out on your family.
We are willing -and here-to listen"

The counseling center for men was one example of the form of psychologization that occurred after the July War and aimed to identify the psychological in everyday life pressures (see chapter four). ABAAD sought to prevent domestic violence by changing how Lebanese men psychologically dealt with the pressures of life, without undermining their masculinity and the "macho-ness of men" (ABAAD website). The purpose of the study I encountered in Tyre was to guide the psychologists working at the men's counseling center in this process, by informing them of the different cultural understandings of masculinity and violence that circulated among Christians and Muslims in Lebanon. Through psychotherapy, the violent aspects of Lebanese masculinity were to be transformed into non-violent ones, while its positive aspects- like the man's role in protecting women- were to be reinforced in ways that were socially and individually acceptable. The study was part of the increasing professionalization of Lebanese

NGOs following evidence-based therapies that could present commensurable outcomes for donors and international partners[127].

Figure V.2 Campaign for the men's counseling center "Are you talking frantically? Don't hurt yourself don't hurt your family,"

The launching of the men's center came after a year of active mobilization against violence against women, which led to drafting a law against domestic violence (The Daily Star 2012). This mobilization was itself part of a history of women's activist, militant and institutional work of organizing against violence against women in Lebanon. The work of many women's advocacy

[127] The organization was also holding meetings with various national advocacy centers and organizations, with the collaboration of IMC and the ministry of social affairs, in order to organize a standardized national response to domestic violence in health and service centers across Lebanon.

organizations had placed the issue of domestic violence in the forefront of public and political debates in Lebanon.

Domestic violence has been a pressing reality in Lebanon. As a student intern in psychotherapy in 2004, many of the women I saw for counseling were abused by their husbands. The policy adopted at my internship was to try and bring the husband into the clinic to do 'marriage counseling' for both of them. After the July War domestic violence became- more visibly- a human rights issue[128]. Global humanitarian organizations, policies and programs became invested in addressing and preventing domestic violence. Hotlines, legal and medical consultations, psychotherapy for domestic violence victims, and reform initiatives were advanced by women's advocacy NGOs and global humanitarian organizations like IMC interested in reconstructing and rehabilitating mental health in Lebanon. This made domestic violence a priority, while the Lebanese government and religious leaders fought viciously to maintain the status quo, especially in the household.

Within this active work of women's advocacy NGOs, ABAAD stood out as providing a new kind of therapy against domestic violence in two aspects that reflected the emergent forms of psychologization at play after the July War in Lebanon (see chapter four).

First, these therapies did not target women suffering from gender based violence, but sought to therapeutize angry men as victims of their own masculinity- a masculinity that made them psychologically unequipped to act in non-violent ways. While NGOs have traditionally intervened to support women victims of domestic violence through legal-psychological support,

[128] Domestic violence has been a human rights issue in Lebanon ever since the 1990s but the NGO structures made it much more institutionalized. The process of binding women's movements with a non-governmental structure, linking them more to global agendas of women rights. This became much more noticeable and institutionalized after the July War, as the focus on 'the women question' in post-conflict societies, like Lebanon, became a pressing issue.

drama therapy and psychotherapy (Khattab 2010), ABAAD's therapies were a psychological intervention for social change, aiming not at alleviating distress of women victims of domestic violence, but at creating non-violent forms of masculinities through therapy.

Targeting Lebanese masculinities in the fight against 'violence against women' was not a specific focus to ABAAD, but was part of a growing interest in many women's advocacy organizations. Later that year, KAFA, another woman's advocacy NGO, launched its own masculinity campaign[129] called "towards alternative concepts of masculinity". The campaign questioned dominant forms of Lebanese masculinities, especially the ones that had the potential to produce violence, and highlighted alternative masculinities that were not necessarily patriarchal and violent[130]. Campaigns for alternative masculinities in Lebanon came out of a legal-reformist trend within women movements that informed Lebanese feminist discourse (Bernadette 2014; 2015**)**. This approach represented what feminist researchers described as "the third wave of feminism" for women organizations (Bernadette 2014), where "The man question" became central to feminist work and discourse in Lebanon[131] (Makarem & Rizk 2015).

Demands for equal nationality rights, labor rights, and lobbying for a law against domestic violence and marital rape, were all part of a feminist (legal) reform of masculinity in

[129]The ad was called "Hon rjoulitak? Fatteish 'ala insanitak" "Is this where your manhood is?…search for your humanity" The ad depicts a famous Lebanese actor enacting and signaling 'violent masculinity' as he points to his biceps, a gun in his waist, takes out his sun glasses and showing his angry eyes with a tattoo on his biceps, then holds his hand in a gesture of abuse, showing lots of cash, pointing to his penis. His search for his manhood is followed by a woman voiceover asking him where his manhood is located, in a mocking tones: "where is your manhood? Is it here…can it be here? Or here? Are you serious? NO, you're very strong. Is this your manhood?" don't waste your time, search for your humanity" the name of the campaign "towards alternative concepts of masculinity" is then depicted on the screen.

[130] KAFA published the experience of some Lebanese men- many of whom were activists- who represented an alternative form of Lebanese masculinity defiant of the dominant and patriarchal image of the Lebanese man (Kafa

[131] Debating masculinity became a topic of concern by the end of the 90s, with the increase in political participation of women and the institutionalization of the work against gender based violence (Makarem & Rizk 2015).

Lebanon that produced a counter-discourse on "masculinity in trouble" and "threatened masculinity" (Makarem & Rizk 2015). While the feminist humanitarian desire to transform masculinity was not a new initiative in Lebanon, transforming masculinity through psychotherapy was unique to ABAAD's work and humanitarian vision, and a reflection of the process of humanitarian psychologization that took place after the war (see chapter four).

Second, the men's counseling center framed violence against women to be first and foremost a result of an archaic and conservative understanding of masculinity in Lebanon- of "years and years of illogical rules" that determined socially acceptable manifestations of masculinity in Lebanese society[132]. This was in line with the forms of psychologization that targeted archaic and traditional understandings of self and society as a source of mental illness (see chapter four). In that sense, the center focused on teaching men how to control their anger in everyday life through therapy[133].

Drawing from various literature on social psychology, anthropology, sociology and theology studies- especially positive psychology (Abaad website)- the men's center tried to account for the social and economic daily stressors men faced in Lebanon as 'psychological pressures' (see chapter four) that triggered violent behavior and emotion. Transforming masculinity was at the heart of these therapies. The men depicted in the ABAAD's campaign were of various class backgrounds, but what they all had in common was their inability to deal with life stressors in a non-violent way- regardless of the reason behind their anger. The rationale behind these therapies was that violence against women occurred not because of patriarchal, legal and power dynamics that structure marital relations between husband and wife, but because these men did

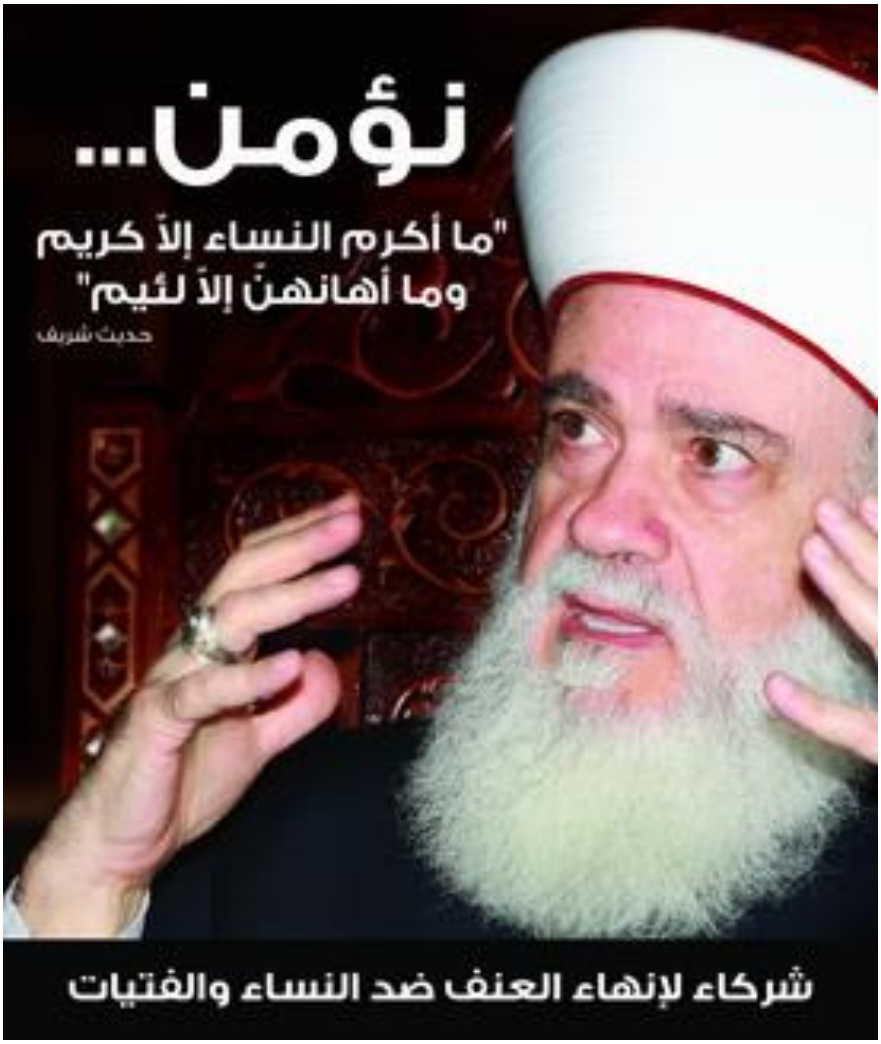
[132] Seminar by Anthony Keedi 2014.
[133] Interview with Anthony keedy psychologist 2014.

not have the necessary psychological tools to react to life pressures in a non-violent manner. Men did not know any way but to use violence in the household because they were raised this way *as men.* It is precisely this form of traditional and social pedagogy of masculinity that ABAAD aimed to transform through psychotherapy, as a way to end domestic violence in Lebanon.

One clear example of how these therapies aimed to target conservative cultural notions of masculinity as a way to end domestic violence, was the "We Believe" campaign" that ABAAD launched in partnership with Lebanese religious leaders against domestic violence in 2012. This move was heavily critiqued by many feminist activists and scholars in Lebanon (Khattab 2010, Daou 2014, Salameh 2014) because of the historical feminist struggle with religious leaders and the overall system of sectarianism in Lebanon- considered as constitutive of patriarchal discourses that legitimize domestic violence. ABAAD's partnership aimed at showing that the source of domestic violence was the traditional and backward attitude about women, not religion itself (Abaad website**)**. The "We Believe" campaign aimed at changing "the culture of domestic violence" by representing different religious leaders as condemning domestic violence against women. In the series of dialogues[134] ABAAD hosted with different religious leaders, domestic violence was raised as an issue caused by a traditional "tribal culture" that uses religion to justify the violence- not as a result of patriarchal, religious and structural powers (Baydun 2015). In that sense, the men's counseling center became an intervention that aimed at changing traditional understandings of masculinities.

[134] ABAAD's we believe campaign was followed by a series of dialogue the organization hosted with different religious leaders and selected women civil society organizations and groups around several topic of interest to women civil society (heritage, violence, divorce etc.). I was invited to attend a session on marital rape and domestic violence. In the session, the two attending religious scholars explained that there is no violence in religious scriptures but in the archaic, tribal and traditional cultural convictions and beliefs that reside in Lebanese society.

Figure V.3 The “We Believe” campaign: “one who honors women is honorable & one who offends them is depraved”. Partners to end violence against women and girls



These premises behind ABAAD’s therapies unfolded in the research study I encountered in Tyre, measuring the relation between violence and masculinity across religious sects. This chapter follows the difficulties faced by the study in Tyre. These difficulties revealed tensions between new forms of psychologizing and treating violence, and the structural context of living in South Lebanon after the war. They also revealed a deep form of de-politicization of domestic

violence by removing it from its patriarchal and structural context and turning it as an internalized psychological injury of angry men themselves. Domestic violence became a result of poor psychological skills in dealing with life stressors, while all 'angry men' became both aggressors and victims.

As this chapter will show, psychologists faced numerous difficulties gathering the Christian focus group in Tyree, where the study's premises were contested by communities as they were being convinced to participate. The overwhelming violence occurring in Tyre at the time of the study seem to also contest the study's premises. When the focus groups were finally formed and the study started, both Christian and Muslim participants spoke of structural and patriarchal forms of violence that informed their definitions of masculinity, thereby challenging the assumption that domestic violence as a product of archaic and traditional pedagogy that varied from one religion to another and is treatable by psychotherapy. This chapter shows how therapeutic governance of angry Lebanese masculinity turned men into vulnerable humanitarian subjects in need of assistance. It produced knowledge about violence as a result of archaic pedagogy that varied based on religion. Therapeutic masculinity turned violence into an individual psychological problem detached from patriarchal, political and structural context, while reifying existent projects of sectarian difference and inequalities in Lebanon.

Overall, the research study was predicated on the messy and chaotic work of recruiting and interviewing Muslim and Christian men and women in Tyre. And, as the last section will show, the study's premises were challenged many times in the focus groups. However, this was neither uncommon, nor was it a unique failure of a humanitarian intervention. These messiness and contradictions were rather an inherent part of humanitarian work itself, what Dunn called "Humanitarian adhocracy": a form of bureaucratic humanitarian power that "creates chaos and

vulnerability as much as it creates order" (Dunn 2012, 2). Chaos and messiness in humanitarian work was an intrinsic property of global humanitarianism, where multiple organizations proposed and designed projects ad hoc, using "rough-and-ready ways of knowing to quickly arrive at improvised solutions" (Dunn 2012, 15). ABAAD's new therapies were just that, proposing new ways of eradicating domestic violence by psychologically targeting archaic forms of social pedagogy, instead of addressing the structural issues that determined this form of violence. This chapter focuses on the slippages and negotiations that occurred around the research study I encountered in Tyre, as a way to deconstruct the implications the notion of therapeutic masculinity and how it was countered in practice.

I first provide a short history of the women movements against violence against women in Lebanon, I then turn to describe how the research study encountered difficulties in recruiting participants for the focus groups, and the ways in which the study ended up reifying violence projects of difference in Tyre. I then recount how the focus groups contested understandings of domestic as a product of masculinity proper by evoking multiple structural conditions that constituted both notions of masculinities and domestic violence.

II. A short history of violence against women movements and psychologization in Lebanon

The violence against women movement is part of a rich history of political struggle against patriarchy, rights, class hegemony and sectarian regime in Lebanon (Daou 2014; Khattab 2010; Abisaab 2010). Recent work has sought to understand the evolution of women political action in Lebanon in terms of four successive waves emerging from: 1) an elite-based women

organizations in post-independence Lebanon[135], 2) a leftist organization for social equality in the 1960s, 3) the rise of civil society, growing NGO-ization and human rights discourse in the 1990s after the civil war, and 4) anti-globalization and anti-war movements at the beginning of 2000 in Lebanon (Daou 2014). While other recent work provides a different reading of the history of women's movements in Lebanon by relying on queer temporality that allows for the emergence of subaltern narratives and voices (KaedBey 2014), I rely on the third feminist wave of NGO-ization and civil society reform- as conceptualized by Daou (2014) - as a dominant trend that facilitated the constitution of women as therapeutic aid communities in Lebanon.

The process of NGO-ization in postwar Lebanon after the civil war is part of a global shift in liberal reforms and policies directed towards the Arab world (Jad 2004; Brynen et al 1995; Karam 2006)[136]. At the end of the civil war, women became one of the main targets for development, reforms and reconstruction. The NGO-ization of Lebanese women's movements was part of a process of democratizing the Arab world, where 'civil society' became seen as the mobilizer for social change (Jad 2004). This intersected with a growing global human rights interest in the problem of 'violence against women-, a discourse that started taking shape and form in the early 1990s "as the lowest denominator from the women's movements in the North and the south, taking the issue of bodily integrity as a universal concern that they could rally around" (Ticktin 2011, 17).

[135] Forming on the eve of the independence of Lebanon from France in 1943 and influenced by the Human Rights Charter, this form of women mobilization was influenced by national independence movements and was mainly led by Lebanese elites (Daou 2014)

[136] Interview with Ghassan Makarem, 2015.

Another factor in the rapid NGO-ization and professionalization of women's movements in the 1990s was the flow of international funding to movements working on women issues[137]. The mobilization of funds came hand in hand with growing international interest in women's rights and violence against women "as a problem at the highest level" in "conflict-affected countries" (Ticktin 2011, 240)[138]. Violence against women became a priority in 'conflict-based countries' like Lebanon, urging humanitarian psychological care side by side with political participation and economic development.

The Beijing Summit on the question of the women rights[139], held in 1995, provided an opportunity for diverse Lebanese women's groups, activists and leaders to participate and organize following humanitarian rights, laws, and interventions[140]. The Summit allowed for a new kind of political organization based on rights, and called for specialized groups around three main themes: violence against women, citizenship rights and economic opportunities for women[141] (Khattab 2010). The Summit's resolutions provided a new agenda and visions for women's movements in Lebanon[142]. These committees enabled the emergence of specialized and professionalized local women's advocacy organizations that were directly linked to global

[137] With all agencies focusing on the same topic, the multiplicity of funds have created competition within NGOs that strived to become more specialized in order to distinguish themselves from each other (Khattab 2010).
[138] In 2009,The UNSC unanimously adopted a resolution to end violence against women in conflict-affected countries (Ticktins 2011, 240).
[139] The fourth international conference on the question of women rights.
[140] The groups organized and prepared between 1993 and 1995.
[141] To follow up with the convention's resolutions, different committees were created to lobby for the implementation of CEDAW (Convention on the elimination of all forms of discrimination against Women)'s resolutions (Daou 2014).
[142] The summit's resolutions were, as summarized by Daou (2014): 1) Making women aware of their rights; 2) Calling and ensuring more women participation in the different sections of political and public life on a national level and 3) Respecting human rights and women's rights specifically, ensuring equality (20).

human rights agendas and funding-- like KAFA an ABAAD[143], the two main current NGOs present in Lebanon today.

The increased process of NGO-ization of women's movements in the 1990s was accompanied by a growing interest in the psychology of women exposed to civil war and violence. A look at the *Al Raida* journal[144] between 1993 and 1995- the two years leading to the Beijing summit- reveal the different campaigning and research conducted for the preparation for the Beijing summit, with a new interest in focusing on and understanding the mental health of women in war and violence[145]. Articles mainly focused on the psychological effects of the civil war on women as wives and mothers of fighters[146] and the psychological effects of domestic violence[147].

[143] While ABAAD is a recently established women rights NGO, founded in 2011, its current structure and programs must be located into a broader historical context of feminist and women activism in Lebanon, both in the context of organizing around the Beijing under LECROVAW committee, as well as the succeeding ruptures and schisms resulting from problems and disputes over the elections of the executive committee (Daou 2014). It is in this context that KAFA saw the light in 2005 as some activists and professionals broke from LECRVAW to establish their own NGO-based organization. Years later, KAFA went through the same fate as some of its members split to establish a new women's rights-based NGO (Daou 2014). The founding of KAFA and then later on ABAAD was accompanied by a feminist discourse that broke from its leftist and revolutionary roots and aligned itself with discourse of human rights that targeted segmented causes, and reforms of existing laws (Daou 2014; Khattab 2010). As one militant feminist stated in an interview with Bernadette Daou, the feminist leftist discourse of 1970s Lebanon adapted to the requirements of globalization by "taking out the liberation of women from the liberation of society" (Daou 2014, 22).

[144] A journal published by the Institute for Women's Studies in the Arab World (IWSAW) at the Lebanese American University (LAU) since 1976.

[145] A look at issues prior to 1993 shows no such interest or research conducted on understanding and studying the psychological distress of women from war.

[146]Furthermore, literature on the relation of women to war has also been published in Shehadeh book on '*Women and war in Lebanon'* published in 1999, which included a chapter by psychiatric nurse Leila Farhood on war trauma in women and their specific vulnerability during the civil war. Lebanese women were being constructed as psychologically vulnerable to civil war and domestic violence in the 90s, and also in need for special psychological attention. While this was the focus of the studies, needless to say that women were an active players in the civil where many women were fighters, had political opinions, and engaged actively in combats. After the war however, women seem to be constituted first and foremost as victims of violence.

[147] New classes in women studies, among them 'the psychology of women' were introduced at Beirut University College around the same time.

After the July War, there was much more professionalized and specialized psychological care for women, as the issue of domestic violence became more organized around specific NGOs, funding and strategies. A look at recent policy documents produced by the European Union, United Nations and USAID on women and violence in Lebanon show that funding after the July War mainly focused on three issues: providing economic opportunities for women, increasing political participation and the alleviation of social distress caused by Gender-Based-Violence (Khattab 2010). This alleviation took on different service relief form, from psycho-legal support, counseling, individual psychotherapy and to drama group therapy- all seeking "to mitigate women's social distress, making them feel better but not empowered" (Khattab 2010). After the July War, funds dispensed for the 'women question' in Lebanon were framed in terms of a broader plan for reconstruction of infrastructure, economic and human rights development in post-conflict countries like Lebanon[148]. Women's movements became equipped with financial resources to do nation-wide projects they could never have afforded before. This connected them, both materially and ideologically, to a global discourse on human rights on violence against women.

III. "We're all the same": Recruiting Christian-only participants and the making of the masculinity study in Tyre

Salma continued to text anxiously on her phone, updating her supervisor in Beirut on the problems she was facing in organizing the Christian focus group for the masculinity study. Only two women of the six who promised to participate showed up. Recruiting participants in focus groups and awareness sessions was part of Mounira's job as Amel center's social worker, with

[148] For example, the European Union (EU)'s country strategy paper for Lebanon details development initiatives EU funded in Lebanon from 2007-2013 (EU 2007). The document frames the "the participation of women in political, social and economic life is of utmost importance to ensure sustainable development" (EU 2007,16)

deep ties to the communities of Tyre and nearby towns. The day before, Mounira helped set the Muslim women group, which was a relatively easy task. All she had to do was invite some women a day before, and then assemble the rest on the day of the study with the women who happened to be visiting the center. But the Christian group was proving to be much harder to gather. Mounira's weak connections with the Christian residents of Tyre made finding participants for the study much harder, creating a problem in participation.

Mounira turned to one of the two women waiting and asked her why the others did not come: "Is it because it is held in Amel? Is it because it is so far away? We can pay for transportation…or maybe it would help if we held it in Caritas?[149] (A faith-based Christian organization)". While Amel is a secular non-governmental organization with a long established history of aid and community development in South Lebanon, it seemed to be mainly servicing Muslim communities of Tyree, while Christians seem to rely on more familiar organizations like Caritas and the church for aid and support.

Catherine, a strong and outspoken woman in her early fifties- with a rogue voice that implied heavy smoking, and grey hair pulled back in a ponytail- replied that everyone promised her to come but they did not show up. She was Mounira's connection to the Christian communities in Tyre and she was not happy that she let her down. Being a sort of a fixer herself- a community fixer- meant easier access and connection to services from Amel for her and her community. Catherine suggested that the problem might be timing. Women are normally working or attending to their house choirs in the morning. But if they held the session in the afternoon, everyone will show up. They could even hold it in the church located in Tyre's "old

[149] Caritas is an international Catholic humanitarian organization founded in 1897. Caritas Lebanon was first established in Lebanon in 1972. It offer different health services and programs for Christian communities in Lebanon and lately for refugees as well.

town"[150], where the main Christian communities live**.** Catherine knew the priest and he would not mind hosting the session. This way, they could grab whomever was walking by and ask them to participate.

Mounira was more than aware that she was tapping into someone else's aid community when she asked whether Caritas- the usual Christian local aid provider- would be more suitable and "closer" than Amel. While Caritas is physically closer than Amel, residing right at the outskirts of the old town of Tyre, Amel is only seven minutes walking distance from Caritas. What Mounira was signaling here as "closer" was not the physical distance, but the extent to which Amel was reaching out to other humanitarian organizations' aid communities.

Salma, still frantically texting on the phone, pushed Mounira to make calls and organize the focus group she promised to have for the study. The other woman, one of Catherine's acquaintances, tried timidly to inquire when "the session" would start. Mistaking the research study for another awareness or educational session, she mentioned that all these sessions were beneficial because one always learned something new, so why not just start now, even with two people? "I left a patient behind that I am looking after", she added. She was hired by a local doctor to take care of sick people in her community and check up on them. Faced with silence, she commented politely, "It would not be a problem for me to come here if there is something in it for me". Catherine, also fidgeting in her seat, inquired as to the nature of the session: "What's this *jalseh* (session) about, anyway?" Mounira explained that they would not be participating in an awareness session, but in a research study that measured the effect of religion on domestic violence and masculinity.

[150] The "old town" of Tyree, located at the port of the city, is predominantly Christian. It is also called "the Christians' neighborhood".

Both women protested: “Religion has nothing to do with that, we all have been raised and raise our children the same way”. Catherine in particular was displeased with this kind of grouping: “I raise my son on both religions. Before he became (a man) he read the bible and the Quran. He even participates in Ashura (Shia religious practice) every year”. Mounira tried to justify this grouping one more time: “Don’t misunderstand me, I don’t mean it in a bad way. The study wants to explore if there is an effect of religion on domestic violence.” “*Kelna nafs al shi* (we are all the same)”, replied Catherine disapprovingly. Quite uncomfortable with these types of group divisions herself, as she would later tell me, Mounira remained silent.

Recruiting distinct religious groups created visible tension and anxiety for Catherine, her friend and even Mounira. Tyre could be described as one of the few remaining cities in South Lebanon that had maintained a somewhat delicate mixture of multi-sectarian communities. The division of neighborhoods according to sect in Tyre dates back to the civic organization of the Lebanese population in the 1920s under French Mandate (Diab 2010). It reflected the sectarian project in the region that became at the heart of the Lebanese republic’s project of sectarian governance. These sectarian borders were more visibly solidified in the civil war, where most Christians moved away from the center into Tyre’s “old city” next to the port.

By producing knowledge on Christian and Muslim masculinities separately, the masculinity study created disapproval and anxiety for local citizens of Tyre. Commenting on sectarian difference in public in the presence of ‘the other’ is seen as highly impolite and threatening. Catherine’s blunt disapproval of this scientific grouping was a refusal of this politics of difference. It was also a form of public politeness, since it was important in everyday encounters in Lebanon to establish similarities and social kinships more than difference across sects. But beyond her gesture of politeness, Catherine evoked an alternative and ‘messy’

formation of masculinity by giving her son as an example of a man who, born a Christian, has been educated on both religions and even participates in the Shi'a practice of Ashura just like any Shi'a man would. Ashura, as a religious practice, is also a place where masculinities are performed and practiced. Catherine's son was one example of a masculinity formed by entangled socio-religious practices, and by the messiness of religious co-existence in Tyre.

Catherine and her friend were not regular recipients of aid from Amel. Perhaps this made it easier for them to directly challenge the very premise of the study- the relation between violence, masculinity and religion-- before it even started. Catherine and her friend were subtly implying that attending a "session" or a research study- no matter how informative or interesting it might be- was predicated on an-already established material aid relation that neither women had yet acquired at Amel. In this morning's gathering, a subtle and polite negotiation of aid emerged as a commentary on the complex aid relations, through which Catherine and her friend agreed to participate in the masculinity study while being openly opposed to its very premise. Becoming part of Amel's network and aid community implied receiving aid and services. Only then could they attend workshops, trainings and be part of research studies- even ones they essentially disagreed with. Only then could they be constituted as a local aid community that could be shared and exchanged between humanitarian organizations for data collection and local knowledge.

Finally, everyone agreed to gather back at the center at 3 pm, where Catherine would have recruited a new group for the study. Relieved, Salma smoked a cigarette with Catherine as coffee was being served. Now that she was asked again to recruit the Christian group, Catherine became blunter and asked about the different programs and services the center offered. A wife of a fisherman who had suffered a disability at work and was now unable to provide for his family,

Catherine was the sole breadwinner. She worked as a nurse for a woman in her community who had been severely injured in the July War and was abandoned by her family. A doctor assigned Catherine to check up on her and write a report about her health every day. Catherine's friend also held a similar nursing job, caring for a woman who has lost both of her legs from diabetes.

Mounira gave them a summary of the services, and asked them if they would be interested in joining the weekly psychological sessions that the center offered. "Yes, I would be interested." said Catherine. "My husband is going crazy, especially after his accident. He just sits at home and sometimes all of a sudden, he starts crying and says that he wants to die, that he wants to kill himself. He even chopped off his daughter's finger with a knife. He wanted to kill himself and his daughter tried to stop him so he chopped off her finger". Mounira had to take a phone call, but she asked Catherine to stay so she could talk to her later about her situation.

The conversation then rapidly moved to chitchat. There was a lot to talk about. Yesterday, on Sunday after midnight, a bomb exploded in the elevator of a club-restaurant in downtown Tyre – famous for holding night entertainment and serving alcohol- injuring seven people. The explosion was one of a series of bombs exploding in Tyre in the last few months and targeting Muslim-owned liquor shops and restaurants that served alcohol. Also yesterday, a young man had set himself on fire in protest, when police started raiding some unlicensed beach tents serving food and beverages, targeting those who did not have the proper connections with the authority to pass unnoticed by the police**.** I asked Catherine about this incident while we had coffee:

> *"They (the police) got to where the tents are and started breaking them down one by one; they didn't notify anybody that they were going to do that. Hussein told them "it is either the tent or me" but they didn't care. He threw gasoline on*

himself and set himself on fire[151]. They already took three jobs from him, including a car he was using as a service (public taxi). Hussein sustains three families by himself. He just couldn't take it anymore. There was also a woman who has two kids to feed who has set her tent there. She told them "how can I feed my children now?" they told her "go feed them somewhere else" As if the only illegal thing happening in Lebanon were these tents[152]"

Catherine's statement "we are all the same" – that Christians are the same as Muslims in Tyre – might be read through the lens of social politeness to a certain degree. But her disapproval of the premises of the masculinity study takes on another meaning when she spoke of Hussein, the young Muslim man who set himself on fire, and the woman with three children whose tents were removed by the police. Hussein and the woman who lost their tents were part of Catherine's working class background regardless of their religion. When I asked Catherine what her son did, Catherine sarcastically replied: "he is investing in a career of hanging out by the sea". Catherine saw her own son's lack of employment as connected to Hussein's. The "we" in Catherine's statement takes on a certain class position regardless of religious and sectarian affiliation.

Hussein and the woman's struggle to provide for their families was something Catherine was much familiar with, as they all shared the same fate under the brutality of the police and the neglect of the state. The severe economic crisis and high prices of living in the Middle East, which provoked revolutions from Tunisia to Yemen, have also been severely felt in Lebanon. The increasing unemployment rates in Lebanon- especially in cities distant from the capital- coupled with the inflated prices created a severe economic condition in Lebanon since 2011, especially for communities like fishermen.

[151] Newspapers have reported that three tents were removed by the police and that Hussein set his own tent on fire and threw himself in it. He suffered major burn injuries.

[152] While many of these tourist tents have not acquired the municipality's approval, most of them have political connections with Lebanese leaders who allow them to remain protected from police raids.

As Catherine was finishing her sentence, a man suddenly walked into the room and said: "Are you talking about violence? Someone needs to address the violence that NGO workers go through. I just came back from the UNRWA[153] (The United Nations Relief and Works Agency for Palestinian Refugees) office. We closed down all our offices in Tyre. A group of fifteen Palestinian (refugee) men just stormed into UNRWA office and beat up a main official there. Someone needs to address the issue of violence against NGO![154]". The man was Mounira's relative who came to tell her what happened. We poured him some coffee to calm him down. He worked at UNRWA and was there when the Palestinian refugee men stormed in to protest UNRWA's unfair treatment of Palestinian refugees and the dearth of aid it was providing by beating up a local humanitarian worker.

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Catherine eventually was able to find four women who agreed to participate. But the study required at least six participants to produce valid results. Mounira was running out of options as Salma continuously pushed her to recruit the group she promised to deliver. They all finally decided to pay a visit to "the complex" in Abassiyeh town at the outskirts of Tyre, where Mounira knew a woman who lived there. *Moujama' al Baka' al Sakani*, or the "staying/survival residential complex" was constructed fourteen years ago by the Roman Catholic archbishop on the church-owned land in an attempt to support the remaining Christian fishing families residing in Tyre and neighboring towns, and to provide them with incentives to stay in South Lebanon.

[153] UNRWA: The United Nations Relief and Works Agency for Palestinian Refugees, established by United Nations General Assembly Resolution 302 (IV) in 1949 following the 1948 Arab-Israeli conflict to carry out direct relief and works programs for Palestine refugees. The Agency began operations on May 1, 1950 and has been providing humanitarian assistance for registered Palestinian refugees living in the West Bank, Gaza, Syria, Lebanon, and Jordan. UNRWA has a bad reputation in the camps of being corrupt and of contributing to producing miserable conditions in the camps.

[154] NGO workers exposed to violence.

The complex first hosted Catholic-only fishermen from Tyre then all Christian fishermen were invited to live there in apartment's buildings[155]. Since the complex contained Christian-only aid communities, the focus group would surely find its participants there.

While driving through the complex, Mounira recognized a girl and asked if her mother was around and whether she could invite some of her neighbors to sit with us. The child led us to an apartment, which soon was filled with women coming to see what the visit was about. Coffee and juice were served while Salma rushed to set up for the study. She asked that children would be taken out of the apartment because the noise would interfere with the study that was going to be recorded. The women, still not quite comprehending what the purpose of the study was, started to politely ask what this is all about. After setting the recorder, Suha read a consent form out loud describing the purpose of the study and announced that the focus group will take around two hours and a half. Stunned, some of the women stared at each other. Some asked if they "had to participate". But Salma tried to convince them to stay, to voice their opinions about masculinity and domestic violence, an issue that should be a concern and interest to all women. After a long day of negotiations and search for Christian research participants, the study finally found its targeted Christian participants.

IV- "Are you talking about violence?" The angry men of Tyre, sectarian aid communities and projects of difference.

In an almost ironic twist, the study on domestic violence and masculinity was surrounded by angry 'Muslim and Christian' men of Tyre. Catherine's husband- whose disability and loss of job turned him into a physically violent man towards his daughter- Palestinian refugee men

[155] The complex, composed of 78 apartments rented out for a symbolic price for 99 years, was constructed with funding from the Spanish government, a local non-governmental organization and a Christian donor from the city of Tyree. Currently, most of the residents are fishermen and their families.

storming UNRWA's office and beating up a humanitarian worker, and Hussein burning himself in protest of police violence and his unemployment; all were men confronted by what the study would quickly summarize as "life stressors" requiring psychotherapy. But to what extent was their anger and violence a result of an archaic and traditional pedagogy? And to what extent can this anger be transformed through therapy? In other terms, to what extent were they therapeutic subjects, requiring individual psychologization? In what way was their anger and violence an individual and psychological injury that could be transformed through therapy?

First, the masculinity study – and the form of therapies it informed – targeted masculine anger as the prime cause of domestic violence. In this sense, Hussein setting himself on fire -a quintessential form of political protest after the eruption of the Tunisian and Egyptian revolution- Palestinian refugees beating up an UNRWA staff, and a disabled unemployed father chopping off his daughter's fingers; all become angry acts of violence considered as psychological individual pathologies caused by these men's inability to express feelings and frustrations properly. These acts could be avoided and changed through talk therapies in which men would learn other ways of dealing with life's stressors. Likewise, Palestinian refugees could be taught through psychotherapy how to communicate their anger in a non-violent way to the historically deaf ears of UNRWA and the abrupt and ongoing suspension of aid to Palestinian refugees.

Through studying the relationship between violence, masculinity and religion, the masculinity study in Tyre tried to isolate violence from the complex economic, historical, social, sectarian and political fields that produce it, like economic and health inequalities, state politics, bombs and unemployment. It did so by locating violence within a psychologically internalized form of 'cultural pathology' (Ticktin 2011) of masculinity proper. In this sense, the masculinity study was not interested in the different forms of violence that took place in Tyre at the eve of

the focus group meeting in Amel center, but in how men reacted and dealt with them as "life stressors". Therefore, the study reduced political and structural violence into everyday events, forms of external social stressors that one must cope with on a psychological level. The study saw violence as a pathological reaction to a normal and possible event, where random bombs exploding at alcohol-serving restaurants; state violence against poor and politically unconnected individuals; permanent injuries from war episodes, health problems and job accidents, all became equated and understood as "life stressors and incidents" that incited violent masculine reactions.

Second, the research study was used to make therapies of masculinity 'culturally appropriate'. This was done by trying to account for the forms of pedagogies, attitudes, beliefs and opinions on masculinity that were supposed to vary between Christians and Muslims. This premise of sectarian difference however intersected with and unintentionally reified other projects of difference in Tyre, which manifested in the explosion of a bomb in downtown Tyre in alcohol-serving restaurants.

The bomb exploding on the eve of the masculinity study meeting in Tyre was not an unfamiliar event in any sense. It was the third bomb that targeted alcohol-serving places run by Muslim Men, in the last few months. It evoked older "projects of separation" and purification that date back to the end of the civil war, where entire neighborhoods and regions on the coastline heading to Tyre were violently attacked and Muslim alcohol store owners slaughtered for selling alcohol[156]. The rapid purification of certain areas after the civil war in Lebanon and the re-establishment of the sectarian state with distinct and discrete religious communities to govern claimed communities as either Muslims or Christians and drew new sectarian boundaries

[156] The liquor shop owner from the store my family bought alcohol from on our way to the south was slaughtered in the early 1990s. After a while one could not find any alcohol shops in the region.

in cities and neighborhoods. One way this was done was through attacking alcohol stores and businesses- making alcohol hidden in places considered to be Muslim and restricting it to areas and neighborhoods "reproduced" as Christian in the south. The return of the most recent sectarian bomb, reminded local residents of Tyre, who were becoming messier in their practice sharing- from Muslims drinking alcohol to Christians participating in Ashura- of the old delineated sectarian lines in the city. The masculinity study joined and intersected with these projects of difference implemented by bombs and by the state- as projects of difference that worked to separate and mark Christian spaces from Muslim ones in Tyre**.**

Third, the scientific separation that the study imposed was reinforced by the humanitarian institutions of care that produce different aid communities based on religion and sect. Aid was distributed along sectarian borders, reproducing these borders itself, even when it functions under premises and assumptions of neutrality and secularism, as was the case of Amel organization. The problem of finding Christian research subjects continued as Catherine failed to gather the required number of participants for the masculinity study. As a last resort, the aid providers reached outside of their own communities to 'the complex', a Christian-only space that provided aid and housing for fishermen at the outskirts of Tyre. The problem of participation was resolved by "popping in" the complex and asking certain families if they could pay them a visit, literally imposing themselves on the families, something that Mounira was deeply uncomfortable with.

The women who hosted us and later became research subjects for the study were very friendly. Some of them were excited to talk and share their opinions about domestic violence, men and masculinity. Others were not. But everyone stayed and participated. What surprised me the most was the ease through which the study was eventually launched, in one of the fishermen

families' apartment that afternoon, and how easily the men and children were rushed out of the house. Women did not inquire about the purpose of the visit. They just knew that women from different humanitarian organizations wished to speak with them. It seemed incredibly easy to 'just drop in' and start the study that lasted for two and a half hours. Why did they agree on talking for two and a half hours with people they did not know, had no relation to and were not getting any kind of aid from?

The 'complex', a visible space of sectarian aid provision for Christian fishermen, had already constituted its residents as an aid community. Therefore it was easy for aid providers to go in and select a research group for a study that lasted two and a half hours. Some forms of polite protests did emerge when women asked if they really needed to participate, while others joked about how their husbands were going to divorce them and do "domestic violence" because they kept them outside of their house for two and a half hours.

Overall, humanitarian psychologists faced many difficulties recruiting and convincing Christian women to participate in the focus group. These difficulties reveal an embedded and complex relationship to aid, where aid was distributed along sectarian borders, reproducing them and intersecting with state projects of difference in Lebanon. While it was hard to recruit Christian women to participate through Amel organization, Mounira had a much easier time recruiting both Muslim men and women groups, as they were constituted as Amel's main aid communities in Tyre. As I waited with Mounira for the humanitarian psychologist to arrive and conduct the Muslim men focus group a week after the Christian women focus group took place, I saw her approach some men sitting in the café next to the center, asking for their participation in a research study the center was hosting. Some had been approached by her days before and had been waiting for the focus group to start in the café, while others were quickly convinced to join.

The recruitment process took only a few minutes as these men knew Mounira and trusted her and were beneficiaries of Amel's services.

V- "What makes a violent man?" War, unemployment, the state and religious law

In this section, I highlight the ways in which the focus groups challenged and contested the research study's premises around domestic violence and masculinity. I look at how both the Christian women and Muslim men focus groups reacted to the relationship between masculinity and violence, countering the notion that violent masculinity can be transformed and changed through psychotherapy. They spoke of different structural contexts they felt had a much bigger impact on producing violence and making certain kinds of masculinities. Both focus groups kept bringing up structural factors that they felt needed intervening and changing like the war, the corrupt Lebanese state, the religious sectarian law and the problem of alcohol in the complex. All these factors however had been reduced to 'life stressors' by the masculinity study, whose main focus was to measure domestic violence as the product of specific kinds of Lebanese masculinity. What required intervention was men themselves, not the structural conditions they were in.

Relying on a standardized questionnaire designed for the study, psychologists asked questions for both groups about the definition and meanings of masculinity today; how it was performed; how it evolved and changed historically; and what the relation between violence and masculinity was. Psychologists also asked participants to engage in two hypothetical exercises. In the first one, they were asked to imagine that they would, if they had a magic wand, erase all bad and violent traits related to masculinity. In the second exercise they were asked to imagine and describe "a society free from violence" and then a society "where violence is prominent everywhere". While Psychologists asked specific questions to understand and separate violent

from non-violent traits of Lebanese masculinity, both women and men pragmatically defined masculinity along more social, political and economic terms, evoking war and the state as forces that conditioned domestic violence.

When they were asked about what makes a man, the women group mentioned having money, and being connected in society as formations of masculinity, while morally commenting on how things have shifted in Lebanon so that a man was now defined by these things more so than by his nobility, kindness and generosity. Beside his economic situation and his ability to rise in society, physical traits like virility, physical violence (getting into fights) and looks were also mentioned as comprising a Lebanese man. The women insisted on talking about money and relating it to masculinity while Salma the psychologist tried to probe them into talking more about "social and cultural things", like how girls and boys were raised differently in the household. Similarly, when asked what the criteria associated with for masculinity was, almost all men replied with "money", "a million dollars", while one man said jokingly "his personality" and everyone started laughing. Other mentioned criteria were how much he was worth, how many connections and protection he had in Lebanese society.

When asked to imagine what a "good man" looked like if, with a magic wand, the women group were able to erase all the bad qualities of men, one woman said that good masculinity looks like "a gay and effeminate man", who does not curse, is generous and protective. Gay and effeminate men were also mentioned to describe how current society in Lebanon understood masculinity, where "men lost their importance, we don't need him that much anymore. A woman now looks for her life future before she looks for a man". In this sense, both groups provided a complex definition of masculinity in Lebanon that was constituted along economic, political, social and physical factors.

Furthermore, both groups spoke of the war as a constitutive of masculinity, violence and chaos in the household. One woman described the civil war as a cause for violence and tension between genders, the postwar period as "better", although "now it is worst again because of the economic situation and the stresses of life". The men's group was more confrontational, referring to structural problems and constantly evoking, wars from Israel, the state and corruption as the making men violent, rather than an archaic form of pedagogy. They would occasionally interrupt the flow of questions/answers by commenting on the nature of the questions themselves. This was partly because they felt directly targeted by the questions as men. They drew clear connections between a violent and angry man and the quality of political and economic life he was leading.

> *"I cannot give you a clear image of society and a description of manhood. Which man are we talking about? A man is someone who is able to endure and live through wars. As I am talking to you right now I am getting angry. One walks out of the house and does not know if he will return or whether he will provide food on the table for his family".*

The state or *al dawleh* was also directly evoked by the men group to discuss changed in traits of masculinity and manhood:

> *"There are men, and there used to be men but al dawleh (the state) has entered in each house and the family has changed and men-women relations have changed. If the state is good, then we are good as well".*

> *"A man is like a bull or a cow. His eyes gets red and he will end up in the slaughterhouse. That's a general description for you"*

When psychologists addressed the issue of domestic violence, the women group saw that the causes were related to illiteracy, money problems and when the wife does not feel like having

sex. There was tension in the women group, where some were uncomfortable talking about their marriage in this way -while others spoke adamantly and passionately against domestic violence but not on a personal level. An older woman, who was uncomfortable with the lines of questions from the beginning, said that it is not always the man's fault when he hits his wife. Sometimes the wife is acting immorally. She was directly challenged and criticized by a younger woman, who refused these kinds of accusations for women: a man should never abuse his power and hit his wife. Another woman mentioned her friend who had been struggling to get a divorce from her husband. Perhaps her story would benefit the study? They called her to come in and she stopped by to tell her story about struggling to get a divorce under Christian law from an abusive husband: "Christian divorces are very hard to get you know" one woman said, "You Muslims are lucky".

A similar if not more noticeable tension occurred in the men's group when the psychologist started asking direct questions about domestic violence. There was dead silence in the room and discomfort. Some of the men subtly glanced at Mounira, feeling uncomfortable and defensive, possibly not knowing that this study was linking masculinity to domestic violence. Feeling threatened and concerned, probably because they were the target of this study, men challenged the psychologist many times by calling for more attention to context and complexity than the questions permitted. The discussion, lasting for two and a half hours, remained tense as many of the men challenged the premises of the questions. One man ironically talked about how his son should discipline him now since he is not allowed to punish him physically anymore, commenting on the new ways of raising children than many NGOs promote. Another said that everything was violent and everyone was being violent to everyone in Lebanon, and that this problem could not easily be summarized as a problem of individual masculinity. Another talked

about how a smart woman knows how not to push her husband's buttons, making a similar argument to the older woman in the women focus group. Another man said that domestic violence was completely unacceptable and should never happen.

Finally, the women's group referred to structural problems that created domestic violence in the household. All wives of fishermen living in the complex with very little economic stability, they spoke of an "alcohol problem" in the complex, for the men had all day to get drunk because of unemployment: "he (my husband) is nice to me until he gets drunk", said one woman while another demanded that the problem of alcohol be addressed in an intervention for their husbands. The women also spoke of their living conditions, asking for an intervention for alcohol consumption and unemployment and on whether we could mediate with the church into allowing them to own their own house at the complex and sustain their own livelihood.

Therapies of masculinity or structural interventions?

Both groups constantly evoked structural and economic issues when they spoke of masculinity and violence, like the Lebanese state, money, unemployment, connections in society, the war, Israel and health, thereby countering the premise that domestic violence can be prevented with a psychological intervention on men themselves. On the other hand, questions about domestic violence brought up many tensions between both groups. Most of the women seemed eager to talk about the problems they face in their marriage, although not on a personal level. The only story worth sharing was that of their friend who had been struggling to get a Christian divorce from her husband. Both men and women barely related the causes of domestic violence to a traditional and an archaic form of pedagogy. They instead spoke of structural conditions that informed violence in society and the household.

In that sense, masculinity was seen as constituted and informed by economic conditions, civil and Israeli wars, the state, religious law and employment. These structural conditions, considered as life pressures for ABAAD were for both groups the determinants of masculinity itself. A man is defined by how he survived war from Israel. Civil war breaks the family apart and makes a man angry and violent. A man becomes angry because he has no job, no ability to sustain his family. He becomes enraged like a bull, then he is led to the slaughterhouse, having no control over his life.

Furthermore, the state and religious law were both evoked as forces that directly shifted and altered marital relationships. Living in the complex in Tyre with no stable livelihood and prospect of a better life**,** and not owning your own house, turned you into a kind of a man who drinks too much and might become violent. It is these structural conditions that both groups felt were in need for change and intervention as a way to reduce domestic violence. Both groups were similar in that extent, defying the premise that psychotherapy could shape masculinity within the presence of the structural conditions they evoked. What required an intervention were structural conditions of living in South Lebanon, the problem of alcohol abuse, the neglect and corruption of the state, and the constant living in violence, not knowing if you are going to return home and provide food on the table for your family.

Even when women spoke of alcohol, they spoke about it as a problem caused by economic inequalities. ABAAD's advertisement -where men from all different class position and backgrounds were seen getting angry because they have been raised to react to life pressures this way as men- seems to entirely miss the point here. Both groups saw masculinity as constituted and inter-subjectively embedded in economic, political, structural and legal contexts. The implication of the state in everyday gender relations disrupted and complicated the assumption

that masculinity is the product of an archaic and 'tribal' forms of pedagogies circulating in Lebanese society.

The masculinity study and the therapies it informed were part of the process of humanitarian psychologization in postwar Lebanon, drawing on similar trends that pathologize and seek to treat certain reactions to life pressures. The focus on Lebanese men themselves as an essential type of person whose behaviors and affect were psychological pathological and required treatment resonated with how personality disorders like antisocial and paranoid personality were used by Samer to explain certain unhealthy and psychologically harmful behaviors of men and husbands- like being overly possessive and angry. Ironically enough, when the men's group was asked about what constitutes a man, one of them jokingly said "his personality" and every laughed. Personality styles, seen by Samer as mainly constitutive of social and cultural pedagogy, barely factored into what causes violent masculinities. For both groups, there was nothing essential, or internal to men themselves that made them violent. The focus groups focused much more on highlighting the external and structural conditions of living in Tyre that constituted both violence and masculinities.

Therapeutic masculinity

The therapeutic reading of domestic violence as embodied in Lebanese masculinity blurred the boundaries between aggressed and aggressors somewhat in similar ways that trauma disturbed and confused civilians with soldiers. In both cases violence became sourceless and its presence a marker for vulnerability and victimhood. Therapeutic masculinity, as an intervention of domestic violence, misrecognized political engagements with social reality and inequalities. It emerged as part of the massive form of psychologization that occurred after the war in Lebanon. But it also was part of the discourse on angry Middle Eastern and Arab masculinity that was both

threatened and threatening, becoming a site for intervention and governance by war on terror policies, feminism and humanitarian organizations. Arab men have become hypervisible subjects, even more so after the revolutions in 2011, inhabiting public discourses and representations "as problems to solve" (Amar, 2011, 40). In practice however, the project of therapeutic masculinity that I observed in Tyre was contested by both the participants and the context of life in Tyre after the war. It reified old projects of sectarian difference in a town that strived to achieve 'co-existence'. The masculinity study revealed all these tensions and slippages.

VI. Conclusion

Lebanese scholars and activists have recently addressed the de-politicization and growing professionalization of women movements in Lebanon and the Arab world (Daou 2014; Khattab 2012; Jad 2003). Some have highlighted the ways in which the post-civil war NGO-ization of women's movements have unintentionally contributed to empowering the patriarchal and sectarian regime in Lebanon (Khattab 2010). Recent debates and scholarship on women movements and social change in Lebanon have raised the question of sectarian patriarchal rule and how the process of democratization and NGO-ization of women movements enabled and unintentionally reinforced sectarian discourses and state projects of religious difference in Lebanon (Baydun 2002; Daou 2014; Khattab 2012; Jad 2003). This chapter sought to add to this emerging scholarship and debates by showing how the project of therapeutic masculinity led to a de-politicization of violence against women and how, in practice, humanitarian 'evidence-based' techniques reified state projects of sectarian difference. The problem of domestic violence however in Lebanon remains a severe reality that became more visible in later years. Since 2012, cases of domestic violence, many of them leading to murder, were on the rise with no proper sentencing from the Lebanese law (Kafa 2015; CSKC 2015). Protests of women advocacy NGOs

and many feminist activists on international women day became a practice to call for a law against domestic violence and legal protection**.**

Chapter VI

The 'Syrian refugee crisis': Trauma, Shifting Realities of Aid, and new narratives of suffering

I. Introduction

"I wish this crisis would never end*"* said Gebran jokingly. I was in Qobayyat in the summer of 2012, a town in Akkar at the northern borders with Syria, to observe a three-day training on Psychological First Aid (see Chapter two) for humanitarian workers assisting Syrian displaced communities in Lebanon. After teasing him about what he said, Gebran took it back "I am only kidding of course*"*. Gebran was a native resident of Qobayyat. He had just started working as a driver for International Medical Corps (IMC). A member of the IASC's task force (see chapter two), IMC was mandated to provide training on psychological support for humanitarian organizations working in emergencies and crises (see chapter two).

The Syrian revolution in 2011 quickly escalated into state violence against different opposition fractions in different areas in the country, resulting in multiple civilian massacres, and leading to the displacement of Syrians and Palestinian refugees living in Syria into countries like Jordan, Iraq and Lebanon. Gebran's town was turning into a site for emergency intervention as the Syrian refugee crisis continued to escalate. As he was driving the IMC coordinator, Samer- who was responsible for the training- and me into town, Gebran spoke of the financial aid that poured into Qobayyat, where global humanitarian organizations were renting rooms, building infrastructures, renovating clinics, and employing the locals.

Qobayyat had become a humanitarian space (Paulmann 2013; Barnett 2011), where Medecins Sans Frontiers, Save the Children and Danish Refugee Council established offices to help with the incoming displaced Syrians and Palestinians. And the town was indeed blooming. The tourist season was hit hard because of the crisis so the town was benefiting from the presence of the NGOs settling there.

Once he knew I was a researcher, Gebran asked me what I thought "about all this" as he parked next to a big building, now turned into a humanitarian compound that offered offices and housing for NGO workers. Multiple four-wheel drive cars with humanitarian stickers were parked outside the compound, where security guards protected the building. Humanitarian workers were standing nearby, setting up meetings and coordinating trainings on their cellphones, while NGO drivers sitting on balconies playing cards and smoking hookah, waiting for errands. Gebran shouted to one of them: "no work today huh? I hope you're enjoying your time". The driver laughed and waved, as Gebran told us that most humanitarian organizations do not have much work for the drivers -- who are in it for the easy cash- while he seemed to have gotten into the wrong organization, as he was working too hard. The IMC coordinator was on the phone organizing the psychological training, ordering food and coordinating necessary equipment: a small electricity generator[157] and a projector. The psychological training manuals were already printed in Beirut where we came from. All this "busy work" turned the town a place of urgency.

Samer and I stared at the compound, listening to humanitarian terminology easily shared and communicated between the NGO staff: 'action plan', 'per diem', 'registration strategy'. Samer

[157] Electricity cuts are usually much more frequent and aberrant in regions distant from the capital, where electricity usually cuts for three hours a day.

smiled and whispered to me: "I don't understand NGO people. I can never be one of them". He has been working as a humanitarian psychologist with IMC since 2007, leaving his clinic to travel around the country and conduct psychotherapy for new communities like Palestinian refugees, war-affected Lebanese, and now Syrian refugees, while also holding trainings for humanitarian workers. These encounters had been exciting to Samer but somewhat alienating: "I understand much more how it all works "he reflected, "but I still feel like a stranger among them. I am more of a clinician, you know…"

From the looks of it, the making of crisis and emergency in Qobayyat seemed to be in full swing, except that there were no refugees in sight. During the three days of my stay there, I asked around about the location of the refugees, but no one seemed to have a clear response. Hassan, a health consultant working for IMC who joined us outside the humanitarian compound, dismissed my question, saying that the number of refugees was anyway exaggerated. He was there to consult on strategies for refugee health management and infrastructure, but I wondered how he was supposed to design a full health plan and structure without meeting a single refugee. The IMC coordinator also confessed ignorance. Gebran said that all the refugees had been placed in areas "outside" town, while others rented houses with humanitarian stipends.

As there were no rooms left in town, all of them occupied by humanitarian workers or turned into offices, Gebran drove me to an outdoor cabin in the woods at the outskirts of Qobayyat that oversaw the borders --borders that Gebran kept mentioning did not really exist before the crisis: "we used to cross to Syria all the time to attend music concerts in the summer and spend nights in Homs in the best restaurants and pubs. Homs' nightlife was very much like what Monot[158] was in Beirut, you know". But as we stepped outside the car to check out the cabin, the heavy

[158] Monot is a street in Beirut that was famous for its nightlife in the early 2000s.

shelling and bombing we heard coming from Syria seemed to mark the presence of these borders more than ever, like the heavy presence of global humanitarian organizations and their infrastructures were marking the contour of the new refugee crisis.

The place I stayed in was a beautiful eco-village style cabin in the woods, owned by a local guide from Qobayyat who organized hiking trips. The place had recently opened but was deserted because of the crisis. United States Agency for International Development (USAID) stickers and brochures laid on the counter outside, as the cabin was part of USAID's project on ecotourism and sustainable development in Lebanon (USAID 2014) - one of the many humanitarian projects that expanded and were made possible by the July War[159]. In contrast to Qobayyat, where the shelling was not noticeable, the sound of the bombing was clearly heard from my cabin, disturbing the peace of nature, hiking, and the quiet hammock hanging between two trees next to my room.

After agreeing on where I would stay, Gebran drove us back to town again, promising Samer-- who wanted to take pictures of the shelling- to take him to the outskirts of town where Gebran and his friends sometimes go to watch the bombing. Qobayyat must be the safest town in Lebanon, I thought. It is governed by humanitarian organizations and agencies, but step outside just a bit and you can hear the bombing, and you probably will find the refugees gathered outside town somewhere.

The making of the Syrian refugee crisis was made possible by a humanitarian space of governance that comprised old and new experts, interventions, manuals, health management

[159] While USAID's ecotourism project officially started in 2002 in Lebanon, most of the work of building ecotourism cabins and alternative tourism in Lebanon was conducted after the July War, as tourism was conceived to be directly related to war, violence and insecurity. Many of these ecovillages appeared in different rural areas in Lebanon after the July War.

strategies, trainings, electricity generators, humanitarian terminologies, stickers, compounds and of course, money, as Gebran kept reminding us. By then, humanitarian psychology became a familiar intervention in crisis management in Lebanon, where violence was delicately separated from intervention, and refugees from humanitarian space and workers. Humanitarian psychological packages like Psychological First Aid-and experts like Samer that accompanied them circulated in familiar ways in 2012 as a response to the Syrian crisis.

While the making of the Syrian refugee crisis in Lebanon relied on pre-existing humanitarian forces of intervention and psychologization that emerged during the July War, it brought with it new conditions of aid and suffering. This chapter traces the new realities of aid brought forth by the Syrian refugee crisis, where trauma once again was at the center of humanitarian psychology as a legitimate category of suffering that became intimately tied to a refugee status and to access to aid and services. This chapter follows how the new conditions of aid shifted and transformed narratives and politics of suffering in Lebanon, where different aid communities compete for recognition and access to aid.

I observed these new realities of aid unfolding in the Psychological First Aid (PFA) training that Samer provided for humanitarian workers assisting displaced Syrians in Akkar. Psychological First Aid was designed to replace invasive psychological emergency interventions -- like debriefing-- that focused on making individuals recount in detail their traumatic experience of violence (see chapter two). PFA provided overall psychological support for anyone exposed to violence without directly addressing the psychological trauma. In the training however, Samer's vision of psychological care --as predicated by PFA-- was constantly challenged and contested on the basis of "truth telling", where humanitarian workers needed to detect and distinguish the true form of suffering that made Syrians eligible for a refugee status. A

double bind of psychological care emerged, where providing psychological support served to prevent the occurrence of the same psychological disorders that were needed to legitimize suffering and provide access to aid.

I further encountered the material implications of these new realities of aid when I worked in a mental health clinic for Palestinian refugees in the south, and when I lectured about the politics of trauma in Israeli wars by the end of my research. What seemed especially powerful to me was the change in the narrative and discourse around suffering from war and violence in Lebanon, where Lebanese communities began speaking of war in terms of psychological suffering, as a way to remind others that "they too have truly suffered".

I started thinking of suffering not as a definite and discrete category but as an inter-subjective position contingent on aid and violence; two things that kept abruptly shifting and changing while transforming the discourse and articulations of suffering in Lebanon. Within the context of the Syrian refugee crisis, humanitarian psychology constituted war, massacre and violence as traumatic psychic wounds that required identification *for* recognition and aid. This was very different from how trauma was employed during the July War, where local aid was a way to prevent a psychological breakdown and ensure community resilience.

I start this chapter by providing a description of the shifting conditions of aid brought forth by the Syrian refugee crisis. I look at how a political economy of trauma emerged in Lebanon. This political economy was made possible by humanitarian understandings of victimhood. I follow the material implications of the change in aid priorities and services on aid communities. I examine this shift by looking at the economies of psychological care that emerged around war trauma during the July War, exploring how the Syrian crisis brought forth new relations between aid and suffering.

In the next section, I present the debates that emerged during the Psychological First Aid training between humanitarian workers and Samer. These debates reveal tensions around the meaning and purpose of psychological emergency care within these new conditions of aid and suffering. In the training, debates around PFA revealed how humanitarian psychological care and psychological disorders became constituted as practices of truth-telling that allowed humanitarian workers to detect 'authentic' forms of suffering,

In the last section, I introduce the narratives of suffering that emerged within these new realities of aid**.** I provide examples of both Lebanese communities and Sudanese refugees, who struggled for their psychological suffering from war and violence to be recognized. The first example is that of a privileged narrative of suffering, where Lebanese constantly sought to privilege their own suffering over that of the Syrian displaced, denying the latter any articulation of suffering outside of a humanitarian narrative of trauma. I show how the Lebanese form of suffering shifted from defiance and contestation of trauma into a narrative that sought recognition of psychological suffering. I argue that this shift should also be read within the changing geopolitical scene in the Middle East and Hezbollah's war in Syria -- a war that was more difficult to frame as just, divine or as a form of resistance, than Israeli wars. The second example is that of the "forgotten" Sudanese refugees, who struggle for visibility and access to aid and resettlement[160].

[160] As in the previous chapters, I use the category of "the postwar" to denote not only a temporal period following the July War but a space of reconstruction and development partly established through global humanitarian interventions, donor funds, humanitarian infrastructures, "developmental humanitarianism" and shifting economies of suffering in Lebanon, making and producing Lebanon as a "post-conflict" site. It is in this site that the Syrian refugee crisis unfolded onto pre-existing humanitarian work, channels, networks of aid, bringing new material and economic realities with it as well.

II. The Syrian refugee crisis: new conditions for aid and suffering

In this section, I provide a general description of the changing conditions of aid and suffering in Lebanon that resulted from the Syrian crisis. I argue that a political economy of trauma emerged, where legitimate forms of suffering were now tied to aid and services. I then trace the implications of the shift in aid priority and services for the different aid communities, focusing on Palestinian refugees.

Political economy of trauma

After the July War, Lebanon became host to new communities like Iraqi and Syrian communities from neighboring countries- fleeing sectarian civil war, regime oppression, state violence random massacres and violence[161]. The presence of United Nation Higher Refugee Council (UNHCR) offices in Lebanon turn it into a country of 'first asylum', where asylum seekers can file for refugee status and resettlement. Many global humanitarian organizations that left Lebanon after the July War returned and re-opened their offices, shifting their 'action plan' to mainly focus on the Syrian refugees, while attending to the needs of the Lebanese as "vulnerable host populations". Aid poured in at a much larger scale than for Iraqi refugees to fit

[161]Displaced Iraqi communities arrived to Lebanon in different moments seeking refugee status since the US war on Iraq in 2003, then in higher numbers fleeing sectarian violence like the bombing of the holy shi'a Al Askaraiyya shrine in Samarra in February 2006. An estimated 20.000 to 50.000 Iraqi refugees were thought to reside in Lebanon as humanitarian agencies and organizations called for assistance in 2008. High levels of psychological distress were reported among 50% of Iraqi refugees in Lebanon, where 34% of these had experienced extremely stressful events such as: witnessing the assassination of relatives and friends; kidnapping; torture; and rape[161]. In 2007, global organizations like IMC and Restart partnered with UNHCR to provide psychological care for Iraqi refugees suffering from torture and violence. The team followed a clinical model: psychiatrist, psychotherapist, neurologists and physiotherapist and a separate team for the children with a child psychologist, focusing on PTSD model and cognitive behavioral therapy for the refugees suffering from mood and anxiety disorders. Displaced communities from Syria, both Syrians and Palestinian refugees, started arriving in 2012 in increasing numbers until there was an estimate of one million in 2014, fleeing massacres in Yarmouk and other forms of violence and fights.

the scale of the Syrian crisis. Aid included relief, food distribution, psychiatric and psychosocial support, housing, vocational formation, health awareness and treatment[162].

Similarly, the UNHCR launched its emergency action plan, coordinating with humanitarian organizations that worked as implementing partners, following its recommendations and procedures. Psychiatrists and psychologists working for these humanitarian organizations spoke of new pressures regarding diagnosing PTSD. I talked to one humanitarian psychiatrist who was critical of the over-medicalization of refugees. He felt that a PTSD diagnosis was not very useful in fulfilling the mental health needs of the Syrian refugees whose whole world and economic survivability had collapsed. His patients were more concerned about securing a livelihood and a new life in a safe country than talking about the violence they had encountered. He knew that the diagnosis of PTSD now had the possibility to reinforce their refugee claim file and possibly give them a chance to be resettled in a country where they might start anew. He was however torn between over-diagnosing them and prescribing medications on one hand, and referring them to counseling and psychotherapy that might help them better figure out the new conditions they were in, on the other.

PTSD and trauma were becoming 'indicators' used by UNHCR to identify who is a refugee and who is not. The psychiatrist I spoke with was pressured to present 'pure clinical PTSD cases' that could be incorporated as statistical and commensurable information about Syrians. This allowed UNHCR to read the Syrian displaced clearly. He would get reprimanded

[162] While Iraqi refugees became a humanitarian interest in Lebanon in 2008, they also underwent a similar process where their suffering had to be identified and categorized as traumatic in order for them to gain refugee status and access to aid services. However, the scale of the Syria refugee crisis, reaching around one million refugees in Lebanon, created a material commodification of suffering, where the ability to identify a true refugee became a crucial practice in managing the crisis.

by UNHCR through his organization when his did not provide enough "PTSD indicators". He felt torn between over-medicalization and providing a PTSD claim for the refugee. He also became confused over what his job as a clinician was in all of this. Was his main responsibility to provide psychological care or was it to allow refugees the possibility of a new life, by identifying them as victims through a PTSD diagnosis? He felt burdened as "psychological care" was becoming confused with the ability to produce a clear form of suffering.

In that sense, PTSD became an indicator of suffering that became linked to a refugee status, and to access to services and aid. Having PTSD reinforced the Syrian asylum seeker's file because it provided evidence that this person was indeed a victim of violence. Narratives of suffering were now intimately tied to aid and services. This constituted a major shift from how the humanitarian trauma model was used during the July War, when there were no material claims attached to a diagnosis of trauma from Israeli war, either vis-à-vis the Lebanese state or humanitarian organizations. Getting a trauma diagnosis during the July War meant getting mental health services in the form of psychotropic medications and/or psychotherapy. These therapies were in many instances infiltrated into medical services and hidden from the communities who did not necessarily desire them as a mode of intervention (see chapter three).

In fact, one might argue that there was a political economy around resilience itself during the July War, rather than around trauma. Local grassroots forms of aid, like the *Samidoun* collective, and Hezbollah's own aid apparatus during and after the war, worked to prevent a collective breakdown and to ensure a form of communal cohesion and resistance to the war (see chapter three). With the Syrian refugee crisis however, the trauma model became a form of psychological screening, a tool to legitimize certain narratives of suffering, where trauma was directly tied to aid and a refugee status. Despite the different kinds of contestation and resistance

to the diagnosis of PTSD from the Israeli invasion and the July War in Lebanon, it became once again the dominant model used by practitioners, experts and humanitarian workers as a way to identify true victims of violence during the Syrian refugee crisis.

In that sense, a political economy of trauma emerged from the Syrian refugee crisis (James 2004). The political economy of trauma- where suffering became directly tied to refugee status, aid, and the promise of a new life- turned humanitarian psychological assessment tools into techniques and practices of "truth-telling", used to authenticate and legitimize certain categories of suffering (James 2004). While humanitarian psychologists were asked to reach out to communities during the July War to find trauma, the center of the debates then revolved around whether trauma from war existed or was absent. In the Syrian refugee crisis however, humanitarian agencies, like the United National Higher Refugee Council (UNHCR) -- responsible for governing refugees- now engaged in bureaucratic work to identify evidence of victimhood and suffering. PTSD consisted of such evidence, becoming a clear indicator through which displaced communities were recognized as legitimate sufferers. Humanitarian psychologists were asked to prepare what Erica James spoke of as "trauma portfolios" (2011): "the aggregate of documentation and verification which "recognizes" or transubstantiates individuals, families or collective sufferers into "victims" and "survivors" (James 2004, 131). A PTSD diagnosis was central to this portfolio, becoming a clear indicator for access to aid services.

Shifting of aid priorities and services

Moreover, the scale of the Syrian refugee crisis -- turning into one million refugees in 2015-- drastically shifted aid priorities in Lebanon, sometimes cutting off services from other aid communities for the sake of others. New aid communities intersected and competed for aid and

recognition with older communities like Palestinian refugees, Sudanese refugees and war-affected Lebanese. In many instances, competing and lobbying for aid became a reality, as aid priorities kept shifting and changing abruptly and quite aggressively, especially with the arrival of Syrian refugees, cutting services from one community for the sake of the other[163]. These new realities of aid were imposed by erupting violence, humanitarian crises, donor funding trends and aid apparatuses.

With the arrival of multiple humanitarian communities and crises to Lebanon, aid priorities shifted rapidly to Iraqis, then to Syrian refugees in 2012, leading to a dizzying foregrounding and backgrounding of different forms of suffering. For example, many times during my research, social workers told me how they struggled to provide the same mental health services they used to have in their centers and NGOs, now all directed towards new aid communities with their suffering. The example of Mounira struggling to convince IMC of providing access to psychological and mental health services to Lebanese at the Amel center, now designed for Iraqi refugees in South Lebanon, was one manifestation of this abrupt suspension of aid. These programs were redesigned to service Iraqi refugees and "vulnerable host communities", mostly because of Mounira's lobbying.

By then, local organizations had become more intimately linked to global humanitarian strategies, and donor trends that shifted humanitarian priorities and emergencies on the ground. It was difficult to maintain older services while abiding to aid trends and donor preferences. Many social workers negotiated and advocated for psychological services to remain accessible for the communities they had built ties with. "Slipping in" a number of Lebanese beneficiaries for

[163] One example of that was the Palestinian refugee men in the last chapter, storming into UNRAW office in Tyre and beating up an NGO worker in protest over the dearth of aid.

mental health services directed at Iraqi refugees for example was one way to do it, while maintaining the quota necessary for these services to still count as "mental health services for Iraqi refugees".

A more brutal shift in psychological aid services was noticeable when the Syrian refugee crisis unfolded by the end of 2012. Palestinian refugees living in Syria mainly fled the massacres committed by the Syrian regime in Al Yarmouk refugee camp. Palestinian refugees do not fall under UNHCR's governance but have their own agency, UNRWA that provides aid. Most of the Palestinian refugees coming from Syria ended up in the already over-crowded and barely livable Palestinian camps that exist in Lebanon. A new aid category emerged as a result, that of the "Syrian-Palestinian refugee", to differentiate them from Palestinian refugees living in Lebanon. The result was a drastic shift in aid from what came to be called "Lebanese Palestinian" to "Syrian Palestinian".

During my time working in an early child development clinic in a Palestinian camp in South Lebanon, the clinic started suddenly receiving many cases of PTSD and trauma for Palestinian children and parents fleeing from Syria. I distinctly remember one five year old child who came in with his father. The child's hair had gone white and he was not talking. The father said that the child's hair "turned white" when they fled their house in Yarmouk camp after the massacres. These cases were more imminent and urgent than many of the other cases that the clinic was following, which somewhat faded into the background in comparison. After all, how can a child with white hair not overshadow the slow and structural form of violence and suffering in Palestinian camps in Lebanon?

Not only that, material aid shifted dramatically as UNRWA prioritized aid for 'Syrian Palestinians' over 'Lebanese Palestinians', sometimes cutting aid access all together from the

latter. The local clinic where I worked and did research was approached by a global organization with a proposal to use the clinic as a place to distribute aid to Syrian Palestinians. An announcement about the services and registration was circulated in the camp and 'Palestinian Syrians', often accompanied by 'Palestinian Lebanese', came in to ask about the aid. The social workers at the clinic were to sit and fill a long questionnaire with the Palestinian Syrians. Then by the end of the survey, would tell them that the aid would come after they had compiled all the necessary data.

Feeling conflicted about it, the social workers communicated the need to provide any kind of aid since they promised the refugees. Eventually the clinic bought bread and distributed it when refugees were filling out the survey. One day when as I arrived to the clinic, all the social workers were in tears crying. A 'Palestinian Syrian' four year old baby passed away while they were trying to provide her with the medication she needed but could not refer her to proper services. The social workers were feeling guilty about the whole process. I left the clinic after my research without seeing any aid arrive. In a conference around six months later, I ran into a friend who happened to work at the same global organization that approached my clinic. When I asked her about it, she mentioned, very excited, that now that "the database was complete", they will start analyzing the data that will surely affect the kinds of aid to be distributed to the Syrian Palestinian refugees in the camp.

Around 2015, funds for psychological and psychiatric services for Syrian refugees were suspended almost overnight. Food stipends were also becoming scarce while the UNHCR started throwing donation campaigns to collect enough money for them. The humanitarian psychiatrist I spoke with said that he was suddenly, without prior notice, asked to stop and discharge all the patients he was seeing. When he asked why, the answer was that there simply were no more

funds available for psychological care. When he asked how he was supposed to discharge patients, many of them taking psychotropic medications, without providing them with any form of support, he was answered that he should counsel them on how to seek non-medical and non-clinical alternatives, and give them tips on self-care. The psychiatrist was appalled since suspending treatment, especially psychotropic medications without prior notice was detrimental to patients' health, but the reality of aid and funding once again was more powerful and exigent than humanitarian ethics like "do no harm" practices or support like "psychological care". Whether the sudden lack of funding intersected with UNHCR's statement that it would no longer register refugees, abiding by a request from the Lebanese government in 2015, remains a question that requires further investigation and interviews[164].

New realities of aid

At the time of writing this chapter, the United Nations had already declared the Syrian crisis to be the worst humanitarian crisis of the 21st century. Discussions about how to distinguish "a true refugee" from "an economic migrant" have emerged in Europe as the Syrian refugee crisis reached its borders. Denmark for example adopted a controversial law to seize cash and valuables from Syrian refugees, to be used as a form of aid to cover their expenses (CNN 2016). This controversial law evoked representations of refugees as individuals who are stripped of all kinds of material belongings and dignity, except for her suffering and her humanity. Only those who were completely depraved of everything but of suffering and illness can cross the border (Ticktin 2011). If displaced Syrians arrived to Denmark with valuables and money, this meant that they were *perceived* as economic migrants, not refugees. In an interview

[164] Today, some mental health services for Syrian refugees remain, completely contingent on availability of funds, becoming implemented on a short-term level.

for NPR on February 18th 2016, the German ambassador to the United States clearly declared the need for this distinction:

> *"We want to help those country - those refugees fleeing political persecution and civil war - a cruel civil war in Syria. So we don't want to cap those people. But we've got to distinguish between those who really need our help because they are persecuted, because they are fleeing a war, and those who are just coming for economic motives. And we've got to be clear, those who are just coming to our country to have a better life have to return, and we've got to repatriate them." (NPR 2016)*

The work of distinguishing a true victim-refugee from someone "seeking a better life" depended on the ability to recognize and see forms of suffering that justified entry to Europe. Europe's distinction between victims and those seeking "a better life" heavily resonate with Ticktin's work on the illness clause as the humanitarian exception that gives legal status for undocumented migrants in Europe (2011). PTSD and gender violence were among the forms of suffering that justified a condition of victimhood and allowed entry to Europe (Ticktin 2011). More than ever, trauma and PTSD became crucial markers and signifiers of victimhood (Fassin & Rechtman 2010) and of authentic suffering

In Lebanon, the Syrian refugee crisis put the humanitarian trauma model once again at the center of humanitarian psychology. The trauma model was contested and challenged both by experts and communities during the July War in Lebanon (see chapter three). Local forms of aid and community-based approaches to mental health - initiated in the first days of the July War- worked as alternative models for community support and resilience (see chapter three). The Syrian refugee crisis however predicated access to aid and services- and to a refugee status- on a diagnosis of PTSD. In other words, the more the Syrian displaced can provide evidence of psychological suffering, the more likely she was to be a victim of violence, and to receive a status of a refugee. Providing visible evidence of suffering from violence became a crucial

practice that allowed Syrians to become refugees with access to aid and a promise of resettlement to Europe and North America. Trauma became a condition for victimhood, a category that legitimized suffering (Fassin & Rechtman 2010) and enabled access to aid. In the next section, I look at how these new realities of aid unfolded in the training of humanitarian workers on Psychological First Aid.

III. Psychological First Aid Training: sexual violence, practices of truth telling and the double bind of psychological care in the Syrian refugee crisis

"What happened to you?" asked Samer

"They raped me" said the male registration officer in an exaggerated feminine voice, and everyone started laughing.

Samer carried on with the simulation anyway. He was playing the role of the humanitarian worker responsible for providing emergency psychological care for people who had experienced violence, while the registration officer, working for the UNHCR, was playing the role of a Syrian woman victim of rape.

Samer started asking questions in a rapid and specific way: "How old were you? When did it happen? Tell me what happened to you exactly? How did you go back home afterwards? How did the incident happen, did they attack you? How many were they? What time was it when it happened? What did they do to you first? And then what did they do? How did you feel? Did you feel terrified? Can you describe your emotions? Did you try resisting them?" The officer replied to the questions in a similar pace, trying to keep up.

"This is debriefing", said Samer at the end of the simulation:

> *"It is making people who went through a violent event relive the experience by talking about it. It is not efficient, because it makes them relive the trauma. We have the tendency to rely on intrusive questions to dig deeper and bring things*

to the surface. We use this a lot here in Lebanon. Psychological First Aid however, is not intrusive like Debriefing."

Samer used the simulation exercise to explain the difference between Psychological First Aid (PFA) and Debriefing, two humanitarian packages of psychological emergency interventions that circulated among humanitarian experts and the communities they assist in Lebanon (see chapter two). Standardized and universalized as global humanitarian psychological aid packages, debriefing and PFA became "immutable mobiles" (Latour 1986) now used in every conflict and disaster emergencies[165].

All humanitarian workers involved in the management of the Syrian refugee crisis were a target of these trainings. The job of the Lebanese junior UNHCR registration officers was to conduct interviews with the Syrian asylum seekers and, based on a standardized survey, determine eligibility for refugee status, make ID cards for them, and, if eligible, refer them to services,.

UNHCR junior registration officers were considered one of the first humanitarian contacts Syrians will encounter in Lebanon. Knowing how to provide psychological support to the Syrian displaced was now seen as part of their job description by IASC's guideline on mental health, as providing immediate psychological support for communities and individuals exposed to violence reduces the risk of developing psychological disorders. Almost all registration officers were young college graduates women and men, from various academic backgrounds in business, anthropology, political science and nursing. At the beginning of the training, they sat giggling and talking to each other, going through the printed training manuals and whispering to each

[165] Both emergency psychological care packages were originally designed and used as military tools. While debriefing was an American military interrogation technique used for soldiers as a form of a de-traumatizing intervention, PFA also emerged as a military tool used to "stabilize" soldiers in battlefields to keep them going.

other jokingly-- as if they were in school again-- while Samer tried to quiet them down throughout the training and keep them engaged. The UNHCR officers seemed restless throughout the training, some people constantly joking around, while others seemed tired and disengaged. Like similar workshops that they had to participate in as part of their job, the training was long, covered many dull definitions, policies and terminologies of humanitarian care. But Samer worked hard to make it fun and interactive.

At the end of the simulation exercise, Samer explained the difference between Psychological Fist Aid and Debriefing by relying on a metaphor of a physical wound:

> *"Let's say I was wounded in my arm here, and that the wound healed. I felt at one point that I am able to come tell you about the wound and tell you that ten years ago, five years ago, or a year ago, my hand was wounded and they stitched it up, they took me to the hospital, and it was okay, it went well. Think of violence as a wound. In debriefing we say, show me your wound, open it up again and tell me how you felt. In Psychological First Aid, it is important to let the person talk when they feel like it while focusing on supporting basic needs instead. I could have tried to see if the woman in the simulation was hungry, thirsty, to satisfy her basic needs, before asking her about her wound. And this is the thin line between PFA and debriefing, when someone is ready to talk, he will talk."*

Samer used the metaphor of a physical wound to explain how violence also leaves psychic wounds and injuries that require healing and mending. He also evoked the practice of "telling" and narrating the wound to show that in Psychological First Aid, treating psychic wounds of violence does not necessarily rely on "talk therapy" , like Debriefing. Psychic wounds of violence can heal by themselves, if the person received overall support and her basic needs were satisfied. She might speak of her wounds after they healed and she might speak about them directly when they happen. However, the thin line between PFA and debriefing was that

providing a narrative of the experience of violence was not necessarily a form of psychological care. It was up to the person to share this experience or not.

At the heart of both these emergency psychological interventions was an understanding of violence as a psychic wound that could develop into trauma and PTSD. Both emergency interventions worked to immediately treat and support Syrian displaced who had experienced violence. While debriefing invited individuals to narrate all the details of their psychic wound produced by violence to relieve them from trauma, PFA works around the psychic wound, providing overall assistance and support to the victim by fulfilling her basic needs.

Working cautiously around, or gazing invasively inside the opened psychic wounds of violence, humanitarian emergency psychological interventions like PFA and debriefing became the normative way for understanding psychic injuries of violence Lebanon. While the Lebanese Red Cross staff tried -- to no avail -- to give my mother a debriefing intervention while she was working on providing emergency aid to displaced Lebanese in the July War (see chapter one), Psychological First Aid became a much more acceptable and less invasive form of psychological intervention in later years in Lebanon that could be implemented during emergency settings like the Syrian refugee crisis.

The training on Psychological First Aid however quickly escalated into a site of debate between Samer and UNHCR registration officers on how to "dig deeper" for evidence for the existence of these psychic wounds of violence. UNHCR officers challenged Samer's vision of psychological care after he introduced PTSD as a disorder, by using the Israeli invasion of Lebanon in 1982 but from the perspective of the Israeli soldier as an example:

> *"Have you seen a movie called Waltz with Bashir? It is a true story about Israeli soldiers going into Qana camp. The soldier suffered from PTSD 10 years after the event and if you watch the movie carefully, you'll see how the*

soldier receives PFA from the bartender in one scene. It is a very good movie, you all should watch it".

Mistaking the movie's "true story" - of the Sabra and Chatila massacre of 1982- with the Israeli massacres committed in Qana village in South Lebanon in 1996 (see chapter one), Samer used the movie *Waltz with Bashir* (2008) --an Israeli movie addressing the war trauma suffered by Israeli soldiers as they invaded Lebanon in 1982 and participated in the massacres of Palestinian refugees in of Sabra and Chatila camp -- to show that any kind of violence had the ability to produce individual psychic wounds years after; and the ease within which PFA can be administered to support someone who had been exposed to violence, regardless of context, history and politics. The use of Waltz with Bashir as an example of trauma and PFA could have been an individual choice of Samer, but it still revealed a deep form of de-politicization of the wounds of violence that humanitarian psychological aid interventions like PFA a can produce in sites like Lebanon layered with various occurrences of violence and terror[166]. By taking "Waltz with Bashir" as an example, Samer was inviting the UNHCR registration officers to see all violence as one regardless of context and politics. With PFA, there was no need to identify these wounds or where they come from. All one had to do was provide overall psychological support, like a bartender, to protect against psychological disorders like PTSD[167].

[166] While trauma still appeared in Israel decades after the invasion of Lebanon in 1982, as described by Waltz with Bashir (2008), there was a complete absence of recognition, narrative or representation for the suffering of the Palestinian survivors of the Sabra and Chatila massacre, not to mention that of the Lebanese during the invasion. As discussed before, trauma was much harder to be found in Lebanon in 1982 and later on in the July War. Ironically enough, Waltz with Bashir (2008) registers this 'absence' of trauma and indifference to violence in one scene, also a "true story" of an Israeli journalist accompanying the Israeli military during the invasion of Beirut, who notes his shock and surprise in one scene at the sight of Lebanese people watching the invasion and the bombing from their balconies and not hiding in shelters, representing yet again the Lebanese as essentially indifferent and unaffected by violence.

[167] For PFA predicated a certain universal psychological precariousness in the face of violence, any kind of violence, as Samer explained: "Anyone who heard, was next to or encountered a bomb or an explosion is troubled, including humanitarian workers. We are all troubled, including the psychologist and the humanitarian workers. Everyone is affected psychologically. Therefore the support has to be for everyone. Around 72-94% of people exposed to violence develop later psychological problems like PTSD".

However, very quickly during the training, Psychological First Aid became contested by UNHCR registration officers on the basis of "truth telling". Many of the UNHCR officers explained to Samer that they needed to identify a true Syrian victim from one who has carried weapons and fought in Syria -- regardless of whether the person was engaged in a revolution against the Syrian regime or was protecting her family or her own life. Anyone who carried arms in Syrian was automatically not considered a refugee even if it was for self-defense. PTSD ensured this kind of evidence of victimhood; imagined by humanitarianism to be the condition of a refugee: a completely apolitical and helpless victim. What was at stake in the training turned out to be less about psychological care itself than about the ability to detect true and authentic articulations of suffering.

UNHCR officers mentioned sexual violence during the training as one form of violence they knew existed but were unable to detect during registration. As humanitarian and media reports increased about an epidemic of sexual violence (Ticktin 2011) in Syria, humanitarian workers in Lebanon were asked to identify sexually abused women to provide them with proper medical and psychological interventions, something they were having a hard time doing, especially because sexual violence was not a topic that these women would be comfortable sharing with registration officers. Plus, sexual violence and rape stood out as visible and truthful forms of suffering worthy of humanitarian care, where women became "the ideal victim" to humanitarian organizations (Ticktin 2011, 259). UNHCR registration officers needed assessment tools to identity psychological signifiers of sexual violence. One of the UNHCR registration officers said: "It is not natural that I don't find raped women"'. She was not able to ask the right questions or use the proper tools to make the women refugees talk about sexual violence. She

had been looking for more than three months for cases of sexual violence because she knew these cases existed from the humanitarian reports and statistics published, but they had gone undetected by her. She wanted to know how she could approach potential women-victims and read rape on their bodies and psyches. How could she identify who had been raped?

Samer stressed again that:

> *"PFA is not about snooping around someone. It is not debriefing. We normally have a tendency to ask these intrusive questions. In Lebanon, we are used to this and we say "tell me and you will feel better".*

However, UNHCR officers needed tools to be able to tell who experienced sexual violence in order to fill their questionnaire and see how to refer people to the proper services, as well as how to file a refugee claim. As one of them said: "But I need to know and have the techniques so that I know what to write in the claim. I have to refer". In the registration interview, asylum seekers had to answer a long survey of questions, where one of the indicators was gender-based violence. UNHCR registration officers needed some sort of a lie detector skill to separate the victims from the non-victims, the truly traumatized from the fighters, and the refugee victim from the non-refuge claim. One of them explained to Samer: **"**in order to identify a refuge and refer him/her to a focal point, she (the UNHCR registration officer who couldn't find cases of sexual violence) needs to be able to identify". For some wounds like sexual violence, one needed to dig deeper in order to find them.

Samer, struggling to explain the usefulness and importance of the kind of care PFA provided, and a bit appalled by the registration officers' insistence on 'knowing who got raped', tried to explain one more time that psychological care was more about gaining trust than asking invasive questions and digging deeper:

"There is no right question to ask especially in cases of abuse and rape, some people just come and talk while other wont (...) It is more of an issue of trust, if someone trusts you he might telling without you have psychological skills. I have been practicing for 12 years and I can never figure out or know if someone had sexual abuse"

Unconvinced, the UNHCR registration officers were more interested in the "true stories" that PTSD and trauma brought to the surface. After all, this was their job and they were not able to find which psychological wounds were authentic.

'Digging deeper' for indicators of Sexual violence

Sexual violence and rape were specific psychic wounds that UNHCR officers were having a hard time detecting in Syrian refugees. As Syrians fled to Jordan, Iraq, Turkey and Lebanon in unprecedented numbers, humanitarian and media reports started to pour in about the sexual violence against and rape of Syrian women (FIDH 2012; Masterson 2012). By August 2012, the International Rescue Committee published the results of a rapid GBV assessment of Syrian women and girls in Lebanon. The assessment was based on a series of focus groups conducted with Syrian women and girls displaced to Lebanon, with the help and technical support of local NGOs. Rape and sexual violence were identified as the most extensive form of violence faced by these women during the conflict (IRC 2012). Survivors of Gender-based violence were however seen as reluctant to report the violence they went through "due to restrictive cultural values and stigma", refraining from getting support because of the shame they will face by dishonoring their families (IRC 2012). This reluctance was also reported by the UNHCR (UNHCR 2012). Sanj Srikanthan, an International Rescue Committee (IRC 2012) Emergency Field Director was quoted in an IRC report as saying:

"The stories we've heard talking to Syrian women in Lebanon are truly horrific. Many of these women have experienced rape and torture in Syria, but as refugees can't find the support they need to heal their physical and

emotional scars—let alone provide food and shelter for their families." (IRC 2012)

In 2012, the UNHCR was only able to identify around 200 refugees as victims of sexual and gender-based violence, and provided them with medical, psychosocial and material support (UNHCR 2012). Identifying women who had suffered from sexual violence was crucial to know whether to register them as refuges, and to decide the types of services they were eligible for, like psychological assessment for trauma and PTSD.

What PFA offered to UNHCR officers however was a form of first aid that anyone can administer, which focuses on satisfying the troubled person's "basic needs" based on Maslow's hierarchy, rather than digging deeper for the trauma. As Samer explained during the training:

> *"If you dig deeper because sometimes it is not visible, and he won't talk about it, it won't show. Regardless of the symptoms, a crisis and an emergency is the psychological problem itself. (There is) No need to look deeper for symptom."*

"Digging deeper" into an asylum seeker's wounds and stories of violence was a main concern of these registration officers who had to decide, classify and register individuals as victims or as perpetrators of violence, and identify whether they were telling the truth. One UNHCR officer said: "In our line of work, we are used to digging deeper. We have to abide by certain criteria". While another argued that: "We go deep, because some families remain silent because they don't think we can help them. We go very deep to know what the problem is".

UNHCR officers deeply challenged PFA as they needed psychological tools that could help them know, assess and distinguish between authentic suffering and lying, something for which debriefing might have worked best. As one UNHCR officer argued during the training: "We work on psychological, security and protection. Because sometimes they (refugees) lie, and we need to find out who lies and who doesn't. That is why we need to dig deeper".

Samer tried to explain that knowing and gazing inside the wounds was not even the psychologist's job who needed to respect the privacy of the patient, especially in issues like rape and sexual violence: "Digging deeper might be hurting the person more than helping her". While PFA predicated that all suffering and its articulations were authentic and true, the reality of aid as seen by the UNHCR officers predicated the need to assess the authenticity of suffering itself.

The double bind of psychological care

PFA was used to "stabilize" and "normalize" the subject exposed to violence, thereby decreasing and preventing the outburst of psychological disorders like PTSD. However, it was these same psychological disorders that the UNHCR officers wanted to dig deeper into them- in order to assess the authenticity of suffering of refugees. The debates that emerged during the Psychological First Aid training raised questions about what kind of psychological care was possible within these new realities of aid, where trauma and PTSD were crucial for determining refugee status and recognition for suffering. Sexual violence and rape stood out as a form of violence that produced pathological authentic wounds of suffering, a form of a true "emergency illness" that requires both immediate intervention and recognition of suffering[168]. As Samer struggled to explain the usefulness of PFA as a form of psychological care that aimed at preventing the outbreak of psychological disorders like PTSD, it was exactly these disorders that were needed to be identified by UNHCR officers in order to file a refugee claim.

[168] "Approaching gender-based violence as a medical or health issue alters how violence is both approached and understood; that is, rather than understanding gender violence in the context of gendered relations of power, or as part of larger histories and expressions of inequality which are inseparable from histories of class or race or colonialism, this type of medicalization transforms gender-based violence into an emergency illness, requiring immediate intervention. Furthermore, it narrows gender-based violence into its subset, sexual violence, in which sexual violence refers to certain forms of violence done to specific parts of the biological body, which are then treated by biomedicine (…)" (Ticktin 2011, 255).

A double bind of psychological care emerged in this training that represented the new realities of aid in Lebanon. Humanitarian workers were both asked to provide psychological care to prevent psychological disorders while looking for the same psychological disorders as a marker of true suffering and victimhood. This paradox became more noticeable with the humanitarian shift in using less invasive forms of psychological care like PFA, a form of psychological care based on the principle of "do no harm" that was not interested in "true stories" of suffering as much as providing overall psychological support.

The debates between Samer and UNHCR registrations officers during the PFA training revealed the tensions around the meaning and purpose of psychological care within these new realities of aid, where trauma and PTSD became technologies that can legitimize certain forms of suffering as eligible for aid and refugee status. Samer communicated his confusion and frustration to me during a break in the training. The humanitarian bureaucratic work required for legitimizing suffering seemed alien to him, probably because his job as a humanitarian psychologist then consisted more of providing psychological therapies and awareness sessions to communities, and probably -- like he said at the beginning of the chapter -- because he was more of a clinician. I read these debates and Samer's confusion as revealing the new shifts in aid politics, where technologies of humanitarian psychology become intimately implicated in practices of truth-telling, and in the commodification of suffering. In the next section, I introduce the new narratives of suffering that emerged from the changing realities of aid in Lebanon.

IV. "We too have truly suffered! ": Changing narratives of suffering in Lebanon

This is about a type of encounter between a Lebanese and a Syrian, taking place in public taxis, in cafes, the supermarket, the post office, and in waiting rooms of clinics and centers. It is

an encounter that I have witnessed and have heard anecdotes about in Lebanon during the end of my research.

The Syrian is usually silent and quiet, avoiding interaction, and does not want to speak of the massacres, violence and terror she had witnessed and what she has gone through. What she had seen. The Lebanese, by the mere fact of identifying a Syrian by her accent, starts telling her that 'what is happening in Syria' and what she experienced is little compared to what he has gone through in the civil war, during the Israeli invasion, and the July War. Story after story, he recalls specific events of suffering in war and violence that he witnessed and experienced: waiting for long hours in line to get bread and water; hiding and running away from shelling everyday; seeing dead bodies in the streets, random massacres and losing loved ones.

The Lebanese suddenly purges past stories of his own suffering; stories that probably would not have been shared publically if it was not for the 'Syrian presence'. Frantically, he recites past stories of war and suffering while the Syrian sits quietly, perhaps not knowing what to answer, or perhaps appalled at the distastefulness of the recounting of Lebanese suffering that became more valuable than her own untold but more recent experience. I witnessed this recurrent interaction numerous times. It usually ends with the Lebanese telling the Syrian that her suffering was nothing compared to what he had gone through in Lebanon, "and we also were ruled by the Syrian regime, don't forget that!" he might add to her in conclusion.

In one trip I took in a service (shared taxi), the driver commented on the aid stipends that Syrian refugees received "for their suffering" while they continued to exploit the Lebanese economy and "take our jobs". The driver was angry after he noticed a sticker in the display window of a liquor store that said: "we accept refugee cards". He was probably referring to the United Nations World Food Programme (WFP)'s e-card system that provided monthly stipends

for Syrian refugees in Lebanon with a value 20$ per month- an amount that became intermittent due to loss of funds. "Do they also get to buy alcohol with their stipends?!" He added angrily, appalled that the stipend would allow the refugees to buy anything other than their basic and vital needs. Then he added: "No one ever gave *us* anything for our suffering in the civil war! And we suffered so much more than them, but alas we got nothing in return".

Since 2012, the 'Syrian presence' in Lebanon increased to reach around one million people in 2015 according to the UNHCR[169]. This presence has caused different forms of anxieties within the Lebanese society coupled with increased and overt forms of discrimination against the Syrians (Moghnieh 2014). Stories of how "the Syrians" were ruining the country became commonplace and hard to avoid in everyday interaction. These narratives were fed by state institutions that started blaming all the country's pre-existing problems on "the Syrians"[170]. Many municipalities imposed curfews on Syrian refugees, restricting their movement (Human Rights Watch 2014). The rise in anxiety and discrimination against the Syrians was accompanied with massive mobilization of humanitarian organizations that shifted most of their aid to attend to the Syrian refugees.

Encounters like the one I described above reveal how articulations of suffering from violence and war are intimately contingent on emerging economies of care and aid. The growing discourse of de-legitimizing the suffering of Syrians I observed was intimately tied to competing economies of suffering, aid and discrimination in Lebanon. These economies -- set by global

[169] According to UNHCR estimates, by early 2014 Lebanon was a host to 927,638 Syrian refugees in Lebanon, of whom 879,907 are registered with the UNHCR, representing around 21 per cent of the total population in the country. (http://www.ilo.org/wcmsp5/groups/public/---arabstates/---ro-beirut/documents/publication/wcms_240134.pdf

[170] At one point, the Syrians were to blame for everything: the state of the country's economy, the lack of jobs, corruption in aid, electricity cuts, traffic, sewage in water, increase in garbage, the increase of violence and petty crimes.

humanitarian organizations, UNHCR criteria for refugee, and humanitarian psychological diagnostic tools-- participated in the commodification of suffering, as was shown in the previous sections.

The new realities of aid and violence raised questions about the hierarchies of suffering in Lebanon. The Syrian suffering, as a humanitarian category of victimhood, became attached to economic resources and allowed for new kinds of articulations of suffering and claims for recognition in Lebanon. The new realities aid in Lebanon not only set conditions for what suffering counts as authentic and recognizable. They also evoked past experiences of violence and war in Lebanon that were rarely retold and narrated as individual injuries and claims in Lebanon (Haugbolle 2012). As if the Lebanese suddenly remembered the multiple layers of violence that inhabited their world and for which they had neither official frame of recognition (Butler 2009) nor compensation. This was similar to Omar Dewachi's recent article on Hussein, an Iraqi refugee working as a bartender in Beirut, whose wounds of violence disturbed and agitated memories and articulations of suffering from the Lebanese civil war (2015). Within the absence of a national discourse on the war and violence, and the trouble in finding trauma, the Syrian suffering disturbed and transformed politics of suffering in Lebanon.

Stuck between humanitarian global markets of suffering-- manifested in trauma and PTSD that the UNHCR in hosting countries needed to see and recognize in order to give refugee status -- and the Lebanese's own privileged suffering Syrians' experience of loss, violence and pain were in this case left unrecognized, unaccounted for and forbidden to emerge, except as aid communities seeking refugee status.

"We too have truly suffered!" The geopolitics of violence, aid and suffering

The change in the narrative on suffering should also be read within the changing geopolitical scene. By the end of 2012, I planned a series of interviews with people in South Lebanon on their experience about the July War. I had started to do a couple of interviews when I encountered difficulty in getting people to talk about the July War. I had easy access to people to interview being from the south myself, and while the July War was easily discussed and narrated both in media and in regular conversations, I now sensed a lot of tension and reluctance in talking about the war at the time.

By then, it was well known that Hezbollah had entered into a war defending the Syrian regime against different opposition rebel groups and Islamic radicals; a war that was more controversial and far less morally justifiable than a war of resistance against Israel. Bodies of Hezbollah fighters were returning to the south as martyrs, their pictures posted on walls in neighborhoods. Remembering the July War now produced anxiety and unrest, and maintaining a narrative of resilience and resistance was no longer a self-evident discourse. Most of the aid and reconstruction for the July War were now long gone, as if everyone has forgotten, like Sana said they would (see chapter three). But bodies of fighters were being returned to the south, martyred from a cause that was not as obviously or clearly "just". I sensed that tension and the reluctance in talking and I decided to postpone my interviews indefinitely as I felt people were now visibly uncomfortable to remember the war now.

Later in 2013, I started giving public lectures on the problems of finding trauma in Lebanon, mainly in Beirut. Some of these lectures were more accessible to a nonacademic public audience. During discussion, several people from the south and the suburbs of Beirut challenged in anger that Lebanese were not traumatized by the war. One of them emphasized in protest that "we have suffered psychologically as well", stating numbers of mental health cases that emerged

in these areas after the war, like depression and suicidal tendencies. By 2013, the offensive Hezbollah launched in alliance with the Syrian regime, along with the flood of Syrian refugees into Lebanon, has masked or somewhat caused the suffering experienced by the 2006 war, to be placed in the background.

What used to be an absence was now a right to suffering that needed claiming. Statements like "we have suffered; a lot of us have mental health problems' might be a reflection of the expansive force of psychologization in postwar Lebanon (see chapter four). But it should also be read within the geopolitical transformations of violence and aid described in this chapter, as a longing for recognition of suffering within new forms of warfare -- with Hezbollah going into war inside Syria.

The forgotten suffering of the Sudanese refugees

Within this new reality of aid in Lebanon, Sudanese asylum seekers and refugees became "the forgotten and invisible refugees" **(**The Daily Star**)** as they struggled to receive services from the UNHCR and to build a refugee claim file that would allow them to be resettled. In 2015, Sudanese refugees and asylum seekers started a strike outside of UNHCR headquarters in Lebanon, protesting the discrimination of the agency against them. The UNHCR was accused of abruptly closing refugees' claim files, suspending resettlement plans and of racist treatment of Sudanese refugees. Furthermore, refugees competed for visibility next to the Syrian refugee crisis that overshadowed their presence in Lebanon. According to the UNHCR there are around 500 Sudanese asylum seekers in Lebanon, having fled conflicts in Sudan in recent years. The fight of Sudanese asylum seekers for visibility and recognition of suffering and resettlement continues as the new realities of aid privilege certain kinds of suffering bodies over others, while other wounds of violence remained invisible and unacknowledged.

V. Conclusion

This chapter followed how humanitarian psychology in Lebanon intersected with new conditions of aid brought forward by the Syrian refugee crisis and contributed to the commodification of suffering -- where a political economy of trauma emerged (James 2004; 2011). These new realities of aid unfolded in a training of Psychological First Aid for humanitarian workers assisting Syrian displaced in Lebanon, where a double bind of psychological care appeared, where humanitarian workers were being asked to provide psychological support to prevent the occurrence of the same psychological disorders they needed to provide evidence of suffering for a refugee status that provides aid and a promise of resettlement. This chapter showed how subject positions towards violence (as suffering, resisting, activist, masculine, victorious, resilient, indifferent) were contingent on market economies and the geopolitics of violence and aid. Subject positions and subject formations from violence and war were contingent on the evolving economies and moralities of care that allowed for their formation.

Chapter VII

‘The violence we live in’: Humanitarian psychology, violence and suffering in Lebanon

It is not easy,
It is not at all simple,
To walk easily and slowly,
With gunshots reaching my head, a tank over my footsteps
And the gunmen are lurking around, waiting to curse my essence
It is not easy,
It is not at all simple,

It is not easy
To speak Arabic or Turkish,
With gunshots reaching your head, a tank over your footsteps
And the gunmen are roaming around, waiting to curse your essence
It is not easy
It is not at all simple,

It is not easy at all to dream,
After it you directly regret,
With gunshots reaching your head, a tank over your footsteps
And the gunmen are lurking around, waiting to curse your essence
It is not easy,
It is not at all simple”

“Mesh Hayyen” (not easy) by Khaled Al Haber, 1991

The Lebanese song “Mesh hayyen”, performed by singer Khaled El Haber at the end of the Lebanese civil war in 1991, is a powerful example of the embodied experience of living in violence in Lebanon; an experience that could not have been captured by humanitarian therapeutics such as the interventionist model of trauma. The practice of living-in violence in Lebanon is still crucial today, as anticipating and witnessing car bombs, suicide bombers, Israeli wars, political assassinations and civil war strife continue to be a pressing reality.

Reading violence and assessing its threat level has become an overwhelming daily task; one must distinguish what is safe from what is risky: *"Are these fireworks or gunshots? Are we at war or is it just a street fight? Should we move out of this neighborhood or should we stay? Is this life threatening or are they just trying to scare us? Is this bomb terrifying or does it carry a contained political message? Does it target someone in particular or is it random? Can I still go to work as usual or should I stay at home today? Should I buy more food just in case or just the regular amount? Can I take the regular route or should I avoid certain streets?"* Decoding violence in the everyday- as all Lebanese know- is a crucial work of not only experts, politicians, media personnel and humanitarian workers, but of regular people as they try to assess and make sense of a social reality that is always at the edge of livability, always threatening to collapse into chaos, disorder and terror.

Humanitarian psychology in Lebanon operated along war/postwar and emergency /development binaries, identifying and treating different forms of violence and forms of suffering in each case. It sought to treat war trauma during war; then shifted focus to address other forms of violence- like domestic violence and the refugee experience- in postwar Lebanon. Through techniques like psychologization and therapeutics- like trauma therapies and masculinity therapies- humanitarian psychology worked to contain and treat violence foremost as a form of psychological precariousness detached from the history and politics in which it is embedded. However, 'political violence'--what I am loosely calling the political assassinations, booby-trapped cars, civil war street fights, suicide bombers- increasing in pace since 2012, seems to have fallen outside of humanitarian psychological governance, as global humanitarian organizations have not designed any psychological intervention for these incidences. Somehow 'political violence' seems to fall outside of humanitarian psychological governance, disturbing

war/postwar binaries and challenging ideas about what kinds of violence are constituted as traumatic and what kinds become normalized as part of everyday living in Lebanon.

This dissertation addressed the humanitarian therapeutics of war and violence in Lebanon. It looked at the different ways in which humanitarian therapies of violence were contested, appropriated and debated by communities and experts. It highlighted the experience of living-in violence in Lebanon- what Dr. Al Amine called "Al Mou'ash" and what Dr. El Hage referred to as "the field" of living. While war trauma was deeply contested, the July War allowed for the possibility of psychologization as a new mode of intervention that expanded and proliferated in postwar Lebanon, as part of the psychological reconstruction of self and place. Based on four ethnographic case studies, each focusing on specific forms of therapies and technologies of humanitarian psychology in Lebanon, my dissertation drew from ethnographic methods to examine the processes and techniques of psychologizing violence in Lebanon through humanitarian aid; as well as the forms of contestation and appropriation around suffering that emerged in response.

Summary of the case studies

My dissertation focused on the rise and expansion of humanitarian psychology in Lebanon in response to the July War in 2006, while historically drawing on the different processes of psychologization of violence in Lebanon since the late 19th century. Global humanitarian organizations, partnering with local organizations in Lebanon, employed psychiatric diagnoses, therapies, trainings and awareness campaigns to treat war trauma following Israeli wars. They then focused on psychologizing social inequalities, personal lifestyles, violence against women, and the refugee experience in the aftermath of the July War.

The first case study explored the humanitarian trouble of finding trauma and PTSD in Lebanon following humanitarian interventions after the Israeli invasion in 1982 and the July War in 2006. It discussed the different expert, political and intellectual debates emerging around the absence of trauma in both wars, and introduced the non-traumatized and nontherapeutic subjects that humanitarian psychologists encountered, whose suffering was resistant to psychologization and trauma. These subjects took on a position of *soumoud* -or steadfastness and resistance- to war, where trauma was understood as part of warfare, rather than an individual expression of the aftermath of war. Through the story of Bilal, the case study complicated the experience of suffering beyond a trauma/resistance binary.

After the July War, massive psychological trainings, assessments, studies and rehabilitation of institutions and practitioners in Lebanon were under way. The second case study explored the psychologization process that took place in postwar South Lebanon. In contrast to the humanitarian trouble in detecting trauma from war, 'the psychological' was everywhere in in the south. Local practitioners and aid communities were learning, through diagnostic training and psychological education, how to see life's pressures as psychological symptoms of potential disorders and pathology. The focus turned from diagnosing and treating PTSD to psychologizing the pressures of living in the aftermath of war by relying on diagnoses of personality disorders like histrionic, anti-social and obsessive compulsive personality types. Personality disorders served to enable new forms of therapeutic subjects who understood their selves and their surroundings in psychological terms.

Within this expansion of the psychological into everyday life, new therapies emerged that targeted domestic violence as a result of psychological life pressures experienced by men, rather than the result of structural and patriarchal inequalities. The third case study followed the

difficulties faced by a research study in Tyre used to inform therapies of masculinity against domestic violence in Lebanon. The case study was an example of the deep de-politicization of domestic violence behind therapeutic masculinity that removes violence from its patriarchal context, turning it as an internalized psychological injury of angry men themselves.

Through these therapies, domestic violence became a result of poor psychological skills in dealing with life stressors. This case study followed how psychologists and social workers faced numerous difficulties gathering focus groups, where the study's premises were contested by communities as they were being convinced to participate. The violence occurring in Tyre at the time of the study seemed to also contest the study's premises. When the men and women focus groups were finally recruited, participants mostly spoke of structural and patriarchal forms of violence that informed their definitions of masculinity, thereby challenging the assumption that domestic violence was only a product of archaic and traditional pedagogy that varied. In this case study, I also provided a short history of the women movements against violence against women in Lebanon

By the end of 2012, new aid communities like Iraqi and Syrian refugees arrived to Lebanon fleeing war, violence and torture. The Syrian refugee crisis in particular transformed the relation between aid and suffering in Lebanon. The fourth case study followed how the new conditions of aid shifted and transformed narratives and politics of suffering in Lebanon, where different aid communities competed for recognition and access to aid. The fourth case study first provided a description of the shifting conditions of aid brought forth by the Syrian refugee crisis. It examined this shift by looking at the economies of psychological care that emerged around war trauma during the July War, exploring how the Syrian crisis brought forth new relations between aid and suffering. Whereas aid and services during the July War were used to protect

community from trauma and a psychological breakdown, a political economy of trauma emerged during the Syrian refugee crisis, where PTSD became intimately linked to a refugee status and access to aid. This case study followed the material implications behind the changing conditions of aid, and its effect on old and new aid communities like Iraqis, Syrians, Palestinians, Sudanese and Lebanese. It introduced the debates that emerged around the purpose of psychological care within these conditions of aid, as they unfolded in a training on Psychological First Aid in Akkar. A double bind on psychological care occurred, where humanitarian workers were asked to provide psychological support to prevent the same psychological disorders they needed to detect as evidence for refugee status and victimhood. With these realities of aid, new narratives of suffering emerged. This case study provided examples of both Lebanese communities and Sudanese refugees who both sought in different ways to have their suffering become visible and compensated. In the first example, the Lebanese constantly sought to privilege their own suffering over that of the displaced Syrians, denying the latter any articulation of suffering outside a humanitarian narrative of trauma. The shift in the Lebanese narrative from defiance and rejection of trauma to a narrative that sought recognition of psychological suffering should be read within the current changes in geopolitical events like Hezbollah's war in Syria. The second example was the "forgotten" Sudanese refugees, who struggle for visibility and access to aid and for resettlement within a humanitarian hierarchy of suffering

Violence, suffering and humanitarian psychology

The reconfiguration of suffering into individual psychic injuries as well as the psychologization of violence depended on different assemblages of techno-moral discourses embedded in humanitarian psychological programs and therapies, NGO-ization, diagnostics and trainings. Studying the humanitarian psychologization of violence and war revealed many

tensions, debates and contestations about the politics of suffering and its contingencies on violence, aid and the reconstruction of Lebanon.

This dissertation highlighted two general processes of humanitarian psychiatry that were contested and challenged by experts and communities alike. First, that humanitarian psychology in many times ends up pathologizing forms of motherhood, womanhood and masculinities that do not conform with classed understandings of gender roles, thus misrecognizing gendered structural inequalities as individual pathologies that require therapy. Second, humanitarian psychology works to pathologize violence by producing it as psychological precariousness, thereby emptying it of history, context and politics.

In many times, the diagnoses given for aid communities were highly gendered, employed as treatment against what was perceived to be unfit forms of mothering or masculinities. For example, personality disorders like histrionic personality disorders were repetitively used and diagnosed during group therapies and awareness sessions, to psychologize and pathologize certain emotional experiences of "marginalized and refugee" women. My dissertation recorded how humanitarian psychologists worked to transform bad motherhood and violent masculinities into social roles seen as psychologically more healthy, normative and acceptable, through the use of personality disorders,

Chapter three, five and six showed the different ways and processes through which violence became pathologized as an individual form of psychological vulnerability in the form of war trauma, a psychologically inept form of masculinity and as psychic wounds marked by the 'refugee experience' of displacement, loss and violence. Both trauma and therapeutic masculinity provide two examples of how the psychologization of violence uprooted it from structural, historical and political contexts. Chapter Six highlighted the material relations

between aid and suffering, where a political economy around trauma emerged during the Syrian refugee crisis. This created competition between different aid communities for access to aid and recognition of suffering.

In this sense, this dissertation showed how suffering from violence and war is not a discrete and distinct condition that one either has or not, but a form of subject position contingent on violence and aid. For example, being traumatized by Israeli wars did not bring any form of recognition for the Lebanese side. On the contrary, one may argue that there was a political economy around resilience and resistance during the war. In 2012, with the changing realities of aid, trauma became a desired commodity that provided aid and a future of a better life. While Lebanese communities envied this form of suffering and started speaking of their suffering as psychological, there was no space for this kind of narrative earlier in Lebanon, where ideologies of erasure of war through reconstruction sought to remove any physical and semiotic presence of the violence.

Contribution to practice

This dissertation provided several contributions to the practice of intervention on violence and suffering in Lebanon. First, the massive forms of psychologization occurring in Lebanon have led to a trend of over-diagnosing both mundane and structural life happenings. Teaching social workers and nurses how to detect psychological symptoms by relying extensively on clinical diagnostics and psychological disorders have led, for example, to diagnosing a woman who likes to wash her hands as having obsessive compulsive personality disorder. Over-diagnosing, and as a result over-medicalizing communities is a general critique of psychologization in general. This dissertation has shown specific processes in which this psychologization takes place. Furthermore, it showed how the shifting realities of aid ended up

abruptly suspending psychotropic medications from aid communities like the Syrian refugees, producing more health problems.

Since many of the accessible psychological interventions and mental health services in Lebanon seem to be dependent on external funds and aid that are bound to be suspended anytime, a more appropriate model should rely much less on clinical and psychiatric approaches, and should incorporate a more community-based approaches to mental health that are less medicalized and dependent on pharmaceutical medications. Furthermore, the local expertise on mental health developed in the different Israeli wars during war should also be taken into consideration when designing mental health interventions during war (Moghnieh July 2015), rather than solely relying on humanitarian top-down and standardized interventions, like the humanitarian trauma model.

The integration of mental health in primary healthcare centers in South Lebanon has become a national program, adopted by the ministry of health in Lebanon in 2015. Thorayya and other social workers and nurses' trainings in South Lebanon were part of a pilot study to measure the efficiency of this kind of integration recommended by WHO's MhGap program. This dissertation therefore contributes to critiques around the unintentional results of psychologization in Lebanon. This dissertation has shown that, in many instances, psychological diagnoses tend to be highly gendered, focusing on communities thought to be "marginalized" and poor. In fact, the national mental health integration plan talks about poverty as one of the main and significant producer of mental illness. These issues have become urgent with the launch of the national program. Chapters five and six have shown how psychologizing structural and health inequalities, turning them into medicalized psychological disorders and treated by medications, serve to heavily de-politicize them.

Second, this dissertation contributes to critiques on international and global interventions in local sites. International social work is specifically playing an important role in global development and intervention (Estes 1997; Estes 2000; Askeland & Payne 2008; Ramon 2008). However, international social work has been perceived as undermining the ethics and principles of social work by uncritically participating in and propagating Western policies, values and understandings of the self (Mohan 2008; Midgeley 2001).

Other authors have questioned the validity of global "social work" knowledge. In *Globalization and international social work: postmodern change and challenge,* Payne & Askeland (2008) locate the role and nature of international social work within a postmodern global world and discuss global issues that affect the people social workers are attempting to help and the kinds of intervention that international social work provides The idea that knowledge is socially constructed affects the ways in which "western" social work knowledge is transferred across cultures and raises the question of incorporating other forms of knowledge and practices into international social work instead of mainly relying on a European-based and American-based knowledge (Askeland & Payne 2008).

Finally, a powerful critique of both humanitarian psychology and international social work was provided by Ann Rall in *Trauma and the politics of exclusion: social work and "Post-war Rwanda"* (2005). In her dissertation, Rall (2005) explores the effects of some psychological interventions implemented by international NGOs in Rwanda during the eight years following the end of the civil war. She traces the social and professional actors around "psychological trauma" and the forms of political and meaningful relationships that emerge out of these encounters (Rall 2005). Rall's critique is based on Said's theory of orientalism, where the production of knowledge about the oriental other is always in relation to the western self, but her

dissertation itself is a "writing against culture", a critical representation of and writing against the forms of knowledge produced by humanitarian psychology that reify global forms of suffering like trauma and produce a politics of exclusion in Rwanda (2005).

This dissertation attempted to critically address and locate the history, principles and programs of humanitarian psychology as a new form of intervention on violence in Lebanon. It offers implications for local and international social work practice. In the last decades, social workers have been hired more and more by non-governmental organizations and are working more with humanitarian institutions rather than the state. This is definitely the case in Lebanon, where the presence of NGOs and humanitarian organizations, has shifted both the professions of psychology and social work into more professionalized NGO workers, whose job role is now structured by global humanitarian policies, procedures and standards.

As social agents and practitioners, social workers and nurses mediate the work of global organizations in local sites and are constantly becoming incorporated into the humanitarian market, whether by working with NGOs or with global humanitarian organizations (Moghnieh July 2015). In Lebanon, social and community workers, predominantly women, work as "gatekeepers", mediating global humanitarian programs and standardized guidelines in their familiar local context. Many were recruited into global humanitarian organizations with salaries that local organizations cannot afford, while others who work with local NGOs that have become "local partners" of global agencies and organizations, have to put up with double pressure to fulfill the expectations of both programs.

Finally, this dissertation contributes to the practice of international social work, where the need for reflection on and a critical understanding of the effects that humanitarian psychological programs and the different cultural assumptions about trauma and violence, is crucial.

Humanitarian psychology produces a form of knowledge that conceptualizes violence and war as an event that breaks with everyday life and causes traumatization**.** However, this conceptualization of violence does not fit with how communities deal with and cope with war, where violence is seen and understood as part of everyday life, and is therefore handled differently. Social workers as humanitarian workers, especially international social workers who are recruited into a new site of violence, encounter violence in a very different way than do the communities, and will view war and violence as a traumatizing events for themselves. This difference in the encounter of violence between the humanitarian/practitioner and communities living-in violence should be discussed and highlighted so that international social workers do not project their own experience of violence onto the community.

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