CULTURAL APPROACH IN RED CROSS MHPSS

TOWARDS CULTURAL COMPETENCY IN MENTAL HEALTH AND PSYCHOSOCIAL SUPPORT (MHPSS) INTERVENTIONS: AN ANALYSIS OF THE RED CROSS RED CRESCENT MOVEMENT'S CONCEPTUALIZATION AND INTEGRATION OF CULTURE IN ITS MHPSS RESPONSES

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Lay Abstract

Effective mental health care respects and incorporates the cultural beliefs and practices of the individuals receiving it. However, according to the literature, there is a pattern amongst international aid agencies of applying Westernized mental health ideas globally. In this study, I investigate how the Red Cross Red Crescent Movement understands and incorporates local culture in its mental health and psychosocial supports (MHPSS). The study reveals that the Movement recognizes culture holistically. The Movement closely works with communities, aiming to ensure that the support matches local ways of understanding well-being and distress. However, the Movement tends to apply a more universal understanding regarding specific mental disorders. This discrepancy highlights issues within the humanitarian field at large. My findings suggest that while the Red Cross does well to integrate cultural understandings of psychosocial distress, there is a need for better collaboration between universal and local perspectives in MHPSS.

Abstract

Culture is critical to delivering effective mental health care, necessitating tailored approaches aligned with the respective cultural contexts. The rise of globalization and transcultural psychiatry highlights the importance of integrating culture comprehensively into mental health and psychosocial interventions within humanitarian contexts.

Existing research underscores the significance of culture in mental health. However, a prevailing influence of Western perspectives on mental health is evident globally, leading to the widespread implementation of Euro-American viewpoints in humanitarian fieldwork. This approach negatively impacts individuals affected by crisis by sidelining culturally grounded understandings of illness.

While several studies examine the impact of culture on mental health care, there is limited research on how humanitarian organizations perceive and incorporate culture in training materials. This study aims to examine how the Red Cross Red Crescent Movement conceptualizes and integrates culture within its mental health and psychosocial support (MHPSS) intervention.

I collected data from nineteen Red Cross guidebooks to conduct a thematic analysis and extract insights into the organization's approach. I found nine themes: understanding culture through self, culture as behaviour, culture as meanings, community-based approach, assessment, planning and implementation, training, monitoring and evaluation, and universality of mental illness.

My findings indicate that the Red Cross conceptualizes culture holistically, and by doing so, they aim to produce culturally relevant care. While the Red Cross emphasizes cultural relativism in its MHPSS responses, encouraging cultural competency, it also tends towards universalism when discussing mental health, reflecting the nuanced nature of MHPSS interventions. This tension highlights the complex relationship between these two perspectives in creating the Movement's MHPSS responses and speaks to broader challenges in delivering mental health and psychosocial care in humanitarian fields. Further avenues for research lie in exploring strategies to reconcile relativist and universalist frameworks, aiming to produce seamless MHPSSs.

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List of Abbreviations

Abbreviations	Full Descriptions
APA	American Psychological Association
DSM	Diagnostic Statistical Manual of Mental Disorders
IASC	Inter-Agency Standing Committee
ICD	International Classification of Diseases
ICRC	International Committee of the Red Cross
IFRC	International Federation of Red Cross and Red Crescent Societies
IPSS	International Pilot Study of Schizophrenia
LMIC	Low- and Middle-Income Country
M&E	Monitoring and Evaluation
MGMH	The Movement for Global Mental Health
MHPSS	Mental Health and Psychosocial Supports
NGO	Non-governmental Organization
NS	National society
PFA	Psychological First Aid
PS Centre	IFRC Reference Centre for Psychosocial Support
PSP	Psychological Support Programme
PSS	Psychosocial Support
PTSD	Post-Traumatic Stress Disorder
SGBV	Sexual and Gender-based Violence
TA	Thematic Analysis
UN	United Nations
WHO	World Health Organization

Declaration of Academic Achievement

I, Aysha Akhtar, hereby declare that research presented and described in this thesis is entirely my original work, except where cited or referenced. No part of this thesis has been previously submitted for any other degree or academic qualification at this or any other institution. Furthermore, I declare that this is a true copy of my thesis, including final revisions, as approved by my thesis committee and the School of Graduate Studies.

Introduction

On December 26th, 2004, a 9.0 magnitude earthquake struck off the coast of Indonesia, triggering a destructive tsunami. This catastrophic event wreaked havoc across countries in South Asia and the east coast of Africa, with communities in India, Sri Lanka, Thailand, and Indonesia experiencing most of the damage. The United Nations considers the tsunami one of the worst natural disasters in recent history, claiming an estimated 270,000 lives (United Nations International Strategy for Disaster Reduction, 2006).

The Indian Ocean tsunami had far-reaching consequences for the affected communities with numerous societal, economic, political, ecological, and health implications (Rodriguez et al., 2006; Authokorala & Resosudarmo, 2005; Kar et al., 2004). The World Bank estimates a total of 4.45 billion dollars (USD) in damages and losses across the affected regions (Authokorala & Resosudarmo, 2005). Between 14,000 and 51,000 individuals went missing, and over 1.5 million were displaced, losing their homes and properties to the disaster (Rodriguez et al., 2006). The destruction of infrastructure, including roads, railways, clinics, and ports, resulted in numerous injuries (Shaw, 2006; Rodriguez et al., 2006). Vulnerable populations experienced even more precariousness due to losses in livelihood and income, forcing many into deeper poverty (Authkorala & Resoudarmo, 2005; Rodriguez et al., 2006; Kar et al., 2004). The loss and stress endured because of the tsunami and its effects caused many to experience distress and poor mental health (Kar et al., 2004; Rodriguez et al., 2006).

Given the scale and extent of damages, an unprecedented global response ensued. Governments, non-governmental organizations (NGOs), and humanitarian actors came together to provide aid

through donations, clean-up assistance, and humanitarian care such as mobile clinics and psychiatric services. However, not all support provided proved beneficial. Prior to the tsunami, several of the affected communities lacked "official" mental health support. International aid organizations recognized that these countries were not equipped to provide the support needed in the tsunami's immediate aftermath and sent teams of health professionals, including psychotherapists, social workers, and psychiatrists, to help (Hansen, 2009). The influx of foreign aid workers overwhelmed local response networks, resulting in uncoordinated care (Hansen, 2009). In a chapter of the book Crazy Like Us: The Globalization of the American Psyche, author Ethan Watters (2010) documents a series of problematic and harmful psychiatric practices inflicted on the affected populations in Sri Lanka. Several of these workers were "cultural outsiders." Many foreign workers utilized Western-based practices such as psychological checklists, single-session grief counselling, and therapy without translators (Watters, 2010). The psychosocial response to the Indian Ocean tsunami is not an isolated occurrence. With increasing natural disasters, political unrest, and violence warranting international aid, there has been a rise in psychosocial responses from the international community. However, as Watters (2010) points out, such practices have brought more harm than good due to cultural errors.

Some scholars report that the Western understanding of mental health is often considered universal, with its basic conceptualization of causes, classification, and treatment of mental health problems seen as globally applicable (Summerfield, 1999; 2012; Fernando, 2014). In the West, mental health is intrinsically grounded in science, and biomedicine is widely understood to be immune from cultural bias. Therefore, the Western understanding of mental health is assumed to be objective (Kleinman, 1977; Littlewood, 1990). However, as Kleinman explains, what the

Western world regards as "mental health" is best seen as an explanatory model uniquely tailored to the Euro-American context (1977). Despite the ethnocentricity of Western concepts about psychopathology, they are nonetheless globalized, as seen through the Movement for Global Mental Health (MGMH). While the MGMH addresses challenges of mental health care in low-income settings through increased funding for psychosocial interventions, professional training, and public campaigns, it has faced significant pushback and criticism (Summerfield, 2012; Fernando & Mills, 2017; Ingleby, 2014; Mills, 2014; Watters, 2010). Specifically, the Movement exports mental health understandings, systems, tools, and technologies primarily embedded in Euro-American cultural frameworks to the global south.

For example, following the Indian Ocean tsunami, Western-trained mental health professionals presumed an epidemic of PTSD, depression, and suicide (Watters, 2010). However, local experts predicted otherwise (Christopher et al., 2014). Had foreign workers and international agencies worked alongside local psychosocial experts, an understanding of local ways of being, dealing with distress, and treatment would have been gained (Christopher et al., 2014). Instead of wasting efforts from foreign mental health professionals, they would have learned that Western therapeutic practices and medicalized views of distress did not correspond with local understandings of suffering (Christoper et al., 2014). These individuals experienced Western-based treatment methods, which fail to account for culturally appropriate treatment methods that may prove more effective (Summerfield, 1999). Overall, research indicates that responses to psychological distress are more effective when the distressed individual's culture is considered (Boothby, 1992; Summerfield, 2008).

Considering these criticisms, the failure of coordinated efforts during the tsunami and other global catastrophes, and a growing need for multi-sectoral responses, the Inter-Agency Standing Committee (IASC) reference group released a set of guidelines on mental health and psychosocial support in emergency settings (IASC guidelines) (2007). Comprised of 18 humanitarian organizations and consortia, the IASC is the highest-level humanitarian coordination forum (IASC, n.d.). The IASC guidelines are an "inter-agency framework that enables effective coordination, identifies useful practices, flags potentially harmful practices, and clarifies how different approaches to mental health and psychosocial support complement one another" (IASC, 2007, p.1). The term *mental health and psychosocial support* (MHPSS) was introduced in this document, referring to various services bridging together clinical and psychosocial approaches in emergency settings. In doing so, MHPSS goes beyond a traditional psychiatric and clinical focus to encompass social factors and their impacts on well-being. The document also addresses the importance and need for culturally competent care (IASC, 2007). In response to the IASC recommendations, several NGOs have developed, adapted, and changed their approaches to treating mental health and psychosocial distress in emergency settings to align with the IASC guidelines. One such NGO is the International Federation of the Red Cross and Red Crescent Societies (IFRC).

A member of The Red Cross and Red Crescent Movement, also known as 'the Movement' (comprised of the International Committee of the Red Cross (ICRC) and National Societies of the Red Cross Red Crescent), the IFRC is the world's largest humanitarian network (IFRC, n.d.). The IFRC organizes and directs international aid to communities that fall victim to natural disasters, conflict, and crises. The IFRC supports 192 national societies of the Red Cross and

Red Crescent by coordinating responses and helping them to develop in areas such as emergency responses and psychosocial support. To assist national societies in promoting the psychosocial well-being of staff, beneficiaries, and volunteers, the IFRC established The Reference Centre for Psychosocial Support (PS Centre). An integral part of the Movement, the PS Centre creates awareness about psychosocial reactions following a disaster; sets up and improves preparedness and response mechanisms at global, regional, and local levels; and facilitates psychosocial support before and after a disaster (PS Centre, n.d.). To help National Societies, the PS Centre produces training guides and participant handbooks relating to MHPSS interventions.

Although there is a vast amount of literature on Global Mental Health, MHPSS interventions, and culture, researchers have rarely examined NGOs and their MHPSS training, such as those produced for the Red Cross and Red Crescent Movement, from the perspective of culture. Thus, I explore how the Movement conceptualizes and integrates culture within its MHPSS training materials. To answer this, I analyze several training guides and participant handbooks produced by the PS Centre for staff and volunteers across the Movement. My analysis reveals that the Red Cross Red Crescent Movement conceptualizes culture within its MHPSS responses as multifaceted, encompassing culture as a system of behaviours and a set of meanings. Through this holistic perspective, the organization recognizes culture as a dynamic phenomenon shaping mental health and psychosocial needs and how Red Cross workers should address it. The Movement's commitment to integrating cultural relativism through community-based approaches throughout all stages of MHPSS response planning, as seen through training guides and participant handbooks, largely encourages the development and execution of culturally competent interventions. However, tensions arise when the organization discusses mental

disorders in the handbooks, taking on a universalist perspective. Therefore, while the Movement emphasizes cultural relativism, it also tends towards universalism when addressing mental illness, highlighting the complex relationship between the two perspectives in creating the organization's mental health and psychosocial support interventions.

I have compiled the results of my thematic analysis across three chapters. Chapter Four discusses how the Red Cross conceptualizes culture. Based on my analysis of the handbooks, the Red Cross perceives culture as meanings and behaviour, contributing to the organization's holistic view of culture. This framework serves as the foundation for my fifth chapter, in which I delve into how the Red Cross intends to incorporate local culture into their MHPSS responses. Chapter Five examines each MHPSS response stage (assessment, planning and implementation, training, and monitoring and evaluation) that incorporates culture through a community-based approach and emphasizes beneficiary participation. The analysis reveals how basing responses off local understandings of psychosocial well-being established during assessment and maintained throughout other stages enforces a cultural relativist understanding of psychosocial well-being, which, if practiced as outlined, should result in culturally competent care. The last chapter of my analysis explores the inconsistencies in the Movement's conceptualization of culture in that the organization frames mental illnesses through a universalist lens despite the Movement's intended efforts to address psychosocial distress through a culturally relevant lens. Thus, while Red Cross training primarily encourages the creation of culturally informed interventions and care, the application of the universalist perspective calls into question the overall cultural competency of the organization's MHPSS responses.

Chapter Two: Background

Introduction

Culture is an equivocal concept that finds applications across various domains of human life. In this literature review, I briefly explore the evolving understandings of culture since the 18th century, drawing distinctions between subjective and objective culture. I also discuss two facets of culture: behaviour and meaning. Delving deeper into culture, I examine the interplay between culture, health and mental health. Transcultural psychiatry stands at the centre of my review, revealing how universalism and cultural relativism frameworks shape interpretations and responses to psychopathology. These frameworks are discussed at length in my review of the global mental health movement, highlighting the shortcomings of a strict universalist stance. Emerging from the global mental health movement is the need for cultural competence in mental health care across humanitarian settings. As this paper focuses specifically on how the Red Cross Red Crescent Movement aims to deliver culturally competent care through its mental health programming, I close off the chapter with an overview of the Red Cross and its general approach to MHPSS.

2.1. Culture

There is great disagreement amongst some scholars over the understanding of culture, leading to debates across and within disciplines. Highlighting this contention, Jahoda (1984) describes culture as one of the most elusive concepts in the social sciences, with nearly two hundred different and evolving conceptualizations and definitions. The term 'culture' originated from the Latin word *cultura*, first associated with agrarian practices such as crop cultivation, i.e.,

agriculture (Tucker, 1913; William, 1981). By the 18th century, as urbanization and political institutions evolved in Europe, the meaning of culture shifted. Culture became associated with civility, knowledge, and power, indicating the cultivation of character (Elias, 1982; Gellner, 1988). As a result, culture transformed into something "one has," symbolizing class, sophistication, and elegance. With this shift, the concept of "high culture" emerged, in which people, typically the elite, could enter the realm of high culture through higher education (Gripsrud, 2006; Elias, 1982; Gellner, 1988). Such shifts in understanding position culture within a developmental hierarchy, emphasizing group membership as a significant component of culture that continues to influence our perspectives of culture today.

Even within the field of anthropology, which is the study of culture, several different definitions of culture are endorsed. One of the earliest recorded definitions of culture was by anthropologist Edward Tylor (1871 p.1), who defines *culture* as "…that complex whole which includes knowledge, belief, art, law, morals, customs, and any other capabilities and habits acquired by man as a member of society. Anthropologist Leslie White (1959, p.3) supports Tylor's understanding of culture by describing it as an "extra somatic, temporal continuum of things and events dependent upon symbolling." White suggests that culture is not inherent to the individual and extends beyond their physical being while evolving. A widely cited definition amongst anthropologists is by Kroeber and Kluckhonh (1952, p.181), who provide a more specific perspective, arguing that "culture consists of patterns, explicit and implicit, and for behaviour acquired and transmitted by symbols, constituting the distinctive achievement of human groups, including their embodiment in the artifacts." The authors (1952) propose that culture is a set of learned beliefs and behaviours differentiating groups from one another, which generations pass

down through intangible and tangible mediums. Similarly, Kroeber and Parsons (1958, p.583) define culture as "transmitted and created content and patterns of values, ideas, and other symbolic-meaningful systems as factors in the shaping of human behaviour." More recently, Hofstede (2011, p.3) offers a modern take on culture as they liken it to "mental software," meaning "the collective programming of the mind that distinguishes the members of one group or category of people from another." All these definitions demonstrate varied attempts to define and clarify culture into a universally acceptable definition.

While culture lacks a universally agreed-upon definition, certain elements are common among most understandings. These elements include group membership, its nature as a learned construct transmitted across generations, and its role in offering people frameworks to interpret their surroundings. Concrete and abstract forms, from symbols to relationships and ideas, serve as avenues for sharing values and traditions. Culture is a dynamic set of behaviours, norms, meanings, and values that shape society, guiding individuals in constructing unique perspectives on their identity and the world.

In addition to the absence of a single statement that describes culture, several ontological uncertainties surround it. For example, Singelis and colleagues (1999) describe culture as residing *inside* and *outside* the individual. Culture residing inside refers to the individual's shared beliefs, values, and thought patterns. In contrast, culture *outside* the individual refers to shared human-made parts of the environment, including religious and political institutions, educational and economic systems, art, and infrastructure (Singelis et al., 1999). This dual perspective aligns with categorizations of culture as subjective and material (Triandis, 1972, 2022) and with the

nominalist and realist perspectives of culture (Rohner, 1984). Subjective culture, aligned with the nominalist perspective, is immaterial and resides in the mind. It consists of ideas, knowledge, unstated assumptions, and codes of conduct passed onto generations (Triandis, 2002). Subjective culture also includes categories through which people interpret and understand the world, their beliefs, attitudes, norms, roles, tasks, values, and value orientation (Triandis, 2002).

In contrast, material or objective culture, aligned with the realist perspective, resides outside the individual and often takes a tangible form (Minkov, 2013; Rohner, 1984). This view means objects such as clothing, artifacts, work instruments, and infrastructure constitute culture. Invisible elements of objective culture also exist, including institutions such as marriage and family systems, laws, and political and religious bodies (Minkov, 2013). The realist perspective emphasizes culture's objective existence and impact, whereas the nominalist perspective emphasizes culture's subjective, socially constructed nature (Rohner, 1984). While Rohner (1984) argues that these perspectives are incompatible, Triandis's (1972, 2002) and Singelis and colleagues' (1999) explanations imply that both subjective (nominalist) and objective (realist) approaches to culture can be complimentary.

Related to the debate surrounding subjective and objective culture is the debate regarding the facets of culture. Typically, scholars describe culture in one of two ways: culture as a set of behaviours or culture as a set of meanings (Rohenr, 1984; Minkov, 2013). Keesing (1974, p.44) articulates the former when they state, "Cultures are systems (of socially transmitted behaviour patterns) that serve to relate human communities to their ecological settings. These ways-of-life communities include technologies and modes of economic organization, settlement, patterns,

modes of social grouping, and political organization, religious beliefs, and practices, and so on". Brown (1991, p.40) echoes these sentiments stating, "culture consists of conventional patterns of thought, activity, and artifact that are passed on from generation to generation." Thus, from a behaviouralist perspective, one can consider culture a series of behavioural patterns shared through generations and shape how communities interact with their environment, influencing their ways of life.

In contrast, culture as a collection of meanings hinges upon ideational theories (Rohner, 1984). Keesing (1974) identifies three ways of approaching culture as a system of ideas. First, they frame culture as a cognitive system in which underlying ideas and beliefs underpin observable phenomena (Kessing, 1974). One can also approach culture through a structuralist perspective in that it is a shared symbolic system reflecting "the creations of the mind" (Kessing, 1974). Lastly, one can understand culture as a system of symbols (Kessing, 1974). Like Keesing, Geertz (1973) and Pepitone and Triandis (1987) highlight the centrality of shared symbolic meanings in culture. For them, culture is about the underlying shared conceptions, meanings, and norms that inform visible practices of culture. Thus, the behaviouralist perspective emphasizes the external observable actions and practices that structure how groups interact. At the same time, the ideational viewpoint focuses on the internal, symbolic meanings, norms and beliefs that inform and give significance to behaviours.

2.1.1. Culture, Health and Mental Health

Regardless of which cultural approach one aligns oneself with, culture may shape assumptions, beliefs, and expectations of how things are and should be. These assumptions are a part of what

some psychiatrists refer to as the *assumptive world* (Beder, 2005). Psychiatrist C.M. Parkes defines the assumptive world as a "… strongly held set of assumptions about the world and the self which is confidently maintained and used as a means of recognizing, planning, and acting… Assumptions such as these are learned and confirmed by the experience of many years" (as cited in Beder, 2005, p.258). Thus, culture plays a critical role in shaping assumptive worlds.

The relationship between culture and health has been extensively explored in the literature, establishing a solid connection between the two. In the book *Persuasion and Healing: A Comparative Study of Psychotherapy,* Frank and Frank (1991) contend that perceptions of what constitutes an appropriate understanding of illness, healing, and, by extension, health are integral to a culture's assumptive world. In this sense, culture provides a conceptual framework that helps individuals and societies make sense of health and illness (Beder, 2005). These frameworks, also known as models of illness, encompass various elements such as beliefs, traditions, customs, and knowledge systems that determine or influence how one perceives, experiences, and responds to health and illness.

The biomedical model of illness is one of the most dominant models today (Wade & Halligan, 2004; Larson, 1999). It is widely discussed and utilized in many societies but primarily in the West (Wade & Halligan, 2004). The biomedical model defines *health* as the absence of disease and disability (Larson, 1999; Wade & Halligan, 2004). It is grounded in a reductionist and positivist perspective that views health and illness in terms of biological and physiological factors (Tamm, 1993). As a result, the biomedical model posits that all illnesses and symptoms arise from an underlying biological abnormality, which is referred to as disease (Tamm, 1993;

Wade & Halligan, 2004). Under this framework, the focus is on discovering the pathology of disease (Tamm, 1993; Wade & Halligan, 2004). It emphasizes restoring health through medical interventions rooted in science, such as pharmaceuticals (Mehta, 2011). Furthermore, Mehta (2011) explains that this model of illness rests on Cartesian mind-body dualism, in which the mind and body are separate entities. As a result, mental phenomena are unrelated and separate from physical bodily health (Mehta, 2011; Wade & Halligan, 2004). By isolating the body from the mind, the model reduces the body to the sum of its parts. As such, the body is devoid of any lived embodied experiences and sociocultural context (Zola, 1973).

The biomedical model has been praised for advancing medical sciences and health (Wood, 1986; Larson, 1999). Despite its praise, critics have heavily criticized the biomedical model due to its limitations. For example, the reductionist nature of the model excludes any psychological, social, and ecological factors (Engel, 1977; Tamm, 1993; Culyer, 1983; Larson, 1999). Social constructionists and cultural relativists take issue with the scientific objectivism expounded by the biomedical model. According to Fabrgea (1989), the biomedical model perceives *objects* of science, medicine, and illness as empirically true, thereby endorsing the notion that they are free from subjective value judgements and cultural biases. However, critics argue that science is a product of and integral to Western cultural tradition (Fabrega, 1989). As a result, a distinctive amalgamation of culturally influenced ways of knowing and understanding the world converge in the Western biomedical tradition (Fabrega, 1989). Therefore, critics challenge claims of neutrality and objectivity, seeing the biomedical model as a product and reflection of Western culture.

The biomedical model's difficulty in adapting to psychiatric disorders and phenomena best demonstrates its limitations and criticisms. While one can trace physical conditions to specific biological markers and mechanisms, one cannot objectively measure and validate psychiatric phenomena similarly. Mental disorders are complex as they involve interactions between biological, psychological, environmental, and social factors (Engel, 1977). Thus, the biomedical model's reductionist approach may overlook these disorders' complexity and interconnectedness. Similarly, the separation of mind and body encouraged by the biomedical model poses challenges in accounting for and adapting to psychiatric phenomena due to its inability to account for the intricate mind-body interactions inherent to these conditions (Larson, 1999). Moreover, some critics of the biomedical model consider psychiatric illnesses as abstract "objects" and social constructions of medicine (Fabrega, 1989). Consequently, competing models of health and illness have emerged, addressing these criticisms.

Psychiatrist George Engel (1977) published a landmark paper calling into question the biomedical model, its reductionist character, and its limited utility for psychiatry. Arguing that biology alone cannot account for the complexities and intricacies of the human experience, Engel proposed a new model of illness, *the biopsychosocial model*. Encompassing biological (age, gender, and genetic composition), psychological (thoughts, emotions, and behaviours) and sociological (peer relationships, family dynamics and socioeconomic status) factors, the model recognizes health as both a scientific construct and social phenomenon (Engel, 1977). Critics argue that the framework needs to be narrower, with some suggesting that one should understand it as a theory rather than a model (McLaren, 1998). Others claim the model lacks a scientific basis and marginalizes disease (Smith, 2020; Bolton & Gillett, 2019). Nonetheless, scholars and

practitioners widely praise the model for its holistic perspective and ability to account for disease and illness (Wade & Halligan, 2018). Consequently, the WHO adopted the model in 2002, and many use it to structure international guidelines and clinical care (Wade & Halligan, 2018).

The literature very well documents the relationship between mental health and culture. Some scholars argue that culture shapes and determines how we understand and respond to experiences of mental distress (Kirmayer & Young, 1998; Mezzich et al., 1999). Culture also determines help-seeking behaviours and who treats mental problems (Lindinger-Sternart, 2015; Guo et al., 2015). Moreover, studies have focused on the role of culture as a social determinant of mental health (Masotti et al., 2020; Bernal & Saez-Santiago, 2006; Klien Velderman, 2014). While scholars largely agree that a relationship between culture and mental health exists, the characterization of this relationship is a source of contention within psychiatry.

Specifically, Berry and colleagues (2002) identify three theoretical orientations characterizing the relationship between culture and psychology, which also apply to psychiatry. The orientations are *Absolutism, Universalism,* and *Cultural Relativism*. Absolutists deny the existence of a relationship between culture and mental health, while universalists characterize the relationship between culture and mental health as superficial (Berry et al., 2002; Kalra & Bhugra, 2010; Basset & Baker, 2015). Cultural relativists emphasize the centrality of culture in mental health, arguing that mental health and illness are culturally defined concepts. As mentioned, most scholars agree that there is a relationship between culture and mental health; therefore, the absolutist approach has generally fallen out of favour (Kalra & Bhugra, 2010). For this reason, I do not further discuss this perspective. Universalist and cultural relativist

orientations have divided the field of psychiatry, and this debate has played a central role in the development of transcultural psychiatry.

2.2. Transcultural Psychiatry

Transcultural psychiatry, also referred to as cross-cultural psychiatry and cultural psychiatry, focuses on the study of mental health and illness within the context of culture and cross-cultural interactions. It examines how cultural, social, and environmental factors influence mental health conditions' development, manifestation, and treatment. As both a concept and a discipline, transcultural psychiatry, and more generally psychiatry, has gone through significant epistemological and ontological transformations.

Initially, Western psychiatry aligned itself with a more positivist epistemology, emphasizing universalism in which it sought to establish objective and generalizable knowledge about mental health and illness across cultures (Littlewood, 1990; Bains, 2005; Kirmayer, 2007). This approach, known as universalism, aims to identify commonalities while downplaying cultural differences (Berry et al., 2002; Basset & Baker, 2015; Kalra & Bhugra, 2010). Universalism in psychiatry assumes that mental health and illness exhibit universal similarities across cultures, with shared biological bases and diagnostic features (Berry et al., 2002; Basset & Baker, 2015; Kalra & Bhugra, 2010). Universalists use this framework to find similarities across cultures, resulting in their advocacy for the use of standard diagnostic criteria such as those outlined in the *Diagnostic Statistical Manual of Mental Disorders* (DSM) and the *International Classification of Disease* (ICD) to identify, interpret, and classify psychopathology across populations (Fabrega, 1989; Thakker & Ward, 1998). Patel and Winston (1994) explain that

supporters of universalism believe mental disorders defined in Western classification systems will manifest similarly cross-culturally because they result from a physiological dysfunction, and all humans share common physiology.

However, universalism does not entirely disregard the role of culture. Tseng (1997) explains that any cultural difference in psychological phenomena across cultures is *pathoplastic* (Tseng, 1997). This concept refers to the idea that cultural factors may influence how mental disorders manifest or are expressed, but culture is secondary in shaping psychiatric phenomena (Tseng, 1997). This way of thinking is reflected in early cross-cultural psychiatric studies as many scholars attributed differences in psychopathology to developmental deficiencies, which they attributed as characteristic of non-Western cultures (Kraepelin, 1904; Leff, 1981; Murphy; 1982; Margetts, 1968; Benedict & Jacks; 1954). For example, in his analysis of the International Pilot Study of Schizophrenia (IPSS) materials, Leff argued that Western countries had more sophisticated and extensive emotional vocabulary than non-Western societies (1981). He suggested that non-Western languages were at an earlier stage of development, lacking specific words for feelings and instead focused more on somatic experiences of emotions. Leff's explanation portrayed Western societies and cultures as more complex in their understanding of emotions than non-Western cultures (1981). Antić (2021) suggests these sentiments contributed to a growing body of Eurocentric and colonist theories as early psychiatrists understood members of non-Western cultures as having simplistic psychological profiles and undifferentiated personalities.

Many scholars and practitioners during the early era of transcultural psychiatry subscribed to universalism, forming what Littlewood refers to as the "old cross-cultural psychiatry" (1990). Many experts considered European and Western psychiatry the standard and ideal, while non-European psychiatric systems were assessed primarily regarding how well they aligned with Western classification systems (Littlewood, 1990). This perspective, as stated, reflects Eurocentric bias in the understanding and evaluation of mental health practices. In 1977, psychiatrist and anthropologist Arthur Kleinman published a seminal paper, *Depression, Somatization and the "New Cross-Cultural Psychiatry*," critiquing the discipline's colonialist and Eurocentric past. In his paper, Kleinman (1977) calls for a renewed interest between cultural anthropology and psychiatry, which resulted in an epistemological and ontological shift in the field.

A new transcultural psychiatry emerged as part of a larger global project within Western psychiatry (Antić, 2021; Bains, 2005). This project aimed to transcend the colonial history that shadowed Western psychiatry, fostering an inclusive and respectful exchange between Western and non-Western conceptions of mental illness and healing (Antić, 2021; Bains, 2005). Furthermore, a sense of optimism for a post-war world infused this undertaking where international and interdisciplinary collaboration and understanding could shape more compassionate and socially comprehensive psychiatric care (Bullard, 2007; Bains, 2005). As such, transcultural psychiatry advocated for a cultural relativist approach.

Cultural relativism in psychiatry is an approach that emphasizes the significance of cultural context and diversity in understanding and evaluating mental health and illness (Fabrega, 1989).

It recognizes that cultural beliefs, values, norms, and practices are crucial in shaping individual experiences, expressions and interpretations of psychological distress and well-being. Unlike the universalist approach, cultural relativism aligns itself with the biopsychosocial model, advocating for consideration of social roles, intellectual capacity, emotional stability, and psychological well-being (Winders, 2013).

In his overview of the debate between universalism and cultural relativism, Fabrega (1989) explains that one uses concepts of "normal" and "abnormal" behaviour as a means of identifying psychiatric conditions. One must recognize that definitions of "normal" and "abnormal" are culturally constructed as behaviours that are deemed normal in one culture may not be regarded as the same in another (Fabrega, 1989). One may group behaviours perceived as "strange" or deviations from cultural norms to form diagnostic categories (psychiatric labels). Cultural relativists argue that these diagnostic labels are typically based upon Western conventions, as people believed Western culture was the epitome of civilization and the global standard against which one should hold oneself. However, as mentioned previously, universalists believe these categories are objective and grounded in science. Kleinman (1977) challenges the assumption that Western diagnostic categories are culture-free. He explains that what the Western world regards as "mental health" is better understood as an explanatory model uniquely tailored to the Western context. Thus, cultural relativists assert that the understanding and assessment of mental health should consider the cultural context in which it occurs, as different cultures may have unique conceptualizations and expressions of psychological well-being and distress. (Kleinman, 1977; Fabrega, 1989). Failure to do so is fundamentally problematic, as it commits what Kleinman calls a *category fallacy*, which he explained is "the reification of one's culture's

diagnostic categories [and their application to people] in another culture, where these categories lack coherence, and their validity has not been established" (1988, p.14).

Despite criticism against the universalist model, it continues to dominate the field of psychiatry. This occurrence is in part due to its alignment with positivism and empiricism, which comprise the dominant frameworks in our current scientific paradigm. Fabrega (1989) suggests that the universalist approach persists due to its methodological traditions of scientific objectivism, allowing researchers to deal with "experience-distant concepts" (p.416). In contrast, a cultural relativist approach calls for in-depth anthropological and ethnographic research methodologies, which is less widely appreciated (Fabrega, 1989). Patel & Winston (1994) suggest that psychiatry is similar to medicine in that it seeks clearly defined illness categories that one can use to explain biological change. The quest for universality encouraged by universalism validates these illness categories (Patel & Winston, 1994). Winders (2013) and Thakker & Ward (1998) believe that the DSM's global dominance allows universalism to continue to flourish. The debate between cultural relativism and universalism continues to plague the field of transcultural psychiatry, with the effects and consequences of each approach extending into global mental health and the Movement for Global Mental Health (MGMH).

2.3. Global Mental Health

Global mental health is a concept and interdisciplinary field of study and practice concerned with mental health issues worldwide (Johnson, 2013; de Jong, 2014). As a concept, global mental health emerged following shifts in both public health and psychiatric agendas prompted by globalization (Johson, 2013). Consequently, experts viewed health as a global issue, seeking

solutions to address inequalities across the world through international collaboration (MacFarlane et al., 2008). Studies from the WHO (1973, 1979, 2001) revealed the global distribution and burden of mental health problems, prompting the organization to add mental health to its broader global health agenda. The WHO's commitment to tackling mental health further cemented its position in the global health agenda by adopting the slogan 'no health without mental health' (Prince et al., 2007).

2.3.1. Cultural Competence

Globalization brought forth many challenges and questions to the field of psychiatry, including those surrounding the provision of mental health care to multicultural populations (Kirmayer et al., 2003; de Jong & Van Ommeren, 2005; Gopalkrishnan, 2018). Cultural diversity poses several challenges to mental health care due to language barriers, translation of psychiatric terms, differing understandings of mental health between patient and practitioner, and stigma (Gopalkrishnan, 2018). It is widely recognized amongst scholars and clinicians that mental health services and practitioners should consider culture to provide ethical and effective care (Anderson et al., 2003). Generally, cultural competence refers to practitioners' effectiveness in working with people of diverse cultural backgrounds (Kirmayer, 2005; Yahalom & Hamilton, 2023). This concept includes the practitioner's ability and capacity to consider and respond to a patient's culture and effectively meet their needs (Yahalom & Hamilton, 2023). Some experts believe that research and work into cultural competence are critical in tackling cultural biases and knowledge gaps in mental health care (Merino et al., 2018; Nelson, 2002). Also, it can help to address and understand disparities in help-seeking behaviours and mental health service utilization (Kam et al., 2019; Chen & Rizzo, 2010). Thus, cultural competence aims to make

healthcare services more accessible, relevant, and effective for people from different ethnocultural backgrounds (Kirmayer, 2012).

Several cultural competence models exist in mental healthcare (Kirmayer, 2012). However, it is beyond the scope and aim of this paper to discuss these in detail. Yahalom and Hamilton (2023) suggest that researchers have often approached cultural competence through two perspectives: 1) as a set of skills and 2) as a cultural process. The former focuses on developing cultural awareness by acquiring specific skills and techniques (Borelli et al., 2010; Sue, 1990; Yahalom & Hamilton, 2023). In practice, this approach may look like the adaptation of materials to meet the needs of the targeted cultural groups (Borelli et al., 2010; Sue, 1990; Yahalom & Hamilton, 2023). As the name suggests, proponents of the later model liken cultural competence to a dynamic process wherein one perceives culture as fluid and ever-changing (Kleinman & Benson, 2006). Under this perspective, cultural competence is not a set of skills one can attain but is an ongoing interaction in which clinicians learn how patients identify with, respond to, embody, and experience their cultural worldview (Yahalom & Hamilton, 2023; Kleinman & Benson, 2006).

While clinicians often use these methods to complement one another, some scholars criticize these approaches for their insufficiency as they essentialize, commodify, and appropriate culture, ultimately leading to the stereotyping of patients (Kleinman & Benson, 2006; Yalahlom & Hamilton, 2023; Benson & Hedberg, 2016; Bentancourt, 2004). With skills-based approaches to cultural competence, culture is conceptualized as a fixed static entity, implying that culture is predictable and quantifiable (Yalahlom & Hamilton, 2023; Kleinman & Benson, 2006). Many models under this approach also associate culture with ethnocultural group membership

(Yahalom & Hamilton, 2023; Kirmayer, 2012; 2013). Given the intersectionality of culture, individuals can belong to multiple cultural groups. This further problematizes skills-based models as they ignores cultural nuances and diversity within cultures. As explained by Kleinman & Benson (2006), when thought of as a skill, competency becomes a series of "dos and don'ts" outlining how practitioners should treat patients solely based on their ethnocultural background. Advocating for a broader perspective, Garanaccia and Rodriguez (1996) urge for a more inclusive understanding of culture in competency. Instead of limiting 'culture' to aspects like race, ethnicity, or language, they emphasize integrating these aspects with social structures, symbols, perceptions of mental illness, celebrations, and individual values to help account for diversity. Furthermore, Yahalom and Hamilton (2023) identify power dynamics as a common criticism of skills-based cultural competency models. Culture is subjective and influenced by the positionality of the clinician and the patient. This critique suggests that any conclusions about culture reinforce existing power imbalances, and competency models should recognize and acknowledge these dynamics (Yahalom & Hamilton, 2023).

In response to these criticisms, dynamic process approaches to cultural competence emerged. These models are premised on dynamic anthropological perspectives of culture, acknowledging power dynamics (Kleinman & Benson, 2006). It shifts focus from cultural groups to individual experiences and highlights a collaborative process between patient and practitioner. For example, Kleinman offers an explanatory model approach to cultural competency in which practitioners act as anthropologists and partake in ethnographic practices to learn about their patients' culture and illness experiences (Kleinman & Benson, 2006). In his model, Kleinman emphasizes the reflexive role of the clinician, addressing issues of power imbalances with skills-based methods

(Kleinman & Benson, 2006). This approach prioritizes gaining cultural knowledge to understand a person's life circumstances, social context, and values. It also appreciates individuals as cultural beings with varying identifications and cultural backgrounds and adapts dynamically to their surroundings.

While some scholars praise the cultural dynamic approach, Yahalom and Hamilton (2023) criticize its use alongside skills-based competency models. According to Yahalom and Hamilton (2023), this is because there is a fundamental tension between a patient's subjective experience and the objective truth that guides a clinician's work. Therefore, there is much debate and contention over cultural competency models as practitioners have yet to agree upon a method. Despite a lack of consensus, this debate highlights that different conceptualizations of culture influence how cultural competency is delivered, ultimately influencing the effectiveness, efficacy, and overall delivery of mental health care.

2.3.2. The Movement for Global Mental Health

Shifting focus away from cultural competency, other pertinent debates and issues arising from global mental health emerge from the Movement for Global Mental Health (MGMH). The MGMH emerged following *The Lancet* Global Mental Health Series, which called for action against mental disorders, as they represent a substantial proportion of the world's overall disease burden (Patel et al., 2007; Patel & Prince, 2010; Summerfield, 2012; Fernando & Mills, 2017). The series highlighted gaps in mental health treatment across Low and Middle-Income Countries (LMICs), advocating for the need to scale up mental health services, both pharmacological and

psychosocial, across these regions, mirroring those in the Global North (Patel et al., 2007; Das & Rao, 2012; Fernando, 2014).

While the movement addresses challenges of mental health care in low-income settings through increased funding for psychosocial interventions, professional training, and public campaigns, it has faced significant pushback and criticism (Summerfield, 2012; Fernando & Mills, 2017; Ingleby, 2014; Mills, 2014; Watters, 2010). Many criticisms against MGMH reflect those brought against the universalist approach toward mental health. In his article, *Against Global Mental Health,* Summerfield challenges the term' global mental health, calling it an oxymoron (2012). According to Summerfield, 'global mental health' implies the universality of mental disorders, which, as established, cannot be definitively known (2012). Similar to critiques around universalism in psychiatry, the knowledge base and validity of MGMH have been questioned by a range of scholars and psychiatrists (Summerfield, 2012; Fernando, 2014; Das & Rao, 2012; Watters, 2010; Thomas et al., 2005)

Kirmayer (2006) describes psychiatry as an "agent of globalization" because the global mental health movement and other efforts strive to standardize nosological systems, diagnostic practices, and treatment methods. Kirmayer and others argue that these are biased toward Euro-American models of understanding the individual, body, and mind (Kirmayer, 2006; Summerfield, 2012; Fernando, 2014). Summerfield (2012) echoes these sentiments, explaining that Western psychiatric templates, such as diagnostic categories found in the DSM, cannot be used to generate a valid universal knowledge base. These templates often fail to reflect the reality of patients and thus do not capture the experiences and perspectives of those from other cultures.

He states, "The problem in cross-cultural research is not accurate translation between languages, but accurate translation between worlds" (Summerfield, 2012, p.523). Therefore, Summerfield suggests that Western-based approaches are not effective in cross-cultural work. Within the context of MGMH, the global health mental agenda is problematic as the movement aims to develop diagnostic practices in LMICs where values, norms and beliefs often differ from those of Western countries (Summerfield, 2008; Fernando, 2014). Such efforts give way to issues of category fallacy, wherein one's cultural diagnostic categories are erroneously applied to another culture without considering its validity in the new context (Kleinman, 1988).

Some scholars argue that the application of Western conceptions of mental health does more harm than good, as they displace local understandings and knowledge of distress and care (Summerfield, 2008; 2012; Tseng, 2006; Higginbotham & Marsella, 1988). For instance, Davar (2017) suggests that the MGMH has impacted indigenous healing practices in India as traditional approaches are vanishing in favour of Western psychiatric practices, while Argenti-Pillen (2003) has argued that the introduction of Western approaches to trauma work in Sri Lanka negatively affected the culturally mediated coping strategies of Sinhalese women who experienced war trauma. These concerns have prompted some scholars to call for including and integrating local and traditional knowledge in the global mental health knowledge base (Fernando, 2014).

Other scholars have likened the MGMH and global mental health to imperialism and neocolonialism, as it pushes Western neo-liberal ways of being onto the world (Thomas, 2005; Orford, 2013; Walker, 2013; Fernando, 2014; Summerfield, 2012; Davar, 2017; Bhugra, 2014; Connell, 2007; Johnson, 2013). Bhugra (2014), for instance, believes that global mental health as

a concept appeals to the West because it builds on missionary and white saviour stereotypes. Similarly, Summerfield argues that "global mental health workers are the new missionaries" (2012, p.525). He contends that psychiatric universalism frames indigenous knowledge as inferior, similar to beliefs espoused during the colonial era. The language used around the MGMH supports this notion further, as non-Western populations are often described as having "limited knowledge of mental health" and "lacking mental health literacy" (Summerfield, 2012, p.525). Furthermore, Connell (2007) argues that globalization and the surrounding theories and movements arising from it, including MGMH, have emerged from the Global North and taken on a perspective favouring knowledge systems in the West. As a result, globalization has constructed a model of the world in which individuals carry Western values of neoliberalism, rationality, and individualism. All healing systems are premised on a version of the self, and through the MGMH, Western mental health and concepts of the 'self' and 'personhood' are also being globalized (Summerfield, 2012; Johnson, 2013). Terms like "mental disorder" or "global burden" reinforce this notion, drawing attention to how the MGMH constructs those with mental illness. Based on the language the MGMH uses, those with mental illness are seen as undisciplined people burdening society, while the movement perceives mentally healthy individuals as rational, responsible, and neoliberal subjects (Orford, 2013; Walker, 2013; Johnson, 2013). Thus, the universalist underpinnings of the MGMH can influence perceptions of the self, supporting a neocolonial and neoliberal agenda.

Other criticisms of the MGMH and global mental health concern its reductionist nature. Similar to universalism, the emphasis on biology, medicine, and technology has discounted the role of social determinants in mental health. With this comes the risk of medicalizing social problems

such as war, poverty, and disasters, as mental health services are scaled up worldwide (Fernando, 2014). Echoing Fernando, Kirmayer (2006, p.138) succinctly explains these risks

> *There is a danger that focusing attention on mental health needs serves to divert attention from more difficult social problems that demand political and economic solutions. Psychiatry may collude with those who benefit from the status quo, neutralizing political challenges by reframing problems as aspects of individual mental health and offering treatment to individuals who are, after all, expressing the pain of a system out of joint.*

In response to the issues and criticisms levelled against the field of global mental health and MGMH, some scholars have called for more cultural relativist approaches in tackling mental health issues worldwide. For example, Summerfield seeks more integration of anthropological approaches in psychiatry (2012). He contends that valuable and robust data comes from research that adheres to a cultural relativist orientation. For him, researchers should engage with subjects without preconceived ideas or assumptions about what health and illness are in their worlds (Summerfield, 2012). Local concepts must be the starting point for creating valid instruments to produce culturally valid data, improving and rectifying the current psychiatric knowledge base. He underscores a bottom-up approach (Summerfield, 2012). Furthermore, supporters of community psychology advocate for integrating participatory action research and community involvement in the MGMH as they shift focus away from bioessentialism towards a model of care that views mental health holistically (Johnson, 2013). Ultimately, people and their communities should be given choices on their ways of life - including defining and identifying mental health issues – which one can facilitate through a cultural relativist approach.

The issues and criticisms outlined above are prominent in delivering mental health care following a crisis. When viewed in the humanitarian context, it is evident how issues

surrounding MGMH, Global Mental Health, and transcultural psychiatry exist in tension. Thus, the following section explores literature pertaining to mental health in the humanitarian landscape.

2.4. Mental Health and Humanitarianism

Globally coordinated efforts to respond to humanitarian crises gained prominence in the mid-20th century following the establishment of the United Nations (UN) and its affiliated bodies (Paulmann, 2013). Until the 1970s and 1980s, relief efforts largely ignored mental health problems as they prioritized other needs such as food, shelter, and safety (Paulman, 2013). Events and paradigm shifts leading up to the global mental health movement, coupled with increasing humanitarian crises, resulted in the recognition of mental health as a priority in humanitarian settings. In particular, the wars in the Balkans following the dissolution of Yugoslavia, the Rwandan genocide, and the 2004 Indian Ocean Tsunami served as pivotal moments in the development of mental health and psychosocial support responses (Fassin & Rechtman, 2009; Ventevogel, 2018).

The Inter-Agency Standing Committee (IASC), the primary coordination agency of global humanitarian relief efforts, officially formalized the term *Mental Health and Psychosocial Support* (MHPSS). The IASC defines MHPSS as "any type of local or outside support that aims to protect or promote psychosocial well-being and prevent or treat mental disorder" (IASC, 2007). Problems that fall under the scope of mental health and psychosocial well-being are wide-ranging, as they focus on social and psychological functioning issues. These problems include general emotional distress, common mental disorders associated with humanitarian crisis (e.g.

depression and post-traumatic distress), severe mental disorders (e.g. psychosis and substance use disorders) and intellectual and developmental disabilities (Ventevogel, 2018). Given its broad scope, MHPSS interventions encompass elements of education, health, and community involvement (Ventevogel, 2018).

MHPSS interventions, based on existing literature, fall into two main categories: clinical and psychosocial, each rooted in distinct theoretical assumptions (Ventevogel, 2018; Miller et al., 2021). Within the clinical approach are trauma-based interventions in which psychological traumas are considered the primary mental health challenge in the affected population (Ventevogel, 2018). The prominence of these interventions increased with the introduction of PTSD in the third edition of the DSM, further reinforcing the importance of MHPSS in humanitarian responses (McHughson & Triesman, 2007; Ventevogel, 2018). However, some scholars question the legitimacy of this approach. Although MHPSS literature remains limited due to its recency, much of it critically evaluates trauma-based methods. The central critique lies in the assumption that PTSD, a widely adopted concept in these interventions, is a cross-culturally valid psychopathological response to crises (Kienzler, 2008). Thus, many criticisms targeted at trauma-based responses share similarities with criticisms levied at universalism and the MGMH. Critics argue that PTSD is rooted in Euro-American perspectives of the self and imposes Western understandings of trauma, necessitating Western therapeutic remedies (Summerfield, 2004). The broad application of the PTSD diagnostic label and resulting treatment methods can lead to issues of category fallacy, potentially suppressing local understandings of trauma and yielding ineffective outcomes (Kirmayer et al., 2010; Patel, 1995; Argenti-Pillen,

2003; Kienzler, 2008; Lemelson et al., 2007; McHugh & Triesman, 2007; Summerfield, 2000, 2005).

Summerfield (1999) highlights these issues in his research on humanitarian responses in Rwanda and Bosnia. Summerfield found that NGOs frame war as a mental health emergency, referring to the afflicted communities as experiencing an epidemic of PTSD (1999). Through carrying over PTSD to different cultural contexts, NGO workers risked overlooking local expressions of distress that are unfamiliar in Western society and potentially medicalizing "normal" human responses to the crises (Summerfield, 1999). Summerfield (1999) points out that in such circumstances, survivor populations may not have asked for trauma programmes, as he questions the ethics and helpfulness of these responses. Additionally, treatment methods such as individual counselling, which reflect Western culture, are often inflicted upon the affected people, failing to account for culturally appropriate treatment methods that may prove more effective (Summerfield, 1999).

Some critics also take issue with trauma-based interventions for their exclusive concentration on trauma and PTSD. For instance, following the 2004 Indian Ocean Tsunami, van Ommeren and colleagues (2005) challenged the widespread belief that PTSD was the most common mental disorder arising from the crisis. They presented research which indicated the presence and concentration of other mood and anxiety disorders, questioning the push for trauma-centred care in humanitarian settings (van Ommeren et al., 2005). Several scholars build on this critique, adding that such trauma responses often fail to grasp the complex experiences of crisis survivors. According to these scholars, interpreting all distress as psychological trauma in these situations

diverts attention from socio-political causes of emotional distress (Summerfield, 1999, 2000, 20005). Further, they argue that practitioners might best understand psychological trauma as a normal reaction to abnormal and stressful events (Summerfield, 1999; 2000; 2005). According to Kienzler (2008), by overly focusing on trauma, these approaches risk reducing survivors to "passive vessels of negative psychological effects" (p.222). Therefore, some humanitarian organizations, policymakers, scholars, and practitioners have reservations over trauma-based approaches (Ventevogel, 2014).

Debate and tension between proponents and critics of trauma-focused MHPSS led to the development of less radical and more reflective strategies toward humanitarian crises, giving rise to psychosocial approaches (Kienzler, 2008). These responses are rooted in community psychology, peace psychology, and the human rights movement (Ventevogel, 2018). Unlike trauma-centred interventions, this framework adopts a holistic understanding of mental health, considering the relationship between individual emotional well-being and the social environment (Strang & Ager, 2003). These types of interventions view mental health beyond pathology, seeking to improve social capital and social cohesion through humanitarian relief efforts (Ventevogel, 2018). Advocates for psychosocial interventions emphasize the active involvement of community and local stakeholders in defining what is "at stake" and determining the course of action following a crisis (Schinina & Tankink, 2018; Wessells, 2009; Johnson, 2013). This perspective acknowledges survivors as active and capable problem solvers by allowing them to negotiate their life course, loss of status, culture, and shock in ways that make the most sense to them (Kienzler, 2008). However, Ventevogel (2018) and Wood and Kallestrup (2021) highlight that some scholars criticize psychosocial approaches for their insufficient documentation on

efficacy and reliance on unclear definitions of potential causal pathways to well-being. Despite these criticisms, support for psychosocial approaches continues to grow, as seen by the IASC *Guidelines for Mental Health and Psychosocial Support on Emergency* (2007). The widely followed guidebook provides practical suggestions for humanitarian actors to follow when addressing crises, emphasizing the importance of integrating psychosocial frameworks within MHPSS responses (IASC, 2007). Following the guidelines, several NGOs, part of the IASC consortium, have developed interventions incorporating psychosocial approaches.

With the IASC (2007) outlining the importance of cultural competency, international mental health initiatives have subsequently strived to take on a more culturally sensitive approach, as evidenced in a systematic review of the impact of MHPSS interventions on people affected by humanitarian emergencies (Bangpan et al., 2017). The review aimed to identify critical elements of effective MHPSS and found that socially and culturally meaningful programs significantly reduced depression and distress (Bangpan et al., 2017). For example, a study on the rehabilitation of Mozambique child soldiers found that including traditional cleansing rituals helped subjects process feelings of shame and guilt (Boothby et al., 2006). Another study found that incorporating Mayan beliefs and practices into creative workshops enabled women impacted by armed conflict in Guatemala to engage in Indigenous meaning-making, improving their mental health (Lykes & Crosby, 2014). Despite these initiatives, there are still calls for mental health development in the Global South to adopt a more sustainable sociocultural approach (Fernando, 2019).

As I mentioned, the recency of MHPSS has resulted in limited research. Much of the research has focused solely on interventions addressing mental disorders instead of psychosocially oriented interventions (Tol et al., 2011; Haroz, 2020). Moreover, research pertaining to cultural competency and effectiveness is limited to specific interventions. Thus, researchers have yet to examine humanitarian agencies as a whole concerning their approach to culture. Considering how one conceptualizes culture influences how culture is approached and integrated through cultural competency efforts, in this project, I seek to understand how NGOs conceptualize culture and integrate local culture into MHPSS interventions. Specifically, I focus on the Red Cross Red Crescent Movement.

2.5. The International Red Cross and Red Crescent Movement

The Red Cross Red Crescent Movement, (hereafter referred to as either the Movement, the Red Cross, or the Red Cross Movement) comprises three independent parts: the International Committee of the Red Cross and the Red Crescent (ICRC), the International Federation of the Red Cross and Red Crescent Societies (IFRC), and the national societies (NS) (IFRC, n.d.). While these organizations operate autonomously, they share common principles, objectives, symbols, and statuses. They share seven fundamental principles: humanity, impartiality, neutrality, independence, voluntary service, unity, and universality. These serve as comprehensive ethical, operational, and institutional frameworks guiding all their endeavours (ICRC, n.d.). Overall, the Red Cross aims to protect human life and health while ensuring respect for all peoples and to prevent and alleviate all forms of suffering (IFRC, n.d.).

The Movement originated from the 1863 Geneva International Conference, establishing the International Committee for the Relief of the Wounded, later known as the International Committee of the Red Cross (ICRC, n.d.). As an impartial and independent organization, the ICRC safeguards the lives and rights of individuals affected by armed conflict and other instances of violence. It is mandated to uphold international humanitarian law, promote, and monitor compliance with global humanitarian standards, and aid in mitigating human suffering (ICRC, n.d.). Within the Movement, the ICRC directs and coordinates international relief efforts during conflict (ICRC, n.d.).

The International Federation of the Red Cross and Red Crescent Societies was established in 1919 after World War I (IFRC, n.d.). Originally named the League of Red Cross Societies, it was later renamed the IFRC in 1991 (IFRC, n.d.). As the world's largest humanitarian network, the IFRC coordinates international aid for communities affected by natural disasters, conflict, and crises (IFRC, n.d.). This involves guiding and coordinating 192 National Societies and over 16 million volunteers worldwide (IFRC, n.d.). With a mission to improve the lives of those affected by disasters through voluntary action, the Federation focuses on assisting survivors of humanitarian crises while strengthening the capacities of national societies (IFRC, n.d.). This is achieved through promoting and advocating humanitarian values and principles, disaster response and preparedness, and health and community care (IFRC, n.d.). National societies, such as the Canadian Red Cross Society or the Bangladesh Red Crescent Society, are independent and impartial entities operating within their respective countries (IFRC, n.d.). They provide humanitarian assistance and support at the national level through services such as disaster preparedness and relief, community-based programs, and health and social initiatives (IFRC,

n.d.). National Society volunteers are often the first to respond to crises and maintain a long-term engagement with affected communities (IFRC, n.d.). Within the Movement, the ICRC focuses on armed conflict and violence. In contrast, the IFRC and NS have broader mandates encompassing disaster response, risk reduction, advocacy, community resilience, and developmental activities. Consequently, the IFRC and NS operate in various humanitarian contexts, such as natural disasters and armed conflict, while the ICRC mainly operates in contexts involving humanitarian laws (ICRC, n.d.). The IFRC provides strategic, operational, and financial support, guidance, and assistance to NS and frontline responders. Overall, the ICRC, IFRC, and NS work together to promote and uphold the shared principles and objectives of the Movement.

2.5.1. The Reference Centre for Psychosocial Support

The Red Cross has long been interested in addressing and responding to mental health and psychosocial needs in humanitarian settings. As mentioned, humanitarian actors began recognizing and prioritizing mental health needs in the 1990s. In response to this growing concern, the Federation launched the Psychological Support Programme (PSP) in 1991 (PS Centre, n.d.). To help the Federation implement the programme, the Danish Red Cross and the Federation established the Reference Centre for Psychological Support in 1993 (PS Centre, n.d.). Reference Centres play a pivotal role in the Movement, as they provide specialized knowledge and services to members of the Movement (IFRC, n.d.). However, by the mid-1990s and early 2000s, there was growing dissatisfaction amongst scholars and humanitarian actors over trauma-focused MHPSS, giving rise to alternative approaches such as psychosocial approaches (PS Centre, n.d.). Thus, in 2004, the Reference Centre for Psychological Support changed its name to the Reference Centre for Psychosocial Support (PS Centre) to better reflect changes in the

humanitarian field. To this day, the PS Centre is an organization that remains critical to the development and implementation of MHPSS interventions by The Movement.

The PS Centre collaborates with National Societies, academic institutions, donors, international humanitarian organizations, and other stakeholders to enable psychosocial support (PS Centre, n.d.). Though not directly intervening in disaster responses, the Centre plays a vital role in assisting the Movement, including the IFRC and NS. It supports the development, production, and implementation of psychosocial training, educational materials, toolkits, and best practices. Additionally, the PS Centre provides technical and operational assistance to NSs in implementing MHPSS responses, encourages research and shared learning, and helps build and strengthen regional and local psychosocial support networks at the community level (PS Centre, n.d.). Thus, the PS Centre is a pivotal member of the Red Cross Movement.

2.5.2. Psychosocial Responses within the Movement

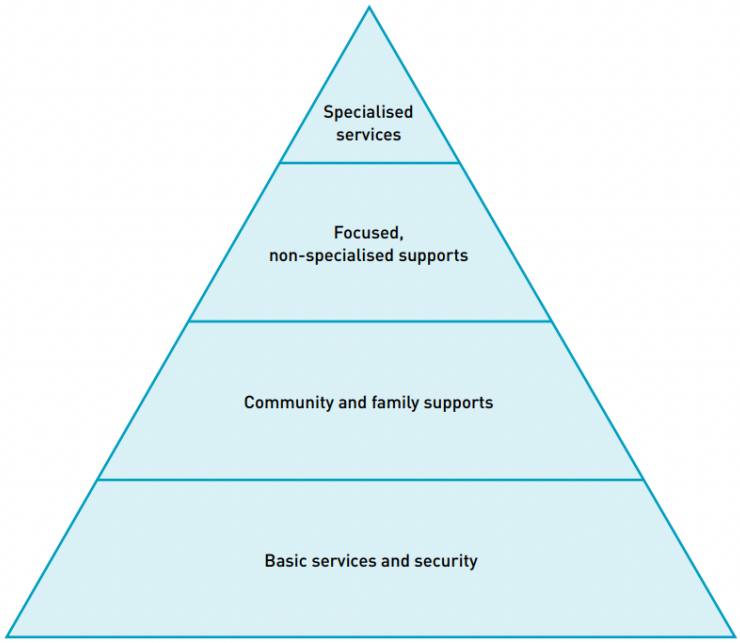
As members of the Inter-Agency Standing Committee, the IFRC and ICRC assist with developing and endorsing guidelines, policies, and agendas produced by the IASC. As such, MHPSS interventions by the Red Cross align with the IASC Guidelines (2007). The Federation defines *psychosocial support* as "a process of facilitating resilience within individuals, families, and communities enabling families to bounce back from the impact of crises and helping them to deal with such events in the future. By respecting the independence, dignity, and coping mechanisms of individuals and communities, psychosocial support promotes the restoration of social cohesion and infrastructure" (Hansen, 2009). In line with the IASC Guidelines, the

Movement provides MHPSS through community-based interventions to strengthen social bonds within affected communities, promoting empowerment and resilience.

In organizing MHPSS, the Red Cross Movement follows a multi-layered approach, again aligning with the IASC Guidelines (2007). This approach, represented by a pyramid (see Fig. 1), addresses the varying needs of different groups during emergencies. Each layer of the pyramid is essential and ideally implemented concurrently. The first layer focuses on ensuring basic services and security. This includes the (re)establishment of security, governance, and needs such as food, shelter, water, and healthcare (IASC, 2007). The second layer encompasses community and family support. This is accomplished through psychosocial support activities facilitating family tracing, reunification, and communal healing ceremonies (IASC, 2007). The third layer involves focused, non-specialized supports, targeting individuals requiring more targeted interventions, such as basic mental health care through family and group interventions (IASC, 2007; Hansen, 2009). The top layer represents specialized services, catering to a small percentage of the population with significant difficulties requiring professional psychological or psychiatric support (IASC, 2007; Hansen, 2009). According to the Movement, these layers form a comprehensive framework for MHPSS interventions, ensuring a holistic approach to address the varying needs of individuals and communities in emergencies (Hansen, 2009). The work of the Movement focuses primarily on the first three levels, meaning MHPSS interventions by the Movement may only be considered psychosocial supports (PSS). However, resources from the Movement continue to employ the term 'MHPSS'. Therefore, I use 'MHPSS' throughout this paper when discussing interventions unless stated otherwise.

Figure 1

IASC intervention pyramid for mental health and psychosocial needs in emergencies



Note. From "IASC Guidelines on Mental Health and Psychosocial Support in Emergency Settings" by IASC, 2007, p.12. https://hr.un.org/sites/hr.un.org/files/Guidelines%20IASC%20Mental%20Health%20Psychosocial_0.pdf. Copyright 2007 by Inter-Agency Standing Committee

Chapter Three: Methods

3.1. Resources

The International Red Cross and Red Crescent Movement (hereafter referred to as either the Movement, the Red Cross, or the Red Cross Movement) is a crucial humanitarian movement offering MHPSS. My thesis focuses on the Red Cross Movement due to its global reach and commitment to addressing and responding to mental health needs in humanitarian crises — a dedication evidenced by the organization's IASC membership and establishment of the PS

Centre. My study aims to uncover how the Movement understands culture and integrates local culture within its MHPSS responses. I decided to focus on participant and training handbooks because Red Cross workers use these manuals to guide their on-field MHPSS work, elucidating Red Cross goals, beliefs, and practices. As a result, in this study, I do not assess the efficacy of in-field MHPSS responses but instead focus on how the Red Cross conceptualizes and integrates culture based on its prescribed methods and approaches for MHPSS development and execution.

I explored 19 psychosocial support resources (see Table 1) collected from the PS Centre website between September 2021 and September 2022. These resources include participant and training handbooks on MHPSS programme design, specific interventions like psychological first aid, toolkits, and working with specialized populations. The PS Centre produces these resources for Movement staff, volunteers, trainers, and psychosocial practitioners, all collectively known as workers or helpers, as well as for workers from other humanitarian agencies. Although these handbooks provide instructions for workers, the Red Cross does not compel workers to follow them strictly. Nonetheless, these psychosocial support resources are valuable resources for Red Cross helpers. However, it is important to recognize that the resources may not accurately reflect how the Movement universally conducts MHPSS responses in the field. Field operations may vary due to contextual factors, such as time, money, and type of crisis.

3.2 Thematic Analysis

After collecting the psychosocial support resources, I analyzed the data using thematic analysis informed by an inductive approach. Thematic analysis (TA) involves actively searching for patterns across a data set, which are then coded and collated into meaningful themes (Braun &

Table 1: Summary of Analyzed Psychosocial Response Resources produced by the PS Centre for the Red Cross Movement

Title	Year of Publication	Author(s)/ Editors	Organization(s)	Description
Lay Counselling — A trainer's manual	n/a	The PS Centre	IFRC Reference Centre for Psychosocial Support; University of Innsbruck; Danish Cancer Society; War Trauma Foundation	This training manual is specifically designed for trainers of lay counsellors to conduct basic training. It focuses on developing participants' understanding of lay counselling, the necessary skills, and the roles and responsibilities of lay counsellors.
Community-based psychosocial support — Participant's handbook	2009	Nana Wiedemann (Ed)	IFRC Reference Centre for Psychosocial Support	The handbook overviews of Community-based psychosocial support. It draws upon guidelines from the Sphere Project and the Inter-Agency Standing Committee (IASC) on Mental Health and Psychosocial Support. The book aims to raise awareness, improve preparedness and response, facilitate psychosocial support, promote resilience, and enhance emotional assistance for staff and volunteers. It comprises seven modules and provides supplementary material and resources for further learning. The book can be used as an introductory reader, refresher course book, or reference guide.
Community-based psychosocial support — Trainer's book	2009	Nana Wiedemann (Ed)	IFRC Reference Centre for Psychosocial Support	The book provides instructions for training workshop participants using the community-based psychosocial support modules found in the participant's book.
Psychosocial Interventions — A handbook	2009	Pernille Hansen	IFRC Reference Centre for Psychosocial Support	The handbook guides how to plan and implement psychosocial interventions. The practices outlined are derived from lessons learned after the 2004 Indian Ocean tsunami. Examples of lessons learned are presented as either best practices, promising practices or those that are best to avoid. The handbook provides detailed guidance for all MHPSS planning and implementation stages, including assessment, planning and implementation, training, and monitoring and evaluation.
Broken Links: Psychosocial support for people separated from	2014	Wendy Ager	IFRC Reference Centre for Psychosocial Support	The field guide is a practical resource to support Red Cross Red Crescent staff and volunteers in providing psychosocial support to families separated from their loved ones due to conflict, crisis, or disaster. The module and field guide covers the causes and consequences of separation, methods to restore and maintain contact, and approaches for reuniting families and addressing missing persons cases.

family members (A field guide)				
Broken Links: Psychosocial support for people separated from family members (Training module)	2014	Louise Steen Kryger	IFRC Reference Centre for Psychosocial Support	The book provides instructions for training workshop participants using the 'Broken-Links' modules found in the field guide.
Strengthening Resilience: A global selection of psychosocial interventions	2014	Pernille Terlonge	IFRC Reference Centre for Psychosocial Support	This handbook is a compilation of psychosocial interventions to inspire and support organizations setting up psychosocial activities. It includes best practices, case studies, and various psychosocial activities and programs worldwide. The book aims to illustrate the breadth and diversity of psychosocial support, covering fundamental activities, interventions in specific contexts, and programs for different population groups. It complements the 2009 handbook, "Psychosocial Interventions."
The Resilience programme for young men — A psychosocial handbook	2015	Louise Steen Kryger	IFRC Reference Centre for Psychosocial Support; Danish Red Cross; Roskilde Festival Charity Society; The Palestine Red Crescent Society	The handbook is a resource for programme managers and trainers in providing psychosocial support for young men. The manual provides guidance in managing psychosocial support programmes and sets out a two-day training workshop for psychosocial activities specifically designed for young men.
Sexual and gender-based violence [SGBV] — a two-day psychosocial training guide	2015	Barbara Niklas	IFRC Reference Centre for Psychosocial Support	This is a basic training guide on psychosocial support for those affected by SGBV. It prepares staff and volunteers to work with those affected by SGBV. The guide provides information on different types of SGBV and how to provide psychosocial support. It gives participants the skills and knowledge to deal with disclosures of SGBV.
Different. Just like you — A psychosocial approach to the inclusion of	2015	Tina Juul Rasmussen, Nana Wiedemann, Katrin	IFRC Reference Centre for Psychosocial Support; International	This practical handbook is aimed at professionals and volunteers working with individuals with disabilities. It focuses on empowerment, providing guidance, real-life examples, and a legal framework to support the planning and implementation of inclusive psychosocial activities. The activities range from psychosocial activities

persons with disabilities		Koenen, Johannes Trimmel,	Council of Sport Science; Light for the World; Juul Jounralistik & Kommunikation	that are accessible to all to physical activities that are adapted to include those with disabilities.
IFRC Monitoring and Evaluation Framework for Psychosocial Interventions — A guidance note and overview	2017	Leslie Snider	IFRC Reference Centre for Psychosocial Support	The guidance note overviews monitoring and evaluation (M&E) approaches and principles within the program management cycle. It covers psychosocial program objectives, indicators (both quantitative and qualitative), and guides on developing M&E plans. Ethical principles and capacity building for M&E activities are also addressed. While not intended as an in-depth M&E guide, it complements existing frameworks and serves as a reference for PS staff and volunteers, providing key concepts, guidance, and terminology related to M&E in psychosocial programs.
IFRC Monitoring and Evaluation Framework for Psychosocial Interventions — Indicator guide	2017	Leslie Snider	IFRC Reference Centre for Psychosocial Support	The indicator guide offers a range of sample indicators broadly applicable to various NS psychosocial programs. These indicators capture key aspects of change that the programs aim to achieve, drawing from experience in M&E within IFRC, NS, and the global community of program implementers and evaluators.
IFRC Monitoring and Evaluation Framework for Psychosocial Interventions — Toolbox	2017	Leslie Snider	IFRC Reference Centre for Psychosocial Support	The toolbox is a collection of guidance and tools specifically for data collection in the monitoring and evaluation of psychosocial programs.
A guide to psychological first aid for Red Cross and Red Crescent Societies	2018	Pernille Hansen	IFRC Reference Centre for Psychosocial Support	The guide provides general information about psychological first aid (PFA). This guide is part of the PFA for Red Cross and Red Crescent Societies package.
Training in psychological first aid for Red Cross and Red Crescent Societies module 1	2018	Pernille Hansen	IFRC Reference Centre for Psychosocial Support	The module introduces participants to basic PFA skills. The module aims to enable participants to know what PFA is, understand 'Look, Listen, and Link,' practice providing PFA, and be aware of the importance of self-care when giving aid. This module includes instructions, notes, and training resources for facilitators. This

An introduction to PFA				training module is one of four in the PFA for Red Cross and Red Crescent Societies package.
Training in psychological first aid for Red Cross and Red Crescent Societies module 2 Basic PFA	2018	Pernille Hansen	IFRC Reference Centre for Psychosocial Support	The module introduces participants to applying basic (PFA) skills for effectively managing complex situations and reactions. It also offers guidance on self-care strategies for helpers. The module aims to equip participants with knowledge of distress reactions, understanding of psychological first aid, familiarity with the 'Look, Listen and Link' principles, practical experience in providing PFA, awareness of complex reactions and situations, and recognition of the importance of self-care in helping others This training module is one of four in the PFA for Red Cross and Red Crescent Societies package.
Training in psychological first aid for Red Cross and Red Crescent Societies module 3 PFA for children	2018	Pernille Hansen	IFRC Reference Centre for Psychosocial Support	This module introduces participants to PFA for children. This training is developed specifically for those working with children and their caregivers. It covers children's reactions to crisis, the principles of PFA, and includes practical exercises. It is one of four modules in the PFA for Red Cross and Red Crescent Societies package.
Training in psychological first aid for Red Cross and Red Crescent Societies. Module 4. PFA in Groups – Support to teams	2018	Pernille Hansen	IFRC Reference Centre for Psychosocial Support	This module introduces participants to PFA for Red Cross teams. The training is developed specifically for those responsible for the well-being of teams of Red Cross and Red Crescent National Societies staff or volunteers. It is one of four modules in the PFA for Red Cross and Red Crescent Societies package.
Training of Trainers in Psychological First Aid for Red Cross and Red Crescent Societies	2021	Pernille Hansen	IFRC Reference Centre for Psychosocial Support	This module prepares trainees to conduct their own PFA trainings.

Clarke, 2006, 2012). Thematic analysis is a widely used methodology across the social sciences as it lends itself well to qualitative research. TA allows for detailed accounts of the data, a rich exploration of meanings and contextual understanding while encouraging reflexivity on the researcher's account (Braun & Clarke, 2006, 2012).

According to Braun and Clarke (2006, 2012), as a methodology, TA is highly flexible and accessible. TA can be applied to various research contexts, questions, and data because it is independent of any set theory or epistemology (Braun & Clarke, 2006). TA does not require in-depth theoretical or technological knowledge or approaches, allowing it to be conducted in many ways (Braun & Clarke, 2006, 2012). As a result, it offers more accessible forms of analysis as it makes results available to a broader audience and is well suited for qualitative researchers early on in their careers (Braun & Clarke, 2006, 2012).

While TA does not adhere to a specific theory or epistemology, Braun and Clarke (2006) emphasize the importance of decision-making regarding these aspects. My research question—How does the Red Cross Movement conceptualize and incorporate culture within their MHPSS interventions? — guided my choice to conduct an analysis using an inductive approach. In TA, an inductive approach involves identifying themes directly from the data without imposing any pre-existing theory, framework, or preconceived notions, making it a data-driven, bottom-up process (Braun & Clarke, 2006). The research question guided the data collection, focusing on patterns and themes related to the conceptualization or incorporation of culture. However, since I did not assume a pre-established theoretical position, the project still adheres to an inductive approach. Braun and Clarke (2012) further explain that the patterns identified through TA must

be meaningful to the specific topic and research question explored, reinforcing the appropriateness of this method for my study.

Following the six phases of thematic analysis outlined by Braun and Clarke (2006), the analysis process involved multiple iterations of data familiarization, coding, and theme generation. Social constructionism emerged as a key theoretical perspective as the data analysis progressed. Born out of phenomenology, symbolic interactionism, and social problems theory, social constructionism is a theoretical approach and conceptual framework that explains how people come to describe, explain, and understand the world, themselves, and reality (Brown, 1995; Conrad & Baker, 2010). Underpinned by an interpretive worldview, social constructionism refutes the existence of objective reality and absolute truths. Instead, this approach focuses on how meanings of phenomena are developed through social interactions within a particular social, cultural, and historical context (Conrad & Baker, 2010). Under this theory, there is no one reality but multiple social realities. Therefore, those who subscribe to social constructionism are interested in examining how individuals, groups, structures, and institutions produce and perceive different realities and phenomena (Conrad & Baker, 2010). Thus, human knowledge is subjective and constructed. Knowledge is produced and situated within a particular sociocultural context and time. There is no singular uniform theory or approach to social constructionism, as there are multiple versions, especially within the context of the social sciences. To account for the wide variety of approaches within social constructionism, I employ a more generalized approach that considers symbolic interactionism and structural elements, allowing for analysis across micro, mezzo, and macro levels (Brown, 1995).

Adopting a theoretical lens of social constructionism further informed the identification and development of themes arising from my analysis. I identified nine themes, organizing them into two separate categories to help my research question. The first set of themes, explored in chapter four, answers how the Red Cross conceptualizes culture. The themes are as follows: (1) *Understanding culture through the self,* (2) *Culture as behaviour,* (3) *Culture as meanings.* The first theme, *understanding culture through the self*, examines how the Red Cross Movement defines culture with reference to how the Movement understands the individual. *Culture as behaviour* explores how the Movement conceptualizes culture as a set of behaviours. Similarly, the theme of culture as meanings explores how the Red Cross culture understands culture as a system of beliefs.

I identified five themes explaining how the Red Cross integrates local culture into its MHPSS interventions. The themes explored in chapter five are as follows: (4) *community-based approach,* (5) assessment, (6) *planning and implementation,* (7) *training,* and (8) *monitoring and evaluation*. Community-based approach examines the role of community-based approaches as a driver of cultural relativism. The remaining four themes look at the phases of psychosocial intervention planning and implementation, highlighting how cultural relativist principles are upheld throughout MHPSS development, encouraging culturally competent responses.

As part of the inductive thematic analysis process, researchers sometimes encounter interesting data that does not directly answer the proposed research question yet feel it is noteworthy and adds to the study (Braun & Clarke, 2006). As such, through my analysis, I identified an additional theme: (9) *Universality and Mental Illness.* In chapter six, I explore how the Red

Cross frames mental illness as universal experiences within the guidebooks, discounting the influence of culture on psychopathology. This framing reveals inconsistencies in how the Movement approaches psychosocial distress and mental illness.

Based on my analysis of the psychosocial support resources, I conclude that within the context of its MHPSS responses, the Red Cross Movement conceptualizes culture objectively and subjectively. The Movement also views culture as a set of behaviours and as a set of meanings. The Red Cross's endorsement of this holistic perspective of culture shapes the Movement's approach to addressing mental health and psychosocial needs across various settings, emphasizing the importance of understanding and integrating local culture into their MHPSS responses. By adhering to the principles of cultural relativism through promoting community-based approaches during all phases of MHPSS planning, the Movement encourages cultural competency from field workers and the creation/adaptation of MHPSS interventions that align with local understandings of psychosocial distress. However, tensions arise when the Movement frames mental disorders as universal conditions in their materials, contrasting its the cultural relativist framing of psychosocial distress. This tension highlights the complex relationships between these two perspectives in creating the Movement's MHPSS responses and speaks to broader challenges in delivering mental health and psychosocial care in the humanitarian field. Therefore, I argue that while the Red Cross Movement emphasizes cultural relativism in its MHPSS responses, encouraging culturally competent care, it also tends towards universalism when discussing mental illness, reflecting the nuanced nature of MHPSS interventions.

Chapter Four: The Red Cross Movement's conceptualization of culture

4.1. Introduction

Building upon a comprehensive review of anthropological and psychiatric literature, this chapter delves into how the Movement understands the concept of culture and approaches it within the psychosocial resources. My analysis explores the relationship between the individual and culture as presented by the Movement, focusing on the emphasis placed on behaviours and the significance attributed to shared meanings. This examination allows for a deeper understanding of how the Red Cross Movement views the way culture shapes mental health and psychosocial well-being and how this understanding informs the provision of support in humanitarian contexts. In the following sections, I argue that the Red Cross conceptualizes culture as a holistic phenomenon within its MHPSS responses, recognizing it as an objective entity existing outside the individual and a subjective experience existing within. This perspective, as reflected in the Red Cross materials, lays the groundwork necessary for understanding the role of culture in the Movement's MHPSS interventions. The insights gained from my analysis set the stage for a detailed exploration in the following chapter, chapter five, where I discuss the Red Cross Movement's commitment to cultural relativism through community-based care.

4.2. Understanding culture through the "self"

The relationship between culture and the "self" is interrelated. By examining culture, one can gain insights into the "self" and vice versa (Suh, 2000; Markus & Kitayama, 2010). Culture provides individuals a framework to understand themselves, the world, and their position. Moreover, the specific nature of this relationship varies depending on the understanding of

culture that is adopted. For example, collectivist cultures emphasize the connection between self and community, while individualistic cultures prioritize self-fulfilment through personal autonomy (Triandis, 1989; Markus & Kitayama, 2010). Similarly, describing the "self" is critical for better understanding how culture is conceptualized and comprehended. For example, by first understanding the self, we can infer that the individual likely comes from a culture that highly emphasizes individualistic or collectivist values. Therefore, examining the understanding of the individual adopted by the Red Cross Movement makes it possible to comprehend how the organization perceives and approaches culture.

The *Psychosocial interventions handbook* (Hansen, 2009) states that The Red Cross Movement uses a community-based approach for its MHPSS interventions. In doing so, the Movement adopts a social-ecological model based on Urie Brofenbrenner's *Ecological Systems Theory of Human Development* (1979), as seen with the inclusion of Figure 2 in the handbook (Hansen, 2009). The model examines interactions between an individual and their social and physical environments, suggesting the individual is shaped and influenced by these environments (Brofenbrenner, 1979). Brofenbrenner highlights the importance of understanding how immediate surroundings, the connections between different settings and groups, the external environment, and larger societal structures influence an individual (Brofenbrenner, 1979). Thus, the individual exists within a broader social-ecological context.

Therefore, by adopting the socioecological model, the Red Cross Movement believes the individual is an extension of their environment (see Fig. 2). Hansen (2009) emphasizes that Red Cross helpers must consider individuals and communities in need in their "entire social and

ecological context" (p.87). As explained in the *Psychosocial Interventions Handbook* (Hansen, 2009), when targeting interventions at specific sub-populations, such as children, the interventions should not solely focus on the individual but also involve their caregivers, teachers, and other community members. Therefore, the Movement endorses a holistic understanding of the self, encouraging workers to consider the social and physical environment when working with beneficiaries.

Figure 2:

Social ecological model

Note. The PS Centre originally adapted the image from Brofenbrenner (1979). From "Psychosocial Interventions: A Handbook" by P. Hansen, 2009, p.87. Copyright 2009 by International Federation of Red Cross and Red Crescent Societies Reference Centre for Psychosocial Support. https://pscentre.org/wp-content/uploads/2018/02/PSI-Handbook_EN_July10.pdf

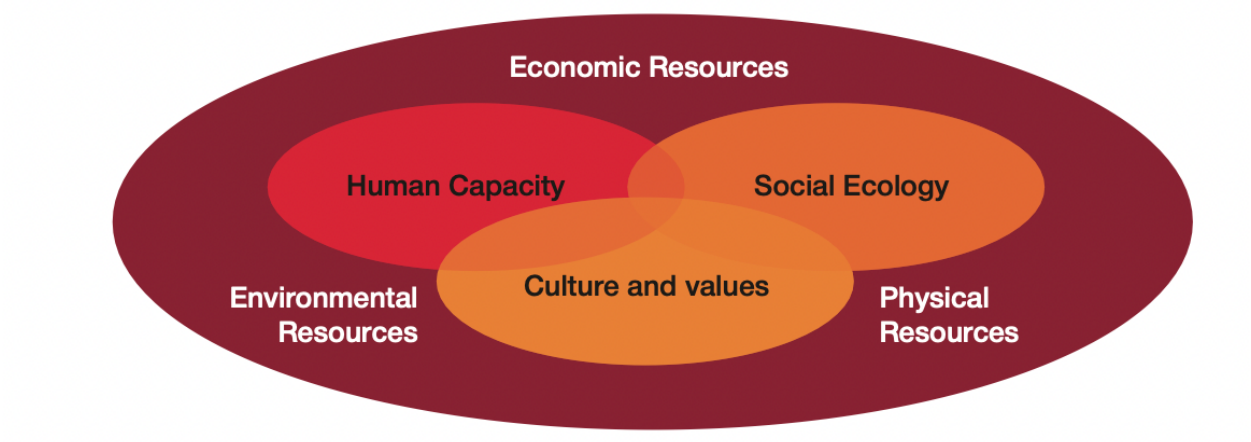
The biopsychosocial model can also be used to understand how the Red Cross Movement perceives the individual. According to Summerfield, all models of health, wellness, and healing "rest on a version of a person" (2012, p.8). This notion suggests that one can gain a fundamental understanding of personhood within any medical framework. For example, the biomedical model perceives the individual on an anatomical basis (Wade & Halligan, 2004). While the Red Cross Movement does not explicitly define selfhood, examining the model of health and well-being

adopted by the Movement provides an understanding of how the individual is defined, thereby giving insight into how the Movement conceptualizes culture. The Movement endorses a holistic understanding of health, adopting the WHO definition (Hansen, 2009, p.26). According to the WHO, health is "… a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity" (1995, p.1). This definition aligns with the biopsychosocial model of health, which emphasizes the interplay between biological, psychological, and social factors.

The Movement's understanding of psychosocial well-being further reinforces and strengthens the biopsychosocial perspective. In the *Community-based psychosocial support participant's handbook* (Wiedemann, 2009), the Red Cross urges workers to consider psychosocial well-being in reference to human capacity, social, ecology, and cultural values. These domains mirror the biopsychosocial model as human capacity refers to physical and mental health, social ecology speaks to relationships and social networks, and cultural values are about value systems. These three domains are important in determining psychosocial well-being, as the Red Cross believes well-being depends on one's capacity to draw on resources from these core areas (Wiedemann, 2009). These domains exist within a larger "social interactive" domain in which economic, environmental, and physical resources work together to influence psychosocial well-being (see Fig. 3). The Red Cross further states that individuals experience psychosocial well-being within themselves. Thus, at the centre of this model lies the individual. Therefore, the Movement implies an understanding of the individual as a product of all these domains, endorsing the notion of the 'self' as an embodied being existing outside the physical body.

Figure 3:

the psychosocial working group conceptual framework



Note. The PS Centre adapted the original image from the Psychosocial Working Group. (2003) Working Paper. 'Psychosocial Intervention in Complex Emergencies: A Conceptual Framework". From "Psychosocial Interventions: A Handbook" by P. Hansen, 2009, p.28. Copyright 2009 by International Federation of Red Cross and Red Crescent Societies Reference Centre for Psychosocial Support. https://pscentre.org/wp-content/uploads/2018/02/PSI-Handbook_EN_July10.pdf

Examining culture through the lenses of the "biopsychosocial self" and the "socioecological self" reveals the Red Cross's belief that culture is not solely an external construct but also interconnected with an individual's internal processes. For example, in several guidebooks, Red Cross workers are advised to encourage those affected by the crisis to draw on their cultural systems in times of distress, using culture as an external influence and resource to help them navigate their social environment. This notion reflects how the Red Cross frames culture as a protective factor against psychosocial distress. For example, in *A Guide to Psychological First Aid* [PFA] (Hansen, 2018a), "maintaining one's cultural practices and beliefs" is considered a personal protective factor to help maintain one's well-being (p. 94). In the same handbook, Hansen (2018a) repeatedly emphasizes that culture and cultural involvement through religion and spirituality help people cope positively (Hansen, 2018a). In these examples, the Red Cross portrays culture as an external resource one draws and relies upon to combat psychosocial

distress. However, as established through the biopsychosocial model, the Movement acknowledges that culture also influences the internal aspects of an individual, as it shapes their thoughts, emotions, and behaviours.

According to the Red Cross, individuals actively engage with their sociocultural environment, shaping and being shaped by cultural dynamics. By examining the 'self' through relationships between behaviour, capacities, environment, and meanings, culture emerges as a defining factor in psychosocial well-being. It leads to conceptualizing the 'self' as a cultural artifact. Therefore, I interpret the Movement's understanding of culture as a dynamic phenomenon situated internally and externally to the self. This perspective supports a robust understanding of culture in which subjective (culture within the individual) and objective (culture outside the individual) approaches to culture complement one another. This holistic understanding underscores the Red Cross Movement's recognition of culture as a multifaceted force that operates at various levels, playing a crucial role in the design and delivery of MHPSS interventions, as discussed in chapter five.

4.3. Culture as behaviours

My analysis of the handbooks reveals that the Red Cross Movement frames culture through behaviour. This view aligns with the behaviouralist perspective, which views culture as a learned system of behaviours shared over generations (Rohner, 1984). Gradually, these behaviours are adopted and evolve as they become ingrained in the social fabric of a population, shaping how individuals interact and view one another (Rohner, 1984). For example, if individuals consistently engage in a specific behaviour, such as bowing as a greeting, one may infer that

bowing is a cultural behaviour. Over time, this greeting may reflect particular values such as respect and sincerity. Therefore, under this perspective, behaviour is best understood as a vehicle for culture, serving as a common thread, tying individuals together and allowing for group identity formation and transmission of values and traditions.

Culture shapes norms and expectations, which in turn influence how individuals behave. Within the handbooks and training guides, the Red Cross acknowledges gender, age, power relations, beliefs, and religion as elements that culture structures. The Red Cross advises workers to consider these areas when planning activities, interacting with beneficiaries, and providing care. For example, in *A Guide to Psychological First Aid* (PFA), Hansen (2018a) provides PFA helpers with questions related to each element to reflect upon while providing care. Questions pertaining to gender, age, and power relations include,

> *Who may I approach? Are there social or cultural norms that affect who I can approach? Is it appropriate for me, as a male helper, to approach a woman in distress on my own? If I see a young child walking along the pavement alone looking lost, is it appropriate for me to take the child with me on my own to protective services, or should I contact someone else to join us?* — Hansen, 2018a p. 85-86

These questions encourage workers to reflect and adapt their behaviour accordingly, best fitting the local community's cultural expectations.

Other psychosocial support resources such as the *PFA modules* (Hansen, 2018b; 2018c; 2018d; 2018e)*, Resilience Programme for Young Men Handbook* (Kryger, 2015)*, Broken Links handbooks* (Kryger, 2014; Ager, 2014), *Lay Counselling Training Manual* (PSCentre, n.d.)*, and the Sexual and Gender-Based Violence* [SGBV] *Training Guide* (Niklas, 2015), teach

prospective Red Cross workers that some elements of active listening, such as eye contact, might not suit local cultural customs. Instead, trainers encourage future helpers to express signs of active listening in a culturally appropriate manner. As a result, the Red Cross indirectly encourages workers to analyze and understand the local culture through a behavioural lens to provide culturally appropriate care. As Movement members take on these behaviours, they may adopt them as part of their cultural repertoire, thus perpetuating the local behaviour system. These examples demonstrate how the Red Cross Movement implicitly regards culture as a set of behaviours and a critical element of culturally competent care.

However, some scholars caution (Rohner, 1984; Geertz, 1973; Keesing, 1974) against reducing culture to a series of behaviours as it may result in an overly simplistic view of culture. This act may lead to notions of cultural homogeneity within groups, potentially resulting in care premised on cultural stereotypes (Sue, 1998; Trimble & Dickson, 2005; Kirmayer, 2012; 2013). Instead, some experts (Guarnaccia & Rodriguez, 1996) advocate for an intersectional understanding of culture. Although the Red Cross does not explicitly state this, my analysis of the psychosocial resources suggests the Movement promotes an intersectional approach toward culture. The psychosocial resources frame cultural behaviour within broader contexts of gender, age, power dynamics, religion, and beliefs. For example, the PFA guide (Hansen, 2018a) encourages helpers to think of culture beyond a homogenous construct by rhetorically asking, "Are there special things to consider in terms of behaviours around older people, children, women or others [when providing PFA]?" (p. 85-86). This question highlights the intersections between gender, power, and age within the local culture. Additionally, some handbooks guide Red Cross volunteers to identify and be aware of beneficiaries from marginalized groups who are often disadvantaged

due to "characteristics such as gender, ethnicity, religious beliefs, race, sexual orientation, or age" (Hansen, 2018a, p.50). This detailed consideration likely encourages Red Cross workers to consider how these identities intersect within the local culture, consequently influencing their behaviour when providing psychosocial care.

Based on my analysis, The Red Cross Movement aims to think of culture beyond a simplistic behavioural view through its comprehensive approach that considers intersectional components of culture. My analysis suggests that the Movement recognizes behaviour as an essential component in understanding and interacting with beneficiaries, reinforcing its role as a critical aspect of their cultural approach. By considering nuanced understandings of culture, the Red Cross aims to effectively adapt its practices to align with local norms and expectations.

4.4. Culture as meanings

My analysis also reveals that the Red Cross understands culture through meanings. This perspective views culture as a shared set of meanings, values, and representations attached to concepts, categories, and rules (Keesing, 1974; Geertz, 1973; Minkov, 2013; Rohner, 1984). It is these shared meanings that tie individuals together. For example, indigenous cultures view land as an intrinsic part of identity as it holds spiritual significance (Wilson, 2003; Akiwenzie-Damm, 1996). In these cultures, humans and nature are deeply interconnected. Cultural meanings assigned to the land thereby shape indigenous values, customs, and daily practices (Akiwenze-Damm, 1996). Understanding culture as meaning acknowledges the subjectivity of meaning-making and the socially constructed nature of reality. Thus, when analyzing culture through an

ideational lens, it is important to understand the meanings a group ascribes to specific phenomena to understand that particular culture.

The Movement's approach to psychosocial well-being demonstrates how the organization conceptualizes culture as a set of meanings. One of the overarching goals of MHPSS programming delivered by the Red Cross, as stated across the psychosocial resources, is to normalize reactions to distress following crises. For example, psycho-education training provided by the Red Cross focuses on relaying the notion of "normal reactions to abnormal events" (Hansen, 2009, p.129). Furthermore, the *Psychosocial Interventions Handbook* (Hansen, 2009) advises workers against the use of clinical psychology tools to measure psychosocial well-being due to potential risks of medicalizing 'normal' reactions, category fallacy, and the imposition of values such as individualism that may not be culturally appropriate across diverse settings. This notion is also reflected in PFA training as instructors teach prospective helpers that most people who go through traumatic events experience "common reactions to abnormal events" (Hansen, 2018a, p.16). However, what constitutes "normal" varies cross-culturally. For example, hearing voices in one culture may be regarded as a normal experience, while it is a sign of psychopathology in another culture. Therefore, the PS Centre instructs workers to gather information about local ways of life from the affected population, asking questions determining normal and abnormal reactions to distress within the local cultural context (Hansen, 2009; Snider, 2017c). Thus, helpers learn what "normal" means to the affected population, promoting a cultural relativist approach to defining psychosocial distress. This aspect is further explored and discussed later in the paper.

In training staff and volunteers, the Movement encourages reflection on aspects of the prospective workers' culture, thus acknowledging that culture comprises meanings. For example, in the *Sexual and gender-based violence* [SGBV] *training guide* (Niklas, 2015), the Movement provides workshop facilitators with insights into how cultural norms impact survivors of SGBV. The guide highlights how survivors may face stigmatization, blame, and social exclusion within their community due to underlying cultural assumptions (Niklas, 2015). As part of training, Niklas (2015, p.16) states: "Participants [prospective helpers] need to be made aware of their own assumptions in relation to SGBV." Workshop facilitators prompt participants to explore personal thoughts and reactions towards SGBV through a series of questions, including:

> *What are your thoughts on SGBV? (Describe physical and emotional reaction) Do you think that SGBV can happen to anyone?*
> *Do you think that survivors of SGBV are sometimes responsible themselves for being sexually abused? How?*
> *How do you feel if you had to discuss SGBV with beneficiaries?*
> — Niklas, 2015, p. 16

By engaging participants in reflection, the Movement aims to address biases and cultural assumptions that may perpetuate stigma and hinder effective, culturally appropriate support for survivors. This process of introspection also emphasizes the Movement's framing of culture as a set of meanings as it prompts participants to examine their own cultural perspectives, the meaning they attach to various concepts, and how these beliefs influence their worldview.

The PS Centre encourages similar training exercises in other workshops, like ones for working with young men (Kryger, 2015) and differently-abled people (Juul Rasmussen et al., 2015) as well as in PFA (Hansen, 2021), lay counselling (IFRC. n.d.), and family reunification (Kryger, 2014) training, in which the authors instruct workshop facilitators to ask prospective workers to reflect on their cultural biases and how this may influence their provision of care. By

encouraging this reflection, the Red Cross attempts to make workers cognizant of how their culture may contribute to existing biases and assumptions. This practice reinforces the Red Cross's view that culture is a socially constructed system of meanings, which is a core element of their MHPSS responses.

4.5. Chapter Conclusion

In this chapter, I explored three parts contributing to the Red Cross Movement's conceptualization of culture: culture through the "self," culture as behaviours, and culture as meanings. One cannot tease apart these parts completely or consider them independently and instead should regard them as parts of a whole that must work together to give an understanding of the Red Cross's view of culture. Specifically, behaviour and meaning are interdependent, where each concept operationalizes the other. By recognizing the complex interplay between individual experiences, community dynamics and cultural contexts, the Movement is better equipped to design and deliver MHPSS interventions that are sensitive to cultural diversity in local contexts and promote well-being among affected populations. This holistic perspective of culture existing internally and externally lays the groundwork for community-based MHPSS responses. In the next chapter, I examine how the Red Cross uses these responses to effectively integrate culture within MHPSS programming, adhering to the principles of cultural relativism.

Chapter Five: How the Red Cross Aims to Integrate Local Culture in its MHPSS Responses

5.1. Introduction

In the previous chapter, I established that the Red Cross conceptualizes culture as a holistic phenomenon. This understanding implies that Red Cross MHPSS responses are not developed or implemented in isolation. Instead, the organization acknowledges the interplay between an individual and their social environment, advocating for MHPSS responses that are informed by and responsive to the cultural context in which they are implemented. The handbooks show that this approach encompasses going beyond the individual and engaging with the whole community. In advocating for this approach, the Red Cross aims to recognize the cultural beliefs, practices, and values of the community and its members as essential elements in their MHPSS responses.

Based on my analysis, I suggest that the Red Cross' adoption of a community-based approach facilitates culturally appropriate MHPSS responses, as it facilitates cultural relativism. When I use the term "culturally relativist approach" within the context of this study, I am referring to a set of principles, actions, and practices in MHPSS responses. Based on the literature I examined, the prioritization of local knowledge is central to cultural relativism. This principle recognizes the value of beliefs, practices, and understandings within a culture. Therefore, no knowledge is inherently superior to another but instead values local understandings within its respective context. Furthermore, a cultural relativist approach refrains from imposing "universal" values or standards, recognizing the socially constructed nature of concepts like 'normal' and 'well'. Understanding that these meanings differ cross-culturally gives way to an open-minded and non-judgemental approach. Additionally, this approach recognizes culture as a dynamic and evolving

entity. I infer these principles are at the root of community-centred care and engagement practices. Therefore, my analysis indicates that by advocating for community-based MHPSS interventions, the Red Cross aims to integrate local culture that adheres to the principles of cultural relativism.

Building on this premise, in this chapter, I focus on the practical integration of these perspectives of culture within the Movement's MHPSS programming. In the following sections, I discuss and analyze the relationship between community-based MHPSSs and cultural relativism in more detail, walking through each phase and outlining how the Red Cross uses community-based approaches in the assessment, planning, training, and monitoring and evaluation (M&E) of their MHPSS responses. My examination reveals that the intersection of the Red Cross's community-centred approach and cultural relativism forms the foundation of the Movement's approach toward developing and executing culturally competent interventions.

5.2. Community-based approach: An avenue for cultural relativism through community engagement

The PS Centre defines community-based approaches to MHPSS as a model that prioritizes community-level responses to humanitarian crises, focusing on social cohesion, community engagement, and resilience (Wiedemann, 2009a). Through this approach, it appears the PS Centre recognizes the collective capabilities, capacities, and knowledge of affected communities, leveraging these elements as strengths and resources to provide context-specific support following a crisis (Weissbecker et al., 2019; Wiedemann, 2009a; IASC, 2007). Moreover, an analysis of the guidebooks show that the Red Cross's community-centred approach embraces

participatory engagement from community members across all phases of MHPSS design and implementation, with the aim of promoting ownership and effectiveness of interventions (Wiedemann, 2009; IASC, 2007).

The Red Cross Movement, as the psychosocial support resources show, follows a community-centred approach in its MHPSS programming and interventions, advocating for the principles of community-based care. Psychosocial support resources, particularly the contents of the *Community-based Psychosocial Support* handbooks (Wiedemann, 2009a, 2009b), the *Psychosocial Interventions* handbook (Hansen, 2009) and the *Strengthening* Resilience handbook (Terlonge, 2014) echo these principles. Several examples in the resources illustrate the Movement's endorsement of these principles, as seen below.

> *A former boy soldier in Angola felt stressed and afraid because the spirit of a man he killed visited him at night. The problem affected the community because everyone saw him as contaminated and feared the spirit. Humanitarian workers consulted local healers, who said they could expel the angry spirit through a cleansing ritual. An NGO provided food and animals to sacrifice, and the healer conducted the ritual. Afterwards, the boy and people in the community reported increased well-being* (Wiedemann, 2009a, p.56)

The example highlights essential elements of community-based approaches, such as social cohesion and the interconnected relationship between individual well-being and community. The PS Centre frames the boy's distress as a communal problem and emphasizes the community's advisory role in restoring individual and communal well-being. While Wiedemann does not specify if Red Cross workers directly facilitated this intervention, the inclusion of this case in the handbook signals the Movement's intent is not only to respect local understandings of health and healing and incorporate them into MHPSS responses but also to call on active participation from

community members. The narrative suggests the Red Cross values local knowledge and skills and views them as a resource, which the organization claims can empower the community, emphasizing the Movement's pursuit of these principles in community-based approaches to MHPSS responses.

From my analysis, it appears the Red Cross Movement's community-based approach to psychosocial responses aspires to facilitate cultural relativism and foster cultural competency. Evident in the guidebooks is the Movement's endorsement of active participation from beneficiaries within the affected community, encouraging them to incorporate their understandings and practices. The case of the Angolan child exemplifies this aspiration as NGO staff interpreted his distress within his culture, assuming a facilitating role while locals took charge. Through the depiction of this dynamic between NGO workers and beneficiaries by the Red Cross, I suggest the Movement hopes to uphold values of cultural relativism in their MHPSS responses. Simultaneously, this emphasis on community-based psychosocial responses indicates the potential of the Movement's strategies to facilitate culturally competent interventions, requiring an understanding of local cultural contexts and their integration into care. As demonstrated through the inclusion of the example of local healers treating the Angolan child, the Red Cross seems to prioritize culturally informed interventions, integrating local knowledge and practice through community-based supports.

In current literature, Greene and colleagues (2022) propose a model for community-based MHPSS interventions that emphasize local adaptability and active community participation, allowing affected communities to define their own needs, issues, and solutions. This process

inherently respects and centres local values, beliefs, and norms in defining psychosocial issues, resulting in a culturally informed response. Similarly, Wood & Kallestrup's (2021) meta-analysis of MHPSS for displaced populations highlights NGOs incorporating local expressions and understandings of distress via beneficiary engagement in MHPSS responses. According to the authors, these interventions aligned with participant values, resulting in effective care (Wood & Kallestrup, 2021). Nersisian and colleagues (2021) note that the involvement of the Rohingya community in some MHPSS development led to NGO workers incorporating aspects of the affected people's culture into interventions, resulting in decreased psychosocial distress amongst participants. These authors demonstrate how community-based approaches emphasizing beneficiary participation enable cultural relativism and lead to cultural competency. Thus, my analysis of the relationship between the Red Cross's community-based approach and culture aligns with existing literature, supporting the notion that such approaches facilitate cultural relativism and foster cultural competency.

5.3. Assessment

The assessment phase is the first stage of Red Cross MHPSS response planning and design. According to the PS Centre, during this stage, Movement workers collect contextual data about a crisis, its setting, and the affected population, including information on their mental health and psychosocial needs. Hence, assessments are crucial to Red Cross MHPSS responses as they help to identify needs, barriers, and resources. Despite its importance, it is beyond the scope of this paper to provide a detailed procedural overview of this phase and any subsequent phases of MHPSS planning.

Based on the analysis of the psychosocial resources, Red Cross workers often use surveys and interviews with the targeted populations as assessment methods (Hansen, 2009). Movement staff and volunteers typically conduct needs assessments and impact assessments. Needs assessments usually occur in the early stages of humanitarian responses, and workers use them to learn about the needs and resources of the target population. In contrast, workers conduct impact assessments during and after interventions to evaluate them (Hansen, 2009). For this section, I focus on needs-based assessments.

In accordance with its recognition of psychosocial well-being as a socially constructed concept, the PS Centre instructs workers to ask the target population questions about their understandings of well-being, feelings of life satisfaction, roles and responsibilities within their family and community, local power dynamics, and aspirations, during a needs assessment (Hansen, 2009). Workers ask these questions intending to integrate these findings into MHPSS responses and care (Hansen, 2009). The PS Centre provides examples of questions used in needs assessments, shown in *Table 2.* Please note that helpers are not required to ask these exact questions, which will vary depending on the context. According to the handbook author, most of these questions are open-ended (Hansen, 2009). Workers can use them in various assessment methods, such as surveys, one-on-one interviews, and focus groups. However, they may also adapt them for quantitative and close-ended data collection methods.

These questions provide insights into individual and communal values, beliefs, and practices, as seen in questions about stress management, religious rituals, actions to take when unwell, community/family structure, and power dynamics. By directly instructing workers to ask these

Table 2:

Sample Questions for Needs Assessments Found in Red Cross Psychosocial Support Resources

Source	Topic/ Title	Questions
Psychosocial interventions — a handbook, 2009, p.62; Strengthening Resilience: A global selection of psychosocial interventions, 2014, p.12	Sample Questions for needs-based assessments exploring contextual understanding of psychosocial wellbeing	• *How do you know when people in your community are doing well? Not doing well?* • *What has changed in your daily life and in the community following the crisis event?* • *What were the good things in your life prior to the crisis event?* • *What changes would be desirable for you and for your community in the next month and within a year?*
IFRC Monitoring and Evaluation Framework for Psychosocial Interventions — Toolbox, 2017, p.8-9	Psychosocial Response and Violence Protection Assessment (only questions pertaining to stress and coping, and formal/informal support resources have been included)	• *Since the emergency, what changes have you noticed in yourself and others?* • *What do women, girls, boys, and men normally do to overcome difficulties/difficulties with stress?* • *How would you describe a normal day before the emergency?* • *What are some stressors for women, girls, boys, and men in the community?* • *How is stress shown in the community?* • *How is stress handled in the community?* • *How can you tell when women, girls, boys, or men in the community are not doing well or in distress?* • *How do people usually get through difficult times?* • *What are the best solutions to enhance stress relief, mental health, and safety?* • *What happens in families and communities when people die or go missing? What are the traditions and rituals? Are they different for women, girls, boys, and men? What are the spiritual beliefs?* • *What do people normally do when they feel happy?* • *What do people normally do when they feel sad?* • *How do people support each other in the community?* • *What formal or informal support resources are in place in your community to help people cope with the emergency?* • *What protective systems exist to solve problems around unhealthy coping, mental health and violence? How do people access these services?*

		Are the protective systems working (can people access etc.)? What are the barriers? What can be done to overcome the barriers? Who best could spread awareness of psychosocial well-being and violence protection in the community?
IFRC Monitoring and Evaluation Framework for Psychosocial Interventions — Toolbox, 2017, p.10-11	Sample needs assessment questionnaire about traditional views and systems	• *What are the traditional views in the community about mental illness? (e.g. is there stigma or shame?)* • *What are the traditional/informal systems to help people who have mental illnesses or psychosocial issues?* • *What are the referral systems for people who are experiencing mental health or psychosocial issues and acute stress?*
IFRC Monitoring and Evaluation Framework for Psychosocial Interventions — Toolbox, 2017, p.10-11	Sample needs assessment questionnaire about specific emotional or social problems in the community.	**Ask the respondent to explain what kind of emotional or social problems they know people are facing in the community. Use the respondent's answer to put in the brackets below for the subsequent questions.**[1] • *What kind of emotional or social problems do people face in this community?* • *How big of a problem do you think [ ] is in this community?* • *What would you do if someone you loved suffered from [ ]?* • *How confident do you feel about your ability to help someone who is suffering from emotional or social problems, like [ ]?* • *How easy is it to get help for someone suffering from [ ]?* • *Where (or to whom) could you take the person suffering from [ ] for help?* • *How much do people in this community know about the services available for people suffering from [ ]?* • *How much do you think the person suffering from [ ] can benefit from receiving the available services/help?* • *Is there anything you would like to add about the problems facing people in this community, or the help available to them?*

IFRC Monitoring and Evaluation Framework for Psychosocial Interventions — Toolbox, 2017, p.35-36	Sample questions to determine local concepts of wellbeing[2]	• *Think of someone [woman, girl, boy, man] in your community.*
		  ○ *How do you know when he/she is doing well? What do you see?*
		  ○ *How do you when he/she is not doing well? What do you see?*
		• *When someone is "well", what words would you use to describe the way they feel? For example, what might they be experiencing in their body, mind, and heart?*

		• *When someone is "not well", what words would you use to describe the way they feel?* "Use probes for more information" Asl about local descriptions of sadness, anger, despair, negative or suicidal thoughts, hopefulness, optimism, self-esteem, thinking of the future, physical symptoms (pain in the body)" • *When someone is "well", how can you tell by their relationship with family, friends and others in the community? For example, what are they like (how do they interact and behave) with family, friends, and others?* • *When someone is not well", how can you tell by their relationships with family, friends, and others in the community?* *Ask about local descriptions of feelings of belonging, feeling connected to family members and others, having one or more close friends, ability to relate to others in positive ways* • *When someone is "well", how do they behave in their daily life (e.g., their school or work inside or outside of the home)?* • *When someone is "not well", how do they behave in their daily life (e.g., their school or work inside or outside of the home)?* • *What are the 'positive' coping strategies that people use during difficult times (e.g., how do they behave)?* • *What are the "negative coping strategies that people use during difficult times?* * Ask about local descriptions of ability to make decisions, ability to function in one's role (studies, job, caring for household), capacity to adapt to changes* • *Please describe any other ways you can tell if someone is 'well' or 'not well' in this community that we have not discussed*
Psychosocial interventions — a handbook, 2009, p.65-64	Sample questions to guide situational analysis (part of some needs assessments) relevant to identifying psychosocial needs and responses	• *What are the cultural and traditional family structures in the communities affected by the crisis?* • *Have people been relocated due to the crisis?* • *Are families living in the same community they lived in before the emergency situation?*

		• *What power structures exist within the community and how do these affect the families?* • *What roles do the targeted families play in the community?* • *What are influential factors in the community that existed before the disaster that still influence the families?* • *How disrupted is the community by the crisis event? How does this affect each family?* • *Which stakeholders are planning to or already assisting the targeted community?* • *What is the role of the Operating National Society in comparison to other stakeholders?* • *What do the assisting stakeholders expect from the community?* • *What does the community expect from the assisting stakeholders?* • *Does the community have specific expectations to each family?* • *What are the social, political, and economic factors that influence the communities?* • *How do these circumstances affect the planning and implementation of psychosocial response?*

[1] Asterisks ** indicate instructions for data collectors.
[2] This is not specified as a needs assessment. However, given the purpose of this survey and the goal for needs assessments, Red Cross workers may ask these questions during needs assessments. Moreover, some questions are similar to others in questionnaires specified as needs assessments further implying its use during needs assessments.

questions to members of the targeted population, it becomes evident that the Movement seeks to gain a culturally grounded understanding of well-being and distress, promoting culturally informed MHPSS response. Therefore, the Red Cross does not appear to impose outsider perspectives of local ways of life on beneficiaries. Instead, these questions signal the organization's attempts to collaborate with the community as they respect and validate local views and experiences. These intended practices embody principles of cultural sensitivity, respect, and community engagement. The following statements from the PS Centre further signify the Movement's goal of culturally competent MHPSS responses.

> *It can be damaging to assume knowledge of how people react to a situation, on their needs following a crisis, due to having responded to a similar crisis event before. Every situation will be different and unique, as good assessment demonstrate. It is therefore important to make assessments as neutral as possible, and not ask questions through a predefined model of understanding. An example of such a mistake would be assuming that the effected population is severely distressed by their experiences and asking them specific questions relating to one's own expectations of how people should be affected. This invites misinterpretations and can have long lasting negative consequences by planning inappropriate responses.* — (Hansen, 2009, p.57)

> *The way people deal with issues varies according to religious and cultural understandings. The loss of family members, the possibility of permanent disability or dealing with psychological shock, for example, are all likely to be interpreted in a wide variety of ways. Any intervention that does not take such norms into account is likely to fail. Sensitivity in approaching people in modes of giving advice is needed. When new interventions are planned, the starting point is talking to key members of the community to find out what is already going on and to understand social structures and networks in the community…* — (Wiedemann, 2009a, p.56).

These passages demonstrate the Red Cross's acknowledgment of the dangers of approaching target populations with assumptions, highlighting the importance of cultural sensitivity and respect while promoting the goal of community participation in MHPSS responses. I argue that

the participatory nature of the assessment phase and the inherent cultural relativism embodied within the Red Cross's community-based approach promote collaborative assessments, providing foundations for culturally appropriate and competent interventions and care.

Such an approach is at the root of culturally competent care, according to some scholars like Kleinman and Benson (2006). They argue that for care to be culturally informed, practitioners, or in this case, Movement helpers, must act as anthropologists by engaging in ethnographic practices. Ethnography is "an anthropologist's description of what life 'is like in a *local world'"* (Kleinman & Benson, 2006, p.2). As Malinowski (1944, p.25) said, anthropologists are "to grasp the native's point of view, his relations to life, and to realize his vision of his world." As such, ethnography emphasizes engagement with members of the community under study.

While a complete ethnographic study is not feasible in a clinical setting, Kleinman offers a six-step explanatory approach to accomplish this in such situations. These steps include: 1) asking the patient about their ethnic identity and the importance of this to their sense of self; 2) asking the patient what is at stake; 3) asking the patient about their illness narrative, explanatory models of illness and worldview; 4) asking and determining psychosocial stressors in the patient's life; 5) reflecting on the influence of culture on the clinical relationship; and 6) evaluating the efficacy of this approach with each patient (Kleinman & Benson, 2006). Recognizing it may not be possible to follow all six steps, Kleinman and Benson suggest asking patients what matters most to them in the illness experience and during treatment (2006).

Although the PS centre does not advise workers to follow this approach, their assessment questions echo general ethnographic objectives. For example, questions like, "What kind of emotional or social problems do people face in this community?", "How do you know when people in your community are doing well? Not doing well? "How do people support each other in the community?" attempts to investigate the worldview of the local communities and their explanatory models of illness while teasing out what matters most to community members. The Red Cross can then integrate this information into the planning and execution of culturally appropriate MHPSS.

So far, I have suggested that cultural relativism strongly underpins the Red Cross's assessment phase through community participation and the nature of the assessment questions. However, it is important to note the degree to which this sentiment holds varies depending on the type of intervention. For instance, while an intervention such as psychological first aid (PFA) requires a needs assessment, the actual response remains essentially the same from setting to setting. PFA after an earthquake in rural Japan would largely resemble a PFA response to armed conflict in Ukraine. Both responses aim to reduce psychosocial distress similarly and direct individuals to the appropriate resources and services. Given the urgent nature of this intervention, Red Cross workers do not necessarily require a deep understanding of well-being and distress. A programme like PFA will integrate culture differently and is less reliant on detailed needs assessments. In contrast, a programme developed from the ground-up, for instance, a MHPSS programme directed at survivors of sexual and gender-based violence, may rely more heavily on detailed assessments and centre the entire intervention around these findings. Therefore, while Red Cross assessments aim to provide foundational information to help create culturally

competent MHPSS interventions, I suggest the degree of cultural competency may vary depending on the intervention.

My review of the guidebooks demonstrates that The PS Centre also makes efforts to integrate local culture in the design and conduct of the assessments. For example, the Centre encourages workers to translate interview questions (Hansen, 2009). The organization also promotes the inclusion of key community members through an iterative design process of the assessment questions, allowing several avenues for integrating local knowledge and attempting to ensure questions are culturally sensitive and robust (Hansen, 2009). Furthermore, the guidebook continually reminds staff and volunteers to behave in culturally appropriate ways when conducting assessments (Hansen, 2009).

I deduce cultural relativism and community participation are essential elements in the assessment phase of the Red Cross Movement's MHPSS responses. The organization's attempts to understand local understandings of psychosocial well-being, healing, and coping through the endorsement of an ethnographic approach highlight its implicit commitment to cultural relativist practices. When coupled with instructions for culturally sensitive and respectful dialogue and behaviour for Red Cross workers through assessment design and conduct, it is apparent the Movement develops foundations for culturally competent care.

5.4. Planning and Implementation

During the planning phase, as outlined in the *Psychosocial Interventions* handbook (Hansen, 2009), Red Cross workers develop a plan to address the needs and concerns identified during the assessment phase. According to the PS Centre, this phase involves brainstorming or developing

interventions, identifying resources, and seeking out potential stakeholders (Hansen, 2009). Implementation is closely related to this stage, which involves putting the plan into action. Based on my analysis, much of the planning and implementation concerning cultural integration depends on the assessment phase. The data obtained during a needs assessment guide the design of interventions and adaptation of materials. Thus, I suggest that the most critical aspects of cultural integration occur during the assessment phase. Nonetheless, the Red Cross attempts to involve the community during planning and implementation.

The *Psychosocial Interventions* handbook (Hansen, 2009) outlines areas Red Cross workers should consider when planning an MHPSS response. These include meeting the basic needs of the target population, entry into the community, awareness raising and psychoeducation, phases of psychosocial recovery, gender and age, religious affiliation, protection, type of response, and community empowerment (Hansen, 2009). Although the author does not explicitly list culture as a planning variable, I recognize that culture cross-cuts several of these areas. For example, when planning entry into the community, the author of the handbook reminds prospective workers that "interactions should be respectful and appropriate" (Hansen, 2009, p.89), even advising consultations with community members to help determine what qualifies as respectful and appropriate. Including these guidelines in the handbook suggests that the Movement continues to value community participation and cultural competency throughout the planning phase.

In the *Psychosocial Interventions* handbook (Hansen, 2009), the Red Cross emphasizes the importance of identifying the target population for a psychosocial response during the planning phase. The Movement believes responses must address those within the community experiencing

psychosocial distress, as defined by the community members themselves (Hansen, 2009). As I established in the previous section, Red Cross workers begin this process during the assessment phase. One could interpret the Red Cross's emphasis on the target population as a response to criticisms aimed at past MHPSS interventions for their universal conceptualizations of trauma. Critics such as Summerfield (1998, 1999, 2000, 2005) argue that MHPSS responses premised on a universal understanding of trauma can perpetuate the medicalization of normal trauma responses, resulting in unwarranted and often culturally inappropriate treatment for individuals. As observed in my analysis, the Red Cross appears to counter these risks by centring its interventions on local understandings of psychosocial well-being, distress, and healing. In doing so, the organization aims to ensure beneficiaries receive culturally appropriate care while preventing unnecessary treatment for those deemed unwell based on universal standards but normally processing distress within their cultural context. This approach indicates the Red Cross's implied dedication to cultural relativism and competency.

For the Red Cross, another critical aspect in determining target populations in psychosocial responses is identifying subgroups of the population, including children, men, women, young adults, older adults, and those who are marginalized (Hansen, 2009). For example, following the Indian Ocean Tsunami, the Danish Red Cross and the Sri Lankan Red Cross implemented psychosocial responses in Sri Lanka (Hansen, 2009). The programme had several components, each targeting a specific subgroup due to their varying needs and circumstances. For instance, due to religious beliefs, newly widowed women in the community were not allowed to leave their homes. Recognizing that these women needed employment, income, and company, the two National Societies provided sewing machines to make and sell clothes while remaining at home,

respecting their religious and cultural norms (Hansen, 2009). Identifying subgroups and determining their specific needs, as outlined in the example, demonstrate the Movement's strategy to avoid overgeneralization, with the intention to enhance the effectiveness of MHPSS interventions by accounting for cultural nuances and variations amongst the targeted population.

My analysis of the Movement's strategy for planning and implementing MHPSS responses further reinforces the organization's implied intent to incorporate cultural relativist principles through community-based care. As the Movement's approach is rooted in addressing the needs of individuals and groups as defined by the community itself, the Red Cross aims to align with local understandings of distress and well-being, thereby promoting cultural relativism and cultural competency. The case of the Sri Lankan women exemplifies the Movement's intention to uphold cultural competency by validating and respecting local practices while attempting to account for cultural diversity within a community. Even when parts of the guidebooks do not explicitly reference culture, the Red Cross's community-based approach implies that culture is an essential consideration for workers, as it indirectly guides the practices of workers during the planning and implementation phases.

5.5. Training & Recruitment

My analysis found that the Red Cross prioritizes cultural respect and integration in their training and recruitment processes by actively involving the community. The Movement demonstrates this commitment by encouraging recruitment from the affected population, adapting training materials to fit the local culture, and incorporating personal experiences into training. These

efforts show the Red Cross's intention to align its training with local contexts, suggesting a strong commitment to cultural relativism and the promotion of cultural competency.

According to PS Centre guidelines (Hansen, 2009), trainers and volunteers should ideally possess knowledge and understanding of local cultural attitudes, beliefs, practices, values, language, systems of social support, and social structures, which is why the Centre highly recommends recruiting helpers from the affected communities. Cultural brokers, within the context of MHPSS responses, are individuals with an understanding of the local culture. Their role is to mediate and bridge knowledge and culture gaps between the community and outsiders, such as external aid providers and stakeholders (Shah, 2012; Wilkinson, 2018; Arambewla-Colley, 2021; Crepet et al., 2017). Traditionally, professionals with formal training, including consultants, clinicians, counsellors, and anthropologists, took on this role (Arambewla-Colley, 2021; Shah, 2012). Although the Red Cross does not officially refer to locally recruited personnel as cultural brokers, I suggest the organization's practices indicate a desire to position recruited community members in roles resembling these traditional brokers, as seen in the following example.

> *Following the Indian Ocean tsunami, new volunteers were recruited in the affected areas of Sri Lanka. The Sri Lanka Red Cross Society programme manager of the psychosocial response engaged the local Red Cross volunteers in an initial assessment. This served both as a source of information for the programme and also as an introductory activity for the volunteers. The volunteers were asked in groups to draw a map of the area, noting the sea, houses, schools, institutions, and any other relevant details. The volunteers were asked to include the houses they lived in themselves. When the volunteers explained what they had drawn, it became clear that some of them had lost everything due to the tsunami. They were in fact part of the same affected population they had been recruited to help. This information surprised the programme manager and some of the other volunteers. The expectation had been that the volunteers who had signed up to help were not part of the affected population. It*

> *was a very useful activity for both the programme manager and the volunteer groups, as personal challenges were shared amongst the volunteers in this way, strengthening understanding and bonds between the group. It also informed the programme manager on the extent of the impact of the crisis event.* — Hansen, 2009, p.63

This example from the Red Cross highlights the organization's appreciation of local volunteers. Similar examples in the handbook seem to indicate the Movement's desire to leverage the dual identity of Red Cross helpers as both members of the Movement and as members of the affected community in providing care. Scholars widely encourage local volunteer and staff recruitment in MHPSS contexts as some argue it may help overcome challenges of communication due to language and knowledge barriers and improve the relevance of MHPSS interventions (Perera et al., 2019; Greene et al., 2022; Elshazly et al., 2019; Wesselles & van Ommeren, 2008; Arambewla-Colley, 2021). This strategy aligns with practices in the humanitarian sector, where involving community members as culture brokers can lead to improved accessibility and utilization of MHPSS interventions, increased beneficiary satisfaction, and increased psychosocial and social well-being due to culturally informed provision of services (Weissbecker et al., 2019). In essence, the Red Cross Movement supports principles of cultural relativism by encouraging local recruitment. By acknowledging and respecting the knowledge of local volunteers, as seen with the Sri Lanka example, the Red Cross seems to indicate its goals towards culturally competent practices.

Another way the Red Cross aims to integrate local culture in its MHPSS responses is by adapting MHPSS training materials. In the *Psychosocial Interventions Handbooks,* Hansen (2009) acknowledges potential challenges such as time and cost with adapting materials but nonetheless advises programme managers to account for these when planning. Hansen (2009) even

recommends community and stakeholder consultations when developing and training materials. These recommended actions indicate the organization's desire and commitment to produce culturally relevant materials. Further support for this desire is evident in the design of Red Cross training manuals. The PS Centre appears to formulate the content of their training manuals with a broad nonspecific scope, as evidenced by the limited references to specific groups or locations within the manuals, suggesting an intent for adaptability. Messages encouraging adaptation from the PS Centre within these manuals support my interpretation. As provided below, these messages offer various adaptations, signalling cultural integration.

> *The training should also be adapted to the specific geographic and cultural context. The trainer must not only have a thorough knowledge of the material in this manual but should also know something about psychosocial needs and programmes in the society/ region where the training takes place. Explore whether leaflets, pamphlets, or information relevant to psychosocial support have been circulated in the area and review them* — Wiedemann, 2009b, p.14

> *Like all general guidance, the ideas and activities in the kit will need to be adapted to the specific cultural context in which teams are working. Any part of the training kit may be cited, copied or translated into other languages or adapted to meet local needs without prior permission from the International Federation of Red Cross and Red Crescent Societies Reference Centre for Psychosocial Support, provided that its source is clearly stated* — Hansen, 2009, p.133

> *The manual outlines a two-day training workshop in basic lay counselling, suggesting a timeframe and training methods. As the trainer, you can choose exactly how you deliver the programme so that it is relevant to your participants and organization. For example, you can emphasise certain areas more than others or adapt materials to make them specific to your situation. The training activities and materials offered here are simply guidelines in offering basic training* — The PS Centre, n.d. p.19

Based on the handbooks, the PS Centre encourages trainers and workshop facilitators to collect data from the local community before training. For example, the PS Centre advises sexual and gender-based violence (SGBV) workshop facilitators to gather information on the attitudes,

knowledge, and discourses surrounding SGBV within the context of the local population prior to the workshop and to tailor content accordingly. I suggest these instructions signify the Red Cross's aim to involve the community in making MHPSS workshops more culturally informed and respectful.

In addition to the adaptation of training materials, training workshop content is another area I noticed the Red Cross attempts to integrate local culture using community participation. Though trained in specific interventions or skill sets, the PS Centre simultaneously teaches helpers to maintain consideration and respect for local culture. For example, when taught how to interact with distressed individuals, the PS Centre recommends behaviours like maintaining eye contact, but they caution some behaviours may not be appropriate across cultures, indicating the organization's intent to align care with local customs. Furthermore, through training workshops, the Red Cross encourages helpers to engage in reflexive exercises assessing their cultural biases, identities, and privileges. This specific activity encourages self-reflection, an important element of culturally competent care.

Moreover, I argue Red Cross training materials promote a participatory approach that facilitates the integration of local culture, as the organization encourages prospective helpers to share and draw on personal experiences during training workshops. For example, *The Resilience Programme for Young Men* handbook instructs facilitators to ask participants for local examples of difficult life circumstances (Kryger, 2015, p.36). Facilitators ask participants to define feelings such as safety, calmness, and hopefulness, sharing examples of when these were felt (2015, p.36). Therefore, I posit that the PS Centre's suggested use of open-ended questions and personal

prompts provides an avenue for integrating culturally-based information into learning, which could inform future care practices.

5.5 Monitoring and Evaluation

As explained by the PS Centre, monitoring is the continuous process of collecting and analyzing data to assess the progress and developments of an MHPSS intervention. It is a means of keeping a check on planned inputs, outputs, and outcomes of a response (Hansen, 2009). Evaluations are objective assessments that measure and determine the success of implemented activities or programmes based on the goals set during an intervention (Hansen, 2009).

Wood and Kallestrup (2021) examined the benefits and challenges of community-based participatory MHPSS interventions in a meta-analysis. The cited studies in the analysis support the involvement of the targeted population in the M&E process, as this strategy ensures that measures and tools used are locally relevant and provide meaningful results (Wood & Kallestrup, 2021). Take, for example, a community within a collectivist society. During the assessment phase, beneficiaries and local stakeholders took part in an NGO-led community consultation and revealed a belief that within their community, personal well-being is strongly tied to one's relationship with one's family. During the consultations and at the onset of planning an intervention, the targeted population states the desired outcomes, which in this case is to achieve and sustain personal well-being. Therefore, an indicator of well-being for this community may be feeling a strong sense of belonging within their families.

According to the Red Cross, one of the main goals of their psychosocial responses is to improve well-being, and Red Cross workers require some form of evaluation to determine if they have

reached this goal. However, an examination of the guidebooks (Hansen, 2009; Snider, 2017a, 2017b) reveals that developing a sound evaluation proves challenging due to the difficulties around quantifying and measuring psychosocial well-being accurately, given its subjective nature. In my analysis, I discovered that The Movement recognizes this inadequacy and highly emphasizes the involvement of beneficiaries and key stakeholders in the monitoring and evaluation (M&E) process. More specifically, the Movement advocates for including the community's input in developing goals, measures, and indicators, as documented in the guidebooks (Hansen, 2009; Snider, 2017a, 2017b).

The PS Center advises workers to conduct stakeholder consultations and focus groups, in which Red Cross workers ask beneficiaries questions similar to the assessment questions I list in Table 2 to determine their understandings of well-being (Hansen, 2009). Based on the data collected from beneficiaries, the PS Center instructs Red Cross staff to develop appropriate psychosocial well-being indicators rooted in local understandings (Hansen, 2009; Snider, 2017a, 2017b). As such, this demonstrates that the Red Cross intends for any resulting evaluation criteria and metrics to be grounded in the cultural norms and values of the community.

5.6. Chapter conclusion

In this chapter, I explained how the Red Cross Movement's strategic approach attempts to infuse local culture into MHPSS responses. My analysis reveals a framework that places community engagement at its core across all four stages of the MHPSS response. The Red Cross aims to exhaustively integrate cultural elements by adopting a community-based approach. This approach begins with the initial phase, assessment, where community members identify and define the parameters of psychosocial well-being and distress according to their perceptions.

According to the guidebooks, The Red Cross instructs its workers to conduct assessments respectfully, demonstrating the Movement's commitment to preserving the importance of culture. In the subsequent planning stage, the Red Cross aims to leverage the insights gathered from the assessment process to inform the development of interventions tailored to the targeted culture and population. During the training stage, the Movement instructs program managers to recruit volunteers and trainers from within the target community, reflecting a deliberate move toward achieving a representative cultural perspective. By encouraging the adaptation of training materials to suit local contexts, the Movement encourages trainers to draw from their personal experiences, thus enriching the cultural relevance of the MHPSS responses. In the final stage of monitoring and evaluation, the Movement's apparent inclusivity of the community's perspectives in developing goals, indicators, and outcomes of evaluations also demonstrates the organization's commitment to culturally grounded and locally relevant interventions.

Therefore, the emphasis on community participation, as seen across all stages of the MHPSS response, underscores the Red Cross's alignment with the principles of cultural relativism, whereby diverse cultural beliefs and practices are valued and embraced. By taking on such an inclusive approach, the Red Cross strives to cultivate the conditions for culturally competent care, reinforcing the potential for more impactful and effective MHPSS interventions within diverse communities.

Chapter Six: The Universalization of Mental Disorders within the Red Cross Resources

6.1. Introduction

In their MHPSS responses, the Red Cross Movement attempts to employ a cultural relativist understanding of psychosocial distress. This approach is evident when the PS Centre promotes the involvement of targeted populations in defining psychosocial well-being and distress within their local cultural contexts and encourages the adaptation of MHPSS responses accordingly. However, a different perspective on mental health emerges when analyzing discussions surrounding mental disorders in the psychosocial response resources. These resources frame mental disorders as biological entities with set features, courses, and outcomes. As a result, the Red Cross appears to adopt and promote a universalist understanding of mental health, suggesting that while culture determines and influences psychosocial well-being and distress, mental disorders possess cross-culturally consistent core features. So, while Red Cross MHPSS interventions largely aim to reinforce a cultural relativist understanding of psychosocial well-being, encouraging culturally competent and informed care, the Movement's framing of mental illness demonstrates a potential pitfall. This approach risks advancing a universalist agenda of mental health, which is problematic. Adhering to universalism undermines the essence of culturally competent care as it fails to account for the culturally dependent nature of mental health experiences. This divergence in the framing of psychosocial well-being and mental health by the Red Cross Movement highlights broader tensions within the field of MHPSS interventions in which mental health responses and psychosocial interventions are disjointed and fragmented due to incompatibility between universalist and cultural relativist frameworks.

6.2. Universalist definitions of mental disorders within Red Cross resources

As I previously stated, when providing mental health and psychosocial support, the Red Cross offers basic services and security, community and family supports, and focused, non-specialized supports. The Movement does not provide specialized services such as professional treatment for individuals or families with severe psychological disorders, as outlined in the guidebooks. Instead, Red Cross MHPSS responses aim to primarily target those experiencing psychosocial distress and moderate to mild mental health concerns. Consequently, the guidebooks focus heavily on psychosocial well-being and distress with little mention of psychiatric conditions.

Specific conditions such as depression, PTSD, anxiety, and prolonged grief, when mentioned, are described by the PS Centre as biological disorders. Most notably, the guidebooks describe depression as a 'medical condition' treated by a medical professional through biologically based treatments such as pharmaceuticals (Hansen, 2018a; The PS Centre, n.d.). Similarly, the PFA guidebook (Hansen, 2018a) suggests that those experiencing panic attacks may require 'medical help,' reinforcing the biological nature of this experience. By framing these conditions as medical conditions, the Red Cross draws heavily from the biomedical model of mental health. This approach promotes a universalist perspective on mental health because it considers these mental disorders as being rooted in individual biology instead of being influenced by culture or social contexts. The biomedical model operates on the assumption of universal human physiology, thereby suggesting that specific conditions are universally experienced, manifested, and treated in the same manner worldwide.

In contrast, as I outlined in Chapter 2 of this paper, a relativist position on mental health recognizes the influence of culture and social context on individual pathology. Cultural relativists argue that one cannot separate an individual's mental health from the culture to which they belong. As I explained in the previous chapters, the Red Cross takes on a cultural relativist perspective of psychosocial distress in asking the affected community to define and explain what that looks like to them, something the Movement fails to do with respect to mental disorders. In taking on two separate approaches, the universalist approach could lead to inappropriate or ineffective care within some cultural contexts. While the cultural relativism seen with the Movement's framing of psychosocial distress acknowledges the nuances and complexities of culture, aiming to ensure that interventions are more resonant and likely to succeed in reducing distress and improving well-being.

The Red Cross further supports a universalist understanding of mental health by providing standardized definitions of the disorders, closely aligning with the descriptions in diagnostic manuals such as the DSM and ICD. For example, in the ICD-11 (WHO, 2018), PTSD is described as a condition that develops after exposure to a horrific event and is characterized by:

1. Re-experiencing events in the present.
2. Avoidance of thoughts or memories related to the event.
3. Persistent perceptions of heightened current threats (indicated by heightened arousal)

Symptoms such as flashbacks, intrusive thoughts and memories, overwhelming emotions like fear, and hypervigilance further characterize these symptom clusters. The *PFA guidebook* (Hansen, 2018a) and *Lay Counselling* manual (PS Centre n.d.) similarly describe PTSD through the same symptom clusters and specific symptoms as I demonstrate in Table 3.

Table 3:

Descriptions of Psychiatric Conditions within the Red Cross Psychosocial Support Resources

Disorder	Description and recommended course of action[3]
Depression	*Depression is characterized by a prolonged feeling of sadness, diminished interest in activities that used to be pleasurable, loss of hope, weight gain or loss, agitation, fatigue, inappropriate guilt, difficulties concentrating and sometimes, recurrent thoughts of death. Depression is more than a 'bad day'. It is a medical condition that can seriously affect a person's life and their ability to function. It is also different from short episodes of feeling depressed, which are common to most people, but which also tend to pass quite quickly. People can develop depression if they have severe reactions that are left untreated, such as prolonged stress or prolonged grief, including sleep problems. People showing signs or symptoms that they may be experiencing depression should be referred for mental health support, if available.* *People living with depression typically need referral to clinical psychologist or psychiatrist. These specialists can evaluate if anti-depressant medication is needed, together with psychological therapeutic treatment, such as cognitive behavioural therapy (CBT) which is often used to help people with depression. If available, the person may also benefit from participating in Problem Management Plus, an intervention developed by WHO for people experiencing symptoms of depression* — A guide to psychological first aid, 2018, pg.48
	Characterised by depressed or sad mood, diminished interest in activities that used to be pleasurable, weight gain or loss, agitation, fatigue, inappropriate guilt, difficulties concentrating, and sometimes recurrent thoughts of death. Depression is more than a "bad day", it is a medical condition that can seriously affect a person's life and their ability to function – Lay counselling, p.63
Post-Traumatic Stress Disorder	Some people who experience traumatic events, such as natural disasters, armed conflicts, physical assault, abuse or accidents, may develop post-traumatic stress disorder (PTSD). This is a disorder that can only be diagnosed at least one month after the experience of a traumatic events and is characterized by the persistence of the following three types of symptoms throughout the month: i) re-experiencing the event, ii) avoidance of reminders of the event and iii) symptoms of increased arousal such as nervousness, sleep-related problems, stomach problems, and difficulties concentrating. Many people with PTSD have recurrent thoughts and images of the event. They also report feeling emotional numbness and tend to isolate themselves and spend less time than usual with others. Post-traumatic stress disorder can have debilitating effects on a person' life and affects a person's behaviour and relations with others, leading to problems with family, friends, and work. The affected

	person will most often need mental health treatment and support. If a PFA helper suspects a person has PTSD, connect the person with mental health services for assessment and treatment, if available. — A guide to psychological first aid, pg. 48
	PTSD if characterized by the persistence of the following three symptoms groups at least one month after the experience of a traumatic event: • Intrusions (thoughts, images, sounds, and other memories of the event that cannot be controlled) • Avoidance (of places, persons or other things that remind the person of the event) • Arousal (a heightened state of being alter, jumpy and watchful of danger, often with sleep and concentration problems) All of these three symptom groups must be present, and the daily functioning of the person must be severely impaired to diagnose PTSD. If a person experiences these symptoms for more than a month after the event, he/she should be encouraged to seek professional help — Lay counselling, p.63
Anxiety & Panic Attacks [4]	Any perceived distressing event can lead to a panic attack. However, panic attacks are most common after accidents or situations that are frightening. A panic attack is a distinct episode of anxiety during which a person feels fear and apprehension. The anxiety reaches its peak within 10 to 15 minutes. During the panic attack, the person can have many different physical symptoms, such as faster heartbeat, shortness of breath, chest discomfort, profuse sweating, dizziness, and light-headedness and nausea. Many people also feel very afraid, for example of dying, losing control or fainting. The first step in assisting someone with a panic attack is helping them feel calm. See the Listen section of the previous chapter for an example on how to make someone feel calmer through quiet and focused breathing exercises. If the physical reactions continue, it is important for medical help. — A guide to psychological first aid, 2009, p.44
	[Panic attacks:] Feelings of intense anxiety that may occur suddenly without any apparent cause. Symptoms may include palpitations, chest pain, nausea, dizziness, numbness, hot flashes, chills, trembling, feelings or terror, a need to escape, nervousness of doing something embarrassing, and/or fear of dying. An attack typically lasts more than 10 minutes. Most people who experience one panic attack will most likely have others. — Lay counselling, p.63
Prolonged Grief [5]	Prolonged grief is also known as unresolved grief. This is when the person who has lost a loved one finds it hard to accept the loss and adapt to life without them. Prolonged grief can impair a person's normal functioning and their relations with others. Examples of symptoms of prolonged grief are extreme focus on the loss and reminders of the loved one, intense longing and pining for the deceased, continued feelings of anger about the death, isolation from others, feelings of hopelessness, and suffering physical symptoms similar to that experienced in the deceased's final moments. Prolonged grief can be recognized when

	reactions and emotions are not changing around six months after the person has lost their loved one(s). Persons experiencing prolonged grief should be referred to lay counselling or mental health services if available. — a guide to psychological first aid, 2018, p.46

[3] Recommended courses of action were included only if it was directly stated in the guidebook.
[4] Although panic attacks are not a recognized disorder within the DSM or ICD, they are described in each diagnostic manual and understood as a marker of anxiety disorders such as panic disorders.
[5] Although prolonged grief is not a condition in and of itself. Prolonged grief disorder is listed in the ICD-11 and Persistent Complex Bereavement Disorder (PCBD) is listed as a condition for future study in the DSM-5.

However, unlike the ICD-11, which does not necessitate a particular time for which symptoms should persist after exposure to a horrific event, the two guidebooks specify one month, suggesting that all humans – regardless of culture - process and internalize trauma similarly.

Scholars have explored the validity of PTSD as both a pathological construct and a cross-cultural diagnosis (Hinton & Lewis-Fernández, 2011; Maercker, 2013; Miller et al., 2009). For example, in some cultures, avoidance, considered a PTSD symptom in the Red Cross guides, is an expected response, not indicative of psychopathology. Miller and colleagues (2009) found that Afghan study participants were reluctant to discuss their traumatic memories. The participants explained that openly discussing traumatic memories was atypical amongst Afghanis to avoid upsetting others struggling with war-related traumas (Miller et al., 2009). The authors suggest this tendency might indicate a higher than estimated PTSD prevalence amongst participants in the study (Miller et al., 2009). However, one could also argue that Afghan culture's strong communal values encourage avoidance to maintain social cohesion, suggesting it is not a pathological sign. Consequently, the Red Cross promoting avoidance as a universal sign of PTSD may lead to category fallacy, implying that a one-size-fits-all symptom list may not capture the cultural nuances and differences in mental health experiences.

The Red Cross's depiction of anxiety and panic attacks shows a similar pattern of standardization closely aligning with the descriptions in the *DSM-5* (APA, 2013) and *ICD-11* (WHO, 2018). The *DSM-5 and ICD-11* describe panic attacks similarly as abrupt or intense discrete episodes of fear. Accompanying this distress are various physical and cognitive symptoms, including shortness of breath, feelings of choking, chest pain, nausea, feelings of dizziness, light-

headedness, chills or hot flashes, paresthesia, derealization or depersonalization, and fear of impending death (APA, 2013; WHO, 2018). Again, the descriptions in the *PFA* guide (Hansen, 2018a) and the *Lay Counselling* manual (PS Centre n.d.) closely mirror this description, implying similar experiences and expressions of panic attacks worldwide, regardless of culture.

However, researchers have found significant cross-cultural variations in panic symptoms (Amering & Katsching, 1990; Lewis Fernandez et al., 2011; Marques et al., 2011). For example, in many cultures, symptoms not linked to anxiety or panic attacks in Western contexts, such as feelings of heat emanating from specific parts of the body (which scholars suggest is inadequately described by 'hot flushes'), joint pain, and tinnitus, are common (Lewis Fernandez et al., 2011; Marques et al., 2011; Amering & Katsching, 1990). Some scholars (Amering & Katsching, 1990; Lewis Fernandez et al., 2011; Marques et al., 2011; Hinton et al., 2009) also note how culturally specific syndromes such as *Koro*, *Khyâl, Kayak-Angst*, *Trung gió* and *Ataques de Nervios,* may be manifestations of anxiety and panic attacks. Therefore, the terms and conceptualizations of 'anxiety' and 'panic attacks' might not be recognized or directly correspond to experiences in another culture. For instance, *Ataques de Nervios* is a condition among Latin Americans meeting the symptom criteria for panic attacks, but in some cases, A*taque de Nervios* represents a culturally sanctioned expression of grief or anger (Lewis-Fernandez et al., 2011; Hinton et al., 2009). In such cases, *Ataque de nervois* is not a medical concern requiring further investigation. Therefore, the Red Cross's inclusion of standardized descriptions of mental disorders found in diagnostic manuals promotes a universalist perspective, as they neglect to mention any potential cultural variation in symptomology or experience.

Moreover, the description of prolonged grief enforces a universalist approach toward grief and loss. Based on the PS Centre's description, grieving after a loved one's death should be completed within six months. The PS Centre suggests Red Cross volunteers refer individuals to specialized mental health services if symptoms of grieving extend beyond this period (Hansen, 2018a; The PS Centre, n.d.). This time frame fails to consider cultural, social, and religious norms that may have longer grieving periods. For example, Rosenblatt, Walsh, and Jackson (1976) used ethnographic studies from 78 cultures to explore how people understand and handle death cross-culturally. Based on their findings, the authors found it was common for many cultures to have a year-long mourning period (Rosenblatt et al., 1976). Even in the ICD-11, the description of prolonged grief disorder, although bearing similarities in symptoms with the Red Cross description of prolonged grief, states: "grief reactions that have persisted for longer periods [more than six months] that are within a normative period of grieving given the person's cultural and religious context are viewed as normal bereavement responses and are not assigned a diagnosis" (WHO, 2018, p. 49). Thus, the guidebooks fail to consider cultural norms in bereavement, inadvertently promoting a universal approach towards grieving.

I understand that the Red Cross's inclusion of standardized descriptions of depression, anxiety, PTSD, and prolonged grief alone does not indicate and actively promote the universalization of mental disorders. After all, Red Cross MHPSS responses do not involve diagnosing individuals with psychiatric conditions or treating those with severe conditions. Yet, the training manuals provide these descriptions to PFA helpers and lay counsellors, equipping them to recognize these standardized symptoms. Therefore, by choosing to include these descriptions and training staff

and volunteers to recognize these symptoms without mentioning cultural variation, the Red Cross indirectly reinforces a medical and universal model of mental health.

It is worth mentioning that universalist assumptions of mental health hold practical value for global mental health and humanitarian relief efforts. If mental health conditions are assumed to be universal, resources such as funding, research, and mental health professionals can be allocated and applied worldwide with the expectation that they will be helpful in any context. Furthermore, standardized diagnostic criteria, tools, and treatments mean mental health professionals in any country can use the same guidelines to diagnose and treat patients. Therefore, professionals are not required to create or adapt culturally validated instruments and techniques (Hubbard & Miller, 2004). This standardization would ensure consistency across contexts and facilitate easier cross-cultural collaboration among professionals and researchers. However, despite its practical benefits, universalism neglects critical cultural differences in understanding and treating mental health conditions, potentially leading to issues of category fallacy and ineffective care, further exacerbating and worsening wellbeing, as explained in *Chapter 2* of this paper. Therefore, even as the Movement attempts to provide culturally competent care through its culturally grounded understanding of psychosocial wellbeing, the Movement's failure to see mental health through a culturally relativist lens undermines the overall essence and purpose of culturally competent MHPSS in that it can harm beneficiaries.

The Red Cross's framing of mental disorders as universally experienced medical diseases and psychosocial distress as culturally determined realities underscores a broader tension within the MHPSS response field. The tension lies between clinical and psychosocial MHPSS approaches

to understanding and addressing mental health and psychosocial needs. Various conceptual and competing frameworks exist within the field of MHPSS responses (Miller et al., 2021; Ventevogel, 2018). These frameworks fall under two broad approaches: clinical and psychosocial, each with its own theoretical underpinnings. The clinical approach, grounded in biomedicine, encompasses biological, psychological, public health and trauma-based frameworks for treating mental health and psychosocial distress (Miller et al., 2021; Kirmayer & Pedersen, 2014; Ventevogel, 2018). These frameworks target intrapersonal factors (Miller et al., 2021; Kirmayer & Pedersen, 2014; Ventevogel, 2018). In contrast, the psychosocial approach comprises psychosocial and community-based frameworks, targeting the social determinants of health (Haroz et al., 2020; Miller et al., 2021; IASC, 2007).

Treatment of mental health and psychosocial distress depends upon the conceptualization of mental health and psychosocial distress. For example, from a biomedical perspective, solutions will focus on individualized treatments grounded in biomedicine. Thus, advocates of clinical approaches argue that people require evidence-based interventions targeted at the individual level (Neuner, 2010). Typically, clinically based interventions have a more substantial evidence base as their scientific and individual nature lends itself well to randomized control trials, unlike psychosocial interventions. From a socio-environmental lens, solutions will typically address housing, access to healthcare, and income inequality (Miller et al., 2021). Thus, advocates are critical of the reductionist nature of clinical approaches and focus on community-level responses (Kienzler, 2008; Ventevogle, 2018). Here, a fundamental disagreement and tension exist between the two perspectives.

The IASC guidelines (2007) and the institutionalization of the term "mental health and psychosocial support" attempt to bridge the practical and theoretical differences between clinical (universalist) and psychosocial (cultural relativist) approaches. However, the field continues to grapple with these challenges, evidenced by the numerous reviews (Barenbaum et al., 2005; Ellis et al., 2012; Betancourt et al., 2013; Jordans et al., 2016; Tol et al., 2011) in which clinical and psychosocial approaches remain disjointed with interventions addressing targeting either mental health *or* psychosocial needs. The Movement's focus on the first three levels of the IASC intervention pyramid and lack of involvement in level four could reflect the Red Cross's struggle to merge and integrate the universalist and cultural relativist paradigms within their MHPSS programming. By not fully integrating the specialized services that treat and address mental health and taking a dual approach towards mental health and psychosocial wellbeing, the Red Cross embodies the challenge faced by the MHPSS field at large: how to merge clinical universalist approaches with psychosocial cultural relativist approaches in a way that respects and draws on the strengths of both perspectives.

Chapter Seven: Thesis Conclusion

In this thesis, I explored how the Red Cross Red Crescent Movement comprehends and integrates culture within its Mental Health and Psychosocial Support (MHPSS) responses. My analysis reveals that the Red Cross Movement demonstrates a comprehensive and anthropologically sound understanding of culture. The Movement views culture as a system of behaviours and meanings encompassing socioecological and biopsychosocial models of the 'self.' This perspective acknowledges the role and importance of culture in shaping mental health and psychosocial needs.

This anthropological understanding of culture necessitates an anthropological response toward mental health and psychosocial well-being, emphasizing the significance of cultural context and local experiences. The evidence from the psychosocial response resources suggests that the Red Cross Movement adheres to this perspective through a community-based approach. As envisioned by the Red Cross, this approach calls for the targeted population's participation throughout the MHPSS lifecycle. The PS Centre encourages an ethnographic approach during the assessment phase, where Red Cross staff and volunteers learn about the local ways of life, interpretations of psychosocial well-being, distress, and coping mechanisms of the affected populations. Findings from the assessments form the foundations for MHPSS programs, influencing the goals and objectives of the response and the conduct of Red Cross workers. Furthermore, targeted recruitment practices that aim to engage community members as helpers provide an avenue for cultural integration, as these volunteers may act as cultural brokers. Thus, the Movement strives to foster the development and execution of interventions that uphold the principles of cultural relativism, encouraging culturally competent MHPSS programmes and care.

My analysis indicates the Red Cross Movement provides sound guidance for creating culturally competent MHPSS interventions, aligning with scholarly findings that support the efficacy of the Movement's intended approaches. Assuming other NGOs follow similar practices to the Red Cross, a noteworthy question emerges: Why do many scholars continue to advocate for more effective, culturally competent interventions? I point to a divergence between the conceptualization of mental health interventions versus psychosocial interventions as a plausible

contribution to this query. As I mentioned, the Red Cross attempts to centre its psychosocial responses around local understandings of psychosocial well-being and distress, supporting a cultural relativist framework of illness. However, although Red Cross MHPSS interventions do not provide clinical care or diagnostic services, the inclusion of standardized definitions for depression, PTSD, anxiety/panic attacks, and prolonged grief, coupled with referral instructions, suggests the Movement indirectly reinforces a universal model of mental health within their psychosocial support resources. In practice, this may mean an increased risk of beneficiaries receiving care that does not align with their cultural beliefs and values. A predicament emerges when psychosocial support initiatives, although aiming for inclusivity, inadvertently align with the universalist framework. It is crucial to address this issue to facilitate a seamless continuum of care.

There is limited research spotlighting the gap between mental health and psychosocial interventions. Despite the existence of these terms, a distinct fragmentation persists between the two concepts. I believe this incongruity stems from the incompatible nature of these approaches, as cultural relativist frameworks typically support psychosocial interventions, while mental health interventions continue to be dominated by universalist frameworks. The differential approach to addressing psychosocial distress and mental illness reflects broader tensions within the MHPSS field, shedding light on the challenges of harmonizing cultural relativist and universalist paradigms in multilayer MHPSS responses. In response, I advocate for researchers to explore a means of integrating cultural relativist and universalist frameworks. My research points towards an avenue for investigating the tension between these two approaches.

The implications drawn from this study carry weight for MHPSS practices in humanitarian contexts and future research. The Red Cross Movement serves as an exemplar for other humanitarian organizations, showcasing how adopting a holistic understanding of culture and a community-based approach encourages the development, delivery, and execution of culturally competent care. Furthermore, the contrasting interpretations of psychosocial distress and mental disorders by the Movement underline the ongoing need for improved dialogue and synergy between the various layers of the IASC MHPSS interventions pyramid, as well as the need for reconciliation between cultural relativism and universalism. To advance culturally competent MHPSS responses, future investigations should pinpoint exactly where NGOs may falter in terms of cultural competence and prompt an examination of organizational processes to scrutinize the potential efficacy, advantages, and consequences of combining mental health support with psychosocial interventions in humanitarian settings, as this may potentially bridge the gap between universalist and cultural relativist paradigms. The intricate interplay between mental health and psychosocial interventions illuminates potential avenues for strengthening cultural competence and fostering culturally relevant care.

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