

Concerning ‘Neglect’

Perspectives on the Prioritisation of Mental Health Conditions in Protracted Displacement Contexts

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Abstract

‘Neglect’ is a lucrative concept attracting billions of US dollars in research and development funding and transforming what is prioritised in global health. Stemming from a wider project aiming to improve healthcare at the intersection of gender and protracted displacement amongst Somali and Congolese internally displaced people and refugees, this article unpacks conceptualisations of ‘neglect’ in relation to mental health. Drawing on interviews with people with professional mental health expertise and/or lived experience of displacement, this article makes three contributions. First, we argue that ‘neglect’ must be considered in the context of competing health priorities and health-seeking behaviours, particularly given the additional challenges associated with disruption to social care networks in protracted displacement contexts. Second, we illustrate ‘neglect’ in light of our respondents’ distinctions between overt bodily expressions of distress that are socially disruptive and more internalised expressions of distress that are more socially containable. Third, we unpack the intersectional ‘neglect’ of women and girls by sexual violence’s distinctive confluence of social withdrawal with strategies of containment to avoid social disruption.

Keywords

Displacement, Refugees, SGBV, Mental health, Neglect.

Introduction

'Neglect' is a key concept in global health discourses and the United Nations (UN) Sustainable Development Goals, most iconically in the World Health Organization (WHO) response to what are known as Neglected Tropical Diseases (NTDs) (WHO 2020). Increasingly, the concept is finding traction in regard to other health conditions including mental health (WHO 2019). Global health and international development funding agencies similarly target 'neglected diseases' (Morel 2003) and 'neglected populations' (Manderson et al. 2009). Targeting 'neglect' has been prioritised by various UK international development programmes, most recently in the form of a partnership between the Foreign, Commonwealth & Development Office—then called the Department for International Development—and UK Research and Innovation (UKRI) for a programme of international development research via the Global Challenges Research Fund (GCRF). A 2019 GCRF funding call tasked applicants with responding to the challenge of how to expand healthcare systems for displaced people to cover areas that are usually neglected such as treatment of mental health.

Through longstanding debates about universal measures of mental illness versus cultural and social mediation of mental distress (Kleinman 1988), medical anthropology and transcultural psychiatry have made sustained contributions towards establishing the prevalence, expressions, and burden of mental disorders (Charlson et al. 2019; Kohrt, Mendenhall and Brown 2015, 28). Diagnosis and treatment of mental distress are embedded in cultural concepts of health and illness, and entangled in their social, political, and economic environments. Addressing mental health can be even more complicated in displacement contexts, where displaced people, host communities, and local and international healthcare providers will likely have differing priorities and perceptions of need and neglect in relation to health. The prevalence of sexual and gender-based violence (SGBV) and its associated health complications are widely recognised as problems in contexts of conflict and displacement. However, differing conceptualisations of the causes and impacts of such violence often complicate understandings of responsibility and appropriate responses. This can result in the misunderstanding and chronic neglect of the needs of SGBV survivors.

In this article we draw on a UKRI GCRF project aiming to improve healthcare at the intersection of gender and protracted displacement to explore conceptualisations of 'neglect' in relation to mental health. Engaging with insights from medical anthropology and transcultural psychiatry, we articulate why and how different people—with (in some cases overlapping) professional mental health expertise and/or lived experience of migration or displacement—come to understand certain mental health conditions to be 'neglected' in protracted

displacement contexts. First, we argue that 'neglect' must be considered in the context of differential health priorities and health-seeking behaviours, particularly given the additional challenges associated with disruption to social care networks in protracted displacement contexts. Second, we illustrate 'neglect' in light of our respondents' distinctions between overt bodily expressions of distress that are socially disruptive and more internalised expressions of distress that are more socially containable. Third, we unpack the intersectional 'neglect' of women and girls by sexual violence's distinctive confluence of social withdrawal with strategies of containment to avoid social disruption.

Framing neglect in global (mental) health

International concern for 'neglected' diseases can be tracked from European colonial anxieties about the perceived dangers of 'tropical diseases' in their colonies (Gold 2021) to the establishment in the 1970s of the 'Great Neglected Diseases of Mankind' programme by the Rockefeller Foundation. The Rockefeller Foundation's attempt to coordinate interdisciplinary research, development, and technological innovations in addressing 'tropical diseases' lost momentum, and by the end of the twentieth century it was estimated that, globally, less than 10% of spending on health research was dedicated to diseases or conditions that account for 90% of the global disease burden (Morel 2003). This apparent 'market failure' was blamed for producing a 'global drug gap' (Morel 2003), in which drug development and research were overwhelmingly for the benefit of affluent countries.

The launch of the Global Fund to Fight AIDS, Tuberculosis and Malaria in 2002 marked a turning point in global health, with international research, budget, and policy priorities focused on HIV/AIDS, TB, and malaria—the so-called 'big three'. This reinvigorated calls from global health actors, including the WHO and the Bill and Melinda Gates Foundation, to raise the profile of other 'neglected' infectious diseases (Parker and Allen 2014). Underscored by a logic of elimination and eradication, these calls claimed that NTDs should be tackled through increased research, funding, and, ultimately, mass availability of drugs. This approach, it was theorised, would not only improve health, but potentially 'make poverty history' (Molyneux et al. 2005; Parker and Allen 2014). The use of the term 'neglect' draws attention not only to neglected diseases, but also to the neglected populations they primarily affect. As such, NTDs can be understood as 'neglected diseases of poverty': they largely affect people who are poor and marginalised in processes of establishing research agendas and public health priorities (Manderson et al. 2009, 283–4). Marginalised populations are not homogenous groups, and experiences of illness and health-seeking behaviour within such groups are intersectional, shaped by factors such as gender, race, nationality, and socioeconomic status (Kapilashrami and Hankivsky 2018).

'Neglect' proved to be a lucrative brand, attracting billions of US dollars in medical research and development and transforming global health prioritisation (Parker, Polman, and Allen 2016). The 'packaging' of diseases as 'neglected' has powerful moral implications that convey a sense of urgency and the potential to 'make a difference' (Vanderslott 2021). In line with arguments about the 'anti-politics' of development (Ferguson 1994) and the 'biopolitics' of humanitarianism (Fassin 2007; Ticktin 2006), we argue that global health framings of 'neglect' as a failure to address fundamental human rights (UN 2006, Article 25) can lead to the depoliticisation of interventions on 'the neglected' as a 'just and moral cause' (Parker and Allen 2014, 224). In this discourse it can seem logical to direct resources towards treating the health condition alone (often through administering drugs) rather than by also addressing its broader social, economic, and political contexts (Singer et al. 2017). This top-down, technical approach arguably neglects the broader inequalities affecting human health and wellbeing. By contrast, Parker, Polman and Allen (2016) have drawn attention to the inherently social and relational nature of 'neglect', producing and reproducing colonial hierarchies of responsibility, prioritisation, and care.

Neglect, as a powerful marker for priority research, funding, and interventions, has seeped beyond infectious diseases and into the broader discourse of global health. The WHO's *Special Initiative for Mental Health (2019–2023)* states that 'mental health remains a neglected part of global efforts to improve health' and highlights the problem of 'limited commitment and funding for sustained implementation and the scale-up of services' (WHO 2019, 2). The WHO's *Comprehensive Mental Health Action Plan 2013–2030* asserts that: 'Action must be taken to address decades of inattention to and underdevelopment of mental health services and systems, human rights abuses and discrimination against people with mental disorders and psychosocial disabilities' (WHO 2021: v). Only a tiny fraction of global development assistance for health is dedicated to addressing mental health (Liese, Gribble, and Wickremsinhe 2019). This persistent underfunding perpetuates the prevalence of top-down interventions, as medical professionals and institutions only have capacity to react to acute needs, rather than implement an integrated care model (Walker and Vearey 2022).

The WHO maintains a list of specified NTDs; in contrast, questions remain about which mental health conditions are being neglected and by whom, and about what should be done and by whom. As Pendse et al. (2022, 2) note, 'colonial power relations have been defining factors for what forms of distress have been validated by clinicians as being "mental illness" and provided care, and what forms of distress have been ignored'. One reason for the neglect of mental health in global health programmes could be the relative intangibility and invisibility of mental health symptoms and the attendant challenges of identification and appropriate

response, at least in comparison with more visible physical diseases (Kohrt, Mendenhall and Brown 2015, 26; Miller et al. 2021). Diverse mental health problems necessitate diverse responses from individuals, families, communities, and mental health professionals. Some problems may require hospitalisation and medication, others might be tied to daily stressors, while still others might exceed mental health frameworks. For instance, as we discuss in this article, aside from physical or mental trauma, SGBV can result in social shame, stigma, and exclusion, as a result of the complex intersection of social norms concerning sex, gender, ethnicity and the social and economic status of both perpetrator and victim. Focusing on the neglect of narrowly defined mental health conditions risks turning a wilfully blind eye to the complex contexts in which such conditions emerged.

Research context and methods

The co-authors collaborated in a UKRI GCRF project on improving healthcare at the intersection of gender and protracted displacement. Our larger consortium comprised research institutes and non-governmental organisations (NGOs) based in Somalia, the Democratic Republic of the Congo (DRC), Kenya, South Africa, the UK, and the Netherlands, and focused on Somali and Congolese internally displaced persons (IDPs) and refugees. We selected Somalia and Eastern DRC as key research sites because both have been involved in decades-long protracted conflicts. Somali and Congolese people have faced prolonged exposure to numerous human rights violations, including torture and sexual violence (Human Rights Watch 2022) and repeated and often protracted internal and external displacement (IDMC 2021; UNHCR 2020). Significant displaced populations from both countries are resettled worldwide, including in our research sites in Kenya, South Africa, and the Netherlands.

The DRC and Somalia are both marked by unstable governance and weak health systems. In Eastern DRC, the state has remained fragile yet present in the delivery of basic health services (OCHA 2022), whereas Somalia lacked a functioning state until the establishment in 2012 of the federal government, which continues to have limited capacity (OCHA 2021). The populations of both sites rely heavily on humanitarian assistance. International agencies and organisations are involved in the delivery of health services in the DRC (OCHA 2022), whereas security problems have limited the presence of foreign actors in Somalia (OCHA 2021). Despite vastly different cultural and religious contexts, SGBV is a widespread problem in both countries, and victims are stigmatised through prevailing gender and sexual norms (Jefferson 2004). The low social status of women and girls is compounded by persistent conflict, insecurity, and displacement.

Displacement is shaped by many factors, including nationality, race, religion, gender, socioeconomic status, countries of transit and settlement, and duration

and reasons for displacement. We do not suggest a homogenous experience of displacement, but rather highlight that the diverse and intersectional experiences of displaced people can produce different conceptualisations of health needs and areas of neglect.

Most anthropological research on global mental health has focused on 'sufferers' rather than on the perspectives of mental healthcare providers or policy makers (Mendenhall and Kohrt 2015, 44). Thus, the different ways in which mental health professionals and affected populations themselves understand mental health and its neglect in humanitarian settings warrants continuous attention (Tol et al. 2011). In our research, we sought neither to artificially delineate professional from experiential knowledge, nor to privilege either professional or experiential perspectives, but instead to incorporate both. Snowballing via professional/social networks and local community-based organisations, we recruited interviewees who met either or both of the following selection criteria: lived experience of migration or displacement from Somalia or the DRC to the Netherlands; relevant professional experience working with Mental Health and Psychosocial Support (MHPSS) and/or gendered violence in the protracted displacement context of our project's focus countries. The latter were psychologists, MHPSS experts, field practitioners, researchers, policymakers, and government officials. These selection criteria allowed us to explore different conceptualisations of 'neglect' from various perspectives, including some people with professional MHPSS expertise, some people with lived experience of migration and displacement, and some people with a wide range of contextualised perspectives from both a professional and personal viewpoint. Out of twenty interviewees, eight had professional experience alone, seven had personal experience alone, and five had overlapping professional and personal experience.

All Somali and Congolese refugees and migrants in our sample had lived in the Netherlands for at least a decade. The Netherlands hosts around 40,000 people who were born in Somalia, and around 9,000 people who were born in the DRC. Most of these people entered the Netherlands as asylum seekers; others, by family reunion or as students. Most Somali migrants fled Somalia's protracted conflict, albeit during different phases, coming to the Netherlands either during the early 1990s or the mid-2000s. The conflict in Eastern DRC started in 1994 and has resulted in a relatively stable influx of asylum seekers and family reunions in the Netherlands. Government shelters provide accommodation, basic medical services, and sometimes mental health services to asylum seekers in the Netherlands. In general, mental health services oriented towards migrant populations (encompassing cross-cultural understandings) are inadequate and inconsistent, depending on region and resources (Lamkaddem et al. 2014). We did not recruit Somali or Congolese interviewees via mental healthcare services or

based on any (in-)direct experience with mental health problems, and thus this piece of research did not necessitate medical ethics review beyond the project's overarching institutional research ethics approval. During interviews, however, some Somali and Congolese interviewees spontaneously disclosed personal experience with mental health problems and/or a comparative perspective on perceptions of mental health(care) in their countries of origin and in the Netherlands. Between September 2020 and March 2021, four interviewers conducted a total of twenty semi-structured interviews via videocalls averaging an hour each. Interviewees opted to be interviewed in either Dutch or English, apart from one interviewee who opted for Somali with a translator. This article springs from an interdisciplinary exploration, combining insights from the domain of mental health psychosocial support (MHPSS) alongside social and medical anthropology perspectives.

'Neglect' of mental health in displacement contexts

To what extent do approaches to mental health in displacement contexts replicate some of the decontextualised top-down assumptions discussed above about what is neglected and what is needed? Over the past decades various efforts have been made globally to develop, implement, and evaluate MHPSS interventions for displaced populations, promote psychosocial wellbeing, and prevent or treat mental disorders (Turrini et al. 2017). A couple of general critiques of mental health approaches—for their focuses on the individual rather than the community and on trauma and post-traumatic stress disorder (PTSD) in particular—resonate strongly in protracted displacement contexts. First, derived from biomedical models dominant in the global north, an individual-focused approach to mental health research is common. For displaced people, however, this underplays the social context for mental distress and can attribute problems to individuals rather than to their wider adverse social circumstances (Miller, Kulkarni, and Kushner 2006, 414; Watters 2001, 1711–12). In the context of mental health amongst displaced people, focusing on pre-determined 'neglected' conditions risks neglecting the wider social, political, and economic contexts of conflict, protracted displacement, and chronic marginalisation (Matthies-Boon 2018). The second critique, focusing on trauma in general and PTSD in particular overlooks that traumatic stress is only one of many possible expressions of distress within a wider range of mental health responses which may consequently remain 'neglected' (Miller, Kulkarni, and Kushner 2006; Summerfield 1999, 1452, 1454).

Research on mental health amongst migrant populations emphasises challenges in relation to communication between patients and mental health professionals (Feldman 2006), migrants' limited use of mental health services due to stigma (Boynton et al. 2010), 'ineffective advocacy' (Im, Ferguson, and Hunter 2017),

disparate expressions of symptoms (Bettmann et al. 2015), and limited treatment options (Ellis et al. 2010). Notwithstanding valid critiques of exceptionalism (Cabot and Ramsay 2021, 288; Summerfield 1999, 1452, 1454), research has shed light on mental health problems and treatment gaps in protracted displacement contexts, some even declaring a 'mental health crisis' (Ibrahim et al. 2022). Mental health conditions are prevalent worldwide, but exposure to extreme adversity before, during, and after displacement can exacerbate pre-existing mental health problems and precipitate new ones (Porter and Haslam 2005, 610). This is encapsulated by the excerpt below from an interview with a Dutch psychiatrist and mental health adviser in his mid-fifties, with over 25 years of experience working in conflict and post-conflict settings:

. . . the standard dogma or paradigm in refugee mental health is that refugees have mental health problems, just as anyone else has. But the number is increased, or the severity is increased, because of several factors, such as the loss of protective factors, social systems, stable family situations, etc. . . . I think the problems of Somali and Congolese refugees—but I talk more in general, refugees in general—are to some extent the pre-existing disorders that get exacerbated. Because of . . . the loss of support and the social upheaval and the fact that treatment is not available even though it may have been minimal anyway. But the stability is gone and then you have problems that are caused by events that people have had, but as much in my view, it's not just the events of the past in the country of origin, it's as much the problems during the flight and . . . the problems that refugees have in their ordinary living. So . . . which one of those is more important? I can't say, but those are important things and all are important. Now, the first group of pre-existing problems are often overlooked and . . . that's important that people with severe mental disorders—there are not that many, but their suffering is extreme and we can also say more or less confidently that the prevalence is higher than in non-conflict-affected populations.

Other interviewees—with professional expertise and lived experience alike—similarly identified several interconnected vulnerabilities associated with displacement that reduce access to treatment. Mental health services might reasonably be described as universally inadequate, underdeveloped, and underfunded (Patel et al. 2016), but several interviewees noted that in protracted displacement contexts, governments and funders tend to prioritise humanitarian interventions that target infrastructures such as primary healthcare, housing, nutrition, and water and sanitation over mental healthcare provision. Resonating with the literature on 'daily stressors' (Miller and Rasmussen 2010; Walker and Vearey 2022), interviewees also noted that in contexts of chronic socioeconomic marginalisation, displaced people may (need to) prioritise collective wellbeing—protecting and providing for their families—rather than individual mental health. Additionally, hinting at structural neglect, several interviewees noted that this

dearth of mental healthcare services results in the burden falling disproportionately on kinship, religious, and other social support networks. Finally, displacement is likely to have disrupted those pre-existing social support structures. Consequently, in the words of a Congolese psychiatrist interviewee: 'It's very challenging to treat people who [are] having those other problems when they are refugees or when they are depressed because you don't have the social resources that you may have with people who are living in their communities.' Thus displacement can both exacerbate intersecting vulnerabilities and, simultaneously, exacerbate the neglect of mental illness due to the associated reductions in treatment options and opportunities.

Interviewees remarked that people predominantly attribute mental health problems to religious and spiritual factors, and consequently religious healing is their initial preferred treatment. However, they noted that displacement results in the loss of access to socially and spiritually important communal religious spaces, and in the longer term can disrupt knowledge and experience of performing specific rituals to promote mental health and alleviate mental health problems. During her interview, a South African researcher cited her own research finding that some displaced people's cultural traditions had been 'demonised' by their host community, with the effect of discouraging them from turning to religious healing practices from their countries of origin. A displaced Somali woman resettled in the Netherlands told us that some families, either in their country of origin or living abroad, are putting pressure on people: "She is sick, bring her to Somalia, Alhamdulillah, bring the children." The pressure that is put by the family is big.' This alludes to a strong steer towards familiar healing practices (albeit an option which is not available to everyone for a combination of financial and/or immigration reasons). Notions of 'home' are embedded in conceptualisations of health, illness, and healing. Ailments were often understood as forms of religious distress, such as demon possession, and a result of dislocation from cultural and religious norms. Here, and in other interviews, the importance of remedies that were deemed both culturally and religiously resonant were perceived as most effective, and clearly linked with a perception of displacement as spiritually and physically disruptive.

In common with participants in our wider project's research activities, interviewees frequently mentioned the importance of family and the home as a primary site of support for people in mental distress. This care included both meeting the needs of individuals and containing them within the home so that they cannot be exposed to, or cause, harm. In a discussion of the dual challenges of stigma surrounding people with mental health problems and the limited mental health resources in Somalia, a Somali healthcare worker in his fifties commented, 'The only cure is to have a good family who will help you with rituals, and will bring you to an Imam, to read you, your body. That is the only cure to deal with people with mental

problems.' 'Home', as a geographical notion and domestic space, is crucial to conceptualisations of illness and care. In Somalia, Islamic healing, where the Qur'an is recited to individuals with perceived 'mental problems', is facilitated and at times provided by relatives. The implication is that without good familial support, individuals are at risk of an absence of care and protection from stigma (as discussed further in the following sections).

As noted above, displaced people are already dislocated from their familiar healthcare systems, which can heighten the reliance on kin and other social support networks, which are often similarly fragmented or unavailable. Domestic labour is most frequently performed by women and girls (Federici 2020), and conceptualisations of normal and pathological behaviour are highly gendered, highlighting the need for an intersectional lens to understand the wider repercussions of illness and caring responsibilities. In contexts of conflict and displacement, women and girls are often left to care for children and the elderly and infirm (Walker 2015). During her interview, a Korean cultural psychologist noted that displaced women refugees in Kenya often face the 'extra duties' and 'extra stressors' of providing and caring for their families, which exacerbates mental ill-health. This reliance on gendered domestic labour reveals how forms of care and containment can result from neglected health needs and can further exacerbate structural neglect.

Containment has been deployed as a top-down intervention, for instance, as a public health measure to control the spread of infectious disease (e.g., Abney 2018) or as a humanitarian measure to segregate displaced people into camps (e.g., McConnachie 2016); in both examples, containment is at least as much about protecting those on the outside as it is about protecting those who are being contained. In this article, by contrast, we engage with social containment as an emic concept described by interviewees as an individual or household protection strategy. As we discuss further in the next section, when distress is managed and contained within the home it is less likely to be identified by the community as a problem to be addressed. Neglecting health needs simultaneously compounds the burden put on those performing (usually unpaid) labour that is required to fill this gap.

The interplay between neglect and expressions of distress and social disruption

There is a long trajectory of research on culturally contextual 'idioms of distress': that is, 'socially and culturally resonant means of experiencing and expressing distress in local worlds' (Nichter 2010, 405). Beyond simply the terms in which it is expressed (e.g., Carroll 2004; Greene, Ventevogel, and Tol 2016; Im, Ferguson,

and Hunter 2017), embodied and behavioural expressions of distress can also be highly socially and culturally resonant. Most relevant here is Ventevogel et al.'s (2013) identification of two distinctive categories of expressions of distress that resonated—albeit in localised ways—across their field sites in South Sudan, Burundi, and the DRC. The first, 'severe behavioural and cognitive disturbance', was characterised by 'violence', 'walking anywhere', 'walking naked', 'talking nonsense', and 'collecting rubbish'. The second, 'sadness and social withdrawal', was characterised by 'sadness' and 'social isolation' (Ventevogel et al. 2013, 7).

Interviewees in our study similarly distinguished between distinctive bodily or behavioural expressions of distress and more internalised expressions of distress. However, as we will show, they did not consider that the latter necessarily indicated a health problem. In this section we explore the recognition and prioritisation of socially disruptive bodily or behavioural expressions as reflective of mental illness and the relative containment of more internalised expressions as normalised responses to everyday life. We then examine how these perspectives on what constitutes mental health and illness inform how interviewees categorised certain conditions and not others as 'neglected'.

When asked about common mental health disorders within the Somali and/or Congolese communities, most interviewees initially described characteristics that evoke Ventevogel et al.'s (2013) first category: conspicuous bodily expressions of distress alongside associated behaviours and decision-making. In the words of a Congolese interviewee, a financial analyst in his mid-thirties, resettled in the Netherlands for around 5 years:

You would have mental health problems when you are on the street, and taking off clothes . . . And you don't make rational decisions anymore, and I don't mean rational decisions in general, but you, like you're going crazy. That's the idea of mental challenge. So, if you still can eat, drink, work, sort of, by yourself, somehow, you're not considered as mentally challenged. So, if you [are] from my background, from the culture in the Congo, that's what we see. What we expect by the people who are having mental issues. That's the common idea of mental issues. That you're really not able to make rational decisions, like simple decisions, like sleeping on the bed, eating the right food. Like clean food, not just healthy food. You're not able to work, you're not able to put on clothes by yourself. That's the idea of mental challenge. So, it's only when it's at that level.

There are several points worth unpacking in this quote. First, this interviewee defined mental illness in terms of not being able to take care of oneself on a basic level: eating and drinking, dressing and working. Second, he reflected a common understanding that 'mental health issues' are reflected in bodily expressions. Third,

he implied that it is only when someone reaches these extremes that they would widely be considered to be suffering from a 'mental health problem'.

Other interviewees similarly determined that a 'mental health problem' would be identifiable when someone no longer appeared to understand or to follow social norms. Once someone has been labelled as 'crazy' or 'mad', they may encounter marginalisation within their own social milieu. The emphasis placed on explicit outward manifestations of distress exemplifies the popular discourse that stigmatises those who are perceived as 'crazy' and indicates why people might be reluctant to discuss their distress within a mental health framework. Social 'neglect' is not limited to displaced communities: people suffering from mental health conditions often face discrimination, isolation, and stigmatisation within their communities (Turan et al. 2019). Nevertheless, in the context of displacement, this can compound pre-existing marginalisation and stigmatisation by the host society (Bäärnhielm et al. 2017; Im, Ferguson, and Hunter 2017, 645). Additionally, intersections with non-conforming gender identities, sexual orientation, and experiences of sexual violence might put people at further risk of exclusion, stigmatisation, and violence (Larkin 2019). These prospects make it quite unappealing—either for the individuals in question, or those who might associate with those individuals—to be classified as having a mental health problem. In this context, interviewees understood such visible expressions of distress to reflect the failure of protective measures and neglect by the individual's immediate family and wider social structures alike. Several interviewees mentioned that in response to such visible displays of distress, some families might resort to containing the individual within the household.

WHO prevalence studies focus on the mental health burden of internalising problems such as depression, chronic stress, and anxiety (Charlson et al. 2019). By comparison, none of the interviewees with lived experience of migration or displacement spontaneously described any of the characteristics associated with Ventevogel et al.'s (2013) second category of internalised or covert forms of distress, such as 'overthinking', 'sadness', or 'withdrawal', as mental health problems. A displaced Congolese woman in her early forties who has been resettled in the Netherlands for around 15 years told us: 'You know, in Africa we have a lot of problems. We have hunger . . . But people are not depressed. They don't have depression, so I've never experienced that. Maybe it's there, but I don't know.' Several others clarified that the expression of internalised idioms of distress within their communities would not be understood as being a 'mental health problem' within their cultural context. A Somali interpreter in his mid-fifties who has been resettled in the Netherlands for over 25 years explained:

. . . mental wellbeing and mental health, it is a void. It is a complete void in Somalia. Regarding language it is also a complete void, and the people are also not aware of it . . . When your child is a little bit sad, the father is not going to his children, 'Are you sad? What are you sad about?' Where, they know, sadness, they know, but they also don't pay any attention to it. Because you also never learned it, to look at oneself. To look and to recognise what he feels at that moment, how they feel. People don't pay attention at all.

Other interviewees commented that although some people might discuss their emotions, these would not be understood as mental health problems. A Somali woman in her mid-thirties noted, 'It's not hard to just openly tell people you have nightmares or sadness. That's just normal for Somali people to talk about. They sympathise with each other, but that is not seen as psychological complaints, or signals that one is going crazy.' A Somali health researcher in her early forties observed that 'in Somalia, there's a whole range of depressive symptoms, if you will, but then depression in Somalia can be everything, I mean, I think there are six different words that describe that. And not necessarily long-term kind of depression.' Together these interview excerpts illustrate that despite ample vocabulary to discuss mental and emotional distress, there are limitations in where these conversations might take place, and how they are understood in relation to mental health problems. This perspective on sadness or distress indicates why people might not identify them as priorities in need of healthcare.

Generally, then, interviewees confirmed Ventevogel et al.'s (2013) ethnographic observations of distinctions between 'severe behavioural and cognitive disturbance' and 'sadness and social withdrawal'. Asking questions about 'neglect' allows us additionally to consider the differential implications for formal and informal healthcare. Whereas 'sadness and social withdrawal' might be experienced as containable within the household, it might not be experienced as necessitating support beyond the household, and might therefore be particularly susceptible to neglect. By contrast, 'severe behavioural and cognitive disturbance' might indicate that an individual's pre-existing support network is unequipped to address their condition, which is not containable within the household or even in the wider community, thus calling for some form of external engagement. One interviewee, a Congolese postal worker in his mid-fifties, who has been resettled in the Netherlands for around 20 years, remarked:

You see, if someone has a mental [health] problem, back home we always say 'he's crazy' so everything he says doesn't make any sense, you can't follow what he's saying, you can't take him seriously. You can't even talk to him because he doesn't have any significance. He has lost his mind. So, there you go, because of that, he's neglected, he's neglected by everybody, except maybe his family, but possibly even by his family, even other families. So, you see, back home in Congo, we won't put up with you anymore, you are

abandoned, you sleep outside, you sleep in garbage cans, you walk around everywhere aimlessly, you eat from garbage cans, things like that. There, if you're walking around when it's getting dark, that's where you will settle down for the night, you sleep midway through your travels, you can sleep under bridges, you sleep everywhere, well you don't have time to wash yourself, you don't have time to communicate, to change clothes you are abandoned, all because someone has fallen ill, because he has a mental [health] problem People can't deal with it; moreover, we don't have that kind of patience. Back home, if someone gets mentally ill Maybe the parents may have this kind of patience, but your brothers, your sisters, your cousins . . . they won't put up with you.

This indicates a perception of a binary between behaviour which is considered 'normal' and therefore not a mental health problem, versus behaviour which is considered 'crazy' and therefore potentially a mental health problem. This perception of a binary burdens the individual and their informal social networks with the responsibility to handle 'sadness and social withdrawal' (which might remain manageable and socially containable) and to prevent 'severe behavioural and cognitive disturbance' (which might deteriorate and become socially disruptive). In a context of scarce resources and responsive rather than preventative (international) mental healthcare provision, the effect may be that care providers consider 'sadness and social withdrawal' to be relatively responsive to mental healthcare, but 'severe behavioural and cognitive disturbance' relatively challenging to treat.

The neglect of sexual violence and use of social containment

Notably, it was only when we asked interviewees with lived experience of migration or displacement specifically about the mental wellbeing of sexual violence survivors that they spontaneously mentioned social withdrawal. Personal experience of sexual violence was not a selection criterion, and we did not probe individual experiences during interviews; rather, interviewees responded to questions about sexual violence in general by reflecting on their professional or social experiences. All interviewees focused predominantly on women and girls as victims (of e.g., female genital cutting, forced marriage, and marital rape), and only a few specifically mentioned men, boys, and LGBTQI+ people as victims. Thus, they reflected a more widespread assumption that SGBV generally concerns violence by men towards women and girls, and our interview material thus compounds the corresponding neglect of other perpetrators and victims of sexual violence.

The gendered perception of women and girls as the victims of male sexual violence was apparent in interviewees' focus on the social significance of female virginity and chastity. Congolese and Somali interviewees alike commented that women would struggle to marry in the future if they were no longer virgins, and that families would likely try to conceal any sexual violations due to the dishonour it would bring to the victim and their wider family. A female Somali interviewee, a sociologist in her mid-sixties who has been resettled in the Netherlands for over a decade, commented,

. . . the honour of the family is really important. And when you are a woman or a girl it is sensitive . . . the social control of the girls is really high . . . We also have to realise that we are living within a patriarchy community. The women's words are not so big, so we also have our problems. We are less worthy than the men.

The pressure to conform to sexual and gender norms is therefore key to understanding how victims and their families react to experiences of sexual violence and conceptualise neglect. Drawing on focus groups in the DRC, Kelly et al. (2012) report that women and men alike articulated that 'some of the greatest challenges women faced were navigating the shame, humiliation, and ostracization arising from negative community perceptions of rape survivors' (Kelly et al. 2012, 290). Thus, they understood sexual violence as 'not only a physical and psychological problem, but also a problem of social isolation' (Ibid.). Interviewees in our study similarly identified social exclusion and social isolation—and consequently neglect—as a common outcome of sexual violence. In the words of a male Congolese interviewee in the Netherlands: 'Yeah, the mental problem is rejection. You see, it's shame. When she sees that everybody knows that she was raped she becomes ashamed, she's shut [and] turns inwards to herself and deep into her own thoughts.' Like several other interviewees, he suggested that—beyond the incident itself—the social response to sexual violence would impact the survivor. One thread running clearly through our interviews was the idea that containment is a major concern in the aftermath of sexual violence, and interviewees identified three potential sites for this containment: the individual, the household, and the wider community.

Firstly, in relation to containment within the individual, several interviewees articulated that the victim's fears about other people's responses might disincentivise victims from disclosing sexual violence to others, but that this containment might also result in social isolation. Three interviewees specified that in the aftermath of sexual violence the victim was likely to lose trust—in one's husband, in one's community, in support services—but they didn't assume that this lack of trust indicated mental illness. For instance, a male Congolese interviewee commented: 'Should I call it mental health issues? I think trust issues . . . But I

don't know if I would call that depression, really. I think it is one problem, one big problem, that may lead to depression. In general, it's a problem of trust.' Thus, the survivor's response was sometimes—but not always—framed as a mental health problem. This indicates that interviewees viewed the interpersonal consequences of sexual violence as distinct from mental health conditions more generally.

Secondly, in relation to containment within the household, interviewees noted that following disclosure, the victim and their family might seek to restrict knowledge about the incident to a select group, in some cases by moving the entire household away from the social setting. When reflecting on the response by the family of someone who had been raped, a female Somali interviewee told us: 'they did not do anything, they did not press charges. They moved elsewhere. So it is still a taboo. But in their culture, when somebody within the family is raped, they just do not talk about it.' Similarly, when asked about the relationship between mental health and social consequences for survivors of SGBV, a male Congolese psychologist (in his mid-thirties, with around 10 years of professional experience) responded that:

In some cases they isolate themselves or they will be forced to go into exile, another village or into the city where again they don't have the support system. So it's not just the war that displaces these people . . . So if they can live with it, unless there is physical damage and they need medical treatment, they rather . . . just start over a new life, and hoping nobody will ever know what happened to them. And there is a fear there, because there is always this idea that maybe someone will come from that community, and see her, and identify her.

Thus, in displacement contexts where social support networks have already been severed, household containment—either through isolation or through moving away—has the potential to compound pre-existing social isolation. This supports Porter's (2017, 68) suggestion that victims of sexual violence might prioritise their own social and economic wellbeing rather than punishment of the perpetrator.

Thirdly, in relation to containment at a community level via social institutions, other potential responses to sexual violence include transforming the violation into an 'appropriate' sexual interaction through marriage, seeking reparations in the form of compensation, or initiating retributive justice. Such responses resonate with our wider consortium's research findings on treatment pathways indicating that in Somalia a commonplace principal response to sexual violence is families and extended clan networks seeking compensation from the offending parties to the victim's family (Boeyink et al. 2022, 8). This implies a framing of sexual violence not only as a mental health concern and physical assault for which the victim might

warrant medical attention, but also crucially in terms of as a (dis)honour and (in)justice for which the victim's family should be compensated.

Legal forms of redress for sexual violence are limited in both Somalia and the DRC, especially for displaced populations, which also reflects the lower social value and intersectional neglect of women and girls. Discussing the case of a displaced Somali teenager who had been raped, a female Somali interviewee (a health researcher in her early forties, with over 15 years of professional experience) told us,

. . . she actually complained to the camp leaders. And there was an NGO, that NGO helped her, she went to the police station and the guy was caught and, you know, he stayed in jail for two days. And since then, that's when the abuse started. He rapes her constantly. As a punishment. So, you have the rule of law that is not doing its job. The government's not doing their job, you have the NGO, of course they do help, but then they don't look at the consequences. You're not addressing the issue. And that's why women don't come forth, because it's easier. Maybe it happens to you once. And if you keep quiet, then it stops. But then you talk and you get punished.

The social implications for survivors of the use of sexual violence as a weapon of war reflect norms of gender and sex (Porter 2017). Where containment, either by the individual or their family, is successful, the problems interviewees identified are in the distress and shame of experiencing violence. Where containment fails and the social disruption of sexual violence is exposed, the main problem was the social response to the victim and the implications that might have for their (understood as 'her') future. These responses cut across categorisations of distress as either potentially overt and socially disruptive or internally expressed withdrawal. This contrast demonstrates the importance of considering social containment in the development and implementation of (mental) healthcare services.

Sexual violence escapes containment when it is understood as a social transgression, which in the context of our research was understood predominantly as sex outwith marriage. Notions of consent were vague, and some interviewees focused instead on the capacity of the individual to be transgressed; for example, sex workers were perceived to regularly engage in socially transgressive sex, and therefore would not be understood as victims. Similarly, marital rape was often not considered rape because it was an activity that occurred within the normative context of marriage. The pursuit of compensation by victims' families or marriage to the perpetrator is therefore intended to repair social disruption, rather than address the consequences for the victim as an individual. Two Somali interviewees commented on the vulnerability of women from marginalised minorities, and their limited capacity to seek any form of redress, thus reducing the likelihood that they

would tell anyone about the assault. 'Innocent' young girls from 'respectable' social backgrounds were therefore seen as the most legitimate victims.

The heightened risk of social disruption associated with sexual violence might compound the inclination to overlook the harm it causes the victim in favour of containing and maintaining family honour. Porter (2017) emphasises the need to acknowledge the sex in sexual violence, rather than focusing on it exclusively as an act of violence and power. Like daily stressors, sex is a normal aspect of many people's lives. It is the ordinariness of sex, Porter argues, that allows for vagueness in defining rape and challenges in pursuing justice. This makes it harder to identify transgression and therefore easier to neglect violent dimensions that cause harm or illness.

SGBV is a prominent focus of humanitarian responses in protracted displacement contexts. Ticktin prompts us to ask ourselves 'at what point identifying sexual violence as special or different (for women in particular) threatens to reproduce notions that see sexual integrity as the most important thing about a woman' (Ticktin 2011, 259). To what extent does a humanitarian focus on SGBV come at the expense of the neglect of other health problems (particularly but not exclusively women's health problems)? Echoing Tol et al. (2013), we suggest that a humanitarian focus on the mental health of individual survivors of sexual violence risks neglecting the social implications in contexts where survivors (and their families) prioritise social containment.

Conclusions

International calls to address neglected mental health conditions require careful consideration, not only of who can define what is or is not neglected, but also what is categorised as a 'mental health problem'. Echoing long histories of top-down colonial interventions, the concept of 'neglect' is imbued with assumptions firstly about the capacity to know what's best for (marginalised) others and secondly about a call to attend to those needs. Our examination of 'neglect' illuminates how unaddressed mental health needs among displaced people can exacerbate existing intersectional inequalities.

A focus on 'neglected populations' (Manderson et al. 2009), rather than on neglected mental health conditions, demonstrates that neglect (and efforts to address it) is intersectional. Local and global hierarchies of power and marginalisation shape the manifestations, perceptions, and prioritisation of distress and illness, and are therefore crucial to understanding potentially divergent categorisations of 'neglect.' For instance, the care and containment of those experiencing distress usually takes place within the 'home', and is most often performed by women and girls, demonstrating the gendered nature of often

unrecognised labour. Similarly, interviewees highlighted that gender, ethnicity, socioeconomic status, and the availability of local support networks together inform the forms of social harm experienced by survivors of sexual violence.

Examining what is or is not considered a neglected mental health condition within contexts of protracted displacement can shed light on understandings, experiences, and techniques to cope with illness and distress. Perceptions of distress and the need for containment—or other social, medical, or religious interventions—demonstrate how people in contexts of protracted displacement respond to the structural inequalities that shape their vulnerability to daily stressors, limited healthcare, and the risk of SGBV. These challenges are not unique to displaced populations and are faced by other marginalised or neglected communities, but the likelihood of fractured support networks, precarious immigration status, disruption of spiritual/religious healing practice, and unfamiliarity with available healthcare options can exacerbate these vulnerabilities for displaced populations.

MHPSS providers and beneficiaries might differ in their understanding and associations with the concept of 'mental health problems'. Interviewees' articulation of mental wellbeing in terms of a binary—'normal' versus 'crazy'—contrasts with biomedical mental health frameworks offering a wide range of diagnoses associated with various potential interventions. This mismatch in 'mental health' connotations may create a barrier that hinders acceptance by beneficiaries and may therefore undermine the aims and diminish the effectiveness of MHPSS services. Setting mental health priorities and formulating appropriate responses within contexts of protracted displacement will benefit from close collaboration with beneficiaries to avoid reinscribing colonial hierarchies of responsibility, prioritisation, and care. Responding to critiques of MHPSS as individualised, decontextualised, and potentially neglectful of the social contexts of mental health and illness, we therefore advocate for a responsive and integrated approach to mental healthcare in protracted displacement settings.

MHPSS practitioners are part of a wider community of practice that sets the priorities for what is addressed or neglected. Interrogating the framing of specific mental health conditions (and not others) as 'neglected' might prompt MHPSS practitioners to reflect on the implications for their roles as mental healthcare professionals. Who gets to decide what to target, and whose perspectives are neglected? What ends up being targeted and why, and consequently what is being neglected? The call to address 'neglected' mental health conditions might appear to be an inherently good and morally worthy pursuit, but it is not apolitical. For instance, given funder prioritisation of specific neglected mental health conditions, it is worth asking ourselves which other mental health conditions are currently

being neglected by the fixation within global mental health with scalable and preventative interventions with measurable outcomes, and which other health problems and social implications of SGBV are currently neglected by a humanitarian focus on the individual mental health of sexual violence survivors.

Authorship statement

All authors were involved in conceptualisation, methodology and formal analysis. They also took the following roles: RS: Investigation; writing—original draft; review and editing. LL: Writing—original draft; review and editing; supervision; project administration; funding acquisition. DNW: Investigation; writing—original draft; review and editing; project administration. EG: Investigation; writing—review and editing; supervision; project administration; funding acquisition. LJ: Writing—original draft; review and editing; supervision; project administration; funding acquisition; data curation.

Ethics statement

As confirmed by the Medical Ethical Committee of the Amsterdam Medical Centre (W20_382 # 20.427), this piece of research did not necessitate medical ethics review in the Netherlands, beyond the project's overarching ethical approval granted by the University of Edinburgh (CAHSS2002/01).

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References

- Abney, Kate. 2018. "Containing" Tuberculosis, Perpetuating Stigma: The Materiality of N95 Respirator Masks.' *Anthropology Southern Africa* 41 (4): 270–83. <https://doi.org/10.1080/23323256.2018.1507675>.
- Boeyink, Clayton, Mohamed A. Ali-Salad, Esther Wanyema Baruti, Ahmed S. Bile, Jean-Benoît Falisse, Leonard Muzee Kazamwali, Said A. Mohamoud, Henry Ngongo Muganza, Denise Mapendo Mukwege, and Amina Jama Mahmud. 2022. 'Pathways to Care: IDPs Seeking Health Support and Justice for Sexual and Gender-Based Violence through Social Connections in Garowe and Kismayo, Somalia and South Kivu, DRC.' *Journal of Migration and Health* 6: 100129. <https://doi.org/10.1016/j.jmh.2022.100129>.
- Bäärnhielm, Sofie, Kees Laban, Meryam Schouler-Ocak, Cécile Rousseau, and Laurence J. Kirmayer. 2017. 'Mental Health for Refugees, Asylum Seekers and Displaced Persons: A Call for a Humanitarian Agenda.' *Transcultural Psychiatry* 54 (5–6): 565–74. <https://doi.org/10.1177/1363461517747095>.
- Bettmann, Joanna E., Deb Penney, Pamela Clarkson Freeman, and Natalie Lecy. 2015. 'Somali Refugees' Perceptions of Mental Illness.' *Social Work in Health Care* 54 (8): 738–57. <https://doi.org/10.1080/00981389.2015.1046578>.
- Boynton, Lorin, Jacob Bentley, J. Carey Jackson, and Tresha A. Gibbs. 2010. 'The Role of Stigma and State in the Mental Health of Somalis.' *Journal of Psychiatric Practice* 16 (4): 265–68. <https://doi.org/10.1097/01.pra.0000386914.85182.78>.
- Cabot, Heath, and Georgina Ramsay. 2021. 'Deexceptionalizing Displacement: An Introduction.' *Humanity: An International Journal of Human Rights, Humanitarianism, and Development* 12 (3): 286–99. <https://doi.org/10.1353/hum.2021.0018>.
- Carroll, Jennifer K. 2004. 'Murug, Waali, and Gini: Expressions of Distress in Refugees From Somalia.' *The Primary Care Companion to The Journal of Clinical Psychiatry* 6 (3): 119–25. <https://doi.org/10.4088/PCC.v06n0303>.
- Charlson, Fiona, Mark van Ommeren, Abraham Flaxman, Joseph Cornett, Harvey Whiteford, and Shekhar Saxena. 2019. 'New WHO Prevalence Estimates of

- Mental Disorders in Conflict Settings: A Systematic Review and Meta Analysis.' *Lancet* 394 (10194): 240–48. [https://doi.org/10.1016/S0140-6736\(19\)30934-1](https://doi.org/10.1016/S0140-6736(19)30934-1).
- Ellis, B. Heidi, Alisa K. Lincoln, Meredith E. Charney, Rebecca Ford-Paz, Molly Benson, and Lee Strunin. 2010. 'Mental Health Service Utilization of Somal Adolescents: Religion, Community, and School as Gateways to Healing.' *Transcultural Psychiatry* 47 (5): 789–811. <https://doi.org/10.1177/1363461510379933>.
- Fassin, Didier. 2007. 'Humanitarianism as a Politics of Life.' *Public Culture* 19 (3): 499–520. <https://doi.org/10.1215/08992363-2007-007>.
- Federici, Silvia. 2020. *Revolution at Point Zero: Housework, Reproduction, and Feminist Struggle*. Oakland, CA: PM Press.
- Feldman, Rayah. 2006. 'Primary Health Care for Refugees and Asylum Seekers: A Review of the Literature and a Framework for Services.' *Public Health* 120 (9): 80916. <https://doi.org/10.1016/j.puhe.2006.05.014>.
- Ferguson, James. 1994. *The Anti-Politics Machine: "Development," Depoliticization, and Bureaucratic Power in Lesotho*. Minneapolis, MN: University of Minnesota Press.
- Gold, Marina. 2021. 'Health, Migration, and NTDs: An Anthropological View.' *Medical Anthropology* 40 (6): 491–96. <https://doi.org/10.1080/01459740.2021.1953494>.
- Greene, Claire, Peter Ventevogel, and Wietse Tol. 2016. *Mental Health and Psychosocial Wellbeing in Congolese Refugee Survivors of Gender-Based Violence: A Desk Review*. Baltimore, MD: Johns Hopkins University.
<https://www.mhpss.net/toolkit/emergency/resource/mental-health-and-psychosocial-wellbeing-in-congolese-refugee-survivors-of-gender-based-violence-a-desk-review>.
- Human Rights Watch. 2022. *World Report 2022: Events of 2021*. New York, NY: Human Rights Watch.
https://www.hrw.org/sites/default/files/media_2022/01/World%20Report%202022%20web%20pdf_0.pdf.
- Ibrahim, Mohamed, Hamayun Rizwan, Muhammed Afzal, and Mamunur Rahman Malik. 2022. 'Mental Health Crisis in Somalia: A Review and a Way Forward.' *International Journal of Mental Health Systems* 16: 12.
<https://doi.org/10.1186/s13033-022-00525-y>.
- IDMC (Internal Displacement Monitoring Centre). 2021. 'Internal Displacement in a Changing Climate.' *Global Report on Internal Displacement 2021*. Geneva: IDMC. <https://www.internal-displacement.org/global-report/grid2021/>.
- Im, Hyojin, Aidan Ferguson, and Margaret Hunter. 2017. 'Cultural Translation of Refugee Trauma: Cultural Idioms of Distress among Somali Refugees in Displacement.' *Transcultural Psychiatry* 54 (5–6): 626–52.
<https://doi.org/10.1177/1363461517744989>.
- Jefferson, LaShawn. 2004. 'In War as in Peace: Sexual Violence and Women's Status.' *Human Rights Watch World Report 2004*. New York, NY: Human Rights Watch.
<https://www.hrw.org/legacy/wr2k4/15.htm>.

- Kapilashrami, Anuj, and Olena Hankivsky. 2018. 'Intersectionality and Why It Matters to Global Health.' *Lancet* 391 (10140): 2589–91. [https://doi.org/10.1016/S0140-6736\(18\)31431-4](https://doi.org/10.1016/S0140-6736(18)31431-4).
- Kelly, Jocelyn, Justin Kabanga, Will Cragin, Lys Alcayna-Stevens, Sadia Haider, and Michael J. Vanrooyen. 2012. "If Your Husband Doesn't Humiliate You, Other People Won't": Gendered Attitudes towards Sexual Violence in Eastern Democratic Republic of Congo.' *Global Public Health* 7 (3): 285–98. <https://doi.org/10.1080/17441692.2011.585344>.
- Kleinman, Arthur. 1988. *Rethinking Psychiatry: From Cultural Category to Personal Experience*. New York, NY: Free Press
- Kohrt, Brandon A., Emily Mendenhall, and Peter J. Brown. 2015. 'Historical Background: Medical Anthropology and Global Mental Health'. In *Global Mental Health: Anthropological Perspectives*, edited by Brandon A. Kohrt and Emily Mendenhall, 19–36. London: Routledge.
- Lamkaddem, Majda, Karien Stronks, Walter D. Devillé, Miranda Olf, Annette Am Gerritsen, and Marie-Louise Essink-Bot. 2014. 'Course of Post-Traumatic Stress Disorder and Health Care Utilisation among Resettled Refugees in the Netherlands.' *BMC Psychiatry* 14 (1): 90. <https://doi.org/10.1186/1471-244X-14-90>.
- Larkin, Brigid. 2019. 'Pride and Prejudice: LGBTIQ Community to Disaster Worldwide.' *Australian Journal of Emergency Management* 34 (4): 60–66. https://knowledge.aidr.org.au/media/7283/ajem_102019-17.pdf.
- Liese, Bernhard H., Rebecca S. F. Gribble, and Marisha N. Wickremesinhe. 2019. 'International Funding for Mental Health: A Review of the Last Decade.' *International Health* 11 (5): 361–69. <https://doi.org/10.1093/inthealth/ihz040>.
- Manderson, Lenore, Jens Aagaard-Hansen, Pascale Allotey, Margaret Gyapong, and Johannes Sommerfeld. 2009. 'Social Research on Neglected Diseases of Poverty: Continuing and Emerging Themes.' *PLoS Neglected Tropical Diseases* 3 (2): e332. <https://doi.org/10.1371/journal.pntd.0000332>.
- Matthies-Boon, Vivienne. 2018. 'Towards a Critical Trauma Studies: A Response to Felix Lang.' *Middle East – Topics & Arguments* 11: 159–62. <https://doi.org/10.17192/META.2018.11.7812>.
- McConnachie, Kirsten. 2016. 'Camps of Containment: A Genealogy of the Refugee Camp.' *Humanity: An International Journal of Human Rights, Humanitarianism, and Development* 7 (3): 397–412. <https://doi.org/10.1353/hum.2016.0022>.
- Mendenhall, Emily, and Brandon A. Kohrt, 2015. 'Anthropological Methods in Global Mental Health Research.' In *Global Mental Health: Anthropological Perspectives*, edited by Brandon A. Kohrt and Emily Mendenhall, 37–50. London: Routledge.
- Miller, Kenneth E., Madhur Kulkarni, and Hallie Kushner. 2006. 'Beyond Trauma-Focused Psychiatric Epidemiology: Bridging Research and Practice with War-

- Affected Populations.' *American Journal of Orthopsychiatry* 76 (4): 409–22.
<https://doi.org/10.1037/0002-9432.76.4.409>.
- Miller, Kenneth E., and Andrew Rasmussen. 2010. 'War Exposure, Daily Stressors, and Mental Health in Conflict and Post-Conflict Settings: Bridging the Divide between Trauma-Focused and Psychosocial Frameworks.' *Social Science & Medicine* 70 (1): 7–16. <https://doi.org/10.1016/j.socscimed.2009.09.029>.
- Miller, Kenneth E., Mark. J. D. Jordans, Wietse A. Tol, and Ananda Galappatti. 2021. 'A Call for Greater Conceptual Clarity in the Field of Mental Health and Psychosocial Support in Humanitarian Settings.' *Epidemiology and Psychiatric Sciences* 30: e5.
<https://doi.org/10.1017/S2045796020001110><https://doi.org/10.1017/S2045796020001110>.
- Molyneux, David H., Peter J. Hotez, and Alan Fenwick. 2005. "Rapid-Impact Interventions": How a Policy of Integrated Control for Africa's Neglected Tropical Diseases Could Benefit the Poor.' *PLoS Medicine* 2 (11): e336.
<https://doi.org/10.1371/journal.pmed.0020336>.
- Morel, Carlos M. 2003. 'Neglected Diseases: Under-funded Research and Inadequate Health Interventions: Can We Change This Reality?' *EMBO Reports* 4 (S1).
<https://doi.org/10.1038/sj.embor.embor851>.
- Nichter, Mark. 2010. 'Idioms of Distress Revisited.' *Culture, Medicine, and Psychiatry* 34 (2): 401–16. <https://doi.org/10.1007/s11013-010-9179-6>.
- OCHA (United Nations Office for the Coordination of Humanitarian Affairs). 2021. *Somalia: Humanitarian Response Plan 2022 (December 2021)*. Geneva: OCHA. <https://reliefweb.int/report/somalia/somalia-humanitarian-response-plan-2022-december-2021>.
- OCHA (United Nations Office for the Coordination of Humanitarian Affairs). 2022. *Democratic Republic of the Congo: Humanitarian Needs Overview and Response Plan 2022 at a Glance (February 2022)*. Geneva: OCHA. <https://reliefweb.int/report/democratic-republic-congo/democratic-republic-congo-humanitarian-needs-overview-and-response>.
- Parker, Melissa, and Tim Allen. 2014. 'De-Politicizing Parasites: Reflections on Attempts to Control the Control of Neglected Tropical Diseases.' *Medical Anthropology* 33 (3): 223–39. <https://doi.org/10.1080/01459740.2013.831414>
- Parker, Melissa, Katja Polman, and Tim Allen. 2016. 'Neglected Tropical Disease in Biosocial Perspective.' *Journal of Biosocial Science* 48 (S1): S1–15.
<https://doi.org/10.1017/S0021932016000274>.
- Patel, Vikram, Shekhar Saxena, Helen Frankish, and Niall Boyce. 2016. 'Sustainable Development and Global Mental Health—A Lancet Commission.' *Lancet* 387 (10024): 1143–45. [https://doi.org/10.1016/S0140-6736\(16\)00208-7](https://doi.org/10.1016/S0140-6736(16)00208-7).
- Pendse, Sachin R., Daniel Nkemelu, Nicola J. Bidwell, Sushrut Jadhav, Soumitra Pathare, Munmun De Choudhury, and Neha Kumar. 2022. 'From Treatment to

- Healing: Envisioning a Decolonial Digital Mental Health.' In *CHI '22: Proceedings of the 2022 CHI Conference on Human Factors in Computing Systems*, edited by Simone Barbosa, Cliff Lampe, Caroline Appert, David A. Shamma, Steven Drucker, Julie Williamson, and Koji Yatani, 1–23. New York, NY: Association for Computing Machinery. <https://doi.org/10.1145/3491102.3501982>.
- Porter, Holly. 2017. *After Rape: Violence, Justice, and Social Harmony in Uganda*. Cambridge: Cambridge University Press.
- Porter, Matthew, and Nick Haslam. 2005. 'Predisplacement and Postdisplacement Factors Associated With Mental Health of Refugees and Internally Displaced Persons: A Meta-Analysis.' *JAMA* 294 (5): 602. <https://doi.org/10.1001/jama.294.5.602>.
- Singer, Merrill, Nicola Bulled, Bayla Ostrach, and Emily Mendenhall. 2017. 'Syndemics and the Biosocial Conception of Health.' *Lancet* 389 (10072): 941–50. [https://doi.org/10.1016/S0140-6736\(17\)30003-X](https://doi.org/10.1016/S0140-6736(17)30003-X).
- Summerfield, Derek. 1999. 'A Critique of Seven Assumptions behind Psychological Trauma Programmes in War-Affected Areas.' *Social Science & Medicine* 48 (10): 1449–62. [https://doi.org/10.1016/S0277-9536\(98\)00450-X](https://doi.org/10.1016/S0277-9536(98)00450-X).
- Ticktin, Miriam. 2006. 'Where Ethics and Politics Meet: The Violence of Humanitarianism in France.' *American Ethnologist* 33 (1): 33–49. <https://doi.org/10.1525/ae.2006.33.1.33>.
- Ticktin, Miriam. 2011. 'The Gendered Human of Humanitarianism: Medicalising and Politicising Sexual Violence.' *Gender & History* 23 (2): 250–65. <https://doi.org/10.1111/j.1468-0424.2011.01637.x>.
- Tol, Wietse A., Vikram Patel, Mark Tomlinson, Florence Baingana, Ananda Galappatti, Catherine Panter-Brick, Derrick Silove, Egbert Sondorp, Michael Wessells, and Mark van Ommeren. 2011. 'Research Priorities for Mental Health and Psychosocial Support in Humanitarian Settings.' *PLoS Medicine* 8 (9): e1001096. <https://doi.org/10.1371/journal.pmed.1001096>.
- Tol, Wietse A., Vivi Stavrou, M. Claire Greene, Christina Mergenthaler, Mark van Ommeren, and Claudia García Moreno. 2013. 'Sexual and Gender-Based Violence in Areas of Armed Conflict: A Systematic Review of Mental Health and Psychosocial Support Interventions.' *Conflict and Health* 7 (1): 16. <https://doi.org/10.1186/1752-1505-7-16>.
- Turan, Janet M., Melissa A. Elafros, Carmen H. Logie, Swagata Banik, Bulent Turan, Kaylee B. Crockett, Bernice Pescosolido, and Sarah M. Murray. 2019. 'Challenges and Opportunities in Examining and Addressing Intersectional Stigma and Health.' *BMC Medicine* 17 (1): 7. <https://doi.org/10.1186/s12916-018-1246-9>.
- Turrini, Giulia, Marianna Purgato, Francesca Ballette, Michela Nosè, Giovanni Ostuzzi, and Corrado Barbui. 2017. 'Common Mental Disorders in Asylum Seekers and Refugees: Umbrella Review of Prevalence and Intervention Studies.'

- International Journal of Mental Health Systems* 11 (1): 51.
<https://doi.org/10.1186/s13033-017-0156-0>.
- UN (United Nations). 2006. *Convention on the Rights of Persons with Disabilities*. Geneva: UN. <https://www.ohchr.org/en/instruments-mechanisms/instruments/convention-rights-persons-disabilities>.
- UNHCR (United Nations High Commissioner for Refugees). 2020. *Global Report 2020*. Geneva: UNHCR. https://reporting.unhcr.org/sites/default/files/gr2020/pdf/GR2020_English_Full_lo_wres.pdf.
- Vanderslott, Samantha. 2021. *Attention and Responsibility in Global Health: The Currency of Neglect*. London: Routledge.
- Ventevogel, Peter, Mark Jordans, Ria Reis, and Joop de Jong. 2013. 'Madness or Sadness? Local Concepts of Mental Illness in Four Conflict-Affected African Communities.' *Conflict and Health* 7 (1): 3. <https://doi.org/10.1186/1752-1505-7-3>.
- Walker, Rebecca. 2015. 'Negotiating Risk: Exploring the Experiences of Mothers during the Conflict in Eastern Sri Lanka.' In *Mothers Under Fire: Mothering in Conflict Areas*, edited by Arlene Sgoutas and Tatjana Takseva, 23–39. Bradford, ON: Demeter Press.
- Walker, Rebecca, and Jo Vearey. 2021. 'Behind the Masks: Mental Health, Marginalisation and COVID-19.' *The Polyphony* (blog), 21 September 2021. <https://thepolyphony.org/2021/09/21/behind-the-masks-mental-health-and-marginalisation-covid-19/>.
- Watters, Charles. 2001. 'Emerging Paradigms in the Mental Health Care of Refugees.' *Social Science & Medicine* 52 (11): 1709–18. [https://doi.org/10.1016/S0277-9536\(00\)00284-7](https://doi.org/10.1016/S0277-9536(00)00284-7).
- WHO (World Health Organization). 2019. *Special Initiative for Mental Health (2019–2023): Universal Health Coverage for Mental Health*. Geneva: WHO. [https://www.who.int/publications/i/item/special-initiative-for-mental-health-\(2019-2023\)](https://www.who.int/publications/i/item/special-initiative-for-mental-health-(2019-2023)).
- WHO (World Health Organization). 2020. *Ending the Neglect to Attain the Sustainable Development Goals: A Road Map for Neglected Tropical Diseases 2021–2030*. Geneva: WHO. <https://apps.who.int/iris/handle/10665/338565>.
- WHO (World Health Organization). 2021. *Comprehensive Mental Health Action Plan 2013–2030*. Geneva: WHO. <https://apps.who.int/iris/handle/10665/345301>.