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### Discipline, Diagnose & Punish: A Critical Analysis Of Ptsd Diagnostication Amongst Syrian Migrants In Jordan

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Discipline, Diagnose & Punish: A Critical Analysis of PTSD Diagnostics amongst  
Syrian Migrants in Jordan

A Thesis Submitted to the  
Yale University School of Medicine  
in Partial Fulfillment of the Requirements for the  
Degree of Doctor of Medicine

by

Erik James Kramer

2020

Diagnose, Discipline & Punish: A Critical Analysis of PTSD Diagnostication amongst Syrian Migrants in Jordan

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This qualitative project seeks to explore sociopolitical factors influencing post-traumatic stress disorder (PTSD) diagnostication in Syrian migrants living in Jordan. Interviews were performed with twenty-three key informants, comprised of clinicians, organizational staff, and scholars, using semi-structured techniques which were analyzed with grounded theory analytic approaches. The results illuminate the complex social forces governing the practice of PTSD diagnostication in the Syrian migrant population in Jordan, with a focus on the effects of financial pressures. This is the first study to report extensively on the financial pressures affecting PTSD diagnostication in this setting. These data served as rooted substrate for a critical theory-informed secondary analysis through the dyad of Foucault's concept of the carceral archipelago and the concept of abolition geography from black radical scholarship. The analysis suggests that the phenomenon of overdiagnostication of PTSD in Syrian migrants represents an instance of both totalitarian and colonialist instrumentalization of psychiatry.

## Acknowledgements

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## Key Terminology

- **Asylee:** an individual who is seeking international protection. In countries with individualized procedures, an asylum seeker is someone whose claim has not yet been finally decided on by the country in which he or she has submitted it. Not every asylum seeker will ultimately be recognized as a refugee, but every recognized refugee is initially an asylum seeker.<sup>1</sup>
- **Displaced person:** persons who have been forced or obliged to flee or to leave their homes or places of habitual residence, in particular as a result of or in order to avoid the effects of armed conflict, situations of generalized violence, violations of human rights or natural or human-made disasters. This is an umbrella term which is agnostic to a person’s immigration status and includes undocumented migrants, refugees, and asylees.<sup>1</sup>
- **Inter-Agency Standing Committee (IASC):** an inter-agency forum of UN and non-UN humanitarian partners founded in 1992, to strengthen humanitarian assistance. The overall objective of the IASC is to improve the delivery of humanitarian assistance to affected populations.
- **International Medical Corps (IMC):** a global, nonprofit, humanitarian aid organization dedicated to saving lives and relieving suffering by providing emergency medical services, as well as healthcare training and development programs, to those affected by disaster, disease or conflict.
- **Institute of Migration (IOM):** a leading inter-governmental organization in the field of migration which works closely with governmental, intergovernmental and non-governmental partners.
- **Mental Health and Psychosocial Support (MHPSS):** any type of local or outside support that aims to protect or promote psychosocial well-being and/ or prevent or treat mental disorder, with an emphasis on layered system of complementary supports that meets the needs of different groups.<sup>2</sup>
- **Migrant** – An umbrella term, not defined under international law, reflecting the common lay understanding of a person who moves away from his or her place of usual residence, whether within a country or across an international border, temporarily or permanently, and for a variety of reasons. The term includes a number of well-defined legal categories of people, such as migrant workers; persons whose particular types of movements are legally-defined, such as smuggled migrants; as well as those whose status or means of movement are not specifically defined under international law, such as international students. At the international level, no universally accepted definition for “migrant” exists. *This is the term that will be primarily used to describe Syrians living in Jordan, as they represent a mixture of asylees, refugees, documented migrants, and undocumented migrants.*<sup>1</sup>

- **United Nations High Commission for Refugees (UNHCR):** a United Nations agency with the mandate to protect refugees, forcibly displaced communities and stateless people, and assist in their voluntary repatriation, local integration or resettlement to a third country.
  
- **Refugee:** a person who, owing to well-founded fear of being persecuted for reasons of race, religion, nationality, membership of a particular social group or political opinion, is outside the country of his nationality and is unable or, owing to such fear, is unwilling to avail himself of the protection of that country; or who, not having a nationality and being outside the country of his former habitual residence, is unable or, owing to such fear, is unwilling to return to it. In technical usage, it refers to someone who has been granted refugee status by UNHCR.<sup>1</sup>

## Introduction

*Neo-colonialism is... the worst form of imperialism. For those who practise it, it means power without responsibility and for those who suffer from it, it means exploitation without redress.*

Kwame Nkrumah (1965)<sup>3</sup>

### I. Background

The Syrian war and the resulting displacement of Syrians has had a profound impact on the mental health of Syrian refugees. The United Nations High Commission for Refugees (UNHCR) has stated that the most prominent medical issue facing Syrian refugees (where appropriate, hereafter referred to as Syrian migrants, a more inclusive term than the colloquially used term “refugee”) are “emotional disorders” of various kinds including post-traumatic stress disorder (PTSD).<sup>4</sup> Simultaneously, it has long been recognized that categories of psychological pathology are frequently distinct between Western and non-Western cultures.<sup>5</sup> This is particularly true for those diagnoses which are heavily influenced by the ebb and flow of social, political, and cultural contexts such as PTSD.<sup>6</sup> Specific sociocultural factors (e.g. linguistics, traditions, collective experience, explanatory models of disease) are known to diminish clinicians’ abilities to accurately diagnose mental illness in non-Caucasian populations, and can alter disease progression and outcomes.<sup>7</sup>

Broadly building untested, Western-centric assumptions into psychiatric diagnostics and care of Syrian migrants has poor construct validity at best, and at worst is disenfranchising and psychologically damaging. Recent scholarship within the transcultural psychiatry literature by authors such as Barkil-Oteo and others have called into

question the validity of epidemiological studies which estimate that 30-50% of Syrian refugees meet criteria for PTSD based on Diagnostic and Statistical Manual 5 (DSM-5) standards.<sup>8,9</sup> This point suggests that there is indeed a fundamental gap that exists between published research on Syrian trauma and the lived experience of Syrian trauma. There has been limited research to illuminate the borders of Syrian migrants' explanatory models for, and the discourse around psychological trauma. According to Quosh, "despite calls for culturally sensitive and locally grounded mental health research, only a few studies regarding Syrian mental health have sought to understand how Syrians who have survived war and displacement personally interpret their immaterial needs."<sup>10</sup>

In light of this, an initial research proposal was created with the goal of investigating the ontological formations of psychological trauma in Syrian migrants. This initial project was envisioned as a collaboration between the authors and several medical professionals affiliated with Hashemite University in Jordan who would conduct the interviews with Syrian informants, organized by a non-governmental organization (NGO) called the Collateral Repair Project based in Amman, Jordan. After approval and five initial interviews, it became clear that some of our research associates in Amman lacked the theoretical background and ethnographic skillset to appropriately conduct the inquiry as designed. Interviewee well-being was also a serious concern, as it rapidly became clear that the interviews were distressing for both the interviewees and interviewers. Although the participants consented and were generally enthusiastic about participating, our team did not feel that the conclusions of the inquiry would be worth the emotional toll extracted from the participants. Parallel to this development, an interesting subject arose in our conversations, focusing on the various structures and pressures present within

internationally operated clinics encouraging clinicians to give Syrian migrants mental health diagnoses. I was particularly sensitized to this topic because of my interest in making use of transformative-emancipatory research paradigms which preferentially attend to issues of power and equity. As a result, it was decided to shift the focus of the inquiry towards a more sociological investigation of how PTSD diagnostics was being practiced in international non-governmental organization (INGO) mental health clinics. The new participants, which included practitioners, managers, and clinic staff were deemed to be a far less vulnerable population and fell within the purview of our Yale University human subjects committee review as well as the institutional review of our partner organization in Jordan, the Collateral Repair Project.

The malleability and apparent inapplicability of the PTSD diagnosis in the Syrian population naturally lead to questions concerning the instrumental utility of the diagnosis: who is making use of the diagnosis, under what circumstances, and why? The new aim of the study therefore sought to understand the factors influencing the use of the PTSD diagnosis from the perspective of organizations involved in the provision of mental healthcare services for Syrians in Jordan.

## II. Theoretical Approach

It has been recognized that “trauma studies related to the MENA (Middle-East and North Africa) region is not only an emerging field in the humanities and social sciences, but also a political and social field of manifold struggles over power and dominant regimes of truth.”<sup>11</sup> Much has been written regarding the instrumental use (sometimes called secondary gain) of mental health diagnoses by migrants and other victims of violence

particularly in Palestine, as a means of gaining rights. In a seminal work, Didier Fassin lucidly characterized what he calls the new “moral economy” of the 21<sup>st</sup> century, wherein victims of trauma use diagnostic categories to call for justice and substantiate asylum claims through the process of political subjectification (becoming subjects with agency as opposed to objects).<sup>12</sup> The established discourse surrounding this process, while complex, is broadly written about in a positive light, as it is currently understood as a method of co-producing agency for subaltern individuals. The present research sought to investigate how diagnostication occurs, and whether the ecology of the practice confirms or contradicts the established narrative that clinically documenting trauma is universally a rights-granting activity. In other words, is the malleability of the PTSD diagnosis (and other mental health diagnoses) mobilized for instrumental purposes by actors other than the clients themselves?

In the following, I present a case for reimagining the diagnosis of PTSD in Syrian migrants within Foucault’s biopolitics framework as an entity which instead serves the interests of states, INGOs, and the mental health profession in Jordan. Foucault’s formulation of biopolitics and the carceral archipelago in *Discipline and Punish* provides a useful scaffold for conceptualizing this alternative narrative.<sup>13</sup> There is at once the creation of “docile bodies” within Syrian patients, subjected by the power of both INGO mental health clinics and state-governed immigration regimes, and “docile bodies” within mental health providers as they are influenced by streams of thought within Western psychiatry and international funding channels. These forms of control represent manifestations of a carceral archipelago which I argue limits the mobility of Syrian migrants into the Global North and governing the discipline of mental health in Jordan. Given this analysis, I ultimately argue that such use of PTSD constitutes a process

consistent with two categories of psychiatric instrumentalization defined in the literature—colonial and totalitarian instrumentalization. Finally, I make use of scholarship from the black radical tradition to consider how the concept of abolition geography and the critical reappraisal of time can help subaltern communities imagine ways of collectivizing, living democratically, and evading state-sanctioned misrepresentation.

This research inquiry was informed by a transformative-emancipatory framework, with an explicit focus on questions related to and arising from issues of power and equity.<sup>14</sup> In effect, our study became bi-phasic because of the unforeseen challenges as described in the introduction. We allowed participant and community-informed feedback to redirect and refine the inquiry. This research approach lends potency and validity to the study, and in theory, dissolves the boundaries between research, advocacy, and community development.<sup>15</sup> As prior authors in transcultural psychiatry have done, we adopted a critical-interpretivist approach which reflects the nature of organizations and their members as socially constructed, while maintaining an awareness of our positionality within the researcher-subject dynamic, allowing the project to “a process of invention and intervention and of co-construction between the researcher and the researched.”<sup>14</sup>

## Methodology

### I. Study Design and Sample

The Collateral Repair Project (CRP) was founded in 2006 by two American women in an effort to counterbalance the devastating impact of displacement caused by the Iraq War. It serves as a community center and provides emergency assistance and programming for displaced persons living in Amman, Jordan. As a community hub for Syrians living in Amman, it was an appropriate site to reach an adequate number of key informants. This research is intended to be hypothesis generating, rather than conclusive. Therefore, a target sample size of 10-20 informants was established to achieve theoretical saturation. In total, 23 interviews were conducted; further details about these informants are provided in the results section. Qualitative interviews were carried out with key informants who were identified by snowball-sampling until no new thematic information arose during interviews (theoretical saturation). As described, the initial phase consisted of five interviews with Syrians displaced to Jordan as a result of the Syrian War. These initial informants were beneficiaries of CRP, and were not professionals in healthcare or humanitarianism. Following this initial phase, new inclusion criteria were established: informants of any nationality, age, gender, or profession who are working or had worked in any capacity on behalf of beneficiaries that included Syrian migrants. The only exclusion criterion was Syrian migrants not currently or previously acting in roles related to the delivery of services to other Syrian migrants. Because no inclusion or exclusion criteria were established based on other demographic information, this demographic information was not collected. No official screening process was used to identify key informants. Key informants included

organization managers, clinic directors, clinical consultants, psychiatrists, social workers, and academic faculty. A semi-structured, eight question interview guide was developed with the assistance of Yale faculty in the Anthropology and Psychiatry Departments for use in the interviews (Appendix A). The interview guide also included several “warm-up” questions and between zero and nine prompts for each of the eight questions. Interviews were conducted with the assistance of an Arab-language medical interpreter when appropriate.

Human subjects committee approval (#2000023921) was obtained from Yale University, and from the institutional review board at the Collateral Repair Project which served as our organizational research partner registered with the Ministry of Social Welfare of Jordan.

## II. Data Collection

From October 2018 to December 2018, three researchers trained in qualitative research methods conducted twenty-eight individual interviews with key informants. Interviews were recorded on a HIPAA compliant device which was kept locked at all times. Interviews were transcribed verbatim and uploaded into Nvivo for analysis. One researcher (EK) reviewed the transcripts and used the constant-comparison and grounded theory (inductive reasoning) approaches to data synthesis.<sup>16</sup>

## III. Data Analysis

Data analysis was conducted by EK using the standard constant comparison method.<sup>17-19</sup> On completion of coding and reaching thematic saturation, the coded data were organized

into a conceptual taxonomy, and themes were developed and applied. Nvivo 10 was used for analysis (QSR International, Melbourne, Australia).

## Results

Key informants included 5 displaced Syrians in the initial phase. The second phase comprised of 2 organization directors and managers, 3 clinic directors, 2 clinical consultants, 2 psychiatrists, 5 social workers, 3 academic faculty, and 1 legal scholar, for a total of 23 interviews. The average length of the interviews was 52 minutes. At thematic saturation, fifteen themes were synthesized which were then organized into eight domains. These domains are: ambiguity of client histories, clinical criteria, client agency, state of the profession, financial incentives, problematizing cross-cultural diagnostication, and co-constructing images of the migrant.

### Domain 1: Ambiguity of client histories

One aspect which clouded the ability of practitioners to make assessments in their clinic was the ambiguous clinical histories of the patients they saw. Many displaced Syrians came to Jordan with medications and diagnoses and few records. Some patients were able to articulate their clinical histories, but others attended their appointments with empty bottles of medications or nothing at all.

*There are few re-assessments going on. So if you make this diagnosis then it will be attached to this beneficiary forever. It is complicated though because some of them received a diagnosis from a doctor in Syria, and it's hard to account for what is causing their symptoms – is it that they have the disorder, or from the meds they were receiving in Syria, or is the effects of the war or their current situation that is making the symptoms occur?*

The fact that case formulations from previous clinicians created prior to flight from Syria lends itself to a certain malleability of present case formulations. Without prior histories, it is difficult to remove diagnostic labels from their files.

## Domain 2: Clinical Criteria

### *2.1—Conflation of effects of conflict with present context*

Almost all informants discussed this theme at length: many felt that the clients being seen in their clinics were suffering from psychosocial stressors much more related to their living conditions and liminality rather than from direct aftereffects of their experiences with the conflict and flight from Syria.

*They are suffering indirectly [from the conflict]. What I mean by this is the family conflict, the economic situation, and this is indirectly related to the war because they lost their property, their job, and their social network and sources of support.*

Another provider expanded on this idea:

*They are still suffering from some issue in their life like family conflict, sometimes depression, sometimes anxiety but it is not related to the war and displacement, because they can adapt with that, but it is something related to their history, most of the patients from when they were a child [sic] and is not directly related to the war. Maybe it is not expected to say that, but this is in reality what I see in the clinic. Most of them do not come to the clinic because they are suffering from the war. Most of them are suffering because they had poor treatment when they were a child, and from the economic situation in Jordan because most of them are suffering from the hard-economic situation, they have no good education for their children, no jobs for the men, they are not allowed to work, they don't have access to work, and this issue impacts on them psychologically.*

### *2.2—Self-fulfilling prophecy of pathology*

Many informants described how the clinical environment in Jordan was arranged to excessively pathologize the mental health of displaced Syrians. At a systems level, informants related this to what they believe is a Western predisposition towards viewing all Syrians as being traumatized.

*There is increased PTSD partially because it is almost obsessively looked for in these populations, so it is a self-fulfilling prophecy... In reality in the clinic what*

*we find is that it is 3-4% of people who actually have the disorder and need follow-up which is more reflective of reality.*

Thus, when clinics and health systems are informed by this tendency to look for higher incidences of PTSD, the informants felt that higher rates would be “found” and documented. A high-level director explained that, “if you look at after arrival, basically there is no difference in rates between the host population and the refugee population, except for a very slight increase in PTSD.”

The prior discussion hinged on criteria being used to make a dichotomous decision about the client’s status: disease present or disease absent. Informants also used disease severity as a lens to view the issue, giving the discussion more granularity.

*In my perspective, many of these diagnoses can be seen in a different way and be treated differently, without psychotropic medications. The severity of the problem is not often taken into account.*

Informants said that while for many clients, there were symptoms present which could fulfill the majority of clinical criteria for a diagnoses, but that the universal requirement that “symptoms create distress or functional impairment (e.g., social, occupational)” was often not present or too mild to qualify:

*For example, for mild or moderate cases, they could often be treated with non-pharmaceutical approaches like counseling or therapy or other supports, more psychological intervention or psychosocial support.*

Notably, European and American informants used more veiled or diplomatic language to describe what they felt were inappropriate diagnoses: “Quite a good number of diagnoses that I see, can be... viewed in another way. I think there are many diagnoses that are maybe not appropriate.” In contrast, their Jordanian colleagues were often much more forthright about the same sentiment.

## Domain 3: Client Agency

### *3.1—Addressing clients demands for receiving diagnoses*

Several informants who worked directly with clients clinically or to prepare their dossiers for application to the migrant resettlement system described encounters which sometimes felt adversarial, with clients demanding the receipt of diagnoses. Informants explained that these demands are rooted in the belief that having a mental health diagnosis like PTSD would be helpful for their resettlement claims.

*There is a good number of clients who come to the clinic and demands a psychiatric report to put into UNHCR [sic]. They think that it will be very helpful for them to be resettled outside of Jordan which is not true. They are not going to take somebody who is suffering from low mood and suicidal ideas, “we don’t need you.” Of course, they want families who can build, not to go to Paris or to Madrid to be admitted to a psychiatric hospital. Sometimes it is my job to clarify for the clients this point.*

Another informant described how these adversarial encounters could sometimes escalate very quickly, to the point where clients would endorse suicidal ideation, interpreted by the informants as conspicuous threats:

*And there are some cases where, especially young women, who have a very strong reaction and come to UNHCR and say “I will commit suicide unless I am resettled.” So it reinforces this pattern. So now we only do the assessment if UNHCR asks us for the report. But even when we do this it is very synthetic, we don’t give very much detail and it is very superficial.*

### *3.2—Diagnosis as organizing concept*

Simultaneously, however, many providers also explained that other clients who sought these labels did so for therapeutic purposes. Possessing a diagnostic entity to affirm or validate their lived experiences can be useful for their healing.

*They explain that it is very useful for them to differentiate between the cognition and healing and the body sensation. They feel that sometimes they say like, I get it*

*now and I find what is the resource of my disorder, when I can label all this I can understand myself more.*

There thus exists a tension for providers between providing artificial diagnoses to clients who appear to be seeking diagnoses for external goals (secondary gain), and those who are consciously or sub-consciously searching for a diagnosis as a central organizing concept to explain the phenomenological manifestations of their mental distress. In some clients, providers described that both goals could be present at once. Navigating these tensions are an added layer of complexity for providers in this context.

#### Domain 4: State of the profession

##### *4.1—They don't believe in psychiatry*

In conversation with a Jordanian psychiatrist about why many Jordanian medical students avoid training in psychiatry, they responded that many medical students and “doctors maybe don't believe in psychiatry” in Jordan. As for patients afflicted with mental health disorders and their families, psychologists and psychiatrists are typically seen as last resorts.

*Most of the clients will visit a psychiatrist at the end of his suffering, after visiting imam, family [sic]. It is a last resort. Why? Because at the beginning most of their families and they don't believe in psychiatry as a specialty.*

Informants explained that this reflects both the strong filial responsibilities expected and practiced by their clients and their families, as well as the novelty and otherness associated with psychiatry, which they are often unfamiliar with. Informants also said that students feel that the reimbursement for psychiatry is much lower than in other specialties: “they think that maybe in the future even if they open a private clinic, they won't gain money, as much as surgeons or obstetricians.” They explained that the residency for psychiatric

training is the only training program in which residents must pay tuition to complete the residency. Informants felt that these issues stemmed from societal and governmental biases about the legitimacy of psychiatry in Jordan, which propagate the difficulties of practicing in the country.

Some informants believed that due to these many barriers in pursuing psychiatry, the quality of training is quite poor in the country. This then catalyzes a vicious downward cycle delegitimizing the specialty. One European informant connected this training quality with the process of over-application of inappropriate diagnostic criteria, both in their NGO and throughout the country:

*This is the way [this NGO] is working but also because this is the way Jordan is working. I think this is related to the quality of training for psychologist and psychiatrist which is quite low in Jordan.*

#### 4.2—Monopolized power to change diagnoses

In Jordan, only licensed psychiatrists are able to officially make mental health diagnoses, to change them, or to remove them from a client's record. Non-psychiatrist informants universally felt that this was problematic for their practice in several ways. First, they felt that it leads to an overemphasis on medicalized pathology over psychosocial pathology, pushing many clients unnecessarily towards pharmacological treatments rather than psychosocial interventions.

*In Jordan only psychiatrists can give diagnosis, psychologists cannot, things are often medicalized [sic]. What I mean by this... So a beneficiary will first see a case manager who will decide what needs to happen next, then they will see a psychiatrists who will give them a diagnosis always, then their plan will be followed by the team in terms of the goal and objectives. Most of the beneficiaries they will receive a mental health diagnosis.*

It is important to note in the excerpt above, that the informant twice emphasizes that the psychiatrists that they worked with will “always” give a diagnosis and that “most” beneficiaries will receive a diagnosis. It was clear that the informant felt that this diagnostic monopoly, in addition to contributing to over-reliance on pharmacological interventions, was a contributor to the overuse of diagnostic criteria.

Other informants shared this perception. They felt that there were many more Syrian migrants being diagnosed with mental health disorders including PTSD than was needed or appropriate. However, they felt powerless to change the diagnoses because they required a psychiatrist’s approval to do so. One informant said:

*For me, this [patient did not have] psychosis, and I couldn’t negotiate with the doctors... and they said, “Yes but they have the symptoms.” And I said, “Yes but these symptoms do not equate with a diagnosis!”*

This was seen as a reflection of the profession of psychiatry in Jordan attempting to consolidate its control over the larger field of mental health which includes psychologists and other mid-level providers. This diagnostic monopoly helps regulate how and where reimbursements are directed.

## Domain 5: Financial incentives

### *5.1—Achieving diagnostic quotas*

Several providers working for INGO mental health clinics stated that they often felt pressured by their managers to meet target numbers for mental health diagnoses. In other words, if they were not giving out enough diagnoses within a given timeframe, they would be encouraged to increase their numbers to meet a pre-established quota. The majority of

informants readily acknowledged the tension between diagnostic quotas and the low prevalence of PTSD seen in their clinics.

*Yes, most of the clients must not be diagnosed with PTSD [sic]. Not most people in Syria or Iraq must have PTSD. It must just be symptoms that do not meet the criteria of the disorder. It might be reactive depression, it might be anxiety. But it [the diagnosis] is important for the organization or the people who give us the funds. They concentrate on the target of clients. It is very important for them to meet a big target of clients for the funds.... for some clients, honestly there is no need to open a file for them.*

Several providers independently stated that their clinics received \$100 USD from UNHCR for each new diagnosis that they made. This reimbursement was higher than what was received for seeing clients for follow-up visits, leading to a managerial preference to see new clients. Another informant described how this pressure created a temporal tension between funding bodies' requests and the realities of making clinical diagnoses:

*They [donors] want diagnoses in the first session; they cannot understand it sometimes takes longer to make the diagnosis. So, I say "Ok, if you need to know the diagnosis I will give you my first impression, but I cannot make a full diagnosis at this time."*

Informants also described another factor informing how clinics respond to their financial constraints. Donors (such as private foundations and governmental grants) are typically tied to one to two-year funding cycles. This short cycle length encourages donors to force clinics to collect and report on short-term indicators (e.g. how many sick patients seen, how many initiated on pharmacotherapy), rather than what they felt are more relevant longer-term metrics like symptomatic resolution and social functioning.

The pressure to make additional diagnoses was differentially sensed at different organizations. Larger, better funded organizations operating at larger economies of scale appeared to apply less coercion on staff to make additional diagnoses, with smaller organizations making more use of this kind of pressure. One informant working as a

psychiatrist at a larger organization said, “[If a diagnostic quota is not met] the staff will be blamed and they will try to increase the target.” This informant went on to say that they had not witnessed severe repercussions for psychiatrists at their organization who consistently underperformed their quota. However, they stated that “in other organizations yes, [you might be fired].”

### 5.2—Financializing trauma

Some providers discussed how donors (typically private foundations) demanded specific confidential information about clients for use in research and to use for fundraising campaigns:

*Some private donors want to know the patient’s trauma story and want their confidential information for their own data. And my manager told me, yes you should send them all the data.*

This provider went on to describe how this practice felt exploitative; that the clients were not being consented to having their information used in these ways and that it was being done without their knowledge. For this provider, this practice brought up issues surrounding trauma voyeurism. For the clinics though, providing more diagnoses and the trauma stories that donors requested helped to ensure future funding.

### 5.3—Resisting financialization pressures

Despite these pressures, the providers whom I interviewed felt that they had their own ways of resisting these financial pressures:

*It [this pressure to diagnose] is unethical... but for me—alhamdulillah—I didn’t open a file for a client who wasn’t really suffering, who really couldn’t benefit. If he is free of any psychological problem, I will write he is free.*

And yet, it is unclear how this informant has chosen to problematize the issue of “benefit.” In other words, how and where is the threshold of benefit versus harm for the patient set? And, is that value strictly being located within the patient, or in consideration of the patient’s larger social context? For this informant, it was enough if the client would gain some relief of psychosocial suffering from engaging with the clinic. Many individuals who have any degree of psychosocial suffering might benefit from being seen by mental health providers, but in whom assigning diagnoses would be unethical.

## Domain 6: Problematizing cross-cultural diagnostication

### *6.1—Validity of “Western” diagnostic criteria*

The majority of informants discussed concerns about the validity of using diagnostic criteria developed in the stream of European and American traditions of philosophy of mind and psychiatry, i.e., “Western psychiatry.”

*I also have doubts about these diagnosis because they often don’t have the full tools to make these diagnosis... They are using Western tools that have not been validated in Jordan, or for Syrians living in Jordan, or account for educational differences.*

Despite the gap in validated tools for diagnosing certain conditions, in regard to trauma and PTSD, the majority of informants from Jordan and Syria felt that the model of PTSD as understood in the Western psychiatric tradition was very translatable to how trauma is conceived and experienced by their clients:

*I think it is similar in our culture. When you ask anyone, “What do you think about the trauma,” they wouldn’t say it is psychological trauma, they say “It’s a shocking incident.” They say, “We are shocked.” Any individual in our culture when you ask about psychological trauma they will say, “I am shocked because something unexpected happened to me and it impacts me deeply, especially from the person who is very close to me or anything that is very close to me impacts on my life [sic].”*

## 6.2—Irrelevance of validity

All informants interviewed emphasized that, whatever the limitations of applying Western psychopathological taxonomies to their clients are, these limitations can be escaped in large part by directing their care towards the experienced symptoms, the “small problems” of daily living:

*If somebody comes to the clinic with difficulty sleeping, low mood, low energy, eating difficulties the psychiatrist will make the diagnosis of depression easily. But instead of focusing on and treating “depression,” we should instead make a care plan that addresses the sleeping and eating problems and low energy.*

## Domain 7: Co-constructing images of the migrant

### 7.1—Resettlement process as neutral observer

Speaking with a high-level director who helps oversee global refugee resettlement processes, the informant stated that officially, carrying a diagnosis of PTSD does not affect the likelihood of your application for resettlement being approved.

*Having a PTSD diagnosis doesn't harm or doesn't help. These countries have exclusive conditions—there are mental health checks, if you have them then you cannot go. The other conditions are not preventing you to go, purely from a bureaucratic perspective.*

It is worth noting the informant's language in stating, “purely from a bureaucratic perspective.” The informant implies that these are the official directives on an international level, but that there is hypothetically room for supra-regulatory decision-making on the part of state actors at the level of state policy or state officials involved in the resettlement process.

Many of the informants interviewed were directly involved in the preparation of mental health assessments for use by their clients in the resettlement application process.

In general, it was felt by the informants that the officials at the resettlement processing centers were impartial towards their clients' applications, or even tended towards a stance of advocacy on their behalf:

*Sometimes they [states' resettlement processing centers] will ask for more details and clarification, and it is for this reason that I think they are using this information to support the refugee's case for resettlement. I think they are asking for the details to push the case forward.*

In the case of the United States resettlement process, an American attorney reported in an interview that the resettlement adjudication hearing is a non-adversarial encounter (in the legal sense) in which attorneys are not allowed to be present with the client for the hearing. This informant felt that despite this lack of transparency and missed opportunity for client advocacy, that the adjudicators were typically working in the interests of the client.

## *7.2—How organizations view Syrians*

Informants with scholarly backgrounds or who worked at higher managerial positions in organizations described the changing shape of how international organizations are approaching PTSD in the Syrian context. One American scholar described “the trauma wars,” a tongue-in-cheek reference to a period of intense debate in the early 2000s where scholars and directors of international organizations tried to find policy answers to the question of managing post-conflict PTSD. On one side were those who preferred to focus on the biomedical model of PTSD and adhere to stringent clinical criteria and treatments including pharmacological interventions. The other group felt that global mental health as a field had become fixated on PTSD as a result of sociopolitical and cultural reasons, and that the symptoms observed in post-conflict populations were being overly pathologized. With the creation and adoption of the Inter-Agency Standing Committee (IASC) 2007

Guidelines, it was established within global humanitarian doctrine that an approach focused on alleviating “psychosocial suffering” should be taken when working with post-conflict populations, rather than an intense focus on making PTSD diagnoses. One informant described their understanding and personal practice regarding this issue:

*I like to avoid utilizing the trauma terminology too much, and there is a movement within MHPSS [Mental Health and Psychosocial Support] to try to not focus on it too much. If we think about PTSD, as a diagnostic term, yes for sure some people will experience PTSD, but they also might depression, anxiety, or absolutely nothing pathological at all, but just might have stress in response to the situation. So we try to de-pathologize it a bit more, because we always say that statement [sic] “normal reactions to abnormal events.”*

Although many informants shared similar views and treated PTSD in a similar fashion, other informants described what they felt as a worrisome rise in re-emphasizing the centrality of PTSD on a global, institutional level:

*[In 2007], we all agreed that it [PTSD] shouldn't be the central focus [of our efforts], but somehow in the last few years it is coming back. I think probably we are too reliant that we had reached an agreement—then the superpowers of the medical model came back into the picture... Or it might be simply, that in a way, the migrant influx is changing the discourse.*

The informant did not elaborate on how they felt that the influence of the “superpowers of the medical model” had waxed in recent years, nor how the political effects of post-Syrian War migration have shaped the current discourse. This informant did go on to describe how the proponents of the medicalized model have “a strong belief that we are doing the best for people, but [over-emphasizing diagnoses] decontextualizes suffering.” In other words, for this informant, the lived experiences and the sociopolitical causes of migrants’ suffering are diminished while the pathology is fixed more securely within their conceptualized selves.

### 7.3—Discourse

Several informants spoke to the interplay between the PTSD diagnosis, contemporary political discourse on trauma, and how they inform or reinforce one another. One informant said that when institutions mark displaced Syrians with the PTSD diagnosis, they “objectify them as a pathologized person, rather than having to recognize the problem that you [Western governments] have created.” Another informant explained how this happens in the ontological mode:

*Part of receiving the diagnosis of PTSD is dehumanizing. It says to the patient that there is a trauma in your past and that your ability to have humanity is damaged because of that broken symbolic link. The symbolic chain is fragmented.*

Here, the informant is referring to concepts understood from their background in Lacanian psychoanalysis. The wholeness of the symbolic chain, they believe, is required to experience the totality of one’s humanity. In their view, not only is the client the audience of this psychoanalytically derived rupture, but implicitly, so too are the constituents of societies viewing the client at distance. This works directly in opposition to the stated goals of clinicians attempting to frame PTSD as “normal reactions to abnormal events.”

Another informant stated that this dehumanization has direct implications for the desirability of displaced Syrians to be received by other societies. “The discourse of the traumatized migrant becomes a discourse about integration, these people will be difficult to integrate.” They tied this to the contemporary geopolitical situation in the post-9/11, post-Syrian War era, wherein:

*Migration is managed as a risk with a risk management approach. Increasingly after 9/11 the discourse has become a discourse governed by security and risk. Basically, the important information you want to know about migrants is—how risky they are, how many risks they bring to you, to your system, to public health. This creates entire systems that look for vulnerability, and when you look you will find it.*

For this informant then, the overemphasis on the PTSD diagnosis not only reinforces the image of the displaced Syrian as a security threat, but supplies a *raison d'être* for the securitized framework, and also leads to futural pursuit of these “security threats.” A perpetual motion machine is activated to reify the dehumanized construct of the displaced Syrian. Finally, this informant concluded with a warning, saying that although for states like the US, PTSD does not currently qualify as a diagnosis of resettlement exclusion, but “that doesn’t mean it won’t become one in the future. That’s another story.”

## Discussion

This study sought to identify and understand the interweaving structures and socially mediated forces that influence the use of PTSD as a diagnostic category in internationally operated mental health clinics serving displaced Syrians living in Jordan. Fifteen themes were identified and nested within seven broad domains: ambiguity of client histories, clinical criteria, client agency, state of the profession, financial incentives, problematizing cross-cultural diagnostics, and co-constructing images of the migrant. Rather than discussing the domains in sequential order, a synthesized analysis will follow. The primary data will be problematized through the analytical lens of Foucauldian streams of theory and transformed through a framework rooted in scholarship from the black radical tradition. Here, viewing PTSD diagnostics through one aperture, we see an insidious manifestation of Foucault's carceral archipelago. From another aperture, not in opposition but instead forming a productive dialectic, we see a social and psychic space ripe for place-making through the concept of abolitionist geography. On one hand subjection to state and institutionally-based control and fragmentation—on the other, a reimagining of “governability” and collectivizing.

### I. PTSD Diagnostics as Carceral Archipelago

To understand how the current state of PTSD diagnostics in Jordan can be conceptualized within the framework of the carceral archipelago, Foucault's ideas on governmentality, the medical gaze, and power relations must first be outlined. According to Dean et al, for Foucault, “government is any more or less calculated and rational activity,

undertaken by a multiplicity of authorities and agencies, employing a variety of techniques and forms of knowledge, that seek to shape conduct by working through the desires, aspirations, interests and beliefs of various actors, for definite but shifting ends and with a diverse set of relatively unpredictable consequences, effects and outcomes.”<sup>20</sup> These techniques and forms of knowledge are ultimately challenged by fluctuating social, cultural, and power dynamics, stimulating actors to adjust the techniques they employ to control the behaviors of a society. Foucault introduced Bentham’s concept of the panopticon into his theory of governmentality. In this metaphor, a prison is constructed as a multi-leveled torus with a central clearing. In the center stands a guard tower, towards which the prisoner’s cells are faced. With one-way mirrors surrounding the tower, prisoners cannot know when the guards are specifically surveilling them. Under constant threat of observation, the prisoners begin to modulate their own behavior without external intervention. According to Hancock, “as the gaze of surveillance is turned upon oneself, self-scrutiny becomes the most pervasive and effective form of social control. Foucault conceptualized the panopticon as a template for all forms of social control in modern society.”<sup>21</sup> For Foucault, governmentality, as conveyed through the channels of surveillance, is thus decentralized, ubiquitous, and encourages self-regulation rather than direct correction by the state. “He who is subjected to a field of visibility, and who knows it, assumes responsibility for the constraints of power; he makes them play spontaneously upon himself; he inscribes in himself the power relation in which he simultaneously plays both roles; he becomes the principle of his own subjection.”<sup>13</sup>

To apply this logic as it has been thus developed in this argument to the situation of PTSD diagnostics in Jordan could lead to conclusions about the nature of subjection

and subjectification—how Syrian migrants subject themselves to a system to be essentialized as “people with mental illness,” and the damage that goes in hand with that process. The associated questions of rights gained through the dialectic process of subjectification (gaining agency) would then follow. These questions have been covered at length by several authors including Fassin, Ticktin, and others.<sup>6,12,22,23</sup> Instead of resting among these questions, the argument can be expanded towards Foucault’s concept of the carceral archipelago to allow for greater engagement with the primary data. Hancock summarizes the metaphor of the carceral archipelago as “the way that the body is always ensnared in a plurality of social relations, which are constantly surveilling, observing, conditioning, regulating, and normalizing it within the workings of everyday life.” Power relations are “both dispersed and running through the entirety of a society, power relations are not a merely unidirectional gaze; “rather, they are the intersecting and crisscrossing lines of socialization within which we are embedded.”<sup>21</sup> In other words, it is not simply that there is only one group, in this case the Syrian migrant, whom the state seeks to control. The exercise of governmentality is explicitly not confined to the institutions of the state, but include non-state institutions, associations, and racial and class-based groups, each co-existing in an ecosystem of power. The concept of the carceral archipelago allows for groups at all levels of the power hierarchy to exist in a dynamic interchange, a multiplicity of ties, including the directors and clinical staff at international organizations providing mental health services for Syrian migrants.

A brief contextual digression is needed to describe the mental health services infrastructure in Jordan. Mental health services for Syrians in Jordan are primarily split between clinics run by INGOs (particularly International Medical Corps [IMC]) and newly

integrated primary care-mental health clinics operated by the Jordanian Ministry of Health in collaboration with the WHO. The UN Mental Health and Psychosocial Services (MHPSS) Working Group is chaired by representatives from IMC and WHO. This working group, along with UNHCR and the Ministry of Health, help to coordinate the MHPSS activities for Syrians in the country. The development of mental health infrastructure in Jordan was catalyzed by the involvement of INGOs and global governance responding to the influx of Iraqi migrants following the Iraq War. Prior to their involvement, there was no systematic, organized approach to providing mental health services for the country. The Jordanian government first published a national mental health plan in 2011 following the recommendations of a WHO commission. MHPSS services have been further strengthened via foreign donors and global governance in the last seven years in response to the Syrian War.<sup>10</sup> Mental health stigma is not limited only to illness and service users but to service providers as well. Many non-psychiatric medical specialists and medical students view mental health as pseudoscience and illegitimate. At the 2018 Muslim Mental Health Conference in Amman, many discussions for young students centered around methods for confronting their parents' pressures to reconsider their choice to pursue mental health careers, which many participants felt was the single largest barrier to cultivating adequate numbers of mental health providers in the region.

With this context in mind, it is possible to consider who might be the constituents within the metaphor of the carceral archipelago. The interconnected web of actors spans migrants, their peer networks, (I)NGOs and clinical staff, the Jordanian Ministry of Health, foreign funders (especially government entities), and global governance structures (UNHCR, IOM). The present discussion will flow from the local on towards transnational

forces. Again, the topic of how trauma functions to modulate claims to rights for migrants has been discussed by many scholars in other contexts, particularly in the work of Fassin and Ticktin.<sup>12,22</sup> This is a complex topic, whose treatment here will remain brief. It suffices to say that amongst the interviewed providers working with Syrian migrants it is reported that there are widely varying narratives about the utility (as it relates to resettlement) of carrying a mental health diagnosis like PTSD. Some Syrians believe that it is harmful to their resettlement application, while others believe that it is essential for a successful dossier. This latter viewpoint is said, according to professionals interviewed in this study, to explain much of the artificially elevated epidemiological studies being conducted on Syrians. This finding has been noted by many authors, including in an article authored by a psychiatrist who has worked extensively with Syrian migrants under the auspices of the WHO, stating that he and his co-authors' "clinical experience concurs with evidence in the literature that a classic PTSD diagnosis has many limitations in this context and does not accord with the clinical picture of many of the refugees we have treated."<sup>8</sup> In other words, some providers point to these prevalence studies as proof (in addition to clinical experiences) of the notion that some Syrians misrepresent their mental health symptomatology because they believe it will benefit them (in resettlement, or by receiving additional services in Jordan). This phenomenon falls in line with Fassin's analysis, which suggests that in the moral economy of the contemporary globalized world there is tremendous utility in migrants' seeking validation of their suffering and rights as claimants.<sup>12</sup>

Considering this context, it is conceivable that there are certain ways in which local mental health providers both consciously and subconsciously make use of international funding streams and global governance structures in order to rationalize the validity of their

profession. As a concrete example, psychiatry training programs are the only post-medical doctorate training programs where trainees are not paid and in fact must pay tuition. Lack of governmental funding extends past training throughout the practice as a whole, creating need for external (and often international funding). This is reflected in the anxieties expressed by Jordanian practitioners within the profession and students considering mental health as a specialty, as demonstrated in this study. In Goldstein's analysis of Foucault's discussion on professional knowledge and professional self-interest in *Discipline and Punish*, she argues that in addition to the subconscious responses of professionals to the "faceless bureaucratic apparatus" of the state, there is also ample space for intentional self-interest within a profession. Self-associating with Western organizations and funders provides at least two benefits to Jordanian practitioners and organizations. They gain access to funds, and to "Western legitimacy" to enhance the validity and viability of their profession. One Syrian physician articulated the general situation, not specifically in the Jordanian context, in this way: "the organizations who work in mental health with Syrians care just about prestige and donors... They do things just to be able to say that [they] did something, not to actually effect change."<sup>24</sup> By demonstrating inflated prevalence data, providers and organizations are able to demonstrate extreme need and thus make dramatic appeals for continued funding as those streams dry under the duress of the current political environment (MHPSS funding was 47% of target for Jordan in 2017). It may thus be concluded that local clinicians and organizations serving Syrian migrants are making use of the PTSD diagnoses for reasons outside of the direct purpose of benefiting their clients. In other words, an instrumental use of the practice of psychiatry has evolved in this setting.

In regard to transnational forces, it is important to first acknowledge the current political climate. In Western countries including the US, the UK, and Germany, rising tides of right-wing conservatism are encouraging the expression of xenophobic sentiments and politicians articulating these views have won many campaigns in the past few years.<sup>25</sup> One example of these shifting political views finds expression in the repatriation movements, seen both in the US and Germany where either right-wing organizations or members of government themselves have begun advocating for the return of migrants to their home countries including Syria, which they find themselves oddly arguing is safe to return to despite obvious evidence to the contrary. There has also been an upsurge in many Western countries of the narrative of the “traumatized refugee” who is at once violent, emotionally stunted, and unable and unwilling to integrate into society.<sup>26</sup> Given these trends, it is essential to question how over-diagnosis and poorly conducted epidemiological studies may contribute to and unwittingly validate this stereotype. Another consideration that must be made is what effect these changing views may exercise on the state-backed channels of migration. According to the Institute of Migration, the primary UN body which orchestrates the resettlement process, there are mental health “exclusion criteria,” that if present, will automatically disqualify the migrant for resettlement. These criteria vary by host country. For the US, the two exclusion criteria used are 1) active suicidality/homicidality, or 2) having a diagnosed substance use disorder. Without discussing the aporia of those two criteria, we must consider also that, according to the MHPSS director of IOM, that countries can modify or add exclusion criteria at will. As xenophobic sentiments towards the “traumatized refugee” continues to grow, it is within the realm of possibility that Western governments would consider adding further exclusion

criteria, such as PTSD, to severely curtail future resettlement. Whether the pressures to overdiagnose PTSD in Syrian migrants is emanating from actors within the carceral archipelago intentionally or unintentionally, it is clear that the diagnoses is serving an instrumental purpose. The act of making a PTSD diagnosis is serving a political function. According to Van Voren, the political instrumentalization of psychiatry has been historically framed dichotomously as totalitarian instrumentalization versus colonial instrumentalization.<sup>27</sup> In the context of PTSD diognostication in Jordan, I argue that both forms of instrumentalization are taking place, or at the very least, space has been created for the facile enactment of both forms of instrumentalization.

Ramos and others have written extensively about the co-optation of psychiatry by totalitarian regimes in South America and Eastern Europe who used mental illness as expedients to institutionalize political opponents without trial.<sup>28</sup> These trials represented the most direct and dire political instrumentalization of psychiatry, which occurred when governments sought politically acceptable means of suppressing opponents: “psychiatry was used as a kind of mask with respect to the real objectives of totalitarian regimes.”<sup>29</sup> The other mode, colonial instrumentalization, has been discussed in the context of Canada, Algeria, and Australia amongst other histories. Writing on the devastation of indigenous communities in Canada, Kral states that “the civilizing mission of colonial psychiatry [contributed] to the destruction of social organization.”<sup>30</sup> By labeling and pathologizing alcohol dependence among the Inuit, the problem was constructed as a personal deficiency. These characterizations helped the state argue for further dismantling Inuit communities and family separation.<sup>31</sup> The Canadian government’s intentional fragmentation of Inuit society was thus disconnected from the alcohol dependence epidemic. In parallel, the

psychological effect of receiving a PTSD diagnosis is not always benign; many authors have discussed the trauma diagnosis and its dehumanizing effects. As alluded to earlier, the trauma diagnosis acts to re-center the “problem” away from the effects of geopolitics, and towards personal inadequacy. This concept was also discussed by several of the informants in this study. In other settings such as during the Algerian civil war, revolutionaries were diagnosed with psychotic disorders, effectively obliterating the intellectual force of their demands for freedom and autonomy.<sup>32</sup> This represents the totalitarian version of instrumentalization. In parallel, the Syrian migrant is diagnosed with PTSD, a binary characterization subsequently subjected to the decision making of the global refugee resettlement regime. This, in theory, could provide a simplified route for denying resettlement applications, following the currents of international political sentiment. Therefore, the overdiagnosis of PTSD may represent an instrumentalization of psychiatry that hybridizes the totalitarian and colonialist forms by policing bodies (by controlling Syrian migrant movement) and by injecting discord into a historically colonized community (by requesting independent psychiatric evaluations of Syrians within a system which they have directly contributed to the process of overdiagnosis). Bridging these two forms of instrumentalization becomes a self-reinforcing and self-sustaining process of oppression. This instrumentalization then appears as a central feature of the relations within the metaphor of the carceral archipelago. The tensions between the actors within it, in the name of “care and rescue,” are what Ticktin describes as “antipolitics”—the incoherent network of power distributed amongst these actors who ostensibly deny political will are—through their incoherence—affecting

political change which “ultimately work to reinforce an oppressive order... reproducing inequalities and racial, gendered, and geopolitical hierarchies.”<sup>22</sup>

## II. Abolition Geography: Marronage, Time, and Rememory

Despite the immense attention given to the conflicts in MENA since the beginning of the Arab Spring and the focus on the accompanying psychological trauma, it is evident that “it has been difficult to translate this shared observation into a politics of social or global justice.”<sup>11</sup> Having problematized the study data from the perspective of the Foucauldian carceral archipelago, I turn now to what I propose as its dyadic partner: abolition geography, taken from black radical scholarship. Utilizing concepts from abolition geography in this context is appropriate within the rubric of emancipatory internationalism—itself a school of thought in the black radical tradition. For example, Ortiz and Morelo have written on the subject of recognizing international solidarity which transcends national borders between the US and Latin America, and with Palestine. “Activists on both sides of the Atlantic have been articulating connections of solidarity and support for the last several decades—from meetings held in Algiers between representatives of the Black Panther Party and Fatah in 1969 to the contemporary collaboration of Black and Palestinian hip-hop artists... to the use of civil rights iconography by Palestinians protesting segregated streets and bus lines in the occupied West Bank.”<sup>33</sup> For Ortiz, it is racial capitalism—deriving social and economic benefit from racialized identities—that is the central fulcrum provoking these geographically disparate movements for emancipation.<sup>34</sup> Part I of the discussion attempted to answer what some of these “social and economic benefits” of overutilizing the PTSD diagnosis are. According

to Gilmore, abolition geography “shows how relationships of un-freedom consolidate and stretch, but not for the purpose of documenting misery. Rather, the point is not only to identify central contradictions—inherent vices—in regimes of dispossession, but also, urgently, to show how radical consciousness in action resolves into liberated life-ways, however provisional, present and past.”<sup>35</sup> In other words, how can the concept of abolition be used to “pierce the future for hope?”<sup>36</sup> There are two concepts stemming from abolition geography that might lend provisional guidance towards liberative thinking: marronage and a critical reappraisal of the construct of time.

Here I again begin with the question of Syrian migrants and clinicians as governable subjects. From within the black radical tradition, Quan writes that governability is ontological: “we are the way we are governed, and being ungoverned is nonbeing. State evasion and other forms of avoidance of being governed are deviant behavior that necessitates disciplining, from reconditioning to total annihilation.”<sup>37</sup> In part as a result of this, in the face of “annihilation” or non-existence when evading the state, Quan argues that we inhabit an era of state-addiction. Citizens, migrants, clinicians; each depend on the state to confirm our existence through legal documentation, and even closer to the core of our actualized selves, the roles that we define for ourselves. What is a Syrian migrant without documentation? The narrative desired and imposed by the state is that of nonbeing. A migrant must submit herself to the authority of state-sponsored migration or exist in suspension. In this sense, Quan’s view of governmentality goes beyond just composing the networks of power which hold the archipelagic actors in constellation, but contributes to defining the shape and form of the constituents themselves. In the face of totalizing erasure, scholars of the black radical tradition point to maroon communities and the reappraisal of

time as provisional solutions to mitigate the degree of control that states are able to exert on the subaltern.

After the “discovery” of the New World, groups of Blacks and Amerindians began fleeing the impositions of white settler-colonialism, establishing camps and communities outside the governance of the colonists. These maroon communities existed throughout the Caribbean and the Americas. In what is now the United States, large communities of escaped slaves existed in Florida and Louisiana.<sup>38</sup> “Through community building, where the terror and violence of racial capitalism and white supremacy were temporarily suspended, free men and women negotiated their own terms of living, and in the process, negated the terms of order.”<sup>37</sup> These maroon societies provided a commensurate response to the totalizing subjugation of chattel slavery—corporeal and psychological existence while choosing to refute external rule-making. How can this legacy be applied to the PTSD diagnostic archipelago? Creating physically constituted maroon societies, while not impossible, would present myriad challenges for migrants already living directly on the edges of the chasms of liminality. Instead, the question must be: how can we form and reinforce existing affective and mentally constituted maroon societies? Cedric Robinson, a central figure within the black radical tradition, wrote that the focus of the black radical tradition has always been “on the structures of the mind. Its epistemology granted supremacy to metaphysics not the material.”<sup>39</sup> What are the bonds of humanity and solidarity that can be emphasized which can have lives outside the projections of state power?

Significantly, we must realize that as we ask ourselves these questions, the answers are abundantly available in the present. As such it is important to recognize the value in

refocusing our minds to have an awareness to, as Sojoyner has pointed out, that Western constructions of time can and are used as mechanisms of control. According to his formulation, time is presented as a blank canvas within which individuals must make decisions about how to spend their time. Its construction as universal, unbounded, and equivalent for all people allows choice to be the central determinant of our life trajectories. “Within the paradigm of choice, the individual chooses how to use time. Choice as an operative of Western constructions of time works to move the individual beyond the perils of structural circumstance.”<sup>40</sup> Considering the use of time in the immigration regime: consultation time, processing time, appeal time, decision-making time; all maintain the migrant in a field of stasis, one that asks the migrant to look forward in time towards a nearly intangible future. In fact, time does not even begin until he submits himself to the immigration process. And yet for many migrants this remains the best use of their time. When the state-sponsored narrative of their present circumstances is constructed as strictly temporary, futural thinking is encouraged, amongst migrants and the organizations and clinicians who serve them, at the expense of considering the present. We see this in the counterproductive two-year funding cycles that many INGOs in Jordan function on, forcing them to—in the present—to focus primarily on interventions and metrics that will secure their future. What might be accomplished if that gaze is turned towards the present? Speaking on the Israel-Palestine conflict, Burris writes that to grasp at and move towards a more liberated future for Palestine, “one does not have to look to the mythical heavens or peer into a crystal ball. Instead, one has only to uncover the ways in which the Palestinian future is already lying dormant all around us. Each moment that Zionism fails—that is, each instance in which the specter of Palestinian liberation manages to seep through the

governing order's cracks—we do not only see glimpses of the Palestinian past; we also see traces of the Palestinian future.”<sup>33</sup> Running in parallel then, each moment that the subjugating force of PTSD diagnostication fails, each time that it fails to reconstitute the migrant as a governed object rather than a self, a liberated future of the Syrian migrant is illuminated. Each time that a new intervention or metric exists less for the future propagation of the organization and more for the sole benefit of the client, a liberated future is found.

This abundant future-present, through the pursuit of mental marronage and reappraisal of time, could be consistently illuminated through the practice of what Toni Morrison has called “rememory.”<sup>41</sup> The characters in her novel, *Beloved*, live “in a society and a system in which the conquerors write the narrative of their lives. They are spoken of and written about – objects of history, not subjects within it”—an attribution that would equally apply to Syrian migrants. To combat the binds of the carceral archipelago, Morrison would offer the practice of pursuing rememory—“recollecting and remembering, as in reassembling the members of the body, the family, the population of the past.”<sup>41</sup> Each time that migrants and their clinicians refuse the pressures to apply diagnostic labels which simplify, dislocate, or essentialize the migrants' experiences is an act of rememory; each time a clinician engages a migrant and explores their past, their present, and future, and the mechanical application of diagnostic criteria is not the end-goal, it is an act of rememory. When organizations reflect critically on the antipolitics in which they are engaged, and how the shadow of their antipolitical agenda erases lived experiences, it is an act of rememory. When researchers and scholars critically examine the forces compelling their research agendas and the antipolitical implications of their findings within global

sociopolitical context, it is an act of rememory. The cultural production of Syrian and other middle-eastern artists and authors vividly reinforce the notion that “remembering and suffering are crucial positions against state violence and patriarchy that seek to erase and hide the traces of violence they committed.”<sup>11</sup>

### III. Conclusion

This study initially attempted to understand ontologies of psychological trauma in Syrian migrants living in Jordan, but ultimately developed into an inquiry into the sociopolitical and cultural factors influencing PTSD diagnostication in the same population. It considered the role clinicians, care organizations, immigration processes and structures, and international political climates. The qualitative results were synthesized into a critical theory-informed analysis to appraise the phenomenon of PTSD overdiagnostication. Foucault’s concept of the carceral archipelago was used to problematize the phenomenon as a form of hybridized totalitarian and colonialist instrumentalization of psychiatry. Marronage, reappraisal of time, and rememory, each stemming from abolition geography within the tradition of black radical scholarship, were borrowed in an effort to explore alternative affective and mental schema which might provide further questions in the pursuit of liberating Syrian migrant narratives and existences from the antipolitics of PTSD diagnostication.

### IV. Limitations

There were several limitations to this study. First, this research was limited by our sample in that we did not include Syrian migrants. This is a significant limitation that occurred

because our team did not feel that the emotional cost to the interviewees would outweigh the value of knowledge created through this project. While their input would be significant, there are other conclusions which were available and that were made, based on the information gathered from informants who make decisions about how diagnostics occur. The sample was also limited in that we were not able to interview any informants working for the Jordanian government or for the US government; this necessarily introduced a need for more assumptions about what the explicit intentions of these governments are. While we reached out to these groups, we were denied interviews. However, this inquiry is focused more on the implicit and unintentional, or antipolitical actions, of the involved actors. Second, as with all quantitative data, the information was self-reported by our informants and was only verifiable to the extent that themes were repeated amongst informants. Third, the data reported in this study are subject to change as the political climate and policy structures change, which can happen rapidly and frequently in Jordan. Finally, this research project was approached from a transformative-emancipatory research paradigm, which may have introduced bias by sensitizing the focus towards structures of oppression rather than other dynamics affecting the process of PTSD diagnostics.

## V. Recommendations

This research, as a qualitative study, is intended to be hypothesis generating. As such, the recommendations provided here are necessarily provisional. The recommendations are aimed towards only certain actors that were identified as constituents in the metaphor of the carceral archipelago. Importantly, they do not include recommendations for Syrian

migrants as they were not included as informants in the study, as discussed in the limitations section, nor do I possess the positional authority to make claims in that domain. Each recommendation echoes a particular theme discussed in the 2018 Middle East – Topics & Arguments Journal edition on trauma, where it is recommended that all actors in fields interacting with trauma in the Middle East be attentive to “the political implications of discourses on trauma, but also how certain political regimes use(d) violence and traumatization as a tool to produce human devastation and submissive subjects, and how oppositional groups counter these devastating politics by creating their cultural trauma.”<sup>11</sup> Put another way, a salient focus on the phenomenon of trauma in the Middle East must be about the antipolitics of care and methods for supporting rememory activities.

In regard to international organizations and their practitioners involved in providing mental health services to Syrian migrants, there are two recommendations. First, these organizations should implement a root-cause analysis approach to understanding the specific pressures to make use of the PTSD diagnosis, particularly with a focus on reimbursement schemes.<sup>42</sup> This analysis should be attentive to contextual factors and psychological factors as discussed in the seminal text by Johns.<sup>43</sup> These investigations should be conducted by commissions outside the direct chain of command. Second, these organizations and the service providers working with them should consider how their services are a form of antipolitics: how do the decisions about where, to whom, and how they provide care have external political effects on local, national, and international contexts? Bioethical principles must be applied to these political considerations, in addition to their standard application to provider-client exchanges. Are these externalities aligned with the desires of their clients and their communities? How do the prerogatives of Global

North states shape their clinical practice and contribute to the erasure of subaltern experiences? What steps can be taken in the present to reinforce intellectual and emotional maroon communities which resist these prerogatives? What steps can be taken to participate in the active support of rememory for Syrian migrants?

In regard to recommendations for researchers, future projects should continue to explore the social, political, and cultural factors which shape how PTSD diagnostics is used in clinics for Syrian and other migrants with a focus on more specific contexts. Qualitative research should be conducted to identify ways that mental health practitioners in these settings use intentional strategies to encourage reappraisals of time and rememory to counteract state-driven narratives of trauma. Other related research should investigate associations between epidemiological data, political messaging, and public perception of migrants as traumatized individuals. All research on these and related topics should be as aligned with the values of community-based participatory research as possible, and include members of the constituent community as co-investigators.<sup>44,45</sup> As Wallerstein wrote in his book on power and discourse, *European Universalism*, to avoid the Orientalist trap we must “accept the continuing tension between the need to universalize our perceptions, analyses, and statements of values and the need to defend their particularist roots against the incursion of the particularist perceptions, analyses and statements of values coming from others who claim they are putting forward universals.”<sup>46</sup> All research, particularly that which is funded and conducted by investigators from the Global North, must acknowledge this tension; there will always be limits about what is appropriate for us to make conclusions about, and that there will be always be sanctified epistemological spaces that only the voices of the subaltern can fill. Despite that, we must be reminded that

“revolutionary action entails a process of uncovering something that already inhabits the shadows of the present,” and our research agendas should reflect this reality.<sup>47</sup>

## References

1. Key Migration Terms. International Organization for Migration, 2019. (Accessed December 28, 2019, at <https://www.iom.int/key-migration-terms#Asylum-Seeker>.)
2. IASC Guidelines on Mental Health and Psychosocial Support in Emergency Settings. 2007. at [https://www.who.int/mental\\_health/emergencies/guidelines\\_iasc\\_mental\\_health\\_psychosocial\\_june\\_2007.pdf](https://www.who.int/mental_health/emergencies/guidelines_iasc_mental_health_psychosocial_june_2007.pdf).)
3. Nkrumah K. Neo-colonialism: The last stage of imperialism. 1967.
4. Hassan G, Ventevogel P, Jefee-Bahloul H, Barkil-Oteo A, Kirmayer LJE, sciences p. Mental health and psychosocial wellbeing of Syrians affected by armed conflict. *Epidemiol Psychiatr Sci* 2016;25:129-41.
5. Fabrega Jr H, Nguyen Jr HJP. Culture, social structure, and quandaries of psychiatric diagnosis: A Vietnamese case study. *Psychiatry* 1992;55:230-49.
6. Fassin D, Rechtman R. The empire of trauma: An inquiry into the condition of victimhood: Princeton University Press; 2009.
7. Alarcón RD. Culture, cultural factors and psychiatric diagnosis: review and projections. *World Psychiatry* 2009;8:131-9.
8. Barkil-Oteo A, Abdallah W, Mourra S, Jefee-Bahloul H. Trauma and resiliency: a tale of a Syrian refugee. *American journal of psychiatry* 2017;175:8-12.
9. Bracken PJ, Giller JE, Summerfield D. Psychological responses to war and atrocity: The limitations of current concepts. *J Social Science and Medicine* 1995;40:1073-82.
10. Quosh C, Eloul L, Ajlani R. Mental health of refugees and displaced persons in Syria and surrounding countries: a systematic review. *J Intervention* 2013;11:276-94.
11. Milich S, Moghnieh L. Trauma: Social Realities and Cultural Texts. *Middle East-Topics & Arguments* 2018;11:5-15.

12. Fassin D. Humanitarian reason: a moral history of the present: Univ of California Press; 2011.
13. Foucault M. Discipline and punish: The birth of the prison, trans. Alan Sheridan. New York: Vintage Books; 1977.
14. Tyson L. Critical theory today: A user-friendly guide: Routledge; 2014.
15. Boser S. Power, ethics, and the IRB: Dissonance over human participant review of participatory research. *J Qualitative Inquiry* 2007;13:1060-74.
16. Goodman LA. Snowball sampling. *The annals of mathematical statistics* 1961:148-70.
17. Glaser BG, Strauss AL. Discovery of grounded theory: Strategies for qualitative research: Routledge; 2017.
18. Miles MB, Huberman AM, Huberman MA, Huberman M. Qualitative data analysis: An expanded sourcebook: Sage; 1994.
19. Bradley EH, Curry LA, Devers KJ. Qualitative data analysis for health services research: developing taxonomy, themes, and theory. *Health services research* 2007;42:1758-72.
20. Dean M, Zamora D. Did Foucault Reinvent His History of Sexuality through the Prism of Neoliberalism? *Los Angeles Review of Books* 2018.
21. Hancock BH. Michel Foucault and the problematics of power: Theorizing DTCA and Medicalized Subjectivity. *The Journal of Medicine and Philosophy: A Forum for Bioethics and Philosophy of Medicine*; 2018: Oxford University Press US. p. 439-68.
22. Ticktin MI. Casualties of care: Immigration and the politics of humanitarianism in France: Univ of California Press; 2011.
23. Loyd JM, Ehrkamp P, Secor AJ. A geopolitics of trauma: Refugee administration and protracted uncertainty in Turkey. *Transactions of the Institute of British Geographers* 2018;43:377-89.

24. Brykalski T, Rayes D. " It's a power, not a disease": Syrian Youth Respond to Human Devastation Syndrome. *Middle East-Topics & Arguments* 2018;11:30-42.
25. Greven T. The rise of right-wing populism in Europe and the United States. A Comparative Perspective [La emergencia del populismo de derechas en Europa y Estados Unidos Una perspectiva comparada] Friedrich Ebert Foundation, Washington DC Office 2016.
26. Varvin S. Our relations to refugees: Between compassion and dehumanization. *The American Journal of Psychoanalysis* 2017;77:359-77.
27. Van Voren R. Ending political abuse of psychiatry: where we are at and what needs to be done. *BJPsych Bulletin* 2016;40:30-3.
28. Ramos MA. Psychiatry, authoritarianism, and revolution: The politics of mental illness during military dictatorships in Argentina, 1966–1983. *Bulletin of the History of Medicine* 2013;87:250-78.
29. Buoli M, Giannuli AS. The political use of psychiatry: A comparison between totalitarian regimes. *International Journal of Social Psychiatry* 2017;63:169-74.
30. Kral MJ. Suicide and suicide prevention among Inuit in Canada. *The Canadian Journal of Psychiatry* 2016;61:688-95.
31. Kral MJ. Postcolonial suicide among Inuit in arctic Canada. *Culture, medicine, and psychiatry* 2012;36:306-25.
32. Fanon F, Sartre J-P, Farrington C. *The wretched of the earth*: Grove Press New York; 1963.
33. Burris G. Birth of a (Zionist) nation: Black radicalism and the future of Palestine. *Futures of black radicalism* 2017:120-32.
34. Ortiz P. Memories of revolution. *Cultural Dynamics* 2019;31:410-7.
35. Gilmore RW. Abolition geography and the problem of innocence. *Tabula Rasa* 2018:57-77.

36. Lawson P. *The London Hanged: Crime and Civil Society in the Eighteenth Century*: Linebaugh, Peter: New York: Cambridge University Press, 512 pp., Publication Date: February 1992. *History: Reviews of New Books* 1992;21:15-6.
37. Quan H. "It's Hard to Stop Rebels that Time Travel": Democratic Living and the Radical Reimagining of Old Worlds. *Futures of Black Radicalism*: Verso; 2017:173-93.
38. Ohadike DC. *Pan-African Culture of Resistance: A History of Liberation Struggles in Africa and the Diaspora*: Global Academic Publishing; 2002.
39. Robinson CJ. *Black Marxism: The making of the Black radical tradition*: Univ of North Carolina Press; 2000.
40. Sojoyner D. Dissonance in time:(Un) making and (re) mapping of blackness. *Futures of black radicalism* 2017:59-71.
41. Morrison T. *Mouth full of blood: essays, speeches, meditations*: Random House; 2019.
42. Williams PM. Techniques for root cause analysis. *Baylor University Medical Center Proceedings*; 2001: Taylor & Francis. p. 154-7.
43. Johns G. The essential impact of context on organizational behavior. *Academy of Management Review* 2006;31:386-408.
44. McTaggart R. *Participatory action research: International contexts and consequences*: Suny Press; 1997.
45. Viswanathan M, Ammerman A, Eng E, et al. Community-based participatory research: Assessing the evidence: Summary. *AHRQ evidence report summaries: Agency for Healthcare Research and Quality (US)*; 2004.
46. Wallerstein IM. *Universalismo Europeo/European Universalism: El Discurso Del Poder/the Discourse of Power: Siglo XXI*; 2007.
47. James CLR. *Mariners, renegades, and castaways: The story of Herman Melville and the world we live in*: UPNE; 2001.

## Appendix A: Interview Guide

### Warm-up question (5-10 minutes)

- a) How long have you been in Amman?
- b) Please describe the work you do in Amman [who do you work for/with?]
- c) Do you work in mental health or work with mental health providers?
- d) Have you received training in mental health or psychosocial support?

### 1. Personal explanatory model of psychic consequences of witnessing violence, hardship, unexpected death

#### Prompts

- a) Asks for clarification or short response – How have these events affected your well being, and why? When you think about these events, how does it make you feel and why? How is your point of view similar or different from your clients? If different, who holds different views and why do you think that is?
- b) How has your education and training shaped how you think about these events?
- c) How has your religious beliefs shaped how you think about these events?
- d) Outside of religion, what else or who else has shaped how you think about these events? Is there someone in particular in your family or community that have had a strong influence on how you think about these events?
- e) How have your teachers or elders affected how you think about these events?
- f) How have community centers or international organizations affected how you think about these events?
- g) How have doctors or other healthcare providers affected how you think about these events?
- h) How has the media or social media affected how you think about these events?
- i) **“I never think about those things / they do not make me feel any particular way.”** -- May I ask why that is? [make sure you understand why]

### 2. Clients' explanatory models of psychological consequences (15-20 minutes)

Many of your Syrian clients witnessed or experienced terrible things happening to the people around them, or they may have personally experienced these kinds of events. In your mind, how have your clients come to understand these events *AND* has it changed since they arrived to Jordan?

#### Prompts

- a) Asks for clarification or short response – How have these events affected their well being, and why? When they think about these events, how do you think it makes them feel and why? Do all your clients think the same way about these events, if yes, why? If not, who holds different views and why do you think that is?
- b) How has their religious beliefs shaped how they think about these events?

- c) Outside of religion, what else or who else has shaped how they think about these events? Is there someone in particular in their families or communities that have had a strong influence on how they think about these events?
- d) How have their teachers or elders affected how they think about these events?
- e) How have community centers or international organizations affected how they think about these events?
- f) How have doctors or other healthcare providers affected how they think about these events?
- g) How has the media or social media affected how they think about these events?

### 3. **Discourse of psychic trauma**

Can you describe how your clients discuss these kinds of events and the thoughts and feelings that come with them?

#### **Prompts**

- a) Asks for clarification or short response – When, how often, and why discuss these things with you and with each other? Describe how open they are in discussing this topic with you. Who is more open or more closed? Why are they so open/closed about discussing it with you? What kinds of words do they use to describe their thoughts and feelings on the topic?
- b) “We don’t discuss those things” – May I ask why that is? Do you know people who do discuss it openly? “NO” – why do you think that is? “YES” – what is different about their relationship/family that allows them to discuss it?
- c) Are there certain people or groups of people who they feel like they can talk about these issues to? Are there certain people or groups of people they feel like they cannot discuss this with? Why or why not?
- d) How has the way that these things are discussed changed since they came to Jordan? “YES” - What do you think caused that change? “NO” – But they are in a very different environment now, has that not affected how they think or discuss these things?

### 4. **Interaction with Western mental health models**

Now I would like to focus on your thoughts on / understanding of Western models of mental health, specifically regarding psychological trauma. How does the Western concept of post-traumatic stress disorder “PTSD” differ from Syrian refugees’ understanding of psychological trauma and how do refugee’s views of psychological trauma change through interacting with providers who have internalized the notion of “PTSD”?

#### **Prompts**

- a) Can you describe a client you worked with or knew whose ideas about psychological trauma changed after interacting with a provider coming from Western schools of thought?
- b) How did interacting with them change how they felt or thought about their negative experiences in Syria?

- c) Did they consult their friends and family to discuss their changing beliefs? How did those conversations shape their thoughts and feelings about their negative experiences?
- d) Had any of their friends or family interacted with this kind of model and how did it shape their views?

**5. Organizational perspectives on ontological distance**

What is your organizations perspective on the divide between the Western PTSD model and the explanatory models employed by Syrian refugees?

**Prompts**

- a) Is that view heterogeneous within the organization?
- b) Is there conflict about that perspective within the group?
- c) How have those conflicts been mediated?
- d) If homogenous, why do you believe there is no opposition to that point of view?

**6. Organizational attempts to bridge ontological distance**

This will be a different kind of question: can you list what—if any—direct or indirect attempts to educate Syrian refugees about the Western model has your organization engaged in, and how successful they have been, and why?

**7. Factors affecting the use of PTSD diagnosis**

Please describe your thoughts on the use of PTSD as a diagnosis in the clinic that you work, and whether you feel that it is appropriately used. If so, why? If not, why not?

**8. Use of social resources for resilience**

I would like to speak now about the social interactions and supports that your clients make use of to support their emotional well-being. Please describe the kinds of interactions that your clients use to help themselves feel better when they are affected by the negative experiences from the war in Syria.

**Prompts**

- a) Asks for clarification or short response – Social interaction can have many forms, this might be anything from talking, asking for advice, seeing a healer, sharing a meal, watching TV or listening to music together, playing a game together, or simply being together. Do any of these activities help them feel better, and why?
- b) With whom do they participate in these activities? Are there people who they would like to interact with who they do not interact with? Why not?
- c) Can you describe how they feel before the interaction and how they feel after the interaction.
- d) Has any organization, healer, or other professional helped them? How?
- e) How has the way they manage these thoughts and feelings changed since they came to Jordan?
- f) Can you identify any other sources of support in their community that has helped them, or that you think could help them?