RESEARCH ARTICLES

Infrastructures of Suffering

Trauma, *sumud* and the politics of
violence and aid in Lebanon

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Abstract

This article traces the infrastructures of suffering under the governance of humanitarian psychiatry to explore how material conditions of war and aid have shaped the politics of trauma and *sumud* [steadfastness] in Lebanon. Based on 29 months of ethnographic fieldwork undertaken from 2011 to 2013, I look at the expert, economic, and techno-political assemblages of trauma and *sumud* during the July War in 2006 and the Syrian refugee crisis in 2011. Mental health experts faced unexpected difficulties in diagnosing war trauma during the July War. This led political actors to claim that these difficulties reflected a general absence of suffering from war and a sign of Lebanese resilience, drawing on economies of *sumud* in postwar reconstruction. The Syrian refugee crisis however radically transformed the politics of suffering in Lebanon. A new political economy of trauma emerged where the Lebanese now competed with other aid communities to have their past suffering recognised as traumatic. Comparing the relations between violence, aid, and suffering in both instances serves to contextualise and historicise suffering beyond a particular discourse or event. It also serves to highlight the contingencies of suffering rather than its internal and psychic elements.

Keywords

Introduction

During a televised speech delivered on the eve of Ashura in Beirut in 2009, Hezbollah's leader, Hassan Nasrallah, gave what he called a 'modern reading' of the events of Karbala, extracting and foregrounding what he saw as moral tools of resistance for use in the present.[1] One of the tools he spoke of was the emotional strength of the Lebanese during the July War[2] in 2006. He pointed to how global organisations who came to treat the psychological effects of war in Lebanon found only 'patient people who, despite the loss of life and livelihoods, were aware of the moral sacrifice required in the fight with Israel' (Nasrallah 2009). Finding no clear traces of trauma, these organisations witnessed what Nasrallah referred to as a unique phenomenon in history. This unique phenomenon was none other than *sumud*, a concept which in local vernacular means a form of psycho-political steadfastness, patience, and resistance in the face of unjust war and violence.

Three years later, I sat in the office of the chair of the psychology department at the Lebanese University asking about war trauma in Lebanon. Dr Elham al-Hage, both an academic and a practitioner, had many years of experience working on trauma-related interventions with humanitarian organisations such as L'Association pour la Protection de l'Enfant de la Guerre [The Association for the Protection of the Child from War] and Médecins du Monde [Doctors of the World]. As a practitioner, she has worked with survivors of the Qana massacre in 1996,[3] the detainees of the Khiam Detention Center (a detention centre established by the Israeli Defense Forces [IDF] in 1985 in Khiam village), and children affected by the July War.

I asked al-Hage whether she had encountered many cases of (broadly defined) trauma or psychological shock. She echoed Nasrallah's claim that trauma was not common in Lebanon:

> There is a book that a fellow psychologist published. He did a study on PTSD and found its prevalence to be 25 per cent. I am surprised at his findings. Since the liberation [from Israeli occupation in 2000] until the 2006 war, I would say that PTSD rates were around 2 percent [...] At first glance, one might see symptoms of PTSD, and, in a survey, one might answer the questions in a certain way, but when you dig deeper you will see that there is no trauma […]

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1   Ashura is a Shi'a mourning practice that commemorates the martyrdom of Imam Hussayn, and has taken on various sociopolitical and ideological meanings in Lebanon (Deeb 2006).
2   The July War began on July 12, 2006 with an Israeli attack following the capture of two soldiers by Hezbollah. It quickly transformed into a full-on Israeli military operation that went on for 34 days. In Lebanon, 1,200 people were killed, 4,400 injured, and one million displaced (López-Claros and Hidalgo 2008, 103).
3   On April 18, 1996, Israeli forces bombed a UN compound in the village of Qana where hundreds of civilians had sought refuge. More than 100 civilians were killed and a further 100 wounded.

The psychologist working in the field knows that this is not trauma. People have different ways of dealing with war.

The perspectives of Nasrallah and al-Hage offer a glimpse into the political and expert debates on the suffering that followed the July War in Lebanon. They are two of many I encountered during my ethnographic research who cited an absence of trauma among the Lebanese people. Humanitarian workers and mental health practitioners with whom I spent time spoke of unexpected difficulties in finding traumatised subjects, leading many to conclude that there was an overall absence of the kind of suffering normally caused by war. But how could there have been an absence of trauma? And why was this absence of trauma translated into an absence of suffering altogether?

Following the Lebanese Civil War (1975–1990), one particular discourse around trauma became a focus of popular attention and debate in many arenas of Lebanese life, reflecting the global increase of attention paid to the psychological effects of violence in the fields of psychiatry and humanitarian intervention. Two events exemplified this trend: the first was the admission of post-traumatic stress disorder (PTSD) as an anxiety disorder into the Diagnostic Statistics Manual (DSM) III in 1980, an event closely related to the end of the Vietnam War (Young 1997), and the second was the emergence of humanitarian psychiatry as a set of aid practices and expertise that incorporated psychiatric disorders such as trauma into humanitarian action (Humphrey 2002). Trauma, anthropologists Didier Fassin and Richard Rechtman argue, thus became the universal model of suffering from violence: 'a suffering without borders, and a suffering that knows no cultural barriers' (2009, 239). It created a frame within which experiences of war and violence were grievable only through individualised and psychic injuries (Butler 2009).

In Lebanon, communities have lived through massive political and social upheavals in the form of both the 15-year civil war and multiple Israeli military operations that led to the occupation of Southern Lebanon[4] until its liberation in 2000. Humanitarian psychiatry has followed in the wake of massacres and episodes of violence since the Israeli invasion of Lebanon in 1982. The July War in particular prompted debates about trauma and suffering during an unprecedented expansion of humanitarian intervention, which included the provision of psychological aid and trauma-related interventions (López-Claros and Hidalgo 2008, 102). Humanitarian organisations opened offices in Lebanon,

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4   Israel has launched a series of military operations against the Palestinian Liberation Organisation (PLO) and other militant groups in Lebanon since 1978 that led to the occupation of Southern Lebanon. In 1982, Israel conducted 'Operation Peace for Galilee'. The death toll was estimated to be roughly seventeen thousand, and 30,000 were wounded. In April 1996, Israel launched a 16-day military operation, 'Grapes of Wrath', which killed 165, wounded 400, and caused the displacement of around four-hundred thousand people (Volk 2010).

created mental health jobs, and provided both funding for psychological aid and training in trauma evaluation and treatment for local health practitioners. They established partnerships with local organisations, binding these to global forms of expertise and economies of aid and care, and implemented standardised trauma programmes such as psychological first aid and debriefing (Reyes and Jacobs 2006). These partnerships served to institutionalise humanitarian psychiatry in Lebanon (Reyes and Jacobs 2006).

Despite this assemblage of global mental health in Lebanon (Lovell et al. 2019), experts faced unexpected difficulties in actually finding examples cases of war trauma. They debated contradictory prevalence rates of PTSD—as referenced in al-Hage's quotation above—and the appropriate mental health intervention to adopt in the local context. Many spoke of not being able to find traumatised people at all. The inability to produce a discernible trauma diagnosis was quickly translated into specific claims by political actors. Hezbollah interpreted this absence as a sign of *sumud*, while its political opponents claimed that this was a non-modern reaction to violence and loss encouraging a 'culture of death'.[5] In both of these claims, the absence of trauma was presented as an overall absence of suffering from war, thereby relegating other non-traumatic articulations of suffering to the side-lines of public discourse.

In this research article, I examine the alleged absence of trauma in Lebanon and explore what lies behind it. Much as the emergence of a psychiatric object depends on its ecological niches (Hacking 2002) and a network of other circulating objects, bodies, and technologies (Mol 2003), its absence is also registered in sites of expertise. The difficulty of finding trauma following the July War was registered in places such as clinics, humanitarian organisations, and techno-scientific sites in the form of contradictory prevalence rates and seemingly incongruent diagnoses, as this article will illustrate. I first trace the absence of trauma through my visit to a mental health clinic in Khiam village in Southern Lebanon during my fieldwork. Next, I unpack the political claims made about this absence by members of war-affected communities, mental health experts, and political actors by looking at the relationship between suffering, violence, and aid. These claims often equated the difficulty of finding trauma with a general absence of suffering from war, generating a dichotomy of trauma/*sumud* that made other experiences of violence impermissible (Segal 2016). My reading of these claims is not limited to the politics of suffering caused by the July War, but extends to the transformations of violence and aid during the Syrian refugee crisis in 2011, when new articulations of suffering emerged. By engaging the changing dynamics of violence and aid in Lebanon, I

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5   After the July War, Hezbollah was accused by March 14, a political coalition, of encouraging a 'culture of death' among its Lebanese Shi'a constituencies. These communities were seen to be not properly expressing grief and shock at the deaths of their loved ones, instead rejoicing in their martyrdom (Chaib 2011). A political campaign countering this 'death ideology' was then launched with the slogan 'I Love Life' (Helou 2013).

draw attention to the infrastructures of suffering there: the expert, material, and techno-political assemblages that shaped the nature and experience of suffering (Larkin 2013). Attending to these assemblages serves to highlight the contingencies of suffering, rather than it being a determinate category of subjectivity proper (Biehl et al. 2007).

My analysis is based on 29 months of ethnographic fieldwork I conducted in Lebanon between 2011 and 2013 and on personal observations drawn from a brief period of volunteering as a psychologist during the July War. My ethnography took me to various institutional sites of trauma and suffering, including humanitarian organisations that provided mental health services, psychological education for communities and refugees affected by war, and training sessions on how to detect trauma. I followed psychiatric tools, humanitarian manuals, therapies, psychological programmes, and diagnostics as they travelled to treat aid communities in various parts of the country. My research oversaw the ways in which mental health practitioners trained humanitarian workers in techniques of psychological assessment, implemented group therapies and awareness campaigns, and held debriefing sessions to discuss psychiatric cases. It was based on participant observation and interviews undertaken in eight local and global organisations. In addition to spending time with experts and practitioners, I spoke with members of various aid communities about their experiences with violence and aid, ranging from Lebanese people affected by war to Palestinian, Iraqi, Syrian, and Sudanese refugees and asylum seekers, as well as an indefinite community of those deemed by organisations and psychologists 'marginalised people'. My double positionality—firstly as a mental health practitioner and researcher and secondly as someone who lived in Lebanon for 28 years prior to my fieldwork—have further sharpened and contextualised my analysis of the relationship between violence, suffering, and aid.

Experiences of violence: Trauma and *sumud*

The interest in writing about trauma in the context of conflict across disciplines—from law to gender studies—reveals a privileging of the psychological in the study of violence and war. Clinical research has addressed trauma's cultural specificities, identifying social and local responses to violence as well as different forms of recovery (Kirmayer et al. 2007). Trauma studies and anthropology have tackled the act of narrating and witnessing unfathomable violence (Caruth 1996), raising questions about its temporality in the everyday (Thiranagama 2013) and the currency of suffering in humanitarian aid (Feldman 2018). Some of these approaches aimed at decolonising trauma (Mengel and Borzaga 2012) and unravelling a Western-centric notion of suffering that depoliticises and psychologises structural and social conditions (Summerfield 1999; Afana et al.

2010). Recently, trauma research has shifted to focus on psychological resilience, introducing in doing so concepts such as post-trauma growth (Joseph et al. 2012). This new focus on resilience was partly ushered in by the increasing number of critiques of trauma as a category of passive and apolitical victimhood. Yet this research has created a trauma/resilience binary where experiences of violence can only be studied either as psychic injury or as emotional strength. Within this framework, other articulations of suffering become illegible. Anthropological literature on social suffering, mourning, and grief continues to problematise this binary, asking for more complex ethnographies of suffering that account for the various painful ways violence is lived (e.g., Kleinman et al. 2007; Farmer 1996).

In many Arab-majority societies, *sumud* is evoked to explain communal strength and steadfastness in the face of war and occupation. A Palestinian concept *par excellence*, *sumud* is often equated with psychological resilience. Recently, however, scholars have argued that *sumud* is much more than just its psychological aspects. Seen as a radical and political subject position against Israeli occupation, *sumud* is a communal agentive force, a postcolonial tool of resistance, a political movement, and an everyday embodied practice (Meari 2014; Wick 2008). In Palestinian refugee politics, *sumud* embodies a politics of refusal that precedes liberation, return, and independence, and posits living itself as a political act (Sayigh 1993; Feldman 2018). Less a radical alterity in this context than a strategy of survival and struggle (Khalili 2007), *sumud* is an ideology of endurance in unchanging and miserable conditions under which people 'suffer yet persist' (Feldman 2015, 429). It is an endurance that also exhausts and delimits the forms of suffering one can publicly articulate and acknowledge (Segal 2016).

Khiam village: Humanitarian psychiatry in accumulated violence

I went to Khiam in 2012, visiting a health clinic that belonged to Amel, a local organisation with an established history of providing aid in Southern Lebanon. Khiam was one of the 125 villages on the Southern Lebanon border zone that had been occupied by Israeli forces since 1978 (Beydoun 1992). In 1985, Israeli forces established the Khiam Detention Center, where civilians were illegally detained and tortured for years.[6] Since its liberation from Israeli occupation in 2000, the village has become the site of many humanitarian psychological interventions. It thus represented an ideal research site to investigate war trauma.

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6   The Khiam Detention Center [*Mo'takal al-Khiam*] was originally established as a military barracks by French forces in Southern Lebanon. It was turned into a detention centre in 1985 by the Israel Defense Forces (IDF) and the South Lebanese Army, a Lebanese militia who ran the centre during the Israeli occupation. Many locals from the occupied South were detained and tortured there, and some remained in detention until the liberation of Lebanon in 2000 (Shuraym 2011).

The clinic, established in 2000, collaborated with global humanitarian organisations including the United Nations Development Programme (UNDP), Médecins du Monde, and Medico International to provide health services for nearby villages. These services included a psychological rehabilitation programme for former prisoners of the Khiam Detention Center and, after the July War, a series of psychological programmes for communities affected by war.

Badly damaged during the July War, the clinic had been fully renovated and repaired by the time I arrived. It was a large two-storey house with a garden and was located on the village square. Posters about physical and mental health hung on the walls, and a variety of health brochures were placed in the waiting room. Various signs indicated the psychological nature of the clinic. A big plaque, hung at the entrance, read 'Amel's Psycho-Physiological Center', while a barely visible smaller plaque placed inside referred to the clinic as 'Amel's Center for the Treatment and Integration of Detainees'. The little plaque, and the many others that surrounded it, were engraved with the names of the global humanitarian programmes that had passed through the clinic, marking one particular history of humanitarian assistance in Southern Lebanon. While these plaques covered the wall along the staircase, the clinic itself, almost too big for its purpose, seemed empty.

The signalling of the psychological woven into the clinic's title—and safely phrased to offer 'integration' and broad assistance to detainees—is a result of the merging of psychological interventions with medical practice in the south of the country. According to Amel's mental health programme manager, this merging was a means of avoiding communal resistance to therapy. The programme manager—a young French woman who first joined the Lebanese organisation as an intern—was quick to point out that therapies had to 'infiltrate' social and medical services as many people, including the prisoners of the Khiam Detention Center, 'would not admit they were suffering from psychological problems'. This was a recurrent problem; in her words, it became increasingly 'hard to define and measure what is psychological, and what is not' (ibid.).

At the clinic I met Sana, a social worker who had been working intermittently with Amel for more than thirty years. When she heard about my research on trauma, Sana was at a loss. She did not know what exactly I would be observing that could count as 'psychological', but suggested I come back on Wednesdays to observe the weekly reproductive health awareness sessions she conducted with women from the village. Next week's topic was gender—maybe this counted as a psychological topic I would be interested in? Concerned that Sana might not have understood the aim of my research, I tried to explain my project to her once again, asking her to recall the psychological interventions performed in collaboration with

Medico International in the clinic after the July War. Sana smiled and said in a matter-of-fact tone:

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

Although Sana did not identify these doctors, their programmes were part of the many mental health interventions supported by global humanitarian organisations after the July War. Accumulative experiences of war, violence, and displacement did not produce a recognisable form of suffering like, for instance, trauma. Western experts trying to find trauma by using torn and broken dolls received only humorous reactions from Sana and others; their programmes did not and could not capture Lebanese children's experiences of war. Her commentary on the doctors who went mad facing the absence of suffering showed, to her, these doctors' inability to fathom a life entangled with war and violence and the constant possibility of these phenomena's reoccurrence in the everyday.

I asked Sana anxiously about the Khiam Detention Center and the psychological programmes designed with Médecins du Monde for the prisoners exposed to torture and illegal detainment, which were mentioned on the clinic's plaque. She said, 'There were programmes, but the prisoners did not like them. They said: 'Do we need integration? How do they want to integrate us?' Now, they [the global organisations] found work for everyone.'

'Are there any more mental health programmes here?' I asked again.

'No, now it is over. They forgot—I am sure that they forgot. It is like when someone dies, with time you forget … They say everything gets stronger with time, except for pain; it weakens.'

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

Al-Hage's experience of treating detainees of the Khiam Detention Center corroborated Sana's account. As one of the psychologists who worked on the integration programme organised by Médecins du Monde between 2000 and 2005,

she had been taken aback by the lack of participation in the programme. She told me that their strategy was to introduce psychotherapy within already-established medical centres as a way to 'sneak in' psychological services without stigmatising the detainees. However, al-Hage was surprised to find that the detainees did not come to ask for psychological help, as they were considered heroes by their families and societies. Al-Hage also felt that the programmes failed to provide psychological care as they were strictly clinical. She asked, 'What is the use of psychotherapy if one has nothing to eat, no job or future?' Eventually, she and other psychologists insisted that the integration programme should provide workshops on vocational training.

What started off as a psychological programme focused on treating individual trauma ended up as a vocational programme to help detainees secure jobs and personal futures. For al-Hage, standalone psychological programmes were not successful because they neglected the economic factors essential for reintegration into society. Seeking economic justice and rehabilitation was more important than clinical diagnoses and treatment that prioritised psychological suffering. In that sense, being traumatised by war was countered by a will to resume what Israeli war and violence had suspended: economic and social normality and the rebuilding of businesses, jobs, and homes. This resonates with other accounts of the July War. In the documentary *Remnants of a War* (2009), Jawad Metni follows the lives of people from Southern Lebanon working with global NGOs to help clear the mines and cluster bombs dropped by Israel during the last days of the war. The people depicted in the documentary spoke of their suffering in the war in economic terms. They spoke of their lands lying fallow, of losing their homes and businesses, of taking on new jobs made possible by the July War in the hope of ameliorating their economic situation.

Past and future violence overshadowed the clinic and the mundane conversations I had with the staff there, most of whom lived in Southern Lebanon. On my second visit, the woman responsible for cleaning the centre, a local from Khiam, asked if I wanted to join her outside for a smoke. I explained that I was trying to quit. She nodded sympathetically. She had quit smoking five years ago but had started again. 'I have been in a bad psychological place, you know, because of *al-ahdath* [the events], then I lost my father, so I started smoking again. Now, I just smoke to pass the time.' I wondered which 'events' she was referring to. Could she have meant the Lebanese Civil War, commonly called '*al-ahdath*' in reference to the intermittent nature of the violence (Sawalha 2014)? Or could she be referring to the July War as a series of violent events?

As the sun rose over the village, I sat in the garden with the nurses and the doctor, who were joking around and stealing each other's pens. It was early and there

were no patients yet. As coffee was served, they started chatting about life in the village. One of the nurses spoke of a man who had lost three of his wives consecutively during 'the events'. It seemed that two of them had been killed in different episodes of violence and that he had divorced the third. *Al-ahdath* were evoked again to talk about a conglomeration of wars as a series of events; that is, to signal a condition of recurring and protracted war. Interrupting the light chitchat about life in the village of Khiam, the doctor, sipping his coffee slowly, said in a serious tone, 'The war is coming. When? That is the question. But the war is coming.' We all fell silent for a few seconds, staring at the rising sun and the landscape overlooking the garden as though trying to see traces of the upcoming war that seemed so inevitable here; the future in the south of the country always burdened with a new war. We then continued joking, chatting, and drinking coffee. Shortly after, I left the clinic, having found no traces of trauma, no sign of the psychological marks of war.

Al-mouʻash: Expert assemblages of trauma and the experience of living in violence

My visit to Khiam clinic in 2012 captured the conditions that accompanied the then-permanent possibility of war in Southern Lebanon. Less so a traumatic event, war emerged as a haunting reality in the south, creeping into conversations, jokes, and cigarette breaks. It was experienced as a form of slow violence that injured and contaminated bodies, livelihoods, and lands (Touhouliotis 2018). The experience of living in violence, rather than encountering it, predicated forms of suffering that were not necessarily psychological or traumatic (Moghnieh 2017). Nevertheless, humanitarian institutions and agencies working in Lebanon continue to advance trauma and PTSD as the only legitimate forms of war-related suffering.

In this section, I look at the sites of expertise that sought to assemble trauma as an ontological and therapeutic diagnosis in mental health practice (Varma 2012) after the July War, and at the problems and challenges they encountered. The debates that ensued around contradictory prevalence rates, the diagnoses of war, and the difference between the clinic and the field constitute a testimony to the scalability of mental health professions under humanitarian psychiatry and to the tensions and problems that emerged from therapeutic outreach in Lebanon into everyday life (Dole 2020).

For example, during the war, the World Health Organization (WHO) asked the Ministry of Health to mobilise mental health practitioners and open psychiatric facilities to receive traumatised communities—especially children—in anticipation of a trauma epidemic. Following the WHO call, meetings were held at the Ministry of Social Affairs to discuss suitable interventions. Psychiatrists, psychologists, and

psychoanalysts debated the usefulness of treating PTSD with medication. Some suggested that mobile psychiatric clinics could be set up in schools and parks in Beirut, where many displaced families were staying. Others disapproved of the use of this clinical approach and advocated a more cultural and communal form of mental health intervention.

At the heart of these debates was the suggestion that the humanitarian Western-centred trauma model failed to capture the totality of the experience of war-related suffering in Lebanon. When I asked Anissa al-Amine—a Lebanese psychoanalyst who attended the meetings—about these debates, she evoked the concept of '*al-mou'ash*', or the 'lived experience' of war and violence. In her view, a community-based approach to mental health meant giving attention to the specificities, contexts, and nature of the war experienced rather than privileging a blind adoption of humanitarian and psychiatric interventions (Giacaman et al. 2011).

Understanding war as '*mou'ash*' is partly about becoming habituated to violence. Israeli wars became part of the conditions of possibility of living in Lebanon. Many communities employed their embodied knowledge of war to prepare for it by, for example, buying and stocking up on bread, cans, and cigarettes; cracking windows open to avoid shattering glass during shelling; renovating old shelters; avoiding certain roads; etc. Many spoke about how the sounds of bombing in the July War brought back memories of shelling during the Lebanese Civil War, which ended in 1990. The affective, sensorial, and material practices that constituted preparations for war in Lebanon (Al-Masri 2017), where recollections and widespread anticipation of violence are fused together (Hermez 2017), in turn embodied a temporal experience that deeply disrupted psychiatric and humanitarian frames of war (Butler 2009).

Absence also registers: Contradictory clinical indicators

The WHO's expectation that traumatised patients would pour into hospitals and mental health centres did not materialise, and the clinics remained relatively empty during the July War, despite the use of both clinical and communal approaches. The absence of trauma was also registered in epistemological and scientific sites in the form of contradictory prevalence rates and gaps in psychiatric diagnoses. Following the war, studies found drastically contradictory prevalence rates of PTSD and trauma in Lebanon, ranging from 2 to 30% (Karam et al. 2008; Farhood et al. 2006; Shaar 2013). Several humanitarian workers and psychologists with whom I spoke, including al-Hage, commented on the wide and conflicting range of these prevalence rates, which created more confusion about the existence of trauma and, most importantly, about what the best model to capture the suffering experienced in the July War was.

Furthermore, interviews with two leading Lebanese trauma researchers revealed that PTSD was rarely diagnosed in clinics during the war. Both researchers had found high prevalence rates of PTSD through symptom-checking and population surveys of war-affected individuals. However, they seemed to agree that in the clinic there was an increase in the number of patients who presented symptoms of depression during war rather than PTSD. In an interview with Dr Laila Farhood, in 2012, she said:

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

Dr Karam, during an interview in 2013, reiterated this point: 'We don't see PTSD in the clinic. But we see depression during war.'

What is the significance of finding high prevalence rates of PTSD in the field but not in the clinic in the aftermath of war? Keeping in mind the role of class, gender, and age in determining who seeks mental healthcare in Lebanese clinics and recognising the importance of the historical and cultural semantics of psychological experiences beyond their clinical framing (Behrouzan 2016), I posit that the discrepancy between cases of clinical depression and PTSD during and following wartime is indicative of how certain social communities in Lebanon experienced and reacted to war.

The humanitarian trauma model was predicated on the assumption that traumatic events during war produce symptoms like nightmares, distressing flashbacks of violent events, and a constant feeling of fear and anxiety. However, depression suggests a condition of being disinterested and sad. Becoming depressed during war suggests that war and the violence it entails are experienced as inexorable, repetitive, and relentless; the individual feels they have no control over its unfolding.[7] As Sana suggested, being displaced seven times from one's village by multiple military attacks turns acute suffering into chronic and seemingly perpetual condition of life.

Furthermore, being both clinicians and researchers, Farhood and Karam drew attention to the difference between finding war trauma in the clinic and finding it in the field. For these experts, the clinic and the humanitarian field represented two sites where suffering was experienced differently and where distinct knowledge practices of violence were produced. For example, most of the young

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7   Similar findings have been discussed in the Palestinian context, which is telling of the forms of suffering in protracted violence. See for example Wagner et al. (2020).

psychologists I met during my fieldwork had sustained both a clinical and field practice, and some of them also engaged in research. As they moved from the boundedness of the clinic into the open humanitarian field, these psychologists encountered and classified new patient groups with distinct economic burdens.

The clinic was seen as a laboratory that isolated war from its ideological and material contexts, enabling an individualised enactment of suffering through psychiatric diagnoses like PTSD and depression. The field, on the other hand, was seen as complex and raw, layered with past violence and the constant anticipation of new wars. The field reflected what Dr Anissa Al Amine referred to as '*al-mou'ash'* [the lived experience] in all its complexity and messiness.

Benton and Atshan (2016) have poignantly argued that the clinic is an ideological site that contains, intervenes in, and interprets political violence and that it should not be taken for granted as a laboratory regulated by medical neutrality. My argument here is that Lebanese psychologists drew these distinctions between the clinic and the field for two reasons: first, because, they claimed, the move from the boundedness of the clinic into the humanitarian field introduced them to new groups distinct from the patients they usually encountered in the clinic, both in terms of socio-economic status and psychological awareness. Psychologists learned to translate and subvert the humanitarian practices and programmes into their clinical professions. They spoke of the challenges they faced in working with these groups, the new kinds of evaluation tools and treatments they had to adopt, and the cultural barriers to psychotherapy they had to overcome. Secondly, the work of identifying traumatised subjects in the field was far messier for them, as finding the explicitly psychological aspects of experiences of war required further work (of the sort they had not necessarily been trained in) to disentangle them from the everyday.

Not only was trauma hard to excavate as a psychological disorder in the field, leading to contradictory prevalence rates, but for psychologists like al-Hage, trauma was simply not there. Al-Hage's quotation in the introduction speaks directly to this scientific messiness; she suggests that a psychologist who 'knows the field' understands that what she found using clinical scales and measures 'is not trauma', but another kind of suffering. Field subjects were seen as more accustomed to war and 'immunised' from it.

The materialities of suffering: Trauma as war-making and *sumud* economies

As soon as the ceasefire went into effect on the morning of August 14 2006, Al-Manar, Hezbollah's television station, opened its phone lines for people to call in and congratulate the party on its victory. Calls poured in from all over Lebanon,

especially from regions that had been heavily bombarded by the Israeli military. The callers talked about how they had lost loved ones, homes, and entire neighbourhoods, and how they had fled the war. A very common expression used to describe their loss was '*fida ijr al-sayyed*', or 'a worthwhile sacrifice for Sayyed Hassan Nasrallah', Hezbollah's secretary-general. I watched the television, listening to people call in and offer their congratulations while I packed my bags to return to the United States. I stopped to listen to one woman caller who was, unlike most other callers, angry: 'I have lost seven children! I lost all my children in this war!' The newsreader was taken aback. He quickly tried to console the woman, telling her that her children were in heaven and that everyone had lost loved ones, but she was inconsolable: 'No, I lost seven of my children. The woman who just called said she lost only five. And you called her *Umm al-Shuhada* [the mother of all martyrs]. I am the mother of martyrs, not her. I lost *all* my children.' The newsreader, bewildered, tried to explain that all mothers who lost their children in the war were mothers of martyrs, but the woman was still angry: 'No. I lost all my children. I am *Umm al-Shuhada*.' In the end, the newsreader surrendered, calling her, and her alone, the mother of all martyrs.

Over the next few days, many people publicly made similar statements about how they had experienced the war, at times openly deriding or disregarding the humanitarian trauma model brought forth by aid programmes and psychological interventions. These articulations created a divisive debate in Lebanon, especially among public health professionals, journalists, and politicians. The debates oscillated between, on the one hand, explaining the absence of a visible and legible suffering in terms of *sumud* and, on the other, ideological talk that covered up the real and inevitable trauma caused by war. Meari has argued that *sumud* embodies 'a radical alterity to the conceptions, sensibilities, attachments, and practices of humanitarian psychiatry' (2014, 77). Similarly, the debates on suffering that emerged after the July War revolved around an understanding of suffering as a dichotomy of trauma/*sumud*. I seek to unpack (rather than accept) this dichotomy in this section. My point is not to investigate whether individuals and communities were actually traumatised by war or indifferent to it, but to understand what is at stake when one experiences war in Lebanon. In other words, why did some experts, politicians, and observers feel that the lack of recognisable suffering after the war was extremely problematic, while others found it to be a unique phenomenon that illustrated, yet again, Lebanese resilience? I attend here to the material and economic infrastructures of trauma and *sumud* that delimited the politics of suffering in Lebanon.

Trauma as war-making

As evidenced by Nasrallah's 2009 speech (quoted earlier), trauma in Lebanon following the July War was transformed from the psychological embodiment of

violence into a strategic tool of war itself, its absence used to mark victory and heroism. In his earlier speeches, Nasrallah had already spoken about the fundamental role played by psychological warfare during the July War. Indeed, terrifying the enemy and breaking their morale was an important Israeli goal. For example, the use of the Dahiya doctrine—the Israeli military strategy of targeting civilians and civilian urban infrastructures with the aim of causing civilian suffering and thus local rebellion—was a form of psychological warfare that aimed to shake the morale of the Lebanese. Trauma was thus a crucial actor in war-making in Lebanon, as *sumud*—which sometimes literally meant controlling one's fear and state of mind—during war became a valid tool and a subject position of resistance to be employed against Israel.

For Hezbollah, the presence of trauma among its communities would have indicated that the war itself was lost. In contrast, in Israel, trauma was central to a national discourse of victimhood and suffering among Israeli soldiers, and PTSD research was historically prolific. Multiple forms of trauma were detected in Israeli soldiers, medical personnel, and civilians in general, and these findings were heavily documented by Lebanese media (Khatib 2011). Israeli soldiers were returning home clearly expressing symptoms of traumatisation from the war (e.g., Ben-Ezra 2010). Furthermore, the 'Lebanon Trauma' was a concept regularly evoked in mainstream media and reports in Israel to describe how Lebanon, as an unconquerable site, had become traumatising to the Israeli military and nation (e.g., Jerusalem Post Staff 2006; Domingos et al. 2017). The same term was also used in 1982 to describe the Israeli invasion of Lebanon in popular Israeli discourse.

Trauma was, by the end of the July War, clearly coming to lie at the heart of Israeli and Lebanese understandings of war and suffering. It enabled an underlying subversive dialogue of power that oscillated between a psychological absence of war trauma on the Lebanese side and the psychological shock over unbearable atrocities in Israel; in other words, between resistance and victimhood. The striking contradiction of an alleged absence of trauma from war in Lebanon and the reification of trauma as a recognisable form of suffering in Israel is indicative of the deeply political and economic values that trauma can acquire in specific contexts and of the different claims that accompany these articulations of suffering.

While traumatised soldiers were claiming victimhood in the eyes of the Israeli state, demanding compensation and protesting what they came to see as an immoral and horrific war, being traumatised in Lebanon carried with it gendered notions of being an emasculated fighter fighting for a morally wrong cause. Lebanese television channels repeatedly showed footage of Israeli soldiers crying and running away from battlefields during the July War. Expressions such as, 'When

Israel bombs us we do not hide in shelters like Israelis, we go to the balcony and watch' and 'We are not affected by the war' were frequently repeated as statements during the war. Years after the end of the war, Lebanese newspapers would report on the trauma and PTSD of Israeli soldiers, the nightmares they had about the village of Bent Jbeil (a village that witnessed some of the most vicious fighting during the war [Khatib 2011]). Hezbollah fighters, on the other hand, reported experiencing the war as divine, with many of them recounting experiences of religious visions and miracles during the fighting (Nasr 2009).

Sumud economies

Apart from its value in terms of military morality, trauma—or more accurately its absence—was intimately linked to locally organised aid for the displaced and wounded in Lebanon. For example, local forms of aid grew during the July War under the name of *samidoun* [we are steadfast], a collective form of relief that provided aid, health services, and mental health care to the displaced (Chit 2007). *Samidoun* got underway in the first days of the war, providing food and non-food items to the displaced as well as medical and psychological support when needed. Similar local aid initiatives had also formed during Israel's wars against Lebanon in 1982 and 1996, as Lebanese and Palestinian local experts, students, activists, doctors, and community members joined forces and organised a communal aid response. These aid collectives were conscious of the relationship between communal resilience and aid; aid was first and foremost a political act aimed, alongside intervention, at bringing closer Lebanon's liberation from Israeli forces. In this sense, these forms of aid differed radically from global humanitarian aid, which purports to be neutral and separates the psychiatric or psychological from the political.

The aid organised by Hezbollah also provided important forms of support for the displaced communities and ultimately worked as protection against psychological breakdown. While Nasrallah in his speech referred to the absence of trauma as a phenomenon unique to Lebanon, Hezbollah actually worked hard to maintain the morale of communities affected by war. Indeed, it prevented collective psychological breakdown by providing communities with multiple social, medical, and health services, sometimes mobilised within hours of the arrival of the displaced, where 'the relief body succeeded in centralizing all humanitarian aid within days' (Nuwayhid et al. 2011). Sports activities for children and prayer sessions for adults were organised in the displacement centres, and there was immediate mobilisation to support mothers who had lost children in the war (Nuwayhid et al. 2011). Finally, the rapid return of the displaced to their towns and villages on the day of the ceasefire and the accelerated process of reconstructing bridges, homes, and neighbourhoods (Al-Harithy 2010) all played a major role in creating a form of political economy for *sumud* that protected against trauma. Local

aid and solidarity campaigns during the war were constitutive of the infrastructures of *sumud* itself as an affective, economic, and military-moral subject position.

Trauma in the Syrian refugee crisis: New relations of violence, aid, and suffering

In this last section, I look at the trauma debates that unfolded in the context of the Syrian refugee crisis in Lebanon at the end of 2011, drawing a comparison with the politics of suffering of the July War in 2006. The Syrian refugee crisis under the governance of humanitarian psychiatry in Lebanon created a different political economy for trauma where Lebanese people now competed with other aid communities to have their past suffering recognised as traumatic. In the July War, it was difficult to find cases of trauma and *sumud* economies emerged as a subject position towards violence and loss, valued both economically and socially. In the context of the Syrian refugee crisis, trauma became a narrative of suffering that brought forth recognition of 'true' victimhood, economic claims, and the possible promise of a better future.

Comparing the relations between violence, aid, and suffering in both instances serves to contextualise and historicise suffering beyond a certain discourse or event. It locates it less as an internalised condition of subjectivity proper (Biehl et al. 2007) and more as a subject position contingent on violence and aid, both of which constantly shift and change in the Lebanese context. More concretely, by introducing the politics of the suffering of refugee communities living in Lebanon, I am able to avoid privileging a Lebanese narrative of suffering and *sumud*.

After the July War, Lebanon became host to new aid communities fleeing political and state violence from neighbouring countries.[8] The Syrian presence, in particular, increased to around one million people in 2014 (International Labour Organization 2014). National anxiety about the Syrian presence in Lebanon was accompanied by multiple forms of daily discrimination against Syrians[9] and a massive mobilisation of humanitarian organisations to attend to their needs. Aid poured in on a large scale, including relief, food distribution, psychiatric and psychosocial support, and accommodation.

During the July War, the main debates about suffering revolved around whether trauma from the war was absent or not. There were no material claims attached to a diagnosis of war trauma, either vis-à-vis the Lebanese state or humanitarian

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8   Palestinian refugees have been residing in Lebanon since 1948. In 2008, 20,000 to 50,000 Iraqi refugees were estimated to live in Lebanon. Displaced Syrian communities first arrived in 2011. There are also some 2,000 estimated Sudanese asylum seekers in Lebanon.

9   For example, many municipalities restricted the movement of Syrian refugees through the imposition of daily curfews (Human Rights Watch 2014).

organisations. Receiving a diagnosis of trauma during the July War meant having access to mental health services. These therapies were in many instances integrated discreetly into medical services and kept hidden from the communities, who did not necessarily want or approve of this mode of intervention.

In the case of the Syrian refugee crisis, however, humanitarian agencies such as the United Nations Higher Refugee Council (UNHCR) now engaged in bureaucratic work to identify evidence of true victimhood. PTSD constituted such evidence, becoming a clear indicator through which Syrians were recognised as legitimate victims. Psychiatrists were asked to prepare what Erica James refers to as 'trauma portfolios'—'the aggregate of documentation and verification which "recognises" or transubstantiates individuals, families or collective sufferers into "victims" and "survivors"' (James 2004, 131). A PTSD diagnosis was central to this portfolio and became a clear ticket allowing access to aid services. For example, a psychiatrist working for a non-governmental organisation (NGO) told me he felt pressured to present 'pure clinical PTSD cases' that could be incorporated as statistical and commensurable information about Syrians. This would allow the UNHCR to read the population of displaced Syrians clearly as victims. The psychiatrist was reprimanded by the UNHCR and his NGO employers when he did not provide enough 'PTSD indicators'. He felt torn between over-medicalisation and providing the refugee with a PTSD claim. He also became confused over the role of the clinician in all of this: was his main responsibility to provide psychological care, or was it to allow refugees the possibility of a new life by identifying them as victims through a PTSD diagnosis?

This new political economy of trauma radically shifted the politics of suffering in Lebanon. Within this context, Lebanese communities now struggled to have their own suffering recognised as traumatic. This was evident in the daily encounters I observed between Syrians and Lebanese—in public taxis and cafés, at the supermarket and the post office, in the waiting rooms of clinics—where Lebanese people competed to show how their own suffering was greater than the Syrians'. They would angrily recite past stories of violence, especially from the Lebanese Civil War, now expressing a suffering not previously shared in public.

In one example, a *service* [shared taxi] driver commented on the aid stipends that Syrian refugees received 'for their suffering' while even while continuing to exploit the Lebanese economy and 'take our jobs'. The driver became angry after he noticed a sticker in the display window of a liquor store that read, 'We accept refugee cards'. It was probably a reference to the United Nations World Food Programme's (WFP) e-card system, which provided monthly stipends worth $20 per month to Syrian refugees in Lebanon—a provision that later became intermittent due to loss of funding. 'Do they also get to buy alcohol with their

stipends?!' he said angrily, appalled that the stipend would allow the refugees to buy anything other than goods to meet their basic and vital needs. Then he added, 'No one ever gave *us* anything for our suffering in the civil war! And we suffered so much more than them, but got nothing in return.' Another encounter I observed was a Lebanese man telling a Syrian man he encountered at the post office, unsolicited, about the long waiting lines to buy bread during the Civil War and how he was in line once when a shelling massacred everyone around him. He then said that what is happening in Syria is nothing compared to the suffering the Lebanese have experienced. The Syrian man remained silent throughout the conversation.

Such daily recollections of violence repeatedly de-legitimised the suffering of Syrians. These recollections were intimately tied to competing economies of trauma and aid in Lebanon. The presence of Syrians thus prompted the sharing of past experiences of violence that had rarely been narrated in the public sphere or framed as individual injuries and claims. Similarly, Dewachi (2015) argues that the story and injuries of Hussein, an Iraqi torture victim and asylum seeker in Lebanon, disturbed and agitated Lebanese people's own memories of and articulations of suffering from the Civil War. It was as if the Lebanese suddenly remembered the multiple layers of violence that inhabited their world and for which they had neither an official frame of recognition nor compensation.

This new politics of suffering should also be read within the context of the changing geopolitics of violence and war in the region. At the end of 2012, I planned a series of interviews with people in Southern Lebanon to gather data on their experiences of the July War. I had already done a couple of interviews and was having difficulty getting people to talk about the war. I had easy access to interview participants, being from Southern Lebanon myself, and while the July War had been a welcome public topic of conversation (normally this topic involves the articulation of *sumud* and the sharing of stories from the war as a matter of national pride), I now sensed significant tension and reluctance. By the end of 2012, it was well known that Hezbollah was engaging in military operations alongside the Syrian regime against different opposition groups. This war was more controversial and far less morally justifiable than the war of resistance against Israel. While fighters were celebrated as martyrs in their own villages, there was a growing whisper that many were now suffering from PTSD and receiving psychological treatment. I heard this story from several people from Southern Lebanon, but always as rumours and anecdotes. These whispers of trauma indicated that the maintenance of a narrative of *sumud* could no longer be relied upon.

By 2013, most *sumud* economies, such as the humanitarian programmes and local aid initiatives established after the July War, were long gone or had shifted their resources to attend to other aid communities. It was as though everyone had

forgotten, as Sana had said they would. Towards the end of my research, I gave a public lecture in a non-academic venue in Beirut on the problems of finding trauma in Lebanon. During discussions, several people from the south of the country and the suburbs of Beirut, the two areas most affected by the July War, angrily challenged the notion that the Lebanese were not traumatised by the war. One of them protested, saying, 'We have suffered psychologically as well,' before listing the mental health issues, such as depression and suicidal tendencies, that had emerged in these areas after the war.

In contrast to the insistence following the July War that the Lebanese people were not traumatised, many were now speaking about their mental well-being and recalling in public how much they had suffered. Where there used to be *sumud* and an absence of trauma, there now was a right and a demand for the recognition of suffering. This recognition was provided once again within the framework of trauma, while other articulations of suffering remained unacknowledged. The arrival of new aid communities and mental health policies, the emergence of a political economy around trauma, and the transforming nature of violence itself created possibilities for new expressions of suffering in the Lebanese public discourse—but always only within the confines of the *sumud*/trauma binary. This discourse often overshadowed the suffering of other communities, like the Syrian refugees whose experience of loss and displacement was frequently forcibly denied and left unaccounted for except as aid communities through the humanitarian trauma model (Fassin 2010).

Conclusion

In this article, I have traced the expert, economic, and political debates on trauma and *sumud* that followed the July War in Lebanon. I took trauma—whether defined and framed by psychiatry and humanitarianism as PTSD, or as evoked in popular Lebanese society and discourse—as an elusive thing that takes on various material, political, scientific, and healing values for different actors and communities. I did so by unpacking the various claims of trauma and *sumud*, as well as 'Lebanese exceptionalism'—that is, the conviction that Lebanese people are inherently resilient to war and violence. I drew attention to the difficulties and ruptures faced by humanitarian psychiatry as a global project of mental health in Lebanon. These difficulties were translated by local political actors into an overall absence of suffering from war. In the context of the Syrian refugee crisis of 2011, however, new forms of violence and aid emerged that radically shifted the politics of suffering. Trauma gained new currency, now linked to refugee status and a promise of a better life. Communities now competed to have their suffering recognised and acknowledged through the humanitarian trauma model.

By looking at both these cases together, I have sought to highlight the infrastructures of suffering rather than posit suffering only as an internal and psychological condition. The multiple faces of trauma and *sumud*—sometimes intersecting, other times clashing—provide us with an understanding of the contemporary politics of suffering and violence in Lebanon. In both cases, however, suffering is reduced to either trauma as classified by humanitarian psychiatry or *sumud*, a strategy of resistance and survival. Other expressions of suffering that do not fall within the *sumud*/trauma binary are left unacknowledged in the public discourse.

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About the author

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