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**The Work of Disaster:
Events of Affliction, Care, and Intervention in Nepal**

A dissertation submitted in partial satisfaction
of the requirements for the degree
Doctor of Philosophy in Anthropology

by

Aidan Seale-Feldman

2018

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ABSTRACT OF THE DISSERTATION

The Work of Disaster:
Events of Affliction, Care, and Intervention in Nepal

by

Aidan Seale-Feldman

Doctor of Philosophy in Anthropology

University of California, Los Angeles, 2018

Professor Christopher J. Throop, Chair

This dissertation offers an ethnographic account of mental health governance, psychosocial interventions, and forms of shared affliction in Nepal before and after the 2015 earthquakes. By thinking with theories of event and crisis through the lens of critical phenomenology, I ask the following questions: How can ethnography approach emergent phenomena? How does an affliction become knowable through a particular concept and made into an object of intervention? How is evidence for therapeutic efficacy made visible in the midst of a psychosocial encounter? What are the local/global historical, political, and socioeconomic forces that have brought about the emergence of mental health governance in Nepal? Based on 24 months of field research, I conducted participant observation, interviews, focus groups, household surveys, and followed psychosocial counselors in the field to respond to these questions. In the first part of the dissertation I outline the history of mental health governance in Nepal in relation to the emergence of the Global Mental Health movement. In the second part I examine cases of adolescent “mass hysteria”

as they were conceptualized as “conversion disorder,” “hysteria,” *chhopne*, and *bhut/pret, pissach laagne*. In the third and final part I track the humanitarian mental health response in the aftermath of the disaster and its ramifications. In order to address the ethical question of the possibilities and impossibilities of field research under situations of emergency, I discuss how new forms of ethnographic engagement were needed to respond to the unfolding disaster. As a conclusion, I conceptualize what I call the *work of disaster* as a way to frame what was generated through the event of disaster and what was destroyed, what was accomplished through various narratives of crisis and what was foreclosed, the processes by which affliction was made visible or rendered invisible, and the historical contexts that created the possibility for these formations.

This dissertation of Aidan Seale-Feldman is approved.

Sherry B. Ortner

Douglas W. Hollan

Jeffrey Prager

Christopher J. Throop, Committee Chair

University of California, Los Angeles

2018

This dissertation is dedicated to
those who lost so much
on April 25 and May 12, 2015

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- 2016 "Transient, Accidental, Improvised: Psychosocial Care in Post-Disaster Nepal," American Anthropological Association Annual Meeting, Minneapolis, MN, November 16-20

PROLOGUE

Ethnography in Times of Disaster

When I began my dissertation research, mental health in Nepal was considered a minor issue both among Nepali government officials as well as among most international researchers. In a country plagued by unstable politics, lack of basic infrastructure, lack of access to health care, and eight years out from a decade of civil war, mental health was not considered a pressing concern when compared to, say, communicable disease. But the visibility of affliction waxes and wanes in different times and places, and is also tied to a politics of suffering, in which certain events enable particular forms of illness to become momentarily visible while others recede into the background or remain invisible. I saw this happen in Nepal, when the central region was struck by a massive 7.8 magnitude earthquake in April 2015, causing a flood of money and humanitarian aid projects and suddenly placing mental health into the center of public discourse and humanitarian action. As one Nepali psychiatrist exclaimed during a UN cluster meeting for mental health “The earthquake was a boon for mental health in Nepal!” In this dissertation, I think about what it means for an earthquake to be a “boon.”

In September 2014, I went to Nepal to study a form of shared affliction, known most commonly in the media as “mass hysteria.” When the earthquake happened, I was in a rural *pabadi* village in the hills of Eastern Nepal where I had been following a case of “mass hysteria” among a group of adolescent girls. Although the district was spared from the total decimation of both earthquake and aftershock, the shaking was felt, heard, and feared by all. For the month following April 25th we (my adoptive family and I) slept outside, together, in mangers and on porches, avoiding the inside of the house as much as possible. The solar powered radio was kept on at all times, and this was our main source of information as newspapers were not delivered to the village, and

although there was a television, power cuts, which then plagued the country, dictated the few hours it was possible to watch it.

At night we listened to Radio Nepal as we lay side by side under blankets in the open air. On the broadcast the voice of a man talked about *manasik rog*, “mental illness,” and explained the concept of depression, listing its symptoms. In every day that followed, a psychosocial program called *bandai sundai*, speaking listening (funded by UNICEF), was broadcast on Radio Nepal. Callers would call in and explain their symptoms, and receive advice from a psychosocial counselor or psychiatrist live.

The appearance of the radio program and the sudden presence of mental health as a problem in public media discourse was an indication that the disaster could have implications for this once minor field. In the end of May 2015, I returned from the village to Kathmandu to search for a way to put my expertise to positive use, and to follow the humanitarian mental health effort as it unfolded on the ground. As a graduate student in medical and psychological anthropology at the University of California, Los Angeles I had studied the relationship between culture, mental health, and experience; subjectivity and social suffering; transcultural psychiatry and idioms of distress— all of which would be topics of practical relevance to the humanitarian mental health response. Likewise, I had worked closely with mental health professionals in Kathmandu prior to the earthquake all of whom had been swept up into the humanitarian response. I found myself situated in a unique position from which I felt an obligation to translate my expertise into a form of immediate and engaged action. This task was far easier said than done.

INTRODUCTION

The contemporary world is increasingly one of unfolding disasters, the result of which is the growing perception that we are living in the midst of a period of crisis—political, economic, environmental, and moral (Chakrabarty 2009; Masco 2017; Roitman 2014). Histories of capitalism, colonialism, and social inequality have resulted in the uneven exposure to disaster and conflict, distributed along lines of class, gender, and ethnicity. As Anthony Oliver-Smith and Susanna Hoffman write, “a disaster becomes unavoidable in the context of a historically produced pattern of ‘vulnerability’” (2002: 3). It is not unlikely, therefore, that such disasters will increasingly become part of ethnographic fieldwork, either as a conscious decision or by matters of chance. As Sherry Ortner has written in her diagnosis of trends in anthropological research since the 1980s, “academic work, at least in the social sciences, cannot be detached from the conditions of the real world in which it takes place. The theoretical frameworks we use, and the phenomena we choose to explore, are affected in myriad ways by the political, economic, and cultural circumstances in which we carry out our research...” (Ortner 2016: 47). This dissertation and the ethnographic research on which it is based took form in an unanticipated context of disaster—a major earthquake—that shifted the terrain and my conceptualization of the anthropological fieldsite, and demanded a different form of ethnography— one requiring the ethnographer to “follow events, to engage ethnographically with history unfolding in the present...to anticipate what is emerging” (Marcus 2008: 3).

This dissertation offers an ethnographic account of mental health governance, psychosocial interventions, and forms of shared affliction in Nepal before and after the 2015 earthquakes. Specifically, it is a study of the phenomenology of events of affliction and crisis that traces the emergence and stabilization of these phenomena in the midst of social interaction, in a context defined by a history of insecurity, inequality, and “ephemeral care” (Citrin 2010, 2012). In this way,

this study aims to link phenomenology to history, by analyzing the intersubjective dimensions of affliction, intervention, and care from the micro perspective of social interaction, and connecting these to a genealogy of the constitution of mental health as an object of intervention in Nepal.

Conceptual Framework

An overarching question that guides this dissertation is how ethnography can approach emergent phenomena—be it transient forms of group affliction such as “mass hysteria”—the spreading of dissociation through a group; or the sudden shift of tectonic plates that jolts the earth and sets into motion a massive movement of money, people, politics, and intervention in response to an event of crisis. I engage critical phenomenology (Good 1994; Desjarlais 1997; Willen 2007) as a method for tracing how emergent phenomena of different types and scales become fixed through pre-given frames and what Berlant refers to as “genres” (Berlant 2011).¹ This phenomenology is critical as it is concerned with describing the dynamics of power and inequality that inform the ways such emergent phenomena crystalize as facts. By engaging the Husserlian concept of *bracketing* one’s pre-given assumptions and understandings of a given phenomenon, it becomes possible to describe the ways in which an emergent phenomenon is given form in the midst of indeterminacy so that it may be experienced as knowable (Throop 2010). One could argue that all phenomena are emergent, but what are the conditions that allow for a phenomenon or an emergent situation to take form in a particular way and not another? How does an affliction become knowable through a particular concept, and made into an object of intervention? How is evidence for therapeutic efficacy made visible in the midst of the psychosocial encounter? What are the local/global historical, political,

¹ In *Medicine, Rationality, and Experience* (1994), Byron Good introduced the idea of critical phenomenology as “an approach which can provide a critical analysis of illness experience without the self-authorizing language of mystification or false consciousness” (Good 1994: 63). In a similar vein, Desjarlais writes of critical phenomenology as a way “to bridge phenomenological approaches and considerations of political economy” (Desjarlais 1997:25).

socioeconomic, and contingent forces that have brought about the emergence of new mental health care formations in Nepal? How is a situation constituted as a crisis and what are the concrete effects of this?

Thinking with theories of event and crisis through the lens of phenomenology, this dissertation is organized in three parts. In Part I: “Histories,” I outline the history of mental health governance in Nepal in relation to the emergence of the Global Mental Health movement. In Part II “Concepts,” I examine cases of adolescent “mass hysteria” in Nepal as they were conceptualized through the varying concepts of “conversion disorder,” “hysteria,” *chhopne*, and *bhut/pret, pissach laagne*. In Part III: “Crisis,” I track the emergence of a new “mental health crisis” in the aftermath of the disaster and its ramifications. Addressing the question of the (im)possibilities of field research under situations of emergency, I demonstrate how new forms of engagement are needed to create conditions for interpretation and contribution of anthropological insights to the unfolding situations of disaster at hand (Fortun 2001). In this way, I offer an ethnography of what I call the “work of disaster,” that is, I explore what was generated through the event of disaster and was destroyed, what was accomplished through the “genre of crisis” and what was foreclosed, the process by which affliction was made visible or rendered invisible, and the historical contexts that created the possibility for these formations.

Nepal

Nepal, a country of roughly 30 million people, is located between two superpowers—China and India. It is frequently described as among the poorest countries in the world, despite its rich hydropower potential driven by the rivers running from the Himalayas, comparable only to that generated by the Brazilian amazon. The 2014 *Human Development Report* ranked Nepal 145th out of 187 countries, reporting an estimated Gross National Income per capita of US\$2,311. When the

earthquake struck in 2015, 24% of the population was surviving on less than US\$1.25 per day (UNDP 2015). The densely-populated capital city of Kathmandu is one of the fastest growing cities in South Asia, with rural to urban migration accounting for the rapid increase in population over the past 30 years (Muzzini and Aparicio 2013).

Since the 1990s, the people of Nepal have been actively engaged in political struggle to transform the state to a democratic republic. The First People's Movement, *Jan Andolan I*, that began in 1990 inspired mass protests in the capital city which ultimately succeeded in bringing about a government transition from the partyless *Panchayat* system of "guided democracy" to a multiparty system, yet retained the role of the King in the government. In 1996, a cell of Maoist insurgents began to form in the Mid-Western hills. The Maoists targeted the Nepali state, demanding a list of widespread social and economic reforms or else threatening to launch an insurgency (Hutt 2004; Whelpton 2005). The government of Nepal refused, and the Maoists began the "People's War." The insurgency lasted 10 years, hundreds of thousands of people were internally displaced by the conflict, and over 13,000 people lost their lives at the hands of both the Maoists and the Nepal Army and Police (IRIN 2005). The vast majority of the acts of violence carried out during this conflict have not yet seen justice. In 2015, the Truth and Reconciliation Commission (TRC) and the Commission of Investigation on Enforced Disappeared Persons (CEIDP) were established in Nepal, and thousands of reports have been submitted to investigate cases of those who raped, tortured, and murdered during the war.

In 2005, the King launched a military backed coup and announced a state of emergency in which he suspended the rights of all political parties. As a result, in 2006 the banned political parties united with the Maoists and signed the Comprehensive Peace Agreement (CPA), which laid the foundation for a coalition government. In 2006 the Second People's Movement, *Jan Andolan II*, inspired mass protests demanding the King be removed from power. The second *Jan Andolan*

brought about the end of constitutional monarchy and the creation of a fully democratic republic. In 2008 the newly formed government, which included the new Maoist party, created a constituent assembly in order to begin drafting a new constitution, the goal of which would be to reform the country into a Federalist system through the restructuring of internal boundaries into provinces in order to create the possibility for equal representation in the government along lines of caste and ethnicity. Until the new constitution was promulgated and the new federal boundaries were decided upon, there could be no local elections.

Economic growth in Nepal has been hindered by political instability throughout this transition to democracy. Since the 1980s, much of the male population and increasing numbers of women have sought employment abroad through “manpower agencies,” particularly to Malaysia and countries in the Persian Gulf where labor can be deadly (Pattison 2013). Despite the risks entailed, the social and economic impact of this outmigration is evident in the estimated US\$6.6 billion in remittances received by families in Nepal in 2016, amounting to 31.3% of the GDP and placing Nepal the top receiver of remittances in the world (The World Bank 2016).

In the months after the 7.8 magnitude earthquake in April 2015 which claimed the lives of over 9,000 people, the Constituent Assembly began to fast-track the promulgation of the constitution after years of deadlock. In the region of the Southern Terai, the politics of the new provincial boundaries were widely contested, accused of being designed to keep Madhesi and Tharus in a position of political powerlessness. The Madhesi people, whose communities straddle the border between Nepal and India, have long faced discrimination by the Nepali state, which identifies them as Indian and therefore non-Nepali, and in some cases even denies them citizenship.

In August 2015, 45 people were killed in the southern Terai region during protests against Nepal’s new constitution. One of the dead was an 18-month-old child. The protests involved both Madhesi and Tharus against the Nepali state. Both groups have historically been oppressed, socially

and politically, by high-caste Hindus from the hills. Police violence was used to control the anti-government protests, and curfews and “restricted” zones were established. Following the killings, *bandhas*, strikes, were frequent in the southern Terai (Human Rights Watch 2015).

Despite these protests, on September 20, 2015 Nepal’s Constitution was promulgated, replacing the 2007 Interim Constitution. That same month, an “unofficial” Indian blockade at the southern border began, halting almost all imports into Nepal for the next six months including vital medicines, creating an acute shortage in gas and oil, a black-market economy for essential goods sold at inflated prices, and severely crippling the reconstruction progress. For a country that relies on India for the majority of its imports, the situation was considered to be a new political and humanitarian crisis (Plesch 2015).

Theorizing Events

What is an event and what does it do? How does an event become recognized as such? How can anthropology approach events? In their reflection on the ways in which the social sciences might approach events, Alban Bensa and Eric Fassin, drawing on the ideas of Gilles Deleuze (1990), suggest that “the event triggers a new intelligibility—in other words, it makes a new series conceivable, which it inaugurates, or it brings to light what had already begun, without one having yet seen it” (Bensa and Fassin 2001: 9). In this conceptualization, a quality of the event is its ability to create the possibility for new understanding, by rendering visible and legible that which was previously imperceptible. As they write, “in the break, [social scientists] must analyze what breaks—what is undone, or what is made. It is here that the social sciences bring what is most lacking in the event: an added value of intelligibility” (Bensa and Fassin 2001:9). Yet in order for this new intelligibility to emerge, they argue, the present moment must be historicized.

In his book *Logics of History*, William Sewell’s theorizes the event as a way to think about the

relation between social structure and social change. An interdisciplinary scholar trained in history, Sewell points out that “the conceptual vehicle by means of which historians construct or analyze the contingency and temporal fatefulness of social life is the *event*” (2005: 8). To attend to the contingency of social life is to acknowledge the ways in which the outcome of any particular event depends on “the complex temporal sequence of which it is a part” (2005: 7). Historical events have a “fractal character,” in the sense that one event may actually comprise a series of multiple events that “cascade” from the initial event. Events may accelerate history, and they may radically restructure society. Drawing on theories of structure and agency from the work of Anthony Giddens and Pierre Bourdieu, and building directly on Marshall Sahlins’ work on Captain Cook and event as the “structure of conjuncture” (Sahlins 1985), Sewell crafts a theory of historical events, the large events that may “change the course of history,” as defined through their ability to transform existing structures. As Sewell argues,

Events should be conceived of as sequences of occurrences that result in the transformations of structures. Such sequences begin with a rupture of some kind—that is, a surprising break with routine practice...But whatever the nature of the initial rupture, an occurrence only becomes a historical event, in the sense in which I use the term, when it touches off a chain of occurrences that durably transforms previous structures and practices (Sewell 2005: 227).

Yet more recently, scholars have begun to question the process by which an occurrence becomes an event, as Sewell put it, by focusing on the politics of the designation of situation as an event or crisis. Elizabeth Povinelli offers the concept of “quasi-events,” “the ordinary, chronic, cruddy rather than the catastrophic, crisis-laden, and sublime” as a way to think about “eventfulness below the threshold of the catastrophic.” She writes,

If events are things that we can say happened such that they have a certain objective being, then quasi-events never quite achieve the status of having occurred or taken place. They neither happen nor not happen. I am not interested in these quasi-events in some abstract sense, but in the concrete ways that they are, or are not, aggregated and thus apprehended, evaluated, and grasped as ethical and political demands in specific late liberal markets, publics and states, as opposed to crises and catastrophes

that seem to necessitate ethical reflection and political and civic engagement (Povinelli 2011: 13-14).

Through the concept of “quasi-events,” Povinelli finds a way to speak of chronic forms of suffering that do not garner public attention or demand ethical response, unless they are made visible as “crisis,” transformed into a “spectacular event” through statistical representation, for example.

Similarly, Lauren Berlant’s reflection on the “genre of crisis” serves to critique the ways in which crisis is itself an “interpretive genre,” a framing that obscures and even erases forms of suffering that do not follow a temporality of emergency but are “marked by ongoingness, getting by, and living on” (2011: 99-100). As she writes,

“...across diverse geopolitical and biopolitical locations, the present moment increasingly imposes itself on consciousness as a moment in extended crisis, with one happening piling on another. The genre of crisis is itself a heightening interpretive genre, rhetorically turning an ongoing condition into an intensified situation in which extensive threats to survival are said to dominate the reproduction of life. At the same time...the genre of crisis can distort something structural and ongoing within ordinariness into something that seems shocking and exceptional” (Berlant 2011: 7).

In this way, Berlant draws our attention to the “becoming-event” (2011: 6), the ways in which perception of a given phenomenon takes shape in relation to prior interpretative frames. “How do we learn to process x happening as an emerging event,” she asks, “and how do the conventional genres of event potentially foreclose the possibility of the event taking shape otherwise, as genres y and z , which might hover as possibilities but end up being bracketed...” (2011: 6).

In *Anti-Crisis*, Janet Roitman, drawing on Reinhart Koselleck’s (1988) conceptual history of “crisis,” illuminates the relationship between crisis and critique by focusing on the ways in which claims to crisis are made, how crisis can be known, and the impact of the judgement of a situation as being in crisis. The term “crisis” Roitman reminds us, is drawn from the Ancient Greek *krino*, meaning to decide or to judge. In the context of the field of medicine as part of the Hippocratic school, “crisis” referred to a critical moment, a turning point in which the decision made would determine the outcome of life or death. Yet today, Roitman writes, “we now presume that crisis is a

condition, a state of affairs, an experiential category” (2014:16). As Roitman argues, “the aim is not to invalidate ‘crisis’ or to critique the term as inaccurate or merely symbolic. There is no reason to claim that there are no ‘real’ crises. Rather the point is to observe crisis as a blind spot, and hence to apprehend the ways in which it regulates narrative constructions, the ways in which it allows certain questions to be asked while others are foreclosed” (Roitman 2014: 94).

Anthropologists have also focused on the ways in which events, both exceptional catastrophes and private events, may in turn shape subjectivity. In *Life and Words*, Veena Das works to “to find a medium to portray the relation between the critical events that shaped large historical questions and everyday life” (Das 2007: 2). As she writes, “my interest is...not in describing these moments of horror but rather in describing what happens to the subject and world when the memory of such events is folded into ongoing relationships” (2007: 8). Similarly focusing on questions of the relation between events and subjectivity, Jarrett Zigon (2013) draws on Alain Badiou’s (2001) philosophy of the Event² in his analysis of events of love as “an ethical procedure or process by which one attempts to cultivate new moral subjectivities” (Zigon 2013: 204). Likewise, Carolyn Humphrey, also drawing on the work of Badiou, has drawn attention to the “decision-events,” the many moments in people’s lives in which “a link is made between the intelligible known persona(e) one was before the break of the event and the other persona—also intelligible but belonging to a different conception/perspective— that one becomes” (Humphrey 2008: 320). As Humphrey writes, the moment of the “decision-event” is one in which a person “opens themselves to a radically different composition of the self, a switch that has a lasting effect and involves the most significant—but not all—ways in which that person conceives of her or himself” (2008: 371).

² For Badiou, the Event can generate subjects and forms of subjectivity through a truth procedure he calls “fidelity to the Event” (2001).

Intersubjectivity

In *Time and the Other*, Johannes Fabian wrote that “there is no knowledge of the Other which is not also a temporal, historical, a political act” (1983:1). Building on this insight, the approach to the ethnographic material in this dissertation is defined by an attention to temporality, intersubjectivity, and the intersubjective production of anthropological knowledge. In the 1980s, Fabian demonstrated that throughout the history of anthropology, the deployment of “time” in representations of the Other has been shown to function as a form of distancing through the “denial of coevalness,” that is, the “persistent and systematic tendency to place the referent(s) of anthropology in a Time other than the present of the producer of anthropological discourse” (Fabian 1983: 31). Drawing on Alfred Schutz’s application of phenomenology to the social sciences, Fabian argued that the recognition of “intersubjective time” is a powerful corrective to the “denial of coevalness” of the Other. As he writes,

To recognize *Intersubjective Time* would seem to preclude any sort of distancing almost by definition. After all, phenomenologists tried to demonstrate with their analyses that social interaction presupposes intersubjectivity, which in turn is inconceivable without assuming that the participants involved are coeval, i.e. share the same Time (Fabian 1983: 30).

Fabian’s concept of intersubjective time follows Husserl’s original notion of intersubjectivity as the foundation for social action, i.e. “the condition whereby I maintain the assumption that the world as it presents itself to me is the same world as it presents itself to you, not because you can ‘read my mind’ but because I assume that *if you were* in my place you *would* see it the way I see it” (Duranti 2010: 6). Husserl’s idea of intersubjectivity is reiterated in Schutz’s notion the “We-relationship.” For Schutz, “...the pure We-relationship, which is the very form of every encounter with another person, is not itself grasped *reflectively* within the face-to-face situation. Instead of being observed, it is lived through” (Schutz 1967: 170). From this perspective, intersubjectivity, at its most basic level,

is a concept that describes being with another in time. I combine this foundational understanding of intersubjectivity with Michael Jackson's approach that recognizes that "the field of intersubjectivity includes persons, ancestors, spirits, collective representations, and material things" (Jackson 1998: 9).

This dissertation aims to contribute an examination of the intersubjective dimensions of insecurity and intervention by exploring how these forces structure programs, generate forms of affliction and care, perceive and prescribe mental health care, and manifest in interactions between people, including the ethnographer. In this way, my ethnographic focus is not on individual subjective experience, but on interaction and intersubjectivity, and the forces—geological, historical, social, economic—that create the conditions for these encounters.

Dissertation Summary

Chapter 1 situates the field of psychiatry, psychosocial intervention, and the rise of mental health NGOs in Nepal within a broader history of global health, development, and local politics. I argue that shifting trends in global health development aid can be identified through the history of mental health intervention in Nepal, and that Nepal has figured as an important site in the production of knowledge for the field of global mental health, providing data, case studies, and evidence, and serving as a node through which experts in the network of global mental health and psychosocial intervention have circulated.

Chapter 2 describes the psychiatric and psychosocial discourse of "conversion disorder" and "mass conversion disorder" in Nepal. In this chapter I ask, who did Nepali psychiatrists and psychologists imagine were the subjects of conversion disorder? What understandings of clients were embedded in their various ways of intervening in this form of affliction?

Chapter 3 examines a case of adolescent "mass hysteria" through the Nepali concept of *chhopne*, which means "to cover" or "to conceal," and implies the work of *bhut/pret* and *pissach*, spirits

of those who died a bad death. In this chapter, I present a case as it unfolded in a rural government school where there was no psychosocial intervention. In doing so, I consider the methodological and theoretical implications of studying a form of transient affliction, that appears and then disappears, that begins with one person and spreads to multiple others.

Chapter 4 describes my subjective experience of the 2015 Nepal earthquake through a reflection on the limits of writing.

Chapter 5 is an ethnographic description of the emergence of a new “mental health crisis” in Nepal after the earthquake, and the humanitarian mental health response and projects of “disaster development” that followed. In this chapter I describe the strategic uses of crisis that serve as the basis of the “Building Back Better” approach.

Chapter 6 follows the work of a Nepali NGO which had been sub-contracted to provide “earthquake counseling” to communities impacted by the disaster. In the midst of this project of humanitarian psychosocial intervention, both care and suffering emerged in unexpected and accidental forms. People in earthquake affected areas were not necessarily suffering from problems related to the earthquake. Many were able to receive mental health and psychosocial care for the first time because they happened to live in an earthquake affected area. Yet this care would only last as long as the funding for “earthquake counseling” continued and communities were deemed to be victims of disaster. In this chapter I discuss these paradoxes of humanitarian care as well as the accidental and improvised dimensions of the therapeutic encounters themselves by drawing on participant observation with psychosocial counselors and their clients in three of the 14 earthquake-affected districts.

In chapter 7 I continue to follow the work of post-disaster psychosocial counseling in Nepal, with a focus on the question of therapeutic efficacy. What can ethnography tell us about therapeutic efficacy in the context of transient care, and what might it offer to the discussion of evidence and

the place of qualitative research methods in global mental health projects more generally? The idea that such humanitarian mental health interventions are efficacious is the underlying justification for such projects, yet determining how to measure such efficacy remains difficult in these ethically sensitive, time-limited projects. Inspired by recent discussions of the importance of ethnography to the practice of global mental health (Kohrt and Mendenhall 2016), as well as critical anthropological analyses of evidence and metrics in global health (Adams 2016), in this chapter I discuss the differing ways in which evidence for therapeutic efficacy and improvement, a central concern for everyone involved in the post-disaster psychosocial intervention I followed, was understood, recognized, measured, and commented on by participants in all levels of the project. In doing so I open a space for rethinking the problem of therapeutic efficacy in this particular milieu.

Methods

This study is based on two years of ethnographic fieldwork in Nepal, conducted from 2014-2016, in addition to four months of fieldwork conducted in 2012 and 2013. The majority of the research for this project was carried out in the capital city of Kathmandu and the eastern districts of Dolakha, Ramechhap, Okhaldunga, and Khotang. Additional research was conducted in the districts of Sindhupalchowk, Dang, Chitwan, and Nawalparasi.

The data on which this dissertation is based includes the analysis of newspaper articles published in Nepali and English; open-ended interviews with Nepali psychiatrists, psychologists, psychosocial counselors, community psychosocial workers, government officials as well as expatriate project managers and psychologists; illness narrative interviews with students afflicted by “mass hysteria” and their families; focus groups with teachers and community members in communities where cases of “mass hysteria” occurred; demographic household surveys of 150 households in a community where a case of adolescent “mass hysteria” occurred; and audio and video recordings of

therapeutic encounters (counselling sessions and shamanic healing), as well as of trainings on psychosocial counseling for Nepali counselors and supervisors. In addition to these methods, the foundation of this study was based on participant observation of the everyday activities of: a community and school where a case of “mass hysteria” occurred; an NGO for mental health and counseling; and a psychiatric department in a major Kathmandu teaching hospital. These observations were documented in jottings made throughout the day in a small notebook, and in fieldnotes written at the end of each day.

Data analysis consisted of transcribing, translating, and analyzing recordings of focus groups, counseling sessions, training sessions, and interviews, and triangulating this data with my fieldnotes for central themes. Working with the fieldnotes was a long process that entailed becoming intimate with the details I described. First I transcribed all handwritten fieldnotes into over 600 pages of typed notes. I then re-read the typed fieldnotes and took notes on these, through which I identified central themes.

I have dedicated this dissertation research to understanding and supporting the provision of mental health and psychosocial care in Nepal before and in the aftermath of the earthquake. I did this in a mode of collaboration with a Nepali NGO for mental health and counseling that I had already established a relationship with prior to the disaster. In the context of disaster, there was no other mode for field research to be conducted: I had to be implicated in the work, trying to help respond to the immediate issues on the ground based on the expertise that I brought to the field. Instead of withdrawing from the field and accepting to be evacuated as the disaster happened, I decided to stay and help as much as I could without any pretention to a salvationist stance.

After the earthquakes, I observed, documented, and participated in the work of this NGO which had been subcontracted by a number of donor organizations to provide mental health and psychosocial support to rural communities impacted by the disaster. This NGO had been one of the

leading groups providing mental health and psychosocial care in Nepal, and after the disaster served as a main actor in the humanitarian mental health response, ultimately reaching over 18,000 people across 40 earthquake-affected VDCs with psychoeducation and psychosocial first aid, and provided in-depth psychosocial counseling to 1,195 people.

I began this work when I was invited to join the NGO's team as an ethnographic consultant. The majority of my time was spent accompanying counselors on multiple trips as they traveled to different VDCs within their assigned district, meeting with clients and searching for new clients. While with the counselors I lived and travelled as they did—staying in the cracked homes and tin shelters of local villagers, and traveling by foot and by local bus when available. In a mode of collaborative research, I provided descriptions of what I saw to be shared and interpreted by different staff members in the organization, along with films of counseling sessions which were used to support the supervision of field counselors and as a teaching tool in trainings for the supervisors led by the foreign psychologist. The recordings of counseling sessions were done only after clients provided their informed consent. In many situations, recordings were not made. For all others, master copies were given to the NGO as part of their documentation work.

All names and identifying descriptors have been changed to protect confidentiality. Real names of organizations are used when permission has been granted, other names have been changed. My research was approved by the UCLA IRB (# 13-000717) and the Nepal Health Research Council (Reg no. 252).

Orthography and Naming

Research was conducted in *Nepali bhasa*, an Indo-Aryan language of Sanskrit origin, and in English. Definitions of Nepali words are from Sir Ralph Lilley Turner's *A Comparative Dictionary of the*

Nepali Language (1931), and supplemented by Ruth Laila Schmidt's *A Practical Dictionary of Modern Nepali* (1994).

PART I
HISTORIES

CHAPTER 1

A History of Intervention

Throughout the past 70 years, the shifting trends in global health development aid can be identified through a genealogy of mental health intervention in Nepal. Although this fact may give the impression that Nepal has been mostly a passive receiver of aid, I argue that Nepal has figured as an important site in the production of knowledge for the field of global mental health, providing data, case studies, and evidence, and as node through which key actors within the network of global mental health and psychosocial intervention have circulated. In this chapter, I trace the history of mental health intervention in Nepal and the rise of Nepali NGOs for mental health as it was constituted in and through an assemblage (Ong and Collier 2005) of historical events, local politics, personal relationships and trends in the field of global health development. As Kienzler and Amro have argued, “mental health system reforms are not mainly driven by scientific evidence and international standards, but rather by concrete political constellations, national and international development agendas, local and global socioeconomic contexts, and the interactions between differently positioned actors” (Kienzler and Amro 2015: 113).

Nepal as Nation State (1768-1951)

I begin with an overview of the creation of Nepal as a nation state under absolute monarchy in the 18th century and the shift to oligarchical rule in the 19th century, as these events prefigured the first movement for democracy in the 1950s, which in turn opened the borders of Nepal for development aid. The modern political history of what is now known as Nepal began in 1768, when Prithivi Narayan Shah and his army conquered Kathmandu and created the nation state of Nepal. Prior to this period of consolidation, the territory that lies within the borders of present day Nepal

was made up of more than 60 principalities. Prithivi Narayan Shah was a Gorkha leader, from the region of Gorkha in the western hills of Nepal. Gorkha is the origin place of the Khas language and culture, historical predecessors to the Nepali language and upper-caste Hindu “hill culture” that has remained ideologically dominant in the country today, although has been increasingly challenged by indigenous *janajati* and Madhesi rights movements since the 1990s (Toffin 2009). Throughout the early 1800s, wars were fought with both China and the British East India Company to secure the territory along the southern and northern borders of present day Nepal. The Shah Kings who continued to rule the Kingdom of Nepal throughout the 20th century were all direct descendants of the first conqueror, Prithivi Narayan Shah, who declared divine kingship as the reincarnation of the god Vishnu.

Inside the Shah palace in Kathmandu, political leadership of Nepal was limited to the King and a handful of elite high-caste Brahmin and Chhetri families who served in advisory roles. As Bhuwan Joshi and Leo Rose write in their early political history of Nepal, during this period “court conspiracies and intrigues were the only means available to induce changes in the government” (Joshi and Rose 1966: 25). Following the conspiracy and massacre of the leaders of powerful families in the Shah court, in 1846 the King appointed Jung Bahadur Rana as Prime Minister of Nepal. Jung Bahadur quickly began to leach power from the King, whose role became reduced to a symbolic functionary. Jung Bahadur Rana had effectively taken over and launched a new political system (Regmi 1978).

From this period forward, Jung Bahadur Rana established a line of political rule that his family alone controlled for over 100 years. Under the Rana oligarchy, the Shah kings continued to inhabit the palace, but held little political power. During their century of reign from 1846-1951, the Ranas, like the Shahs kings, avoided investment in the social welfare of their subjects; media was tightly controlled, hospitals and schools were reserved for the ruling urban high-caste male elite, and

a penal system, known as the *Muluki Ain*, conferred legal rights along lines of caste and ethnicity, dividing those who were “enslavable” from those who were “non-enslavable” (Höfer 1979). A highly exploitative system of land taxation kept the majority of the agricultural nation in debt and indentured (Regmi 1978). Joshi and Rose argue that the Ranas were able to maintain power by controlling the military, suppressing political rivals, discouraging education of the people, and cultivating an alliance with British colonizers in India (Joshi and Rose 1966: 36). For these reasons, although Nepal was never colonized by the British, many have likened the Rana period to a brutal form of internal colonization (Regmi 1978; Whelpton 2005). As Mahesh Regmi writes, in order to answer the question “why is Nepal poor,” one must first understand the “parasitic” relation between the state and the peasants during the 19th century (Regmi 1978: x).

The alliance that Jung Bahadur Rana cultivated with the British East India Company enabled the Ranas to maintain control over a sovereign Nepal but also played a part in their later demise. The Shah monarchy had lost considerable territory in the southern Terai during the Anglo-Nepali War (1814-1816). Jung Bahadur Rana was able to regain a significant portion of this territory from the British after he personally led an army of Nepali soldiers to aid the British East India Company in the suppression of the Indian Rebellion (also known as the Sepoy Rebellion or the First War of Indian Independence) in 1857. The outcome of this uprising, which the British won, transferred the colonial power of the British Raj in India from the East India Company to the British government. The alliance with the British continued throughout the century of Rana rule, as different generations of Ranas agreed to the recruitment of Gorkha soldiers into the British Army.³ In exchange, in 1923 the British government formally recognized Nepal as a sovereign nation (Joshi and Rose 1966: 37).

Open opposition to the Ranas only became possible after Indian independence from Britain in 1947. Anti-Rana groups had formed underground in both Kathmandu as well as in Banares, India

³ Nepali soldiers fought for the British in World War I and World War II.

(Varanasi). Both groups were made up of a small class of Nepali intellectuals and students who had studied in India beginning in the 1920s, and witnessed the Indian Independence movement. In the early 1920s the resistance group in India began to agitate against the Ranas from Banares through their publication of the first Nepali language newspaper, the *Gorkhali*. In the *Gorkhali*, the group published articles exposing the reality of life under Rana rule. It was this slow growing movement for democracy that ultimately succeeded in ending Rana rule in 1951.

In 1951, the Ranas were finally overthrown and Nepal emerged as a newly democratic nation. That same year, the first foreign development projects touched down in Nepal.⁴ The 1950's thus marked an era of massive international development aid in the newly democratic Himalayan nation. India, the United States, the Soviet Union, China, Australia, New Zealand, Norway, Germany (East and West), Sweden, and Japan all initiated and supported development projects throughout Nepal during this time (Mihaly 1965). The British government, which had up to a few years earlier enabled the oppressive Rana regime, began funding development projects to improve social services in Nepal. The aim of early development programs in Nepal included water, road, and irrigation projects, factory, school, and hospital construction, and scholarships for higher education study abroad. In the field of health, the focus was on disease eradication.

Revolution, “Development,” and the Eradication of Infectious Disease (1951-1960)

The vast foreign interest in Nepal's “development” must be placed in a broader context of the post-World War II period, when a number of European countries as well as the United States and Japan began to radically expand foreign aid abroad in the wake of decolonization and independence movements in Asia and Africa. Of the many countries that provided development aid

⁴ The earliest anthropological studies of Nepal date from this period as well (Turin 1997).

to Nepal in the 1950s, the first and largest donor to do so was the United States. In 1951, the United States created the United States Operations Mission (USOM), which later became USAID. The initiative was part of President Harry Truman's "Point IV" program, a turning point in post-World War II American foreign policy that introduced financial support for foreign development projects. From the American perspective, supporting development in Nepal, strategically located between China and India, was not merely a benevolent act but also served strategic political purposes. As Eugene Mihaly writes in his evaluation of the political uses of foreign aid in Nepal,

"Economic assistance came into use as a political device largely because of an idea...that the underdeveloped countries are being swept by a 'revolution of rising expectations'. According to this view the peoples of these countries are awakening. They are no longer passive in the face of poverty and misery but are demanding a better life...In the West, and particularly in the United States, foreign policy experts concluded that it was imperative that the newly aroused expectations should be satisfied; for if they were not, frustrated millions would turn to radical political solutions...Communism." (Mihaly 1965: 2)

From the beginning, US development projects in Nepal were ideologically motivated, and intended to transmit liberal, democratic values along with improved social services and infrastructure. As the USOM Nepal program director working in Nepal wrote in his unpublished manuscript, *The First Years*, describing his work in Nepal during this period, the objectives of the first USOM project in Nepal included increasing the production of food, improving housing, creating medical and educational facilities, building roads, developing hydropower and improving land irrigation, supporting reforestation, mining mineral resources, and "developing among the people...a love for liberty and respect for the individual" (Rose 1963: IV-16/17). By 1955, the budget of the USOM project in Nepal was over one million dollars (Mihaly 1965: 36).

Part of the USOM work in Nepal included the US-funded World Health Organization's "Insect Borne Disease Control Program," which focused on the eradication of malaria in the southern Terai region. The idea behind this project was that if the dangers of malaria were removed,

not only would people benefit from improved health, but vast tracts of previously inhospitable but fertile land could be opened up for farming on a large scale. Since the early 1800s, the government of Nepal had explicitly discouraged settlement in the border region in order to maintain the malarial jungle as “a barrier to external aggression” (Regmi 1978: 6). As Paul Rose wrote of the program in his report of the early work of USOM,

A malaria control program was initiated and the homes of more than one-half million people were sprayed with residual insecticides. An organization was established and personnel trained to bring about the control of malaria which the medical authorities considered the principal killer in Nepal (Rose 1963: VII-37).

In Nepal, the ramifications of malaria control were immense. As historian John Whelpton writes, “...the World Health Organization’s malaria eradication program in the Terai...paved the way for mass migration into the region from the hills” (Whelpton 2005: 135). In the end, although malaria was never fully eradicated, the reduction of malarial mosquitos enabled the re-settlement of the Terai region, a process by which the original inhabitants, particularly the indigenous Tharu people, were disenfranchised from their land, many becoming indentured laborers of the high-caste migrants from the middle-hills (Guneratne 2002: 4). The US government and the World Health Organization’s focus eradicating malaria in Nepal was one instance of the international turn to “technical assistance” in the “vertical” (top-down) eradication of infectious disease beginning in the 1950s, what historian Randall Packard has referred to as “the era of eradication” in the history of global health (Packard 2016). As Judith Justice has noted in her early study of foreign aid and health development in Nepal, the 1950s-1970s marked a period of “focus on disease-specific programs and expansion of Kathmandu hospital-based services” (Justice 1986: 9).

Primary Health Care under the Panchayat (1960-1990)

Eight years after the end of the Rana era, Nepal's first democratic elections were held in 1959, but the new democratically-elected government stayed in power only one year. In 1960, King Mahendra, a descendent of the original Shah monarchy, staged a coup and seized power from the Nepali Congress leaders, ending the first popularly elected government in Nepal. Citing the lack of social services and need for development and modernization, the King argued that a return to monarchy rule was in the interest of the nation, because the elected "Ministry did not pay any attention to the miserable and poverty-stricken conditions of the people" (Shah 1967:5, cited in Adhikary 1995). This marked the beginning of a thirty-year period of direct rule. In 1962, King Mahendra created a new constitution, officially banned all political parties, and called his new form of government Panchayat "guided democracy." In Nepali *panchayat* means "five-person council," and in referencing this term Mahendra aimed to create a narrative that his new "partyless Panchayat democracy" was neither like Indian democracy to the south, nor Chinese communism to the north, but instead a typically Nepali, indigenous form of governance. Yet in practice, *panchayat* in Nepal had been "instruments of caste regulation or...judicial bodies in the implementation of Brahmanic social regulations" (Joshi and Rose 1966: 397).⁵

According to King Mahendra, the overarching goal of the Panchayat system was to 'create a partyless healthy, clean, and advanced society' (Joshi and Rose 1966: 406). This objective was in line with the projects of foreign aid, which continued through this time, and the Panchayat period was thus also an era of rapid modernization and bureaucratization in the sectors of education, health,

⁵ Under "guided democracy," village and town *panchayats* were elected by an assembly of villagers. Once elected, this group of 9 men would serve a 6-year term, and were given taxation, administration and judicial authority. A portion of these elected panchayats then elected the district and zonal *panchayats*, who then elected the national *panchayat*. In order to deter groups such as women, youth, laborers, peasants or students from political activism, King Mahendra established "class organizations" as the only legal form of organizing that could be done by these groups (Joshi and Rose 1966).

telecommunications and infrastructure. Yet despite the fact that during this period the government began to write “Five Year Plans” for development, in reality the objectives of development were decided by the donor nations—particularly the leading donors: China, the Soviet Union, India, and the United States— who were providing over 70% of the budget for development. As Joshi and Rose write,

Nepali views on priorities in economic development have to be fitted into this complex structure, and it is little wonder that the government has never really attempted to conceptualize a pattern of economic development that is anything more than a collection of unrelated and sometimes inconsistent development projects. The Nepal government is in no position to extend much practical guidance to the foreign aid agencies in formulating their programs, much less to insist that they conform to an established pattern. As a result, the foreign sources of aid often decide what is to be offered, and the Nepal government has no alternative but to accept, even when the programs do not conform to its priority schedule” (1966: 473).

Modernization in the field of health meant that over the thirty years that stretched between 1950 to the late 1970s, there was a major expansion of health services, including the creation of the Ministry of Health, the construction of 70 hospitals, 550 health posts, and the training of 450 biomedical doctors (Justice 1986: 9). In this way, in Nepal “development” also enabled the rapid expansion of bureaucratic state power in the sphere of health (c.f. Ferguson 1990).

Within the World Health Organization, the 1970s saw the emergence of a new paradigm for international health. This was a shift from “vertical” programs of disease eradication and population control, to so-called “horizontal” programs for primary health care, including, for the first time, mental health (Packard 2016). In the late 1960s, the WHO had begun to focus explicitly on mental health as a problem in so-called developing countries, culminating in the seminal 1973 WHO “International Pilot Study of Schizophrenia,” which aimed to determine the universality of schizophrenia and its symptomology (WHO 1973). In 1978, the Alma-Ata Declaration was inaugurated, in which health was defined as “a state of complete physical, mental, and social

wellbeing and not merely the absence of disease or infirmity” and framed as “a fundamental human right.”⁶ Reflecting the Alma-Ata goals, the 1970s–1980s ushered in a new period of donor funded projects for the development of primary health care in the global South (Packard 2016). This was also true in the case of Nepal, which saw an increase in community health projects during this time (Justice 1986).

Yet the shift in health development agencies from population control and technical assistance as a solution to poverty in the 1960s and 70s, to primary health care via the Alma-Ata Declaration was not without its critics, both at the level of its ideology and discourse (Navarro 1984) and as it was put into practice in Nepal (Stone 1986). For example, Vicente Navarro has critiqued the ideology embedded in the Alma Ata Declaration and the WHO more generally for its apolitical stance toward health (Navarro 1984). As Navarro writes, the “WHO, while being a technical agency of the United Nations, is also a political agency which reproduces and distributes political positions through its technological discourse and practices” (Navarro 1984: 165). In the context of the Alma-Ata declaration and shift to primary health care, although the emphasis is on “community participation,” community is defined as an “aggregate of individuals” (Navarro 1984: 168, cited in Adams 1998), and “community participation” is defined as “the process by which individuals (and families) assume responsibility for their own health and welfare and for those in the community who develop the capacity to contribute to their and the community’s development” (International Conference on Primary Health Care 1978: 20, cited in Navarro 1984). Furthermore, Navarro argues that improvements in health have historically occurred not through health sector reform, but through “changes in economic, social, and political structures” via liberation movements (Navarro

⁶ “The Conference strongly reaffirms that health, which is a state of complete physical, mental and social wellbeing, and not merely the absence of disease or infirmity, is a fundamental human right and that the attainment of the highest possible level of health is a most important world-wide social goal whose realization requires the action of many other social and economic sectors in addition to the health sector” (World Health Organization 1978).

1984: 169). Navarro argues that while a focus on the expansion of primary health care in the global South was clearly a positive shift, the idea that increasing access to care is the central element in the improvement of health sidesteps political questions regarding structures of inequality and their relation to health.

It was during this period that mental health first appeared as an object of foreign development in Nepal. Supporting the effort financially and with expertise was United Missions Nepal, a Christian missionary organization that had been undertaking multi-sector development projects in Nepal since the early 1950s, but which has been particularly recognized in Nepal for their work in the field of health (Harper 2014). In 1984, United Missions Nepal (UMN) launched the “Mental Health Project,” the first of its kind in Nepal, in collaboration with the Government of Nepal, the Nepal Ministries of Health and Education, the National Planning Commission and other Christian INGOs. One part of this project, which ran from 1984-2003, involved the development of psychiatric services and training in the newly created Institute of Medicine at Tribhuvan University Teaching Hospital (IOM-TUTH) (Aich 2010). A second part of the project was a drug abuse program in the Kathmandu Valley. The third part was the “Community Mental Health Project,” which was initially piloted in Lalitpur, and later expanded to four districts over a period of 14 years (Acland 2002). The project was initially justified by a study by Shrestha, Pach and Rimal (1983), in which they found that over 10% of people in a village south of Kathmandu were suffering from mental illness (Acland 2002: 129). The community mental health program drew on an Indian community mental health model, in which mental health services were integrated into the already existing community health services run by UMN at the health-post level, and health workers received training in the identification of mental illness. A description of the UMN project was included in the *World Mental Health Casebook* (Cohen, Kleinman and Saraceno 2002) as an exemplary case study.

According to Sarah Acland, “the promotion of mental health and mental health legislation in Nepal owes a great deal to the work of religious foundations” (Acland 2002: 127). In 1996, with guidance from UMN, the Nepal Mental Health Policy was drafted, calling for the creation of a mental health department within the Ministry of Health (Acland 2002). Out of this project the Center for Mental Health and Counseling (CMC) was established, which later became an independent NGO in 2003.

The People’s War and the Rise of Mental Health NGOs (1990-2006)

The 1990s marked a period of intense political conflict and transformation in Nepal. Pressure for democracy had been building over a period of thirty years, during which time King Mahendra had ruled the nation without allowing political representation. The Panchayat system had been not only a thinly disguised form of absolute monarchy, but its highly authoritarian design encouraged nepotism and corruption, and protected the interests of powerful upper-caste panchayats who gained power through loyalty to the King and his ministers (Adams 1998). By the early 1990s, Nepal’s per capita GDP was 200 USD, with the highest level of income inequality in Asia (von Einsiedel et al. 2012: 16).

In 1990, a coalition of banned-political parties, including Nepali Congress and a consortium of seven communist parties who called themselves the “United Left Front,” backed by the support of Indian political parties across the border, began the First People’s Movement (*Jan Andolan I*). “As the movement progressed, it drew large swathes of Nepali society, including marginalized groups, professional classes, and trade unions, into a broad alliance, with the pro-democracy political parties, challenging the Panchayat’s grip” (von Einsiedel et al. 2012: 7). As a result of the First People’s Movement, political parties were restored, the Panchayat era ended, and a new constitution was promulgated in 1990. Yet in this document the monarchy continued to hold power, and Nepal

became a “constitutional monarchy” in which the King maintained control over the Royal Nepal Army.

Between 1991-2002, a series of twelve short-lived, unstable governments attempted to lead the nation. Leadership alternated between the conservative Nepali Congress party, which supported “constitutional monarchy” and represented the middle-class, and the Communist Party Nepal-United Marxist Leninist party (CPN-UML). This series of unstable governments did little to improve the quality of life for the poor majority. Meanwhile, a new political party had been gathering strength in the villages of the Mid-Western hills. They called themselves Maoists as they drew directly on the tactical strategies of Mao Zedong. The philosophical mind behind the party’s ideology was Baburam Bhattari, an upper-caste man raised in a village in Gorkha district, who had gone on to receive his PhD from Jawaharlal Nehru University in Delhi. The title of his thesis was “The Nature of Underdevelopment and Regional Structure of Nepal: A Marxist Analysis.” As Aditya Adhikari explains, according to the Maoists,

The efforts of NGOs to bring development to the countryside were merely a ploy to pacify the poor, defuse class struggle and ultimately preserve existing social relations. Violent class struggle, led by a revolutionary communist party, was necessary to uproot the feudal class from the countryside and to eventually abolish the monarchy, its ultimate protector and guardian (Adhikari 2014: 21).

Far from Gorkha, the political parties in the capital of Kathmandu paid little attention to the Maoist cell in the Mid-Western hills. In 1996 the Maoists submitted a letter to the Prime Minister, then a Nepali Congress leader. Listed in the document were 40 demands and an ultimatum: if the demands were not met, the Maoists would launch an insurgency. The letter was ignored, and the Maoists declared a war against the state. In his essay “The Political Economy of the People’s War,” Baburam Bhattarai, Maoist leader, explains the reasons behind the need for an armed struggle:

It has become necessary to wage a People’s War in Nepal in order to gain liberation from the oppression of imperialism and to march forward along the path of self-reliant development. From this point of view, the People’s War in Nepal is part of

the world anti-imperialist national liberation movement” (Bhattarai 2003: 123).

Bhattarai calls for an end to the “old semi-feudal/semi-colonial system” that had been sustained by keeping the rural poor trapped in cycles of debt through high-interest loans and exploitative patron-client relations, and by keeping Nepal captive to the Indian market. In this way, according to Bhattari, the revolutionary policy should promote land reform, national industrialization, and “regional balance and integrated development.” The means to achieving these goals was through a protracted “People’s War.”⁷

The struggle between the state, represented at that time by the Nepali Congress party and King Birendra (followed by King Gyanendra after Birendra’s assassination in the 2001 Royal Massacre), and the Maoist People’s Liberation Army was long and violent. By the end of the war over 13,000 people, including civilians, had lost their lives. Many had been raped and tortured at the hands of both the Nepal Police and the Maoists, others had been disappeared. Maoists took to the hills to stage their battles, moving from village to village by night where they forced locals to provide them with food and shelter. By day the Nepal Police would follow, tracking the Maoists and brutally punishing, and often torturing, raping and killing, any villager suspected of providing shelter to the Maoists (Thapa 2011; Pettigrew 2013). Maoists were known for recruiting young children into their ranks as they moved through different villages, often stopping at schools where they gave ideological speeches. Children were forced to join armed groups, and many witnessed the death of their relatives (Kohrt et al. 2010). The fragmentation of village life during this period created deep rents of distrust between people, particularly in rural communities (Pettigrew 2013). In the midst of this violence, human rights organizations began to pay close attention to the situation on the ground, documenting cases of torture and murder and publishing them for an international audience (Thapa

⁷ Tactics of the People’s War were drawn from Chinese Maoists in which an armed People’s Liberation Army lures the State supported military into unfamiliar rural territory where they have the advantage of local knowledge of the terrain.

2011; Weyerman 2010). Occurring simultaneously with the People's War was the influx of 100,000 ethnically Nepali Bhutanese refugees into Nepal, who were resettled in the Eastern district of Jhapa by the United Nations High Commissioner for Refugees (UNHCR).

In February 2005, King Gyanendra took power through a military coup and banned political parties by declaring a state of emergency. In an address to the nation he justified his actions, arguing that "Nepal's bitter experience over the past few years tends to show that democracy and progress contradict each other" (cited in Adhikari 2014: 171). Later that year, in an organized resistance, the banned political parties, both Maoists and a coalition of seven established political parties (SPA), met in Delhi, India and signed a Twelve-Point Understanding in which they agreed on a system of multi-party democracy, federalism, and the creation of a new Constitution through a Constituent Assembly (Adhikari 2014: 179). In April 2006, with the support of the banned parties, a Second People's Movement (*Jan Andolan II*) inspired millions of people in Kathmandu and in district capitals across the country to engage in public demonstrations demanding the end of the monarchy. By November 2006 the Maoists and the SPA agreed to sign a "Comprehensive Peace Accord"; the Maoists had become officially incorporated into the government (Adhikari 2014: 208). In 2008, the new Constituent Assembly abolished the monarchy and declared Nepal a Federal Democratic Republic. This was to be an era of a "New Nepal," *Naya Nepal*.

The influx of 100,000 Bhutanese refugees to Nepal during the 1990s, combined with the violence of the People's War that spanned for a decade from 1996-2006, drew a new breed of international interventions to Nepal. These were peace and conflict programs funded by development and UN agencies, and in the area of mental health, they were psychosocial interventions for conflict-affected communities, with a particular focus on victim groups, as opposed to mental health system development. A number of mental health NGOs were built up in Kathmandu during this time. As Upadhaya et al. write, "...the emergence of mental health NGOs

started only after the 1990s with the numbers increasing during the ten years of the Maoist conflict (1996-2006)” (Upadhaya et al. 2014:114). This growth of mental health NGOs in Nepal during the People’s War was directly linked to the availability of donor funding for psychosocial support in conflict-affected “fragile states.”

This new mode of mental health intervention in Nepal fit into broader, global trends in public mental health (not yet called “Global Mental Health): particularly the growing field of psychosocial support in humanitarian and conflict-affected settings, a form of intervention justified in the language of human rights, and motivated by the idea that by treating the psychological wounds of war and violence among individuals and communities, it would be possible for the nation to fully heal and become stable enough to rebuild (Abramowitz 2009; de Jong 2002). This work has occurred at a global scale, but has been particularly widespread in Bosnia, Kosovo, Gaza and the West Bank (Abramowitz and Kleinman 2008; Fassin 2008; Pupavac 2002).

A review I compiled of 55 past and present projects listed on the websites of the three leading mental health NGOs in Nepal documents the shifting trends in donor-funded mental health and psychosocial support projects in Nepal over the past two decades that have also been pointed out by Luitel et al. (2015). The majority of the early projects were directly related to providing psychosocial support to conflict-affected communities, and to aid in the reintegration of “Children Associated with Armed Forces and Armed Groups (CAAFAG).” Since then, foreign donor-funded projects from a myriad of countries have continued to focus on providing psychosocial support to specific groups of people based on their victim status, including survivors of Gender Based Violence (GBV), women and children affected by HIV/AIDS, former child soldiers, women working in the “entertainment sector,” migrants and their families, Bhutanese refugees, and most recently, earthquake-affected communities. It was only after the emergence of the Global Mental

Health movement that donor-funded projects for the development of the mental health system in Nepal began to appear.

Humanitarian Mental Health Interventions and Psychosocial Support (MHPSS)

A number of scholars have traced the genealogy of the concept of trauma and PTSD from its initial emergence during World War I, to the creation of PTSD as a diagnostic category in the DSM following the Vietnam War, to the globalization of trauma and PTSD in humanitarian interventions (Fassin and Rechtman 2009; Watters 2010; Young 1994). Humanitarian mental health interventions to provide trauma counseling for victims of war and disaster trace their origins to responses to the conflict in Bosnia-Herzegovina and the West Bank and Gaza during the 1990s (Abramowitz 2009; Fassin and Rechtman 2009). Subsequently, the centrality of PTSD and trauma diagnoses in the context of such psychosocial interventions have been the focus of intense controversy and critique (Pupavac 2001, 2002; Summerfield 1999), yet the use of short-term psychosocial interventions as part of the humanitarian response to disasters and violent conflict remains widespread, with a wide range of INGOs and multilateral aid organizations funding and implementing such interventions not only in contexts of war but also in disaster, such as the Indian Ocean Tsunami in 2004 (Watters 2010). Of these, Médecins Sans Frontières and Médecins du Monde have been two of the most visible organizations involved (Fassin 2012; Redfield 2013).

Adjacent to and overlapping with such humanitarian interventions, conducted by an array of organizations, are psychosocial interventions and mental health programs in post-conflict settings, funded by UN organizations, bilateral development organizations, and INGOs. Such interventions build on the language of human rights, and are motivated by the need to re-build stability in societies affected by war through the rehabilitation of specific vulnerable groups, particularly women, children, and refugees (de Jong 2002). The argument for the necessity of psychosocial intervention

is supported through reference to rates of PTSD in affected populations affected by violence and displaced by war. Joop de Jong's 2002 edited volume, *Trauma, War and Violence* is an important citation in this literature, and data from Nepal played a role in providing evidence for this approach, as de Jong was directly involved in research interventions for survivors of torture in Nepal in collaboration with the Nepali NGO the Centre for Victims of Torture (CVICT) (van Ommeren et al. 2002).

A paper written for The World Bank in 2005 outlines the conceptual framework and role of the Bank in supporting mental health in conflict-affected areas by illustrating “the links among conflicts, mental health and psychosocial disorders, social capital, human development and poverty” (Baingana et al. 2005: 2). From the perspective of The World Bank, supporting mental health in post-conflict contexts is aligned with the overarching aim of meeting the Millennium Development Goals, through the argument that “the effects of mental health and psychosocial disorders in conflict-affected populations can be an important constraint in reconstruction and development efforts” (Baingana et al. 2005: 6). Specific attention is paid to the cost of war on women, children and ex-combatants. Yet in the report, the authors note that “there is a general lack of evidence supporting the effectiveness of psychosocial and mental health interventions in conflict-affected regions” (Baingana et al. 2005:19).

By providing psychosocial support to individuals traumatized by war and violence, the hope is that previously traumatized victims will find ways to heal their trauma and become active participants in democracy and “peacebuilding”—the healing of traumatized individuals enables the healing of the post-conflict nation (Abramowitz 2009: 23). Yet as Erica Caple James has argued in her work on military and humanitarian interventions in Haiti, there “the actors providing postconflict assistance tended to view victims as human rights abuses through lenses that objectified or medicalized suffering. They were viewed categorically as ‘women,’ the ‘poorest of the poor,’

‘patients,’ or ‘vulnerable populations,’ rather than in terms of their contributions to democratic processes” (James 2010: 24).

Global Mental Health in Post-Conflict Nepal (2007-present)

In the 1990s, mental health began to be framed as a global problem by major international financial institutions as an issue worthy of investment. In 1993 the World Bank published *The World Development Report* (The World Bank 1993). This report introduced the concept of “disability adjusted life years” (DALYS), the number of years lost to disability caused by illness, arrayed by country and by type of illness, as a way to measure the “global burden of disease.” Building on this report was the publication of the highly influential *World Mental Health* report in 1995, the “first systematic attempt to survey the burden of suffering” related to mental, social and behavioral problems at a global scale (Desjarlais et al. 1995: 6). Here, mental wellbeing is framed both as a universal human right, and as an economic concern, for, according to this logic, by reducing the “burden of disease” caused by mental illness, it becomes possible to increase economic productivity.

In 2007, the Lancet commissioned the first Global Mental Health series (Cohen et al. 2007). The first paper in the series begins with the rallying cry, “No health without mental health” (Prince et al. 2007) and signals a return to the Alma-Ata goals of supporting the development of primary health care systems, with the inclusion of mental health. The argument is structured around findings from the WHO’s Global Burden of Disease Report, in which “about 14% of the global burden of disease has been attributed to neuropsychiatric disorders, mostly due to the chronically disabling nature of depression and other common mental disorders, alcohol-use and substance-use disorders, and psychosis” (Prince et al. 2007: 859). Within the category of non-communicable diseases, the 2005 report found neuropsychiatric disorders to be the leading cause of Disability-Adjusted Life-Years worldwide, accounting for 28% of DALYS.

When the measure of Years Lived with Disability (YDL) is used (as opposed to DALYS), the situation becomes increasingly dire, as the WHO 2005 report found that 31.7% of all Years Lived with Disability were due to neuropsychiatric conditions, with depression as the leading contributor of disability worldwide. Drawing on this evidence, the authors of the Global Mental Health series argue that in “low and middle income countries,” the quality of health services must be improved, psychosocial interventions must be developed and evaluated for effectiveness, health care systems must be strengthened to include mental health care, and mental health awareness must be raised. The need to address mental health at a global scale is supported by the argument that “mental health affects progress towards the achievement of several Millennium Development Goals, such as promotion of gender equality and empowerment of women, reduction of child mortality, improvement of maternal health, and reversal of the spread of HIV/AIDS” (Prince et al. 2007: 859). Although the word “global” is used, it is clear that Global Mental Health is a development initiative largely targeting “low and middle-income” countries in the global South, particularly concentrated in Africa and Asia.

Nepal has become a node in Global Mental Health research, intervention, and the production of evidence. A number of influential researchers connected to the Global Mental Health movement have worked in Nepal since the 1990s. Beginning in 2011, Nepal has been selected as a site for at least four major multi-country, multi-year Global Mental Health interventions, including the “Programme for Improving Mental Health Care (PRIME)” project, funded by the UK Department for International Development (DFID); the “Emerging Mental Health Systems in Low and Middle Income Countries (EMERALD)” project, funded by the European Commission and led by Kings College London; the “Mental Health Beyond Facilities” (mhBEF) project, funded by Grand Challenges Canada and led by Makerere University School of Public Health; and most recently the “Problem Management Plus (PM+)” project, funded by the World Health Organization.

Here Nepal, along with Ethiopia, India, Nigeria, South Africa, Uganda, and Liberia, has become an exemplary site of experiment for the evidence base of Global Mental Health movement. Most recently, the WHO-funded Problem Management Plus (PM+) intervention that runs from 2016-2019, will test the efficacy of 5-session psychological intervention using a randomized control trial (WHO 2016). Pilot testing of the intervention are underway in Pakistan and Kenya, and according to the implementing agency's website in Nepal, "the objective of this randomized control trial (RCT) in Nepal will inform whether WHO should release Group PM+ for global use".

Mental Health as New "Global Development Priority"

Most recently, in 2016 the World Bank in partnership with the World Health Organization held a high-profile event entitled "Out of the Shadows: Making Mental Health a Global Development Priority." Here, during the inaugural panel, mental health was framed as a major constraint to development. Citing figures showing that mental illness is the leading cause of years lived with disability (YLDs), it was announced that "1 trillion dollars is lost every year due to lost productivity in the work place due to depression and anxiety," while every dollar invested in the treatment of depression and anxiety yields a four dollar return in better health and the ability to work (The World Bank 2016). The role of The Bank in this new global crisis would be to provide funding and technical support in order to decrease the prevalence of mental illness in resource poor countries, with the ultimate goal of increasing economic productivity.

Importantly, not all developments in the field of mental health in Nepal have been donor driven. Much of the early development of psychiatric services in Nepal were initiated by Nepalis during the Panchayat period. In 1961, Dr. Bishnu Prasad Sharma established the first psychiatric out-patient department at Bir Hospital, and throughout the 1960s and 1970s, additional hospital-based

psychiatric services slowly increased, but all remained centralized in Kathmandu.⁸ At least until the 1980s, for those without resources or guardians, confinement in the psychiatric prison of Dhulikhel Jail was common (Pach 1990). In the mid-1980s, Lagankhel Mental Hospital was established in Patan, and in the mid-1990s, psychiatric services and training were also built up in Eastern Nepal, at the BP Koirala Institute in Dharan through a Nepali-Indian collaboration. In 2010 the first private-sector psychiatric hospital was established in Kathmandu. Yet psychiatry in Nepal has remained largely separate from the donor-funded community-based projects implemented by Nepali mental health NGOs. Similarly, the use of shamanic healing (*dhamsi jhakri / bombo*), Ayurveda, and Tibetan medicine remain central treatment resources for many people in Nepal, and are frequently sought out in addition to biomedical treatment (Craig 2012). Yet within NGOs for mental health and counseling in Nepal, these forms of healing are generally situated at odds with the goals of “psychoeducation.”

Subjects of Intervention

The impact of the development industry and the discourse of development, *bikas*, in Nepal cannot be overstated. As Vincanne Adams has argued, health development, as one form of development within a larger milieu, functions as “an instrument of modernity” (Adams 1998: 23), and is dependent on “the ongoing representation of the target communities as ‘different’ and therefore needing intervention” (Adams 1998: 22). There is an extensive anthropological literature on international health development in Nepal (Harper 2014; Justice 1986; Pigg 1995; Stone 1986; Stone and Campbell 1984), particularly in relation to discourses of development and the problem of belief

⁸ Prior to this period, those seeking psychiatric services would travel to asylums in India. For example, in 1939 when the famous Nepali poet and Kathmandu intellectual Laxshmi Prasad Devkota suffered a nervous breakdown, he travelled to the “European Mental Hospital” in Ranchi, an asylum in Jharkhand, India, that had been established by the British in 1918 (today it has been renamed the Central Institute of Psychiatry). Devkota stayed in Ranchi for four months (Nepali Dreams, Rubin). His poem *Pagal*, (Mad), remains as a testament to his experience of affliction during this time.

(Adams 1998; Pigg 1996). As anthropologist Stacy Pigg has argued, “In Nepal, development has a different, more profoundly social meaning, a meaning that weaves *bikas* into the fabric of local life and patterns Nepalese national society” (Pigg 1992: 496). In her work on traditional healing, Pigg argues that the motivation of development workers from Kathmandu to look down on people who turn to shamans or *dhami-jhakris*, for healing is tied up in their efforts to distinguish themselves as modern, in opposition to others who they see as “underdeveloped.” As Pigg writes,

Nepali development functionaries use a language of cultural difference to pinpoint and describe the mentality of the target population. At the same time, these Nepali development workers are concerned to distinguish themselves from villagers, for it is precisely their status as “people who understand” that qualifies them for jobs in the development sector (Pigg 1996: 179).

Or, as Vincanne Adams has argued,

Because modernity operates upon subjects who think of themselves as citizens, its functioning is often thought to depend on the elimination of non-modern subjectivity, for everything non-modern comes to be seen as deviant (Adams 1998: 26).

More recently Laura Kunreuther has discussed the influx of neoliberal ideologies of directness, transparency, and care of the self, imported by international development agencies and promoted by FM radio programs in Nepal. These programs encourage and teach people to speak about their desires as self-conscious individuals. As Kunreuther writes,

The ideology of directness imagines a transparent relation between voiced expression and interior thought in ways that irony and other forms of indirect discourse complicate. The kind of subjectivity associated with the directness of FM radio transmission, shaped by neoliberal ideologies of the development industry and the political aspirations of a burgeoning democracy, is notably quite different than the subjectivity enacted by indirect or ironic voices (Kunreuther 2010: 341).

Additionally, Kunreuther analyzes the introduction of new discussions of the cultivation of “life skills” through booklets published by UNICEF, particularly those which address psychosocial problems among youth. These booklets include titles such as “How to determine one’s own goals?”

“How to control one’s own life?” and “Adolescent’s curiosities,” among others (Kunreuther 2010: 343). Ultimately Kunreuther argues that Protestant moral ideologies, imported to Nepal via Euro-American development projects, are encouraging Nepali citizens to become neoliberal subjects.

Following the work of Adams, Kunreuther, Pigg, and Stone one could argue that the effort to produce “modern” subjects is a central part of the work of psychosocial interventions in Nepal, particularly through the practice of “psychoeducation.” As Adams (1998) and Stone (1986) have pointed out in the context of health interventions in Nepal more generally, “culture” is frequently seen as a barrier to development, and great efforts are made toward the “eradication of traditional belief as ‘non-modern’” (Adams 1998: 74). Such attitudes, held and disseminated by Nepali health workers themselves, are often tied up with a complicated relationship to “tradition,” what Ashish Nandy has described through his concept of “the intimate enemy” (Nandy 1983, cited in Adams 1998) and what Dipesh Chakrabarty has described as the fragmentary, “heterotemporal” nature of postcolonial subjectivity (Chakrabarty 2000).

The necessity for mental health programs in Nepal to directly address traditional beliefs in ghosts, magic, and the supernatural is evident in the early training materials used by United Missions Nepal in their Mental Health Program during the 1980s and 90s. The problem of belief is addressed in the next two chapters, which focus on the overlapping concepts of “conversion disorder” and *chhopne* as caused by *bhut/pret*, *pissach laagne* in the context of psychosocial interventions for cases of adolescent “mass hysteria,” also referred to in Nepal as “mass conversion disorder.”



Figure 1 “Behavior Attributed to Black Magic” / “bhutpret wa aatmako prbhaav hunu.”
United Missions Nepal Archives, Yale Divinity School.

जसमा भूतप्रेत वा आत्माको प्रभाव छ

- * केही दिनदेखि सावित्रीको व्यवहार सामान्य छैन ।
- * एक धामी भर्त्रीबाट उनको उपचार भैरहेको छ ।
- * उनको परिवारले उनमा भूतप्रेत या कुनै आत्मा चढेको छ भन्ने सोच्छन् ।
- * जाडु-टुना वा भूतप्रेत लागेर भएको ठानिने रोगीको व्यवहार मानसिक रोगको लक्षण पनि हुन सक्छ ।

WHO IS POSSESSED BY BHUTAS OR SPIRITS

- * Savitri has been behaving abnormally in recent times.
- * She is being treated by a Jhankri (Witch - Doctor).
- * The family members believe that she is influenced by evil spirits.
- * Behavior attributed to black magic or evil spirits can be due to mental illness.

Figure 2. “Who is Possessed by Bhutas or Spirits.”
United Missions Nepal Archives, Yale Divinity School.

PART II
CONCEPTS

CHAPTER 2

The Problem of “Conversion Disorder”

In the summer of 2012 I travelled to Nepal to conduct preliminary research on trauma, migration, and mental health in Nepal. At UCLA I had been a fellow in the Culture, Brain, Development and Mental Health program (CBDMH), funded by the Foundation for Psychocultural Research (FPR), which had a fieldsite in Nepal to study trauma-related disorders from a neuropsychiatric and ethnographic perspective. Through my connection with CBDMH, I gained an affiliation with a Nepali NGO for mental health and counseling in Kathmandu. Once I arrived in Kathmandu, the organization generously allowed me to work from the NGO library where I began to learn about the everyday activities of the organization and their current projects. That summer, the NGO invited me to attend a mental health training for health post workers in the mid-western Terai district of Dang. Dang had been both a central site of violence and destination for people displaced by violence during the People’s War that had ended in 2006. Since then, the organization had served as an implementing agency for both international global mental health research and community mental health interventions on PTSD and trauma in the district. As part of their ongoing work in Dang, the NGO had received funding to conduct a series of mental health trainings for health post workers with the aim of supporting mental health in the long-term. The health worker training was thus done in relation to these earlier projects as a way to improve awareness and treatment of mental illness and psychological distress in an area where many had experienced violence, loss, and torture during the war.

It was during this training for rural health post workers in 2012 that I first learned of the problem of adolescent “mass hysteria,” occurring among teenage girls in government schools.

In Nepal, episodes labeled as “mass hysteria,” or “mass conversion disorder,” have been

reported among adolescent girls in rural schools between the ages of 12-14, although a small number of boys have also been known to become afflicted. In rural Nepali-speaking villages, the affliction is commonly known as *chhopne* a term derived from the verb *chhopnu*, which is defined as “to cover,” but also shares the connotations “to attack,” “to catch,” “to pounce upon,” “to be overwhelmed with an emotion,” “to be overpowered by something,” or “to be paralyzed” (Turner 1965: 203). People suffering from *chhopne* often experience dizziness, clenched teeth and fists, “seeing black,” bouts of unconsciousness, fits of screaming, aggressive speech and sometimes frantic, uncontrollable walking (Pach et al. 2002). The term *chhopne* is used to describe cases of witchcraft and spirit possession, as well what psychiatrists and psychosocial counselors in Nepal refer to as “mass hysteria” or “mass conversion disorder” among groups of adolescent girls in schools. In the context of cases in public government schools, news articles have reported that once one individual shows symptoms others will follow suit, at times affecting hundreds of individuals (Ekantipur 2012a, 2012b, 2013a, 2013b; Shakya 2005, 2013; Sharma et al. 2010).

From 2012-2016 I created an archive of newspaper articles reporting cases of adolescent “mass hysteria” that were published in Nepali and English language online and print newspapers. I collected over 20 cases, reported in government schools across Nepal.

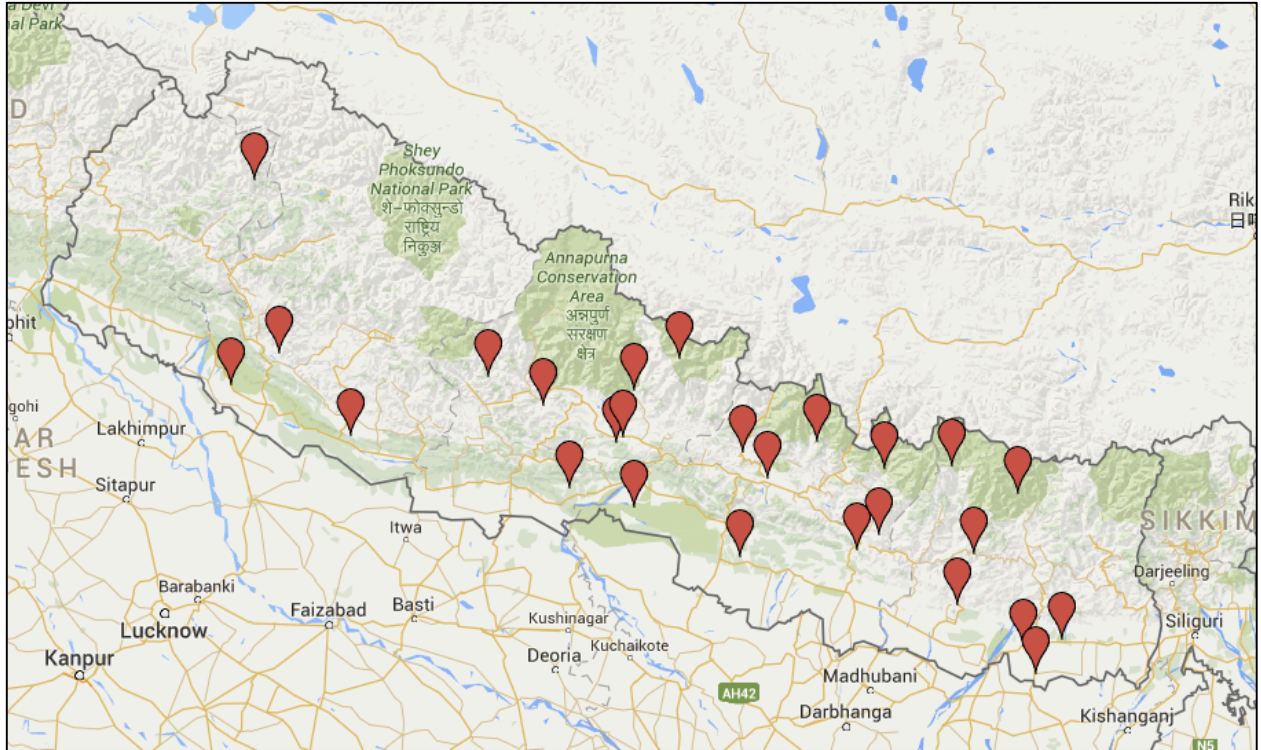


Figure 3 A map of 26 cases of "mass hysteria" as reported in Nepali news media (2012-2014).

Throughout my research in the out-patient psychiatric clinic of a Kathmandu hospital, in Kathmandu NGOs for mental health and counseling, and in rural villages in the hills of Eastern and Central Nepal, and the plains of Mid-Western Nepal before and after the disaster, I observed individual cases of “conversion disorder” and conducted interviews, focus groups, surveys and participant observation in relation to eight cases of adolescent “mass hysteria” occurring in six districts.⁹

This chapter examines psychiatric and psychosocial discourse around the diagnosis of “conversion disorder” in Nepal, specifically as it was applied to cases of adolescent “mass hysteria,” also referred to by psychiatrists and psychosocial counselors in Nepal as “mass conversion disorder.” I discuss images that were circulated of affliction and intervention; an expatriate

⁹ Dang, Nawalparasi, Chitwan, Sindhupalchowk, Dolakha, and Khotang.

psychologist's use of constellation therapy to support a psychosocial counselor in a case of "mass conversion disorder"; and observations of a psychosocial intervention for a case in an earthquake-affected village. In doing so I ask, who did Nepali psychiatrists and psychologists imagine were the subjects of conversion disorder? What understandings of clients were embedded in their various ways of intervening in this form of affliction and what were the gendered dimensions of this? By way of a conclusion I reflect on the problems raised by "conversion disorder" for global mental health and psychosocial interventions in Nepal.

Images

A colleague circulated a number of videos of a case of "mass conversion disorder" to me by email. He knew I would soon accompany a group of psychosocial counselors to observe their intervention in this particular case, and so he shared the films along with a detailed report that his team had compiled.

The first video is shot through the metal bars of a window. The camera is focused on a schoolgirl in her blue uniform as her body twists on the grass. Two male teachers stand near her. One makes eye contact with the camera and smiles slightly. As the girl rolls towards the edge of the hill, the other teacher grabs her arm and drags her back quickly, as if afraid she might strike him. She grabs one of his rubber sandals, leaving him standing with one shoe on. But then he snatches it back. She lays on her back on the ground, her arms outstretched, hands tense. Her sandals have fallen off, and her clothes are twisted. She is letting out high pitched howls and low cries, pounding the ground with her right hand, arching her back. One of the teachers has moved outside the frame, but the other stands near her, watching, his hands clasped behind his back. In addition to her cries you can hear the hushed sound of children talking in the background, perhaps they are also watching from the window. The second teacher walks away. Soon after the girl slowly sits up. As she stands,

she makes eye contact with the camera. Leaves are stuck in her hair. She straightens her shirt and tucks it into her skirt. She slips on her pink sandals and the video ends.

Then there is another video. This one shows a scene happening in the same place on the grass at the edge of a steep hill behind the pink school building. The person holding the camera is standing further away this time, focusing the screen on the unfolding situation. Three girls lay screaming on the grass while six students and a teacher stand nearby watching. Slowly the camera moves towards the group.

The next clip is focused on two schoolgirls writhing in the grass. One lets out high shrieks, the other holds her hands around her neck, as if she is choking herself. The teacher stands nearby. He keeps pulling the girls back from the edge of the steep hill whenever they come near to rolling down it, but when he does so the girls resist, kicking their legs and flailing their arms. Students who are watching the scene can be heard on the film. They are commenting on the girl whose hands are drawn around her throat. As the shrieking subsides, a student can be heard saying “now it has left her,” “*aba chordibalyo*”. Again, a girl nears the edge of the cliff and the teacher pulls her back by the leg. She responds with a sharp scream, and her body thrashes on the grass. One of the girls rolls off the edge. The other continues to hold her hands around her throat. The video ends.

In another video a girl has been taken to a separate room where she lays on a blue tarp, shrieking, her hands around her neck. Another girl sits in a chair watching her.

In the final videos five girls writhe and shriek, some on the grass at the top of the hill, while others have rolled off the edge and lay twisting and screaming among the foliage. A number of students have gathered to watch along with teachers and a member of the intervention team.

One month later I travelled to the rural school where these videos were shot to observe a psychosocial intervention for this case, which had not yet subsided. After a long day of travelling,

the counselors and I retired to the school computer room where would be spending the night. Pinky, a psychiatric nurse and counselor, showed us a film on her laptop. In the film, a psychiatrist is leading a training for health post workers on how to treat a case of conversion disorder. In the spirit of Charcot's theater, he had invited three women diagnosed with conversion disorder to come to the training so he could induce their symptoms and demonstrate treatment for the group. Six months later I met the psychiatrist in the video. We had travelled to a Christian missionary hospital 7 hours east of Kathmandu where he would be providing psychiatric services for a few days. He showed me, the psychiatric nurse, the driver and the woman managing the hospital guesthouse a video of him inducing a patient diagnosed with conversion disorder and then treating her. After we watched the film, the woman managing the guesthouse asked the psychiatrist if this was *chharre rog*, epilepsy. He told her that it was *chhopuwa rog*, i.e. *chhopne*, affliction caused by spirits. "Is that the one where you aren't supposed to show love?" "*maya nadekhone*," she asked. The psychiatrist confirmed this and explained the mechanism of the illness using the metaphor of a pressure cooker. The woman then told a story of a hospital staff member who also had such episodes, but was healed when she converted to Christianity. Later the psychiatrist explained to me privately that "these women use the symptoms in order to survive."

Survival

In Nepal, at the time of my research, "conversion disorder" was a widespread and common diagnosis, particularly among women. As one male doctor told me during the first week of my dissertation research in Nepal, "Oh hysterical conversion, most of the people here have that." Frequently, cases diagnosed as conversion disorder among both individuals and groups were also described with the English word "fainting" or Nepali *behos*, as well as the Nepali term *chhopne*, which will be discussed at length in the next chapter. Psychosocial counselors, psychiatrists, and

psychologists in Nepal held multiple understandings, often simultaneously, of the causes of conversion disorder among women and adolescent girls. One understanding linked conversion disorder to the inability to share and express one's emotions, explained through the gendered metaphor of the pressure cooker.

A pressure cooker is a common kitchen pot found in homes throughout South Asia that uses pressure to decrease cooking time. It is an object deeply associated with the world of women. Here the idea was that the *man*, the heart-mind, was like a pressure cooker. The pot is placed on top of the fire, the fire represents *tension*. On the lid of the pressure cooker is a valve that releases steam, the release of steam represents a person's ability to share her worries with others, steam is understood as a form of coping. Variables such as the thickness of the pot represent differences in personality, or the amount of fire wood, which represents varying levels of tension. If the pressure-releasing valve on the pot gets stuck, pressure builds up and the pot will explode. This explosion caused by built up pressure was the metaphor used for conversion disorder. The overarching idea being that if one cannot share her worries with others and instead keeps those worries to herself, then eventually the pressure will build up and require release. A guiding concept behind the pressure cooker metaphor was the idea that *tension*, if not addressed and verbalized, would be converted into the body and cause bodily symptoms along with dissociation and "fainting," a phenomenon also known as "somatization." Somatization is, as Kirmayer and Young have pointed out, "a term originally tied to a psychodynamic theory of illness causation in which psychological conflict was transformed or transduced into bodily distress" (Kirmayer and Young 1998: 420).

In Nepal, the ongoing dominance of patriarchy was frequently identified as a central cause of psychological conflict resulting in this form somatization. Somatic symptoms in the bodies of women became a way for clinicians to talk about forms of inequality. As one male psychiatrist in Kathmandu explained to me, "In our society, the girls, they get less chance for education, and there

is less opportunity for expression. They don't express much. Lots of things need to be...they have to suffer silently, many times. Of course, conversion is that. If you cannot resolve a conflict then it comes as some physical symptoms. So that is the basic principle.”

Or, as another male psychiatrist explained,

It's usually stress related. Young females usually have arguments with their parents. Married females usually have arguments with their in-laws. It is usually after an argument, or after a major stressor. Some relationship problems, boyfriend problems, fallen relationships, some physical trauma, some instances of infidelity, things like that. And because of those stressors, because of those arguments, some even try committing suicide, but some have conversion. They have fainting episodes, they have shouting, screaming episodes. Usually in Nepal when young females have conversion or hysteria they usually think it is some black magic. They usually go to a traditional faith healer, for treatment. And psychologically it works because they believe that an evil spirit has entered their soul or something like that, so after a puja, after visiting a faith healer they get better.... It is basically stress. They keep everything bottled up. And they try not to expose, try to appear happy, try to control it, but then later on it comes out in some form or the other. Because we have had conversion disorder cases in which people couldn't speak. They come totally mute. Some can't move their hands, can't move their legs, and usually get misdiagnosed. They get diagnosed as transverse myelitis, or something neurological, so that is an extra burden on them. Because conversion disorders, usually we see these females coming from far-away places. Outside of Kathmandu, outside of the valley. They have limited resources. And such patients requiring ICU setup, it is a huge cost.

Another Nepali psychiatrist who had received his training in the United States suggested that conversion disorder among women in Nepal was similar to diagnoses of borderline personality disorder among women in the United States, explaining that in the US he would see “five cases of borderline personality disorder per day” while in Nepal he would see “only one case every five months,” whereas it was the inverse for cases of conversion disorder. In the United States.¹⁰ For the Kathmandu-based counselors, psychiatrists and psychologists, conversion disorder was often described as an affliction of uneducated women living in rural areas, and recognizable sources of conflict that might lead to conversion disorder in women included the stress of school exams, the

¹⁰ Like conversion disorder in Nepal, in the United States, borderline personality disorder is primarily diagnosed among women. In the context of both disorders, manipulation of others is frequently suspected (c.f. Lester 2009, 2013).

pressure for early marriage, conflicts with in-laws, and the inability to express negative emotion. Emily Martin has explored the relationship between medical descriptions of female bodies and the perceptions American women have of their own bodies and senses of self. Focusing on pregnancy, birth, menstruation, and menopause, Martin analyzes the metaphors doctors use to describe these events and the impact of this medical discourse on perceptions of these processes. Ultimately this is a study of the ways in which scientific ideas are linked to cultural assumptions about the nature of “women” (1987). The gendered metaphor of the pressure cooker similarly discloses the way in which psychological discourse on the mechanism of conversion disorder in Nepal is linked to understandings of the nature of women’s emotion.

A second understanding that was held by many Nepali psychiatrists as well as psychosocial counselors was that symptoms of conversion disorder were a form of manipulation related to the ability to receive “primary and secondary gains.” In the context of conversion disorder, primary gain is understood as the unconscious motivation for the symptoms, while secondary gain is the benefit of having symptoms, such as increased care and attention provided by others, or the ability to avoid work and responsibilities. The treatment, from this perspective, is to firmly refuse to give in to secondary gains—hence the description of treatment as “*maya nadekhe*” or “show no love.” Identical observations have been pointed out by Sarah Pinto, who has written on women in North India diagnosed with dissociative disorder, also referred to there as “hysteria.” Her work on this topic is based on research in a public hospital and private psychiatric clinic in North India, where psychiatrists attended to patients in urban institutional settings. In this work, Pinto vividly describes the ways in which Indian psychiatrists understood female patients diagnosed with dissociative disorder as being in full control over their symptoms, which were used to manipulate others (Pinto 2014). This similarity is not surprising, as many psychiatrists in Nepal were trained either in India or by Indian psychiatrists (Aich 2010). As in North India, in Nepal diagnoses of conversion disorder

were often inseparable from gendered forms of power enacted through interactions between psychiatrists and their female clients. As Pinto observed,

The treatment of a disorder understood as female (even in men) by doctors who were in most cases male, or the scrutiny of a woman in deep distress by a room full of men, or the kinds of questions asked and behaviors made note of made [the hospital] a stark tableau of Indian psychiatry's gender arrangements, and allowed dissociative disorder to expose the heavy gendering of Indian medicine's performativity" (2014: 161).

A third understanding held among psychiatrists described conversion disorder as a form of "survival," particularly for lower class, high-caste Hindu rural women imagined to be trapped in oppressive family situations seen as "traditional" and "backwards." Here the intersection of class, caste, kinship, gender, and location became directly implicated in diagnosis. Perceptions of difference between caste, ethnic, and class groups were a common topic of discussion among people I met throughout my research in various locations across Nepal. Frequently, people from different caste and ethnic backgrounds critiqued the dominant *pahadi* culture of high-caste Hindu hill communities as the most restrictive for women, particularly in comparison to the perceived egalitarianism within indigenous janajati groups such as Sherpas, Rais, or Limbus. For example, in the village in Khotang where I conducted extended research on a case of "mass hysteria," when I would visit the home of a Rai school teacher in the neighboring Rai settlement he would often comment to me on what he saw as the distinction between his Rai community and the Chhetris of the village where the case had occurred. "They are not free like us," he explained, citing the evidence of lack of singing. He further noted that even at weddings, fathers from the Chhetri settlement would not allow their daughters to dance or to sing. Yet as Sherry Ortner has observed in the case of Sherpa communities in Nepal, which enact similarly "egalitarian" gender relations as that of Rai communities, while "women are encouraged to be competent, self-assured, independent actors...they are also hemmed in by distinctive structural constraints, and burdened by negative

ideology” (Ortner 1996: 128).

Such perceptions of restriction of high-caste Hindu women often focused on differences in kinship systems between indigenous *janajati* and Chhetri-Bahun communities. Within Chhetri-Bahun communities, many young women practiced the traditional form of patrilocal marriage, requiring them to move from their natal home, known as their *maiti*, to the home of their husband’s family, their *ghar*. This movement from *maiti* to *ghar* is seen as holding significant meaning in the lives of women. As Lynn Bennett has pointed out, traditionally a high-caste Hindu woman’s status shifts drastically when she moves from the position of daughter and sister to that of wife (or co-wife) and daughter-in-law (Bennett 1983). The *maiti* is idealized as a place where a daughter is given love, food, and care, while the *ghar* is a place where a daughter-in-law is initially an outsider. In the *ghar*, the relation between daughter-in-law, *buhari*, and mother-in-law, *sasu*, is frequently described as one in tension, in which *buharis* are dominated by their *sasus* (Bennett 1983). Such traditional kinship arrangements were seen as being pronounced in rural areas, as opposed to the urban cosmopolitan setting of Kathmandu.

Yet in rural areas, women were often reflexive about both marriage as well as the nature of the relationship between *buhari* and *sasu*, and many mother-in-laws went out of their way to critique abusive behavior of other mother-in-laws as wrong. Similarly, Laura Ahearn has described the relationship between changing practices and attitudes towards romantic love and marriage, increasing levels of literacy among rural communities, and social change in Nepal. With new attitudes towards romantic love, Ahearn found that young people in the rural community in which she worked were increasingly engaging in love marriages, or eloping without their parent’s permission. By examining literacy and the writing of love letters in particular, Ahearn traces the transformation of attitudes towards love and marriage as they occur in relation to pervasive discourses of development and new ideas about what it means to be *bikasi*, developed, as they are

transmitted through written material.

A fourth understanding was that conversion disorder was a problem caused by belief in spirits and ghosts, found in poor, rural communities deemed to be “backwards” and “non-modern.” As one male psychiatrist explained, cases of “mass conversion disorder,” “occur in places with high superstition and low education. It absolutely never happens at private boarding schools.” In relation to cases of “mass hysteria,” perceived differences in the treatment of women and girls across lines of caste, class, and ethnicity were mapped onto cases, generally assumed to be a problem occurring only in rural, poor, “backwards” high-caste Hindu communities. Yet during my research I was also told of cases that had occurred in expensive private boarding schools in Kathmandu, Dang, and Khotang among middle class students, and in one case met an afflicted student from one such school, but these cases were never reported in the media. In this way, cases of “mass hysteria” became a blank screen onto which perceptions of difference were easily projected.

Embedded in these various understandings of the disorder lie a paradox that reflected a double bind of femininity and womanhood— on the one hand conversion disorder was seen as a form of survival, as a way in which a woman might momentarily escape a situation of oppression, while on the other hand it was suspected to be a form of manipulation, as a way to access secondary gains. Similarly, when described through the metaphor of the pressure cooker, cases were understood to be the result of a young woman’s inability to express her emotions to others, and yet at the same time, except in the poetic genre of song, the outward expression of sadness, among both men and women, was seen as highly inappropriate (c.f. Wikan 1990). Paradoxically, although psychiatrists might share their theory that conversion disorder was a way to survive the oppression of patriarchy, in some extreme cases their own treatment practices served to recreate gendered hierarchies within the clinical interaction.

“False Belief”: Constellation Therapy for a Psychosocial Counselor

Kathmandu, July 2015

It was a rainy monsoon day in Kathmandu. Aftershocks kept coming. I was attending a training of the NGO supervisors. We sat in a circle of plastic chairs in a nondescript hotel meeting hall for the training, which was led by a foreign psychologist who I will call Michelle. Michelle had travelled to Nepal to do the training because of the recent earthquake, as the NGO had received additional funding from a number of international INGOs and development organizations to start a new project to provide psychosocial care for earthquake victims in rural villages. Michelle was there to help the supervisors through the problems they were facing in their work as supervisors of field level counselors. That day, to Michelle’s surprise, none of the supervisors shared material directly related to the earthquake, even when the training itself was interrupted by a sudden violent aftershock. Instead the counselors talked at length about the problem of “conversion disorder,” particularly a case of “mass conversion disorder,” otherwise known as “mass hysteria” that had occurred among adolescent girls in a rural school before the earthquake. This was a topic that continued to surface as I followed the everyday work of this NGO over the course of a year.

That day, each supervisor was asked to think of a title of a difficult case he or she had faced and present it to the group for discussion and supervision. One of the supervisors, who I call Kumar, presented the title of his case, first calling it “False Belief” but then crossing it out and changing the title to “Difference in Understanding,” “*Bujai ta pharak chha.*” The problem, according to Kumar, was that his was a case involving strong religious beliefs that caused certain types of symptoms. Students would “faint” at home and at school, he explained, because they believed in gods, goddesses and traditional healers. “When we tried to intervene with other methods, we were not successful,” he explained to the group. From Kumar’s perspective, the affliction was caused by

“*tanab*, tension, caused by study or teachers, or reasons of adolescence, body development or puberty, maybe friends are teasing them or perhaps they have marriage pressures.” Not satisfied yet, Michelle, the foreign psychologist, asked Kumar, “what for *you* is the problem?” He replied that he did not know how to make the teachers and patients understand, and that if they don’t understand he could not intervene in the case. The teachers had no interest in him working on the case because they didn’t believe in his work. Ultimately, for Kumar, the problem he struggled with was, as he put it, “how to deal with people who do not believe me?” At this point, Michelle decided to use a constellation therapy-inspired role play activity to think further about the case and work through what she referred to as “Kumar’s blockage.”

This blockage was not Kumar’s alone, instead it spoke to a wider, shared perspective among Nepali psychiatrists, psychologists and psychosocial counselors regarding the possibility of spirits, a tear between the modern and the traditional that ran along lines of class distinction. Nepali psychiatrists and psychosocial counselors insisted, at least publicly, that spirits and ghosts could not exist and prescribed correctives of psychoeducation combined with psychosocial counseling to address what they saw as the real origins of the problem, which were located within the individual and the family.

Michelle was a systemic family therapist¹¹ with a specialization in constellation therapy, an alternative form of group therapy developed by Bert Hellinger, a German Catholic missionary priest in South Africa who later became a therapist. Michelle’s training of the Nepali supervisors involved teaching them how to do systemic therapy as well as using constellation therapy to work on their personal problems in a group setting. As Michelle put it during a supervisor training in Kathmandu,

¹¹ Systemic family therapy traces its roots to the 1950s when there was a cross-pollination of ideas between psychotherapy, cybernetics, and systems theory. Systemic family therapy was influenced by the work of anthropologist Gregory Bateson, who himself had begun to apply ideas from cybernetics to his theories of mind, mental processes, schizophrenia, addiction, communication, epistemology and ecology (Bateson 1972).

“the job of a systemic counselor is to disturb the old thinking pattern and change the focus.” Such “old patterns” were changed through the asking of questions, “questions are interventions, from the systemic approach,” she explained to the supervisors.

Constellation therapy takes the form of brief intervention and is done in a group setting. The therapeutic encounter is a unique event that takes place over 30 minutes to 1 hour, the rest of the time is spent participating in the constellations of others in the group. The formation of the constellation is the intervention, and according to Hellinger, the founder of this approach, no further therapeutic interactions are required.¹² In constellation work, the client picks individuals, known as “representatives” from the group to represent the individuals in the problem, including the client himself. “You choose someone from the audience to represent your father, someone to represent your mother, someone to represent your sister, and someone for you. You can take anyone at all...Then, go to each one in turn, and take the person with both hands and lead him or her to the right place, without saying anything...Place all the representatives in relationship to one another in a way that reflects your inner image of the family at the moment” (Hellinger and Hovel 1999: 2). The therapist pays close attention to the way the different representatives have been arranged in relationship to each other, “I can see the relationships among the various family members. Here, for example, it’s meaningful that the father is turned away and that the son is facing his mother. If you let that work in you, you can see where the problem is” (Hellinger and Hovel 1999: 3).

Throughout the constellation, the therapist guides the client who then moves the representatives into different formations by asking each representative “is it better or worse” in order to find the “natural order,” such as birth order among siblings, or the order of husband and

¹² The single-session model has been criticized and many constellation therapists, Michelle included, continue to do individual psychotherapy sessions with their clients in addition to constellation work.

wife. According to Hellinger, when a new configuration is reached vis-a-vis each other that “feels better,” it is because it has been returned the “natural order.” Along the way, the facilitating therapist asks the participants to repeat certain statements to each other, and then asks “what is the difference” after hearing the statement or repeating it, which is also part of the intervention.

Ancestors from multiple past generations may be introduced into the constellation, and arranged in a line behind a particular representative who shares a blood relation to them. This is related to the idea that Hellinger calls “entanglement,” in which events that occur in a family in past generations are repeated by the client in the present. The client looks on from the outside as his or her constellation takes form. In the end, the client changes place with his or her own “representative” in the group, and enters into the constellation to experience its spatial resolution.

Representatives standing in for different individuals in the constellation react as if they were the actual person, despite having no knowledge of the individual they are representing. Like a spirit medium, representatives may reveal “hidden facts” about the particular case that may not have even been known by the client him or herself. In an interview with Hellinger, he describes this phenomenon in the following way,

The curious thing about these constellations is that once the chosen representatives are in place, they begin to feel like the real family members. Sometimes they even begin to have the symptoms of the real people without knowing anything about them. Once, for example, someone representing an epileptic began to have an epileptic seizure...If we ask about the real person, it often turns out that the symptoms reflect something in the situation of the real people in the family. There’s really no way to explain this, but you see it again and again and again in thousands of constellations” (Hellinger and Hovel 1999: 3).

Practitioners of constellation therapy explain this phenomenon as being enabled through access to the “field of knowledge” or the “knowing field,” a concept drawn from parapsychologist Rupert Sheldrake’s theory of the “morphic field.” According to Sheldrake, “the morphic fields of social groups connect together members of the group even when they are many miles apart, and provide

channels of communication through which organisms can stay in touch at a distance” (Shelldrake 2005). Although the training of constellation therapy in the NGO was a matter of the chance meeting between Michelle and this organization almost a decade earlier, scholars have in fact pointed out the similarities between family constellation therapy and forms of ritual healing in the Himalayas (Sax et al. 2010). In comparing the two systems of healing, Sax et al. argue that the following qualities are held in common by both Himalayan ritual healing and constellation therapy, and provide comparative examples for each: 1) family unity is fundamental, 2) healing is collective rather than individual, 3) dead family members are of crucial importance, 4) space and spatial relationships are central, 5) secrets from the past are revealed, 6) both systems share a “conservative morality” (2010). In this way, without explicitly meaning to do so, Michelle introduced a therapeutic methodology mirroring and in some ways inspired by a healing system that the counselor himself did not believe in.

That day at the training the “constellation” involved 11 roles. Each of the supervisors volunteered to represent one of the actors involved—the afflicted girls, the non-afflicted girls, the teachers, the counselors, the parents, as well as the psychosocial approach, traditional beliefs, and the symptoms. Kumar stood with Michelle, observing his case from the outside.

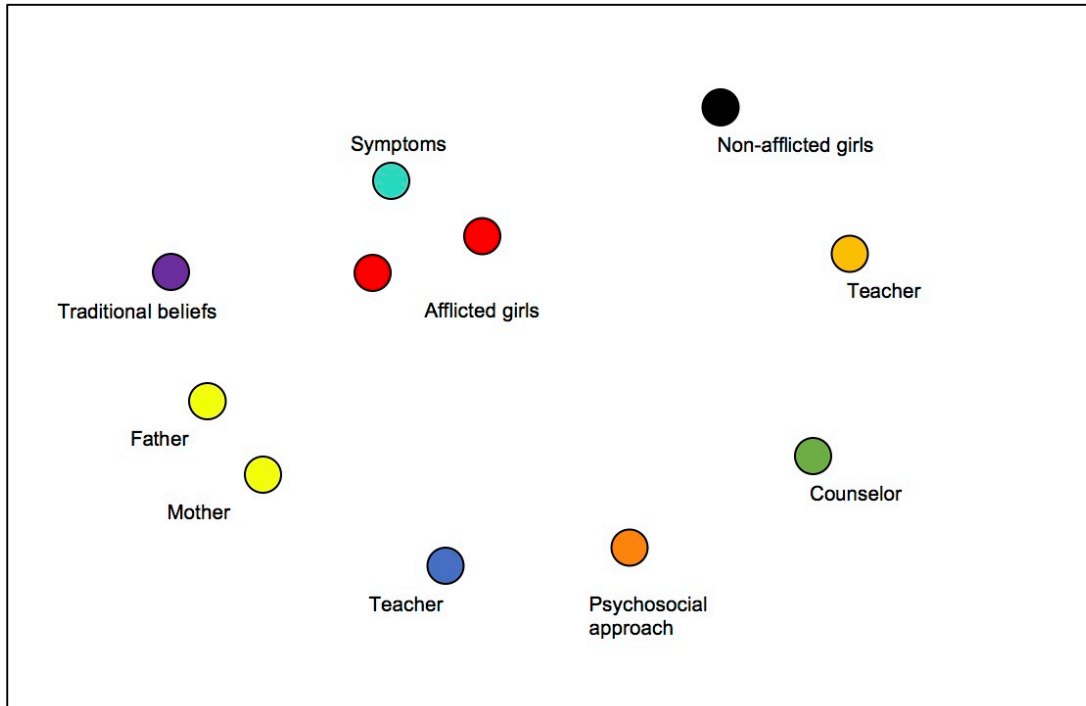


Figure 4 The constellation.

In what follows, I provide an abbreviated transcript of the constellation, which was conducted in English.

Michelle:

(addressing the “afflicted girls”) How do you feel?

Afflicted girls:

I feel protected.

Michelle:

(Addressing “the symptoms”) How do you feel?

The Symptoms:

I feel suffocated

Michelle:

(Addressing “the counselor”) How do you feel?

Counselor:

When I saw the symptoms again, it was a barrier for me.

Michelle:

(Addressing the “afflicted girls”) “my symptoms are not disturbing me they are protecting me,” tell him. “I would be happy if you could support me and see me outside of the symptoms,” tell him.

As the first questions were asked, Michelle’s understanding of conversion disorder had already crystalized. This was the idea that the symptoms of disorder served a purpose, specifically that they were a form of protection. The representative playing Kumar, the counselor, began by communicating that he felt the symptoms were a “barrier” for him. Michelle interpreted the “counselor’s” statement to mean that the symptoms were blocking him from being able to “see” the girls. Michelle then directed the “counselor” to ask the “afflicted girls” if they needed his help, and to tell them that he was there to support them. Following this pledge of support to the “afflicted girls,” Michelle again returned to her hypothesis that the symptoms served the purpose of protection, and that “behind” the symptoms was a reason for their appearance. After Michelle asked “the symptoms” to state that they had “a reason to be here,” the knot of the case began to loosen as

“the counselor” began to “acknowledge” the symptoms. Next, Michelle began to direct the constellation toward helping “the counselor” address the cause of the symptoms and “look behind” them.

Michelle:

(addressing Counselor) “please allow me to look behind you” tell.

Counselor:

Please allow me to look behind you

Symptoms:

I still want to stay.

Through this portion of the constellation role-play, Michelle began to experiment with her hypothesis that the counselor felt afraid to “look behind the symptoms” and address the deeper meaning of their appearance. In the constellation, the refusal to “see” the symptoms was identified by Michelle as a central problem. As such, the resolution to Kumar’s blockage was found in his ability to “see” the symptoms, face them, and say *Namaste*, hello, to them.

A Psychosocial Intervention

In November 2015 I travelled to Dolakha district in central Nepal to observe a psychosocial intervention for an active case of “mass hysteria.” This case had received attention in the Mental Health Sub-Cluster and the Psychosocial Working Group meetings that had been held on a weekly basis in Kathmandu since the earthquake, sparking the interest of the humanitarian group. Dolakha

was a district in which over 90% of the structures had been destroyed after the powerful 7.3 magnitude aftershock in May 2015. Among the humanitarians and the local Nepali mental health professionals who attended the cluster meetings in Kathmandu around this time, the topic of “mass hysteria” had suddenly become an object of interest.

During one of the cluster meetings, the topic was discussed at length. A staff member from an NGO explained “mass conversion disorder” to the group,

We cannot say it is a mental health problem, this is more of our cultural and society environment. The younger girls are in stress, they cannot ventilate, cannot express their feelings, so it accumulates and then it comes out like mass fainting. Fainting in general...the problem comes from family and this is enlarged in the school—how we teach. Teaching with a stick, not in a child friendly environment. These are the key factors which we are trying to address...this is not a health problem...it is a psychosocial problem that started from the family and the school, so we need to intervene in the family...

It was decided in the meeting that representatives from various organizations including UNICEF, WHO, and a Nepali NGO, would work together to create a manual of guidelines on how to deal with mass hysteria cases, to be circulated on a national level. Local staff from UNICEF and the WHO put together a team to evaluate the Dolakha case. A few weeks after their evaluation I had the opportunity to join a Nepali psychosocial intervention on the ground in the school. According to the community, the problem began in relation to the installation of a barbed-wire fence around the perimeter of the school. Before the fence was installed, the community used to walk freely through the school grounds, and would also carry the dead through the school during funerals. A second explanation was also offered, involving the death of a local girl in a landslide near the school, and who, because she died an accidental death, had become trapped in the school grounds by the new barbed wire fence. Additionally, some people mentioned that dead children used to be buried beneath the location of the girl’s toilet, causing the spirits of the dead to haunt the girls. On top of these explanations, there were also accusations that the teachers were abusing students.

In the village in Dolakha, located on a hill about four hours walking from the nearest road, we were told that every day for nine months, female students had been afflicted in the local government school. This problem had begun before the earthquake, in March 2015, but had only received attention in the post-earthquake period, as the case occurred in one of the major earthquake-affected districts. The intervention was carried out by four counselors, two men and two women, while I observed alongside them for the purposes of research and in the role of consultant for the organization. During the intervention I took notes on a notepad. After the intervention, I shared the following observations with the NGO staff, and they were discussed in a group “interview” meeting with the lead psychosocial counselor on the intervention, as well as the Nepali supervisors and myself.

On the first day, we met with the teachers. The intervention was introduced as “community based” and the teachers were told that food would be provided for them if they attended the two-day psychoeducation training. It was a school day and students were filling the grounds of the partially destroyed government school. Around the periphery of the school was a barbed wire fence.

The teachers said that in their opinion the affliction was caused by problems at home—one girl’s mother was sick, they explained. Another’s father had abandoned the family and moved to Kathmandu. The girls were weak in studies, they said. At first, they felt afraid when the girls fell ill in the school, but 9 months later they had become used to the disruption. Suddenly the conversation was interrupted by a scream; a girl had become afflicted. When we looked to see what had happened, we saw a girl, screaming and crying, being carried out of a classroom by four teenage boys. This was the second affliction that day we were told, but the first girl had already recovered and was casually sitting on the grass with other teachers and students watching the events unfold.

Pinky, the lead counselor, conducted a session for the afflicted students. The girls were

assembled in an empty classroom. I stood with her at the front of the classroom while the students sat at long wooden desks facing us. She asked them how they felt about this “*na ramailo*,” “not fun” situation. The students didn’t answer. Then Pinky asked them if they knew how a pressure cooker works. She proceeded to explain, “our heart-mind is just like a pressure cooker,” “*hamro man pressure cooker jastai*.” Pinky then tried to have fun with the students by using a clapping game. She told them that this was not “a serious mental illness,” a “*thulo manasik rog*.” She told them not to play alone, and encouraged them to drink lots of water so they could avoid gastritis, *gyastric*. She said if they just have fun, their fear would go away.



Figure 5 An empty classroom in the government school. November 2015.

Part of the intervention involved providing a two-day training in “psychoeducation” for the teachers. The teachers told the counselors that they had worry, *chinta*, because they had been accused by another NGO of beating the students and therefore causing this problem. They said there had been a misunderstanding and a miscommunication. Pinky gave a lecture in which she explained that the reason the students were suffering was because they don’t know how to solve problems, and that they are unable to express their problems verbally. She said that one reason for such an affliction could be in order to avoid responsibilities. She explained that the more attention you give, the more the affliction will occur. “This comes from anger,” she said to the teachers. “When a child cannot talk about her anger to anyone what happens?” she asked rhetorically, meaning that such anger would come out through the body. Pinky gave the teachers the pressure cooker example, explaining that personality was the thickness of the pot, coping and sharing were the steam, and stress was the fire. “If you can’t cope, that is called conversion disorder” she said. After this discussion one of the teachers explained that “people say it is caused by *bhut/pret*, ghosts, or because the teachers don't teach well. But now we have learned that this is related to the life situation of the students.”

The next day we met with the mothers of the afflicted students. Some of them arrived without shoes and were unable to sign their names to the documentation form because they could not write. They were worried about their daughters. They said that the girls had been suffering from ghostly haunting, *bhut/pissat laagyo*, but also suggested that the teachers may be mistreating their children. Pinky lead a discussion about *chinta*, worry. She told the parents that this problem was related to *tanab*, tension, and that when you can’t express your worries with words you find other ways. Some parents responded that they didn’t know why their children would have any *chinta*, and others explained that only adults could feel *chinta* and not children. Pinky pressed on, insisting that “they have *tanab*, tension, and they cannot talk about it with their words.” She explained that you

carry your *chinta*, your worry, and you need to share it, otherwise you will keep your problems in your body. She reminded them that as parents they must not hit their children but show them love, let them play, and reward them for good behavior. At the end of the mothers' session, Pinky introduced a kind of prayer in order for them to send the "dear symptoms" to go to a nice place and stay there. Looking at me she said, "let's send them to America." So the parents "gave" the symptoms to me to carry away for them.

On the third day, the counselors led an intervention for the afflicted girls. 17 students, all girls, were assembled in the transitional shelter above the main schoolyard. "We have come to have fun. You can't faint or else we can't do our work" a counselor chided to the students. The counselors opened the session by singing and dancing for the girls. Showing them a good time. But pervading the session was an uneasy mood, a sense of the possibility of an impending outbreak. One of the girls had already put her head on the table, refusing to participate. In the front of the room, Pinky drew two faces on a large piece of paper, one happy, one sad, and asked the girls which one they liked. The girls were instructed to come up one by one to mark the image in front of the others. I too was asked to come up and mark my preferred affect. It was clear that there was only one socially suitable answer—the happy face. One girl, who had joined the group late and was not in her uniform picked the sad face. When I later asked Pinky why she chose to use this exercise during the intervention she explained that it served as a simple diagnostic tool. "If they choose the sad face, then they are not happy."

Next the counselors introduced an activity with colored playdough. The girls were given playdough to play with and they were told to make whatever they wanted. They all made the same form out of their dough— *sel roti*, a ringed doughnut made with sugar and rice flour and then fried in oil. The girls seemed to enjoy this activity, as they were laughing and smiling and having fun with each other. Afterwards the girls were instructed to draw a "child life tree" in which they listed their

skills and qualities, a technique to build self-confidence that I had seen used with children across multiple Nepali NGOs. Again, the students wrote identical answers on their “trees”- listing their skills as singing, dancing, and writing poems well.

A student who had fallen ill in the school many times arrived late. After the activities ended, she asked if she might sing a song for the group. She stood in the front of the room and proceeded to sing a sad and somber song, about people who drink during *Tihar*, the upcoming holiday. The atmosphere of the group became tense. Immediately after the singing ended a girl in the group suddenly became afflicted. We were instructed by the counselors to leave the afflicted girl alone, and to give her no attention. The students filed down the hill to another classroom. I remained behind with Pinky and another counselor watching the girl from a distance. The girl rolled off the school bench and fell to the ground. From there she rolled around in the dust humming a song, punctuating it with shrill screams. She lay on the ground with her arms outstretched. She eventually rolled out of the room and lay in the dirt outside the transitional shelter. When she regained consciousness about 20 minutes later, she complained of knee pain.

Once the girl recovered I walked down the hill with her and she sat with the teachers outside of the office. I joined the other students with Pinky in another classroom. She explained to them “This happened to one person and not you all. Do you know what that means? It means you are *thulo*, big. You are one step bigger.”

It was clear that Shrijana, the girl who sang the song that became the catalyst for the affliction, was a powerful presence. As soon as she entered the new room, yet another girl became afflicted and fell to the ground. We were again instructed to exit the room, and went to another empty classroom. Pinky told the students that this was not a big problem, “this is nothing,” she said, trying desperately to reassure them in the midst of chaos. Shrijana replied boldly, “but for us it is huge.” Pinky then said, “when people come from Kathmandu, do you believe them or not?” A

fourth girl then fell ill, then a fifth.

After the intervention I shared my observations with the counselors, the NGO staff, the foreign project manager and the supervising psychologist. We decided to hold a group “intervision” meeting among the Nepali supervisors to discuss the intervention as I had described it. The counselors discussed the foreign psychologist’s observation that the approach seemed not to have been based on her systemic therapy approach. It was decided that the organization would work together to create guidelines for interventions on “mass hysteria” so that there could be a streamlined approach in the future.

In March 2016, the Nepali supervisors of the NGO began to work on creating “guidelines” for managing cases of mass conversion disorder. Meeting during their “intervision” group meetings, a time allotted for the supervisors to provide supervision to each other as a group, they worked together to try to agree on the intervention technique. The supervisors discussed how they should approach the case, either using “their” approach, which saw conversion disorder as attention seeking behavior, a way to escape responsibilities and seek power, and recommended a treatment that involved “removing attention” and not focusing on the symptoms, or an approach drawing on the methods taught by Michelle, which they glossed as “*hami cbhanu timibaru laagi*” or “we are here for you.” During the intervision meeting that day, the supervisors shared their collective experiences responding to various cases of adolescent “mass conversion disorder,” and debated the appropriateness of Michelle’s systemic approach of “acknowledging the facts,” and “welcoming the symptoms.” One supervisor said she felt that such cases were “due to strong culture and power play—this is a strategy for the powerless.” Another supervisor responded that he felt that for issues relating to power relations that the solution lies in the work of social mobilization as opposed to a focus on counseling.

Six months after I completed my fieldwork I received an email from the NGO director, asking me for my recommendations on the guidelines for mass conversion disorder that they had finalized with members of WHO Nepal. The initiative had originated from within Nepal, and had been independently organized by Nepali psychiatrists and NGO staff. In the manual, the symptoms of conversion disorder are defined as being caused by “traumatic events, insoluble and intolerable problems, or disturbed relationships” that “the individual cannot solve” which are then transformed into physical symptoms. In the final version, the manual suggests explaining conversion disorder to those who suffer from it in the following way:

We understand your belief about conversion symptoms based on the cultural explanation that symptoms are because of bad spirits, effects of angry gods, or ghosts etc. You might have tried existing healing processes in your culture, which we respect. However, research has shown conversion symptoms are because of stress experienced by the person and there are scientifically practiced treatment processes which we recommend. As we know when we are in distress, it causes headaches, similarly, stress can lead to conversion symptoms. So we request your cooperation for this treatment.

It became clear that in the guideline, “culture” was defined as something the psychosocial counselor did not share with his or her clients.

In the next chapter, I explore the explanation of symptoms as caused by *bhut/pret* and *pissat*, spirits and ghostly haunting as it played out in a school in the district of Khotang that received no psychosocial intervention but instead treated the affliction with *dharmi jhakeris*, shamanic healers.

CHAPTER 3

Fragments of a Transient Affliction

“Life is never situated in one particular point: it passes rapidly from one point to another (or from multiple points to other points), like a current or a kind of electrical stream.” – Georges Bataille, Inner Experience (2014: 96)

A study of “mass hysteria” is a study of fragments of a phenomenon in its absence. Absent because of its transient nature; in a moment the affliction appears without warning, spreading and transferring from one person to another, and then suddenly it dissipates and is gone. People cautiously return to their lives, unsure when another outbreak might occur. How to study a phenomenon in its absence? How to understand the experience of affliction, when even those who underwent it only come to know about it through the words, photographs, and moving images captured and mediated by others? How to approach a form of affliction that is de-centered from the individual, and instead transferred and shared between people?

In the field I often thought of the fragments of poems penned by the ancient Greek poet Sappho (c. 630 B.C.), as translated by Anne Carson (2002). In the time of ancient Greece, Sappho is believed to have composed many books of lyrical poetry, yet only one poem has survived in its entirety. Everything else remains as fragments, bits and pieces of text on torn papyri. It is this set of fragments that Carson brought together, translating tiny scraps of language from Greek into English but in a way that also visually renders the absences one must read around. In the end, there is no sense of a coherent whole formed from collecting the set of fragments together. I start my thinking with Sappho and Carson as I approach this case. What is a fragment and how might we think with them anthropologically?

In her theorization of the relation between the event and the everyday in the context of collective violence in India, Veena Das suggests that “unlike a sketch that may be executed on a different scale from the final picture one draws, or that may lack all the details of the picture but still contains the imagination of the whole, the *fragment* marks the impossibility of such an imagination” (2007: 5). Here a fragment signifies a kind of limit against which one is unable to recreate any “picture of totality.”

The transient dimension of this affliction has required me to think with fragments. The afflictions seemed to occur at random, they would appear and then disappear quickly. For the first three months of my dissertation research I traveled through districts in Central and Mid-Western Nepal following cases which had always already subsided by the time I arrived. The students had recovered. I could never observe the event with my own eyes, always only through the grainy images and voices of others. Then I found what I was looking for—a friend tore out a small article from the local newspaper and gave me the shred of paper. The headline read “Ghost Shuts School.” In the seamless way in which in Nepal it is possible to be connected to wide networks of people through the kindness of one person, a young psychology student I had met in Kathmandu had a relative who worked as a government school teacher in the same district. Within 24 hours she located and contacted the headmaster of the school, and suggested her brother accompany me to the site. We left Kathmandu as quickly as possible and travelled 14 hours east by shared jeep to Khotang, a remote district in the “middle hills” of eastern Nepal, directly south of Mount Everest. We arrived in time.

After staying in the village for 10 days and observing the active case, I chose the site as the location for my extended study. I returned one month later to begin the long-term work. But by then all the students had recovered. I remained in the village for a stretch of five more months, yet throughout that period the affliction itself was largely absent. I found I could only study it in traces

and fragments—in cell phone videos and audio recordings, in casual discussions of the presence of ghosts and spirits, in evenings when a neighbor suddenly became possessed by spirits, in stories of deaths and their locations in the landscape. The affliction seemed to be everywhere and nowhere at all.

Nomadic Tactics

In Nepal, the newspaper article that led me to this case referred to it as “mass hysteria,” and indeed this is one of at least 70 cases that have been reported in Nepali newspapers between 2012-2016. In these articles, the description of the situation is almost always identical—groups of around 15 adolescent girls suddenly become afflicted in a government school. The students say they have seen a ghost or spirit. The newspaper reports such events as proof of the superstitious beliefs of villagers. As such, “mass hysteria,” as it is called in the Nepali media, is linked to rural communities and seen as a class-based phenomenon, in which its interpretations are deemed to be “superstitious” by Nepali psychiatrists, psychologists, psychosocial counselors, and journalists. In reality, cases have also occurred in private boarding schools in Nepal, but these are shielded from publicity. Given the frequency of such cases, one must ask why groups of adolescent girls are becoming afflicted by spirits in rural Nepali schools?

Recent work on women and adolescent girls in North India diagnosed with “hysteria” suggests that conflict within the family over appropriate “feminine” behavior manifests in certain forms of psychosomatic illness (Marrow 2008, 2013; Pinto 2014). Additionally, within sociocultural anthropology, much work has been done on spirit possession as a form of communication (Crapanzano 1977,1980; Lambek 1981) and particularly as a gendered “idiom of protest” (Boddy 1989; Bourguignon 2004; Lewis 1971; Ong 2010, 1988; Showalter 1997; Stoller 1995). Aihwa Ong’s classic ethnography *Spirits of Resistance*, addresses “mass hysteria” among female Malaysian factory

workers and explicitly links the phenomenon to the broader structural forces of capitalism, arguing that in Malaysian factories, episodes of “mass hysteria” were forms of retaliation against gendered relations of domination in the factory. Building on a crypto-Freudian notion of the unconscious, Ong writes that she wishes to discover “in the vocabulary of spirit possession, the unconscious beginning of an idiom of protest against labor discipline and male control in the modern industrial situation” (Ong 2010: 207). For Ong, drawing on the work of I.M. Lewis, spirit possession within the space of the factory becomes a “nomadic tactic” of resistance (Ong 2010: 213). Similarly, in Michel de Certeau’s historical study of group demonic possession among Ursuline nuns in 17th century France, he argues that “witchcraft and possession make manifest—but in a wild, spectacular way—a sudden widening of a rift” (1996: 2).

In the specific context of Khotang, the district in which the fieldwork for this chapter was conducted, Pustak Gimire has written of a cult of goddess possession among adolescent girls from the Kiranti and Magar ethnic groups in similar terms, arguing that “possession permitted these girls and women to deal with situations of family stalemate and personal inhibition in a socially acceptable way,” in the post-conflict period (Ghimire 2016: 160). From this perspective, such cases of shared affliction are seen as a symptom and response to individual and social disorder.

Naming

The word “hysteria” was originally drawn from the early Greek *hysteria*, meaning “womb” or “uterus.” For the Greeks, hysteria was regarded as a disease caused by a disturbance in the womb, in which a “wandering womb” would cause an illness similar in form to epilepsy. Yet “hysteria” as we imagine it today emerges from a distinct historical location firmly rooted in the 19th century Parisian hospital of Jean-Martin Charcot, and linked to the early development of Freudian psychoanalysis (Breuer and Freud 2009). Charcot became famous for his “Tuesday lectures” at the

Salpêtrière Hospital in Paris, where he would present his hysterical female patients and induce their symptoms in order to teach his male colleagues and students. Charcot remains well known for his photographic *iconographie* in which he meticulously documented the embodied symptoms of hysteria, with the aim of creating a classificatory system (Didi-Huberman 2003). Sigmund Freud's writing on hysteria, particularly his famous case study, "Fragment of an Analysis of a Case of Hysteria" also known as "Dora," suggests an interpretive approach in which hysteria is understood as being caused by repressed psychic trauma and sexual desire, often originating in the family, ultimately released as psychosomatic symptoms in the body (Freud 1989: 172).¹³ Ian Hacking has theorized the possibility for such historically specific forms of illness, with a particular focus on the social history of hysteria as a diagnosis. From an historical perspective, Hacking argues, hysteria is a primary example of a "transient mental illness," existing only within particular "ecological niches," in which it provides "some release that is not available elsewhere in the culture in which it thrives" (1998:2). As Hacking explains,

By 'transient mental illness' I mean an illness that appears at a time, in a place, and later fades away. It may spread from place to place and reappear from time to time. It may be selective for social class or gender, preferring poor women or rich men. I do not mean that it comes and goes in this or that patient, but that this type of madness exists only at certain times and places" (1998: 1).

While hysteria is no longer a common diagnosis in the United States or Europe, its legacy can be seen in contemporary diagnoses of "conversion disorder" in which unexplained physical symptoms are understood to be caused by unconscious trauma that is converted from the mind to the body.

And yet, to call such cases of affliction "mass hysteria" in Nepal, where they are also referred to as *chhopne*, *pissach* or *bhut/pret laagne*, is to produce a transparent commensurability between European and Nepali concepts in which the European concept overrides and erases important

¹³ Freud also uses the concept of "fragment" in his case study, referring to the fragmented ending of the analysis which was broken off by Dora herself before completion.

histories of difference. As Dipesh Chakrabarty argues, "...what translation produces out of seeming 'incommensurabilities' is neither an absence of relationship between dominant and dominating forms of knowledge nor equivalents that successfully mediate between differences, but precisely the partly opaque relationship we call 'difference'" (2000: 17). Indeed, the problem of commensurability was also raised by the rural schoolteachers as we sat discussing this particular case in the village in Khotang. When doctors from the district headquarters came to the school after hearing about the case, they told the teachers that the affliction was called "hysteria" and was caused by sexual desire. As the school teachers explained, they first heard about the concept of "mass hysteria" when it "came from the district headquarters," *jilla bata aeko*, in this way, the naming of the affliction became spatially mapped and linked to other things which "came from the district headquarters" such as money, "development," education, and outsiders (c.f. Pigg 1992, 1996). According to the school teachers, the doctors had suggested that "after a man touched them, they would be better," *purusle chunda thick huncha*, meaning that the girls should be married off in order for their sexual desire to be satisfied in a socially appropriate way. This explanation is one that I encountered in other cases as well, and such explanations were just as frequently a cause for outrage among the families of afflicted girls, as they were reason for the girls to be married quickly with the hope that it would provide a cure and avoid the stigmatization of madness, *pagal*. In Khotang, the teachers, community members, families of the afflicted, and the afflicted girls themselves did not readily accept this explanation as appropriate to their case. When I asked the school teachers why they thought "mass hysteria" *myass hysteria*, occurs, they answered, as if taking a test, with the reasons given by the district doctors. When asked about the causes of *chhopne* and *bhut/pret laagyo*, possession and ghostly haunting, they answered with similar definitional precision.

Idioms

In a similar case of group possession among women in central Nepal, some scholars have argued that the event functioned as a “cultural idiom of distress” (Nichter 1981) that “may allow marginalized women to gain agency and power” (Sapkota et al. 2014: 644). This research “aimed to investigate the characteristics of individuals suffering from possession and explore potential underlying reasons for these incidents” (2014: 647). Using scales adapted to the Nepali context, they measured rates of depression, anxiety, and PTSD among the afflicted and unafflicted in the village, and found that compared to women who were not possessed, “possessed women had a higher number of traumatic exposures and higher rates of symptoms of mental health problems” (Sapkota et al. 2014: 658). The research team also provided “psychoeducation” to the villagers, but these explanations were rejected by the community, along with the findings of the study. According to the authors, the community members “did not see possession as a way of coping. Instead, they reaffirmed their view that spirits that were angry or upset had the ability to inflict harm by possessing people” (Sapkota et al. 2014: 663). What are the politics of such an impasse? What if we began from a different “ontological starting point” (Zigon 2018) than that implied in the concept of “conversion disorder”? Where might such a beginning lead us?

In Nepali the word “*chhopne*” is drawn from the verb *chhopnu*, which means “to cover,” as you should cover the pot of rice so it won’t get cold, “to wrap up,” as you might wrap a baby in a warm blanket, “to protect” as when a mother hen protects her chicks by nestling them under her wings, as well as “to conceal” as a person might conceal his guilt, “to pounce, jump upon or ambush” as could be done to an enemy, or in the context of an illness, and in the sentence structure of “X le chhopeko” with “X” being the thing which caused the illness and “le” indicating that “it was done by,” for example, “*jworle chhopeko*” I have come down with a fever, or “*bhutte chhopeko*” I am sick

because of ghostly possession. Additionally *chhopne* can be used to describe the feeling of being overwhelmed by an emotion, “*malaai dukhale chopyo*” “I was overwhelmed by grief” or “*malai darle chhopyo*,” “I was paralyzed by fear” (Schmidt 1993: 212-213). *Chhopne* was the word used to talk about the experience of evil spirits and ghosts, *bhut*, *pret* and *pissach*, taking over the body, uninvited.¹⁴

In his research on mental illness in a high-caste Hindu Nepali village, Alfred Pach found that within the community he conducted fieldwork, *chhopne* generally afflicted young married women, particularly during circumstances of social distress or during states of ritual impurity. The illness was often said to be caused by witchcraft, which is commonly related to problematic social circumstances (Pach et al. 2002). One case study from Pach’s early dissertation research outlines the details of a young married woman suffering from *chhopne rog*. The afflicted woman’s symptoms included loss of appetite, headache, and fainting while walking in the village. According to Pach she received ritual, Ayurvedic, and biomedical treatment for the illness, although none proved effective. Pach also mentions that in her descent group, two other women were also suffering from seizures, which further exacerbated already pervasive economic problems and caused inter-generational conflict in the extended family.

Pach writes that symptoms of *chhopne* include piercing pain in the body, dizziness, yawning, nausea, feelings of confusion, and pressure on the back of the head and neck. These symptoms are followed by one of two classes of behavior; 1) falling on the ground in an unconscious, or semi-conscious state with fists and teeth clenched, or 2) shaking with fists and teeth clenched while in a seated position. More rare forms of the illness manifested in the form of attacking others, hallucinations, or pulling out one’s own hair. People suffering from *chhopne rog* may have the problem for years, and suggested causes of the illness include witchcraft or “sent illness”, astrological

¹⁴ The common verb *laagyo*, meaning literally “to take,” but often connoting a meaning of “to make ill” is frequently used in a similar way to refer to a wide range of affliction, particularly that caused by spirits (Ghimire 2016; Lecomte-Tilouine 1993: 273).

disjunction, bodily weakness, transference from others through physical contact or blood, anxiety (*chinta laagyō*), or divine punishment due to the neglect of deities. The average age of the first attack was 20 years old for women, although Pach also observed cases among unmarried women aged 14-17 years old. When men experienced *chhopne rog* it was commonly interpreted as a calling into divine, shamanic practice, while women were most often perceived to be suffering from witchcraft (Pach 1998).

Bhut, *pret*, and *pissach* are used interchangeably to describe the presence of ghosts and spirits of the dead, both known deceased members of a family lineage as well as unknown outsiders. Such spirits must be appeased through a *dhami*, a healer, who conducts a *puja*, a healing ritual, in which he discerns the cause of affliction by entering into trance and calling the gods into his body (Desjarlais 1992; Ghimire 2016; Hitchcock 1976; Maskarinec 1995). After the cause is discovered, offerings are made to appease the angry spirits (Hitchcock 1976). Within the Chhetri majority communities of Khotang, *dhamis* incorporate the lineage deity, *kul deuta*, into their bodies during healing rituals, and in addition to their work as healers they also serve as ritual priests for their clan (Ghimire 2016).

Entanglements

Spirits and gods also inhabit the land, residing in forests, streams, rivers, and stones. This region was thus also a place of sacred geography, in which the landscape would spontaneously reveal gods and goddesses. Nearby lies Halesi, a sacred cave and home to the Hindu god Shiva; it is an important site of pilgrimage for both Hindus and Buddhists. The caves of Halesi are filled with rock formations that jut out of the earth. Visitors try to squeeze through the small spaces between the rocks and the walls of the cave for it is said that only those who have no *pap*, sin, can slip through the narrow spaces. These rocks are *murti*, a divine image; they are the form, manifestation, and embodiment of Hindu gods and goddesses, and are covered in vermillion powder by devotees. As

Diana Eck describes it, “the *murti* is more than a likeness; it is the deity itself taken ‘form’” (1996: 39). In Khotang and throughout Nepal, *murti* are commonly found and are likely linked to ancient forms of Hinduism. As Eck writes, “stones, natural symbols, and earthen mounds signified the presence of a deity long before the iconic images of the great gods came to occupy the sancta of temples and shrines” (1996: 33-34).

In this region, sacred forms are continuously emerging from the earth. When the road was being carved out of the hillside four years earlier, a small cave-like crevice was revealed at a lush bend in the path. Now travelers stopped there to pray as they passed by, offering red flowers which lay strewn inside the opening. Even the bus drivers stopped to light incense and pray because, as one friend put it, “god stays there.”

At the top of the hill above the village lie the *devi than*. *Than* means “place,” and *devi* refers to the goddess *bhagvati*.¹⁵ Inside the *than* were smooth rounded rocks poking out of the earth and a frame of golden bells. People had tied thin colored threads around the rocks, and covered them in vermillion, pink, and orange powder. People left offerings of flowers, such as the bright red rhododendrons that blossom in the beginning of spring. A *than* is smaller than a *mandir*, a temple, but may eventually become one. I was told that once a *dharmi* had a dream in which he saw the place where the goddess would emerge from the ground in the form of a smooth rock. When he awoke, he went to the place and found the *murti*, the rock formation. It became the *Devi Than*.

Forms of vision that affect changes in the bodies of others such as *akhaa laune*, a desirous gaze, were also intimately related to relationships of jealousy and desire between people. In the community, rashes, pimples, and unexplained itching were often explained as being caused by *akhaa laune*. It was also said that a compliment could cause suffering, for example if someone

¹⁵ *Bhagvati* can refer to any Hindu goddess, although in this case it describes the local *Panchakanya Devi*, or five virgin goddesses.

complemented your feet, “*kasto ramro kutta*,” later the skin might suddenly begin to crack. *Akkha laune* often implied the work of a *boksi*, a witch, particularly in cases of unexplained illness, although when asked about witchcraft few were willing or able to discuss it in detail, for fear of being met with legal consequences or accused themselves of being a witch (c.f. Favret-Saada 1980; Macdonald 1976). This form of affecting gaze which literally “touches” another speaks to the interrelation of desire, vision and the porosity of bodies as experienced in this community more generally.¹⁶

Friendship meant someone who worked alongside another (c.f. Dyson 2010). “*Malai saathi*,” “you are a friend to me,” my *didi*, elder sister, would say, grinning as I stirred a hot pan of *aloo*, potatoes, crackling in the spiced oil. Sometimes she and I would sip tea and talk about our various shared physical afflictions, she speculating on the possibility of *akkha laune* as cause—my stomach also hurt, she also had flea bites, my knees also hurt today, etc. Once after we had both sat with the *dhimi* who searched for the cause of our problems through *phuk phak*, rice divination and the “blowing” of spells, she turned to me giggling, “*hami ek hal*,” “we are one pair.” *Hal* is a word also used to talk about a pair of oxen who, yoked together, drag the plow through the earth, as opposed to *jor*, which is used to describe a pair of birds, or a just married bride and groom—“*ramro jori*” people often exclaim.¹⁷

Indebted Relations

Khotang district was at the time of my research almost 40% Rai, the indigenous, *janajati*, group native to the eastern region of Nepal, but displaced by the high caste Hindu Chhetris and Brahmins (Bahun) who migrated from Kathmandu during the reign of Prithivi Narayan Shah in the

¹⁶ For more on vision, gender, and ways of seeing in a similar context, see (Pinto 2008: 141-177).

¹⁷ Likewise, to be alone, or even to sleep alone was seen as strange, almost pathological and certainly a pathway to sickness. In his study of a Newar community in the Kathmandu Valley, Steven Parish has argued that it is “more likely that Newars ‘find themselves’ in relationships and ‘lose themselves’ by separating” (Parish 1994:129).

17th century. Despite the large Rai population in the district, this village was an upper-caste Hindu, Chhetri-majority, mixed settlement, with Bhujels, Dalits, Newars and one Rai family (in order of population). The only language spoken in the village was Nepali, and often people referred to an overarching and dominant *pahadi sankriti*, Indo-Aryan hill culture, within which the differences between Newars, Chhetris, Bahuns, Dalits and Bhujels were constantly demarcated and discussed. The community was entirely composed of small-scale subsistence farmers, who grew rice, corn, and millet in rotation on steep terraced fields that they plowed with a yoked team of oxen. The heavy labor marked people's bodies; hands and feet hardened and cracked, and adults, particularly women, often looked much older than their age. In spite of this hard labor, most families still had to buy imported rice from India in large 25 kg sacs because either they could not produce enough rice and millet to cover 12 months of the year due to lack of land, or they did not have enough male laborers to cultivate their land due to external migration (Adhikari and Hobley 2011).

External labor migration has radically impacted life in Nepal. Raising steadily over the past 16 years, as of 2015 remittances accounted for 31.8% of the annual GDP, placing Nepal with the highest percentage of GDP from remittances in the world (World Bank 2005).¹⁸ The impact of migration is palpable in places like Khotang, which has a higher rate of migration than the national average (Adhikari and Hobley 2011). In this ward of 135 homes, 70% of households had at least one male family member that had migrated abroad to work in Malaysia or countries in the Persian Gulf such as Saudi Arabia, Qatar or Dubai to earn money to send back home.¹⁹ In order to secure visas and work abroad, people would go into debt to pay “manpower agents” at minimum \$1000 USD.

¹⁸ Nepal is followed by Liberia at 31.2% and Tajikistan at 28.8% (World Bank 2005), although the three countries have traded places over the past five years.

¹⁹ With the exception of one family, only men migrated to work abroad. The specific type of labor done abroad was something no one wanted to talk about, and family members would often give only vague answers. The nature of the work abroad in factories, on construction sites, or as janitors was difficult for people to talk about.

This initial debt would then take at least one year of labor abroad to pay off. Young men would return home once every few years to visit their families, and when their contract was up they would search for another and soon return back again, often working abroad for up to 10 years. It was impossible for most families to get by in this village without receiving income from a family member working abroad, which meant that almost constant separation of families was inevitable. As one local teacher put it, “three people from every house go abroad.”

Yet labor migration, while not new to Nepal, was largely a new experience in this village. Men in their 60s and 70s, who had come of age in a previous generation, had not spent a significant amount of time working abroad but instead recounted carrying oranges in straw baskets and traveling by foot to sell them in Sikkim to the east; this was as close as they had come to the experience of their sons and grandsons. Outside of these young men working as migrant laborers, most people I met in the village had rarely if ever been to Kathmandu. Contrary to the history of Rai men working abroad in the British or Indian Army and receiving handsome salaries and pensions, in this Chhetri majority village, there was no such history of highly paid employment. The lucky few who were able to access local salaried work found jobs in the government higher secondary school, and these *Sirs* were treated with great respect by all.²⁰

Caste relations within the community illustrated a reality of deeply entrenched social inequality which was articulated in and through spatially mediated forms of sociality. The majority of the Dalit families were still bound in client-patron relationships with wealthy families that stretched back for generations. Dalit adults and even young children would work for others carrying backbreaking loads. Their names were generally shortened to diminutives, and people would not use the formal *tapaai*, you, when speaking to them, sometimes even reverting to the *ta* form, which is

²⁰Young women from the village, mostly unmarried, would also teach in the local school, but would receive much less money than the *Sirs* and did not command the same respect in the community.

reserved for intimate relations (such as a wife, close friend or between siblings), inferiors, and animals. Dalits would not enter into the homes of other caste and ethnic groups, but instead remained on the outside looking in. Conversations unfolded through the thresholds of doors.

While most of the adult women had received little to no formal education, their daughters had completed class 10 and further.²¹ Often women who had not attended school or who had left school after completing only a few grades would explain ironically, “*bibe pass bhayo*,” “I passed the wedding,” referring to the main exam, the SLC (School Leaving Exam) which students must pass, although frequently fail, after completing class 10.²² Others would explain that they couldn't attend school because they had to collect fodder for the animals, “*gass katna paryo*,” implying that they had to work on the farm.

Social issues such as caste and gender inequality had been part of the rhetoric behind the People's War, the 10-year civil war fought between the Nepal Army and the Maoists which had ended eight years earlier. The Maoist movement had begun in Mid-Western Nepal, and it was in that region that the ideological dimensions of the movement were strongest. Yet Khotang, located in Eastern Nepal, had also been subject to violence. The village had its own memories of these events, yet throughout my time there people almost never spoke of them.²³ Slowly I learned that when the Maoists had come they made most of the villagers give them money, food, and a place to stay, requiring expensive animals to be slaughtered for meat and consuming large quantities of rice. This was common throughout Nepal, and put villagers in a complicated situation of forced complicity with the “enemy” in the eyes of the Nepal Army. Villagers were forced at gunpoint to feed and

²¹ The village had raised money to fund the higher secondary school, as the government only provided funds for classes 1-5.

²² Without passing the SLC, one is barred from continuing one's education and is shut out of receiving a salaried job in Nepal. In 2015, Khotang district had the lowest rate of passed SLC exams in the country, at 16.45% (Ghimire 2015).

²³ Perhaps this too could indicate a certain form of trauma which appears as a silence.

house the Maoists, and then later subject to punishment, torture and even death by the Nepal Army who would accuse them of being Maoist supporters (Pettigrew 2013).

Others recounted a story in which the Maoists, who were by then holding their own tribunals to punish local elites involved in corruption, accused a local leader from the village. He had apparently been involved in a case of corruption, in which he siphoned, in Nepali “eaten” money from a village development project. Yet despite this corrupt act, I was told that the people of the village would not allow him to be executed by the Maoists, and stopped this from happening.²⁴ “They came and asked if anyone here had been involved in local corruption,” someone explained to me. “The *Adhyaksa*, the village chairman, had, but we didn't let them kill him. No, we didn't let them. They wanted to, but we said ‘no, there is no one like that here.’” In the neighboring VDC, 10 people had been murdered by Maoists with *kukhuri* knives in the forest. The memory of this violent act remained in the deserted forest of pine, through which a local foot path passed.

Road access to the village appeared in 2010, four years prior to this research, when the Swiss Agency for Development and Cooperation (SDC) partnered with the Government of Nepal to improve local infrastructure. Prior to this road, commodities arrived by mule train, and when people were sick they were carried on a stretcher to the nearest hospital, 5 hours away by foot. The creation of the road changed a number of aspects of village life. Slowly people started to open modest shops in the homes that lined the edge of the road. The road enabled access to and movement through the village which previously had not existed. Unlike the district of Solukhumbu to the north, home of the famed Mount Everest, Khotang was neither a tourist destination nor had it been a popular site of international development projects. Most of the district suffers from increasing drought. As water sources are drying up, neighboring VDCs have had to purchase and pipe in water from elsewhere to be used for everyday household consumption. At the time of my research, the village had not yet

²⁴This accused man was a relative of one of the afflicted girls.

raised the money to buy an external water source. Lack of water was a constant worry and source of frustration for everyone.

While in the village I took up residence in the home of the school headmaster. Krishna, known by all as Sir, was a wealthy local *neta*, leader, who was both a salaried government worker in a region with few such jobs, and the owner of a thriving *pasal*, shop, where he and his hard-working wife, known respectfully as Madame, sold everything from cigarettes, chewing tobacco, phone cards, notebooks, and plastic sandals to salt, oil and 25 kg bags of rice. In their shop, which was located on the ground floor of their formidable four-story mud home, was a worn green book where Madam kept track of debts owed to her by most of the village who bought much of their daily commodities on credit. People came and spoke in low voices as they negotiated, gauging how much they could get that day without having paid their bills. This was a place where almost everyone was deeply enmeshed in relations of high-interest debt with neighbors and relatives, as bank loans were unavailable to those who had neither land nor possessions deemed worthy as collateral. Such relations of indebtedness have been endemic to Nepal for centuries, and were an integral reason for social change in the ideology of the People's War (Adhikari 2014; Regmi 1978).

Thinking with Fragments

In the interest of understanding how this case unfolded in a village where no psychosocial intervention occurred, I now return to the ethnographic details of the story, to examine its phenomenology, bracketing pre-given assumptions that already see this phenomenon as “hysteria,” “conversion disorder,” or “resistance.” In what follows I will present six fragments as nodes through which this story flowed. Drawing on a phenomenological approach, I offer detailed descriptions of the words, gestures, and interactions through which these events unfolded. I attend to language closely, with the understanding that experience takes form in and through language (Csordas 1994;

Throop 2010b) and that language invokes consciousness of phenomena as they are understood in particular social worlds (Desjarlais 2003:14). In this chapter, I experiment in thinking with fragments because this was the form in which the story of the affliction became visible to me. In so doing, I attempt to think *with* the quality of incompleteness instead of trying to form it into a whole. I consider the transient and fragmentary form of the phenomenon I followed as a central dimension of its phenomenology, and I allow this to suggest the form of the ethnography that follows. This presentation of the data remains faithful to the form in which it appeared, always keeping its temporality in focus. By examining the fragmented data in fragments, it becomes possible to follow how others gave form and meaning to an unknown phenomenon.

Fragment #1

December 12, 2014. 11:30 AM. It was overcast and cold. The valley far below was filled with a thick milky fog. The first girl was already lying prone as if sleeping on the wooden bench when I was called to the school. The office was filled with mostly men, *Sir baru*, the teachers, watching and some playing a game of chess, studiously ignoring Laxshmi Basnet from class 8 as she cried and writhed and then fell into what looked like a deep sleep, punctuated by quick breathing, her fists clenched.²⁵ Suddenly she screamed and we all jumped to attention. Thirty minutes later a second girl was brought out of a classroom, led by the arm of one of the young school mistresses. The girl walked as if she could see where she was going; up the steep shortcut path she did not stumble. She was brought into a second room. Someone brought a plastic *gundri* mat and spread it over the packed earth floor. She began to cry and moan, her back against the wall. Her symptoms were different from the girl before her—she cried and spoke in a semi-conscious state saying in the voice

²⁵ All names changed, but caste and ethnic name markers correspond to the original.

of another, “*Ai ja! Ta ai jau baneko! Chito ai jau! Kura na gar! Tero kura na gar! Ai ja!*” “Go away! I said go away! Go away quick! Don't do it! Don't do your thing! Go away!” It was unclear who exactly this was directed towards, or what the *kura*, thing, was exactly. Some teachers came in to alternately watch her or play solitaire on the school computer, talking amongst themselves—they had been informed by the doctors who came from the district headquarters that this was an affliction called “mass hysteria,” and had been advised to separate the girls and to pay as little attention as possible to them when they became afflicted in order to reduce the symptoms. They were trying their best to follow the doctors orders. Some of the teachers looked uncomfortable. One watched, his hands stuffed deep into his jacket pockets; another awkwardly griped the edge of a table. Others seemed to find the episode amusing. Then a third girl was brought in, moaning and shivering. By now it was 1 PM. The third was placed on a wooden bench where the first, who had now recovered, had been lying. The teachers discussed whether or not she had been afflicted before. Two friends, unafflicted, gathered around her with concern but they were told to leave. A fourth girl fell ill and was kept in yet another place. The second girl recovered, returned to the classroom, fell ill again and was brought back into the empty computer room with the plastic *gundri* mat. In the midst of this the headmaster made a phone call and told someone that it was happening again. Later some of the girls reported having seen a ghost, someone dressed in all white, *seto kopra lagaeko manche*, the Hindu color of death. Others said that it was the ghost of an elderly Newari grandmother, *Aji*, who died one year before.²⁶ It was neither clear nor precise. In total, 15 girls between the ages of 12-15 were afflicted.

²⁶ *Aji* is the Newari word for grandmother. Newar is an ethnic group in Nepal, with their own Tibeto-Burman derived language as opposed to Nepali, an Indo-Aryan Sanskrit derived language. In this village Newari families no longer spoke their own language, although Newari kinship terms remained in use.



Figure 6 The government school. December 2014.

Fragment #2

Two days later again it happened.

December 14, 2014. 9:20 AM. A girl became afflicted in class. Bhabana was taken out of the room as her classmates looked on with wide eyes. Ram Sir, a teacher who was also her relative and the local *dharmi*, slung her limp body over his shoulder and carried her to the village *pasal*, store. He laid her down on the cot under the porch and she seemed to fall into a deep and quiet sleep. Ram Sir came and sat next to me asking “how can this be mass hysteria if it only happens at the school and not in other crowds? For example last night we went to the wedding and she was also there but nothing happened. It is not mass hysteria. A ghost is haunting the school and it must be kept away.”

Soon the other students gathered around. They glanced at her uneasily until they were swatted away by the adults. Activity continued at the *pasal* as usual.

Then people began shouting again. Another student had been struck, they said. She was carried out of the classroom and laid onto wooden benches that had been pushed together. A friend came and took her hand, while others gathered around. A group of students decided to carry her to the village *pasal* but when they tried to lay her down on the cot outside this time the drunken owner snapped at them angrily- he was sick of so many disruptions caused by these girls, and refused to move from his bed. It began to rain lightly. This time the girl, who I will call Kalpana Basnet, was taken to the courtyard of the adjacent house. A swarm of students, one teacher, the “peon,” myself and my assistant Prabesh formed a circle around her. Kalpana stood in the center of the circle, her body arched forward, doubled over and shaking. The students surrounding began a kind of public interrogation of the spirit. Led by two friends, Sunita Rai and Gita Basnet (both age 13), who had themselves fallen ill in the days before, the crowd posed questions directly to the ghost who was then inhabiting the body of Kalpana, but mostly it was Sunita and Gita who would respond. “Sir, all this is happening because someone is making [the ghost] play” (*Sir yaha kehi kbelaune chha ra matra yesto bhaeko ho kbelaune. Hoina bhane ta*)²⁷ Sunita announced.

²⁷ The Nepali language varies greatly by region. The language transcribed here documents the regional accent and dialect used in this village in Eastern Nepal.

Sir:

Someone is making it play? What kind of play is being made?

Kbelaune ta ra? Kasko kbelaune?

Sunita:

Making these ghosts play.

Yesto bhutharu kbelaune.

Sir:

What did a person cause this?

Ke thyo, manchele gareko?

Gita:

People just like us. We found out that they do these things.

Aba hami jastai manche ho. Tele tysto gardorabecha.

Sir:

People just like us make it play like this?

Hami jastai manchele yesto kbelaeko?

Sunita:

It [the ghost] is not letting her go.

Janai didaina usle anta.

Onlooker:

Why would that person make it play, I wonder?

Thyo manchele, chahi, kina kbelaeko hola?

Prabesh:

Who [is making the ghost play], do you know?

Ko manchele ho taba chha?

Sir:

You girls know who exactly caused this?

Manche pani taba chha timibarulai?

Sunita:

We know Sir, but it's that it wouldn't be nice to tell.

Taba chha ni Sir banna na milne ra matrai.

Onlooker:

After telling then again... (laughter)

Bhanepachi pberi...

Possessed Girl:

Then you all will find out everything.

Thyo sapai taba paunchan pberi.

Gita:

Chup chup chup! If these things are opened then your things will be opened too.

Chup chup chup! Kura kholio bhane tero kura kholdincha.

Possessed Girl:

And your...

Tero pberi...

Onlooker:

I'm feeling afraid.

Malai ta dar laagirabecha.

Gita:

If these things are opened then whose secret will be opened, do you know?

Kura kholio bhane ani kasko kura kholiacha taba chha?

Possessed Girl:

Inaudible.

Inaudible.

Onlooker:

What is being said here, I can't hear even one thing!

Ke bhanne maile enta kura bhujina!

Gita:

Chup! Don't speak! I found out.

Chup! Na bol. Maile taba pae ni ta.

Prabesh:

And this needs to be made better, who did this? After telling maybe it could be made better.

Ani thik garnu paryo, kasle gareko ho? Bhanera bhayo bhane thik huncha hola.

Sir:

If this happens all the time then how would you all be?

Sadai estai bhaera ani timiharulai pani kasto hune hola?

Other girl:

How would it be if it doesn't leave, Sir?

Kasto bhaera ke garu Sir na gaepachi?

Peon:

Exactly. Because of this the students have destroyed the school.

Teyta nai. Bidyalaya bidyalayama barbat hune bhayo.

Gita:

We aren't doing this on purpose.

Hamile jesto hunchau bhanera gaeko ta hoina.

Prabesh:

No, no, that's not what it being said, but there might be other solutions.

Hoina, hoina, bhaneko ta hoina, tara esko upaya ni esko bikalpa.

Sir:

If you explain to us 'these things are happening to me, these things will make me better,' if you will tell us then we can look for a solution.

Hamile esto bhaeko chha, esto garda thik huncha bhane hamilai laagcha bhanera timiharule bhanyo bhane hami upaya kbojchhau.

Gita:

That person must stop making it play, otherwise it won't obey.

Aba ki thyo manchele kbelaune chaarnuparyo, natra mandai mandaina.

Onlooker:

The person has to stop it.

Manchele banda garnu paryo.

Sir:

A person is really making it play?

Manchele kbelaeko ho ta?

Gita:

Yes, a person is making it play.

Manchele kbelaeko ho.

Peon:

[They are] not dead?

Mareko chaina?

Gita:

They also say these things...(laughter)

Ani yesto pani banchan...(laughter)

Sir:

People just like us are making it play,
it is said.

Hami jasto manchele kbelaerabeko chha bhane.

Onlooker:

Is the person a boy or girl?

Ketaa manchele ki keti manche?

Gita:

(Interrupting the possessed girl before
she can answer) *Chup chup chup!* Do
not say one word, you hear! if you
speak a lot then your things will be
opened.

*Chup chup chup! Ta ek sabda na bol hai. Dherai
bolis bhane terai kura kboliela.*

Sir:

Did a boy or a girl do this?

Keta maanchele ki keti manchele?

Possessed Girl:

A girl...

Keti manche...

Gita:

Enough Sir. If you keep opening and opening things it will become difficult.

Bhayo Sir. Abile kura kholda kholdai apbthyaro pani parna sakecha.

Sir:

No, I won't request much more than that.

Hoina thyo bhandu dherai ma magdina.

Sunita:

You say just a little and everything can be opened and there will be no place left [for secrets] to dwell.

Ali ali garda gardai tapaiharu sabai kholisaknubuncha ani tao nai rabadaina.

Sir:

If you don't dig up everything [lit. pierce the thing] then there won't be a solution, isn't it.

Hoina ta thyo kura nakotyaulai tysko upaya budaina.

Other girl:

(referring to the possessed girl) Ask this girl. This one has been saying things for a long time.

Yeslai sodnuna. Yeslai, agi dheki bhaneko bhane chha.

Sir:

No, we can't ask her because she is not well now.

Hoina, yo ta abile ali saddhe bhaeki chaina.

Onlooker:

Ask her.

Sodnubuncha.

Possessed Girl:

She is making it following us...

Tele hamro piccha garcha...

The interrogation under the veranda resembled a kind of film, a scene directed by Sunita and Gita. Here the story told was one of accusation—in which they accused an unnamed girl of making the ghosts play, *kbelaune*, and causing suffering among the students. Although the word “play” is used, it is an ambiguous playfulness. To accuse one of making the ghosts play, *kbelaune*, is also to imply the work of a witch, a *boksi*, which is a dangerous accusation. There is talk of exposure, of secrets, of the need not to “open” things, *kura na kbone*, not to reveal. What is the phenomenology of a secret? In the Nepali language secrets are things, *kura*, not to be opened, *na kbolne*.

Hysteria has always been tied up with issues of exposure, from the photographic documentation of Charcot to the psychoanalytic exposure of Freud. It is with this heavy history in mind that I proceeded to document this case of affliction among adolescent girls in a village in Eastern Nepal. As part of my research I too filmed the events, in order to better see the choreography of symptoms; in order to perhaps “open” something up. Yet doing so was always also ethically confusing, as the symptoms of the girls took an uncanny resemblance to Charcot's hysterics. It is because of my uneasiness about exposure and the dynamics of power involved in relation to the history of hysteria that I will not reproduce exposing photographs or films of the events here.

Exposure was also at stake in different ways in the events as they played out on the ground. Among the girls there was a resistance to allow all the information to be exposed, “*Chup chup chup*” says Gita to the possessed girl. “Don't speak a word, if you will then your own secret will be exposed.” Here too and later as the story unfolds, exposure is a central trope. Now I have become implicated in exposure, as I proceeded gathering fragments and searching for clues to reconstruct the story of the case. At one point Sunita warns the possessed girl that the video I am shooting could be put online—“and after they put it on the net, then we will be completely dishonored” (*Ani*

netma rakebane, hamro katro bejat huncha). Gita agrees, “now they will take what you have said, they’ll make everyone hear it” (*aba tera boli lagera, sunai dinchan, sabailai.*) This is an apt observation about the ethical complexities of the ethnographic project more generally, and I’ve taken Gita’s warning to heart. The choice of what to reveal and what to allow to remain concealed is never innocent. In this work I found a kind of double exposure, in which my own efforts to search for clues and dig for information mirrored the local interrogations of ghosts that I was witness to.

The scene continues.

Sunita:

I am also surprised. She is just like the witch, *boksi*, of Okhaldunga district.

Malai pani accama lagisakyo. Eta Okhaldungako boksi jasto bhayo ta.

Gita:

We found out about the Okhaldunga *boksi*.

Aba sanchike Okhaldungama boksi patal lageko ni.

Sunita:

Our Daddy recorded it, I was afraid of that recording.

Hamro Daddyle record garnubhaeko rabecha. Maile dar laage.

Sir:

There is a video?

Video nai chha?

Gita:

How many people were eaten? 2-3 people? How many people? “I also ate Sumita” the *boksi* says. “Who ate her, who ate her?” they yell [in the video]. I was afraid and...

Kati jannalai khaeko? 2-3 janna? Kati janna? “Sumitalai pani maile khaeko” bancha. “Kole kole” galli garcha. Malai dar lagera...

Sunita:

The voice was also just like mine.

Swor pani mero jastai.

Gita:

The *dhami* alone couldn't do anything and that's why they called the police and the people. When they reached there she was sitting. Then the *dhami* threw a glass of spelled water over her and after that she started speaking of the things she had done. The next day she hung herself.

Ani tekkai te bhanera dhamile ani ke na lagera gaubadi police sabit bolaera kasti bolaera ani pugda thyo basirabeke glassma paani phukera lagaidieko ani tyaha deki banna talieko bhaneko bhane. Ani boli palta ta jundera marechha.

Prior to this day, images had circulated on the screens of cell phones—a viral video of an accusation in which a woman is put on trial for witchcraft was absorbed by those who watched it. “The *dhami* threw a glass of spelled water over her,” Gita explained, referring to film, “and after that she started speaking of the things she had done. The next day she hung herself.” “She is just like the *boksi* of Okhaldunga,” Sunita remarked, referring to the unnamed accused. “The voice was also just like mine,” she added, observing a similarity between herself and the voice of the *boksi* in the video.²⁸ In this scene, multiple strands of explanation begin to appear, as experience of affliction takes form, intersubjectively and in relation to multiple others, both present and absent. When the peon asked “the person is not dead?” referring to the idea that the affliction was caused by *Aji*, the Newari grandmother who died and returned in the form of a *pissach*, a spirit of the dead, the girls responded to him with laughter as if to suggest that the truth of the matter lay elsewhere. Gita, Sunita and their friends alternately revealed and concealed a new story of a *boksi*, a fellow female student, as being behind the affliction of the girls.

Contrary to what might be expected, the atmosphere of this afternoon under the veranda was not heavy. Instead there were often irruptions of laughter, and intense interest in the excitement of the scene. In the end when the scene died down and Kabita left her hunched and shaking position to stand up straight, she burst into a broad smile and everyone laughed. The students left the courtyard and hiked up the path towards their homes. The adults stayed behind, discussing what had taken place. Sir said, “Sunita and Gita’s mood seemed different...this art, this art they said today...” (*Inibaruko mud pani arkai chha jasto laagisako. Yo Sunita ra Gita ni...yo kalaa inibarule aja bhanneko kalaa...*) In Nepali, *kalaa* is defined as art, proficiency or skill and can also refer to one who is skilled in the arts more generally (Schmidt 1994: 90). Throughout the scene, Kabita stood, doubled over and shaking. Multiple times she tried to “transfer” the spirit to both Sunita and Gita by grabbing

²⁸ This could also be an observation that the voices in the video shared her ethnic group (Rai).

hold of their hands, but despite their willingness she was unable to do so. This scene under the veranda was categorically different from the earlier events in the school, and yet directly connected to it.

In February 2015, I returned to the village. At this point the students had fully recovered from the affliction. In my absence, the headmaster of the school called a known and powerful *dhami* from a different VDC to come and do a large puja in which 300 people attended.

Fragment #3

A young man transferred an audio file to me that he recorded on his cell phone using bluetooth. In the recording the voice of the deceased Newari grandmother, *Aji*, has returned and she speaks through Bhabana, one of the afflicted girls. She answers questions posed from the local *dhami* and teacher Ram Sir, in front of what seems to be a crowd of villagers. “Who was there when you were dying?” a man's voice asks. *Aji* died a sudden, unexpected, and inauspicious death. She was working in the fields with a Dalit laborer when she fell. On the verge of death, the Dalit woman gave her water to drink, something seen as taboo and polluting in this village where Dalits still do not cross the thresholds of the homes of the Brahmins, Chhetris, Newars, Bhujels, and Rais who also inhabit this community. Since this event, the Dalit woman has also died, although her son is present during this spectacle.

Throughout the interrogation, the *dhami* brings up a number of issues which entangle many members of the community. *Aji's* troubled relationship with her daughter-in-law and son “who did not even do [her] *shradda* (a ceremony performed in honor of the deceased ancestors)” is publicly revealed. The father of the first girl to become afflicted is also accused by the voice of *Aji* of taking her land to open the first road to run through the village (the infrastructure development project

funded by the Swiss government pictured earlier). Attempting to appease her, the *dhami* asks “can we keep you in a nice stone cave?” She agrees, and requests that her *dewar*, her younger brother-in-law build her a *thaan*, a special resting place, and provide offerings to her on her *tithi*, her death date. Her *dewar* is present and he agrees. The voice of *Aji* promises that she will not cause any more trouble in the school. In return, the *dhami* promises, “We will establish a *thaan* for you...no one ignores you just because you are dead. We will not let that happen.”

Fragment # 4

I am called to the home of *Aji*. When I ask why, I am told that she has appeared as a *pichaas*, a wandering spirit. At the house the daughter-in-law of the deceased woman has become “possessed,” enabling the voice of her mother-in-law to speak once more. I go with Krishna Sir. We arrived and he sat down by the possessed woman and began to banter with the voice of his deceased *Kaili Aji* (third eldest grandmother, in Newari) in the aggressive and playful manner of a seasoned interlocutor in such situations. She responded, disregarding all rules of polite discourse, using the intimate and subordinating *ta*, you, form to the wealthiest man in the village. Throughout the conversation, which again proceeded as an interrogation with the dead, two intertwined stories played out. A complicated and not unusual conflict between a *sasu*, mother-in-law (the voice) and her *bubari*, daughter-in-law (the possessed) was stitched into the case of the afflicted girls in the school.²⁹

“It has been one year since I've died, and I feel *chinta*. I've already gone far away,” the voice

²⁹ The possession reveals a number of issues within one particular family, between a daughter-in-law and mother-in-law. This in itself is not at all uncommon, and at other moments I also heard the voices of other unhappy deceased women afflict and speak through their daughter-in-laws, who would then appease them through elaborate *dhami pujas*, offerings and blood sacrifice. While not an official rule, I only saw *bhut laagyo*, the afflicting of ghosts, occur among and between women, living and deceased. On the other hand, men would be struck by *denta laagyo*, god possession, which referred to possession by displeased lineage deities.

begins. As *Aji's* voice spoke through her daughter-in-law, we learned that her daughter-in-law, who came from a wealthy family, had purchased an enviable plot of land in the district headquarters from her *maiti*, natal home, and had been living there with her husband, *Aji's* son. This was seen as an embarrassment in the patrilocal community, where women were always expected to live in the home of their husband's family. The voice of *Aji* said that her daughter-in-law had disrespected her in life and also in death. She then claimed that she had been forced to afflict the girls because a local *dhami*, Ram Sir, who was also a government school teacher, messed with the spirits, *chalayera*, and raised her from the dead. But this information was something that should not be spoken about publicly, there was a sense of exposure at stake—"don't talk, don't talk, everyone will hear, don't say" the voice of *Aji* insisted as the interrogation began. Despite this risk, the conversation continued and many pieces of information were revealed to the rapt listeners. She felt that because of him, "she has been disrespected in front of the entire village" (likely referring to the audio recording) and begged them not to call her *pichaas*, but to call her *Aji*, grandmother. She concluded by revealing the identity of a new and unknown *pichaas*, and argued that she should not be the only one blamed for the affliction, because there are many other suffering wandering ghosts who haunt the village and cause problems among the living.

(Excerpt)

Aji's Voice:

Ram will mess with spirits like us, after he messes with us we will jump around *uffri halchhan*.

Krishna:

And where did he mess while doing *chinta*?
Where did Ram do *chinta*? [Woman: He didn't
do *chinta*. After doing *phu phu phu phu* (casting
evil spells) it came out.]

Krishna:

You can't play around with stuff like that.

Aji's Voice:

If someone wakes us, then we have to wake up.
Otherwise god will beat us.

Krishna:

And you make us suffer?

Aji's Voice:

Did I do it?

Krishna:

Who did then? [Woman: Ram did it, I told you
Ram did it.]

Aji's Voice:

I was not the only one, how many others there
were.

Krishna:

If you cause trouble to us then I will make sure
you will be hit.

Aji's Voice:

Over there a woman hanged herself [Krishna:
where?] Over there. She hanged herself. How
much she is moving around. [Krishna: ehh]
You only blame me.

The voice of *Aji* complained that by calling forth her spirit in the form of a *pissach*, a wandering ghost, that she had been dishonored. She insisted that she should not be held responsible for the affliction in the school, but instead Ram Sir should be seen as responsible, for he was the one who caused her spirit to wander in the first place. Krishna Sir responded that due to the accusations made against Ram Sir, he brought a reputable *dhami* from outside the village to perform *chinta basne*, the required healing session, but that he still needed to be sure that she wouldn't cause any more problems. Then the conversation shifted to the topic of ghosts more generally. The voice of *Aji* argued that hers was not the only *pichaas* in the area, but there were in fact many other ghosts wandering, some known and others unknown. In saying this, she also reasserted that she alone should not be blamed for the suffering in the school. She felt that because of Ram, "she has been disrespected in front of the entire village" and begged them not to call her *pichaas*, but to call her *Aji*, grandmother. The desire to maintain one's honor, *ijaat*, continues after death.

(Excerpt)

Other man:

In our house why did people get sick? You have to tell us.

Aji's Voice:

Hahaha you might be blaming me but the *Bhote*³⁰ died there.

Other man:

Where?

Aji's Voice:

On that side of the main gate, *muhl doka*. He died and his bones are near the stones of the gate to your house.

Krishna:

A *Bhote* died?

Aji's Voice:

Yes, *Bhote* died. Your daughter was troubled by him, and after your son-in-law came here he was also sick. What will you do?

...

Krishna:

³⁰ "*Bhote*" is the word, often considered derogatory, used to refer to people of Tibetan origin who inhabit the high Himalayan region.

Where was he from, this *Bhote* who died?

Aji's Voice:

Over near Sarle (place name).

Krishna:

Why there? How did he get there?

Aji's Voice:

During those days *Bhote* didn't have food to eat. They used to beg for flour. He died suddenly in the jungle, and the fox and the jackals tore his body apart. The bones are there.

Krishna:

Oh, your talking about the time when there was still jungle.

Aji's Voice:

He didn't get *Kiriya*³¹. The fox and jackals ate his flesh, *masu*, and the bones are nearby the ancestral gate, *mul doka*, near the path, *hidne bato*. And is that good thing?

Other man:

La. (Exclamation, in this case close to "Well

³¹ *Kiriya* are the thirteen day Hindu death rituals which must be completed by the family of the deceased.

look at that.”)

Krishna:

She is talking about the days when there was jungle.

Aji’s Voice:

Now what will you do. Keep the *dhami*. The *Bhote* doesn't have any family to do *Kirija*, and you can't do it because you aren't his family member.

Krishna:

Eh, you have to clear him away from there.

Aji’s Voice:

Ah, keep a *dhami*, then he might be well so nothing will happen.

As the conversation continued, a new *pissach* was revealed—the ghost of a Tibetan man from high up in the Himalayan mountains who met a violent death in what is now the territory of the village. The voice of *Aji* said that this death occurred in another era, in *Sattayuga*³², a time long before the present when everything was still uncleared forest. The *Bhote* died far away from his family, his body

³²In Hinduism, *Sattayuga* is translated literally as “the era of truth”. It is the first of four *Yugas*, and known as a time of humanity. The final *Yuga* is the *Kaliyuga*, “the era of vice”.

torn apart by wild animals, with no family to complete the proper death rituals. To die alone in the forest, far away from one's family and from the social world, is surely to die a bad death. The wandering ghost of the *Bhote* was offered as a reason behind another sickness in another house, and it was understood that such ghosts must be appeased through the continuous work of the *dhami*. In this way, many forms of sickness were attributed to the suffering of wandering ghosts of those who died untimely deaths. "Ah, keep a *dhami*" said the voice of *Aji*. "Then he might be well so nothing will happen." The suffering of one affects suffering in another. These spirits might be kept at bay only if their own suffering is healed through the work of the *dhami* and through offerings of blood sacrifice, of life itself.

Again, as during the scene under the veranda there was a sense of theater, not in the sense of falsehood but in the sense of entertainment in the unfolding of a story over multiple acts and interlocking scenes and characters. Indeed the voice of *Aji* also addressed my presence, saying to Krishna Sir, "You brought this girl to watch these acts, *ramita*, going on there?" Here *ramita* literally translates as drama, act, or play. After an hour of speaking in the voice *Aji*, her deceased mother-in-law, the woman returned to herself. "What was your experience, *anubab*, just now?" one of the onlookers asked her. "It feels like burning inside, burning inside," she explained. "I don't know exactly. I kind of understand it, and then again I don't hear anything. I am half conscious, *ekoboro*...words come to my mouth, but what I am saying I don't know...Since yesterday I started talking like this. I was making sounds of pain, '*mare, mare*,' 'I will die, I will die,' I was saying such things. And while I was talking like that, my husband said, 'what happened, what is she saying?' And then I said 'I am a dead person, I am a dead person' and I started speaking in that manner. Since yesterday I started to talk like that."

Later Madame showed me a photograph, it was an image of a family standing in front of a lush field of corn. They wear garlands of orange flowers around their necks, it must have been

during the holiday of *Tihar*, everywhere celebrated with copious amounts of marigolds. She pointed to the photograph and showed me the face of the woman “whose voice I heard.” Suddenly the immaterial haunting became material, normalized in the glossy photograph I held in my hand. Who was *Aji* in life, I wondered? And why was she so implicated in this case?

Fragment # 5

The class 9 students organized an event, raised money to pay the expenses, prepared snacks, wrote and performed songs, choreographed dances. I couldn't help but think of scenes from Peter Weir's dreamy 1975 film, *Picnic at Hanging Rock*, as the girls went around together, organizing things, working together, helping each other, holding hands, laughter peeling like bells. The school was the only place where so many girls were all together, and they cared for each other. They were close. During the goodbye program, many of the once afflicted girls performed, dressed as brides in red, they danced individually to songs of love and romance.

Fragment # 6

I found myself sitting with Krishna Sir in the shade in a rare moment when he had spare time. We talked about my project, and what had happened in the school that winter. He said that many ghosts haunt the area, ghosts of people who died by accident or by suicide. We sat on the hill and he pointed in different directions indicating the location of homes or places where such deaths had occurred— a man went to collect mud in a cave and the cave collapsed on him; a woman hung herself in the forest 52 years ago; someone's uncle died when a tree fell on him while he was cutting it down; another person died by the water tap; another fell into the stream and died. There were many such stories, and all of their ghosts were known to cause suffering among the living. The landscape was scattered with such deaths.

The Girls

Of the 15 girls who were afflicted in this case, I spent significant time with Gita, Sunita, Bhuma, and Binda, the central four most affected students.

I often spent the weekends with Sunita and her siblings, accompanying them to the fields while they would graze the oxen or feed the buffalo. One afternoon I walked with Sunita and her cousin along the small paths lining the edges of the terraced fields. The girls climbed high up into a tree. Sunita talked to a friend on her cell phone. Then they came down and started playing a board game they had brought along. They were missing a piece and so they replaced it with the blossom of a flower. Every so often they remembered the oxen and found they had wandered into someone else's wheat crop. The girls would jump up suddenly and take off in a sprint, yelling and leaping down the terraces and chasing the animals out. Later we relocated to another step in the terraced hill. Sunita played a song on her cell phone and the girls did a choreographed dance. They forgot the moves but danced anyway on their grassy stage, behind them a bright blue sky. No one else was around and they were silly and laughing and carefree. On the way home, we picked as many of the sweet, tart *aiselu*, golden Himalayan raspberries, as we could hold and stuff into our mouths. As we walked along the path, Sunita stopped, looked over the edge and pretended to jump. Then she laughed.

Sunita's family was well off compared to other families in the village. They had moved to the settlement recently, while all the other families had lived there for generations. Her father had a small mechanic shop and at the time of my research was the only one in the village to own a motorcycle. Their home had a functioning water tap, which few others did. At home Sunita lived with her parents, two sisters, brother, and her grandmother who was paralyzed from the waist down. Sunita's parents were rarely around, and when I visited she was the one taking care of her siblings,

and cooking the family meals. Compared to the other girls, outside of school Sunita did not have to spend all of her time working—taking care of the animals, collecting wood—but instead could take time to play and watch TV with her siblings. Sunita was the only one of the girls who had been to Kathmandu.

With Gita I would accompany her while she took her family's goats to graze in the afternoon up in the wooded area above the village. Gita was often serious and un-talkative, never playful around me like Sunita, although both girls were distinct in their strong personalities and sharp intellect. Gita's father had worked abroad in the gulf for many years. When I would spend time at their home, he would always apologize for what he felt they lacked. Gita's uncle was active in village politics, and had previously served as the village Chairman, but had been accused of corruption. Her brother was in jail. She had two sisters, one of whom had recently married while I was in the village. Her family home was the ancestral home of their clan, and as such they would host the ritual *kehul puja* for the ancestral deity. Gita and Sunita, were best friends, but after the case of the affliction their friendship changed. They no longer spent time together after school doing chores together as they used to. As Sunita reflected to me, "Gita thinks she is *thulo maanche*," too good for me.

Bhabana was always sweet and friendly, a diligent and talented student. Her uncle by marriage was the *dhami* and schoolteacher Ram Sir, who was also implicated in the case. Her family was somewhat unusual in the village as both her mother, two aunts and sister had love marriages, in an otherwise extremely conservative community. Bhabana's other uncle by marriage was the new village Chairman at the time of my research. While I was in the village, her brother married and the household gained a new daughter-in-law. The group of best friends were all invited to the wedding, as part of the *janti*, the groom's party which travelled by foot to the bride's natal home in a village a few hours away. Throughout the day I watched as Sunita and Gita darted around, always together, holding hands, whispering secrets to each other. Later the girls stayed close to each other, sitting on

the ground under the veranda in a pile.

Binda, the first to fall ill, was from a relatively well-off family. Her father was one of the village *netas*, leaders, highly active in village politics, and it was him who had fought with *Aji* regarding the issue of her land being taken for the opening of the road through the village. Her father had recently opened a private English medium school in the village next to their home, but was struggling to keep it open. Indira's aunt lived at home with the family and suffered from a developmental disability. The family had spent significant amounts of money to treat her but with no improvement.

A Theory of Transfer

Still we have no answer as to why groups of adolescent girls become afflicted in government schools in rural Nepal. Studies of subjectivity have explored the ways in which the personal, experiential, and emotional life of an individual is formed and reformed by shifting local and global economies, unstable political conditions, and ever-increasing situations of insecurity, marginality, violence, crisis and domination (Biehl et al. 2007; Das 2007; DeVecchio Good et al. 2008). In Nepal, the multiple forces of insecurity and change that the country has undergone in recent years (mass out-migration, a decade of war, high rates of unemployment, and then, a natural disaster) directly affect the lives of adolescents, and such cases of shared affliction could be read as a symptom of insecurity and exposure.

In the introduction to the 2008 volume, *Postcolonial Disorders*, the authors reflect on the concept of subjectivity, foregrounding the role of colonialism in causing particular forms of subjectivity to appear. Here they define subjectivity as,

Everyday modes of experience, the social and psychological dimensions of individual lives, the psychological qualities of social life, the constitution of the subject, and forms of subjection found in the diverse places where anthropologists work at the

beginning of the twenty-first century (2008:1).

Subsequently, in this volume the editors argue that use of the term “subjectivity” signals a distinct domain of research that examines experience in relation to social and political issues of our time—such as postcolonialism, violence, subjection— which are “issues different than those raised by classic studies of “self” or “person and emotion” (2008: 2). The emphasis on disorders draws attention to a line of argument that works to connect “the ‘disordered states’ of individuals and polities” (2008: 9). In so doing, the authors call to establish new dialogues within cultural anthropology between the study of the individual and the study of the social, and to connect discussions of the psychological with history and politics.³³

Fragments collected of a story of shared affliction spiral outward into orbits of relationships; each piece involving a form of transfer between beings, both living and dead. A group of friends became momentarily afflicted, and the affliction was transferred from one to another and back again. Their shared affliction was immediately woven into the suffering of yet another woman— *Aji*, who was recognized as being mistreated in life and in death—her land was taken without compensation to open a road through the village; her daughter-in-law wielded unusual power and status; and *Aji*'s death was inauspicious, tainted by bonds of servitude with an “untouchable” laborer who was ultimately punished for offering the dying woman water in a gesture of care. *Aji* suffered and transferred suffering to multiple others. Then there was a second story—the circulation of a viral video and multiple accusations of witchcraft, itself another form of transfer. Layer upon layer, this case builds upon transfers among and between many women, both living and dead. In the end, it was only when a *dharni* from outside the community came to the school to perform *chinta basne* that

³³ Additionally, they argue that studies of subjectivity must attend to “that which is *not* said overtly, to that which is unspeakable and unspoken” (2008:14) in the context of everyday life. In order to examine such mute dimensions of subjectivity, they suggest the use of the psychoanalytic theories of Freud and Lacan, and a greater attention to traumatic memories, topics that individuals are unable to or refuse to speak about in certain settings, and to knowledge symbolically embedded in works of art and performance.

the affliction ceased. I was told that 300 people attended this communal healing ceremony. When I returned again to the village one year later in April 2016, the girls remained fully recovered, but another case had occurred in a village school about one hour away by foot.

After examining the fragments that I collected in relation to this case, it became possible to see the ways in which emerging lines of connection were given form. In ordering the fragments of the transient affliction, people in the community understood this case through a theory of transfer and ghostly haunting, in which suffering flowed between beings, and contaminated a space.

For example, when the girls gathered under the veranda and Sunita and Gita begin to answer questions for the possessed girl, or when they discussed a viral video of an accusation of witchcraft as a way of making sense of the situation, all in front of a rapt audience that encircled them. Similarly, when the girls became afflicted in the school that first day in December and were unable to describe the experience they had undergone, only that they saw a person dressed in white, *seto kopra lagaeko manche*, this sighting was immediately linked to the recent death of *Aji*, whose home also happened to be located in close proximity to the school. From that point on, the experience of group affliction (both the experience of the girls and that of the multiple onlookers and wider community) took form in relation to the story of *Aji's* suffering.

Doug Hollan has argued that there is “the tendency to smooth out the differences between people and their experiences by referring to their purportedly common habitus or routines or practices; in some cases to presume that they are thinking and feeling and imagining the same things simply because they are overtly acting the same ways” (2012: 43). In describing the way the fragments of this case were given meaning by the community I do not mean to deny the fact that the individual girls experienced the event of affliction in unique and singular ways, but in this chapter I have attempted to follow how a group of people collectively made sense of an unknown affliction through the pre-existing concept of *pissat* and *bhut/pret laagyo*, ghostly haunting, which places the

focus on the transfer of suffering and affliction between beings in the context of the broader community, as opposed to the psychiatric concept of “conversion disorder,” in which the problem is understood as a way of coping with adversity.

The centrality of transfer resonates with the concept of intersubjectivity, the ways in which experience (in this case, experience of affliction) is never merely subjective but is always already formed intersubjectively, in relation to multiple others, both present and absent (Csordas 1993; Desjarlais 2003, 2016; Husserl 1983; Jackson 1998; Throop 2010a, 2010b). As Desjarlais has recently described it, intersubjectivity is about how “people relate to—care for, imagine, remember, part from, long for, wound, haunt—important others in their lives” (2016: 8).³⁴ Intersubjectivity accounts for the way in which an unknown affliction became experienced as *pissat* and *bhut/pret laagne*, ghostly haunting. It also relates to the reason why these girls were afflicted while others were not as it points to the dynamics within a close group of friends. As Hollan has noted, one’s susceptibility to “social contagion” will vary between individuals, for “people may find themselves consciously or less than fully consciously, in uncanny ways, ‘falling under the influence’ of new people, ideas, or experiences, or they may find themselves highly resistant to these new influences, depending upon their own prior experiences and the particularities of the new engagements” (Hollan 2017: 222).

Attending to the intersubjective milieu in which this case occurred is also necessary in order to approach the question of transmission of affect between people in the moment of affliction, which in this case begins with one individual and spreads to multiple others through sensory and embodied means. The Nepali word *sarnu*, meaning to move or to be transferred, is also used to describe illness that spreads in the form of an epidemic, *sarne rog*. *Sarnu* is drawn from the Pali word

³⁴ In psychological anthropology, intersubjectivity has generally been examined in and through dyadic forms of face-to-face interaction (Csordas 2008), while collective intersubjectivity remains under explored. As Michael Jackson writes, drawing on the earlier work of George Simmel, “although the elementary structure of intersubjectivity is dyadic, the dyad ‘contains the scheme, germs, and material of innumerable more complex forms’ (Simmel 1950:122)” (Jackson 1998:9).

sarati, meaning to go, flow, move, run along.³⁵ Compound forms of the root *sarati* are contained in related words such as *atisarati*, to go too far, to go beyond the limit, to overstep or transgress; *anussarati*, to remember, recollect, or have a memory of; and *anusarati*, to follow or conform oneself (Pali Text Society 1921-1925). The girls were part of a tight group of best friends, *ekdam milne saathibharu*, that did everything together. Teachers who had observed the moment of transfer said that the affliction flowed through touch and sight. One girl described sensations of pain in her chest and difficulty breathing right before she was struck. Another said that directly before she felt dizziness and directly afterward she suffered from headaches and stomach aches. Once they had fallen, their body positions mirrored that of each other, as if following a corporeal grammar.³⁶ Afterwards, the individual girls were unable to recall the experience that they had undergone; it was a limit experience, an experience at the limits of subjectivity. As Blanchot writes of limit experience, “the self has never been the subject of this experience...we speak as though this were an experience and yet we can never say we have undergone it” (Blanchot 1993: 209-210).

The affliction moves mimetically from one individual to another, the symptoms of one becoming the symptoms of many. It is an example of intercorporeality, the transmission of affect between bodies (Csordas 2008). Early concepts in anthropology, such as James Frazer's theory of sympathetic magic and his law of contagion, and Emile Durkheim's idea of collective effervescence, offer an understanding of the problem of contagion as analyzed from an anthropological perspective yet in both cases a theorization of transfer remains mysterious. As Frazer writes of sympathetic magic, “things act on each other at a distance through a secret sympathy, the impulse being transmitted from one to the other by means of what we may conceive as a kind of *invisible ether*, not

³⁵ Pali is the ancient language in which the words spoken by Gautam Buddha were recorded in written form in the canon of Theraveda Buddhism in the first century BCE.

³⁶ In other cases I observed in Nepal, each locality had adopted its own unique choreography of symptoms, which were shared among the group.

unlike that which is postulated by modern science for a precisely similar purpose, namely, to explain how things can physically affect each other through a space which appears to be empty” (Frazer 2009: 39, my emphasis). Durkheim, theorizing the contagious mood of the sacred in his concept of collective effervescence, imagines the feeling of being swept away in moments of collective sentiment drawing on metaphors of the circulation of electricity.³⁷ “Feeling himself dominated and carried away by some sort of an external power which makes him think and act differently than in normal times, he naturally has the impression of being himself no longer...” (Durkheim 2008: 218). Durkheim further argues that it is from this very form of shared effervescence around the sacred that religion itself may have evolved. As Georges Bataille wrote on “communication” in *Inner Experience* “...your life is not limited to this ungraspable inner streaming; it also streams outside and opens itself incessantly to what flows or surges toward it...words, books, monuments, symbols, laughter are only so many paths of this contagion, of these passages” (2014: 97).

In writing of the ontology of *cen*, the Acholi spirits of the dead in Uganda, Lotte Meinert and Susan Reynolds Whyte describe a form of shared affliction that resonates with cases of contagious affliction among adolescent girls in Nepal described in this chapter. According to Meinert and Whyte, in post-conflict rural Uganda, *cen* occurs when a person dies a bad and violent death; “*cen* is a family, not only an individual, affliction in that it can spread to descendants of the person who directly experienced the violence” (2017: 276). Importantly, in this context, they found that only those individuals who “...showed compassion with the suffering of someone else” were “receptive and permeable” (2017: 281) to affliction caused by *cen*. While from a biomedical perspective, *cen* affliction could be diagnosed as PTSD, such a diagnosis is unable to account for the ways in which a

³⁷ Thomas Csordas, writing on intercorporeality in light of his work on charismatic Christianity and the laying on of hands, asks how we can “concretely account for what is abstracted from the interaction as ‘energy?’” (2008: 112). From Csordas’ perspective, “energy” is not in itself an adequate explanation, but instead speaks only to the symbolic meaning of the phenomenon. Drawing on a phenomenological approach, he argues that such “energy” can be explained as intercorporeality, that is intersubjectivity in embodied form.

person might “suffer from PTSD on behalf of someone else or in generations after the violent event happened. Often *cen* too affects the individual who has experience violence, but not exclusively, because in many cases *cen* also affects a lineage, family, or homestead, and it may ‘jump a generation.’ This difference in the relevant unit of analysis—the individual body and brain versus a wider social network and place—has implications for how we may think of the influence of violence as contagion, contamination, and alien” (2017: 281). In light of these observations, Meinert and Whyte suggest “contamination” as an analytic different from that of contagion, to understand the ontology of *cen*. As they put it, “whereas contagion is a process that moves from one body to the other by means of touch, contamination happens in an environment, sometimes as a process of seeping through layers (of soil, souls, and socialities)” (2017: 284). Jason Throop has written of similar “seepages” which he thinks of as the “‘communicable’ pathways” between mood and world; the ways in which a given mood “may disclose forms of attunement to worldly conditions” (Throop 2017:199).

Not unlike the conceptualization of “contamination” described by Meinert and Whyte, fears of contamination from exposure to toxic waste dumped in proximity to the school emerged as a central concern among community members in the highly-publicized 2012 case of adolescent “mass hysteria” in Le Roy, New York (Goldstein and Hall 2015). Recently, in a case study of “mass fainting” among garment factory workers in Cambodia, the author noted that “mass fainting tended to break out in factories built on sites that were said to be blighted as Khmer Rouge killing fields” (Eisenbruch 2017: 163). In Nepal, such cases occurred within the territory of the school, generally with the explanation that the area has become haunted by spirits, or cursed by the displeasure of angry gods. Working from the ontology of *pissat* and *bhut/pret laagyo* as opposed to “conversion disorder,” it becomes possible to read these types of cases of shared affliction as disclosing forms of connectivity, communication, and contamination between beings and their environment. To

approach such incidents from this perspective invites a reformulation of a largely pathologized phenomenon.

PART III
CRISIS

CHAPTER 4

Writing Disaster

“When to write or not to write makes no difference, then writing changes; it is the writing of the disaster”.

–Maurice Blanchot, The Writing of the Disaster (1995: ix)

Fieldnotes

April 26, 2015

We were up in the forest when it happened—me and Gita and little Sumita. We crouched down and held onto each other. I took the little girl's hands. I was wearing my soft fleece jacket because of the cold. Gita kept saying “*Ram Ram Ram Ram.*” We saw people standing outside their homes and we heard them screaming. The whole village was screaming. We saw from above in our place in the forest. At the moment of the earthquake we were herding goats.

After, we hung around on the hill. Some boys lit a fire of dried pine needles and it ignited. I went over with the little girl to investigate the fire. We were cold and it was warm. Soon we were all gathered around the fire, listening to the news about the earthquake on the radio of a man dressed in white, the color of mourning.

Madame said that on the night before the earthquake the moon was upside down—“*chandra ulto bhayo.*”

April 28

Last night I stayed up watching the news on TV with Krishna Sir and Madame. It was the first time I'd seen the images. We were watching Kantipur. There were images of people lining up for water in Ratna Park, holding buckets and bottles. Water from the Army. There were images of people being brought out of helicopters in stretchers and loaded into a small truck. There were images of stone houses, flattened into a pile of rubble with the tin of the roof laying on top. Images of people sleeping in tent camps outside...Prem Sir and Madame dwelled on a long interview with village leaders from Sindhupalchowk district. They said they had no water to drink. That they needed water.

Tonight we sleep in our rooms. Krishna Sir lectured me on the evil of “*tension*” and “*chinta*,” worry or anxiety. He said “tension is a disease.” He said I can't worry about the earthquake, about death. He said, “if you haven't heard from your friend, your friend is probably dead.” I had to smile because it was so wildly horrific. Others seemed to agree that tension is an illness. Janak Sir said sheep die from tension. Krishna Sir said he's not afraid of death because it will just happen like fainting. I said, “what if it is a slow process?” Then he continued to say, it is one world, even though I was born in American now I have a family here, friends here. That Krishna Sir loves me “*Krishna Sir malaai maya garnuhuncha*.” He said “we are all human, your heart is the same.” He said “you have no reason to feel tension. You are our *mit chbori*, adopted daughter, you have food, a place to stay, you can stay 10 years and there wouldn't be a problem.”

When the earthquake happened, everything seemed silent.

April 29

The mood of the village is more or less the same. Khotang was spared. The village was spared.

Last night, again, Madame says the moon was upside down.

I keep feeling as if things are shaking but they're not. I heard that an eight-story house in Kapan³⁸ fell and people are trapped inside. I wonder was it the house across the way from where I used to live?

People are dead in Sindhupalchowk. I wonder—is Laxshmi's family ok? Has their house been destroyed? Janak Sir said he heard that 90% of the houses were destroyed in Sindhupalchowk—but I don't know if it's true. We've stopped listening to the radio here.

Today the power has been off for 24 hours now. My phone is dead. I can't talk to anyone...

April 30

All I can think about is Laxshmi's sister being buried by the stones of her house. Of the death of her little sister. Of Binod's voice on the phone—"Laxshmi's sister has died."

What was I thinking again? I've forgotten. I can't concentrate.

Jarna and Gaika just came into my room to visit me. I felt immediately relaxed. They stayed and chatted. Gaika brushed my hair and braided it. She put lipstick on me and *gajal* (eyeliner). She gave

³⁸ A neighborhood in Kathmandu.

me a *tikka* (placed between the eyebrows). Everything here is so calm and quiet...Outside the sun has come out and there is a gentle breeze...

The village is tranquil. The light is gentle all day. Planes fly overhead. This morning we watched the news together—me, Tikka, Maili, Saili, Jethi, Aji, Jarna, Bhuma—we watch images of Sindhupalchowk, of people being loaded into helicopters. Of people in Patan hospital and a UNICEF triage tent. An old man stands in the rubble of his home and is interviewed by a newscaster—“What can you tell us about your suffering?” the newscaster asks. “We've received a little bit of *chamal* (rice) from the government, that's all,” he says. What is there really to say? They've lost everything. A child is shown with bandages on her hands and feet. She is sucking on a partially inflated balloon. But soon Bhuma seems to grow tired of the news. She changes the channel to a Hindi soap opera and everyone watches with pleasure. I feel sickened by the juxtaposition of images. I have to leave the room. I can't watch the cross-cut shots of the faces of the hero and heroine as they argue passionately in the bedroom.

Current death toll

5,238

5,498

6,621

7,675

More than 10,000 no 15,000 injured.

Residents in Kathmandu growing frustrated over the slow relief efforts. Protests outside of bus park and Parliament. Residents in remote areas have yet to receive assistance. Supplies of water and food are low or nonexistent in many areas.

Camps have been established in the Kathmandu Valley.

Fears that with the monsoon season coming, cholera, malaria and other diseases may increase.

I heard that during the earthquake the ground moved 1 meter into the air and then fell.

May 1

On the radio, a story of a man wearing a wig running around Kathmandu screaming that the biggest earthquake would come tonight. The man was arrested but the rumors were effective. Even Krishna Sir asked me, “will it come tonight?”

I wonder now with all those who've died so horribly, will Nepal be filled with ghosts, populated by ghosts? It seems very likely the entire central region will become haunted.

May 2

Thought in the night: how strange it is the absence of engagement with the earthquake by people here in this village. It is their country, but they aren't concerned. The rest of the world is rushing to aid Nepal, but the people just outside the quake's range are disconnected, unaffected. What accounts for this absence of concern? Yesterday while walking with Krishna Sir I asked him—why is it that people from my country rush to help Nepal, when those same people ignore those suffering close

by? “Prestige” Krishna replied in English.

May 3

I try to understand what the ethical thing to do would be: stay in the village or go to Kathmandu.

Laxhmi's sister's death has been confirmed, Binod says on the phone. Her mother has burned the body. Laxhmi has returned to the village. I don't know how many have died in the Hyolmo villages but most of the houses have collapsed.

Everyone's reaction, everyone's actions and inactions, seem to be so deeply ethical in this moment.

May 5

Last night, sleepless sleep. Sweating and the sensation of insect bites. Dreams also, but of what? The other night, dreams of someone breaking my microphone and there was a scramble to put belongings into bags.

Yesterday and this morning, more small aftershocks.

May 7

100,000 cartons of noodles for the victims.

May 13

Yesterday I went to a puja at Binda's house. I was told that the puja was for the house and the *bastu* (the animals). A Bahun (Brahmin) priest was there to administer the ritual. The floor was covered in

plates made of leaves containing the usual offerings to the gods—*chamal* (rice), flowers, money, *sel roti*.³⁹ The men brought in a *boca*, an un-castrated male goat, which they slaughtered behind a screen in the back corner of the room, over a pile of *sel roti*. I couldn't see it but I could hear the sounds as they cut. They decapitated the goat and spread his blood on the pillars of the room. As they carried the body of the goat out they touched its bleeding neck to the ceiling of the room and carried the body outside to be shaved. The priest proceeded with the puja lighting a huge fire in the center of the room. A pile of rope made of grass also lay nearby, later to be tied around the exterior of the house to protect it. The ground was decorated with a mandala drawn with flour. The smoke was unbearable, burning my eyes, making them water. I stepped outside to watch the slaughtering of the *boca* by the men. I watched the way they cut the skin and peeled it back, exposing the organs. Inside they found that some organs had been infested with worms, which were still alive.

Soon the puja was completed and I was called inside to receive tikka from the priest. Moments after I received the tikka I went outside to sit on the cot under the veranda and the earthquake happened. People yelled “*Buichalo ayo! Buichalo ayo!*” “Earthquake! Earthquake!” and started running. Everything was suddenly crooked. Binda's sister had left her two-year-old daughter alone and I quickly grabbed her and started running out past the kitchen toward a bit of open land with the girl in my arms...

This earthquake was much more frightening than the one before because it was much stronger for us here. Although the overall magnitude of the quake was lower than the first, 7.3/7.4 instead of 7.8, we were much closer to the epicenter this time. Afterwards, some men continued to butcher the *boca* while others stood in the yard or climbed up the hill adjacent to the house. We stood around in shock. Some ran to see if their own homes had been damaged. Over the following 15 minutes more

³⁹ *Sel roti* is a slightly sweet, ring-shaped donut made of rice flour.

aftershocks came, some again strong.

I felt very uneasy. We all looked around the house and tried to assess the damage. There were some foreboding cracks that had formed. We sat around eating *sel roti* as one after another aftershock came...The women continued to cook rice, the men continued to butcher the *boca*. The protective string of grass was wound round the house, as it stood, vulnerable to collapse, in this moment of uncertainty.



Figure 7 Protecting the house. May 12, 2015.

Unlike the first time on April 25, now people move around with looks of concern on their faces. On the radio they say people are fainting from fear. The students here have been given a 15-day vacation from school. I'm trying to decide what to do. People here are convinced that the village is safer than Kathmandu, but if a big earthquake happens here again the mud and stone houses are sure to be destroyed.

May 15

No opportunity to write. People say that the earthquake will come between 12-2 pm every day. I hear Aji saying this. Krishna says we have to sleep outside on 4 *gate*⁴⁰ for some reason. That day has been deemed inauspicious perhaps. People go around talking about the earthquake, feeling they could die at any moment. "We will all be killed" a man says, wandering drunkenly out of Jethi's house. Binda says this all happened because Nepalis are "*papi*," sinful. "They take only for themselves while they let others suffer, they don't believe in god." She says 50% believe in god and are good dharmic people, while 50% are sinful. Aji corrects her, "No, 1 in 3 people is dharmic, the rest are '*papi*.'"

Everyone is walking around feeling dizzy. Yesterday morning I went to hang up my sleeping bag in the sun and came across a friend sitting alone at the top of the stairs, drinking and eating chicken. She was drinking an entire bottle of Tuborg beer alone. I asked if she had tension but she said no.

⁴⁰ This is a reference to the Nepali calendar, which is universally used in Nepal. The Nepali calendar follows a lunar cycle, and years are counted in reference to *Bikram Sambat*. The *Bikram Sambat* calendar is 56 years ahead of the Gregorian calendar. 4 *gate* here refers to the 4th day in the month of *Jeth* in the year 2072, which spans from mid-May to mid-June. 4 *gate* 2072 was May 18, 2015.

She said she was up there wondering if a big earthquake would come while she was drinking on the top floor.

May 16

No chance to write, very difficult to think.

Last night the Saujis (the wholesale suppliers for the store) came and stayed. They are young, around my age, and they came on a motorcycle from Diktel (the district headquarters). The younger one drank a lot of beer and started talking about how since the earthquake they sleep inside because their “fate is written.” If he is going to die he is going to die, he said. He could die at any moment, on the road on the motorcycle, in his sleep in his bed. He's not afraid because it is fated. I want to say that in my country we believe in the agency of action, not fate and the agency of inaction. But instead I stay quiet. Krishna Sir then launched into his usual lecture about how strong his house is. After which even the fated man says, “yes but if you see the houses that fell in Sindhupalchowk, they were mud and stone just like yours.” He doesn't respond. I sit alternating in thought, wondering is it safer here or in Kathmandu?

Yesterday dizzy all day, as if an earthquake is coming but it didn't come...Krishna keeps saying you can't let your *man* (heartmind) dwell in the earthquake because you'll feel dizzy all day. You could faint. When the earthquake happens you won't be able to escape. These days everyone's mind is on the earthquake, wherever people go they are thinking about where and how they could escape.

Aja (grandfather) says yesterday he felt nauseous all day, perhaps due to fear.

8,400 dead.

May 17

Last night we slept in the manger. Feeling afraid. But when we wake up everything seems ok. I think about how there hasn't been much damage to the village up to this point. But it is the worry and uncertainty that is deeply unsettling. That at any moment a huge earthquake could come and destroy everything, just as everything has been destroyed in Sindhupalchowk, Dolakha, Rasuwa, Gorkha...People here say, "if we die, it's our fate," but I think it would be wiser to build a temporary tent house. Or, I want to ask, is it also my fate?

Now life is lived outside. I sit on the cot and write and try to think with everyone around me instead of alone in my room where thoughts come easily.

Last night I say I am scared and Madame says, "but we haven't left you."

Yesterday Bhuma says, "you will leave us and go back to your country. You will leave us to die here."

On the radio they say 8,600 have died now.

The man drinking *jad* (rice liquor) inside our house says he can sleep at night and that "if you're going to die, you will die."

How vulnerable everyone is here.

May 19

We've been sleeping outside in the manger for three nights in a row. Yesterday we didn't go in the house barely at all because the astrologers predicted a huge earthquake. But it never happened and the radio has been broadcasting a message not to listen to the “soothsayers” or astrologers. We listen to Radio Nepal all day, because it is powered by solar it never goes out.

On the radio they broadcast programs with psychosocial counselors where they talk about depression, anxiety, and trauma. What symptoms might include. They say some people could commit suicide. They invite people to call in and share their symptoms. They talk about “*manasik rog*,” mental illness. Someone calls in, “Karki ji,” and says he has dizziness, “*ringata chalne*,” and leg pain. He constantly feels like an earthquake is coming. His heart races and he worries he has heart problems. They counselors say “*attine pardaina*,” no need for worry, and “don't drink and stay with your family. Meet with a doctor or a psychologist.” They go on to explain “*attini rog*” as “anxiety disorder” with symptoms of heart racing, when “*dar*,” fear, is on the mind, “*ekdam mutu duk duk, sas aftyaro*,” heart pounding a lot, difficulty breathing. It is not a physical illness, they say. “It's nothing. Just stay in a safe place.”

* * *

Shortly after this last entry was written, I left the village. It wasn't an easy decision. Bhuma's voice has stayed with me, “*You will leave us and go back to your country. You will leave us to die here.*” And even though I had stayed through both disasters, ultimately I did leave. Her comment gets to the heart of an uncomfortable ethical gray area in anthropology, that in the end some of us can leave. It

speaks to the fact that ultimately we (anthropologists) leave and the ability to do so is not only part of doing anthropology, but is understood to be a prerequisite for being able to write ethnography, which must happen at a distance. Of course it doesn't mean we won't return again, but that doesn't erase the fact that we have the ability to move in and out of lives as few others can. After the first earthquake happened I didn't know what the right thing to do might be. I went back and forth, weighing the ethical implications of different choices and possible scenarios over the phone with my partner, my parents, my friends, and my advisor. I ultimately decided to stay in the village during that time because it seemed irresponsible to go to Kathmandu immediately, where I would be yet another body to support there. At that time the village had not seen structural damage, and life there continued on almost as it had before while people in Kathmandu were sleeping outside and waiting in line for water. But even so I could have left immediately and even returned to the United States. My university offered to airlift me out of the field. My funding agency had generously offered to reimburse any costs of the travel. At the same time, how could I have left then? Leaving seemed to exert a reality of inequality that I found unbearable. I was the one who had chosen to go there, after all. To learn the Nepali language, to create the project, to find this village, to appear in people's lives. Now I felt I had to bear the ramifications of those decisions. I felt it was a moral responsibility. But what are our moral responsibilities as anthropologists towards the communities we study in a time of disaster?

As I stayed on in the village through both the first and the second earthquake people extended kindness and care towards me, even though I was an outsider. Again and again I was reminded that I was not alone there, that I had not been left alone. The importance of being with others was something I had recognized for a long time in Nepal as central to happiness and wellbeing, and yet during this period of uncertainty it took on a new force. When I felt frightened and shared this feeling with Madame, she said, *"but we haven't left you."* Or another moment, before

the second earthquake when we had returned to inhabiting the house, I remember recoiling to my room where I would sit alone writing, full of fear and anxiety, and then the palpable relief when, unbidden, Jarna and Gaika visited me in my room, brushed my hair, for no other reason than to be with, to be alongside another. The unselfconscious gestures of care and friendly affection, extended through physical contact were always central to this form of being-with, which never ceased to move me as they had become so rare in the cultural world I came from, a place where touch is approached with sideways glances, often with fear and mistrust. This form of unselfconscious caring touch (between people of the same gender) is so common in Nepal it seems almost second nature. And in every place I lived while there, I always had many such visitors. I used to think of them as visitations, in which there was an almost sudden reversal of the practice of ethnography. People would seek me out when I was hiding alone in my room. They would express concern about my wellbeing, and would often empathize with me, imagining out loud about how I must feel, being there alone. Leaving, staying, being alone, being together, the disaster brought out the moral stakes embedded in each of these.

Sounds on the Radio

In my memory when I think of my experience of the disaster in the village, I often think of a song that played again and again on the radio. It was a melancholy recording from an older time, called *Kun Mandirma Hami Janchau Yatri*, To Which Temple Shall We Make Our Pilgrimage. The song is transposed from a poem written by the famous Nepali poet Laxhmi Prasad Devkota and sung by the popular singer Rabin Sharma. It is a widely-known poem studied in schools across Nepal, and I too was asked to read it when I was studying Nepali myself. In the poem, a religious pilgrim is traveling to a sacred temple. “What temple are you going to, pilgrim? What ritual objects will you bring and how will you carry them?” *Kun mandirma janchau yatri? Kun mandirma jane ho? Kun samagri*

puja garne, sath kasari lane ho?” the poet asks. As the poem continues we reach not a physical building, but instead a corporeal one in which one's own body has become the holy place; bones become pillars, flesh becomes walls, the brain a golden roof, “of the senses all the doors.” The poet ends his poem by assuring that “in songs of grief, Indra, god, sings humankind's afflictions.” For a long time the sad sweet melody of this poem-song, with its bamboo flute and sitar refrain that sounded like a faded photograph from the 1970s remained with me. Its allusions to sacred temples and ritual objects took on a different meaning in a time when so many of the ancient holy temples in Basantapur, Bhaktapur, Patan Durbar Square had been destroyed, and so many had lost their homes, possessions, and sacred objects. The idea that humans carry temples within themselves became suddenly more powerful when so much had been lost. Perhaps Radio Nepal broadcast this song to provide comfort to those who might be listening. It is no coincidence that in Nepal, song and poetic speech has always held an important place in the sharing of emotion (Desjarlais 1992).

Other kinds of sounds also began to appear on the radio after the disaster. I have a recording that I made on my phone on the second night after the second earthquake (May 13). We, my adopted family and I, lay side by side under blankets as we prepared for sleep outside under the veranda. Krishna Sir was listening to a small handheld radio, his cigarette glowing in the darkness. Through the sounds of the night a crackling voice spoke about the meaning of feelings like *dar* (fear) and *tras* (fear, terror), how to identify symptoms of “depression” (said in English), negative and positive thinking (*nakaratak ra sakaratak sochai*), and the benefits of “counseling” and “sharing” (said in English). Listeners would call in with to ask questions about the feelings they were experiencing after the earthquake. The knowing voice explained symptoms of depression as including continuous negative thinking (*nakaratak sochaiharu airakne*), insomnia (*nindra nalaagne*), feelings of extreme weakness (*ekdman komjori mausisharu*), loss of appetite (*kbana na ruchna*), difficulty concentrating on work (*kambaru dhyan na dine*), lack of desire to talk with others (*goff garna na laagne*),

and being quick to anger over small things (*ris aune*). He explained that they have medicine for depression (*ek kissimko aushadi*), but that they like to begin by providing “counseling” (said in English). The man's voice continued to talk about “counseling,” explaining that people have many kinds of “tension,” but when people “share” their “tension,” when people no longer make their “tension” hide (*tension lukaera na rakhne*), they can improve on their own; their *man*, (heart-mind) will become light (*man haluka bhaejanchan*). He suggested that people share their tension and talk about their feelings with those close to them. “This is the meaning of counseling, listening to people's problems,” (*Counselingma bhaneke kura ni ye ho. Waabaako kura sunidine*). The man's voice then added that meditation, yoga, and deep breathing can also be helpful in reducing negative feelings. Another caller called into the show, his voice was barely audible but he says something about feeling that the earth won't stop shaking, “*din badi haleko haleko jastai huncha...*” then Krishna switches off the radio.

As the world of psychosocial care was carried over by the sound waves that reached the village, I began to hear this sudden shift in discourse as an indication that something was shifting in the field of mental health in Nepal. It was becoming clear that the disaster had brought a new and forceful focus on psychosocial care and mental health that had not been present when I began my research eight months earlier. On the phone a friend and NGO mental health expert in Kathmandu told me about how his colleagues had been sent out to the earthquake affected districts to conduct “Psychological First Aid” (PFA).

CHAPTER 5

Humanitarianism as Development

April 25, 2015. 7.8 magnitude mega-earthquake, epicenter Gorkha district, strikes Nepal. Over 9,000 people lose their lives and half a million are left homeless across fourteen districts. Kathmandu is largely spared, and the majority of the damage occurs in rural areas. The earthquake causes a massive landslide in Langtang Valley, which buries and kills 310 people. Immediately following the earthquake, the Nepal Army is dispatched throughout 14 affected districts and humanitarian organizations begin to arrive in Nepal. The Prime Minister, Sushil Koirala, establishes the “Prime Minister’s Relief Fund” and urges people to donate directly in a bid for increased transparency. International news media speculate that major outbreaks of cholera will occur in the fast-approaching monsoon season.

May 12, 2015. 7.3 magnitude aftershock, epicenter Dolakha district, strikes Nepal. In a country still reeling from the initial disaster, it is terrifying. Many homes that had remained standing after the April 25th earthquake are now lost. As the monsoon approaches, there is widespread discussion of vulnerability of destabilized, rain-soaked land to landslides.

June 25, 2015. \$4.4 billion is pledged to Nepal by foreign donors in a 50/50 combination of grants and loans during the televised “International Conference on Nepal’s Reconstruction.” India, the largest donor, pledges \$1 billion, and China, the second largest donor, pledges \$760 million in aid (Shrestha 2015).

A New “Mental Health Crisis”

In May 2015, the international news media began reporting on Nepal’s “mental health crisis” (Bennet 2015; Nyenhuis 2016; Stockton 2015). According to these publications, the impact of the disaster would cause widespread trauma, with increased risks of PTSD and depression. From this perspective, it was given that long-term mental health problems could be prevented through immediate intervention. The radio program that I heard broadcast in the village in Khotang was part of the new humanitarian assemblage—the show was called *bandai sundai*, “telling listening,” and had been funded by UNICEF and contracted to a Nepali NGO (Gardner 2015; Newar 2015).

The sense that mental health was now in crisis was palpable in Kathmandu, where there was an unprecedented amount of activity and attention gathering around this new “matter of concern,” enabling the crisis of mental health to emerge as a “matter of fact” (Latour 2004: 235). Prior to the earthquake and before my work in Khotang, I had been conducting research within different Nepali NGOs for mental health and psychosocial care in Kathmandu and following their projects in their “working districts,” as well as observing the work of Nepali psychiatrists in a prominent Kathmandu public hospital out-patient clinic. Now almost all of these experts had become directly involved in the humanitarian response in various ways. In the aftermath of the earthquake the mental health NGO offices were frenetic with activity as project managers from donor organizations arrived in jeeps to negotiate contracts.

Among the many early responders to the mental health crisis was International Medical Corps (IMC), a California-based humanitarian non-governmental organization, funded by a mix of foundations, corporations, and US government grants, which had been chosen by Facebook as “its

featured partner in a worldwide campaign” to help Nepal (IMC 2015).⁴¹ Two days after Mark Zuckerberg, founder of Facebook, posted and indorsed the IMC relief campaign on his wall, Facebook received over \$10 million in donations from more than 500,000 individual contributors. Ultimately, Facebook raised over \$15 million for IMC’s response (IMC report).

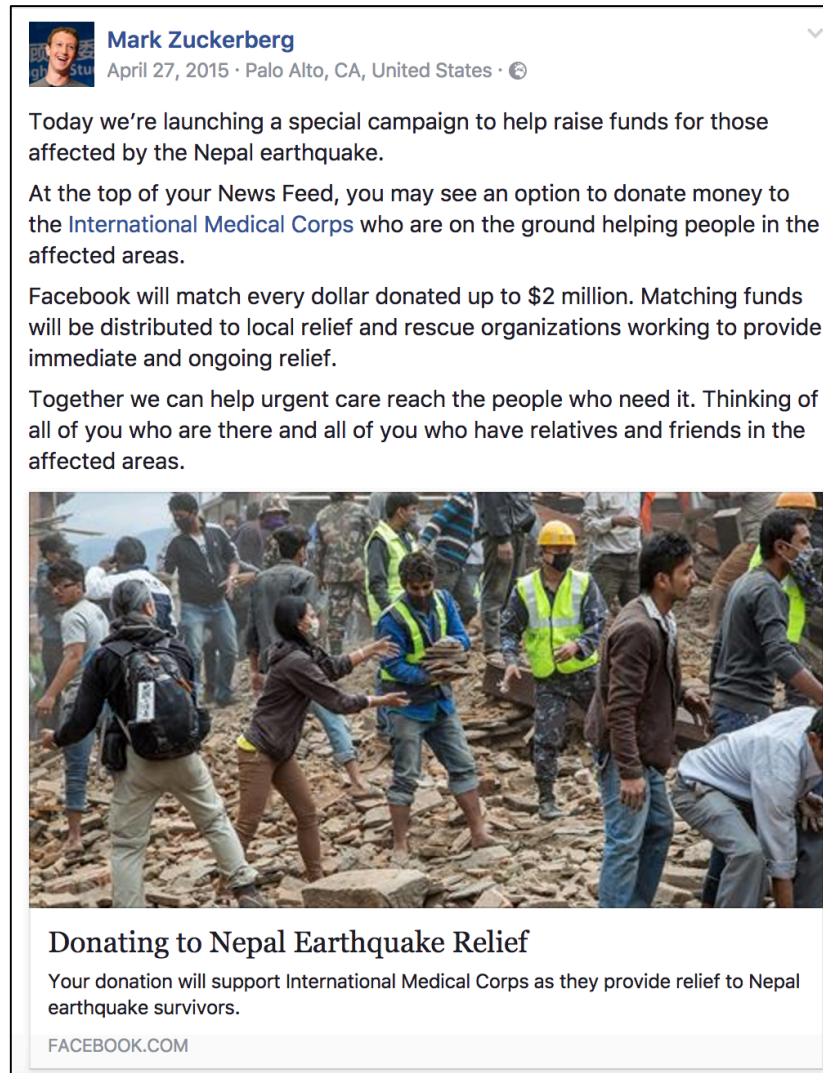


Figure 8 Launch of the Facebook campaign.

⁴¹ In 2015, IMC received additional funding from numerous groups and individuals including the Bill & Melinda Gates Foundation, ExxonMobil, the Merck Foundation, and USAID, as well as charity events such as “music for relief” organized by the band Linkin Park.

In Nepal, although a mental health policy had been drafted and endorsed by the government in 1997, it had never been implemented (Luitel et al. 2015). Two decades later, mental health had not yet been fully incorporated into the health care system in Nepal, and at the time of the earthquake there was no mental health representative in the Ministry of Health and Population (Luitel et al. 2015: 5). Although three major Global Mental Health projects (PRIME, EMERALD, and mhBEF) had been working toward the goal of incorporating mental health into the primary health care system in partnership with the Government of Nepal, psychiatric services remained concentrated in the capital of Kathmandu and in select district hospitals. Outside of these institutional resources, temporally finite donor-funded community mental health programs focusing on specific victim groups had provided uneven access to care in some working districts (Luitel et al. 2015). From this perspective, mental health services in Nepal had been in crisis for a long time, but had not been critiqued as such in public discourse. In order to analyze the emergence of crisis I follow Roitman who argues “there is no reason to claim that there are no ‘real’ crises...the point is to observe crises as a blind spot, and hence to apprehend the ways in which it regulates narrative constructions, the ways in which it allows certain questions to be asked while others are foreclosed” (Roitman 2014: 94).

In this chapter I describe the ways in which the event of the disaster and the international humanitarian mental health response that followed enabled mental health to become visible as a major problem in Nepal; as being in crisis. A central question for the humanitarian mental health response asks how is it ethical to provide mental health care in times of emergency in a place where normally no such care exists, and where after the end of the emergency period people will again be left without access to care. By following the influx of resources and activities for mental health after the earthquake, I describe the blurring of boundaries between humanitarianism and development as humanitarian actors became engaged in the long-term development of Nepal’s mental health system

under the WHO rubric of “Building Back Better” in the midst of disaster (WHO 2013). In this way, it becomes possible to observe the strategic uses of the “claim to crisis” (Roitman 2014) as enabling further foreign and national investment in the mental health system and generating attention to the unequal access to mental health care which had always already been there but had not garnered attention as an ethical demand.

Coordinating Care

On May 29, 2015 the Mental Health Sub-Cluster was formed and held its first coordination meeting in small a tent outside the Ministry of Health and Population, after the National Health Cluster meeting had adjourned. I attended this first meeting with a Nepali colleague who was a staff member of a Nepali NGO for mental health and counseling. At the National Health Cluster meeting the presence of many international humanitarian organizations was highly visible—everywhere people were wearing vests emblazoned with logos and acronyms—the UN, WHO, UNICEF, MSF, IOM, MDM, and others—which served both as a marker of their expert status, as well as a potent symbol of prestigious employment, and proximity to wealth and power.

The mental health sub-cluster was relatively small, an apt reflection of its minor status vis-à-vis “physical” health in United Nations cluster system hierarchy. In the first meeting, the country directors of IsraAID, International Organization of Migration (IOM), Médicos del Mundo (MDM-Spain), Médecins Sans Frontières (MSF-France) and Handicap International (HI) were there, alongside representatives from Nepali mental health NGOs. There was discussion of many issues that would continue to be unresolved even months later. Why was there a Psychosocial Support working group that met separately from the Mental Health Sub-Cluster, and how could the duplication of data be avoided? And what could be done about the problem of hospitals refusing to accept patients without guardians? There was discussion that a referral system would need to be

established, and screening tools would need to be circulated. After the meeting, I spoke with a humanitarian who mentioned it was her first time in Nepal. Like many other donor organizations at this time, her organization was planning a six-month intervention, with the possibility for extension. Prior to this, her organization had deployed a similar intervention for trauma survivors of domestic violence Gaza and the West Bank. She had also worked in Sri Lanka after the tsunami.

The UN Cluster System is a bureaucratic mechanism organized by the UN Office for the Coordination of Humanitarian Affairs (OCHA) in order to manage the coordination of humanitarian activities across organizations, collect data on activities implemented, and avoid “duplication” of services. As Elizabeth Cullen Dunn writes, reflecting on the humanitarian response to internally displaced people (IDPs) in the Republic of Georgia, “the cluster system rendered suffering technical by breaking human needs into nine categories managed at the level of population: shelter, food security, water and sanitation, health, logistics, early recovery, protection, security, and telecommunications” (Dunn 2012: 6).

The role of the cluster meetings was to attempt to coordinate the vast number of humanitarian interventions in order to avoid “duplication” (multiple organizations providing the same services to the same community), but such coordination, not surprisingly, turned out to be a difficult task (c.f. Minn 2010). Two parallel groups were created related to mental health: the Mental Health Sub-Cluster, part of the Health Cluster, held in the Ministry of Health and Population office, and the Psychosocial Working Group, part of the Protection Cluster, held across town in the Ministry for Women and Children. I attended both groups, as did many others. Activities were reported weekly to both groups separately, documenting the who, what, when, and where of the humanitarian activities. This information was gathered for the purpose of accounting, and was periodically shared in reports to the group. Generally, meetings would consist of going around the table, with each representative sharing the number of “beneficiaries” reached and describing the

activities done by his or her organization. I attended these groups from their formation in May 2015 to their dissolution in November 2015 when an “unofficial” blockade at the Indian border made petrol so scarce that members could no longer justify the cost of black-market fuel needed to attend the meetings.

Over this seven-month period I watched as many new faces came and went. Participants in these meetings included representatives from humanitarian INGOs, such as Médicos del Mundo (MDM-Spain), International Medical Corps (IMC), Handicap International (HI), IsraAID, Americares, as well as UNCIEF and UN Women. In addition to these INGOs and multilateral organizations were representatives from the “implementing agencies”—Nepali mental health NGOs such as the Transcultural Psychosocial Organization (TPO), the Center for Mental Health and Counselling (CMC) and the Center for Victims of Torture (CVICT, which had been sub-contracted by a number of international NGOs and UN groups to hire and train psychosocial counselors and do the work of mental health and psychosocial support on the ground in the earthquake affected districts.

In order to support the quality of humanitarian mental health and psychosocial support in the context emergencies, in 2007 the Inter-Agency Standing Committee (IASC) published the *Guidelines on Mental Health and Psychosocial Support in Emergency Settings* (IASC 2007). The aim of the guidelines was to address “potential threats to populations who were receiving untried, untested, and unmonitored mental health and psychosocial support (MHPSS) in the aftermath of wars and disasters” (Abramowitz and Kleinman 2008: 219). As Abramowitz and Kleinman point out, the guidelines were a direct response to the fact that in many places, humanitarian mental health projects had been conducted without coordination and had been employing staff with little training. In an extreme case, they cite the WHO as having documented over 100 uncoordinated humanitarian mental health programs operating in Bosnia (Abramowitz and Kleinman 2008: 220).

In Nepal, perhaps due to years of competition between Nepali NGOs for the donor-funded projects that kept their organizations afloat, after the disaster communication and collaboration between these organizations was limited, and each organization implemented its own unique training of psychosocial counselors, even when they shared a donor organization. Outside of these established organizations, there was a constant flow of small, independent organizations and individuals, both foreign and Nepali, who had decided to provide trauma support in whatever ways they deemed appropriate. For example, one day a European couple appeared in the meeting of the Mental Health Sub-Cluster. When it was their turn to introduce themselves to the group, the man stood up and introduced himself. In a shaking voice, he explained that he and his friend had come as volunteers to teach a “new paradigm without techniques,” that had saved his life. He then gave a sort of confessional speech, in which he described his struggle with depression, drug addiction, and violence, and his experience in jail. In the end, he announced that they would be in Nepal for two weeks, and that they would be holding a training in their “new paradigm” at nearby hotel for anyone who was interested in attending.

There were also local Nepali youth organizations run by cosmopolitan activists. For example, one such Nepali youth group circulated their activities to the Mental Health Sub-Cluster’s shared email listserve, announcing that they had “conducted 7 trauma relief camps for 1500+ children in grades one to five in some of the highest and most remote hill and mountain villages of the region.” By December 2015, the cumulative reporting from the psychosocial working group announced that a total of 334,191 “beneficiaries” had been provided psychosocial support services by over 66 organizations (Humanitarian Response, 5W December 2015). According to these lists, working activities included “capacity building to stakeholders”, “community awareness raising programs”, “community theatre”, “psychoeducation,” “Psychosocial [sic] First Aid (PFA),” phone hotlines, and of course, family, group and individual psychosocial counseling.

Many international humanitarian organizations and their staff had not worked in Nepal prior to this event, and thus imported their interventions from experiences responding to other natural disasters in places like Sri Lanka, Haiti, and the Congo. In this way, like the field of international development, it was clear that for many of the humanitarian organizations the design of psychosocial interventions was understood to be something that could travel across vastly different local contexts (c.f. Ferguson 1994). Like the circulation of development workers and “flagship” projects of INGOs in different “working countries,” humanitarian staff circulated through different zones of disaster, touching down in new locations where they had little knowledge of the local context, history, or language. In order to aid in providing “cultural context,” Global Mental Health practitioners developed and circulated an extensive, highly researched “Desk Review of Existing Information with Relevance to Mental Health and Psychosocial Support” (Greene et al. 2017; IASC 2015), but the extent to which this was used was not clear.

The cluster meetings were split between the Nepali staff on the one hand, and the expatriate humanitarians from a variety of countries on the other. In order to facilitate the work of the foreign humanitarians, cluster meetings were held in English. This seemed to have a silencing effect on some of the local Nepali NGO staff, who appeared less confident speaking formally in English than in Nepali, and who did not ask for help in translation. In the case of the Psychosocial Working Group, the ministry official who attended the meetings would arrive at the start of the meeting, give an update of government activities in Nepali which was then translated into English, and then leave the room. There was no ministry official in attendance in the Mental Health sub-cluster, despite the fact that the meeting was held in the Ministry of Health and Population building, reflecting the fact that at that time there was no official mental health representative in the Ministry of Health.

Crisis, Humanitarianism, and Disaster Development

Humanitarianism is “an ethos, a cluster of sentiments, a set of laws, a moral imperative to intervene, and a form of government” (Ticktin 2014: 274) that responds to human suffering in the “temporality of emergency” (Fassin and Pandolfi 2010). The circulation of images of suffering in the media are central to the recognition of a situation as an emergency, for “the instant global circulation of images makes distant suffering seem immediate; it appears in real time as a simultaneous part of our reality” (Calhoun 2010: 34). Such images of what Luc Boltanski termed “distant suffering” present a moral call to act (Boltanski [1993] 1999; c.f. Kleinman and Kleinman 1996). Emergency is therefore not an a priori dimension of an event but is instead, Craig Calhoun argues, “a way of grasping problematic events, a way of imagining them that emphasizes their apparent unpredictability, abnormality, and brevity and that carries the corollary that response–intervention–is necessary” (Calhoun 2010: 55). As Fassin and Pandolfi have argued, “compassion for far-away suffering and its translation into the moral obligation to act has become one of the strongest political emotions in contemporary life” (Fassin and Pandolfi 2010: 16). Emergency and “spectacular events” of catastrophe, once made visible as such, inspire compassion and demand immediate intervention as moral response in ways that ongoing, chronic forms of suffering do not (Berlant 2011; Povinelli 2011). As Redfield writes, “once a state of crisis has been established, then action (especially technical, expert action) acquires self-authorizing status by virtue of circumstance” (Redfield 2005: 337).

The word “intervention” stems from the Latin *intervenire*, meaning “to say, to speak or to take part in a conversation,” or, in the context of surgery, “to operate.” The contemporary English meaning of “intervention” is 1) “to take part in something so as to prevent or alter a result or course of events,” 2) “to interrupt,” and 3) “to occur in the time between things.” As a “strategy for the governing of life,” humanitarian interventions could be considered a form of biopolitics (Foucault

2002), as they entail “specific strategies and contestations over problematizations of collective human vitality, morbidity and mortality; over the forms of knowledge, regimes of authority and practices of interventions that are desirable, legitimate and efficacious” (Rabinow and Rose 2006: 197). Yet as Redfield has argued regarding biopolitics in the context of the medical humanitarianism of Doctors Without Borders, “the actual practice of organizations in crisis settings presents a fragmentary and uncertain form of such power, extended beyond stable sovereignty and deployed within a restricted temporal horizon” (Redfield 2005: 361).

A number of anthropologists have focused on the intertwining of humanitarianism, professed to be neutral and apolitical, and contemporary politics—that is, the ways in which moral sentiments of compassion in the name of humanitarianism have been used as justification for political action and military intervention in many parts of the world (Fassin and Pandolfi 2010; James 2010; Pandolfi 2010; Ticktin 2011). Not far from Nepal, in the aftermath of the 2001 Gujarat earthquake Edward Simpson has described the political dimensions of work done in the name of humanitarian relief and post-disaster reconstruction, particularly those affiliated with Hindu nationalist organizations such as the Vishwa Hindu Parishad (VHP) cultural society and the Bharatiya Janata Party (BJP) party (Simpson 2014).⁴² As he describes, such private politically affiliated organizations were some of the first responders after the earthquake.

They distributed aid, opened relief camps, and oversaw rescue and cremation operations. Their well-organized systems of communication and hierarchy, as well as the dedication and discipline of their volunteers, meant that many people in Bhuj associate the arrival of the organizations of Hindu nationalism with the initial relief after a major trauma (Simpson: 2014: 25).

In the context of disaster, anthropologists have studied how societies have been unevenly transformed in the aftermath through increased militarization, privatization, neoliberalization, and

⁴² The BJP is one of the major political parties in India. BJP is a Hindu nationalist party, and is the party of Narendra Modi. Modi was elected as the Chief Minister of Gujarat in 2002 following the 2001 earthquake, and was later elected Prime Minister of India in 2014.

development projects (Adams 2012; Klein 2007; Lovell 2012; Pandolfi 2003; Ticktin 2014). An important issue revealed by this work regards the ways in which in the aftermath of disaster certain transformations are prioritized and supported while others are not, and to what ends. For example, as Anne Lovell has demonstrated in New Orleans after Hurricane Katrina, the debate between patients and health activists on the one hand, and planners and politicians on the other about whether to reopen the free public Charity Hospital, which served a predominantly poor, African American population, or support a financially lucrative state-of-the-art biosciences district highlighted the ways in which future development of the city was divided along lines of race and class (Lovell 2011). As Lovell writes of the Charity Hospital supporters,

In advocating reopening Charity Hospital, they resonate with parallel controversies contributing to an inequitable recovery: charter schools versus public schools, ‘green-dotting’ of selected neighborhoods, uneven infrastructural development, razing of public housing, and glutting of an upscale housing market—even what some community leaders call the disappearance of black children from the future city (Lovell 2011: 266).

In the context of Gujarat, Simpson writes that “the earthquake was a boon for those who wrote proposals for international funding because reforms to mechanisms for the provision of infrastructure, urban governance, land regulation, municipal taxation systems and urban planning regimes were at the top of development banks’ list of interests” (Simpson 2014: 31). This was also true in the case of Nepal.

“Building Back Better”

In the influential 2013 publication titled “Building Back Better: Sustainable Mental Health Care after Emergencies,” the World Health Organization urges readers to take situations of emergency, crisis, and disaster as an “important opportunity for mental health reform and development” (WHO 2013: 3). They argue that increased international attention during situations of

crisis enables aid to flow, and that this “paradox” should be seen as an opportunity. They go on to describe cases of building mental health systems in times of emergency, drawing on examples from the West Bank and Gaza Strip, Sri Lanka, Iraq, and Indonesia (Aceh) among others. The take home message from this report is clear: when mental health becomes a political issue in times of emergency, it should be seen as an opportunity to create sustainable forms of systemic change vis-a-vis humanitarian intervention. As the authors of the report put it, “in some countries, senior government leaders express—for the first time—serious concern about their nation's mental health. This is frequently followed by national and international agencies' willingness and financial ability to support mental health and psychosocial assistance to affected people” (WHO 2013: 17). As Mark van Ommeren, an influential global mental health scholar-practitioner and coordinator of the WHO “Building Back Better” report said in a 2016 interview for Reuters, “the interest in mental health in and after an emergency is enormous. It’s not surprising to see that the countries who have made the greatest progress in mental health system development are those that have been through emergencies” (Whiting 2016).

In the months following the 2015 earthquake I began to hear a lot of talk about “building back better,” and I wondered what it could mean for the future of Nepal's mental health system (Seale-Feldman and Upadhaya 2015). In the context of the humanitarian mental health response, there was much discussion of this in the weekly Mental Health Sub-Cluster meetings. As the group began to form over the following months, it became a place where Nepali and expatriate mental health specialists—psychiatrists, NGO staff, development workers, humanitarians, activists, and even anthropologists—would not only report their activities but could also talk about the future of Nepal’s mental health system. The existence of such meetings had never before happened during the years I had spent in Nepal, neither while conducting preliminary research among Nepali mental health

NGOs in 2012 and 2013, nor when I had begun my dissertation research in 2014.⁴³ So much money was flowing into post-disaster mental health and psychosocial support programs for earthquake victims after the earthquake that it seemed almost anything was possible. I too felt infected by a kind of contagious hope and the feeling that suddenly a big change was imminent. As one Nepali psychiatrist exclaimed to me in the Mental Health Sub-Cluster meeting, “the earthquake has been a boon for mental health in Nepal!”

In Nepal, while the majority of the humanitarian mental health programs operated only temporarily, some international donor agencies saw the disaster as an opportunity to initiate long-term programs to support the development of the mental health system, blurring the boundaries between humanitarianism and development work. International Medical Corps (IMC) with funding from Facebook, became a key actor in this long-term work, conducting prescriber trainings and working with the Primary Health Care Revitalization Division in the Department of Health Services to review the health treatment protocol to include three additional disorders (PTSD, suicide, and epilepsy), and update the free drug list. In addition to doing this work in Nepal, IMC had also worked on programs to integrate mental health and psychosocial support services into primary healthcare in Iraq, Jordan, Lebanon, Syria, and Turkey (IMC 2015).⁴⁴

At one of the meetings, an expatriate project manager rose to share her thoughts. She spoke in a voice full of frustration, complaining about the general lack of coordination and unwillingness of groups to work together. She concluded by saying, “We must avoid colonial dependencies and try to create sustainable infrastructures for mental health!” The expatriate humanitarian’s opposition of

⁴³ Although such regular meetings between Nepali mental health NGOs had been held in the past, such as the Kathmandu Psychosocial Forum (KFP). According to NGO staff, competition between organizations over status and donor funding made their sustainability impossible.

⁴⁴ Another activity aimed at developing the mental health system was the WHO-sponsored implementation of the Mental Health Gap Action Program (mhGAP) for government psychiatrists.

“colonial dependencies” with the creation of “sustainable infrastructures” suggested an anxiety and awareness, at some level, of the continuity and potential similarities between the two forms of intervention, colonialism on the one hand, and humanitarianism on the other.

The historical lineage from colonial medicine to contemporary forms of humanitarianism and development is one that has been articulated by both historians and anthropologists (Calhoun 2010; Mills 2013; Packard 2016; Redfield 2012; Ticktin 2011; 2014). As Calhoun writes, “humanitarianism was often part of the ‘civilization’ that colonial powers sought to bring to the people’s they conquered” (Calhoun 2010: 39). These colonial histories continue to “shape the geography of humanitarian intervention in the present” (Ticktin 2014: 282), particularly as humanitarian missions frequently occur in ex-colonies (Redfield 2012: 374). In his work on the French humanitarian organization Médecins Sans Frontières, Peter Redfield has discussed similar anxieties of ex-pat humanitarian workers regarding the resonance between their role as expert foreigners and the history of colonialism, where “any hint of paternalism or cultural arrogance threatened to open old wounds” (Redfield 2012: 374). Here Redfield describes the issue of inequality between expatriate humanitarian workers and national staff, a problem that Didier Fassin has also addressed in his work on the asymmetrical “exposure of lives” through the example of expatriate humanitarians who have the possibility of being evacuated in cases of danger, while national staff do not (Fassin 2010: 45).

Eventually a troubling issue began to surface in the cluster meetings, the problem of the abandoned mentally ill who in Nepal were at that time unable to receive medical services without a guardian willing to take responsibility for them. The only existing help for this group of people was a small Nepali NGO, run by the man who brought the issue to the group’s attention. Vivek was an outspoken mental health activist. I saw him regularly at both the Mental Health Sub-Cluster and the Psychosocial Working Group, and he would continually bring up the problem of the homeless

mentally ill. When he did so, he would often be met with silence. What could be done? Everyone enthusiastically agreed it was a problem. Then in the Mental Health Sub-Cluster meeting one of the humanitarians mentioned that there might be a possibility of securing money to work on the problem. The Mental Health Sub-Cluster unanimously decided to form a working group to tackle the issue, and I too offered to help in drafting any reports or documents they might need. There was a palpable sense of excitement, that maybe something could really be done. One middle aged Nepali woman in attendance said strongly, “you must strike while the iron is hot!” The Nepali facilitator of the group also approved of the idea, and as he was on the staff of the World Health Organization it seemed that maybe the right people with enough power could also be brought into the conversation. But, in the end, the humanitarian worker announced that funding could only be allocated for earthquake-related mental health issues.

Even after this failure, Vivek continued to advocate and raise uncomfortable questions. “What will happen to the abandoned children with mental disabilities? What will happen to the abandoned adults with severe mental illness?” he asked to the room full of humanitarians. Nobody spoke because there were no answers, there were no existing programs or planned interventions. The facilitator of the meeting looked at him solemnly and said, “we don't have the capacity...” In this case “building back better” did not apply to this type of problem, but was instead defined by the development visions and financial stipulations of humanitarian organizations in conversation with Ministry officials.

Collaboration

In July 2015 I was invited to join as an “ethnographic consultant” in a humanitarian psychosocial project that had been subcontracted to one of the Nepali NGOs. I began to follow the work of the Center for Mental Health and Counselling (CMC). In many ways, the ethnographic

narrative I composed is particular to the histories of individuals involved in this NGO; I did not systematically observe the work of the other two leading NGOs in Kathmandu during this period. From what time I did spend elsewhere, CMC's focus and interest in psychotherapy and counseling methods over pharmaceutical intervention was notable. As was their institutional history of funding from development organizations as opposed to Global Mental Health research projects.⁴⁵ In 2002, CMC was created out of the United Missions Nepal Mental Health Program. United Missions is a UK-based Christian missionary INGO that began working in Nepal in 1954. From 1954 to the 1970s, UMN focused their work on health and education infrastructure. From the 1970s-1980s, they transitioned to a focus on rural development and community health projects, including the Mental Health Program. In 2002, UMN began to fully transfer their projects to their local partner organizations. An important dimension of this transfer involved the transfer of key donor relationships. The UMN Mental Health program had played an important role in the support of expanding psychiatry in Nepal. From 1984-2004, they provided support to the department of psychiatry in the TUTH Institute of Medicine. Over thirty years later, some of the original staff, both foreign and Nepali, who had been affiliated with the UMN Mental Health Program were still present in CMC. In this way, while projects came and went, core staff members remained, and long-term relationships with donors and foreign staff were cultivated. This was another definition of sustainability in which donors worked to strengthen NGOs, who would then work in parallel with the government (c.f. Ferguson and Gupta 2002). Since 2002 CMC began to operate as an independent local NGO, and during the time of my research it was fully operated by Nepali staff. From July 2015–June 2016 I followed the work of CMC in the office in Kathmandu and on the ground in the earthquake affected districts. During this time, I participated in trainings for

⁴⁵ This history would later prove to be problematic, as CMC felt that their lack of access to the Global Mental Health coffers and lack of experience in conducting research locked them out of funding possibilities and kept them in a position of inferiority vis-à-vis TPO.

supervisors and counselors on multiple projects, attended staff meetings, observed therapy sessions in Kathmandu, and accompanied three newly trained psychosocial counselors on multiple trips to three earthquake affected districts. In addition to participant observation, I conducted interviews with actors at all levels in the organization, including the project manager, the foreign training psychologist and supervisor, Nepali supervisors, psychosocial counselors and community psychosocial workers (CPSWs). Throughout this period, I wrote field reports to be shared with all levels of the NGO staff, with the idea that differing interpretations of the material would be elicited and then discussed.

Counselor trainings were generally held in various hotel halls around Kathmandu, and were based on the training model that had been used in community mental health and psychosocial projects before the disaster. Counselors for the project were known by the moniker “earthquake counselors.” In order to qualify for the job, applicants had to have either a Masters in psychology or have studied up to grade 12 and completed at least 6 months of counseling training prior. During the first “earthquake counselor debriefing” I attended, the counselors had already been to the field. The Nepali trainer, Maya, herself a psychologist, began by asking the group, “who and what does it mean to be a psychosocial counselor?” The group came up with answers like “one trained in the skills of psychosocial counseling,” “solves social and emotional problems of others,” “provides support, no judgements,” “capable of referring and connecting people to experts,” “skilled listeners,” “compassionate and empathic,” and “understands an individual’s *manko kura*, things held in the heart-mind.”

Much of the day was spent reviewing the concept of “neutrality.” The counselors were told to always remember, the “client is client,” the “problem is problem” and the “client is not problem,” which was said in English. In this way, counselors were encouraged to “compartmentalize” their client from the client’s problem as a way to maintain neutrality in a case. Other days of the 5-day

training included explanations of “depression,” which was defined as a cluster of the following symptoms: *pet polne* (burning stomach), *dikka laagne* (boredom), *taoko dukhne* (headache), *jham jham aaune* (tingling sensation in arms and legs), and *kanna man nalaagne* (loss of appetite). For those who are depressed, it was explained that they should be told “don’t stay alone, eat on time, drink water, and stay with family.” In general, it was suggested that with depressed clients, the counselors should “be charming, full of laughter, and bring their own energy,” because “when you bring positive energy then others will laugh also—*milaune*, get along with others.” Counselors were also told to pay attention to body language, and try to interpret the non-verbal body language of their clients. Additionally, counselors were taught a range of body techniques, activities to do with children such as the “child life tree,” and breathing exercises. During the training, the counselors themselves were encouraged to stay hydrated, and bottles of water were made available throughout. Trainings were always punctuated with lengthy breaks of singing, dancing, games, stories, and sometimes even the recitation of *gazals* and poems, which everyone seemed to enjoy greatly. After receiving training in counseling, counselors often said that the training had enabled them to “become more developed,” *bikasit* (c.f. Pigg 1993). A good portion of the training was also spent discussing how to write case reports, and how to collect the data that would be needed in order to report back to the donors.

Content taught to the field level psychosocial counselors was generally different from that taught to the Nepali supervisors by the foreign psychologist who was also part of the project staff. Additionally, over the course of the project, the content of trainings for both supervisors and counselors was continuously being updated as new issues, concepts, or techniques were addressed and elaborated on further. In this way, the content of trainings was not fixed, but always being readjusted. This contributed to an unevenness and lack of uniformity in the trainings to the counselors, that seemed to be compounded by a situation of cascading translations from the complex concepts drawn from systemic family therapy that the foreign psychologist, who spoke

English as her third language, explained to the supervisors, to the translations into Nepali, which was later taught to the counselors.

At the same time, among the supervisors, the fluid and dialogical form of their trainings, conducted in English and simultaneously translated into Nepali, with the foreign psychologist created the possibility for highly reflexive discussions of therapeutic interactions between counselor and client. In many ways, the majority of investment in training, both financially and in time, was going into the “capacity building” of the permanent NGO staff who worked as supervisors on the project and who would continue to work on future projects for the NGO.

The foreign psychologist working as a supervisor trainer on this project described herself as a “family systemic therapist” and “family constellation therapist.” She had been working with this NGO as a trainer on and off for the past 8 years, beginning during the period of the People’s War, when she got a job on a conflict-related project. Michelle’s training as a systemic family therapist with a specialization in family constellation therapy was not something that the NGO had sought out, but was instead the result of chance.

CHAPTER 6

Transient Care

Fieldnotes

Dolakha, August 2015

We drive by jeep into Dolakha district, epicenter of the May 12 aftershock. At first the view of the landscape from the road is beautiful—verdant green hills, waterfalls, and the surging flow of the river filled by the monsoon rains. As we drive through the landscape, one of the counselors points out the window to show us a place “where three people died in a landslide, but an infant baby lived.” We are silent. We arrive in Singati, a small bazaar town on the banks of the powerful Tama Koshi river. It is a place where there used to be multi-story homes made of concrete, but now they are twisted in piles on the ground. We go for a walk around the town. Today a man died in a landslide, his body is burning at the edge of the roaring monsoon river. We watch the orange flames of the cremation from the edge of the suspension bridge in the rain. Bikas Shrestha,⁴⁶ one of the counselors and ever the host, wants to take photos of us all together, posing on the bridge with our umbrellas. But it is difficult to smile. The counselors, all Dolakha natives, show us around. We visit the pristine Red Cross tent hospital, complete with immaculate grey gravel flooring and an x-ray tent. I talk to the doctors there, one from Germany and another from France. The German doctor, ignoring my Nepali colleagues, says that Médecins Sans Frontières is also running a psychosocial program here and asks if we knew of their effective international psychosocial tool. He says that this tool has helped because “it used to be that any crazy person could come and do 'psychosocial counseling'.” He says that in Pakistan he saw ten counselors make the children draw an image of their parents' death and then the Hare Krishnas came and danced.

⁴⁶ All names changed to maintain confidentiality, although surnames marking original ethnic/caste identity remain, as in Nepal caste and ethnic background were regularly and frequently commented upon and discussed among the counselors and clients.

In August 2015, three months after the 7.3 magnitude “aftershock,” whose epicenter was the region of Dolakha, landslides were frequent as the steep hills, destabilized by the earthquakes and then drenched by the monsoon rains were no longer holding together. The green hills of Dolakha were streaked with hundreds of white stripes, all landslides. Accompanying psychosocial counselors working in Dolakha district, I travelled from Kathmandu to the working VDC. Along the dirt road there was not one home that remained standing. Beside the ruins of their old homes people had erected rough, makeshift shelters of wood with roofs of corrugated metal, known euphemistically as “cottages.” We stayed in the home of a family in one of the VDCs, and using that as our base set out each day to visit different communities from there.

In the VDC we visited a mixed *janajati* indigenous community which had suffered perhaps even more than the others. Because their original settlement was located on an extremely steep hill face, they had been told they must relocate entirely, perhaps permanently due to the risk of landslides.



Figure 9 View of the resettled village.

In the midst of this double loss, both home and land, we arrived, suddenly and without warning due to a mishap in communication, at what looked like a shanty town so the counselor who I call Indira Bista, could conduct a group counseling session with some of the community members. Upon arrival, the community psychosocial worker, a local resident and assistant to the counselor, announced to the crowd, “We won't be bringing you relief, nor any GI sheets. We won't be bringing tarpaulin. We don't have all these things. We are here to bring relief to the hearts of all those who have problems...Know it well that we don't have any relief materials. Look we have come empty handed.”

In the beginning, the fact that counselors could not provide material relief was a source of anxiety for them. With each new visit, “psychosocial counseling” had to be explained in lay terms. A group of 20, mostly women, were assembled in a circle beneath a tin shelter. The counselor, Indira

Bista, asked them “*aapbno man, kasto chha?*” or “how is your *man* (heart-mind) doing?” and instructed them to go around the circle and share with the group how they were feeling and enduring their loss. After each person shared, Indira would comment on their words, alternately praising them for their ability to move on, or asking them to reflect on what they could do to help themselves. Sometimes the loss was too much and there was no response that could be given. As she went around the circle, people complained of *taoko dukne* headaches, and *ringata chalne* dizziness, *wak wak laagne* nausea, *kaane man chaina* loss of appetite, *tension* (said in English) and *chinta* worry. People spoke of worries about being able to pay their debt, about their children's education having been disrupted, literally “broken”—“*baccako pardai bigrieko chha,*” some were worried about having to stay on the land of others, in shelters so cramped that there “wasn't even a place to spit,” “*thukne tau pani chaina.*” Many had sons and even daughters working abroad in India, Malaysia or the Persian Gulf, more had thoughts of sending their children abroad in hopes to make some money to somehow start again. Many were worried about how they would feed themselves. Consolation came in the form of hope that maybe the government, some organization or project would help them, or a sense of comfort in the idea that at least everyone had suffered from the disaster, and not just one person. People spoke of what they had undergone, of what they had lost, as their karma, as one's fate which is already “written,” *lekeko.*

Speaking for the community as a whole, a man in muddy rubber boots shared the suffering they had faced, his hand on the knee of the man next to him. “Right now we are staying under sheds,” he explained, “We are dependent on our farming only. We have some maize and potatoes but we don't have a place to store them. The floor is wet. We remember our homes. We had rooms which were neat and clean. It was dry. Actually, we are the victims but we can't always cling to this. However, we doubt if we can ever reach to the state at which we were before. We are hopeful that some organization or project might help us to reach our previous state...We are full of sadness, we

are worried. At night we can't sleep. We are indeed facing adversity but we can't always think like that. Whatever comes, we have to face it. So, we have to forget it and satisfy ourselves thinking that it's not like this for us only. Things like this happen all over the world.”

“*Ekdamai dherai ramro kura garnubho*,” “You have said really good things,” Indira responded. “We can't just dwell on the past. We have to admit these things and move ahead. You have said that maybe some institutions would help you to reach back to the original state, *boina?* Isn't it?”

The group ended with an elderly man, who told us that his son had recently died in a landslide. He said that since the earthquake, his *dimag*, his brain, had gone bad, *dimag thik chaina*. He said he didn't know where to go, where to stay; that he had forgotten how to do the farming. “Instead of my son doing my cremation, I had to do my son's cremation,” he told us.

On our way back from the resettled community a 5.1 aftershock hit. Epicenter Dolakha. It sounded like a bomb going off. The noise came from directly beneath us. The next day while conducting another group counseling session in a place called *Bir Muni*, meaning literally “under the steep cliff,” the community spoke about fear of landslides. They were worried about their children who had to cross a landslide on the only route to the school. Then the land across the valley on the opposite hill face started sliding. It sounded like an airplane, and a dark rip in the earth ran down the hill.

A few days later we left the villages and returned to Charikot, the district headquarters. One of the challenges of working in the field during this period was the lack of places to stay. With most structures destroyed, local people were themselves staying cramped “cottages” or inhabiting severely cracked multi-story concrete buildings, despite the risks. I had heard of the existence of a “humanitarian hub” where there were safe tents to stay in and hot showers. It was supposedly a place where the high level and mostly foreign staff of donor agencies stayed while coordinating from

the field. This option was not available or even known of among the Nepali field staff, who were expected to arrange their own places to stay and who eventually rented rooms in a cracked multi-story concrete building nearby.

Fieldnotes

Dolakha, August 2015

We have come to a “humanitarian hub”. A sterile tent complex in the midst of life in ruins. The tents are white. It costs \$25 USD per person per day to stay there, an amount field level staff cannot afford. There are hot showers; wifi. In the dining hall an ipad displays the words “Spanish Night” and is playing Spanish Flamenco music. We are served couscous, chicken, beef stew, bread, juice. Grey is the motif of the capsule tent rooms, which are made of grey cloth and zip shut, and which come equipped with bed, blanket and a razor sharp Swedish hunting knife. It feels like a strange ship adrift and at sea. Outside the high fence of the compound it is as if the world has ended, yet people still have to keep going.

In the dining tent of the humanitarian hub hung a painting of the humanitarian hub. The image depicts a tranquil scene of an empty camp. Young girls pass by on their way to school, dressed in uniforms. One girl turns to her friend and says, in a red speech bubble, “Hey Parvati! Listen The IHP (International Humanitarian Partnership) is Really Working well in this Critical Condition.” The girls peer over the fence in curiosity. In the distance the Gauri Shankar mountain can be seen through a frame of lush green trees, against a background of a clear blue sky. In this image there are no ruins, no sign of the disaster. There are also no men, and there are no humanitarians. Only the calm beauty of nature and femininity, and the vacant camp.



Figure 10 Painting of the “humanitarian hub.” Dolakha.

Discussing the logics of humanitarianism assistance, Didier Fassin writes of the false notion of the “symmetrical exposure of lives” (Fassin 2010). By this he is referring to a kind of hidden truth among the world of humanitarian aid in which the lives of humanitarian actors are valued over those of the national staff, despite their outward gesture of equal sacrifice in the face of disaster. While humanitarians may volunteer themselves to help in dangerous situations, their lives are protected; they can leave if things become too dangerous. The lower level local field staff, did to have this possibility.

Psychosocial Interventions

In the past two decades, both humanitarian and development organizations from UNICEF to the World Bank have increasingly incorporated a psychosocial component into both disaster and development interventions (Horn 2013, 2014; IASC 2007; Tol et al. 2011; WHO 2003).

Anthropological and journalistic studies of mental health and psychosocial counseling in humanitarian contexts have slowly followed (Abramowitz 2014; Argenti-Pillen 2002; Breslau 2000; Fassin 2008; DelVecchio Good et al. 2010; Good et al. 2015; James 2010; Locke 2009; Pupavac 2001, 2002; Summerfield 1999; Varma 2012; Vaughan 2016; Watters 2010). Such studies are generally split into two camps. One side, which is primarily critical, argues that humanitarian therapeutics and PTSD diagnoses are a historical construction (Fassin and Rechtman 2009) and a form of governmentality in which Western diagnoses are imported and imposed (Pupavac 2001; Summerfield 1999; Watters 2010) resulting in the production of new kind of subjects. For example, Didier Fassin has demonstrated the ways in which humanitarian psychiatry in Palestine worked as a form of “political subjectification” in which Palestinian activists became “victims” through a politics of testimony (Fassin 2008, 2011). Likewise, Erica Caple James has shown how PTSD diagnoses entered into “a political economy of trauma” in Haiti, as *viktim* of politically-motivated violence performed trauma to secure scarce resources (James 2010). In a similar vein, Vinh-Kim Nguyen has described the ways in which “confessional testimonies” among people living with HIV in West Africa became tools for accessing medical treatment, ushering in a new form of “therapeutic citizenship” (Nguyen 2005, 2010).

At the other end of the spectrum arguments are made for the necessity of such interventions – for the need to build up psychiatric services in low and middle-income countries, and the importance of providing culturally-sensitive mental health and psychosocial care in post-disaster and post-conflict settings (Abramowitz and Kleinman 2008; DelVecchio Good et al. 2010; Good et al.

2015; Kohrt et al. 2015; Wilkinson and Kleinman 2016). As Byron Good has argued, reflecting on his collaborative work on a mental health intervention with the International Organization for Migration (IOM) in Aceh, Indonesia, “although we know all of the arguments about the potential that the category of post-traumatic stress disorder serves to medicalize suffering and the critiques of the humanitarian industry, we reject using these as an excuse not to try to help those affected by the violence” (Good 2012: 531). In this way Good argues,

We should recognize involvement in intervention as one critical site for anthropological inquiry. Many things have become evident to us precisely because we have been trying to build systems of care—not only about the inner lives of those treated in the project, but also about the structure of health services and the difficulty of initiating change (Good 2012: 531).

As such, these two approaches, critical on the one hand and applied on the other, are not easily reconciled. In this chapter, I draw from recent anthropological writing on *care* in order to refocus the object of inquiry in this debate. In so doing I explore the ways both care and suffering emerged in the midst of therapeutic encounters, in forms unanticipated by the NGO staff.

Transient Care

From an anthropological perspective, as an object of inquiry *care* is neither bound to the setting of the clinic nor pre-defined in its form, but is instead framed as an open question—what does care consist of and for whom? Annemarie Mol has argued that care has a logic that is context specific and invites experimentation. As she puts it, “the logic of care starts out from the fleshiness and fragility of life” (Mol 2008: 11). Angela Garcia, in her work on intergenerational heroin addiction in New Mexico has shown the ways in which care may also take unfamiliar ethical configurations (Garcia 2010). Likewise, as Lisa Stevenson has demonstrated, the “anonymous care” of colonial era tuberculosis treatment provided to Inuit communities by the Canadian government

were perceived by Inuit as uncaring, and stood in stark contrast to alternative forms of care that happened within the Inuit community (2014: 4). In this way, the interrogation of *care* as a concept brings into focus the points of disjuncture between large-scale interventions done in the name of humanitarianism and other possible formations of caring for and relating to another. As Povinelli writes,

To care is to embody an argument about what a good life is and how such a good life comes into being...the point is not, therefore, to argue that someone really cares or doesn't really care. In the first instance, the question is, what do we believe care to consist of such that when we experience a form of relating to one another socially, we experience that form of relating as a form of caring for others? What we believe care to consist of is directly related to where we believe failure resides or what we believe failure consists of (Povinelli 2011: 160).

In Nepal, what forms of care were possible in the midst of so many limitations—economic, infrastructural, geological, temporal— and what did such care consist of? In order to address this question, I begin by considering the work of post-disaster psychosocial counseling as a form of *transient care*. The word “transient” is defined as “lasting only for a short time; impermanent.” Something transient is temporary, it is short-lived, short-term, ephemeral, momentary. Yet in tracing the word back to its Latin origins, we find it defined as “going across.” In this way, while the original meaning of the word described a quality of movement, the contemporary English definition describes a quality of time. In this chapter I follow the theme of transience in both senses of the word—as ephemeral temporality and as movement, as “going across”—and I explore the forms of care which emerged in this context.

In the post-disaster psychosocial counseling project, transience played out in a number of concrete ways. First, the project itself was set to exist for a limited amount of time. As with other Psychosocial Support (PSS) projects set up after the earthquake, the project was given funding for 6 months. After 6 months, while some projects were closed down, the project that I followed was renewed for an additional year. Despite this renewal, the work itself was still bound to a timeline

with an inevitable end point. Secondly, the counselors themselves were transient figures in the lives of their clients, due to the number of communities they were expected to cover.⁴⁷ Each district was assigned two or three counselors, who covered three VDCs each. Because of the geography and lack of infrastructure in the middle-hills of Nepal, reaching the clients took up the majority of working hours. The counselors would circulate through their three VDCs once every 15-30 days, and there was no guarantee that clients would actually be available to meet when the counselor finally arrived in the village, despite efforts in coordination through cell phone and the local community psychosocial workers (CPSW) who were also hired by the project and whose homes were located in the working VDCs. Thirdly, when the project ended, these counselors too would be out of a job. Their work as field staff on development projects and humanitarian interventions was also tied to a transient timeline; it rarely lasted more than a year at a time.

Yet, as David Citrin has shown, such short-term humanitarian care was far from new in Nepal (Citrin 2010; 2012). Short-term health projects have long existed in Nepal beginning with sterilization camps for family planning in the mid 1960s and followed by eye, ear, dental and uterine prolapse camps in the 1970s (Citrin 2010: 34-35). Health camps may run from 1 day to a week. During the period of the People's War, "the army and the Maoists ran health camps in order to elicit support from the Nepali people" (Citrin 2010: 43).

⁴⁷ Some background knowledge of the way the government of Nepal divided its administrative territory is necessary. At the time of this research, Nepal was divided into 75 districts, 14 of which were affected by the earthquake. Each district was divided into units called Village Development Committees or VDCs. Each VDC was divided into nine wards. One ward could encompass multiple villages, or be a single village. Villages themselves were always broken into further *tois* or neighborhood settlements which are not official administrative units and are organized by family, as well as caste and ethnicity in mixed-villages.

Three Counselors

Indira

In August 2015, three months after the disaster, I began to follow the work Indira Bista, a strong and outgoing newly-minted counselor. As she described herself, “I am the kind of person who likes taking risks and gaining work experience. I have the guts to work.” Indira is a Chhetri woman who was in her 30s during the time of my research. Although she grew up in Dolakha district in a family supported by her father's work in a factory, she had settled in a five story, concrete joint-family home in Bhaktapur, just outside of Kathmandu. While Indira worked in the rural districts full-time, her husband worked in a medical shop in Kathmandu and stayed home with their two children. Indira was what you might call a career NGO field staff. She started working for the Rural Health Development Program (RHDP) funded by the Swiss Agency for Development Cooperation (SDC) at age 16. She spent almost 20 years as an RHDP health worker in Dolakha district, a time which spanned the complex period of the People's War. In this job, she collected data for household surveys, and organized “mothers’ groups” in order to lead discussions with rural community members on maternal and child health, covering topics such as the importance of cleanliness, hand washing, vaccination, nutrition, vitamins and regular post-delivery visits to the doctor. During this time, Indira herself became a mother and as she put it– “I conducted programs while carrying my children on my back and holding my bags in my hands...it was difficult. But now I have the experience of working, even in difficult situations.”

After 17 years, the project based in Dolakha “phased out,” and Indira found a job in nearby Ramechhap district where she worked for 6 months in another program. After this period, she left her job and spent two years in Kathmandu taking care of her children and looking after her home. During this time she began to again feel the desire to work outside the home. We sat in the warm noontday sun on the balcony of her Kathmandu home together, and we talked about her work

trajectory. Reflecting on the topic of women and work, Indira spoke into my recorder, using a well-spoken genre of Nepali *bashan* or formal speech:

“You also experienced how hard Nepali women work. How much difficulty they face. How hard they work for their communities, carrying their own loads. In the context of Nepal, there are many women who can't work as field staff. Many have the conception that women should only stay in the home. I hope that I can also set an example that women don't need to restrict themselves to the home only. They can also work like men and go out to the field and the villages...The work that we do and the experiences that we have gained here will be published in books and we will be exemplary women for all. We will be an example of women who can go out in the field and work even in difficult situations.”

During the earthquake Indira was in Kathmandu. Her family evacuated their home and stayed, as many in Kathmandu did, in a tent outside. During this period of emergency, her father passed away. On the thirteenth day of the thirteen-day death rituals, Indira was called for an interview at CMC, for she had recently submitted an application for a job in the new earthquake program. To do the interview at this time was difficult, as it involved breaking various ritual prohibitions, but she went anyway. She was selected and deployed to Dolakha district.

When we walked through Charikot, the formidable and highly built up district headquarters of Dolakha, Indira seemed to know almost every person we passed. Walking with her was often slow going, as she would stop to greet important people and give her formal introduction to those she had not yet met. Her public persona contrasted with the side I saw when I visited her in her home in the Kathmandu valley. There Indira was reserved, carefully embodying the part of daughter-in-law, as she watchfully attended to the needs of her guests, her children, her husband, her mother-in-law, as well as her 100 year-old grandmother and her younger sister. This was a starkly different side than the Indira I was with in the field, or in the Kathmandu training sessions where

she was always first to offer an answer in front of the group. While in the field, Indira often told me, and any others who might be listening, stories of how difficult it had been to be a young mother working as a field staff. Her motherhood continued to exist in conflict with her work, and she frequently spoke of how difficult it was to be away from her children almost constantly. Indira had completed her studies only up to class 10, but had been fortunate enough to have maintained steady employment in long-term Swiss funded programs as a field staff over the years. One winter afternoon as we sat in her freezing rented room in Charikot, wrapped in thick Chinese fleece blankets, breath visible in the air, Indira showed me her CV. The dossier included a stack of laminated and signed certificates for trainings she had completed over the course of her many years of work with NGOs and INGOs. Yet during the earthquake counseling program Indira was frequently unwell, constantly suffering from gastritis, respiratory infections, fevers and, after falling in the field, a broken arm. When I asked Indira what her plans were after the end of the earthquake counseling project, she said she had dreams of finally opening her own small business, where she could sell clothes.

Bina

In January 2016 I began to accompany another counselor, Bina Tamang. Bina was 35 years old at the time of my research. She was unmarried, and never intended to marry. She sometimes referred to herself as “a student of gender.” When her psychosocial supervisor instructed her during a training to wear earrings and makeup at all times in order to be perceived as a “proper” woman while working in the field, Bina agreed to buy small silver earrings. Bina's status as unmarried woman set her apart from the other counselors, and indeed it was a rarity in Nepal outside the elite cosmopolitan class for a woman to perceive her unmarried status as an active choice. In Nepal at the time of my research, for women especially, marriage was the single most important social institution.

But as Bina put it, when people asked her “*biba bhayeko cha?*” “Has your marriage happened?” She would always make a point in responding “*biba gareko chaina*” “I haven't done the marriage,” indicating that her lack of marriage was not due to her inability to get married because of some defect or flaw, but because she herself had chosen not to do so.

Bina was born to a poor indigenous Tamang family of 10 in a remote village in Solukhumbu, the district where Mount Everest lies. Although she is ethnically Tamang, she did not speak the Tamang language. As a child she remembered not having enough to eat. For money, her parents would cut down trees in order to feed the fire to make Nepali paper. “We used to feed ourselves with the money that we got from it and if the money wasn't sufficient enough, we didn't eat anything..We used to work there for the whole day and at night we would stay inside huge stone caves. We didn't have a proper house. Our father used to bring sugar by selling that paper. We found it very tasty when we dissolved the sugar in a small bottle of water and drank it.” When the situation became unlivable, Bina's father relocated the family to Sikkim where his mother lived, and Bina began to attend school. When she was around seven years old, her father, who had been suffering from asthma, died while walking to the fields without his inhaler. Two years later, her mother also passed away. Supported by her elder siblings, in 1998 Bina completed her bachelor's degree and returned to Nepal with one of her brothers. By that time, the People's War had begun. She settled in Solukhumbu, and got a job as a “house mother,” taking care of orphans in a home funded by a German NGO. Soon she began to volunteer teaching nursery school in the local government school in the afternoons. Eventually she moved to Ramechhap district, where she bought her own land and started running a home for disabled orphans.

In 2014, UNICEF opened a vacancy to train people to work in child advocacy at the district court in Kathmandu. Bina applied and was selected. She went to Kathmandu and began the two-month training, which also provided a monthly allowance of Rps. 50,000 (roughly US\$500). In two

months she had saved about Rps. 60,000 (US\$600) and decided to use it to further her education. She applied for a one year course in counseling psychology and used the money to pay the fees. When the earthquake struck, Bina was in Kathmandu working as a phone counselor for a Nepali-Indian telecom company. Her home in Ramechhap was destroyed, so she travelled from Kathmandu to collect her belongings. Hearing that CMC was hiring psychosocial counselors, she left her CV with a friend who submitted it for her. She was hired. Bina was the only member of her family who was not living off of subsistence farming.

Anjana

In March 2016 I started to work with a third counselor, Anjana Rai. Anjana Rai was born to an indigenous, *janajati*, Rai family in Okhaldunga district. Her first language was Bahing Rai, and she only mastered Nepali later. “When I was young...I only knew my native language,” she explained to me. “I didn't even know the Nepali language. I used to mix Nepali and Bahing while speaking. People used to say 'what kind of person is this, who doesn't know how to speak Nepali.’” By the time I met Anjana she had become an indigenous activist and had spent time teaching her native language to Rai children who had grown up speaking only the dominant language of *Khas* Nepali. Anjana was 33 years old at the time of my research. She was married and a mother of two. She came from a large family of eleven. Her father, as have many Rai men in Nepal, served in the Gorkha Army in Hong Kong. Her mother was a subsistence farmer. Both passed away when she was in her early teens. Growing up, Anjana did not initially have the opportunity to study in school—as her parents only allowed their sons to study and not their daughters. She explained that in her community there was fear that if a girl studied in school she would either become a *boksi*, a witch, or she would elope. So instead of going to school, she looked after the livestock. At around age 7 she began attending an adult literacy class in order to learn the Nepali alphabet. As she says, “When I

first started studying, I began from *Kama*. Others started studying from *Ka* (the first letter of the Nepali alphabet) but I started from *Kama*, which basically means work” (the word for work in Nepali is *kaam*). When she turned twelve, Anjana began to argue with her parents for the possibility of attending school. She had excelled in the adult literacy class, and had not only mastered the alphabet but was also able to read words and numbers. Convincing her parents of her ability, she finally started attending school, and was admitted into grade 5 at the local government school. “I joined the school. I was tall and big, even when I was twelve years old. That's why my teacher used to address me by saying 'Miss'.” Eventually, after much struggle, Anjana passed her SLC exam as well as the exam to become an Auxiliary Nurse Midwife.

Sometime later, Anjana married and gave birth to a daughter. Anjana's husband worked as a trekking guide, making money taking tourists into remote mountainous regions. Like Anjana, he was also actively involved in the indigenous rights movement. The family moved from Okhaldunga to Kathmandu, in search of better opportunities in work and education for their daughter. In Kathmandu, Anjana got a job in an urban nutrition project, funded by the INGO Action Against Hunger. She worked in this project from 2009-2012, and during this time she met CMC as their organization had been involved in the project to provide psychosocial counseling to poor urban mothers participating in the nutrition project. In the nutrition project, Anjana worked to raise community awareness about the importance of childhood nutrition, from pregnancy to age three. She would do house visits, following a number of children over time to track their weight, and provided the families with access to nutritious food, utensils, cooking gas, and stove if they were lacking.

In contradiction to the common image of humanitarian mental health care and psychosocial counseling being conducted by foreigners who are unable to speak the local language, and have little knowledge of the local conditions and history of the regions in which they work, in Nepal, the work

of psychosocial counseling as well as humanitarian psychiatry, was practiced by Nepalis only.⁴⁸ Given the nature of this particular natural disaster, all of the counselors were themselves also earthquake “victims,” and some had also lost their homes. In contrast to their Nepali supervisors, who could speak English, had advanced degrees, and owned their own homes and cars, the counselors had minimal education, spoke little to no English, and were struggling to enter into or sustain a lower middle class lifestyle. In contrast to their clients, who lived in rural villages and survived off of subsistence farming and remittances from abroad, the counselors were clearly cosmopolitan salaried people who no longer had to do manual labor. But, in the case of those with whom I worked, they had all been born in the village and had not forgotten that way of life. Being from the districts in which they worked they understood the local vernacular, and they rarely peppered their phrases with English words which their clients could not understand.

Reaching the Clients

In the work of psychosocial counseling, the majority of time was spent simply trying to reach the clients. Psychosocial counseling was physically strenuous. First, traveling from Kathmandu to Dolakha, Ramechhap or Okhaldunga by bus, shared jeep or “micro” van, took between 5-7 hours, on roads both paved and dirt. In the district of Dolakha, sometimes called “the Switzerland of Nepal,” home to a major hydropower project, long-time recipient of numerous development aid projects, and growing tourist destination due to its beautiful mountain views, roads had been carved out of the hills. Here the counselors were able to travel by local bus to all of their working areas. But local bus travel was also difficult. Buses were few and we would regularly travel for up to six hours on multiple dangerously over-packed public buses as we moved from one VDC to another.

⁴⁸ While the foreign project managers who sat in the psychosocial and mental health UN cluster meetings in Kathmandu more often than not had no experience working in Nepal, in the case of the project I followed, the project manager had been living and working in Nepal for over two decades.

Sometimes in desperation we resorted to traveling on the back of trackers and hitchhiked rides in private trucks. Once we had reached our base site, we would then walk, guided by the local CPSW, between 30 minutes and two hours to reach the “nearby” home of a client. It was not unusual to travel all day only to meet with one client for 30 minutes, if that.

Once we had reached the working VDC, finding a place to stay was sometimes difficult. Despite having been told only to stay in safe structures, the counselors regularly occupied cracked buildings because there were often few other available locations beds to spare and food to purchase. The winter following the earthquake was freezing for those who now found themselves living in temporary shelters of tin and wood. That winter the local newspapers reported multiple deaths due to hypothermia among earthquake survivors in Sindhupalchowk district, prompting a government fund of Rps. 10,000 (about \$100 USD) to be distributed to every earthquake effected family in order to buy warm clothing. Working in Dolakha district from December-February meant that the counselors also had to endure the cold alongside the earthquake affected communities.

Compared to Dolakha district, in Ramechhap and western Okhaldunga transportation infrastructure was considerably less present. Counselors instead had to travel between their working VDCs by foot. In Ramechhap we would sometimes walk for six, eight, or even ten hours as we travelled, carrying our belongings, over high suspension bridges and well worn paths, crossing over steep hills, winding through vast forests of coniferous pine trees, and sometimes carefully following narrow walkways which hugged the sides of steep cliffs in order to reach the clients. In one village located in Himganga VDC, Ramechhap there was neither road access, electricity, nor a source of water nearby. Knowing well how far the counselors had travelled to reach them, clients often commented, perhaps in sincerity or perhaps as a performance of deference, on the *dukeka*, the suffering the counselors had undergone to reach them. In some ways this echoes a form of *darsan*, in which people embark on a pilgrimage to see the image of the gods as a form of “auspicious sight”

(Eck 1998; Sax 1991). In this way counselors, like devotees, take the *darsan, darsan linnu*, of the people they have come specifically to see. Sometimes people themselves would phrase it in this way, “*tapai darsan linubbayo, hami kusbi chau,*” “you took *darshan*, we are happy.” That the counselors had struggled to get there, and that they had done so for them was always verbally acknowledged in a formal way. As one elderly woman who had received counseling after her daughter died in a landslide put it, “*mero lagi dukka garera aunubho*”, “You suffered and came here for me.”



Figure 11 Looking ahead at the days' walk, over these hills.



Figure 12 Crossing through pine forests.



Figure 13 A local CPSW shows us the way. Ramechhap. January 2016



Figure 14 View from our lodgings, eight months after the earthquake. Dolakha.

“When I look in the mirror, I see my own ghost”

Often the counselors would comment on what they saw in the outward appearance of the client, offering it as encouragement or as evidence of his or her improvement. People looked *ujyaalo*, “brighter”, *ramro*, “good” and “fresh” (said in English), and their *anuvaaar*, appearance, it was said, was generally improved. Clients did not always seem to agree with this assessment, but more often than not, such comments opened the way to further reflection.

In August 2015, Indira returned to Dolakha, to meet with a well-off client who had lost her daughter in a landslide. They sat outside in the *agan*, the courtyard, in front of a pile of fallen stones and broken wood. Beginning the session, Indira said “I feel happy seeing your face, I feel happy seeing Amma, getting better than before. How are you feeling? *Ammalai kaasto chha?*” The wind was blowing, and as Indira spoke, she reached out to brush a strand of hair which had fallen into the eyes of her client. Smiling slightly, the woman replied, “*Testo hune babu*, This is how it is, child. Her image keeps coming in front of my eyes at least once a day. *Dinma ek jota aakha waripari gumirabekochha*. I keep remembering her, whether it is day or night. Everybody yells at me *galli garchan*, and tells me not to remember her but I can't help it.”

Later on, Indira again repeated, “Your face looked different last time, but now it looks bright *ujyaalo*. Seeing this, I feel like our *Amma*, mother, is feeling good now. How are you feeling?” Smiling and laughing, the woman replied, “Me? I feel scared to look in the mirror...When I look in the mirror, I see my own ghost.” *Malai? Dar laagcha malai aina berna...aina herepachi mero bhut aeycha*. Gesturing to one side, the woman continued, smiling, saying she avoids reflective objects like glass windows, for fear she might catch a glimpse of herself. Indira insisted, “I find your face to be very bright, it looks so much brighter than last time. Your face looks very fresh and fair. I can see a very good face in front of me which looks much better than last time.” *Ekdamai ramro anuwar maile dekchu. Austiko banda, ekdam ujyalo anuwar dekchu, ani ekdamai seto khalko, ekdam ramro khalko anuwar dekekochu*.

As the wind picked up around us, the woman tried to hold back her tears. “My face looked so different before the earthquake,” she said. “But after the earthquake it has become ugly. Compared to before, it has become broken, but that's how it is, what to do.” *agadiko banda, pachiko bigrieko chha, aba tyestai ho ni, ke garna ta.* “It is difficult for you” Indira said, as she searched inside her purse for tissues. “No, no, I'm fine,” the woman responded. “I am good. You came for me. *Ramro chha. Tapaibaru aunubho, merolaagi.* May success always be with you; may god be always with you. Even though I have faced such tragedy, may you never face any hardship. *Maile dukka pani pae, hazurlai dukka napanhos.*” Indira leaned forward, and wiping the tears from the woman's eyes with a tissue she said, “I understand that this is hard.”

In rural Nepal, it is not uncommon for women to smile and laugh while talking about their suffering. Sometimes people joke or make ironic comments about incredible hardship they have suffered. In general, an outward appearance of happiness or pleasantness combined with a joking banter of *gaph*, a form of entertaining conversation, was often something people seemed to strive for in everyday social interactions. Whether among rural school teachers or with the cosmopolitan Kathmandu-based NGO staff supervisors, an outward expression of warm and positive sociality was commonly held as an ideal way of being with others. During counseling sessions at times clients, especially women, struggled to maintain this form of outward pleasantness, even as they reflected on incredible loss, pain, and struggle.

In December 2016, I returned a second time to Dolakha district with Indira. We searched for the elderly woman we had met in August, but this time she was not at home. Instead Indira found another client, a young man in his 30s who she had made plans with to meet for another counseling session. This time it was winter, and Indira was bundled in a puffy jacket and knit hat to fight the biting cold. They sat, legs crossed, on a woven mat in front of the corrugated tin wall of his makeshift shelter. It was their second meeting, and Indira began by saying “the other day we had a

conversation. After the conversation, I see that your face has become a little brighter, *ujyaalo*. You look happy. Is my guess correct?” The man didn’t confirm her observation, but instead began to talk about how he feels everything is worthless. Yet throughout the meeting, Indira insisted that he is improving. The client said his problem started while he was working abroad as a labor migrant in the Persian Gulf. He often feels fear that he will die. His heart starts pounding and he worries he will have a heart attack, and that he won't be able to reach a hospital in time due to the remote location of his village. He feels his heart beating heavily even while he tries to sleep. He went to have a heart exam, but was told that he was healthy. While he was abroad, his fear of heart attack was so great that sometimes he was unable to get out of bed. “While I was abroad I was in such bad condition that I could not even go to the toilet. I would force myself to bathe. I would be covered in sweat.” Indira listened, asking questions about when and why he feels the fear. She reminded him that the last time they met, he told her he feels better when he is around close friends. He responded by saying “my biggest medicine is alcohol. I have started drinking it not for taste, but for treatment.”

“As per my observation, I have seen that you have progressed by 50%,” she insisted. “I can see many changes in the way you talk and share your feelings. You are involved in work as well. *Hoina?* Make sure to drink 5 liters of water per day...Continue to do the deep breathing exercises. Whenever you feel uncomfortable, do the deep breathing exercise. Also keep doing your daily *puja* rituals. Whenever you feel like it's going to happen, do the deep breathing exercise.” “Ok,” the client replied. “We have already talked three times now,” she said. “According to my observation, you have made 50% improvement; I can see many changes,” she again repeated. Later she reiterated a fourth time, “I have seen many changes from the last time I saw you. I don't know how much difference you have found in yourself from the last time we met, but I have seen changes in you.” Finally the man replied, “I have been thinking about you often. I remember the things that you have told me and I say to myself that nothing will happen to me. What could possible happen? People

don't die of weakness...yet the other day I heard that a man died from a heart attack and after that, I felt afraid.” Towards the end of their meeting, her client said directly that he would like to have more treatment, that perhaps he could go with Indira somewhere for more treatment. “Ok,” Indira responded. “We have already talked 2-3 times with you. If you want to talk more with us, then we have a one year program here, so we will talk to you again.” Acknowledging her client's desire for further treatment, Indira told him that she would return again. It was a moment of relief as she announced the program had been extended for one year. But what will happen after one year has passed, and she can no longer make promises of return?

Water, Air, and Olanzapine

Clean water, fresh air, and psychotropic drugs were the materials that the counselors prescribed to their clients. At the end of most sessions, all of the counselors instructed their clients to do deep breathing exercises and drink 5 liters of water per day. This had been taught to them, and these were tangible things they could recommend and give to all clients as work they could do to improve themselves and relieve tension on their own. Instructing a teenage girl who had been suffering from *chhopne*, or bouts of fainting (often diagnosed as conversion disorder in Nepal, as discussed in chapters 2 and 3), Indira prescribed deep breathing exercises. “You can do it in the morning,” she said. “Whenever you can manage time for it, please do this exercise. This way, fresh air will reach the organs in your body and it will benefit you.” In addition to taking air, Indira also instructed her client to drink more water. During group sessions, Indira would always end the discussion with a round of deep breathing. Often such groups were primarily women, despite men also being present in the area.

During my time spent in the earthquake affected areas, neither the clients nor the counselors ever spoke of psychiatric diagnoses, even when clients had been prescribed medications by the

NGO's psychiatrist such as Olanzapine (anti-psychotic), Fluoxetine (anti-depressant), Amitriptyline (anti-depressant and anti-anxiety), or Lorazepam (benzodiazepine).⁴⁹ Except in the case of epilepsy, diagnoses were unknown and were never inquired about or discussed, although clients did present medical records from previous hospital visits in which diagnostic information was written. In contrast to what Saiba Varma has described as the ways in which counselors worked as psychiatrists in the context of Kashmir (2012), in this project the majority of the work of the counselors was in fact psychosocial counseling, although counselors also had to manage "adherence" to medication, by supporting its delivery and reimbursement.

Clients, particularly those who described prior symptoms of psychosis or epilepsy, said that medication had helped them to improve. In Ramechhap district, Bina met with a middle aged Chhetri man who, prior to her intervention, had largely abandoned his daily farming tasks and family responsibilities to wander incoherently in the nearby forest. We met with him in the upstairs room of his mud home, which had not been destroyed in the earthquake. A month had passed since the client had begun taking Olanzapine 5mg, and Fluoxetine 20mg, along with "Memtone Memory Tonic," an Ayurvedic medicine for "memory loss, stress, depression, headache, sleeplessness, anxiety and forgetfulness."⁵⁰ The client spoke slowly, as if heavy with sleep. Bina listened patiently, often repeating back the phrases he spoke to her as if checking that she understood correctly.

"After meeting you and talking with you, and after taking the medicine, I am feeling a little better," he said slowly. "And after having more medicine, I believe that I will be cured."

"That's very good thinking," Bina replied. "So you are feeling better and comfortable after talking to us and taking medicine?"

⁴⁹ Of the medicines mentioned, only Amitriptyline and Fluoxetine are listed on the "National List of Essential Medicines" in Nepal and should be available in local health posts. In actuality their availability is unreliable.

⁵⁰ "BGR-34" <https://bgr-34.life/products/reduce-stress-with-memtone-syrup>

“Yes,” he answered.

Before taking the medicine, the client said, he had been suffering from back pain, dizziness, burning sensations, high blood pressure, restlessness, and that he would get lost in his thoughts, *ekoboro*, with no reason and stare blankly at things, *tolinu*. Throughout the session, the client continued to repeat, over and over, that he believed with continued use of the medication he would be cured and able to return to his prior state. Bina neither confirmed nor denied his belief in a cure, although it is likely that without the program his access to medication would be greatly limited. On the day of the session, he informed Bina that he had only one more dose of medicine left.

In the program, clients who counselors felt needed to be medicated were referred to Kathmandu, where they would meet with the NGO psychiatrist for a consultation. Clients were transported from remote rural areas to the Kathmandu office free of charge. Once the psychiatrists had given a diagnosis, clients were eligible to receive their medication free of cost through the NGO. Back in the village, clients were asked to either purchase their own medication and submit receipts for reimbursement, or the CPSWs were expected to be notified ahead of time to deliver the medication to clients. But when the program phased out, this access and monitoring would also disappear. Even during the program, if the client ran out of medication unless he or she had started looking for more medication at least 10 days in advance, it was not guaranteed that the medication would actually be available in a nearby pharmacy. Particularly in the months following the earthquake when violent political protests over the new constitution irrupted in the Madhesi region of the southern Terai, causing India to endorse a four month “unofficial” blockade at the border from September 2015-February 2016, medicine (along with fuel, cooking gas, and other goods) was in scarce supply.

Mundane Disasters of Everyday Life

We hiked down the dusty trail of a steep hill to reach the still-standing mud house of an elderly woman. It was Bina's second time meeting with her. The CPSW and local resident, led us to Maya's home. Bina and Maya sat cross legged on a woven mat on the floor inside her modest home. The mud walls are painted in a classical style, red mud on the bottom, white mud on the top. They sat in front of a jumble of household items— aluminum dishes and cups, a copper plate, a woven basket of cloth. "Namaste Amma," Bina said, her hands held together in prayer, the typical Nepali greeting. Compared to Bina's robust health, Maya's body was small and thin. Her face held a sorrowful expression, and her eyes were downcast. "How are you feeling today?" Bina asked. "You all came so I now my *man*, my heart-mind, is a little refreshed, *sital* (literally 'in the coolness of the shade')" *tapaiharu aikana mero manma alikati sital lagecha*, Ganga Maya replied. This was their fourth meeting.

"I don't know what to do," she said to Bina. "I am sick. I just sit and cry. What can I do *ke garne*. I belong to a poor family. We have to work for our livelihood. So I work here and there. This is reality. What to do. Whatever is written we have to face it, right? I have six children but no one is here with me. I don't know where they are. I stay here alone." Maya had recently tried to commit suicide by throwing herself in the Koshi river. She was saved by people nearby who pulled her out of the rushing water. Her son had accused her of hiding the Rps. 10,000 of relief money which the Nepali government had distributed to earthquake victims for winter clothes. She told Bina that her husband is often away at work, and that he rarely comes home except to sleep. She proceeded to tell the following story. "My husband has a very bad habit of talking bitterly. That's the reason I don't want to stay here. I get pain in my lower abdomen. I pulled the placenta myself...I get pain while with him as well. If I say I cannot do it, he gets angry. *Malai budaina bandakheri, usko ris utcha*. That's why I cannot tell him that. So I want to stay away from him and sometimes I feel it would be better

if I die...it's been a very long time. That happened when I gave birth to my third son. He is now 16 years old. Labor started at noon and I gave birth at midnight. At that time nobody took me to the hospital and no one gave me any medicine. The newborn was in front of me. He was crying and his lips were getting dry and blue. So I didn't care about the consequences and pulled the placenta to separate the baby. When I pulled, everything came out. Then with the help of another woman, I put everything back in myself."

"When you pulled, everything came out?" Bina asked.

"Yes. The whole uterus came out. It does not come out now but it comes down to the opening. When I do heavy work, I feel as if it is going to come out."

Maya told Bina that although she has seen a *dhami* about her problem, her husband does not support her to see a doctor. "*Choriko karma hareko jun?*", "a daughter's karma is a life already lost," she explained sincerely, quoting a well known Nepali proverb.

Later Maya continued. "I wish I didn't worry so much. I am taking medicine for that. When I had that medicine, I used to fall asleep everywhere even with the cow." She told Bina.

"Did you take the medicine after proper consultation with a doctor?" Bina asked?

"No, without any consultation. We were talking just like this. I told my problem, and they gave me the medicine." Maya had been prescribed Amitriptyline 25mg, an anti-depressant, by another NGO also providing mental health and psychosocial care in the earthquake affected districts.

Bina proceeded to try a counseling intervention to address Ganga Maya's sadness and thoughts of suicide. Pulling out a piece of white paper from her backpack, she drew two faces, one happy and one sad. As she drew, Ganga Maya seemed to turn away. The connection had grown distant.

"So, this is you" Bina said, drawing a sad face. Pointing to each face, Bina asked "Which one does Amma like?" Maya pointed to the smiling face, "I like that one," she said. "This one is happy, and

this one is sad,” Bina explained. “You don't like this because it looks sad. That's why you liked this happy and smiling image, right?”

“Yes,” Bina replied.

“So if you like the smiling image, how must Amma be?” *Amma kasto bunuparcha?* Bina asked.

“Like this one.” Ganga Maya replied, pointing to the happy face. “If all the family talks nicely then I am happy. I get upset when my family talks badly. When everyone in the family talks badly, then I am sad.”

Ultimately Bina told Maya that despite the way her family is treating her, there is nothing she can do to change them. “If you want change,” she said, “first of all we have to change ourselves. Don't expect others to change...Instead of expecting others to love and talk nicely, we have to be happy with what we have and we have to be able to give love to others. We need to change. If we change ourselves, others will also change. Isn't it Amma? Am I right?”

Maya's story of suffering occupied a different kind of temporality. It did not describe a sudden moment in which everything was lost, instead she spoke of something slower. These are the mundane disasters of everyday life—an abusive relationship with her husband, severe pain due to untreated uterine prolapse, and deep sadness related to family conflict. According to her story, her physical suffering had gone untreated for 16 years. Suddenly, after the event of the earthquake, multiple NGOs had come to her home to provide counseling, anti-depressants, and support to travel to a hospital. Her everyday suffering had become hyper-visible through the frame of the disaster.

“Distant gods, ghosts nearby”

Phul Kumari, age 81, sat on the ground in the courtyard in front of the ruins of her home. She said that she was afraid that she would die in her sleep by being crushed by the remains of her house. She was less worried about dying than about dying a slow and painful death. Her problem was that her sons, who lived on the same property, had not built her a shelter to stay in, and she had not been invited to stay with them in theirs, so she remained alone inhabiting the ruins of her home. Her family problems stretched back many years to a feud over land holdings. Phul Kumari told us again and again that she felt alone. The last time she met with Bina, she told her that she wanted to kill herself, that she was thinking of jumping off of a cliff, or of hanging herself. But that she was worried of what people would say about her. She said these thoughts come to her, and gestured to her chest.

Bina was attentive. She sat close to Phul Kumari; she leaned her body toward her. When the old woman told her that she fell recently, Bina took her hand to examine the swelling. Phul Kumari called her *babu*, child, and Bina called her *Aamaa*, mother. There are certain ways of caring which inhabit the prosody and kinship terms of the Nepali language, and are demonstrated through gestures of touch. In this way language, particularly a form of poetic Nepali *bhasa*, appears as a shelter (Heidegger 1993a, 1993b), perhaps the only form of shelter which could outlive the disaster.

Toward the end of the session, Phul Kumari told Bina, “You talk so nicely and politely. You talk in such a way that you show me reality like in a mirror,” she said as she spread her hands across the ground in front of her. “When you talk I feel that I have everyone, my children, my relatives, and my grandchildren. I feel like my heart has broadened with joy, it is like a *nanglo* (a broad rice winnowing pan). When you leave, it is again the same loneliness.” Responding to this direct comment on separation and the end of care, Bina suggested, “There is an old saying that “even a ghost that is close to us is more helpful than a distant god” *tadako deuta naajiko bhut kaam laagcha*.

“Yes, that's it *babu*,” Phul Kumari agreed. “*Tadako deuta naajikko bbut, thye bbut kam laagcha, najikko kaam laagcha*. Distant gods, ghosts close by, the ghosts close by are more useful.” “*Ho*, Yes,” said Bina. “We are distant, *hami tadako ho*. We will visit you when we can.”

Temporalities of Affliction and Care

After the earthquake, psychosocial care in Nepal was unevenly distributed and always constrained by the timeline set by the donor agencies in which “victimhood” required a practical endpoint. In the psychosocial support cluster meetings in Kathmandu, humanitarian partners were reminded to make a “dignified exit.” Even the most sensitive and engaged foreign project managers could not escape the constraints of the logics of their field—whether development or humanitarian—in which “phasing out” was always required. On the ground, counselors would rarely mention the possibility of the project ending to their clients, an unpleasant truth which no one enjoyed speaking about. When I asked, in the NGO headquarters in Kathmandu, what would happen to clients who had been prescribed free psychotropic medication once the project finally came to an end, the Nepali project supervisors were unable to answer with clarity. Ultimately, the duration of the program was out of their hands. As one NGO officer said to a group of counselors during a training, “Donors *bhane* (Donors say) ‘beggars can’t be choosers’” i.e. NGOs can’t control how long a project exists.

Within the context of the humanitarian project, care was temporally bound. There was a beginning and an end to care, which did not neatly align with the temporality of suffering for clients. This was patchwork care, in the same way some people in Kathmandu patched up the cracks in their concrete homes with putty and plaster, without rebuilding the structural damage beneath. But the counselors had nothing to do with the logic of humanitarian care within which they suddenly found themselves bound. For them it was a job, also transient, and they did what they could under

dangerous circumstances. Through the course of a given counseling session, care might be extended through touch or a certain turn of phrase, through the delivery of medication, through an insistence that one had improved, through a guided breathing session, through a concern over water intake, or simply through the acknowledgement that the counselor had traveled a great distance and suffered for them. Yet just as quickly, a moment of care and connection between counselor and client could disappear into disconnection, a touch could be withdrawn, a judgement could be made, and a face might turn away.

In the work of post-disaster psychosocial counseling three temporalities were braided together. The first strand was the temporality of care, defined by its transience. The second was the temporality of suffering, that often predated the disaster and would certainly outlast this transient care. The third temporality was that of karma, in which suffering was placed in a far longer duration. Clients would talk about their *dukha*, their suffering, as their karma. “Whatever is written we have to face it,” as Maya put it. In the Nepali language, shaped by Hindu philosophy, one's karma, or fate, is inscribed, written, *lekeko*, on your forehead at birth (*nidaama lekeko*). In such karmic understandings, experiences in the present are directly connected to actions done in a previous life (c.f. Desjarlais 2016). In the work of disaster mental health in Nepal, these three forms of temporality coexisted simultaneously, often in the same moment.

What did the disaster do to time and what were the varying temporalities of the disaster? During the temporality of emergency, the time and politics of aid was accelerated and yet little tangible aid was delivered on the ground in time. During this accelerated period, the government of Nepal finally passed its constitution after years of deadlock, but this event caused a political uprising among Madheshi groups in the southern Terai region on the border with India, who argued they had been rendered second-class citizens through the calculated redrawing of federal boundaries. In response, India “unofficially” closed to the border with Nepal for 6 months, halting all imports of

goods and creating another layer crisis. Additionally, a complicated bureaucracy for aid distribution called the Nepal Reconstruction Authority (NRA) was set up by the government, through which barely any aid for the rebuilding of damaged homes was distributed at all. A recent article published in *The Himalayan Times* in March 2017, now two years since the disaster, reported that of the \$4 billion that was pledged to Nepal in foreign assistance after the disaster, so far only one payment of \$450 had been distributed to qualifying families who lost their homes and have been inhabiting shelters of wood and corrugated metal since April 2015. These families have been promised a total of \$1,890 to rebuild their homes (Associated Press 2017).

Through her concept of “quasi-events,” the “forms of suffering that are ordinary, chronic, and cruddy rather than catastrophic, crisis-laden, and sublime,” Elizabeth Povinelli draws attention to the ways in which catastrophic events demand an ethical response while chronic forms of suffering do not (Povinelli 2011: 13). Yet the ethical and political demand to respond to suffering often evaporates once a situation is no longer deemed to be a crisis. As Povinelli writes,

Even tsunamis, earthquakes, and hurricanes that generate terrific waves of empathy and generate moral capital for those who demonstrate outrage leave in their wake a nonplussed public. When the waters recede and the ground stops shaking, empathy also evaporates as ethical sense settles back into doxic accounts of poverty, its causes and consequences (Povinelli 2011: 164).

As I followed other counselors into the field, a great number of clients seen were those who suffered from afflictions that had begun far before the earthquake occurred, but who only happened to receive care because they lived in an earthquake affected district. These were people who had been suffering all along from the slow disaster of poverty, from the mundane disasters of everyday life such as abuse in the family, from severe mental illness, from spirits or witchcraft, *boksi laagne/chhopne*, or from a combination of these. Because of the disaster, their afflictions had become temporarily visible, and in their brief visibility they received transient care.

CHAPTER 7

Evidence for Therapeutic Efficacy

In this chapter I continue to follow the work of post-disaster psychosocial counseling in Nepal, with a focus on the question of therapeutic efficacy. What can ethnography tell us about therapeutic efficacy in the context of transient care, and what might it offer to the discussion of evidence and the place of qualitative research methods in humanitarian and global mental health projects more generally? The idea that humanitarian mental health interventions are efficacious is the underlying justification for such projects, yet determining how to measure such efficacy remains difficult in these ethically sensitive, time-limited projects. Inspired by recent discussions of the importance of ethnography to the practice of global mental health (Kohrt and Mendenhall 2016), as well as critical anthropological analyses of evidence and metrics in global health (Adams 2016), in this chapter I discuss the differing ways in which evidence for therapeutic efficacy and improvement, a central concern for everyone involved in the post-disaster psychosocial intervention I followed, was understood, recognized, measured, and commented on by participants in all levels of the project. Here I do not intend to judge the efficacy of the work I observed but instead will explore how people themselves were attuned to the question of evidence. In doing so I hope to open a space for rethinking the problem of therapeutic efficacy in this particular milieu.

Throughout my work following the psychosocial counseling project, discussions of improvement and efficacy were often present, both between counselor and client, as well as among the counselors with each other and with their supervisors and trainers. By drawing on content taught to them in trainings, psychosocial counselors often tried to incorporate various technologies of measurement into their work in order to discern the degree of improvement in the client after their

intervention. Other times they themselves would exclaim, based on what they perceived in their client's outward appearance, that there had been improvement. Yet sometimes when clients seemed to be improved, psychosocial counselors also wondered—was it really due to their work or was the improvement caused by something else? In this chapter I trace these moments of outward reflection on therapeutic efficacy and improvement as they appeared in the midst of therapeutic encounters and afterwards in casual moments of discussion (c.f. Brodwin 2013). In doing so I am inspired by a phenomenological approach that teases apart the ways both perception and experience (in this case of improvement) are shaped in and through intersubjective interaction (Csordas 1994; Desjarlais 1997; Throop 2010b). By drawing on lessons from phenomenological anthropology to understand the question of evidence for therapeutic efficacy, I offer an example of the ways in which theoretical approaches in psychological anthropology are relevant to key issues in the rapidly growing field of global mental health.

Evidence in Global Mental Health

For the Kathmandu based NGO supervisors and the foreign project manager, the most important question at the heart of the project was always therapeutic efficacy. Everyone wanted to know what the counselors were actually doing on the ground and if it was really working. Were the counselors using the techniques they had been trained in correctly, or if not what kinds of “indigenous” techniques might they be using, the foreign project manager wondered. The counselors themselves also wanted to know if their work was efficacious and if they were applying their recently learned techniques correctly. It was with this problem in mind that I was invited to join the project, with the idea that by following the counselors into the earthquake affected villages and observing trainings for supervisors, counselors, and community psychosocial workers, I could help to communicate the gap between techniques trained, and techniques used in the counseling

sessions on the ground. Yet in doing so, I, not surprisingly, found that the precise identification of therapeutic efficacy was in no way straightforward. Should efficacy be judged in light of the overall intervention, or was it something that occurred in moments of interaction? In the context of psychosocial interventions, the question is further complicated by the difficulty of discerning therapeutic efficacy in the first place—what does efficacy actually look like in practice? In the field of Global Mental Health when psychosocial interventions are evaluated efficacy is measured through randomized controlled trials in order to measure efficacy and promote scientifically validated “evidence based treatment.” When evidence based medicine measures therapeutic efficacy, what exactly is being measured? How is evidence for efficacy defined? What does it look like? How does it become visible?

Recently the question of metrics in global health has come under scrutiny in anthropological circles. Leading this discussion is medical anthropologist Vincanne Adams, who has honed in on the championing of randomized controlled trials (RCTs) in global health interventions. In contemporary global health, interventions are designed in order to generate data that is capable of proving efficacy while also providing services to populations. This kind of intervention is markedly different from other development or humanitarian projects, in that it always incorporates a research component. Critical studies of global health have argued that an intervention designed in order to get data to prove efficacy and secure further funding is more interested in the production of “good numbers” than in the provision of care (Adams 2013). RCTs, for example, always require a control group, a population that receives no intervention and serves as a point of statistical comparison against those who did. As Adams argues, RCTs, which produce seemingly “objective” numerical data are valued by the field of global health over all other forms of information for their statistical power and assumed scientific objectivity which, in the audit culture of neoliberal governance, directly translates into a language of accountability to donors as well as justification for “scalability.” Similarly, such

numerical data can be easily extracted out of its local context for analysis (generally in other geographic locations) by experts who have minimal knowledge or experience of the local lived realities and who are able to generate their analysis without ever having to actually travel to the location in question (Erikson 2012). In this hierarchy of evidence, ethnographic research falls at the bottom of the pyramid and is generally dismissed as subjective, unreliable, anecdotal and otherwise ungeneralizable beyond the situation. Yet, as Adams argues, "...ethnographic research—because it enables a focus on single cases in all of their singular and idiosyncratic complexity but also because it enables a focus on other kinds of evidence writ large—produces empirical data that form not only an evidence base but an evidence base that is sometimes more truthful, proposing alternatives to the evidence-making from metrics work" (Adams 2016: 11).

As opposed to global health interventions, humanitarian interventions are not designed around the production of data for evidence based medicine but rather as time-sensitive, ethically charged projects to provide immediate relief. The idea of conducting a humanitarian intervention using RCTs is ethically questionable for it would require a control group—a similarly disaster-affected population receiving no care, or delayed care. In general, this issue is seen as a double bind from the perspective of Global Mental Health, for whom evidence-based knowledge is foundational (Bemme and D'souza 2014: 856). From the perspective of Global Mental Health practitioners, "it would be unethical not to conduct research and evaluations on MHPSS interventions in emergencies, given the need for more evidence in this field; while it would also be unethical to conduct such research without benefit to beneficiaries" (Tol et al. 2014: 394). Yet the ethical questions of the place of research in humanitarian settings remains open to debate (Blanchet et al. 2017). More recently, Kohrt et al., acknowledging this difficulty, have written that "a challenge in global mental health research is identifying research methods and statistical techniques to evaluate

interventions in settings that may not be amenable to randomized control trials (RCTs)” (2015).⁵¹

The issue of psychosocial support in humanitarian settings is discussed in Vikram Patel’s influential 2014 edited volume, *Global Mental Health: Principles and Practices*. Here the authors argue that one of the main problems for mental health and psychosocial support (MHPSS) interventions in humanitarian settings has been a mismatch between research and “concerns on the ground,” in which “the most rigorous evidence has focused on interventions and outcomes that have received less attention from practitioners, whereas the most popular interventions (e.g. counseling, structured social activities, psycho-education and awareness raising) have received little scientific scrutiny” (Tol et al. 2014: 392).⁵² For the authors, “scientific scrutiny” is shorthand for RCTs which would ultimately provide data for an evidence-based post-disaster psychosocial response. Additionally, this observation suggests that within the hierarchy of interventions, research has focused more on psychiatric interventions than community-based approaches.

When evidence based medicine measures a psychosocial intervention using a randomized control trial, what is measured is an individual’s score on a culturally adapted scale, often for a discrete diagnostic entity such as depression or anxiety, although other more culturally sensitive scales measuring “culture-bound disorders” or ethno-psychological entities have also been developed by anthropologically-trained Global Mental Health practitioners (Kohrt and Hruschka 2010). Participants in the randomized controlled trial are randomly assigned to either the intervention group or the control group. Before the intervention, all participants are administered the scale to establish a “baseline” for later comparison. Then the intervention is conducted with the intervention group, while no intervention is given to the control group. After a distinct period of

⁵¹ The authors argue for the use of Propensity Score Methods (PSMs) to evaluate the efficacy of humanitarian mental health and psychosocial support interventions.

⁵² Perhaps because it is easier to conduct RCTs of “specialized interventions” than of community-based support programs.

time (the intervention must be judged and cannot continue forever) all participants in both the intervention group and the control group are again administered the scale. The change in score for each group is compared, and the efficacy of the intervention is determined. Yet while efficacy can be proven statistically, little can be said about what specific aspects of an intervention were efficacious or how long the effects of the intervention will last.

But what of the place of ethnography as a way of producing data on therapeutic efficacy? It was with the possibility of the usefulness of ethnography and an anthropological approach to understanding question of therapeutic efficacy in mind that I was asked to join the project for humanitarian mental health and psychosocial support as an “ethnographic consultant” in July 2015. The foreign project director who had been living in Nepal for over two decades, had long been a champion of the incorporation of psychosocial components into development projects supporting economic livelihood. Mary was someone who believed in the innate importance of ethnography as a tool for improving the quality of interventions and facilitating cross-cultural translation in Nepal. In July I presented a preliminary paper on adolescent “mass-hysteria” in Nepal at the Social Science Baha conference in Kathmandu. Mary attended the conference, and approached me afterward to talk about practical applications of anthropology in the ongoing humanitarian psychosocial intervention that she had secured funding for through the development organization for which she worked. She said that the project needed someone who could do “thick descriptions” of the work of the psychosocial counselors. Her idea was that if such descriptions were made available, then they could be shared among the Nepali NGO staff and foreign trainers and they could discuss their interpretations of the material. She thought that this would make it possible to better understand the differences in perspective regarding what counts as efficacy in the intervention and the appropriateness of techniques used, instead of having merely herself or the foreign trainer decide from the outside what the definition of efficacy might be. Mary’s openness to the field of

anthropology and the practice of ethnography, her interest in facilitating dialogue and understanding different perspectives, and her willingness to let an outsider into a project with the possibility of witnessing its internal messiness, reflected her own interest in facilitating dialogue between practice and theory. Likewise, the research and writing that followed from this work could also be seen as an experiment in what such collaborative work could look like.

Phenomenology and/of Evidence

Phenomenology is also a method concerned with the question of evidence, one that a number of psychological anthropologists have engaged in influential studies of illness and healing, suffering, embodiment, and everyday lived experience (Csordas 1990, 1993, 1994, 2002; Desjarlais 1992, 1997, 2003; Desjarlais and Throop 2011; Jackson 1996, 1998; Throop 2003, 2010a, 2010b). Anthropologists following this approach of “phenomenological anthropology” draw from a range of theoretical insights introduced by phenomenological and existentialist philosophers such as Edmund Husserl, Maurice Merleau-Ponty, Martin Heidegger, Alfred Schutz, and Emmanuel Levinas, among others (see Desjarlais and Throop 2011). While psychological anthropologists who have taken up phenomenological approaches do so in distinct ways (with, for example, Desjarlais referring to his approach as “critical phenomenology,” and Csordas referring to his as “cultural phenomenology”) there is a shared concern with and close attention to the ways in which experience and modes of perception are given form and meaning intersubjectively. Cultural phenomenology offers a methodology and analytic through which it becomes possible to glimpse the process by which preobjective lived-experience of indeterminate phenomena (such as the somatic sensations of pain in the body) come to be experienced *as* a particular entity (such as an indication of sickness). This “seeing as” is known in phenomenological terms as *intentionality*.

Phenomenology is best understood as a study of phenomena, of things as they appear; the

word “phenomenon” comes from the Greek verb *phainein*, which means to show, to appear, to manifest itself. In this way phenomenology immediately orients us to the question of evidence, albeit in a manner quite different from a randomized controlled trial. Edmond Husserl, the father of phenomenology, is famous for describing phenomenology as going “back to the things themselves!” In order to get to “the things themselves,” Husserl advocated a method he called the *phenomenological epoché*. According to Husserl, in order to engage this method, one must attempt to suspend one’s taken-for-granted assumptions about things in the world by “bracketing” what he called the *natural attitude*. The *natural attitude* refers to the un-reflexive way in which people normally inhabit the world; by bracketing the natural attitude, the phenomenologist aims to destabilize the taken-for-granted meanings of things in the world and attempts to become aware of the ways in which things in the world are themselves objectified as such. As Desjarlais and Throop write, “...a central goal of phenomenological description is to destabilize those unexamined assumptions that organize our prereflective engagements with reality” (2011:88).

Applying this method to topics of research in psychological anthropology has resulted in an extensive corpus of literature that offers nuanced analyses of experience, especially experiences of suffering, affliction, and healing, in a range of sociocultural and linguistic contexts. Before offering my own ethnographic analyses of evidence for therapeutic efficacy in the humanitarian mental health project I followed, I will first summarize how phenomenological anthropologists have approached the complex questions of perception and experience.

In his influential 1990 article, “Embodiment as a Paradigm for Anthropology,” Thomas Csordas, drawing on the ideas of the phenomenologist Maurice Merleau-Ponty, begins by arguing that the body is the existential ground of culture. Applying Merleau-Ponty’s insights to anthropology, Csordas writes,

Phenomenology is a descriptive science of existential beginnings, not of already constituted cultural products. If our perception “ends in objects,” the goal of a

phenomenological anthropology of perception is to capture that moment of transcendence in which perception begins, and, in the midst of arbitrariness and indeterminacy, constitutes and is constituted by culture (2002 [1990]: 61).

Applying the insights presented in this foundational article, Csordas turns his theoretical framework to ethnographic cases. In his piece, “The Affliction of Martin” (1992), Csordas analyzes multiple interpretations of the afflictions of a young man, comparing interpretations from mental health professionals with those of Charismatic healers. By examining these two discourses alongside Martin’s descriptions of his embodied, somatic experiences of illness, Csordas shows the ways in which each interpretation is itself a cultural objectification of meaning, variously embedded in particular healing systems which understand Martin’s affliction as caused by either disease or demons. After comparing medical and sacred interpretations, Csordas turns to the phenomenological description of Martin’s embodied experience itself in order to describe his “preobjective world of distress” (Csordas 2002 [1992]: 126). Here “preobjective” refers to the everyday, spontaneous, yet still always already culturally influenced modes of engagement in the world. By turning to the phenomenological description of preobjective embodied experience, Csordas argues, it is possible to illuminate the existential ground of experience from which various conclusions and interpretations are drawn.

In his ethnography, *The Sacred Self: A Cultural Phenomenology of Charismatic Healing* (1997), Csordas further refines his study of embodiment, beginning (as before) with the understanding that the body is the existential ground of culture, the self, and the sacred. Here Csordas examines the embodied experience of Charismatic Christians in their encounters with the otherworldly, as they face afflictions and find healing through the “laying on of hands.” In this milieu, Csordas attends to the ways in which preobjective sensory experiences are objectified through intersubjective, culturally informed processes of reflection and discernment. As Csordas puts it,

Preobjectively, patients do not “perceive” a demon inside themselves- they of their own accord sense, or with the help of a healer recognize, a particular thought, behavior, or emotion as outside their control. It is the healer, the specialist in cultural objectification, who typically “discerns” whether a patient’s problem is of demonic origin. Also, preobjectively, patients experience “manifestations” as spontaneous and without preordained content. The manifestations are original acts of communication in a highly specified intersubjective milieu. Although they are existentially original, these acts nevertheless take a limited number of common forms because they emerge from a shared habitus, and it is participation in this habitus that allows the healer to recognize and objectify them as manifestations (1997: 226).

As seen in the excerpt above, Csordas combines Merleau-Ponty’s phenomenological insights on the body as the existential ground of culture, Pierre Bourdieu’s concept of *habitus* as a system of enduring dispositions generating practice, and Charles Peirce’s semiotics of sign function. Sensations felt by patients in their bodies are objectified and “read” as signs of particular demonic afflictions in the intersubjective context of healing with others who share the same habitus as themselves.

In his essay “Cultural Phenomenology and Psychiatric Illness,” Csordas outlines a practical method for attending to the “intersubjective influence” on experience in which he suggests that one should attend to 1) word choice, 2) surprises—which reveal taken for granted ideals different from those of the interlocutor, 3) affect and tone, and 4) reflexivity. Here he emphasizes that “the critical point in this endeavor is that the ‘phenomenon’ of interest is not a psychiatric disorder, for the nosological denomination is an abstraction from lived experience. Neither is it a symptom, because the phenomenon described as a symptom was likely already present before having been identified as a symptom. What is at issue is the modulation of phenomena that exist for a person, where the description of these phenomena sheds light on the nature of affliction” (2015: 119).

Robert Desjarlais’ work exemplifies another approach in this line of phenomenological anthropology, which he calls “critical phenomenology.” In *Shelter Blues* (1997), an ethnography of everyday lived-experience among the homeless mentally ill in a Boston homeless shelter, Desjarlais examines the epistemological and ontological status of the concept of “experience.” Desjarlais argues that epistemologically, anthropologists writing about experience have often equated it with

authenticity and truthfulness, a romanticized ideal placed in opposition to “less authentic” discursive or model-based modes of analysis. As Desjarlais writes, “the problem with taking experience as a uniquely authentic domain of life...is that we risk losing the opportunity to question both the social production of that domain and the practices that define its use” (1997: 12). In this way, according to Desjarlais, “experience” as a cultural concept (with its connotations of authenticity, interiority, experiment, test, or of undergoing an event) must also be “bracketed” in order to allow for a true phenomenology of experience.

To bracket “experience” in this way, Desjarlais argues, is also to reveal the underlying linking of authenticity and individual interiority that is itself a cultural construct arising from the Western humanist tradition. “Experience is thus the fodder for the kind of psychological developments or becomings that have characterized ideas of personhood in Europe since the Old Testament at least” (1997: 17). As Heidegger writes, “to undergo an experience with something—be it a thing, a person, or a god—means that this something befalls us, strikes us, comes over us, overwhelms and transforms us” (1997: 16). All this is to say that Desjarlais, in bracketing the concept of “experience,” goes on to argue that the form of everyday lived-experience and way of being-in-the-world found among the homeless mentally ill in Boston is not that equated with adventure, interiority, or the sense of having undergone an event, but one of “struggling along.” The idea that certain persons might not “experience” but instead “struggle along” is a radical one, which could be read as dehumanizing, yet it is also from this point of difference in ways of being-in-the-world that Desjarlais argues for the need for a “critical phenomenology” that goes beyond phenomenological description to analyze how it is that such radically different forms of lived-experience can exist in the first place. According to Desjarlais, a “critical phenomenology” should therefore aim to link processes of feeling and perception to the cultural and political context out of which they are generated.

A critical phenomenology...can help us not only to describe what people feel, think, or experience but also to grasp how the *processes* of feeling or experiencing come about through multiple, interlocking interactions. Such an approach is phenomenological because it would entail a close, unassuming study of ‘phenomena,’ of ‘things themselves’ –how, for instance, people tend to feel in a certain cultural situation. But the approach is also critical in that it tries to go beyond phenomenological description to understand why things are this way: to inquire, for instance, into what we mean by feeling, how it comes about, what it implies, and what broader cultural and political forces are involved. In addition, the phenomenology is a critical one because it tries to take into account the makings of its own perceptions. (Desjarlais 1997: 25)

Building on these prior debates in phenomenological anthropology, in his book *Suffering and Sentiment* (2010b) Jason Throop further addresses the question of “experience” in the context of chronic and acute pain sufferers in the Micronesian island of Yap. Here Throop critiques the ways in which anthropologists interested in the question of experience have often focused only on its fully articulated forms. As he argues, in “looking for certainties, coherences, and structures we have often overlooked the ambiguities, the confusions, the gaps, and the ambivalences that arise in the midst of our own, and our informants’ experiences as lived” (2010b:3). In this way, Throop addresses the complex, intersubjective dimensions of experience by focusing on the question of how experience is articulated, and “how processes of meaning-making are implicated in the articulation of experience and ensuing objectification” (2010b: 9), such as the ways in which somatic experiences of pain begin as indeterminate phenomena and are given moral valence through a process of objectification, in the midst of intersubjective interaction. As Throop explains,

By articulation, I am referring here not (at least primarily) to the capacity to communicate to others the contents of one’s subjective life through various expressive forms including language. Rather, I am referring to the ability to give what may otherwise be indefinite or ambiguous varieties of experience a definite form through symbolic and embodied means (2010b:8).

In examining the ways in which vague, unarticulated experiences of pain are transformed into meaningful experiences, Throop offers a microanalysis of a case in which ordinary pain

“experienced as ‘mere-suffering’ from the perspective of the sufferer, presented opportunities for the healer and her parents to attempt to shift her frame of reference to understanding her suffering in light of a ‘-for’ structure” (2010b: 236).⁵³ This shift in framing of suffering (from “mere-suffering” to “suffering-for”) can be identified within the language of the interaction, as “indexical markers of cultural virtues” (in this case the Yapese virtue of endurance, *m’athamagil*) are used to guide the patient through her experience of pain while providing a structure for the experience. The scene presented is one in which a young girl is undergoing a painful bone-setting. While she screams in pain, her father repeats the command *m’athamagil*, you endure, and in doing so indirectly indexes the cultural virtue of endurance, in which the moral person is defined through her ability to endure suffering for others. The command, “you endure,” is a speech-act intended to have an effect on the listener. Through a careful linguistic analysis of the transcript of the bone-setting, Throop clears a path toward a form of phenomenological analysis of indeterminate experience as it is articulated and given moral meaning in the midst of intersubjective interaction.

In sum, what could a phenomenological approach bring to the question of evidence for therapeutic efficacy? Csordas’ “cultural phenomenology” and his focus on embodiment is useful as it orients our attention to the process in which preobjective somatic sensations come to be objectified, or seen *as* meaningful entities. By drawing our attention towards such processes of objectification, it becomes possible to examine the ways in which perceptions of therapeutic efficacy, which may or may not be shared by the client and the counselor, become objectified as evidence. Likewise, Desjarlais’ critique of the concept of “experience” and the importance of critical phenomenology is relevant to the case at hand regarding the question of evidence for therapeutic efficacy, in that the same exercise of bracketing can be done with the concept of “evidence,” therefore opening up a new line of anthropological inquiry into the epistemological and ontological

⁵³ Here Throop is drawing on Emmanuel Levinas’ concept of “mere suffering.”

assumptions behind the concept itself. If we bracket “evidence,” as it is generally known by global mental health, it becomes possible to rethink what might count as evidence, how it is produced, and what it is assumed to be. Additionally, Desjarlais’ notion of “critical phenomenology” can be applied to the question of evidence for therapeutic efficacy as we examine the cultural and political forces at play within the therapeutic interaction in which perceptions of improvement are negotiated and measured. Finally, Throop’s examination of the “articulation of experience” is one that directly applies to the question of therapeutic efficacy, as clients were asked to communicate indeterminate experiences of affliction and improvement through symbolically mediated forms of measurement. In the remainder of this chapter, I will employ a phenomenological approach which draws on these insights to explore how perceptions of improvement (an indication of therapeutic efficacy) were objectified and made visible in intersubjective interaction between client and counselor, through the use of technologies of measurement.

Measuring Efficacy

In December 2015 I sat in a hotel in Naxal, a busy neighborhood in the center of Kathmandu. I had come to attend a training meeting for the psychosocial counselors from the counseling project. It had been six months since the project began, and the (multiple) donors were calling for the final reports before ending the work. There was talk of the possibility of some of the donors renewing their projects for an additional year, which did ultimately happen, but at this point this was not known by the NGO staff. That day one of the NGO management staff, Vishnu Sir, came to talk to the counselors about “quality reporting.” We sat in a circle of chairs around the edge of the room, the sounds of traffic permeating the carpeted room. Faded framed posters of mountains decorated the gloomy walls. “*Report kasari lekne?*” “How do you write a report?” Vishnu Sir asked the group. The counselors volunteered topics that should be included, and Vishnu Sir

noted their answers, in a mix of English and Nepali, in a list on a white board that stood in the front of the room.

Quality Report:

Kam ke ho (what is the work)

Pristabhumi (background)

Objective

Activities

Method

Achievement

Upalabdi (challenges)

Learning

Analysis

Recommendation

Conclusion

Vishnu Sir then asked the counselors to define “quality report.” Indira responded, explaining “*achievement kati bhayo, ani tespachi ke ke challengebaru ayo, hoina? Ani tespachi, analysis...*” “How much achievement there was, and after that, what kinds of challenges came, right? And after that, analysis...” Vishnu Sir explained that up to that point, there was only data measuring output, “*output matrai bhayo,*” but that now they needed to understand the outcome. “*Qualitative kasari banaune?*” *How do you generate qualitative data?*” he asked the group rhetorically. He said what was needed was *pramaan*, evidence.

Vishnu Sir explained that *pramaan*, evidence, was needed in order to justify what the

counselors wrote in their reports, because without evidence one could also write lies, “*maile jutbo pani lekedinasakchu, hoina ta?*” With this problem in mind he asked the group, “*evidence-based kasari garne? Evidence-based hunuparyo.*” How do you do [make the report] evidence-based? It must be evidence-based.”

Evidenceko lagi hami sanga data nai hunuparne ho. Data, bandakberi numbers bhayo, hoina, ani hami kati wota session gare pani data hola, kun kun tao ma gare pani hola, kati patak gare pani auncha hola, counseling individualma garyo, familyma garyo, groupma garyo...observationma ke aye? Observation important huncha—ke paribartan dekhe?

For evidence we must have data with us. When one says data, it means numbers, right, and how many sessions were done also could be data, in which place was the work done also could be data, how many times it was done could also come as data, was the counseling with an individual or with a family or with a group, and what observations came? Observation is important, what changes did you see (in the client)?

Evidence was required for the purpose of reporting to the donors and communicating the quality and efficacy of the intervention through written proof. This need is also connected to what Marylin Strathern has termed “audit cultures,” in which accountability is increasingly required in order to justify funding (Strathern 2000). Maintaining funding was of course a real and pressing concern for the NGO, because without donor funded projects, the staff had no source of income. And so the reporting done by the counselors took on a role of critical importance, motivated both by a concern for the client's wellbeing and for the maintenance of financial support for the organization. Yet the production of “quality reports” was not an easy task. Reporting was something that counselors struggled with, particularly when they tried to recall exactly what methods they used in their intervention, how the client's “behavior” changed over time, and what could be evidence for therapeutic efficacy.

Uncertainty over the cause of a client's improvement, the possibility of efficacy of *dhami/jhakeris*, traditional healers, and the problem of measuring therapeutic efficacy was something

that Bina directly reflected on to me in conversation. “While doing follow-ups, people say that they have gotten better and recognize the work done by our organization,” Bina explained. “I feel good when they say that it has helped them quite a lot. I sometimes wonder if it is really me who has helped them because I don't have much experience. When they thank us, I sometimes find it hard to believe that they got better because of us. When they thank our organization, at times I doubt if it was really because of us or not...We don't have anything which can accurately measure the work that we do. They are treating themselves with *Jhakris* (healers) as well.”

In the last chapter, I began to describe moments when clients and counselors would talk about improvement during the counseling sessions. Indira exclaimed “you are 50% improved” or that someone’s face “looked bright,” or a client would repeat again and again how he much taking an anti-psychotic medication had helped him, and that with more medicine he believed he could be cured. Clients would often comment in conversation that they felt the counseling was helping them to improve, as they described how certain symptoms had begun to recede after meeting with the counselor. As I described earlier, I recorded these counseling sessions, after receiving the informed consent from clients, in order to produce a corpus of data that I could share with the NGO. This was used in the supervisor training workshops held throughout the project period as a way to identify areas for improvement, further train techniques, and stimulate discussion and reflection on the work of the field level counselors by the Kathmandu-based supervisors. After selecting some films of counseling sessions to share with the foreign psychologist, we met with one of the supervisors who helped to translate the material for her.

After watching the films, one of the issues focused on was that of discernment of improvement and therapeutic efficacy during the sessions. The foreign psychologist began to discuss ways that the counselors could better understand their client’s experience of the usefulness of the sessions, instead of merely offering their subjective evaluation by stating, for example, that “you

have improved 50%”. This idea was heavily trained during the workshop for the supervisors, and was then imparted to the counselors in trainings by the Nepali supervisors. After these additional trainings in Spring 2016, the counselors were taught to take measurements of their client's perception of his or her own improvement and they began to incorporate the use of scales into their counseling sessions. They would ask the client to rate things on a scale of 0-10, including how much the client felt he or she had improved, what percentage of illness remained, and even how much the client liked the counseling session itself. “But what if the client is illiterate and doesn’t know how to recognize numbers?” a counselor asked during a training. This question seemed to anticipate the complications in certain attempts to render experience in discrete abstract terms among people who might not be accustomed to doing so. Prompted by the question, the Nepali supervisor instructed the counselors to go out and collect other objects that could be used as a scale during the sessions. The next day the counselors came back to the training hall, presenting rocks and sticks of various sizes. Indira brought three balloons, which she inflated in decreasing sizes. But in general, counselors were instructed to draw a line on a sheet of paper, marked by the numbers 0-10 to present to the client before and after a counseling session as a way to gauge the client’s perception of his or her own improvement over time, as well as the perceived usefulness of the session that day.

“How are you feeling now?”

Following the work of Anjana in April 2016 I met a young Dalit man who described multiple experiences of extreme paranoia and a history of somatic pain. Like many other clients seen in the program, his afflictions also stretched back to a time before the disaster. The client, who I will call Vishal, was the youngest child of ten. At the time of the meeting he was 26 years old, seven years married with a two-year-old daughter. He lived with his parents, a normal arrangement, but his wife had left him, taken the child, and moved to Kathmandu. He had passed his School Leaving Exam

(SLC), and peppered his Nepali with English words. Vishal wore clean, new clothing and appeared healthy and well put together. Yet as with the other clients seen in the earthquake counseling program, I was able to learn little else about Vishal as I met him only once and soon moved on to the next village, following the schedule of Anjana, the counselor. As with the other clients, during the counseling session there was never any mention of Vishal's diagnosis, nor specific discussion of the name medication he had been prescribed by the NGO. Vishal had not brought his medical file with him that day and Anjana did not know what medication he had been prescribed by the NGO's psychiatrist.

We first met Vishal at the home (a temporary shelter of tin and wood) of the local community psychosocial worker (CPSW), where we were preparing to eat lunch. Vishal had walked at least one hour to reach the counselor that day. It was their third meeting. The CPSW also offered the client food, which he accepted, but as the CPSW was Brahmin (high-caste Hindu) and the client a Dalit, he was not invited into her temporary shelter to eat. Instead he ate his food outside, sitting on a stool that the CPSW had given him. I decided to sit with Vishal outside, in an attempt to communicate my disapproval of the arrangement, as well as to escape the hot, smoke-filled space of the temporary shelter. After Vishal ate, Anjana gave him water and he washed his own plate, bowl and cup, which was expected of him as a way to avoid "polluting" those from a higher-caste. Such forms of tacit caste-based discrimination were common in the field, and despite the fact that the counselors themselves did not approve of this form of behavior, they also did not intervene when these types of incidents occurred between local field level staff (CPSWs) and community members.⁵⁴

⁵⁴ Another example of caste-based discrimination in the field: In Dolakha district, one of the local CPSWs had been born into the Brahmin caste but married a Dalit man in a highly controversial fashion. Henceforth she became a Dalit in the eyes of the community. When the counselors and I travelled to her village as part of the post-disaster psychosocial counseling work, we would always stay in the home of one of the village *netas*, leaders, himself a high-caste Hindu from the Chhetri caste. When having meetings with the CPSW, she was not allowed to enter the home of our host, so all work had to be discussed outside.

After lunch we walked to the still-standing, badly cracked community building where Anjana would conduct the counseling session. Anjana and Vishal sat facing each other in plastic chairs. He proceeded to narrate the story of his affliction, which he said began in the year 2000 in the form of chronic sinus problems caused by cold weather (*chiso*) and “invisible, evil reasons,” *adrisya, bigarkeo karan*. When Anjana asked him what he meant by “invisible reasons” he replied, “*adrisya* means there was *jadu, tuna*, black magic, spells. People don’t believe in these things as this is the 21st century. But still these things exist. That’s why the medicine was not working on me.” He told us he had travelled to multiple private and public hospitals in Kathmandu to receive biomedical treatment for his sinus problems, but no physiological cause was found. “Then it was found out that it was revenge from a girl,” he explained. Vishal then told us about a romantic relationship with a girl from his district that had ended badly. According to him, his problems began six years earlier when black magic and spells, *jadu, tuna*, sent to him by his ex-girlfriend had caused a doctor in Kathmandu to give him a dangerous and poisonous medicine. From that point on, he became convinced that people were trying to kill him. “...she gave me the medicine saying it was sinus medicine but actually it was a medicine which stops the function of nerves, *naso*, and makes you weak, *kamjori*. That medicine makes your brain isolated (*dimaag ekoboro hune*). It was called ‘Evasion’ and was imported from America. An American company manufactures that medicine. You can write down the name –Evasion 500mg....She gave me that medicine and it made my nerves weak, *naso kamjori* which made my brain heavy. I used to think a lot, I was unable to fall asleep and my nerves became weak. So after that, the mental problem arrived, *manasik samasya aipugecha*.”

Vishal experienced the origin of his affliction as being intertwined with a story of love, a deep romantic relationship that had grown over a year of clandestine letter writing between them, a common form of romance especially in an era before the wide use of social media in Nepal (Ahearn 2001; c.f. Varma 2016). When the girl’s family found out about their correspondence, they put an

end to the relationship and arranged a marriage for the girl with someone else. After this event, Vishal described feeling afraid that her male family members would come after him, a fear so intense that it led to a breakdown in the district headquarters in which he was convinced her family members were trying to kill him. He ended up in the district hospital where he was given an injection and sedated.

After this incident, Vishal began to slowly improve and went to Kathmandu to work in construction. Seeing he had become more stable, his father arranged for him to get married. “I didn’t want to get married,” Vishal explained. “When I told my father that he said ‘everything is fixed (*tika thalo bhayo*) so now you cannot say no’.” Despite his protest, the marriage took place and soon after his wife became pregnant. But the marriage was an unhappy one, and Vishal soon left the village again to return to work in construction in Kathmandu. In Kathmandu, Vishal came in contact with a church program in Jawalakhel, a gentrified neighborhood in Lalitpur that is popular with foreigners. Vishal was told that if he became a Christian, he would be healed.

“So I went to the church program in Jawalakhel. It was 2070 (Nepali calendar, 2013 Gregorian calendar). A speaker from a foreign country had come. The program was about healing and illness. So one sister (*didhi*) told me that if that person puts his hands on you, then your illness will be cured. Though I had been taking medicine since 2065 (2001), I went there. There he gave speeches in English where he said that all skin diseases and mental illness will be cured. He said that all the chronic diseases, nerve problems will be cured and there is no need to have the doctor’s medicines. He put his hand on my head and he managed to make me fall down...other people were also falling down when he put his hands on them. He was showing a lot of invisible work there through his power, *adrisya kam dherai dekhaeko thyo shaktile*. Many people were carrying their sick family members and bringing them there. Many disabled people were brought there...He put his hand on my head and used some oil on my forehead. Then I fell down. He said in his language that I am a pure soul. All the people who were on the stage fell down. So I thought that I was healed and cured. So I left the medication. After three months, my problem started again. When it started again it was worse than before.”

After Vishal’s brief exposure to charismatic Christianity, which he described as “superstition,” *bismash* (lit. “belief”), Vishal returned to the Hindu religion but continued to feel he was being tortured by an “invisible power” in the form of black magic, *tuna lagaune*. Anjana asked him to

describe how he found out he was the target of black magic and what an attack physically felt like.

“They shoot me with arrows,” *ban bandine*, Vishal explained.

“How do they use arrows?” Anjana asked.

“I get a stinging and pinching in my body,” *jiima ghocne*, Vishal replied.

“What kind of arrow is it?” *thyo ban kasto kal ko?* Anjana asked.

“It does not have any shape. You just feel something evil come, *ke keharabai ke auncha*, as if someone has left something in your body. Then you can also feel it in the body as it starts to give stinging pains and burning sensations. People who do black magic and play with spirits, *bhut pret kebelanne manche*, have done something bad to my body. If I eat something in front of those people, then I get sinus pain...this is happening because they did something with my food. But I get stinging pain and burning sensations in my body even when all the doors and windows are closed. While I sleep under my blanket, I get those stinging sensations, I feel as if someone is pricking my body with needles.” He explained.

“I still don’t understand,” Anjana replied, “How do they put something in your food?”

“Once I went to buy vegetables in Kathmandu. That person came and looked at my vegetables. I was buying it at the regular vegetable shop from where I generally buy my vegetables. So when I ate those vegetables that he looked at, I was vomiting until midnight.”

Vishal continued to explain that his sickness was caused by people who “do magic and play with demons (*bir kebelanne*).” Pressing him further, Anjana asked “what do you mean by *bir*?” Ram replied, “*bir* is an invisible power, any soul of a ghost that exists in this world, that is *bir (bir bhanne chahi yo sansarma kebi adrisya shakti, pret aatma yo baneko bir)*. Although Science says that such things cannot exist, we say that such power exists, we who have experienced it.” (*Sciencele alikati hamilai ‘hoina hudaina’ bancha tara Sciencelai pani ‘thyo huncha rabecha’ hamile anubhab gareko*).

“How did you experience it?” Anjana asked further.

“I saw it in a dream. It is a small thing with big teeth all over it. It looked like a dead crocodile head. They call it *daree bir*, tooth demon. Those people spell magic through these *bir*,” Vishal explained.

After discussing the topic of invisible power at length, Anjana changed the subject to the efficacy of medication. Since the Nepali month of Ashad (June/July), Vishal had been prescribed medication from the NGO psychiatrist, and Anjana wanted to find out if the medicine was helping him. “My problems will not be cured by the medicines only,” Vishal explained. “My nerves are already dried up, *sukeko*, they are almost dead and my brain is barely functioning. But that medicine is helping to make my body swell and to reopen my shrunken nerves. It is helping me to fall asleep and it has helped me to get my appetite back. I talk a lot and it is also helping me to talk less.”

Anajana, drawing on a technique of systemic therapy-inspired questioning she had been taught in a training, asked Vishal what he thought he would be like if he stopped taking his medication. Vishal replied that he had been doing yoga for a few months and that “even if I am taking the medication, 50% of my health has improved because of yoga.” Anjana responded, “I also feel you have improved a lot. You look very good now. Compared to the time when I first met you, you have gained some weight and your face looks much brighter now. Am I right?” Vishal agreed with her observation, but then continued to discuss his fear that people are trying to harm him with “invisible power,” magic, and witchcraft, and explained that he had recently spent Rp 15,000 (about 150 USD) on a puja, for which he had sacrificed multiple animals after which he had stopped taking his medication, but that again the sensation of stinging and burning arrows had returned along with sleeplessness, so he started taking his medication again. In response Anjana explained that he should feel free to seek any treatment that makes him feel better, whether yoga or puja, but that he should not discontinue his medication. Vishal agreed that he would not stop taking his medication, regardless of the other treatment options he sought out.

Then Anjana suddenly shifted topics and decided to elicit Vishal’s perception of the day’s

session. “How are you feeling now?” she asked.

“I feel light, *baluka*, as I could talk about many things,” Vishal replied.

“You said you feel light. What does “light,” *baluka*, mean?” Anjana asked.

“I could share my feelings. You took it all in a very positive way. So I feel comfortable.”

Anjana then produced another piece of white paper, drew a horizontal line and numbering it from 0-10, asked Vishal to rate how he felt about the day’s session. She told him that it could be good or bad, and that he could even rate the session below zero.

“I really think it was good—(lit. from my heart mind, it is feeling good)” (*thig chha man dhekkei nai ramro lagecha*) Vishal told Anjana.

“When you say ‘good,’ where do you rank it on this scale of 0 to 10?” Anjana pressed further, showing him the paper.

“I feel it has reached from 1 to 10 now,” Vishal replied.

Moving into the end of the session, Anjana then handed Vishal a white sheet of paper and a pen, and explained that she wanted to do an exercise. She then asked him to draw and measure the percentage of his problems he felt had been caused by *jadu, tuna*, black magic and witchcraft, “how much do you feel is in your life, in your body?” (*kati chha jasto laagcha tapaiko jivanma, sarirma?*).

“Shall I start with the *bir*, the demon, problem?” Vishal asked, as he began to draw lines on the sheet of paper. Observing him with a satisfied expression, Anjana praised Vishal’s handwriting. Carefully drawing the X and Y axis of a Cartesian plane, Vishal created a bar graph. Showing Anjana, he explained, “90% of my illness is due to *jadu tuna*, black magic. After doing yoga, I have improved by 50%.”

“So 40% of the problem is left in your body?” Anjana asked.

“Yes. 40% is left,” he replied.

Turning the activity of measurement into an opportunity for reflection, Anjana recreated

Ram's rendering on her own paper, drawing two circles, one large and one small, and labelling them "60%" and "40%," respectively. She then asked Vishal, "So, now do you want to increase or decrease this 40%?" "I want to reduce it," Vishal replied. "How do you want to reduce it?" Anjana asked. Vishal replied that he would like to continue taking his medication, and that he planned to visit a *maataa*, a female healer, in Kathmandu because of the influence of black magic.

Discussion

What happens when you ask someone to translate their experience into a numerical, discrete form of representation? What is created in the asking? What is transformed in the process of communication? Vishal's story, as it was told throughout the counseling session, is one of many examples of the messiness of illness experiences that I encountered while following the counselors into the earthquake-affected communities. This messiness was always present as people recounted their stories of affliction, and yet it often escapes representation in the smoothed over forms of accounting required by donors.

As Vishal pieced together the narrative of his experience of affliction over the past ten years, we learned that this was not the first foreign intervention he had come into contact with; in Kathmandu he had gone to a church where foreigners promised healing and tried to cure him with the laying on of hands. This points to the fact that Evangelical Christianity is becoming common in Nepal, as missionaries from the United States, Korea and elsewhere increasingly come to the country to convert people. Many of those who convert to Christianity are Dalits, for whom leaving the Hindu religion also entails a refusal of the caste hierarchy, although this is not necessarily the only or even main reason for possible conversion, as we can see in the case of Vishal.

Yet perhaps the most startling dimension of Vishal's narrative was his reflection on magic and science and the question of belief, specifically the ways in which he talked about his experience

of magical affliction and rendered them on the page. Throughout the session, Vishal continuously mixed the two opposing domains, science and magic, together. This culminated in a final measurement of his experience of affliction by black magic and witchcraft. As Vishal rendered his experience of magical affliction in the language of scientific measurement, he graphed his experience and divided his suffering and healing neatly into discrete measurements. In this way, he worked to translate his experience of suffering into a language he deemed appropriate to the intervention, and which the counselor herself had requested and then praised. Vishal's continuous reflexivity regarding the existence of magic and its scientific critique appeared throughout the interaction, indicating that he was always already anticipating the perspective of his interlocutor, Anjana, as well as myself, who he may have assumed would deny his belief as superstitious, as he recounted his experience.

When Vishal spoke about science and magic, he said literally, "although Science says that such things cannot exist, we say that such power exists, we who have experienced it." (*Sciencele alikati hamilai 'hoina budaina' bancha tara Sciencelai pani 'thyo huncha rabecha' hamile anubhab gareko*). Here "Science" is imagined linguistically as an entity in conversation with and opposed to "we who have experienced." This "we" includes Vishal and unnamed others, who argue that because they have experienced the effects of magic and witchcraft, they are sure of its existence. Here *anubhab*, experience, serves as a form of proof over and against "Science."

Throughout Vishal's session, Anjana refrained from overtly challenging Vishal's experience of magical affliction and instead questioned him about the nature of his experiences of affliction in detail. This questioning could be taken as a more covert form of skepticism on her part, as a mode of interrogation of the idea of magic in which its impossibility is exposed through an inability to answer the question. This tactic was something I observed in other counseling sessions with other counselors as well. In the end, Anjana entered into a form of questioning that was almost phenomenological in nature, as she asked Vishal to describe his embodied experience of magical

affliction, inquiring into what the experience physically felt like, and what he meant by *bir*, demons.

Phenomenology is concerned with how objects appear, and in our case we are interested in how the object (evidence for therapeutic efficacy) appears, in the midst of intersubjective interaction. The use of the scale enabled a shift in the counselor's perception of the client's experience, in which suffering was given a representation in the language of formal objectivity. The scale was an instrument through which improvement was made visible, even tangible, as it was drawn onto the page. The evidence itself was a product of the intersubjective encounter. The subjective world of the client was translated into a graph, by the client, for the counselor to read and therefore come to know about. It was also directed by the counselor through the suggestion of a particular form of measurement. In some cases, it was not clear whether the clients were familiar with this form of abstract quantification of suffering and improvement. In rendering improvement visually (and therefore in making the improvement visible), the client engaged in a form of translation from his perception of improvement to a graphic representation of it. Yet what is striking and somewhat ironic in this case, is that the client proceeded to create a Cartesian graph of his suffering, labelling the percentage caused by black magic and in this way managing to escape a Cartesian logic while also participating in it. Vishal was thus able to accommodate the objectification of his affliction into Cartesian coordinates, and yet still seems to escape this form of objectification. Ethnography also allows for a close analysis of how the tools of measurement are brought to the field, how they are used, how they are negotiated in the therapeutic encounter, and what escapes measurement or turns such measurement on its head.

CONCLUSION

The Work of Disaster

In August 2017, as Hurricane Harvey was touching down in Texas, and floods and mudslides inundated Freetown, Sierra Leone, in Nepal districts across the southern Terai region were hit by massive flooding caused by the heaviest rainfall in over 15 years.⁵⁵ While the 2015 earthquakes had primarily affected the hill districts of Nepal, which were still rebuilding over two years later, in August 2017 the disaster struck the southern plains, washing away over 40,000 homes, displacing over 100,000 people, destroying vital crops at the height of the growing season, and killing at least 161 people (UNICEF 2017). The flooding was not contained to Nepal alone, but affected 41 million people across Bangladesh, India and Nepal combined, claiming the lives of 1,000 people (Gettleman 2017). In my inbox, I received a newsletter from IsraAID, an Israeli humanitarian organization I had followed after the earthquake, requesting donations to support their emergency flood relief activities in all three disaster zones—Texas, USA; Freetown, Sierra Leone; and Saptari, Nepal. In each location, they reported that their teams were providing psychosocial support, in addition to debris removal, hygiene solutions, and the distribution of “dignity kits.” This was another instance of disaster and its transnational humanitarian psychosocial response that had created the conditions for my field research.

In 2014, I came to Nepal to study the multiple discourses, experiences, and treatments of *chhopne*, “conversion disorder,” and “mass hysteria,” with the hope of contributing to an understanding of the politics and practices of the cross-cultural translation of psychiatric categories.

⁵⁵ In Nepal, such flooding, while extreme, was not new to the southern region but part of a situation of recurring disaster. Three years earlier, in August 2014, heavy rains had inundated the Terai districts of Dang, Surkhet and Bardiya, setting off flooding and a series of landslides that killed over 100 people (AFP 2014). Prior to that, in August 2008, torrential rains caused the Koshi River burst through a poorly maintained dam, resulting in the Bihar Flood that displaced more than 3 million people in India and 100,000 people in Nepal (Catholic Relief Services 2008).

I had intended to draw on this research to contribute to recent debates both within and outside academia regarding the importance and viability of increasing global mental health initiatives in low and middle-income countries (WHO 2013). These debates considered both the serious need for mental health services for the mentally ill in places like Nepal, and questioned the possible ramifications that an increased exportation of psychiatry and psychotropic medication to the “developing” world might entail. When I found myself in the midst of disaster, my original focus on translation of psychiatric categories became amplified by the urgency of humanitarian interventions in Nepal. In the aftermath of the disaster, I watched as the lack of mental health services in Nepal was taken up as a topic of critique and debate in the public sphere.

After the disaster, the object of my ethnographic research expanded from a form of collective affliction among adolescent girls and its psychosocial management, to the collective affliction of a nation and its transnational psychosocial humanitarian response. The framing of the research expanded to reflect not only on the history of mental health care in Nepal, but to place it into a broader global history of health development agendas, humanitarianism, local political change, and the circulation of experts. Yet throughout these expansions, the focus on intersubjectivity and face-to-face interaction remained as an entry point for my inquiry into formations of affliction and care in contexts of insecurity, inequality, and psychosocial intervention.

The framework of the dissertation was animated through the conceptualization of the *work of disaster*. This “work” refers to what was reorganized, made visible, made to emerge by the event and its conceptualization as a major crisis. It also refers to the tremendous labor set into motion. Throughout the dissertation, I have tracked this work of the disaster across various sites and scales. Prior to the earthquake, mental health was not a central issue of concern. The disaster and its humanitarian response brought resources for mental health, and through the framework of “building back better” initiated further development of the mental health system. As actors within

the humanitarian response flooded the 14 affected districts with services and resources, mental health and the suffering of communities became visible as a public issue. An unexpected outcome of these interventions was the new visibility of people suffering from chronic mental illness and problems that far predated the disaster, many of whom received care for the first time because they happened to live within the disaster zone. Even the once obscure affliction—“mass hysteria”—gained visibility in the aftermath of the disaster as it was taken up as a topic of discussion among the humanitarians in the psychosocial working group and the mental health sub-cluster meetings. As a result, a school in an earthquake-affected district received multiple interventions for a case after the disaster, despite the fact that the problem had started long before the earthquake. The work of the disaster also left its mark on ethnography, as it reconfigured “the field,” requiring new forms of anthropological engagement and ethnographic attention to emergent phenomena.

In order to contextualize historical shifts as conditions of ethnographic production, in the first part of the dissertation I traced the history of psychiatry and mental health intervention in Nepal in relation to the shifting agendas of global health development agencies. The aim was to historicize psychosocial intervention and mental health governance in Nepal, and to show the ways in which this field has developed within an assemblage of local politics, trends in global health development, and the circulation of experts. I argued that Nepal has served as an important site in the production of knowledge for the field of global mental health, providing data, case studies, and evidence, and has served as a node through which experts in the network of global mental health have circulated. As such, the history of mental health governance in Nepal provides a clear lens through which to trace the emergence of the global mental health movements, its ideologies, and interventions.

In the second part of the dissertation, I worked through concepts to address the question of adolescent “mass hysteria” in Nepal. The aim was to deconstruct this form of affliction through its

varying conceptualization as “hysteria,” “conversion disorder,” and/or *chhopne*, *bhut/pret/pissach laagne*. In Chapter 2 I described psychiatric discourse and a psychosocial intervention for the affliction interpreted as “conversion disorder,” and the ways in which this conceptualization of symptoms followed divisions of class, caste, and gender, inspiring critiques from psychiatrists and psychosocial counselors regarding the “ongoing life of patriarchy” (Ortner 2014) and the oppression of women in Nepal. Chapter 3, I described a case of this form of shared affliction as it emerged in a community without recourse to psychosocial intervention, where it was conceptualized and experienced as *chhopne*, *bhut/pret* and *pissat laagne*, a form of ghostly haunting, inspiring critiques of immoral action, injustice, and taboo. I demonstrated that by working from the ontology of *pissat* and *bhut/pret laagyo* as opposed to “conversion disorder,” it becomes possible to read these types of cases of shared affliction as disclosing forms of connectivity, communication, and contamination between beings and their environment. To approach such incidents from this perspective invites a reformulation of a largely pathologized phenomenon.

In the third and final part of the dissertation, I concentrated on the question of “crisis,” the event of the disaster, and its unfolding humanitarian mental health and psychosocial response. In Chapter 4, I described my subjective experience of the earthquake and reflected on the limits of writing. In Chapter 5, I described the emergence of a new “mental health crisis” in Nepal, and the blurring of boundaries between humanitarian aid and development through the rubric of “building back better.” A central question for the humanitarian mental health response regards the ethics of providing mental health and psychosocial care in times of emergency in areas where normally no such care exists, and where after the end of the emergency period people will again be left without access to care. As a result, some humanitarian actors became engaged in development work that was strategically initiated in the midst of crisis.

The disaster opened up urgent questions regarding the efficacy of humanitarian mental

health interventions, the ethics of care, as well as the translation of concepts mobilized on the ground in psychosocial interventions. In Chapter 6 I provided an account of psychosocial counseling in three earthquake-affected districts, with a focus on the intersubjective dynamics of therapeutic encounters. I described how a great number of clients seen were those who suffered from afflictions that had begun far before the earthquake occurred, but who only happened to receive care because they lived in an earthquake affected district. These were people who had been suffering all along from the slow disaster of poverty, from the mundane disasters of everyday life such as abuse in the family, from severe mental illness, from spirits or witchcraft, *boksi laagne/chhōpne*, or from a combination of these. Because of the disaster, their afflictions became temporarily visible, and in their brief visibility they received transient care.

The idea that such humanitarian mental health interventions are efficacious is the underlying justification for such projects, yet determining how to measure such efficacy remains difficult in these ethically sensitive, time-limited projects. In Chapter 7, I was concerned with the question of evidence for therapeutic efficacy in humanitarian mental health interventions, as it was discussed in reflections among psychosocial counselors, NGO staff, and the expatriate project director.

What happens to the momentum for change after the urgency of a catastrophic event has faded? Miriam Ticktin has argued that the sentiments of compassion that motivate action to relieve suffering in times of emergency “ultimately work to displace possibilities for larger forms of collective change, particularly for the most disenfranchised” (Ticktin 2011: 3). Likewise, as Povinelli has written, “when the waters recede and the ground stops shaking, empathy also evaporates as ethical sense settles back into doxic account of poverty, its causes and consequences” (Povinelli 2011: 164).

Part of the *work of disaster* in Nepal was the way in which the humanitarian response enabled certain forms of chronic suffering to become visible; in a period of heightened emergency this

previously invisible suffering demanded an ethical response as it was transformed into a knowable object for the humanitarian mental health response. By reflecting on the problem of the eventual withdrawal of humanitarian services, organizations began to use the establishment of a crisis as an opportunity to build the mental health system in times of emergency. But the extent to which the renewed attention to mental health in Nepal will persist, and the extent to which such short-term interventions were efficacious is not yet known. Csordas and Kleinman have argued that “the therapeutic process cannot be understood as bounded by the therapeutic event precisely because it is ultimately directed at life beyond the event” (1996: 20). Yet “life beyond the event” is not easily measured through the tools of evidence-based medicine, or within the temporalities of intervention projects and donor accountability. The lasting responsibility brought about by the *work of disaster* and illuminated by ethnography is the necessity to attend to life beyond the event, to care for others in everyday life, and not only in a time designated as crisis.

BIBLIOGRAPHY

- Abramowitz, Sharon. 2009. "Psychosocial Liberia: Managing Suffering in Post-Conflict Life."
Cambridge, Mass.: Harvard University.
- . 2010. "Trauma and Humanitarian Translation in Liberia: The Tale of the Open Mole."
Culture, Medicine and Psychiatry 34:353–79.
- . 2014. *Searching for Normal in the Wake of the Liberian War*. Philadelphia: University of
Pennsylvania Press.
- Abramowitz, Sharon, and Arthur Kleinman. 2008. "Humanitarian Intervention and Cultural
Translation: A Review of the IASC Guidelines on Mental Health and Psychosocial Support in
Emergency Settings." *Intervention* 6 (3/4):219–27.
- Abramowitz, Sharon, and Catherine Panter-Brick, eds. 2015. *Medical Humanitarianism: Ethnographies of
Practice*. Philadelphia: University of Pennsylvania Press.
- Abu-Lughod, Lila. 1990. "The Romance of Resistance: Tracing Transformations of Power through
Bedouin Women." *American Ethnologist* 17 (1):41–45.
- . 2002. "Do Muslim Women Really Need Saving? Anthropological Reflections on Cultural
Relativism and Its Others." *American Anthropologist* 104 (3):783–90.
- Acland, Sarah. 2002. "Mental Health Services in Primary Care: The Case of Nepal." In *World Mental
Health Casebook: Social and Mental Health Programs in Low-Income Countries*, 121–52. New York:
Kluwer Academic/Plenum Publishers.
- Adams, Vincanne. 1998. *Doctors for Democracy: Health Professionals in the Nepal Revolution*. Cambridge,
UK; New York, N.Y., U.S.A.: Cambridge University Press.
- . 2013. *Markets of Sorrow, Labors of Faith: New Orleans in the Wake of Katrina*. Durham &

- London: Duke University Press.
- . 2016. “Introduction.” In *Metrics: What Counts in Global Health*, edited by Vincanne Adams. Durham & London: Duke University Press.
- Adhikari, Aditya. 2014. *The Bullet and the Ballot Box: The Story of Nepal’s Maoist Revolution*. London and New York: Verso.
- Adhikari, Jagannath, and Mary Hobley. 2015. “‘Everyone Is Leaving. Who Will Sow Our Fields?’ The Livelihood Effects on Women of Male Migration from Khotang and Udaypur Districts, Nepal, to the Gulf Countries and Malaysia.” *Himalaya, The Journal of the Association for Nepal and Himalayan Studies* 35 (1):11–23.
- Adhikary, Kamal. 1995. “The Fruits of Panchayat Development.” *Himalayan Research Bulletin* XV (2):12–24.
- Ahearn, Laura M. 2001. *Invitations to Love: Literacy, Love Letters, & Social Change in Nepal*. Ann Arbor: The University of Michigan Press.
- Aich, Tapas Kumar. 2010. “Contribution of Indian Psychiatry in the Development of Psychiatry in Nepal.” *Indian Journal of Psychiatry* 52 (Suppl 1): S76–79.
- Appadurai, Arjun. 1985. “Gratitude as a Social Mode in South India.” *Ethos* 13 (3):236–45.
- Argenti-Pillen, Alex. 2002. *Masking Terror: How Women Contain Violence in Southern Sri Lanka*. Philadelphia: University of Pennsylvania Press.
- Associated Press. 2017. “Police in Capital Tear down Earthquake Victim Camp.” *The Himalayan Times*, March 14, 2017. <https://thehimalayantimes.com/kathmandu/police-capital-tear-nepal-earthquake-victim-camp-chuchepati/>.
- Badiou, Alain. 2001. *Ethics: An Essay on the Understanding of Evil*. London & New York: Verso.
- Baingana, Florence, Ian Bannon, and Rachel Thomas. 2005. *Mental Health and Conflicts: Conceptual Framework and Approaches*. Washington, D.C.: The International Bank for Reconstruction and

Development / The World Bank.

- Bataille, Georges. 2014. *Inner Experience*. Translated by Stuart Kendall. Albany: State University of New York Press.
- Bateson, Gregory. 1972. *Steps to an Ecology of Mind*. Chicago & London: University of Chicago Press.
- Bemme, Doerte, and Nicole A. D'souza. 2014. "Global Mental Health and Its Discontents: An Inquiry into the Making of Global and Local Scale." *Transcultural Psychiatry* 51 (6):850–74.
- Bennett, Claire. 2015. "The Nepal Earthquakes Have Unleashed a Mental Health Disaster." *The Guardian*, May 15, 2015, sec. Opinion.
- Bennett, Lynn. 1983. *Dangerous Wives and Sacred Sisters: Social and Symbolic Roles of High Caste Women in Nepal*. New York: Columbia University Press.
- Bensa, Alban, and Eric Fassin. 2006. "Les Sciences Sociales Face à l'événement." *Terrain* 38:1–15.
- Berlant, Lauren. 2011. *Cruel Optimism*. Durham & London: Duke University Press.
- Bhattacharai, Baburam. 2003. "The Political Economy of the People's War." In *The People's War in Nepal: Left Perspectives*, edited by Arjun Karki and David Seddon. New Delhi: Adroit Publishers.
- Biehl, João. 2005. *Vita: Life in a Zone of Social Abandonment*. Berkeley: University of California Press.
- Biehl, João, Byron J. Good, and Arthur Kleinman, eds. 2007. *Subjectivity: Ethnographic Investigations*. Berkeley: University of California Press.
- Blanchet, Karl, Anita Ramesh, Severine Frison, Emily Warren, Mazedha Hassain, James Smith, Abigail Knight, et al. 2017. "Evidence on Public Health Interventions in Humanitarian Crises." *The Lancet* 390:2287–96.
- Blanchot, Maurice. 1995. *The Writing of the Disaster*. Translated by Ann Smock. Lincoln: University of Nebraska Press.
- . 2003. *The Infinite Conversation*. Translated by Susan Hanson. Minneapolis and London: University of Minnesota Press.

- Boddy, Janice. 1989. *Wombs and Alien Spirits: Women, Men, and the Zar Cult in Northern Sudan*. Madison: University of Wisconsin Press.
- Boltanski, Luc. 1999. *Distant Suffering: Morality, Media and Politics*. Translated by Graham Burchell. Cambridge: Cambridge University Press.
- Bourguignon, Erika. 2004. "Suffering and Healing, Subordination and Power: Women and Possession Trance." *Ethos* 32 (4):557–74.
- Breslau, Joshua. 2000. "Globalizing Disaster Trauma: Psychiatry, Science, and Culture after the Kobe Earthquake." *Ethos* 28 (2):174–97.
- Breuer, Josef, and Sigmund Freud. 2009. *Studies on Hysteria*. New York: Basic Books.
- Brodwin, Paul. 2013. *Everyday Ethics: Voices From the Frontline of Community Psychiatry*. Berkeley: University of California Press.
- Bruns, Gerald. 2012. "Review of 'Maurice Blanchot and Fragmentary Writing: A Change of Epoch.'" *Notre Dame Philosophical Reviews* (blog). 2012. <http://ndpr.nd.edu/news/maurice-blanchot-and-fragmentary-writing-a-change-of-epoch/>.
- Calhoun, Craig. 2010. "The Idea of Emergency: Humanitarian Action and Global (Dis)Order." In *Contemporary States of Emergency: The Politics of Military and Humanitarian Interventions*, 29–58. New York: Zone Books.
- Carson, Anne. 2002. *If Not, Winter: Fragments of Sappho*. New York: Random House.
- Chakrabarty, Dipesh. 2000. *Provincializing Europe: Postcolonial Thought and Historical Difference*. Princeton: Princeton University Press.
- . 2009. "The Climate of History: Four Theses." *Critical Inquiry* 35:197–222.
- Citrin, David M. 2010. "The Anatomy of Ephemeral Health-Care: 'Health Camps' and Short-Term Medical Voluntourism in Remote Nepal." *Studies in Nepali History and Society* 15 (1):27–72.
- . 2012. "The Anatomy of Ephemeral Care: Health, Hunger, and Short-Term Humanitarian

- Intervention in Northwest Nepal.” University of Washington.
- Cohen, Alex, Arthur Kleinman, and Benedetto Saraceno, eds. 2002. *World Mental Health Casebook: Social and Mental Health Programs in Low-Income Countries*. New York: Kluwer Academic/Plenum Publishers.
- Craig, Sienna. 2012. *Healing Elements: Efficacy and the Social Ecologies of Tibetan Medicine*. Berkeley: University of California Press.
- Crapanzano, Vincent. 1980. *Tubami: Portrait of a Moroccan*. Chicago: University of Chicago Press.
- Crapanzano, Vincent, and Vivian Garrison, eds. 1977. *Case Studies in Spirit Possession*. New York: Wiley.
- Csordas, Thomas. 1990. “Embodiment as a Paradigm for Anthropology.” *Ethos* 18 (1):5–47.
- . 1993. “Somatic Modes of Attention.” *Cultural Anthropology* 8 (2):135–56.
- . 1994. *The Sacred Self: A Cultural Phenomenology of Charismatic Healing*. Berkeley: University of California Press.
- . 2002. *Body/Meaning/Healing*. New York: Palgrave Macmillan.
- . 2008. “Intersubjectivity and Intercorporeality.” *Subjectivity* 22:110–21.
- Csordas, Thomas, and Arthur Kleinman. 1996. “The Therapeutic Process.” In *Handbook of Medical Anthropology: Contemporary Theory and Method*. Westport, Connecticut: Greenwood Press.
- Das, Veena. 2007. *Life and Words: Violence and the Descent into the Ordinary*. Berkeley: University of California Press.
- De Certeau, Michel. 1996. *The Possession at Loudun*. Chicago & London: University of Chicago Press.
- de Jong, Joop, ed. 2002. *Trauma, War, and Violence: Public Mental Health in Socio-Cultural Context*. New York: Kluwer Academic Publishers.
- Del Vecchio Good, Mary-Jo DelVecchio, Sandra Teresa Hyde, Sarah Pinto, and Byron Good, eds. 2008. *Postcolonial Disorders*. Berkeley: University of California Press.

- Deleuze, Gille, and Felix Guattari. 1987. *A Thousand Plateaus: Capitalism and Schizophrenia*. Minneapolis: University of Minnesota Press.
- Deleuze, Gilles. 1990. *The Logic of Sense*. Translated by Mark Lester. London: The Athlone Press.
- DeIVecchio Good, Mary-Jo, Byron J. Good, and Jesse Grayman. 2010. "Complex Engagements: Responding to Violence in Postconflict Aceh." In *Contemporary States of Emergency: The Politics of Military and Humanitarian Interventions*, edited by Didier Fassin and Mariella Pandolfi, 241–66. New York: Zone Books.
- Desjarlais, Robert. 1992. *Body and Emotion: The Aesthetics of Illness and Healing in the Nepal Himalayas*. Philadelphia: University of Pennsylvania Press.
- . 1997. *Shelter Blues: Sanity and Selfhood Among the Homeless*. Philadelphia: University of Pennsylvania Press.
- . 2003. *Sensory Biographies: Lives and Deaths Among Nepal's Yolmo Buddhists*. Berkeley: University of California Press.
- . 2016. *Subject to Death: Life and Loss in a Buddhist World*. Chicago: University of Chicago Press.
- Desjarlais, Robert, Leon Eisenberg, Byron Good, and Arthur Kleinman. 1996. *World Mental Health: Problems and Priorities in Low-Income Countries*. Oxford: Oxford University Press.
- Desjarlais, Robert, and C. Jason Throop. 2011. "Phenomenological Approaches in Anthropology." *Annual Review of Anthropology* 40:87–102.
- Didi-Huberman, Georges. 2003. *Invention of Hysteria: Charcot and the Photographic Iconography of the Salpêtrière*. Translated by Alisa Hartz. Cambridge, Mass.: The MIT Press.
- Dunn, Elizabeth Cullen. 2012. "The Chaos of Humanitarian Aid: Adhocracy in the Republic of Georgia." *Humanity: An International Journal of Human Rights, Humanitarianism, and Development* 3 (1):1–23.

- Duranti, Alessandro. 2010. "Husserl, Intersubjectivity, and Anthropology." *Anthropological Theory* 10:1–20.
- Durkheim, Émile. 2008. *The Elementary Forms of Religious Life*. Translated by Carol Cosman. Oxford: Oxford University Press.
- Dyson, Jane. 2010. "Friendship in Practice: Girls' Work in the Indian Himalayas." *American Ethnologist* 37 (3):482–98.
- Eck, Diana L. 1998. *Darsan: Seeing the Divine Imagine in India*. Third. New York: Columbia University Press.
- Einsiedel, Sebastian von, David M. Malone, and Suman Pradhan. 2012. "Introduction." In *Nepal in Transition: From People's War to Fragile Peace*, 1–36. Cambridge: Cambridge University Press.
- Eisenbruch, Maurice. 2017. "Mass Fainting in Garment Factories in Cambodia." *Transcultural Psychiatry* 54 (2):155–78.
- Ekantipur. 2012a. "Over 400 Students in Rukum Fallen Sick." *Ekantipur*, July 31, 2012, sec. Health. <http://www.ekantipur.com/2012/07/31/national/over-400-students-in-rukum-fallen-sick/358011.html>.
- . 2012b. "Ghost-Scare Creates Fiasco in School." *Ekantipur*, August 10, 2012, sec. Top Stories. <http://www.ekantipur.com/2012/08/10/top-story/ghost-scare-creates-fiasco-in-school/358559.html>.
- . 2013a. "Mass Hysteria in Local School." *Ekantipur*, August 21, 2013. <http://www.ekantipur.com/2013/08/21/national/mass-hysteria-in-local-school/376804.html>.
- . 2013b. "Students Fall Unconscious in School." *Ekantipur*, August 30, 2013. <http://www.ekantipur.com/2013/08/30/national/students-fall-unconscious-in-school/377250.html>.
- Erikson, Susan L. 2012. "Global Health Business: The Production and Performativity of Statistics in

- Sierra Leone and Germany.” *Medical Anthropology* 31 (4):367–84.
- Fabian, Johannes. 1983. *Time and the Other: How Anthropology Makes Its Object*. New York: Columbia University Press.
- Farmer, Paul. 2006. *AIDS and Accusation: Haiti and the Geography of Blame, Updated with a New Preface*. Berkeley: University of California Press.
- Fassin, Didier. 2008. “The Humanitarian Politics of Testimony: Subjectification through Trauma in the Israeli-Palestinian Conflict.” *Cultural Anthropology* 23 (3):531–58.
- . 2010. “Noli Me Tangere: The Moral Untouchability of Humanitarianism.” In *Forces of Compassion: Humanitarianism Between Ethics and Politics*, 35–52. Santa Fe, New Mexico: School for Advanced Research Press.
- . 2012. *Humanitarian Reason: A Moral History of the Present*. Berkeley: University of California Press.
- Fassin, Didier, and Mariella Pandolfi, eds. 2013. *Contemporary States of Emergency: The Politics of Military and Humanitarian Interventions*. New York: Zone Books.
- Fassin, Didier, and Richard Rechtman. 2009. *The Empire of Trauma: An Inquiry into the Condition of Victimhood*. Princeton: Princeton University Press.
- Favret-Saada, Jeanne. 1980. *Deadly Words: Witchcraft in the Bocage*. Cambridge: Cambridge University Press.
- Ferguson, James. 1994. *The Anti-Politics Machine: “Development,” Depoliticization, and Bureaucratic Power in Lesotho*. Minneapolis: University of Minnesota Press.
- . 2002. “Global Disconnect: Abjection and the Aftermath of Modernism.” In *The Anthropology of Globalization: A Reader*. Malden, Mass: Blackwell Publishing Ltd.
- Ferguson, James, and Akhil Gupta. 2002. “Spatializing States: Toward an Ethnography of Neoliberal Governmentality.” *American Ethnologist* 29 (4):981–1002.

- Fortun, Kim. 2001. *Advocacy After Bhopal: Environmentalism, Disaster, New Global Orders*. Chicago: University of Chicago Press.
- Foucault, Michel. 2002. *Society Must Be Defended: Lectures at the Collège de France, 1975-76*. New York: Picador.
- Frazer, James George. 2009. *The Golden Bough: A Study of Magic and Religion*. Oxford: Oxford University Press.
- Freud, Sigmund. 1989. *The Freud Reader*. Edited by Peter Gay. New York: W.W. Norton.
- Fujikura, Tatsuro. 2013. *Discourses of Awareness: Developments, Social Movements and the Practices of Freedom in Nepal*. Kathmandu: Martin Chautari.
- Garcia, Angela. 2010. *The Pastoral Clinic: Addiction and Dispossession along the Rio Grande*. Berkeley: University of California Press.
- Gardner, Elie. 2015. "Preventing Long-Term Mental Health Issues in Nepal." *Al Jazeera*, 2015.
- Ghimire, Pustak. 2016. "'Living Goddesses Everywhere?' On the Possession of Women by the Goddess Bhagavati in Some Mountain Villages in Eastern Nepal." In *Religion, Secularism, and Ethnicity in Contemporary Nepal*, edited by David Gellner, Sondra L. Hausner, and Chiara Letizia. New York: Oxford University Press.
- Goldstein, Donna M., and Kira Hall. 2015. "Mass Hysteria in Le Roy, New York: How Brain Experts Materialized Truth and Outscienced Environmental Inquiry." *American Ethnologist* 42 (4):640–57.
- Good, Byron. 2012b. "Theorizing the 'Subject' of Medical and Psychiatric Anthropology." *Journal of the Royal Anthropological Institute* 18:515–35.
- . 1994. *Medicine, Rationality and Experience: An Anthropological Perspective*. Cambridge: Cambridge University Press.
- Good, Byron J., Mary-Jo DelVecchio Good, and Jesse Grayman. 2015. "Is PTSD a 'Good Enough'?"

- Concept for Postconflict Mental Health Care? Reflections on Work in Aceh, Indonesia.” In *Culture and PTSD: Trauma in Global and Historical Perspective*, edited by Devon Hinton and Byron J. Good, 387–417. Philadelphia: University of Pennsylvania Press.
- Greene, M. Claire, Mark J. D. Jordans, Brandon Kohrt, Peter Ventevogel, Laurence J. Kirmayer, Ghayda Hassan, Anna Chiumento, Mark Van Ommeren, and Wietse A. Tol. 2017. “Addressing Culture and Context in Humanitarian Response: Preparing Desk Reviews to Inform Mental Health and Psychosocial Support.” *Conflict and Health* 11 (21).
- Greenhouse, Carol, Elizabeth Mertz, and Kay Warren, eds. 2002. *Ethnography in Unstable Places: Everyday Lives in Contexts of Dramatic Political Change*. Durham & London: Duke University Press.
- Guneratne, Arjun. 2002. *Many Tongues, One People: The Making of Tharu Identity in Nepal*. Ithaca: Cornell University Press.
- Hacking, Ian. 2002. *Mad Travelers: Reflections on the Reality of Transient Mental Illness*. Cambridge: Harvard University Press.
- Han, Clara. 2012. *Life in Debt: Times of Care and Violence in Neoliberal Chile*. Berkeley: University of California Press.
- Harper, Ian. 2014. *Development and Public Health in the Himalaya: Reflections on Healing in Contemporary Nepal*. London and New York: Routledge.
- Heidegger, Martin. 1993a. “Building Dwelling Thinking.” In *Basic Writings*, edited by David Farrell Krell, 343–64. New York: HarperCollins Publishers.
- . 1993b. “Letter on Humanism.” In *Basic Writings*, edited by David Farrell Krell, 213–66. New York: HarperCollins Publishers.
- Hellinger, Bert, and Gabriele Ten Hovel. 1999. *Acknowledging What Is: Conversations with Bert Hellinger*. Translated by Colleen Beaumont. Phoenix, Arizona: Zeig, Tucker & Co Inc.
- Hitchcock, John T. 1976. “Aspects of Bhujel Shamanism.” In *Spirit Possession in the Nepal Himalayas*,

- edited by John T. Hitchcock and Rex L. Jones, 165–96. Warminster, England: Aris and Phillips Ltd.
- Höfer, András. 1979. *The Caste Hierarchy and the State in Nepal: A Study of the Muluki Ain of 1854*. Universitätsverlag Wagner.
- Hollan, Douglas. 2012. “On the Varieties and Particularities of Cultural Experience.” *Ethos* 40 (1):37–53.
- . 2017. “Dreamscapes of Intimacy and Isolation: Shadows of Contagion and Immunity.” *Ethos* 45 (2):216–31.
- Horn, Rebecca. 2013. “Exploring Psychosocial Well-Being and Social Connectedness in Northern Uganda.” Washington, D.C.: The World Bank.
- . 2014. “Measuring Psychosocial Wellbeing in Democratic Republic of Congo: Report of a Pilot Study.” Washington, D.C.: The World Bank.
- Humphrey, Caroline. 2008. “Reassembling Individual Subjects: Events and Decisions in Troubled Times.” *Anthropological Theory* 8 (4):357–80.
- Husserl, Edmund. 1983. *Ideas, First Book*. Translated by F Kersten. Dordrecht: Kluwer.
- Inter-Agency Standing Committee (IASC). 2007. “IASC Guidelines on Mental Health and Psychosocial Support in Emergency Settings.” Geneva: IASC.
- International Medical Corps (IMC). 2015. “International Medical Corps 2015 Annual Report.” Los Angeles: International Medical Corps.
- Isaacson, Joel M., Christa A. Skerry, Kerry Moran, and Kay M. Kalavan. 2001. *Half-a-Century of Development: The History of U.S. Assistance to Nepal 1951-2001*. Kathmandu, Nepal: United States Agency for International Development (USAID).
- Jackson, Michael, ed. 1996. *Things as They Are: New Directions in Phenomenological Anthropology*. Bloomington: Indiana University Press.

- . 1998. *Minima Ethnographica: Intersubjectivity and the Anthropological Project*. Chicago: The University of Chicago Press.
- James, Erica Caple. 2010a. *Democratic Insecurities: Violence, Trauma, and Intervention in Haiti*. Berkeley: University of California Press.
- . 2010b. “Ruptures, Rights, and Repair: The Political Economy of Trauma in Haiti.” *Social Science & Medicine* 70:106–13.
- Joshi, Bhuwan Lal, and Leo Rose. 1966. *Democratic Innovations in Nepal: A Case Study of Political Acculturation*. Berkeley and Los Angeles: University of California Press.
- Justice, Judith. 1986. *Policies, Plans, and People: Foreign Aid and Health Development*. Berkeley: University of California Press.
- Kalofonos, Ippolytos Andreas. 2010. “‘All I Eat Is ARVs’: The Paradox of AIDS Treatment Interventions in Central Mozambique.” *Medical Anthropology Quarterly* 24 (3):363–80.
- Kienzler, Hanna, and Zeina Amro. 2015. “‘Unknowing’ and Mental Health System Reform in Palestine.” *Medicine Anthropology Theory* 2 (3):113–27.
- Kirmayer, Laurence, and Allen Young. 1998. “Culture and Somatization: Clinical, Epidemiological, and Ethnographic Perspectives.” *Psychosomatic Medicine* 60:420–30.
- Klein, Naomi. 2007. *The Shock Doctrine: The Rise of Disaster Capitalism*. New York: Picador.
- Kleinman, Arthur. 1997. “‘Everything That Really Matters’: Social Suffering, Subjectivity, and the Remaking of Human Experience in a Disordering World.” *The Harvard Theological Review* 90 (3):315–35.
- . 1999. “Experience and Its Moral Modes: Culture, Human Conditions, and Disorder.” In *The Tanner Lectures on Human Values*, edited by G.B. Peterson. Vol. 20. Salt Lake City: University of Utah Press.
- Kleinman, Arthur, and Joan Kleinman. 1996. “The Appeal of Experience; The Dismay of Images:

- Cultural Appropriations of Suffering in Our Times.” *Daedalus* 125 (1):1–23.
- Kohrt, Brandon, Matthew Burkey, E.A. Stewart, and S Koirala. 2015. “Alternative Approaches for Studying Humanitarian Interventions: Propensity Score Methods to Evaluate Reintegration Packages Impact on Depression, PTSD, and Function Impairment among Child Soldiers in Nepal.” *Global Mental Health* 2. <https://doi.org/10.1017/gmh.2015.13>.
- Kohrt, Brandon, and DJ Hruschka. 2010. “Nepali Concepts of Psychological Trauma: The Role of Idioms of Distress, Ethnopsychology and Ethnophysiology in Alleviating Suffering and Preventing Stigma.” *Culture, Medicine and Psychiatry* 34 (2):322–52.
- Kohrt, Brandon, Mark Jordans, Wietse Tol, Em Perera, Rohit Karki, Suraj Koirala, and Nawaraj Upadhaya. 2010. “Social Ecology of Child Soldiers: Child, Family, and Community Determinants of Mental Health, Psychosocial Well-Being, and Reintegration in Nepal.” *Transcultural Psychiatry* 47:727–53.
- Kohrt, Brandon, and Emily Mendenhall, eds. 2016. *Global Mental Health: Anthropological Perspectives*. London and New York: Routledge.
- Koselleck, Reinhart. 1988. *Critique and Crisis: Enlightenment and the Pathogenesis of Modern Society*. Cambridge, Mass.: The MIT Press.
- Kunreuther, Laura. 2010. “Transparent Media: Radio, Voice, and Ideologies of Directness in Postdemocratic Nepal.” *Journal of Linguistic Anthropology* 20 (2):334–351.
- Lambek, Michael. 1981. *Human Spirits: A Cultural Account of Trance in Mayotte*. Cambridge: Cambridge University Press.
- Latour, Bruno. 2004. “Why Has Critique Run out of Steam? From Matters of Fact to Matters of Concern.” *Critical Inquiry* 30:225–48.
- Lecomte-Tilouine, Marie. 1993. *Les Dieux Du Pouvoir: Les Magar et l'hindouisme Au Népal Central*. Paris: Editions du CNRS.

- Lester, Rebecca. 2009. "Brokering Authenticity: Borderline Personality Disorder and the Ethics of Care in an American Eating Disorder Clinic." *Current Anthropology* 50 (3):281–302.
- . 2013. "Lessons from the Borderline: Anthropology, Psychiatry, and the Risks of Being Human." *Feminism & Psychology* 23 (1):70–77.
- Lewis, IM. 1971. *Ecstatic Religion: An Anthropological Study of Spirit Possession and Shamanism*. Harmondsworth, UK: Penguin.
- Livingston, Julie. 2012. *Improvising Medicine: An African Oncology Ward in an Emerging Cancer Epidemic*. Durham & London: Duke University Press.
- Locke, Peter. 2009. "City of Survivors: Trauma, Grief, and Getting By in Post-War Sarajevo." Princeton University.
- Lovell, Anne. 2011. "Debating Life After Disaster: Charity Hospital Babies and Bioscientific Futures in Post-Katrina New Orleans." *Medical Anthropology Quarterly* 25 (2):254–77.
- Luitel, Nagendra P., Mark J. D. Jordans, Anup Adhikari, Nawaraj Upadhaya, Charlotte Hanlon, Crick Lund, and Ivan H. Komproe. 2015. "Mental Health Care in Nepal: Current Situation and Challenges for Development of a District Mental Health Care Plan." *Conflict and Health* 9 (3).
- Macdonald, A.W. 1976. "Sorcery in the Nepalese Code of 1853." In *Spirit Possession in the Nepal Himalayas*, edited by John T. Hitchcock and Rex L. Jones, 376–85. Warminster, England: Aris and Phillips Ltd.
- Mahmood, Saba. 2001. "Feminist Theory, Embodiment, and the Docile Agent: Some Reflections on the Egyptian Islamic Revival." *Cultural Anthropology* 6 (2):202–36.
- . 2005. *Politics of Piety: The Islamic Revival and the Feminist Subject*. Princeton, N.J.: Princeton University Press.
- Marcus, George E. 2008. "The End(s) of Ethnography: Social/Cultural Anthropology's Signature

- Form of Producing Knowledge in Transition.” *Cultural Anthropology* 23 (1):1–14.
- . 2010. “Experts, Reporters, Witnesses: The Making of Anthropologists in States of Emergency.” In *Contemporary States of Emergency: The Politics of Military and Humanitarian Interventions*, 357–78. New York: Zone Books.
- Marrow, Jocelyn. 2008. “Psychiatry, Modernity and Family Values: Clenched Teeth Illness in North India.” Chicago, IL: University of Chicago.
- . 2013. “Feminine Power or Feminine Weakness? North Indian Girls’ Struggles with Aspirations, Agency, and Psychosomatic Illness.” *American Ethnologist* 40 (2):347–61.
- Martin, Emily. 1987. *The Woman in the Body: A Cultural Analysis of Reproduction*. Boston: Beacon Press.
- Masco, Joseph. 2017. “The Crisis in Crisis.” *Current Anthropology* 58:S65–76.
- Maskarinec, Gregory. 1995. *The Rulings of the Night: An Ethnography of Nepalese Shaman Oral Texts*. Madison: The University of Wisconsin Press.
- McHugh, Ernestine. 2001. *Love and Honor in the Himalayas: Coming to Know Another Culture*. Philadelphia: University of Pennsylvania Press.
- McKay, Ramah. 2012. “Afterlives: Humanitarian Histories and Critical Subjects in Mozambique.” *Cultural Anthropology* 27 (2):286–308.
- Meinert, Lotte, and Susan Reynolds Whyte. 2017. “‘These Things Continue’: Violence as Contamination in Everyday Life After War in Northern Uganda.” *Ethos* 45 (2):271–86.
- Meyers, Todd. 2013. *The Clinic and Elsewhere: Addiction, Adolescents, and the Afterlife of Therapy*. Seattle, Washington: University of Washington Press.
- Mihaly, Eugene Bramer. 1965. *Foreign Aid and Politics in Nepal: A Case Study*. London and New York: Oxford University Press.
- Mills, China. 2014. *Decolonizing Global Mental Health: The Psychiatrization of the Majority of the World*. London and New York: Routledge.

- Minn, Pierre. 2010. "The Coordination and Un-Coordination of International Medical Aid in Haiti." *Somatosphere* (blog). 2010. <http://somatosphere.net/2010/03/coordination-and-un-coordination-of.html>.
- Mol, Annemarie. 2008. *The Logic of Care: Health and the Problem of Patient Choice*. Abingdon, Oxon: Routledge.
- Moore, Sally Falk. 1987. "Explaining the Present: Theoretical Dilemmas in Processual Anthropology." *American Ethnologist*, 727–36.
- Muzzini, Elisa, and Gabriela Aparicio. 2013. *Urban Growth and Spatial Transition in Nepal: An Initial Assessment*. Directions in Development. Washington, D.C.: The World Bank.
- Navarro, Vicente. 1984. "A Critique of the Ideological and Political Position of the Brandt Report and the Alma Ata Declaration." *International Journal of Health Services* 14 (2):159–72.
- Newar, Naresh. 2015. "In Nepal, Psychosocial Counselling Goes on the Radio." *UNICEF Newsline* (blog). 2015. https://www.unicef.org/infobycountry/nepal_81770.html.
- Nguyen, Vinh-Kim. 2005. "Antiretroviral Globalism, Biopolitics, and Therapeutic Citizenship." In *Global Assemblages: Technology, Politics, and Ethics as Anthropological Problems*, edited by Ahiwa Ong and Stephen J. Collier, 124–44. Malden, Mass: Blackwell Publishing Ltd.
- . 2010. *The Republic of Therapy: Triage and Sovereignty in West Africa's Time of Aids*. Durham & London: Duke University Press.
- Nichter, Mark. 1981. "Idioms of Distress: Alternatives in the Expression of Psychological Distress: A Case Study from South India." *Culture, Medicine and Psychiatry* 5:379–408.
- Nyenhuis, Michael. 2016. "In Nepal, Mental Health Takes Center Stage." *Huffpost Impact*, 2016.
- Ommeren, Mark van, Bhogendra Sharma, Dinesh Prasain, and Bhava N. Poudyal. 2002. "Addressing Human Rights Violations." In *Trauma, War, and Violence: Public Mental Health in Socio-Cultural Context*. New York: Kluwer Academic Publishers.

- Ong, Ahiwa. 1988. "The Production of Possession: Spirits and the Multinational Corporation in Malaysia." *American Ethnologist* 15 (1):28–42.
- . 2010. *Spirits of Resistance and Capitalist Discipline: Factory Women in Malaysia*. Second. Albany: State University of New York Press.
- Ong, Ahiwa, and Stephen J. Collier, eds. 2005. *Global Assemblages: Technology, Politics, and Ethics as Anthropological Problems*. Malden, Mass: Blackwell Publishing Ltd.
- Ortner, Sherry. 1996. *Making Gender: The Politics and Erotics of Culture*. Boston: Beacon Press.
- . 2014. "Too Soon for Post-Feminism: The Ongoing Life of Patriarchy in Neoliberal America." *History and Anthropology* 25 (4):530–49.
- . 2016. "Dark Anthropology and Its Others: Theory since the Eighties." *HAAU: Journal of Ethnographic Theory* 6 (1):47–73.
- Pach, Alfred. 1990. "Disordered Experience in a Hindu Village in Nepal." Madison, Wis.: University of Wisconsin-Madison.
- . 1998. "Narrative Constructions of Madness in a Hindu Village in Nepal." In *Selves in Time and Place: Identities, Experience, and History in Nepal*, edited by Debra Skinner, Alfred Pach, and Dorothy Holland. Lanham, Maryland: Rowman & Littlefield Publishers, Inc.
- Pach, Alfred, Krishna Prasad Rimal, and Dhruva Man Shrestha. 2002. "Chhopuwa, Distress, and Gender in a Hindu Village of Nepal." *Himalaya, The Journal of the Association for Nepal and Himalayan Studies* 22 (1):40–47.
- Packard, Randall M. 2016. *A History of Global Health: Interventions Into the Lives of Other Peoples*. Baltimore: Johns Hopkins University Press.
- Pali Text Society. 1921. *The Pali Text Society's Pali-English Dictionary*. London: Chipstead.
- Pandolfi, Mariella. 2003. "Contract of Mutual (in)Difference: Governance and the Humanitarian Apparatus in Contemporary Albania and Kosovo." *Indiana Journal of Global Legal Studies* 10

(1):369–81.

———. 2010. “From Paradox to Paradigm: The Permanent State of Emergency in the Balkans.” In *Contemporary States of Emergency: The Politics of Military and Humanitarian Interventions*, 153–72. New York: Zone Books.

Pandolfo, Stefania. 1997. *Impasse of the Angels: Scenes From a Moroccan Space of Memory*. Chicago: The University of Chicago Press.

Parish, Steven M. 1994. *Moral Knowing in a Hindu Sacred City: An Exploration of Mind, Emotion, and Self*. New York: Columbia University Press.

Pattison, Pete. 2013. “Revealed: Qatar’s World Cup ‘Slaves.’” *The Guardian*, September 25, 2013. <http://www.theguardian.com/world/2013/sep/25/revealed-qatars-world-cup-slaves>.

Pettigrew, Judith. 2013. *Maoists at the Hearth: Everyday Life in Nepal’s Civil War*. Philadelphia: University of Pennsylvania Press.

Pigg, Stacy Leigh. 1993. “Unintended Consequences: The Ideological Impact of Development in Nepal.” *South Asia Bulletin* XIII (1 & 2):45–58.

———. 1995. “Acronyms and Effacement: Traditional Medical Practitioners (TMP) in International Health Development.” *Social Science & Medicine* 41 (1):47–68.

———. 1996. “The Credible and the Credulous: The Question of ‘Villagers’ Beliefs” in Nepal — Cultural Anthropology.” *Cultural Anthropology* 11 (2):160–201.

Pinto, Sarah. 2008. *Where There Is No Midwife: Birth and Loss in Rural India*. New York: Berghahn Books.

———. 2014. *Daughters of Parvati: Women and Madness in Contemporary India*. Philadelphia: University of Pennsylvania Press.

Plesch, Valerie. 2015. “Crisis on Nepal-India Border as Blockade Continues.” *Al Jazeera*, 2015.

<http://www.aljazeera.com/indepth/inpictures/2015/12/crisis-nepal-india-border-blockade->

continues-151223082533785.html.

- Povinelli, Elizabeth. 2011. *Economies of Abandonment: Social Belonging and Endurance in Late Liberalism*. Durham & London: Duke University Press.
- Prince, Martin, Vikram Patel, Shekhar Saxena, Mario Maj, Joanna Maselko, Michael R. Phillips, and Atif Rahman. 2007. "No Health without Mental Health." *The Lancet* 370:859–77.
- Pupavac, Vanessa. 2001. "Therapeutic Governance: Psycho-Social Intervention and Trauma Risk Management." *Disasters* 25 (4):358–72.
- . 2002. "Pathologizing Populations and Colonizing Minds: International Psychosocial Programs in Kosovo." *Alternatives* 27:489–511.
- Rabinow, Paul, and Nikolas Rose. 2006. "Biopower Today." *BioSocieties* 1:195–217.
- Redfield, Peter. 2005. "Doctors, Borders, and Life in Crisis." *Cultural Anthropology* 20 (3):328–61.
- . 2012. "The Unbearable Lightness of Ex-Pats: Double Binds of Humanitarian Mobility." *Cultural Anthropology* 27 (2):358–82.
- . 2013. *Life in Crisis: The Ethical Journey of Doctors Without Borders*. Berkeley: University of California Press.
- Regmi, Mahesh C. 1978. *Thatched Huts and Stucco Palaces: Peasants and Landlords in Nineteenth Century Nepal*. New Delhi: Vikas Publishign House Pvt Ltd.
- Roitman, Janet. 2014. *Anti-Crisis*. Durham & London: Duke University Press.
- Rose, Paul W. 1963. "The First Years: Revised Manuscript Volume I."
- Sapkota, Ram P., Dristy Gurung, Deepa Neupane, Santosh Shah, Hanna Kienzler, and Laurence J. Kirmayer. 2014. "A Village Possessed by 'Witches': A Mixed-Methods Case-Control Study of Possession and Common Mental Disorders in Rural Nepal." *Culture, Medicine and Psychiatry* 38:642–68.
- Sax, William S. 1991. *Mountain Goddess: Gender and Politics in a Himalayan Pilgrimage*. Oxford: Oxford

- University Press.
- Scheper-Hughes, Nancy. 1992. *Death Without Weeping: The Violence of Everyday Life in Brazil*. Berkeley: University of California Press.
- Schmidt, Ruth Laila. 1994a. *A Practical Dictionary of Modern Nepali*. Ratna Sagar.
- . 1994b. *A Practical Dictionary of Modern Nepali*. Ratna Sagar.
- Schutz, Alfred. 1967. *The Phenomenology of the Social World*. Evanston: Northwestern University Press.
- Seale-Feldman, Aidan, and Nawaraj Upadhaya. 2015. “Mental Health after the Earthquake: Building Nepal’s Mental Health System in Times of Emergency.” *Cultural Anthropology* Fieldsights-Hot Spots. <http://www.culanth.org/fieldsights/736-mental-health-after-the-earthquake-building-nepal-s-mental-health-system-in-times-ofemergency>.
- Sewell, William. 2005. *Logics of History: Social Theory and Social Transformation*. Chicago: University of Chicago Press.
- Shah, H.M. Mahendra Bir Bikram. 1967. *Proclamations, Speeches and Messages: H.M. King Mahendra Bir Bikram Shah Dev*. Vol. IV. Kathmandu: Department of Publicity. Ministry of Information and Broadcasting. HMG/Nepal.
- Shakya, Rabi. 2005. “Epidemics of Hysteria in a School of Rural Eastern Nepal: A Case Report.” *Journal of Indian Association of Child and Adolescent Mental Health* 1 (4).
- . 2013. “Tackling Mass Hysteria.” *Ekantipur*, January 7, 2013. <http://www.ekantipur.com/2013/01/07/capital/tackling-mass-hysteria/365249.html>.
- Sharma, Pushpa Prasad, Ajaya Kumar Jha, Anish Joshi, and Ritesh Lamsal. 2010. “Mass Hysteria and Adolescent Girls: An Interventional Study.” *Nepal Journal of Obstetrics & Gynaecology* 5 (1):17–20.
- Showalter, Elaine. 1997. *Hystories: Hysterical Epidemics and Modern Media*. New York: Columbia University Press.

- Shrestha, D. M., Alfred Pach, and K. P. Rimal. 1983. "A Social and Psychiatric Study of Mental Illness in Nepal." Kathmandu, Nepal: United Nations Childrens Fund.
- Simmel, Georg. 1950. *The Sociology of Georg Simmel*. Edited and translated by Kurt H. Wolff. New York: The Free Press.
- Simpson, Edward. 2014. *The Political Biography of an Earthquake: Aftermath and Amnesia in Gujarat, India*. Oxford: Oxford University Press.
- Stevenson, Lisa. 2014. *Life Beside Itself: Imagining Care in the Canadian Arctic*. Berkeley: University of California Press.
- Stockton, Nick. 2015. "Let's Stop Nepal's Mental Health Crisis Before It Happens." *Wired*, 2015. <https://www.wired.com/2015/05/lets-stop-nepals-mental-health-crisis-happens/>.
- Stoller, Paul. 1995. *Embodying Colonial Memories: Spirit Possession, Power, and the Hauka in West Africa*. New York & London: Routledge.
- Stone, Linda. 1986. "Primary Health Care for Whom? Village Perspectives from Nepal." *Social Science & Medicine* 22 (3):293–302.
- Stone, Linda, and J. Gabriel Campbell. 1984. "The Use and Misuse of Surveys in International Development: An Experiment from Nepal." *Human Organization* 43 (1):27–37.
- Strathern, Marilyn. 2000. *Audit Cultures: Anthropological Studies in Accountability, Ethics and the Academy*. London and New York: Routledge.
- Summerfield, Derek. 1999. "A Critique of Seven Assumptions behind Psychological Trauma Programs in War-Affected Areas." *Social Science & Medicine* 48:1449–62.
- Thapa, Manjushree. 2011. *The Lives We Have Lost: Essays and Opinions on Nepal*. New Delhi: Penguin Books.
- The World Bank. 1993. *World Development Report 1993: Investing in Health*. Oxford: Oxford University Press.

- . 2016a. “Out of the Shadows: Making Mental Health a Global Development Priority.”
- . 2016b. “Personal Remittances, Received (% of GDP).” *DataBank World Development Indicators* (blog). 2016.
https://data.worldbank.org/indicator/BX.TRF.PWKR.DT.GD.ZS?year_high_desc=true.
- Throop, C. Jason. 2003. “Articulating Experience.” *Anthropological Theory* 3 (2):219–41.
- . 2010a. “Latitudes of Loss: On the Vicissitudes of Empathy.” *American Ethnologist* 37 (4):771–82.
- . 2010b. *Suffering and Sentiment: Exploring the Vicissitudes of Experience and Pain in Yap*. Berkeley: University of California Press.
- . 2017. “Despairing Moods: Worldly Attunements and Permeable Personhood in Yap.” *Ethos* 45 (2):199–215.
- Ticktin, Miriam. 2011. *Casualties of Care: Immigration and the Politics of Humanitarianism in France*. Berkeley: University of California Press.
- . 2014. “Transnational Humanitarianism.” *Annual Review of Anthropology* 43:273–89.
- Toffin, Gerard. 2009. “The Janajati/Adivasi Movement in Nepal: Myths and Realities of Indigeneity.” *Sociological Bulletin* 58 (1):25–42.
- Tol, Wietse A., Pierre Bastin, Mark J. D. Jordans, Harry Minas, Renato Souza, Inka Weissbecker, and Mark Van Ommeren. 2014. “Mental Health and Psychosocial Support in Humanitarian Settings.” In *Global Mental Health: Principles and Practice*, edited by Vikram Patel. New York: Oxford University Press.
- Tol, Wietse, Corrado Barbui, Ananda Galappatti, Derrick Silove, Theresa Betancourt, Renato Souza, Anne Golaz, and Mark van Ommeren. 2011. “Mental Health and Psychosocial Support in Humanitarian Settings: Linking Practice and Research.” *Lancet*, Global Mental Health, 378:1581–91.

- Turin, Mark. 1997. "In Memory of Christoph von Furer-Haimendorf." *Himalaya, The Journal of the Association for Nepal and Himalayan Studies* 17 (2):1–3.
- Turner, Ralph Lilley. 1931. *A Comparative and Etymological Dictionary of the Nepali Language*. London: K. Paul, Trench, Trubner.
- UNDP. 2015. "2015 Human Development Report: Work for Human Development." New York: United Nations Development Programme (UNDP).
- United Nations Children's Fund. 2016. "Child Protection Sub Cluster 5W Update." <https://www.humanitarianresponse.info/en/operations/nepal/document/5w-update-6-sep-0>.
- . 2017. "Nepal Humanitarian Situation Report No. 7 Floods Response." Kathmandu: United Nations Children's Fund. <https://reliefweb.int/report/nepal/unicef-nepal-humanitarian-situation-report-7-15-november-2017>.
- Varma, Saiba. 2012. "Where There Are Only Doctors: Counselors as Psychiatrists in Indian-Administered Kashmir." *Ethos* 40 (4):517–35.
- . 2016a. "Disappearing the Asylum: Modernizing Psychiatry and Generating Manpower in India." *Transcultural Psychiatry* 53 (6):783–803.
- . 2016b. "Love in the Time of Occupation: Reveries, Longing, and Intoxication in Kashmir." *American Ethnologist* 43 (1):50–62.
- Vaughan, Megan. 2016. "Changing the Subject? Psychological Counseling in Eastern Africa." *Public Culture* 28 (3):499–517.
- Watters, Ethan. 2010. *Crazy Like Us: The Globalization of the American Psyche*. New York: Free Press.
- Weir, Peter. 1979. *Picnic at Hanging Rock*. Criterion Collection.
- Weyerman, Barbara. 2010. *Close Encounters: Stories from the Frontline of Human Rights Work in Nepal*. Kathmandu: Himal Books.
- Whelpton, John. 2005. *A History of Nepal*. Cambridge: Cambridge University Press.

- Whiting, Alex. 2016. "Mental Health Care in Emergencies 'Not an Optional Luxury'- Experts Say."
Thomson Reuters Foundation, April 13, 2016.
- WHO and Ministry of Health. 2006. "WHO-AIMS Report on Mental Health System in Nepal."
Kathmandu, Nepal: WHO and Ministry of Health.
http://www.who.int/mental_health/evidence/nepal_who_aims_report.pdf.
- Wikan, Uni. 1990. *Managing Turbulent Hearts: A Balinese Formula for Living*. Chicago: University of Chicago Press.
- Wilkinson, Iain, and Arthur Kleinman. 2016. *A Passion for Society: How We Think about Human Suffering*. Berkeley: University of California Press.
- Willen, Sarah. 2007. "Toward a Critical Phenomenology of 'Illegality': State Power, Criminalization, and Abjectivity among Undocumented Migrant Workers in Tel Aviv, Israel." *International Migration* 45 (3):8–38.
- World Bank Press Report. 2013. "Developing Countries to Receive Over \$410 Billion in Remittances in 2013, Says World Bank." *World Bank Press Report*, October 2, 2013.
<http://www.worldbank.org/en/news/press-release/2013/10/02/developing-countries-remittances-2013-world-bank>.
- World Health Organization. 1978. "Alma-Ata Declaration." Geneva: World Health Organization.
- . 2016. "Problem Management Plus (PM+): Individual Psychological Help for Adults Impaired by Distress in Communities Exposed to Adversity." Generic Field-Trial Version 1.0. Geneva: WHO.
- World Health Organization (WHO). 1973. "Report of the International Pilot Study of Schizophrenia." Geneva.
- . 2013. "Building Back Better: Sustainable Mental Health Care after Emergencies." Geneva: WHO. http://www.who.int/mental_health/emergencies/building_back_better/en/.

Young, Allen. 1997. *The Harmony of Illusions: Inventing Post-Traumatic Stress Disorder*. Princeton: Princeton University Press.

Zigon, Jarrett. 2013. "On Love: Remaking Moral Subjectivity in Postrehabilitation Russia." *American Ethnologist* 40 (1):201–15.

———. 2018. *Disappointment: Toward a Critical Hermeneutics of Worldbuilding*. New York: Fordham University Press.