Mental health in war-affected populations
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Chapter 8

Social capital and mental health: connections and complexities in contexts of postconflict recovery

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Submitted
8. Social capital and mental health: connections and complexities in contexts of postconflict recovery

Abstract

The restoration of social cohesion and cooperative action may provide the basis for sustainable peace and development. Social capital may therefore be a relevant construct for conceptualizing postconflict recovery. Another reason to focus on social capital in war-affected settings is its widely recognized relationship with health. Social capital is increasingly considered an important construct in social policy and health, and it has been written into national and international health policies. As yet, however, evidence is scarce that social capital can intentionally be promoted.

The association between social capital and mental health in particular seems to be more complex. If such association exists, promotion of social capital may impact postconflict recovery both through increased social cohesion and through better mental health. It may also be more cost effective in impacting mental health in war-affected populations than individually focused approaches. The existence and nature of a relationship between social capital and mental health, however, needs to be established more rigorously.

This paper first addresses existing evidence of an association between various components of social capital and health, in particular mental health. It then discusses the relevance and complexities of both the intentional promotion of social capital and its relation to mental health in war-affected populations.

Introduction

Social capital is a way of conceptualizing the social world. The notion in its current use was first referred to in scientific literature in the 1960s, and later developed in particular by the sociologists Paul Bourdieu and James Coleman. Robert Putnam, a political scientist, extended its use and succeeded in attracting much attention to the concept. Today, social capital has been written into national and international health policies. It is increasingly considered a central construct with regards to social policy and health.

The core contention of the concept is that social networks are a valuable asset, providing a basis for social cohesion and cooperation. Within networks, trust between individuals can yield trust between strangers, and trust of social institutions. Ultimately it may become a shared set of values, expectations and behaviours. The more a social network is characterized by norms of trustworthiness and reciprocity, the greater the social capital represented. It then acts as the “glue” that holds people and groups together and makes cooperative action possible.
Beyond this basic characterization, a number of alternative formulations of the concept have been proposed. Woolcock has followed Putnam in distinguishing between three major forms of social capital: social bonds (with family and ethnic, national, religious or other groups), social bridges (with other communities) and social links (with the structures of the state). The former are considered “strong ties”—commonly associated with a principally defensive or protective function—while the latter two are “weak ties,” exploited to secure other resources from the environment.

An important distinction can be made between “structural social capital” (i.e. its behavioural component, e.g., rules, procedures, and roles, as may be reflected by civic participation) and “cognitive social capital” (i.e. its perceptual component, e.g., norms, values, and beliefs, as may be manifested in trust). Another distinction is that between the “social cohesion” or “communitarian” theory of social capital, conceptualizing it as the resources available within a community (e.g., trust, norms, mutual assistance), and the “network” theory, defining it in terms of resources within an individual’s social network (e.g., instrumental support, information channels). Analogically, social capital can be seen as a property of groups or communities (“ecological social capital”) as well as of individuals (“individual social capital”). While the construct echoes previous analyses in terms of notions such as social support, the conceptualization is distinguished by an emphasis on trust, networks and norms. Others indicate sense of belonging and civic engagement as essential elements as well. Social capital’s most commonly adopted definition in health sciences recognizes five characteristics: community networks, civic engagement, civic identity (belonging, solidarity, equality), trust in the community, reciprocity and norms of cooperation.

Analysis in terms of social capital has for some years been championed by the World Bank, which has invested in projects seeking to define and measure the concept. The organization embraces the construct’s broadest interpretation. This view encompasses not only horizontal associations between people but also bridging ties which transcend social divides (religion, ethnicity, socioeconomic status), as well as the social and political environment. It recognizes the relevance of support from both the state and the private sector to the strength of social groups and, similarly, the dependency of the state on social stability and widespread popular support. As the World Bank states, “Economic and social development thrive when representatives of the state, the corporate sector, and civil society create forums in and through which they can identify and pursue common goals.”
Social capital, health and well-being
While initially considered principally with respect to economic advancement, the relationship between social capital and health and well-being has been widely recognized.\textsuperscript{14,15} Kawachi and colleagues demonstrated its relation with infant mortality, life expectancy, heart disease, and self-rated health in the USA.\textsuperscript{16} A nationwide survey of the adult Russian population showed that human capital (education, social class, etc.) and social capital independently accounted for a notable amount of variance in self-assessed health, while the latter increased physical and emotional health more than the former.\textsuperscript{17} In rural China, cognitive social capital was found to be positively associated with self-reported general health, psychological health and subjective well-being, although no such associations were found for structural social capital.\textsuperscript{18} Findings from this study suggested that mechanisms through which social capital affected health and well-being were more consistently linked to its “network” than to its social cohesion or “communitarian” aspects. In a review of empirical findings, Eriksson lists the consequences of individual social capital, assumed to positively affect health, as: access to social support, health-enhancing social influence and control, social participation (enhancing cognitive skills, belongingness and life meaning), and material resources. For collective social capital, these are trust and collective action (facilitating a health-enabling environment, healthy norms, information and knowledge, collective efficacy and political influence), and material resources.\textsuperscript{19} Despite such work, the overall picture of findings from empirical studies on the relation between social capital and health is unclear. This is mainly due to the present lack of definitional clarity of the construct of social capital. In order to draw consistent conclusions from studies there is a need to consolidate definitions and refine measurement tools.\textsuperscript{19-21}

Social capital and mental health
While research indicates that components of social capital may be related to positive well-being, the evidence for a contribution to mental health in particular is more ambiguous. The effects of social ties vary with gender, socioeconomic position, and stage in life.\textsuperscript{22} Also, individual networks, and therefore person-related social support and coping behaviour, are contingent on outer layers of ties like civic associations and voluntarism.\textsuperscript{22,23} In a systematic review of studies exploring the link between mental illness and individual and ecological social capital, respectively, DeSilva and colleagues noted that in adults there is strong evidence of an inverse association between levels of individual cognitive social capital and common mental disorders.\textsuperscript{24} At
the time of their review, no convincing evidence existed for a similar association regarding individual structural social capital or ecological cognitive and structural social capital. A later survey in Japan, however, suggested that both cognitive and structural social capital at the ecological level may influence mental health.25

In another review of primary evidence linking social capital and mental health, Almedom suggests that social capital can be both an asset and a liability, and he argues that it is more relevant to assess access to social capital than the possession of it.26 This is confirmed by a study among homeless persons in a mid-sized southern US city, the findings of which suggest that various forms of bonding social capital (trust, religious affiliation, social support) clearly impact depressive symptomatology, but do not overcome the effect of stressors, such as the lack of access to communal resources.27 Patel hypothesizes that the peak in suicide rates observed in England and Wales during the Great Depression may be linked to the breakdown in bridging social capital, as economic recession affects social classes unequally.28 A study among youth in Columbia showed that ‘classic’ poverty variables (poor education, unemployment) were more important than social capital as risk factors for mental ill health.29 Whitley and McKenzie suggest that high social capital may protect mental health, but could also heighten exclusion of those who are different from the norm.30 From their review of relevant literature they conclude that contextual indicators of social capital should be developed, and that research should qualitatively explore which components of social capital have the greatest impact on mental health and well-being.

Social capital has been suggested to be a particularly relevant concept for conceptualising postdisaster rehabilitation. It is assumed that within war-affected populations, existing social support structures are key in mitigating the mental health consequences of violence and loss. A range of qualitative social science studies have highlighted the importance of a social response to disasters that actively engages the political, social, and economic causes of suffering.31 Such work also argues for the affected community playing a primary role in initiating and executing any “intervention.” One of the main principles of the Inter-Agency Standing Committee (IASC), a group bringing a broad range of UN and non-UN humanitarian organisations together to strengthen coordination of humanitarian assistance, is to “build local capacities, supporting self-help and strengthening the resources already present.”32 They state that “in most emergency situations, significant numbers of people exhibit sufficient resilience to participate in relief and reconstruction efforts,” emphasizing that “affected groups of people typically have formal and informal structures through which
they organize themselves to meet collective needs,” and “it is important to build both government and civil society capacities.”

A recent study by Wind and Komproe on posttraumatic stress in inhabitants of a northern English rural town 1 year after it was struck by a severe flood, indicated an inverse relationship between social capital and posttraumatic stress. Multilevel analyses showed that in communities with high social capital a disaster is less demanding for individual psychosocial resources, thereby suggesting that individual psychological interventions and community interventions aiming to foster social capital exert their effect on mental health via the same individual mechanisms.33 This study clearly supports a preference for community interventions over individually-focused approaches in postdisaster (or postconflict) settings, as the first sort can be implemented with relatively few resources. The study leaves the question unanswered, however, if social capital can indeed be intentionally promoted.

Promotion of social capital

In a groundbreaking study of four conflict-affected countries (Cambodia, Rwanda, Guatemala, and Somalia), Coletta and Cullen discuss changes in social capital resulting from violent conflict; the interaction between social capital, social cohesion, and violent conflict; and how conflict prevention, rehabilitation and reconciliation can be promoted by nurturing social capital.34 The authors stress that while violent conflict can destroy primary bonds, it can also create opportunities for bridges to other networks, thereby facilitating social capital to serve as a key source of reconciliation and reconstruction. They conclude that social cohesion and a society’s capacity to manage conflict are determined by the interface of social capital with the integration of vertical and horizontal relations and crosscutting, bridging ties. As the authors state: “The development of civic institutions that cut across traditional bonding social capital to form new links crossing ethnic, religious, age, income and gender lines can provide the basis for the mediation, conflict-management, and conflict-resolution mechanisms that all societies require to sustain peace and development.” Coletta and Cullen provide clear examples of how governments and international actors promote decentralization, civic participation, social inclusion, empowerment, and the strengthening of grassroots movements.

Pronyk et al. studied an intervention in South Africa—albeit not a postconflict setting—that aimed at changes in solidarity, reciprocity and social group membership through an approach which combined group-based microfinance with participatory gender and HIV training.35 A randomized trial indicated that social capital was successfully strengthened: after 2 years there were higher levels of structural and cognitive social capital, while economic and social gains had enhanced participation in social groups.
These two studies show how social capital may intentionally be promoted, but did not establish the effects of measures taken on health outcomes. However, a longitudinal study among postconflict communities in Nicaragua did simultaneously establish the effects of an intervention on both social capital and health. It showed that systematic interventions promoting management and leadership development significantly increased levels of cognitive social capital, including solidarity, harmony and sociability, and also higher levels of civic participation and political empowerment. No such relation was found for trust. The researchers suggest that the interventions sensitized community members to the noted aspects of social capital, but that trust and the translation of attitudes into more behavioural responses (i.e. into structural social capital) may take more time. They also point to indications that in nonwestern cultures cognitive and structural components may be disconnected. For example, in such contexts structural components such as the existence of associations and civil society organizations might be inspired by strategic choices, funding opportunities and “associational entrepreneurship,” rather than by trust and a horizontal cooperative spirit. Brune and Bossert’s study in Nicaragua found that higher levels of social capital, notably participation and contribution to a group, were related to positive individual health behaviours. Cognitive components were associated with positive community health outcomes. The latter study thus serves as an illustration of how contextual factors may not only mediate the relationship between various components of social capital but also between these and health outcomes. This is especially relevant in less developed countries and/or postconflict communities.

**Building social capital in Rwanda**

In Rwanda, where an estimated 800,000 people were killed and millions were displaced during a genocidal period in 1994, a community-based therapeutic group intervention called sociotherapy has been taking place since early 2006. The intervention aims to facilitate a reassessment and redefinition of values, norms, relations and possible collaborations, through an increase of the level of mutual respect, trust and care in group interaction. Key elements of the working method are debates and the exchange of experiences and coping strategies among participants, exercises, games and mutual practical support. The program is open to any adult wanting to participate. Groups contain 10 to 15 participants and are mostly mixed: both sexes, various ethnic backgrounds, and with a wide age distribution. Weekly meetings take place over a period of 15 weeks, lasting 3 hours each. The program has, to date, enabled the participation of over 10,000 beneficiaries.
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Both quantitative and qualitative research has indicated that the sociotherapy program in Rwanda helps to improve the mental health of participants.\textsuperscript{40-42} There is also strong qualitative evidence that the program contributes to mutual trust, support and co-operation, and helps to increase feelings of security and belonging.\textsuperscript{40,41} It stimulates the sharing of networks and prompts the start of income-generating associations. One woman, an HIV-infected widow who expressed her appreciation of the program and was asked why, spontaneously listed the essential effects of the intervention as follows:

“I can share my story; other people’s stories make me feel less alone; we have started feeling responsible for one another; we have actually started supporting one another; we share networks.”

To assess the program’s impact on social capital by use of quantitative methods, the short version of the Social Capital Assessment Tool (Short A-SCAT) was adapted for local use.\textsuperscript{43-45} The instrument has been extensively validated in two resource-poor settings (Vietnam and Peru).\textsuperscript{46} It was chosen because of its limited length and its presumed relevance for the context of Rwanda. Items of the Short A-SCAT can be categorized in three sections: support (received from groups or individuals), civic participation (collaboration within own neighbourhood, communication with leaders), and cognitive social capital (belonging, trust, safety). A baseline assessment suggested potential independence of these various elements of social capital, and indicated how cautiously concepts like belonging and trust should be used. For example, while 83% of the respondents indicated feeling part of their neighbourhood and 84% feeling safe there, 48% indicated not trusting people in general and, indeed, 56% expected people to take advantage of them given the chance. Analysis of postintervention data from assessments by use of the Short A-SCAT indicated a positive impact of the sociotherapy intervention on one specific element of social capital, namely civic participation (Verduin et al., manuscript in preparation). Our study outcomes thus suggested that both mental health and social capital may successfully be promoted by one sole intervention. It remained unclear, however, if the effects on both outcomes were related to one another, and if the salutary effect on social capital would always exclusively apply for the element of civic participation. Further study is required to confirm the sensitivity of the Short A-SCAT as a measure of social capital in such settings; to determine if specific elements of social capital can intentionally be promoted by sociotherapy in different settings; and to unravel the possible links between the effects of the program on mental health and social capital, respectively.
Conclusions
In war-affected populations there is often severe disruption of society’s cohesion. Commonly communities and networks have become fragmented, societal institutions perturbed, cultural values undermined, and material resources destroyed. Additionally, grief and traumatization, along with insufficient health services and a lack of generally felt security, give rise to an increase of mental health problems.

While social capital provides a basis for social cohesion, there are indications that elements of it are linked to mental health. Also, there is broad consensus that mental health and psychosocial programs in postconflict situations have the most impact and cost effectiveness when targeted at community, group and population levels, rather than solely toward individuals. Taking that one step further, such interventions may primarily aim at raising the amount of social capital, e.g., through promoting interpersonal support and intergroup relations, and meanwhile positively affect mental health.

As yet, only few studies, among which our study in Rwanda, have indicated that social capital may intentionally be promoted. Our work there also hints at the potential role of strengthening social capital in supporting mental health and well-being, but indicates the major complexities in disentangling pathways of influence. Future studies may establish which elements of social capital are associated with mental health and well-being in war-affected populations, and how; and if interventions may particularly promote these elements of social capital.
References


