WHY GLOBAL HEALTH MATTERS

How to (Actually) Make the World a Better Place

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CHAPTER 18

The Role of Mental Health in Peacebuilding Interventions: A 3B's Analysis Approach

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This chapter argues that when trauma interventions are informed by culture and context, we are able to come to a deeper understanding of factors that foster resilience in communities and contribute to more effective ways of healing and peacebuilding. Several studies have emerged indicating that using Western approaches to treat mental illness in non-Western cultures could, in some instances, result in detrimental effects such as increasing traumatic stress or complicating the recovery process (Sijbrandij, Olff, Reitsma, Carlier, & Gersons, 2006). The understandably high estimates of mental health disorders in post-conflict and conflict societies make analyzing the role of mental health within peacebuilding interventions imperative. Interventions that address mental health from culturally sensitive, psychosocial perspectives not only contribute to the well-being of individuals and societies, but also have the potential to strengthen peacebuilding initiatives and reduce conflict recidivism.

Applying a mental health perspective to peacebuilding aids in understanding the high resurgence of conflict in fragile states and can inform development or implementation of alternative approaches to solving complex issues in low resource environments (Pham, Weinstein, & Longman, 2004; Vinck, Pham, Stover, & Weinstein, 2007). The mental health of those living in conflict and transitional societies, particularly those who are displaced, is complicated by contextual factors. Psychological health is influenced by pre-existing disorders, traumatic experiences during conflict, and post-conflict psychosocial stressors and resource insufficiency.

In this chapter, psychosocial interventions are defined as interventions developed to positively influence both relationships within communities and individual thought and behavior, not to the exclusion of biopsychological interventions. Though the exclusion of biopsychological interventions often forms the distinction between medical and psychosocial interventions, researchers in this field have become increasingly aware of the need for combining biological, psychological, and social approaches (Williamson & Robinson, 2006). This combination leads to the development of integrated care for patients. Integration of care is important in cases of trauma when expressions of distress can often be somatic, stigmatizing, and variable in different cultures and contexts.

To illustrate the effectiveness of psychosocial interventions and peacebuilding interventions on global mental health, we will consider a *binding, bonding, and bridging* (3B's) perspective. The 3B's model was developed by Catholic Relief Services (CRS) as a community peacebuilding strategy to strengthen social cohesion in deeply divided, conflict-affected societies (CRS, 20106). To the bonding and bridging of social capital theory, the 3Bs methodology adds binding, which is the space for mental and emotional healing and transformation that occurs within an individual. Binding at an individual level is intended to facilitate effective relationship building within single-identity groups (bonding), and for resolving intergroup grievances and reconnecting estranged and adversarial groups across social divides (bridging) (CRS, 2016). We will refer to these concepts throughout the chapter to highlight aspects of psychosocial peacebuilding interventions.

This chapter draws on four main strands of literature: global health, political science, sociology, and psychology. It utilizes case studies from Africa, the Middle East, and South America to illustrate how culture and context relate to conflict, peacebuilding and mental health. To highlight key components of psychosocial peacebuilding, we divide our discussion into four parts. First, we examine the "psych" of psychosocial, second, we look at the "social' within psychosocial, third, we describe the impact of conflict and trauma on youth, and fourth, we emphasize the importance of mental health to peacebuilding and to preventing conflict recidivism.

The Psych in Psychosocial

Culturally informed practices help mitigate the stigma surrounding mental health in many countries. Trauma, shame, guilt, grief, anxiety, and depression typify conflict and post-conflict societies. Acknowledging these aspects and embedding mental health interventions in tandem with other health programming such as maternal-child care, nutrition, and infectious disease prevention reduces stigma, facilitates access to health care, and provides much needed conjunctive care (Jegannathan, Kullgren, & Deva,

2015). Eisenman et al. (2006) observed how primary care providers in post-conflict societies focused on recognition of trauma symptoms and effectively managed mental health disorders, which in turn increased access to care for patients. By focusing on somatization symptoms and applying culturally-informed diagnoses and treatments, Eisenman and colleagues contend that developmental health programs can help destigmatize mental health, reduce misdiagnoses, and adapt Western approaches to treat mental health in post-conflict societies more effectively.

Women are particularly vulnerable to abuse and stigmatization during violent conflicts (Gizelis, 2011). They also cope with domestic abuse, and in theocracies, high levels of discrimination and marginalization (Hajjar, 2014). Because of rape and sexual and physical assault, women contract sexually transmitted diseases and have unwanted pregnancies that lead to rejection by their families and communities. Strategies to counter stigma and shame include building resilience, acknowledging personal strengths, and putting value on physical and social assets. Treatment provided in Sierra Leone illustrates the value of contextual mental health programming that specifically focuses on destigmatizing women's mental health in a post-conflict society (Betancourt et al., 2010).

Sierra Leone

From 1991 to 2002, Sierra Leone experienced a brutal civil war between the ruling regime and the Revolutionary United Front (RUF). Fueled by blood diamonds, the decade-long war resulted in thousands of deaths and the displacement of hundreds of thousands more (de Jong, Mulhern, Ford, van der Kam, & Kleber, 2000, p. 2068). Questionnaires collected from Sierra Leone residents in 1999 documented that 41% of respondents witnessed the murder of a loved one and 99% suffered from a trauma disturbance (de Jong et al., 2000, p. 2067). Civilians caught in the violence were raped, tortured, and killed by perpetrators from both sides of the conflict (Amowitz et al., 2002).

The conflict left an entire population either directly or indirectly traumatized. Tens of thousands became disabled through torture and the amputation of limbs (Berghs, 2011, p.1402). Amputees became unwanted reminders of the past and were stigmatized and shunned by society, resulting in their inability to provide for themselves and their families (Amowitz et al., 2002). Humanitarian programs designed to address their mental and physical needs and to decrease stigma had some success (Conteh & Berghs, 2014). One intervention relied upon traditional proverbs to lessen stigma and to encourage acceptance, forgivenesss, and reconciliation by developing a "there's no bad bush" campaign (Stovel, 2008). Another program established soccer leagues for the disabled to reconnect amputees to their home communities and to encourage resilience

(Wessells, 2008). Other forms of financial and social support came from the national government, non-governmental organizations (NGOs), and the international community and assisted war victims with transportation, crutches, and jobs. However, the humanitarian assistance eventually shifted towards programs focused on poverty reduction and mainstream national health, thereby leaving the needs of many amputees inadequately addressed (Conteh and Berghs, 2014).

Stigma also affected women abductees. Although male and female returnees were stereotyped as violent – and were therefore avoided and isolated – female returnees were also considered damaged property and were ostracized. As such, they were unable to marry and prosper (Betancourt et al., 2008). One of the most effective methods to counter stigma was to encourage family and the community to help returning female child soldiers reintegrate into society (Theresa Stichick Betancourt et al., 2010). Families and communities applied traditional healing practices that spiritually cleansed females, making them culturally acceptable (Stark, 2006). For male soldiers, community-based interventions that encouraged dialog and truth telling were found to be effective. For both males and females, interventions that combined traditional healing techniques, such as dance and use of proverbs, increased empathy between members from all groups of society (Wessells, 2008).

In contrast to grassroots approaches, the highly visible national Truth and Reconciliation Commission (TRC) processes mostly failed to achieve "reparations and reform" (Graybill, 2011). Instead of connecting victims to family and community support systems, the TRC tried to offer a gender sensitive stage in which victims' voices could be heard. From a mental health perspective, rehabilitation efforts could have been more successful if they had addressed issues that the women cared about most, such as providing for their children and restoring relationships with friends and family (Graybill, 2011).

Similarly, Medeiros (2007) found that many of the street children in Sierra Leone were former child soldiers who had been stigmatized and shunned by their family and community. The loss of social support from their soldier and home communities rendered this population especially vulnerable to negative mental health outcomes. However, without adequate interventions to increase individual, group, and community trauma awareness and resilience, ex-child soldiers turned to street gangs for acceptance – a lost opportunity for healing. Traumatized Sierra Leonean children, youth, and their support communities inflicted long-term social costs on the country to the detriment of reconstituting scarce social capital, rebuilding critical social cohesion, and avoiding conflict recidivism.

On a more positive note, since 2002, Sierra Leone has held non-United Nations-supervised elections and witnessed a peaceful transfer of power at

the ballot box. The country has also overcome a major Ebola public health crisis. Continued incorporation of mental health into public health settings and utilization of gender-neutral assessments and treatments has aided in destigmatizing mental health treatment in Sierra Leone (Betancourt et al., 2008; Medeiros, 2007).

Refugees and Internally Displaced Persons (IDPs)

Impacts on refugees and internally displaced persons (IDPs) are essential considerations in peacebuilding outcomes, both in regards to the void created in their home communities and for the challenges faced when reintegrating and coexisting with host communities. Many victims of violence and conflict seek refuge in camps in neighboring countries sometimes for days or weeks, and often for years. It is common for refugees to be stereotyped as violent and mistaken for ex-soldiers. Consequently, refugees experience maladaptive psychosocial adjustment, much like many Liberian refugees who fled to Sierra Leone did (Abdullah, 1998). Refugees also suffer discrimination and victim-blaming. They often are dismissed as poor, lazy, violent, or gangster-like (Loescher, 2002). Refugees with temporary resident status were found to have poorer mental health outcomes, and fears resulting from past trauma experiences have been linked to resistance to repatriate (Steel et al., 2006). Given the sizeable numbers of refugees worldwide, it seems logical to focus greater attention on their long-term psychosocial needs. Such interventions could advance social cohesion, peacebuilding, and development.

Refugee psychology has become a field of its own. It encompasses trauma due to separation from loved ones, loss of occupation and home, and estrangement from familiar surroundings. In practice, mental health therapy, psychological assessment, and social support services typically receive limited attention in resettlement communities. Deeper psychosocial capacity building, which is vital for successful co-existence with host communities and for resettlement, is often missing. Cultural orientation and language trainings are important, but orienting refugees to the host communities' political, economic, and social services systems and introducing them to social norms and outlets within the refugee and host communities allows for economic and social capital acquisition. As CRS' experience in northwest Central African Republic and Cameroon shows, binding, bonding, and bridging exercises conducted with IDPs, refugees, and refugee-impacted communities can be highly effective in facilitating the return of IDPs and refugees to their homes (Talla, 2016).

Mental health initiatives for refugees and IDPs must take into account the cultural underpinnings from the person's past and must consider the effects of resettlement processes. The lack of self-determination within resettlement has been associated with negative outcomes, including poor

mental health and violence (Simich, 2003). Refugees should be empowered and assisted to seek out extended family for better resettlement outcomes (Simich, 2003). Experience shows that when refugees going through resettlement are guided by individual volunteers, stress is reduced, academic achievement is higher, and employment prospects improve (Mcspadden, 1987). Building social capital within resettlement communities starts with trauma interventions, and effective strategies for strong social cohesion are needed on individual, societal, and political levels (Elliott, & Yusuf, 2014).

The Social in Psychosocial

Mental health is connected to intragroup bonding and intergroup bridging in conflict zones. Putting an end to fighting, protecting civilians, creating safe spaces, and holding intra- and inter-group meetings are vital to peacebuilding (Korir, 2009). In addition, individual transformative peacebuilding can empower other individuals in groups and can develop social capacity for political change (Plonski, 2005).

The symbiotic relationship between psychological and social interventions eliminates the need to focus exclusively on one approach. When a person is able to process their own trauma, they become emotionally available to empathize with opposition groups; similarly, this ability to empathize increases protective factors against mental health disorders (Weder, García-Nieto, & Canneti-Nisim, 2011). Bosnia and Herzegovina are good examples of bottom-up peacebuilding endeavors in which an emphasis was placed on developing shared understanding and relationships that promote social cohesion and peacebuilding, with examples of both bonding and bridging interventions (Phillips, Hemmer, Garb, & Graham, 2006). Interventions aimed at increasing horizontal social capital in the Israel-Palestine conflict and in Bosnia and Herzegovina will be explored next. Comparative outcomes stress the importance of mental health, culture, and context in promoting the development of social cohesion.

Israel-Palestine Conflict

The Israeli-Palestinian conflict is historically deep-rooted and long-lasting, and it has been devastatingly traumatic for both sides. Disputes began in the late 1800's over sovereignty during the Zionist movement and became an inter-state conflict with the establishment of Israel in 1948 (Shafir, 1989). There have been multiple attempts to build peace, the most recent of which involved two-party state solution (Breslau, 2010). Since this conflict is deeply rooted in history, the issues dividing the principal actors are embedded within generational culture. In contexts like this, psychosocial interventions must base their efforts in both psychological and sociological principles aimed at reducing intergroup bias. At the same time, they must

give recognition to individual suffering and points of view. Horizontal social capacity building across ethnic groups allows for recognition of in-group experiences. Concurrently, it recognizes similar experiences in outgroups and attempts to eliminate in-group bias through both bonding and bridging (Handelman, 2016).

Several programs in Palestine have attempted to bridge the divide between Israelis and Palestinians. *Beyond Bullets and Bombs: Grassroots Peacebuilding between Israelis and Palestinians* (Kuriansky, 2007) provides illustrations of such initiatives. To stand a better chance of obtaining peaceful conflict outcomes, Kuriansky highlights the need for developing and sharing trauma narratives within and between adversarial groups by combining elements of bonding and bridging (see also Ross, 2004). Socialization of the population within institutional settings like schools, associations, clubs, and places of worship also offers promising avenues to reshape entrenched attitudes and behavior (Paffenholz, 2010). Wallach and Wallach (2000) found that bringing schoolchildren to neutral places to develop relationships humanizes "the other" and reduces the tendency to label and stereotype. Furthermore, acknowledgment of past suffering and traumatic experiences can aid in the process of rehabilitation and reconciliation when implementing programs (Becker, 2015). Above all, it may be argued that although difficult and time consuming, grassroots, person-to-person interventions are the most realistic approach for enabling change within the holy land because of the deep-rooted, long-repeated narrative from both sides that impedes progress in social and political reform (Weder et al., 2011).

Bosnia and Herzegovina

The Bosnian War (1992-1995) witnessed fighting among Muslim Bosnians, Orthodox Serbs, and Catholic Croats in a bid for sovereignty following the dissolution of the former Yugoslav territory (Belloni, 2009). At least 20,000 persons were raped, 100,000 people died, and more than two million were displaced (Momartin, Silove, Manicavasagar, & Steel, 2004, p. 232). The war ended with intervention from North Atlantic Treaty Organization (NATO) forces (Daalder, 1998) and the signing of the Dayton peace agreement in 1995 (Belloni, 2009).

Although the Dayton Accords brought an end to overt conflict, the agreement encouraged ethno-national politics in Bosnia and Herzegovina (Pinkerton, 2016). As a result, the belligerents erected post-war barriers between ethnic groups while vying for power in what they viewed as a zero-sum game. Given the situation, post-war psychosocial programs were developed to address both trauma and social cohesion by reducing inter-ethnic barriers (Derrida, 1997) and by eliminating systemic intergroup bias and favoritism on societal and political levels (Keil & Perry, 2015).

Among the daunting psychosocial challenges facing the new country was the prevalence of Post-Traumatic Stress Disorder (PTSD) in children. Although depression and anxiety disorders were found to be within normal clinical limits after the war, the rate of PTSD in children was estimated to be 74% (Smith, Perrin, Yule, Hacam, & Stuvland, 2002, p. 147). Similarly, a decrease in perceived power and self-esteem, associated with depressive symptoms, was noted in the general population (Carballo et al., 2004). This decrease has been linked to the continuing political ethnic divisions in the country that foster interethnic competition and discrimination. These divisions prevent citizens from forming interethnic associations and coalitions that could otherwise aggregate social, economic, and political needs across groups and constructively engage with and hold the government accountable to the will of people for the common good (see Carballo et al., 2004).

One means of treating PTSD and raising self-esteem in Bosnia and Herzegovina was addressing stigma. Researchers have found that simply replacing the phrase "mental illness" with "mental health" allowed people who would benefit from treatment to accept help (Hasanović, Sinanović, Pajević, Avdibegović, & Sutović, 2006). In other instances, researchers observed that using music and art therapy trauma reduced symptoms in children (Heidenreich, 2005; Kollontai, 2010; Hasanovic et al., 2009). If interventions aimed at addressing trauma have failed, it is largely because they did not recognize that the comorbidity with mood disorders was also related to continued divisions between families, soaring unemployment, lack of resources, and displacement (Carballo et al., 2004).

Above all, the goal of social cohesion interventions was to bring people together to develop empathy, compassion, trust, and communication. Similar to the soccer leagues for the disabled in Sierra Leone, youth football leagues restored families and communities and built inter-ethnic relationships in Bosnia and Herzegovina; however, some sports programs in active conflict zones fostered intergroup bias (Gasser & Levinsen, 2004). Further, instead of bridging social and ethnic divides, the distribution of foreign aid and government institutions within the country have reinforced ethnic boundaries, thereby perpetuating the conflict (Carballo et al., 2004).

In sum, post-war Bosnia and Herzegovina faced significant developmental challenges that were more formidable and difficult to address because of interethnic barriers and untreated trauma. 41% of the population had acquaintances only from their own ethnic group (O'Loughlin, 2010, p. 47). The minimal social trust among adult populations (Hoogenboom & Vieille, 2010) and the high levels of PTSD in children could benefit from a more holistic psychosocial approach along the lines of the 3Bs. Moreover, greater attention to the vertical axis of social

cohesion could alleviate the structural discrimination perpetuated by the state.

Nearly half of the population of Bosnia and Herzegovina wanted to develop friendships with other nationalities (O'Loughlin, 2010, p. 47). If this interest could be coupled with an emerging awareness of the critical role that caregivers play in mental health and peacebuilding, the country would have more effective programming focused on psychosocial family interventions that promote development of coping skills, knowledge of child development, communication skills, and normalizing of experiences through group work (Dybdahl, 2001).

The Challenge of Youth

South Africa is often praised for its peaceful post-apartheid transition. Citizens hoped they would find forgiveness and justice through the Truth and Reconciliation Commission (TRC), but two decades later, South Africans express discontent regarding the lack of justice and progress in equal economic opportunities and land redistribution. Globally, South Africa ranks in the top ten for the highest crime rates (Breetzke, 2016, p. 277), has the fourth-highest prevalence of HIV/AIDS (CIA, 2014, People and Society subsection, para. 25), and has the world's second-highest inequality in wealth distribution as measured by the Gini Index (.63) (CIA, 2014, People and Society subsection, Country Comparison-Gini Index Table).

According to the CIA, South Africa typifies the developing world's youth bulge and high population growth rate. South Africa has 54.3 million (para. 1) people with an annual population growth rate of .99% (para. 10) (CIA, 2014, People and Society subsection). Fifty-four per cent of South Africans are younger than 24 years of age (CIA, 2014, People and Society subsection, para. 7). As with Sierra Leonean youth, South African youths have experienced devastating losses. In South Africa, these losses include the deaths of family members and friends from acquired immune deficiency syndrome (AIDS). Furthermore, youth have been exposed to crime and urban violence and face dismal job prospects. Approximately 22% of the population has had no schooling, and only 12% has had access to higher education (Rensburg & Botha, 2014, p.145). Reducing crime rates, preventing gang violence, and strengthening social cohesion over the long term will depend on effective psychosocial interventions and youth programs (Chase et al., 2007). Internationally, the growing number of children being forced to participate in conflict as perpetrators has led to severe damaging effects on an individual and societal level (Chase et al., 2007). Psychosocial interventions designed specifically for former child soldiers in northern Uganda and Mozambique might serve as models for

other countries where psychosocial interventions for youth are in short supply.

Mozambique

The Mozambique Civil War began in 1977 and lasted until 1992. Fighting between the ruling party, the Front for Liberalization of Mozambique (FRELIMO), and the Mozambique Resistance Movement (RENAMO), claimed almost one million lives and displaced more than five million more (Andersson, 2016, p. 28). Both sides committed atrocities, engaged in forced enlistment, forcibly relocated civilians to cramped camps and villages, and took away their livelihoods (Englund, 2002). Actions by both RENAMO and FRELIMO led to massive starvation of civilians, resulting in hundreds of thousands of deaths (Andersson, 2016, p. 29).

In 1992, following the Rome Peace Accords, United Nations (U.N.) peacekeeping forces entered the country and oversaw a two-year transition culminating in national elections (Fearon, Humphreys, & Weinstein, 2009). Traditional healers in village and town ceremonies conducted one of the more effective programs. Local leaders brought child soldiers back into their home communities to cleanse them of the "war pollution" they had acquired in battle (Pouligny, 2005). Elders and spiritual leaders led symbolic ceremonies in which victims/perpetrators of war could shed the evil that came from being in war and be forgiven and welcomed back into the community (Stark, 2006). In contrast, in a Western therapeutic intervention, Mozambique youth verbally acknowledged their trauma instead of processing it through spiritual experiences or community practices. This resulted in negative effects leading to increased symptomatology (Honwana, 1997).

Despite the relative success of psychosocial programs in Mozambique, fresh fighting between RENAMO and the highly centrist and autocratic FRELIMO-led government broke out in 2013 (Reisinger, 2009). A number of factors accounted for this relapse into violence. They included the politicization of international aid, corrupt resource management (Reppell, Rozen, & de Carvalho, 2016), failure to decentralize the government, and lack of collaboration among peacekeeping and peacebuilding organizations (Reppell, Rozen, & de Carvalho, 2016). In addition, the United Nations Development Program (UNDP) short-term peace building focused on disarmament, demobilization, and reintegration (DDR), rather than on conflict resolution, mental health services, and social cohesion (LeFranc, 2011). As absorptive, adaptive, and transformative capacities of youthful individuals and communities expand, they will improve their resilience to endogenous and exogenous shocks, and they will be better positioned in the future to demand democratic decentralization and accountability for transparent, inclusive government services (Usaid, 2012).

Uganda

Uganda has experienced protracted periods of violent conflict from the Idi Amin dictatorship of the 1970s to the armed rebellion and ascendency to power of Yoweri Museveni in 1986. From 1987 to 2010, self-proclaimed prophet, Joseph Kony, led a movement called the Lord's Resistance Army (LRA), which staged attacks on government forces, but also forcibly recruited child soldiers, kidnapped and enslaved girls, committed atrocities against civilians, and generally terrorized the Acholi people of northeastern Uganda (Vinck et al., 2007). Citizens were caught between the LRA and Museveni's troops in a catch-22 of assumed guilt from both sides (Roberts, Ocaka, Browne, Oyok, & Sondorp, 2008). Some two million IDPs were moved into confined areas resembling concentration camps, which the LRA could easily attack (Branch, 2007, p. 181).

In 2006, a ceasefire was reached between Museveni's Ugandan People's Defense Force (UPDF) and the LRA that pushed the remaining LRA forces into neighboring territories. The peacebuilding process that followed was contentious. The involvement of the International Criminal Court (ICC) pitted proponents of retributive justice against advocates for restorative justice and traditional reconciliation. Moreover, the blurred lines between perpetrators and victims complicated the peacebuilding process. Over the course of the war, the LRA recruited more than 25,000 children and forced them to fight and commit atrocities (Chatlani, 2006, p. 278). Although reaching peace was the main goal of Ugandan citizens, prosecuting only LRA and not UPDF combatants was perceived as a double standard (Chatlani, 2006).

Often described as a war on children, the LRA-UPDF conflict provided insights for evaluating peacebuilding interventions targeted at youth. First, researchers found that citizens living with PTSD or depression in Uganda were more likely to prefer violent over peaceful means for ending the conflict (Vinck et al., 2007). Second, the way traumatic events were processed was found to dramatically affect mental health outcomes, especially for children (Betancourt & Khan, 2008). Third, "meaning making" after traumatic events was found to reduce or prevent the development of PTSD (Betancourt, Meyers-Ohki, Charrow, & Tol, 2013). Following exposure to life-altering traumatic events, child soldiers, IDPs, and refugees reported that their whole world changed. Often, the people essential in processing the events were no longer part of a child's life. Child soldiers were subjected to forced violence, substance abuse, sexual assault, and physical and psychological torture. The extent of suffering, the fragmentation of society, and the absence of individual social support created the need for in-depth, widespread, and extended rehabilitation programs (Roberts et al., 2008).

Individual therapeutic interventions have been shown to be effective in youth populations in Uganda, and even though it is not feasible to deliver these interventions to a large majority of the population, they should not be undervalued because of the extent of trauma within this population. By using local trainees as therapists and conducting sessions within community home settings, narrative exposure therapy has shown to be effective at reducing PTSD symptoms in former child soldiers in Uganda (Ertl et al., 2010). Interpersonal therapy was also found effective in adolescent girls (but not boys) in reducing depression and PTSD symptoms (Bolton et al., 2007). Research has focused on interventions with the specific aim of reducing trauma, but a deeper understanding of factors of resilience within the child soldier subgroup of the population is needed (Betancourt & Khan, 2008).

Societal level interventions to address trauma in Uganda have been designed mainly through the lens of resilience by focusing on social support, meaning making, and attachment (Betancourt & Khan, 2008). Meaning making following a traumatic event is the way in which one is able to understand and make sense of events and is a significant contributor to mental health outcomes in individuals. The separation from family and loved ones following traumatic events disrupted attachment patterns and altered meaning making in youth. This contributed to poor mental health outcomes and the determent of resilience.

Psychosocial interventions focusing on resilience and developmental goals that were conducted in school-based settings were found ineffective across four countries in the region (Ertl & Neuner, 2014). Studies like these underscore the importance of culture and context, individual experience, reaction, and meaning making during war (Kalksma-Van Lith, 2007). Scholarly research also showed that the role and experience of females in conflict must be given distinct attention. There is a need for gender-sensitive health programs as well as programs designed to decrease stigmatization and increase recognition of traumatic experiences for women during war (Liebling-Kalifani et al., 2008).

Mental Health and Recidivism

According to the International Federation of Red Cross and Red Crescent Societies (IFRC), psychosocial interventions promote the restoration of social cohesion. In turn, social cohesion fosters a decreased chance for recidivism of violence by striving to restore fundamental aspects of a community like trust and resilience. Although it is often argued that economic factors are the main determinants of conflict recidivism (P. Collier, Hoeffler, & Soderbom, 2008), one report found that World Bank spending had "no systematic effect on either conflict recurrence or economic recovery" (Flores & Nooruddin, 2009, p. 1). Recidivism, instead,

was linked to anti-social personality traits, lack of education, and weak social support in former soldiers (Kaplan & Nussio, 2016).

To understand the link between mental health and conflict recidivism, it is helpful to compare and contrast experiences from post-conflict societies that have succeeded in maintaining the peace with those of societies that have slid back into conflict. In this respect, we will single out the role of social cohesion strengthening related to mental health in conflict and post-conflict societies. Research shows that 20-50% of countries that have experienced violent conflict return to civil war within a five year period (Suhrke & Samset, 2007, p. 195).

Columbia

Columbia experienced one of the longest violent conflicts. It concluded in 2016 with a peace agreement between the government and the rebel forces, the Revolutionary Armed Forces of Colombia (FARC). The conflict was known as the "forever war" because violence raged for more than fifty years, making the conflict the longest civil war in world history (Johnson & Jonsson, 2013). The FARC claimed to represent the economically disadvantaged and rapidly gained support from other military and rebel groups that shared their goal to restore government to the people (Gill, 2008). Hundreds of thousands died, millions were displaced, and millions more suffered human rights violations committed by both sides of the conflict (Gill, 2008, p. 136). In 2012, peace negotiations began but were bogged down over the issue of amnesty for FARC fighters (Johnson & Jonsson, 2013). Most Columbians were in favor of punitive justice, which made it virtually impossible to reunite former combatants with their families and reintegrate into their communities (Kaplan & Nussio, 2016).

Poor mental health outcomes are often associated with increased recidivism in post-conflict societies. Indeed, some studies have identified appetitive aggression as a protective factor against the development of PTSD (Meyer-Parlapanis et al., 2016). Appetitive aggression is the positive regard towards violent and aggressive acts. In Colombia, those who willingly gave up fighting and had low appetitive aggression, in contrast to those who were forced to disarm collectively, were more likely to develop PTSD and therefore to be more predisposed to violence (Weierstall, Castellanos, Neuner, & Elbert, 2013). This is an important point within the context of peacebuilding and elimination of potential recurring violence. Although former soldiers suffering from PTSD might receive more interventions and aid, those showing resilience were more likely to return to violence because of appetitive aggressive tendencies.

Evaluating individual-level reactions and meaning making after conflict is essential to appropriately applying interventions to decrease recidivism rates. The involvement of IDPs in the peacebuilding process and in

determining funding and reconciliation measures has been noted in research conducted in Colombia and has been a deterrent in other state's progress to peace (as noted previously) (Ferris, 2009). In Colombia, mental health has been found to be most directly correlated to income, rather than to negative social capital (Harpham, Grant, & Rodriguez, 2004). Being a woman and lacking education were the two factors that contribute most to poor mental health. This illustrates the need for both bottom-up and top-down peacebuilding processes as a means to stop recidivism. In Colombia, traumatic experiences and social fabric were not found to be as influential on mental health outcomes relative to economic and educational opportunities (Harpham et al., 2004).

Central African Republic

Since independence in 1960, the Central African Republic (CAR) has experienced cycles of violent conflict and coup d'états (Kane, 2014). CAR sits at the epicenter of an unstable region, which includes Darfur, Sudan, South Sudan, and northeast Democratic Republic of the Congo (DRC). The LRA continues to terrorize villagers in northeast DRC, South Sudan, and southeast CAR. The Seleka rebellion began in December 2012 when a coalition of fighters from the north swept across the country, eventually seizing Bangui on March 24, 2013 (Groelsema & Talla, 2016). Many youth, facing bleak employment prospects, joined armed groups. Violence, lawlessness, and destruction of property ensued, targeting civilians. Anti-Balaka militias sprang up to counter Seleka, ultimately forcing many indigenous and *Mbororo* (Peuhl herders) Muslims to flee the northwest. In 2014, a transitional government was established, and in late 2015 and early 2016, Faustin Archange Touadera was elected president in national elections.

Although the recent conflict is rooted in poor governance and inequality, conflict actors seized upon differences in faith to divide communities. The resulting inter-religious dynamic polarized CAR and instilled fear, mistrust, and hatred between Muslims and Christians. The horrific atrocities were considered by some to be genocide (Vinck & Pham, 2010). To address social disintegration, the interim government requested CRS to train its leaders and civil servants in social cohesion. Some 1,000 officials from the Ministry of Reconciliation and other government agencies, in addition to civil society leaders, participated in CRS' social cohesion strengthening workshops during 2014-2015 (Groelsema & Talla, 2016, p. 2, "How we do it" subsection).

Much of the recent violence occurred within IDP camps, where displaced individuals and families sought protection and food. Observers estimated that the majority of Central Africans witnessed violence directly and that more than half of the adult population qualified as depressed or

suffering from anxiety (Vinck & Pham, 2010, p. 544). Deep divisions along sectarian lines made it imperative that bonding and bridging activities continued in the post-conflict period. However, in late 2016, large Muslim populations were still residing across the border in Chad and Cameroon (Kane, 2014). To initiate bonding and bridging, CRS led social cohesion workshops in northeast Cameroon with Mbororo Muslim refugees and their host communities and with Christian residents of home communities where Muslims had fled. These activities were vital for preparing refugees and IDPs to return to home communities and increased the chances for success of DDR programs.

Efforts to establish peace and stability were long-term in CAR. In collaboration with USAID and the Gerald and Henrietta Rauenhorst (GHR) Foundation, CRS began leading a Global Development Alliance (GDA) consortium in 2015, which supported an Inter-Religious Platform (IRP) in implementing horizontal and vertical social cohesion strengthening, livelihoods development, and peace education nationally within CAR. The social cohesion component utilized the 3Bs model to which elements of Appreciate Inquiry (AI) were added (CRS, 2016). The GDA consortium enlisted Palo Alto University, an institution focused on psychological research and clinical training, to evaluate and inform psychosocial practices. The intent was that collaboration among government, local and international NGOs, civil society, and researchers would result in more informed and effective mental health practices forming an integral part of peacebuilding processes.

Conclusion

This chapter reviewed the significance of culture and context in informing trauma and highlighted differences in coping, symptoms, meaning making, and factors of resilience. The case of Israel and Palestine can be used to illustrate the role of mental health within binding, bonding, and bridging (referred to as the 3Bs framework) of peacebuilding. People who experienced war or structural violence needed binding for personal transformation; they needed bonding with members of their identity group to reach agreement on their historical grievances, present demands, and view of the "other"; they needed bridging to engage traditional adversaries in non-violent, productive ways that acknowledged the right of the other to exist, to mutually prosper, and to live harmoniously with each other. Although the mix and sequencing of binding, bonding, and bridging activities will vary according to context, post-conflict and conflict-prone countries like Sierra Leone, Columbia, and CAR can advance peacebuilding and avoid conflict recidivism through a more intentional and informed combination of psychosocial and broader peacebuilding activities for traumatized civilian populations.

The integrative model, developed by Miller and Rasmussen (2010), applied a sequenced approach to mental health intervention first by addressing daily stressors and then by providing essential mental health services for people who were still struggling after their daily stressors had been reduced or better managed. Nonetheless, many of the necessary coping skills needed for addressing and eliminating daily stressors were often attained via mental health treatment. In highly conflicted environments like Colombia, providing opportunities to overcome daily stressors should not be stigmatized or considered detrimental. In contexts of war and mass violence, in which trauma and social fracturing are the main contributors to poor mental health, psychosocial peacebuilding can enhance mental health while contributing to more productive and sustainable social, political, and economic outcomes.

This review is not meant to denigrate Western mental health practices. Rather, it highlights the additional benefits of socio-cultural approaches, which together accentuate the benefits of citizen involvement in decision-making. Acknowledging the intertwining nature of mental health, social cohesion, and peacebuilding paves the way for reconciliation on multiple levels. A vibrant social fabric is a key contributor to resilience. Developing social cohesion, through horizontal bonding and bridging and vertical social capitalization, aids in protecting against recidivism and negative mental health outcomes.

Interventions that address mental health in conflict or post-conflict societies are increasing internationally and have the goal of destigmatizing access and use of mental health treatment. The role mental health plays within peace-building processes is increasingly acknowledged, and this allows for the development of culturally appropriate assessments and treatments. Research should first establish the relevance and appropriate approach within a particular population and then continue to expand on developing and evaluating the effectiveness of culturally adapted mental health interventions.

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