

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

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In war affected populations there is often severe disruption of societal cohesion. Additionally, grief and traumatisation, along with insufficient health services and a lack of security, give rise to an increase of mental health problems. Social capital is potentially a key resource to support post conflict recovery, and is increasingly considered not merely as a resource supporting economic and social development, but also an important influence on population health. However, linkages between social capital and mental health are complex. Therefore, this article begins with an introduction to the construct of social capital, then provides an overview of the main findings on its relation to health and wellbeing, as well to mental health in general and in post emergency situations. Finally, it explores if social capital may be promoted intentionally, as pursued through a community based sociotherapy programme in Rwanda. While there appears to be a rationale for promoting social capital within post conflict settings, further work is required, both documenting reliable means of securing it and disentangling pathways of influence on social wellbeing and mental health.

Keywords: civic participation, community based psychosocial intervention, mental health, post conflict recovery, social capital, war

Introduction

The primary intention of this article is to explore whether there could be a rationale for interventions aimed at promoting social capital in post conflict settings. The relevance of social capital to recovery in war affected populations will be investigated, as well as whether social capital can

be promoted intentionally. This is presented through a summary of the most relevant findings from literature on the possible relation between social capital and health, in particular, mental health. Additionally, the authors explore what is known about these relationships within post emergency situations and previous endeavours to promote social capital, include examples from their work in Rwanda, and offer tentative conclusions from their findings.

Social capital

Social capital is a way of conceptualising the social world. Its use within scientific literature dates from the 1960s (Jacobs, 1961), with the application developed later, by the sociologists Pierre Bourdieu (1986) and James Coleman (1988). Robert Putnam (1993; 2000), a political scientist, then further extended its use and succeeded in attracting a lot of attention for the concept. Today, social capital has been written into national and international health policies and is increasingly considered a central construct, in regard to social policy and health (McKenzie & Harpham, 2006).

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 (Beem, 1999). The more a social network is characterised by norms of trustworthiness and

reciprocity, the greater the social capital is represented. It then acts as the 'glue' that holds people and groups together, and makes cooperative action possible.

Beyond this basic characterisation, a number of alternative formulations of the concept have been proposed. Woolcock (1998) has followed Putnam in distinguishing between three major forms of social capital: social bonds (with family and co-ethnic, co-national, co-religious or other forms of groups), social bridges (with other communities, between socially heterogeneous groups) and social links (with the structures of the state). The former are considered 'strong ties', commonly associated with a principally defensive or protective function (e.g. 'together we are strong') While the latter two are 'weak ties', exploited to secure other resources from the environment (e.g. 'knowing someone high up may help your career').

A distinction can also be made between 'structural social capital' (i.e. its behavioural component, such as rules, procedures and roles, as may be reflected by civic participation) and 'cognitive social capital' (i.e. its perceptual component, such as norms, values and beliefs, as may be manifested in trust) (Uphoff & Wijayarathna, 2000). Another distinction is that between the 'social cohesion' or 'communitarian' theory of social capital, conceptualising 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) (Kawachi, 2006). Analogically, social capital can be seen as the 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 conceptualisation is distinguished by an emphasis on trust, networks and norms. Others indicate sense of belonging and civic engagement as essential

elements (Field, 2003; McKenzie & Harpham, 2006). Social capital's most commonly adopted definition in health sciences recognises five characteristics: community networks, civic engagement, civic identity (belonging, solidarity, equality), reciprocity and norms of cooperation, and trust in the community (Putnam, 1993).

Analysis in terms of social capital has, for some years, been championed by the World Bank (Internet-a). Within the framework of this article, the organisation's statements are relevant given its mandate of worldwide poverty alleviation and the well established existence of strong links between low socioeconomic status and poor mental health. The World Bank (Internet-b) has, in recent years, adopted a more holistic, participatory and results based approach to development and poverty reduction. This approach incorporates the notion that development must be inclusive, comprehensive and country owned in order to be effective and sustainable over the long term. In other words, the World Bank embraces the construct of social capital's broadest interpretation. This view encompasses not only horizontal associations between people, but also bridging ties which transcend social divides (religion, ethnicity, socioeconomic status). It recognises 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 upon social stability and widespread popular support. The World Bank (Internet-c) suggests that "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 wellbeing

While initially considered, with respect to economic advancement, the relationship between social capital, health and wellbeing has been increasingly recognised (Lomas,

1998; Hawe & Shiell, 2000). Kawachi et al. (1997) demonstrated social capital's association with infant mortality, life expectancy, heart disease, and self-rated health in the USA. 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 social capital increased physical and emotional health more than the human capital (Rose, 2000). In rural China, cognitive social capital was found to be positively associated with self-reported general health, psychological health and subjective wellbeing, although no such associations were found for structural social capital (Yip et al., 2007). Findings from this study also suggested that mechanisms, through which social capital affected health and wellbeing, were more consistently linked to its 'network' than to its social cohesion or 'communitarian' aspects. In a review of empirical findings, Eriksson (2011) lists the benefits of individual social capital that are assumed to positively affect health as: access to social support, health enhancing social influence and control, social participation (enhancing cognitive skills, sense of belonging and life meaning), and material resources. Health relevant benefits of collective social capital are seen to be trust and collective action (facilitating a health enabling environment, healthy norms, information and knowledge, collective efficacy and political influence), and material resources.

Findings from empirical studies on the relationship between social capital and health, while generally supportive of such suggested links, have been somewhat inconsistent. This appears to be related to the lack of definitional clarity of the construct of social capital used across studies. In order to draw consistent conclusions from studies there is a recognised need to consolidate definitions and refine measurement tools (Eriksson, 2011; Lochner, Kawachi &

Kennedy, 1999; Whitehead & Diderichsen, 2001).

Social capital and mental health

While research generally suggests that social capital may be related to positive wellbeing (see above), the evidence for its contribution to mental health in particular is more ambiguous. The effects of social ties vary with gender, socioeconomic position, and stage in life (Kawachi & Berkman, 2001). Also, individual networks, and therefore person related social support and coping behaviours, are contingent on outer layers of ties, such as civic associations and voluntarism (Kawachi & Berkman, 2001; Wind, Fordham & Komproe, 2011). Finally, the adequacy of emotional response depends on the very situation that elicits them; for example, certain behaviour may be socially unacceptable in usual circumstances, but perfectly suitable as a survival strategy within insecure contexts.

In a systematic review of studies exploring the link between mental illness and individual and ecological social capital, respectively, DeSilva et al. (2005) noted that in adults there is strong evidence of an inverse association between levels of individual cognitive social capital and common mental disorders. 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 (Hamano et al., 2010).

In another review of primary evidence linking social capital and mental health, Almedom (2005) suggests that social capital can be both an asset and a liability, arguing that it is more relevant to assess access to social capital than to possess it (because possession brings liability). This is supported by a study among homeless persons in a mid sized southern US city,

which suggested that various forms of bonding social capital (trust, religious affiliation, social support) impact depressive symptomatology, but does not overcome the effect of stressors, such as the lack of access to communal resources (Irwin et al., 2008). Patel (2010) hypothesised 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. A study among youth in Colombia showed that 'classic' poverty variables (poor education, unemployment) were more important than social capital as risk factors for mental ill health (Harpham, Grant & Rodriguez, 2004). Whitley & McKenzie (2005) suggest that high social capital may protect mental health, but can also heighten exclusion of those who are different from the norm. 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 wellbeing.

Social capital and mental health in post emergency situations

Social capital has been suggested to be a particularly relevant concept for conceptualising post disaster 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 (Batniji, van Ommeren & Saraceno, 2006). 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 global Inter-Agency Standing Committee *Guidelines on Mental Health and Psychosocial Support in Emergency Settings*

(IASC, 2007) is to 'build local capacities, supporting self-help and strengthening the resources already present'. These guidelines further state that 'in most emergency situations, significant numbers of people exhibit sufficient resilience to participate in relief and reconstruction efforts', emphasising 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 & Komproe (2012) on posttraumatic stress in inhabitants of a northern English rural town, one 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. This study clearly supports a preference for community interventions over individually focused approaches in post disaster (or post conflict) settings, given that the former can be implemented with relatively modest resources. The study leaves unanswered, however, the question of whether the development of social capital can indeed be intentionally promoted.

Promotion of social capital

In a ground breaking study of four conflict affected countries (Cambodia, Rwanda, Guatemala and Somalia), Coletta & Cullen (2000) discussed: 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. 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 is determined by the interface of social capital with the integration of vertical and horizontal relations and cross-cutting, 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 & Cullen provide clear examples of how governments and international actors promote decentralisation, civic participation, social inclusion, empowerment, and the strengthening of grass roots movements.

Pronyk et al. (2008) studied an intervention in South Africa (albeit not a post conflict setting in the strict sense of (civil) war) that aimed at changes in solidarity, reciprocity and social group membership through an approach that combined group based micro finance with participatory gender and HIV training. A randomised trial indicated that social capital was successfully strengthened: after two 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 suggest that the development of social capital may intentionally be promoted, but did not establish the effects of measures taken on health outcomes. However, a longitudinal study among post conflict communities in Nicaragua did simultaneously establish the effects of an intervention on both social capital and health (Brune & Bossert, 2009). 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 sensitised 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 non western cultures, cognitive and structural components may be disconnected. For example, in such contexts, structural components (such as the existence of associations and civil society organisations) might be inspired by strategic choices, funding opportunities and *'associational entrepreneurship'*, rather than by trust and a horizontal cooperative spirit (Molenaers, 2003). Crucially, Brune & 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 may be of special relevance in considering the potential for interventions within post conflict communities. In the meantime, endeavours to promote social capital within contexts of ongoing instability and insecurity may face challenges, such as mistrust deemed as a proper attitude.

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 (Richters, Dekker & Scholte, 2008). The intervention aimed to facilitate a re-assessment and re-definition

of values, norms, relations and possible collaborations, through an increase of the level of mutual respect, trust and care within group interaction. Key elements of the working method include debates, the exchange of experiences and coping strategies among participants, exercises, games and mutual practical support. The programme was open to any adult wanting to participate. Groups contained 10 to 15 participants, and were mostly mixed: i.e. both sexes, various ethnic backgrounds, and with a wide age distribution. Weekly meetings took place over a period of 15 weeks, lasting three hours each. The programme enabled the participation of over 10,000 beneficiaries (Significant Change Stories Project, 2011).

Both quantitative and qualitative research has indicated that the sociotherapy programme in Rwanda helped to improve the mental health of participants (Richters, van Brakel & Dekker, 2008; Richters, 2010; Scholte et al., 2011). There is also strong qualitative evidence that the programme contributed to mutual trust, support and cooperation, and helped to increase feelings of security and belonging (Richters, van Brakel & Dekker, 2008; Richters, 2010). It stimulated the sharing of networks and prompted the start of income generating associations. One woman, an HIV infected widow who expressed her appreciation of the programme 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, and we share networks.'

To assess the programme's impact on social capital by use of quantitative methods, the short adapted version of the Social Capital Assessment Tool (Short A-SCAT) was adapted for local use (Harpham, Grant & Thomas, 2002; Tuan et al., 2005; Verduin

et al., 2010). The instrument has been extensively validated in two resource poor settings (Vietnam and Peru) (DeSilva et al., 2006). It was chosen because of its limited length and its presumed relevance to the context of Rwanda. Items of the Short A-SCAT can be categorised in three sections: support (received from groups or individuals), civic participation (collaboration within one's own neighbourhood, communication with leaders), and cognitive social capital (belonging, trust and safety). For example, one item in the questionnaire's support section asks: *'in the last 12 months did you receive any help in improving your economic situation from the group(s).'*² While an item in the cognitive social capital section asks: *'do you think that many people in your area/neighbourhood would try to take advantage of you if they had the opportunity.'*

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 post intervention 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 under review). Our study outcomes suggested, therefore, that both mental health and social capital may successfully be promoted through a single intervention. A relation between the effects on both outcomes, however, could not be shown, and it remains unknown whether the salutary effect on social capital would always exclusively apply for the element of civic participation.

With regard to the earlier discussion, 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 psychotherapy in different settings; and to unravel the possible links between the effects of the programme on mental health and social capital, respectively.

Conclusions

The systematic violence of war usually leads to severe disruption of societal cohesion, which, in turn, may cause a further increase of prevailing mental health problems among the affected population.

While social capital provides a general basis for social cohesion, there are indications that specific elements of it may be linked to mental health. There is broad consensus that mental health and psychosocial programmes in post conflict situations have the most impact, and by consensus cost effectiveness, when targeted at community, group and population levels, rather than solely toward individuals (IASC, 2007). Linking these observations suggests that interventions might appropriately target raising levels of social capital, e.g. through promoting interpersonal support and inter-group relations, thereby positively impacting mental health.

As yet, however, only a few studies have documented the successful promotion of social capital. The author's work in Rwanda hints at the potential role of strengthening social capital in supporting mental health and wellbeing, but indicates the major complexities in disentangling pathways of influence. Future studies need to establish which, and how, elements of social capital are associated with mental health and wellbeing, and which interventions are most successful in promoting these elements in war affected populations.

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