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**Title:** Re-thinking recovery in post-conflict settings: Supporting the mental well-being of communities in Colombia

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**Key Messages**

- Availability and access to post-conflict mental health services are scarce within many areas of Colombia
- Models of post-conflict recovery are currently anchored to Western models of treatment and care – with only minor adjustments to fit into ‘local’ realities. These often underestimate material contexts that support management of adversity and promote long-term well-being.
- Findings suggest the importance of political and cultural contexts (primarily family) to mental health recovery in Colombia, the former which is largely overlooked in recovery paradigms
- We suggest the value of interventions that develop community mental health competencies to promote development of socio-political resources in communities.

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**Re-thinking recovery in post-conflict settings: Supporting the mental well-being of internally displaced communities in Colombia**

**Abstract**

Addressing mental health needs is a central focus of the Colombian Government's framework for socio-political reconstruction following over 60 years of conflict. Informed by WHO standards, country efforts utilise biopsychosocial models that prioritise individual psychological and psychiatric conditions. However, increasing scrutiny of the deployment of Western approaches to mental health and recovery in the global south suggests a need to explore the best route to improving mental health outcomes.

Our research contributes to these debates through a qualitative study of local understandings of mental health recovery related concepts among internally displaced persons in Colombia. Analysis of focus groups with 40 internally displaced men and women established definitions for emotional distress and recovery as parallel processes linked to the fracture and rebuilding of social worlds and family life. Definitions were shaped heavily by cultural, political, economic and legal contexts of everyday survival, often linked to experiences of structural and symbolic forms of violence. We conclude that a locally informed mental health recovery model that stretches beyond individual experiences of mental ill-health to promote ideas of collective social change would be best suited to addressing mental health needs of internally displaced groups in Colombia. Implications for practice are discussed.

## Introduction

How can the mental well-being of conflict-affected communities be supported in the long term? Colombia is home to one of the world's longest civil wars, which resulted in 220,000 deaths and the internal displacement of more than 7 million people (Centro Nacional de Memoria Histórica, CNMH, 2018). As part of its ongoing peace and reconciliation process, the Government established a framework for socio-political recovery that aims to redress both structural and socio-emotional impacts of the conflict. As such, addressing mental health consequences is a priority, alongside the wider project of reconciliation. The latter has absorbed the bulk of resources to date, led by the work of the Centro Nacional de Memoria Histórica (National Centre for Historical Memory)<sup>1</sup>. However, the 2015 national health survey has drawn attention back to mental health, identifying high levels of unmet need. For example, of the 66% of adults requesting access to services in the last 12 months, only 1/3 received treatment or support (Ministerio de Salud y Protección Social, 2015).

Current pathways for mental health care overwhelmingly favour the use of brief psychological and pharmaceutical intervention that focus on disease symptomology (Chaskel et al., 2015). In particular, Cognitive Behavioural Therapy (CBT), problem-solving therapy, and brief individual and group psychotherapy have been adapted and delivered across the country (see Sanchez-Padilla et al., 2009), informed by evidence suggesting their success in other conflict-affected regions (Tol et al., 2011). However, such approaches have been criticised for their inability to support long-term mental health recovery in complex non-western settings (Harper & Speed, 2012; Secker, Membre, Grove & Seebohm, 2002; Bayetti, Jadhav & Jain, 2016; Barakat & Zyck, 2009; Sanchez-Padilla et al., 2009). These demonstrate

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<sup>1</sup> The NCHM was created from law 1448 of 2011 (the victim's law) with a mandate to guarantee the non-repetition of Colombia's violent past through the construction of collective memory of atrocities for all members of the country.

the need to ensure treatment modalities are suitable to particular contexts prior to the launch of large-scale implementation programmes.

It is at this juncture that our paper makes its contribution. In line with critiques warning against the dangers of importing western models of mental health treatment and recovery in non-western settings (Bayetti et al., 2016), we begin with the position that local understandings of key concepts and constructs linked to mental health recovery should be the starting point of service planning. Drawing on analysis from the initial phases of a participatory action research study on the mental health needs of internally displaced persons (IDPs) in Colombia, we seek to answer the following research questions: *how do local communities understand and define key concepts linked to mental health recovery? How might we ensure the best fit between local needs and mainstream models of treatment and support?*

First, the paper provides an overview of the Colombian context and current strategies to promote mental health recovery by state and non-state entities, with a brief discussion of the potential contribution of a recovery paradigm (Anthony, 1993) to local efforts. Next, it reports on our analysis that established local operational definitions for key concepts linked to mental health recovery and wellbeing. The paper concludes with discussion of a potential model to guide the development of interventions as part of post-conflict reconstruction in Colombia.

### ***Colombia's Armed Conflict: Mental Health Concerns***

On 30<sup>th</sup> November 2016, the Colombian government ratified a modified peace agreement ending violence between the largest guerrilla group Revolutionary Armed Forces of Colombia People's Army (FARC-EP) and bringing an end to a 64-year long conflict. In 2011 the state began formal recognition of victims, through the passing of the Victims and

Land Restitution Law (Law 1448, 2011), which established a framework for delivering reparations to Colombians impacted by the conflict. The legislation recognises victims of events after January 1<sup>st</sup>, 1985, and seeks to deliver ‘truth, symbolic reparation and the guarantee of non-repetition’ (p. 5) through the coordination of partners from the public and private sectors of society. The law formally recognises several categories of victims: ex-combatants (army and child soldiers recruited by illegal groups), forcefully displaced individuals, victims of sexual violence, and the relatives of deceased individuals. Victims are given access to free health care, education and different forms of reparation, guided by the national framework of support (see Table 1). Economic reparations focus on the provision of material and structural resources to help families rebuild their lives and can take the shape of continued monthly financial support or one-off payments in recognition of a traumatic event that has occurred during the conflict, such as the murder of a family member or rape. For farmers and indigenous populations, restitution of lands lost during the conflict is also a common expectation.

**-Insert Table 1-**

The war resulted in countless atrocities recognised and unrecognised by the state. Three different groups of armed actors, have been linked to crimes across the country: left-wing guerrillas, right-wing paramilitaries and The National Army. For example, in 2000, the paramilitaries tortured and killed people in the Montes de María region (Caribbean) for 5 days (CNMH, 2009); in 2002, the FARC guerrillas bombed a local church in Bojayá, Chocó, killing 80 people, most of them children (CNMH, 2010). The National Army was linked to

the murder of young men in deprived areas of Bogota, as part of attempts to provide evidence for the capture of guerrilla soldiers (CNMH, 2016) <sup>2</sup>.

The physical consequences of these atrocities are one area of concern. Campo-Arias and Herazo (2014) and Campo-Arias, Oviedo and Herazo (2014) meta-analysis explored the hidden burden of mental health conditions facing victims of the conflict, with an emphasis on IDPs. In relation to mental disorders, symptom prevalence ranged from 9.9-63%; prevalence of possible cases ranged between 21 – 99.3% , and prevalence of confirmed cases between 1.5 – 32.9% . Most studies focused on the expression of PTSD and common mental disorders (anxiety and depression). These findings are in line with the recent national survey (Ministerio de Salud y Proteccion Social, 2015) which identified that 40% of adults aged 18-45, and 44% of adults over 45 have experienced a traumatic event. 7.9% of the population reported the armed conflict as a traumatic event, with nearly 46% who have experienced symptoms of psychological trauma. Depression was identified as the most prevalent mental disorder nationwide.

The NCHM was established in 2011 to promote a shared memory of the conflict in the public sphere in the hopes of promoting peace. Their methods have identified high levels of mental distress nationally. Narrative work with victims uncovered a range of emotional and psychological distresses linked to symbolic and structural violence in communities (CNMH, 2018). Structural violence (Galtung, 1965), a concept popularised by Paul Farmer (2003) is defined as the structural factors embedded in state systems and everyday life that result in harm or limit the ability of individuals to thrive. Among displaced populations in Colombia, structural violence is linked with economic deprivation, inequalities, and insufficient job opportunities that drive intergenerational poverty (Franco, Suárez, Naranjo, Báez & Roza,

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<sup>2</sup> This process was referred to as the murder of ‘false positives’

2006; Ruiz-Eslava, 2015). Lemaitre (2016) and others (Ibáñez & Velásquez, 2009) found this established difficulty in meeting basic needs, including rent and travel. The emotional consequences of symbolic violence defined as the infliction of harm as a result of the misrecognition of identity and restricting of personhood among marginalised groups by more powerful members of society (Bourdieu, 1988) - receives considerably less attention in post-conflict reconstruction efforts (Franco, 2003; Abello-Llanos et al, 2009). For example, while the registration of people as displaced can provide pathways to state support, the label carries dual symbolism, where individuals are viewed as possible members of armed groups in host communities (Ibáñez & Velásquez, 2009). This label carries its own stigma and can lead to social isolation that is known to impact negatively on emotional well-being in the long term (Abello-Llanos et al, 2009; Daniels, 2018).

### ***Responding to unmet need: addressing conflict related mental health issues***

It was not until 2012 that the *Ministerio de Salud y Proteccion Social*<sup>3</sup> took ownership of efforts to address the mental health needs of conflict-affected groups as part of a 10-year strategy (Ministerio de Salud y Proteccion Social, 2012). By 2021, the strategy claims that all municipalities will have constructed, defined and implemented a social agenda providing a multi-sector response to the mental health needs of victims (Ministerio de Salud y Proteccion Social, 2012). Part of this process involved the completion of the national mental health survey in 2015, which attempted to capture the impact of armed conflict and related violence on mental health. Violence was conceptualised in three ways: collective (racism, gangs, among others), political (wars and armed conflicts) and economical (unmet needs), largely in line with the WHO definition of violence as:

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<sup>3</sup> Colombia Department of Health and Social Protection



The intentional use of physical force or power, threatened or actual, against oneself, another person, or against a group or community, that either results in or has a high likelihood of resulting in injury, death, psychological harm, maldevelopment or deprivation (WHO, 2002).

Mental health consequences of violence are given special attention within the Programme for Psychosocial and Integrated Health Care for Victims (Programa de Atención Psicosocial y Salud Integral a Víctimas – PAPSIVI) programme, and 2013 legislation for mental health, which states that particular attention has to be paid to victims of the armed conflict. Assessments of victimhood include screening for deprivation and multiple health conditions (including substance abuse, suicidal ideation and chronic illnesses), reflecting a desire to address physical and emotional consequences linked to the conflict (Ministerio de Salud y Protección Social, 2012).

PAPSIVI's attention to the relationship between mental health and socio-structural realities shares common threads with the recovery tradition in mental health. The Recovery tradition has roots in the deinstitutionalisation and service user movements that dominated the 70's and 80's globally. It avoids illness labels and their associated stigma, emphasising the restoration of personhood and social and emotional wellbeing (Anthony, 1993). Treatment of specific illness forms one dimension of recovery models, highlighting the importance of factors such as work, social networks, trust, hope and self-esteem (Dickens, Weleminsky, Onifade & Sugarman, 2012). However, recovery models in high-income settings have faced critiques concerning their ability to grasp the complexities of contexts where mental wellbeing is achieved over time (Vandekinderen, Roets, Roose & Van Hove, 2012). Insufficient attention to the impacts of issues such as race, ethnicity and socio-political contexts on long-term mental health recovery (Arias-López, 2013) has been linked to the personalisation of

societal risk among individuals who struggle to meet the ideal picture of a ‘recovered’ person in complex settings (Harper & Speed, 2012). These positions resonate with the realities of post-conflict reconstruction in Colombia, where research has identified complex webs of stigma that already surround victims, even in the absence of mental health diagnosis (Campo-Arias & Herazo, 2014). Wider socio-political contexts also have the ability to shape the effective delivery of mental health services (Burgess, 2015), which is critical given that many recovery frameworks rely on the availability of functional mental health systems that work across disciplines to meet a wide range of needs (Bayetti et al., 2016).

While state efforts to expand services reflect a positive policy environment in theory, in practice many gaps remain. As such, our analysis attempts to identify the approaches best suited to promote long-term mental health recovery for internally displaced Colombians, through a study exploring local understandings of key recovery concepts.

## **Method**

### ***The Study***

This paper reports on a mental health and wellbeing project, which is embedded in a larger study exploring the adaptation processes of IDPs in Colombia. The project is a partnership between the Authors’ institution and the CNHM and expands on current efforts by the state to promote mental health recovery. The primary aim is to support IDPs in developing mental health enabling environments (Burgess & Matthias, 2017) in their communities.

The project is guided by participatory action research principles. According to Loewenson, Laurell, Hogstedt, Ambruso and Shroff (2014), participatory action research occurs along an ongoing cycle of five stages: *systematising experience, collectively analysing*

*and problematizing, reflecting on and choosing action, taking and evaluating action and systematizing learning.* This paper reports on findings from the systematising experiences stage, which aims to establish contact between participants and researchers, and develop a new community of practice linked to shared understandings of the topic, key terminology and aims of the research. As such, activities and methods used in this stage are geared towards the development of a shared language and working definitions for key concepts that will guide the rest of the project.

### ***Conceptual Framework***

We combine two conceptual frameworks in order to elicit a contextually relevant definition of mental health recovery for IDPs in Colombia. First, we are concerned with the concept of community, as ‘community-based mental health’ is a pillar of national and global mental health policy frameworks (Ministerio de Salud y Protección Social, 2012; WHO, 2013). In typical approaches to community mental health, definitions are anchored to notions of community of place (geography), or diagnostic community (South, Public Health England, 2015). However, we argue that such positions are limiting, as they fail to acknowledge the plasticity and action inherent in the process of creating community; the everyday actions and engagements between individuals that enable them to feel that they are a part of a collective. Such arguments are mirrored in the work of Howarth, Cornish and Gillespie (2014) who conceptualise community as groups constituted through shared goals and actions. Invoking this definition allows us to explore communities of place, space and ideology simultaneously, not simply to identify their presence, but to understand their purpose and action with respect to the promotion of long-term mental health and wellbeing.

In order to contextualise notions of recovery, our analysis is guided by Saul Franco’s (2003) explanatory contexts theory. Franco’s (2003) conceptualisation of violence in

Colombia states that explanatory contexts support the exploration of phenomenon in light of the specific cultural, economic and social-political conditions that make it possible and understandable. This perspective illuminates the contexts that drive local understandings of mental health recovery in relation to this particular post-conflict moment, to inform service design that matches the specific histories and challenges facing participants. While similar to Arthur Kleinman's notion of explanatory frameworks used in cross-cultural mental health research (Kleinman, Eisenberg & Good, 1978), Franco's contexts enable us to explore mental health meanings in light of important socio-political and legal contexts.

According to Franco, violence in Colombia is shaped by four key contexts; the political, which is linked to a weak government with low credibility, high corruption and a weak State presence; the economic, related to poverty and structural inequality, which lays the foundations for violence, such as the uneven distribution of land among citizens; the cultural relates to social values that are linked to feelings of hate and revenge between various communities in the population, such as uneven access to education. Finally, the legal context represents problems with the implementation of law, which in turn promotes impunity.

### ***Setting***

The study was conducted in a Colombian municipality unaffected by the armed conflict. As such, there are no armed actors within the zone and it experiences relative economic and institutional stability. The municipality contains an active industrial zone, providing employment opportunities in formal and informal sectors, including construction and flower farming. These characteristics drive migration of individuals from across the country in search of better opportunities. 32% of the displaced population that arrives in this province settles in the study municipality, giving it one of the highest levels of IDPs in the region. Most families who choose to settle in the study municipality do so on the advice and

recommendation of friends and families who have moved there previously and cite economic opportunities. When individuals migrate to new areas, they need to present at the local municipal government offices to declare their status as victims to gain access to supports, which helps populate a local database with details including municipalities of origin and other personal details.

### *Sample*

Participants were randomly selected from the municipality's formal register of victims, which is coordinated by the local victims liaison officer as part of a research partnership between the Colombian University and the municipality. Researchers randomly selected participants and the liaison officer contacted potential participants, inviting them to a public meeting where the project was introduced. A total of 40 IDPs (28 women, 12 men) agreed to participate in the study and focus groups (n=6) were held across three days in April 2017. Discussions lasted an average of 3 hours each. Ethical approval was provided by the authors Institution Psychology Department in the UK (Ethics ID 4053216) and in Colombia (Project PSI-65-2017 Ethics ID 102). Participants are summarised in table 2, with full details for each participant in supplementary data table 1.

The municipality where this study is based was not the first place of arrival for many participants during their journey. Forced displacement in Colombia involves multiple migrations within the country by families and individuals until they find a place that can meet their basic needs. Such migration in Colombia due to conflict largely involves movement from rural and peripheral municipalities to areas closer to the capital. As such, participants in this study have originated from different regions, including Sucre, Antioquia, Santander and

Cundinamarca<sup>4</sup>. In these regions, multiple municipalities have been sites of active combat between different groups of armed actors including paramilitary, guerrilla and State forces.

**Table 2 here-**

### *Data collection methods*

Focus groups were organised around participatory learning activities, as part of efforts to explore and share individual experiences and develop collective understandings about the study's key concepts: *emotional distress, wellbeing, recovery and the future*. 'Emotional distress' was used in place of a specific disease category (i.e. depression, anxiety or PTSD) in line with critical mental health research that argues against the imposition of biomedical terminology in contexts where services are hard to reach; pre-existing knowledge of mental health issues may be low; and mental health stigma may be high (Burgess, 2014). Other terms were selected to reflect the broad parameters of the mainstream mental health recovery paradigm (See Anthony 1993, Dickens et al., 2012).

Tree of life (see Figure 1) (Ncube, 2006) and word association tasks (see Figure 2) helped to elicit complex, contextually rich discussions around our key concepts. For the word association task, participants were asked to write a definition for each of the concepts listed above. Flash cards were collected and placed on the wall, and discussion about each concept followed. In the tree of life task, each participant designed a tree to represent their personal histories of conflict and emotional experiences. At the roots they depicted their personal experience of the conflict. At the trunk, they depicted any current emotional distress, articulating how this fed out of their histories. Finally, the leaves enabled the depiction of dreams and expectations for the future or their 'recovered' self. Each individual presented

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<sup>4</sup> Specific details will not be provided in order to protect the identity of our participants.

their tree to the wider group, and subsequent discussion explored similarities and differences in stories. Given the nature of participants' experiences, focus groups were often emotional for participants and researchers. As such the study protocol dictated that individuals who became distressed during workshops were approached at the end of sessions and provided with referrals to the psychological services unit at the second author's institution<sup>5</sup>.

### **Data Analysis**

Audio-recordings were transcribed and translated into English by a Colombian member of the research team prior to coding. Transcripts were read multiple times by both authors to become familiarised with the data. Data analysis followed an expanded version of Attride-Stirling's (2001) thematic network analysis called *grounded thematic network analysis* (Burgess, 2013). This method combines grounded theory insights with Attride-Stirling's structured thematic networks, in order to establish a more reflexive engagement with context during coding. The process involves the addition of a thematic category titled 'contexts', to help make explicit the dimensions of social context related to themes derived at the organisational level, where first order claims about the data are made.

In phase one of our analysis, codes were identified from focus group transcripts using large chunks of participant speech as units of analysis. Codes were then grouped into basic themes. This first phase occurred over a two-week period, as part of an iterative process between the first and second author. In phase two, basic themes were grouped into organising themes and an additional theme describing contexts at the organisational level, (informed by Franco's contexts) was developed. Finally, global themes were constructed by pulling multiple organisational themes (including contextual labels assigned in phase two) together,

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<sup>5</sup> Fees for accessing services were subsidised through project funding to reduce financial barriers to immediate access to psychological support.

to establish an expanded local definition for each of the main mental health recovery concepts driving the project: emotional distress, recovery, well-being and dreams for the future.

Ecological validation (Montero, 2006) of this analysis was completed at the beginning of the '*collective analysis and problematizing*' phase of the PAR project to give participants ownership over the analytical process and claims made on their behalf. Basic themes identified from our analysis were written on flashcards and participants assigned each card to one of the three concepts from the first phase (well-being, emotional distress and recovery) (see Figure 3). Discussion of data generated during this validation process highlighted that participants were in full agreement with the analysis completed by the authors.

### **Findings**

Global themes established local operational definitions for our key concepts relating to mental health recovery. Each global theme was informed by four or more organisational themes. Further detail is provided in the coding framework (see supplementary data tables). Where men and women differed in their understandings and perspectives on a concept is explained below.

#### ***Emotional distress: broken social worlds***

Our first global theme defined emotional distress as the outcome of broken social worlds and reflected the influence of economic, cultural and political contexts within experiences of distress. Participants linked the fracture of social worlds to cultural contexts that promoted emotional distress, particularly the difficulty of providing for sick family members residing in their place of origin, and leaving the comfort of the household and resultant feelings of loneliness:



*We all had houses, all had lands, but how about you leaving one afternoon and they say 'we want you to be out' or they tell you 'either you sell, or we buy from the widow' - no one wants to leave that, no one wants to be displaced. We are people like everyone else, except that it happens to us* (Diego, 10 years living in the municipality, Focus group 5).

Additionally, participants report the confusion experienced in settling into a new place as an issue contributing to their emotional distress: *'When we got here, we didn't know what to do, where to go. We didn't know that we could declare ourselves as victims-we didn't do that when we got here, we just looked for jobs'* (Carolina, 17 years living in the municipality, Focus group 1) as well as the lack of social networks within the municipality. Disputes with neighbours and a lack of social networks to help with childcare were also linked to emotional distress, largely by women: *'My employer asks me to work more, and is going to pay me 9,000 pesos for two hours, and the person who takes care of my children asks for 12,000 an hour'* (Margarita, 8 years living in the municipality , Focus group 1). Women also highlighted links between distress and physical separation from family: *'the hardest thing was to leave part of my family there, because now, if someone gets sick, we can't go and help them'* (Alejandra, 4 years living in the municipality, Focus Group 2).

Reflecting the economic context, participants reported how poverty limits their ability to adapt to the new community, due to constraints in resources such as housing, food and childcare. These absences established a range of daily functional and emotional struggles within families and the wider community. As one participant noted:

*I have a boy and he's not going to sleep in the girl's room - right - which means I need three bedrooms and that will cost between 600.000 -800.000 pesos. I only get paid 300,000 every two weeks. I just gather that money to pay for rent. What about*

*school, what about food, what about children? That is my emotional distress* (Juana, 7 years living in the municipality, Focus Group 1).

Previous quotes also highlight emotional distress attributed to the disparity between economic resources and financial responsibilities. Both men and women described difficulties in securing employment in the absence of formal education and training, and the resultant dependence on informal work: *'Now my emotional distress is that I can't study - I've been out of school for a year and I haven't been able to go to university because I don't have the money'* (Lucía, 3 years living in the municipality, Focus Group 2).

For men, the inability to secure work and its associated distress was also shaped by the stigma attached to the displaced identity and the internal politics around gaining work:

*...it is like the stigma they [general community] have towards us, this is a municipality that provides a lot of jobs, and when someone arrives to ask for a job, then they (people from the municipality) start saying that we arrive to take their jobs, and that is not true, everyone has the right to have a job* (Gustavo, 2 years living in the municipality, Focus Group 5).

Distress was also related to the absence of state support by men and women: *'if when something goes wrong - for example, we have asked [the state] for help and they have always said no - those feelings are bad'* (Carlos, 8 years living in the municipality, Focus Group 5 ). Men, in particular, found the need to rely on state actors for support as distressing, particularly in the face of their awareness of corruption in local public institutions: *'I know there are lots of resources from the government to support displaced population, but usually all the money arrives and the white collar people take it'* (Guillermo, 6 years living in the municipality, Focus Group 6).

***Wellbeing: a positive dialogical relationship between self, family and society***

The second global theme defined wellbeing as the achievement of a positive, dialogical relationship between self, family and wider society. The intersection of economic and cultural contexts was the primary driver of this concept. Many accounts of wellbeing were linked to participant desires to contribute to the household and a need to be close to their families. Both men and women linked wellbeing to the ability to improve family living conditions and the achievement of a stable family life: *'wellbeing is my children and my family [doing well], they motivate me to keep on fighting'* (Silvia, 3 years living in the municipality, Focus Group 2). This included having access to reliable employment and basic needs for women: *'wellbeing is being well - to achieve everything that you want to achieve for example - having a full belly, a house, health, clothes, that is well-being'* (Fabiola, 2 years living in the municipality, Focus Group 1).

Economic contexts were prominent – with participants noting the importance of having a job, accessing social welfare and entrepreneurial ventures. As noted by one participant: *'My husband has a vegetable garden - he works there and he sells things from there, that is wellbeing for me'* (Sarita, 4 years living in the municipality, Focus Group 1). Additionally, achieving wellbeing required a tangible change in self as well as the wider community. For example, women's achievement of personal success was valuable because it helped them support others:

*One of my biggest accomplishments has been education, right now I am applying to study Health Management at a university and then I want to do a postgraduate course, I think that it will ensure a better future for me and my family, better income to help my family that is still [back home], my mom and my little sisters* (Mariana, 2 years living in the municipality, Focus Group 2).

For men, however, wellbeing was linked to tranquillity and security associated to being in a safe place, away from the armed conflict: *'to be calm, here we are fine because we know that there is no armed conflict in this region'* (Guillermo, 6 years living in the municipality, Focus Group 6). Both men and women, argued that positive thinking, inner strength, and commitment to self-improvement supported the achievement of wellbeing individually and relationally. As one participant noted: *'For me, it is [my] decision to be ok'* (Luis, 1 year living in the municipality, Focus Group 6). However, acceptance of loss and perseverance was a sign of wellbeing for women. Among women this fortitude was valued as it supported their role as family caretakers: *'Wellbeing is like, to keep on going - to face things and get out of there - it's everything I do for me, and the people around me'* (Alejandra, 4 years living in the municipality, Focus Group 2).

'Berraquera' is an adjective defined by participants as internal strength and commitment to self-improvement, and was one of the indigenous words participants used to define wellbeing. For them, thinking positively, in addition to tangible examples of progress was a marker of wellbeing for internally displaced victims: *'Wellbeing is like, to keep on going - to face things and get out of there - it's everything I do for me, and the people around me'* (Fabiola, 2 years living in the municipality, Focus Group 1)

### ***Recovery: stability through access to reliable social, structural and relational supports***

Our third global theme defined recovery as *a state of stability achieved through access to reliable social and relational supports*. Whilst individual psychological wellbeing was represented by participant accounts of acceptance and feelings of calm, cultural and economic contexts remained primary drivers of experiences in recovery. Participants identified different scenarios and types of relationships that enabled the achievement of a recovered state, such as safe spaces, strong families and cohesive societies. Safe spaces provided women with

opportunities to develop new relationships and recognize the positive impact that their new community had on their wellbeing.

*Thank god we are in this place - we don't have the house, we don't have the stuff - but we have the opportunity. I did small training for SENA [technical college] - we've been doing bakery and they have given us the opportunity to learn - that's recovery. It means that not everything is lost (Patricia, 2 years in the municipality, Focus Group 1).*

This was also mentioned by older women, who highlighted the importance of safe spaces for the elderly, to get to meet new people: *'In meetings with the elders in the community they put me to do gentle exercises with friends and I make new friends'* (Carolina, 17 years in the municipality, Focus Group 1).

Additionally, family relationships were identified as critical to recovery, as noted by one participant. *'Recovery is being with my daughters - for me it is important to be with them'* (Emilia, 2 years in the municipality, Focus Group 2). Some individuals linked recovery to tangible changes in family living conditions and access to new opportunities for one's children. As one participant noted:

*We achieve recovery by going to university, to school, by studying, moving forward with our family, fighting for a household, not thinking about what happened before but what is there to come and what we really want to achieve, this is one way of recovery (José, 3 years in the municipality, Focus Group 5).*

Jose's comments also highlight the intersection of family wellbeing and basic livelihood needs, or economic contexts surrounding the family, as important to recovery.

Participants consider recovery as an ongoing process enabled by structural support from the state and the government:

*Recovery is a process sometimes - maybe its about forgetting the bad stuff, to replace it with good things. But we can't do that by ourselves. We need tools - for example the university, or SENA (Marieta, 3 years in the municipality, Focus Group 3).*

Men pointed towards the importance of moving beyond the label of victim as central to recovery: *'people have to stop thinking that they are victims, they have to change that idea, if they don't, then they will stay there, all of their lives feeling like a victim and they will never achieve anything'* (Santiago, 2 years in the municipality, Focus Group 5). Some men stated that recovery was unattainable as it was impossible to recover fully from the loss of family in the conflict.

Nevertheless, participants also recognise that recovery implies progress and acknowledging that they are working to live in better conditions that they were before: *'We are no longer in that little house where we lived that was abandoned – we are in a more dignified house living with our children - that is recovery'* (Luciana, 6 years in the municipality, Focus Group 3).

Finally, dreams for the future and the recovered self were defined in relation to new opportunities for families. Political and legal contexts were reflected in this theme. Specifically, participants articulated the importance of the state in providing resources to improve family life. For example, access to education was seen as a route to providing a better future for their children:

*Now I have two children and my husband - and he really supported me to finish high school and now my dream is to be a professional and to work and make sure my*

*children don't go through the same things that I did* (Sarita, 4 years in the municipality, Focus Group 1).

Education was valued for its direct links to improvements in economic realities, and supporting career aspirations:

*My dreams are to be a professional - thank god I finished high school. I had to work to help my dad and my mom, they split up, and it was me and my brothers, I'm the eldest and I worked and helped my mom and took care of my brothers. That was my life* (Cristina, 7 years in the municipality, Focus Group 1).

The state was seen as entirely responsible for promoting access to education for victims, as well as meeting demands for job opportunities, economic reparations linked to their recognition as victims and ultimately the restoration of rights. As articulated by one participant:

*My dream is the day that all the victims are rewarded emotionally and economically - and not to follow anyone to fight for our rights - that's what I want. Benefits for everyone* (Diego, 10 years in the municipality, Focus Group 5).

For some men, the ability to return home was a condition for the achievement of a recovered self, even while acknowledging the potential dangers involved.

## **Discussion**

Our study has explored how a group of IDPs in a small Colombian municipality define key concepts linked to mental health recovery. Our efforts to understand mental health as a local phenomenon were guided by Franco's (2003) notion of explanatory contexts and his extensive work on violence in the country.

Each of these contexts was clearly reflected in the definitions produced by our participants. Emotional distress was linked to economic, political and cultural contexts, via failed support systems, the everyday impacts of systemic poverty, and inequality between displaced groups and the general population in the host communities. In line with previous studies exploring mental health in other conflict settings (Jansen et al., 2015), our study highlights that the emotional distress of individuals displaced by violence was not solely linked to ongoing experiences of psychological trauma, but to how displaced persons experience structural and symbolic forms of violence.

The inability to afford daily amenities due to low paid work or unemployment, and the absence of effective government support services– are challenges faced by our participants and other groups of victims in the country (Ibáñez & Moya, 2010a). These conditions lead to fracturing of social worlds and emotional distress when they become a barrier to individuals improving their lives and ending everyday states of precariousness. This is something that our participants have in common with non –displaced individuals living in poverty. For example, recent South African (Burgess & Campbell, 2014) and Chilean (Han, 2015) ethnographic studies have highlighted that, the everyday structures of poverty, inequality and their impacts on wellbeing are central to everyday accounts of distress.

However, what makes the experiences of our participants unique, is the intersection of structural violence with the implications of their displaced identity. While other groups with less stigmatised labels may have the ability to change their circumstances through access to supports, this is not the always for our participants. Shultz and colleagues (2014) suggest that a distinguishing feature of Colombian displacement is its permanence – as for many people there is no return to life as it once was, a reality confirmed by our participants. Distress was ongoing because displacement was ongoing – they could not return to their families, lands



and thus, return to stability. The stigma associated with the label of *displaced* victim seemed to entrench this distress even further for participants, and was their biggest barrier to engagement with the activities with the greatest potential for changing their circumstances. Recent work by Link and Phelan (2014) on the relationship between stigma and power highlights the ability for stigma to drive already disenfranchised groups further into the margins, limiting their opportunities (i.e – keeping them down). This is seen among our participants and supported by further country evidence highlighting displaced households who remain locked in poverty traps, unable to escape low waged work or achieve stability (Ibañez and Moya, 2010b).

High levels of inequality (Angulo, Diaz & Pardo, 2016) also means that distribution of the impacts of structural violence in Colombia are unevenly distributed – as the poorest (and those most affected by structural violence) are also more likely to be victims of the conflict. In addition, victimhood often intersects with additional categories of marginality – including indigenous identities and race. These multiple layers of marginality leave IDPs among the most vulnerable in society with limited access to critical social networks that could provide opportunities for positive change and increased wellbeing.

The above is supported by participant accounts attributing emotional distress to broken promises from state institutions, and ongoing barriers to achieving the dream promised by their new home: access to jobs, housing and better opportunities for children. Their accounts reflect the emotional consequences of a specific form of symbolic violence identified in the work of anthropologists Commeroff & Commeroff (1999) called the *violence of abstraction* – where the promises of modernisation and capitalism are presented as available to all but are not achievable in practice. This mismatch creates a misrecognition of identity which, in our study community, resulted in emotional distress for men and women. It

is likely that this inability to access supports – despite their availability - is shaped by their stigmatised status. Men in particular noted how stigmatising experiences have limited their ability to access formal and sustained employment – namely their association with the ‘victim’ label. This led participants in our study to be denied access to the very opportunities that could shift their livelihoods in ways that would improve wellbeing. Our findings suggest that displaced persons in Colombia may be locked into what Link and Phelan (2014b) present as a cultural context of stigma; a cycle between individual stigmatisation due to stereotypes which hold negative connotations in society, self policing and subsequent reduced activity in society.

Ultimately for our participants, the achievement of well-being was mediated through economic and cultural contexts, whose presence or absence shaped their ability to contribute to family wellbeing. A local idiom of personhood defined as *Berraquera* – the ability to persevere in the face of challenges and make tangible improvements in ones life, reflects that achievement of autonomy and personal growth was also seen as critical to wellbeing. Characteristics embodied by *Berraquera* reflects resilience in the face of seemingly unchangeable structural and symbolic factors driving distress described earlier; a positive psychological coping strategy directed towards action. In our study wellbeing was also linked to social markers of success and stability such as access to education, employment and the ability to contribute to family economic needs. Our local definitions of wellbeing mirror Corey Keys (1998) assertions that social actualisation – the belief that one’s community and self can co-evolve positively – as critical to psychological wellbeing. He also cites the importance of social contributions and environmental mastery, to wellbeing - something mirrored in our findings. The pervasiveness of accounts of economic challenges in the definitions of our key terms is supported to a certain extent by a recent work by Abello-

Llanos and colleagues (2009) who argued that meeting basic survival needs of IDPs was often more important than self-development.

Despite a recognition of the social challenges linked to post-conflict mental health issues in the country (Ministerio de Salud y Protección Social, 2016), in practice PAPSIVI policy remains driven by attention to individual psychiatric conditions (Organización Panamericana de la Salud, 2016). Our findings suggest that promoting long-term mental wellbeing among displaced populations in Colombia would arguably be better served by recovery models, given its focus on the restoration of personhood (Anthony, 1995). Our study highlighted a perspective on personhood as the ability to escape the limits created by a narrow victim identity and achieve the trappings of a respectable life. For our participants there is no separation between development of individual and familial wellbeing. In fact, efforts to redress emotional distress emerged as a dialogical process where achieving wellbeing and a 'recovered' state is equally about individual and social (mostly familial) reconstruction. This suggests the value of a local recovery model that takes into account political contexts; power and resources (financial and social); individual emotional needs; and community connectedness (where family constitutes the primary community of focus).

But how might we use these ideas to inform interventions? Our findings suggest the first step is complicating the notion of 'community'. Current approaches engage with community largely as it pertains to diagnostic categories (depression vs. PTSD) or place. Yet our findings suggest this may prove insufficient when responding to the diverse experiences of political, cultural and economic contexts that drive emotional distress related recovery for IDPs. Given the stigma associated with the victim label, participants' experience of their community of place are markedly different from the non-displaced populations. Furthermore diversity in the accounts of men and women who are united by two ideals of community - identity (victim),

and a shared community of place – affirm the importance of complicating our conceptualisation of this factor in designing mental health interventions. Gendered experiences of political and legal contexts were reflected in men’s experiences of the ‘victim’ identity and its links to distress. Male participants spoke more directly about experiences of stigma related to the victim identity, and its impacts on their efforts to restore personhood. Women spoke of the distress linked to the burdens of childcare in ways that men did not, due to the loss of social networks created by internal migration.

Second is the need to encapsulate local context in responses. Recent evidence has highlighted the value of capability approaches to promoting mental wellbeing in locally and socially meaningful ways (White, Imperiale & Perera, 2016). Capabilities are defined as resources that enable individuals to make ‘health enabling decisions’ and promote their wellbeing across a range of social and political spheres. Amartya Sen’s (1999) original arguments about capabilities highlighted five areas where deficits must be met in order to improve the lives of others: social opportunity, political freedom, economic facilities, transparency guarantees, and protective security. However, research from other Latin American contexts has highlighted the difficulty of achieving Sen’s capabilities in practice, particularly in the absence of attention to psychological dimensions of personhood which enable individuals to utilise capabilities, including positive social identities, and socially receptive environments (Burgess, 2014). In response, community psychologists have expanded ideas of capabilities to include attention to both psychological and normative realities that impact the achievement freedoms and long-term development. They argue that social and psychological resources, or ‘*community competencies*’ are necessary for marginalised groups to effectively identify and respond to challenges in order to actualise capabilities and achieve freedoms and good health. Such efforts have been linked to

improvements within HIV affected communities, (Campbell, Skovdal & Gibbs, 2011) orphan wellbeing (Skovdal & Campbell, 2009) and more recently mental health (Burgess, 2012; Matthias et al., 2017).

In resource-poor settings in Africa (Burgess, 2012) and India (Burgess & Matthias, 2017) mental health competencies argue for action in four areas; (1) promotion of mental health knowledge; (2) dialogue for the development of solidarity; (3) critical consciousness raising to reflect on and engage with the structural and social causes of mental distress within safe spaces, and (4) opportunities to form partnerships improve mental health. In light of our findings we suggest that the promotion of mental health competencies would be an ideal model for promoting long-term mental health recovery among IDPs in Colombia. We suggest that complex mental health interventions could be co-designed with target communities and include strategies to promote the four competencies outlined in table 3.

**-Table 3 about here**

The model's emphasis on solidarity creates spaces for individuals to self-define their communities around action and practice, rather than assume they will automatically align with the categories around which public health programmes are often designed. This is valuable in complicating notions of 'community' in settings such as ours where doing 'community' mental health is as much about working with families as it is about uniting individuals who share other community identities, such as 'victim'.

Mainstream mental health interventions already create opportunities to increase access to knowledge, often within safe spaces such as support groups. However, a competency approach would expand these spaces to enable opportunities for developing knowledge and action around a wider range of issues. For example, opportunities for dialogue in these groups should promote development of critical consciousness and exploration of connections

between structural issues and mental health outcomes, similar to community conversation paradigms popularised in HIV interventions (Campbell et al., 2011). Such dialogue would also provide opportunities to manage stigma and identity struggles related to victim status and, the loss of a shared heritage that occurs with the move to communities of place.

The development of solidarity in these groups will be critical to promoting individual and collective empowerment in response to the structural issues linked to distress, as well as manage the stigma faced by participants in this study. This is critical in a setting such as ours where participants highlight exposure to violence beyond the physical and psychological violence linked to conflict. In our study, participants connected their emotional distress to the symbolic violence linked to the misrecognition of the victim-identity, and associated barriers to structural support such as employment. Solidarity has the opportunity to manage emotional distress through shared recognition; collective action to respond to the lack of social opportunity in their lives; and achievement of political guarantees and security through mobilising (Campbell, 2019). Such actions have important implications for mental health which has been seen in other Latin American contexts (Laplante, 2007; Ankerman et al., 2005).

Through the presence of key individuals working as bridges between community mental health groups and public and private sector agencies, access resources to help promote stable economic and social development, and foster stronger relationships with state actors could be achieved. In studies exploring health and development needs in Brazilian favelas where complex forms of violence drive daily life, partnerships have been key to promoting wellbeing (Jovchelovitch, 2013). Beyond this, partnerships have the opportunity to shift stigmatising views about victim groups, through exposure which has been shown to moderate

individual levels of stigmatisation and discrimination in some settings (Gronholm, Henderson, Deb & Thornicroft, 2017).

We acknowledge the limitations of our small study in making causal arguments about relationships between social contexts and post-conflict mental health. Nonetheless we feel our study offers a great deal in terms of understanding the contributions of key contexts of everyday life in Colombia to the mental distress of the largest group of victims. The current policy environment in Colombia is well suited for the implementation of competency-based interventions. PAPSIVI guidelines stipulate that any psychosocial mental health interventions should focus equally on mental disorder, addressing the consequences of human rights violations in war, and redressing historically accumulated problems such as race and gender inequalities (Campo-Arias, Sanabria, Ospino, Guerra & Caamaño, 2017). This creates a space for complex interventions such as those we suggest above to become a part of the mental health landscape in the country. Furthermore the recent Lancet Commission on global mental health and sustainable development articulates a similar importance for interventions that engage with the complexities of everyday life and suffering in low and middle income settings (Patel et al., 2018), and others have called for the development of interventions where the focus is equally balanced between socio-structural and socio-relational concerns (Burgess, Jain, Petersen & Lund, in press).

Implementing a competency based model would not be easy, and requires complex mental health interventions that enable simultaneous attention to structural and emotional dimensions of wellbeing. This could result in challenges with ownership over programmes, where mental health is seen as everyone and no one's responsibility within government sectors (Skeen et al., 2010). Furthermore, while our focus on IDPs as the community of focus was anchored to the high levels of victims who are part of this category – currently more than

7 million people, we acknowledge that this population may have difficulty engaging with other wider communities due to the very conditions they are trying to overcome – economic hardship and stigma – to name a few. As such, efforts to support their mobilisation within in mental health programmes would need to take this into account.

All this aside, the value of our suggested approach resides in its broad base. It does not negate the contributions of pharmaceutical or brief psychological approaches and access to such services where needed. Rather, it acknowledges and creates a tangible space for addressing the emotional consequences of other forms of violence(s) that also shape the everyday experiences of people seeking to rebuild their lives and the lives of their families. Such approaches have much to offer the global mental health landscape as a whole and provide opportunities to promote long lasting change in some of the world's most vulnerable communities.



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