

The Influence of Mental Health on Reconciliation in Post-War Lebanon. An Explorative Field Based Study Using Grounded Theory Research

Heiko Fabian Königstein

IFHV Working Paper, Vol. 3, No. 2

Bibliographic information:

Title: The Influence of Mental Health on Reconciliation in Post-War Lebanon. An Explorative Field Based Study Using Grounded Theory Research

Author(s): Heiko Fabian Königstein

Source: IFHV Working Paper, Vol. 3, No. 2

Date: October 2013

DOI: <https://doi.org/10.17176/20220622-130721-0>

ISSN: 2199-1367

Suggested citation:

Königstein, H.F. (2013). The Influence of Mental Health on Reconciliation in Post-War Lebanon. An Explorative Field Based Study Using Grounded Theory Research. IFHV Working Paper, 3(2).



RUHR-UNIVERSITÄT BOCHUM

IFHV Working Paper Vol. 3, No. 2, October 2013

The influence of mental health on reconciliation in post-war Lebanon

An explorative field based study using grounded theory research

Heiko Fabian Königstein

URL: http://www.ruhr-uni-bochum.de/ifhv/documents/workingpapers/wp3_2.pdf

The influence of mental health on reconciliation in post-war Lebanon

An explorative field based study using grounded theory research

Heiko Fabian Königstein *

NOHA Joint Master in International Humanitarian Action,
Heiko.Koenigstein@ruhr-uni-bochum.de

Abstract

This study explores the influence of mental health on reconciliation by conducting grounded theory research in post-war Lebanon. Based on interviews with experts in the fields of mental health and reconciliation, three hypotheses are formulated. Firstly, war affects the mental health of people in a complex way, leading to clinical and subclinical levels of psychological stress. The accumulation of war events as well as individual vulnerabilities and resilience factors are taken into account. Secondly, mental health services are insufficient to care for those in need of psychosocial support. The national health care system is widely inaccessible, Non governmental organizations (NGOs) are overburdened, and mental health is a stigmatized topic. Thirdly, the study concludes that mental health problems disrupt the process of repairing fractured relationship in Lebanon. Poor mental health negatively affects cognitive skills which are necessary to engage in the reconciliation process, such as problem-solving and perspective-taking. People lack trust, there is no feeling of shared responsibility and irrational fears fuel sectarianism. Lessons learnt for the humanitarian community are formulated. First and foremost, humanitarians working in post-conflict societies should integrate psychosocial care in reconciliation activities at all levels of the intervention to increase the effectiveness of their actions.

*This paper is a revised version of a master thesis originally submitted at the Joint European Master's Programme in International Humanitarian Action (NOHA) at the Institute for International Law of Peace and Armed Conflict (IFHV) at the Ruhr University Bochum.

The influence of mental health on reconciliation in post-war Lebanon

An explorative field based study using grounded theory research

Content

List of Acronyms.....	iii
I Introduction	I
1.1 Intent of the study	2
1.2 Defining reconciliation and mental health	5
1.3 The Lebanese context	7
2 Methods.....	9
2.1 Grounded theory approach	9
2.2 Research sample.....	10
2.3 Interview guideline	12
2.4 Coding and hypothesis creation	12
3 Analysis	17
3.1 The impact of war on mental health	17
3.1.1 Mental health is more than the absence of disorders	17
3.1.2 The accumulation of war trauma	20
3.1.3 Vulnerabilities increase the risk of mental health problems	22
3.1.4 Resilience protects against mental health problems	23
3.1.5 Summary.....	24
3.2 Access to mental health service	25
3.2.1 A lacking national system	25
3.2.2 An overburdened NGO system	26
3.2.3 Mental health: a stigmatised topic	28
3.2.4 Summary.....	30
3.3 The influence of mental health on reconciliation.....	31
3.3.1 How mental health problems affect reconciliation	31
3.3.2 Mental health problems among politicians.....	35
3.3.3 Problems among NGO staff.....	36
3.3.4 Summary	37
4 Conclusion	38
4.1 Developing a grounded theory.....	38
4.2 Lessons learnt for humanitarian actors	39
4.3 Directions for future research	41
5 References	42
6 Appendix: Interview guideline.....	46
Acknowledgements	48

List of Acronyms

ADHD	Attention Deficit and Hyperactivity Disorder
APA	American Psychological Association
BBC	British Broadcasting Corporation
DSM	Diagnostical and Statistical Manual of Mental Disorders
ESEMeD	The European Study of the Epidemiology of Mental Disorders
HiCN	Households in Conflicts Network
IASC	Interagency Standing Committee
ICRC	International Committee of the Red Cross
JAMA	The Journal of the American Medical Association
JICA	Japan International Cooperation Agency
LSD	Lysergic Acid Diethylamide
NGO	Non Governmental Organization
NOHA	Network of Humanitarian Action
PTSD	Posttraumatic Stress Disorder
SKOUN	Lebanese Addiction Center
UN	United Nations
UNDP	United Nations Development Programme
WHO	World Health Organization

I Introduction

“Lebanese people in ancient times were called the Phoenicians. In the Phoenician mythology there is a bird called the Phoenix. One day, this bird had decided to fly to the sky, to the sun, and while he was flying, he was burned. So when he was burned he turned into ashes. The ashes fell down to earth. The moment the ashes had touched the ground he was reborn. And he did the same trip again. And each time when he had died, he was reborn from his ashes. He is a symbol of how Lebanese society is eternal. Every time something happens they have the power to be reborn. But there is one thing about this story that nobody seems to have noticed. The mythology of the Phoenix tells us something important about the Lebanese subconscious. This bird has the magical power of being reborn from his ashes each time he dies. But more importantly, each time when he is reborn and he is given a new chance to live he doesn't succeed to stay alive. He dies again and again. And that is exactly what happens throughout Lebanese history. Every time we are given a new chance to live, we create a war about no matter what and the country dies. And after it has died it is reborn from its ashes” (INT5).

The myth of the Phoenix was evoked by one of my interviewees as a symbol for the Lebanese inability to build sustainable peace. The country was dragged into civil war several times in the last decades. How can Lebanese society learn from its past and build peace instead of relapsing into conflict? In this study, the question is approached from a psychological perspective. What happens to people's minds during war that prevents them from making peace with their fellow citizens?

This study draws from the knowledge of two academic disciplines: clinical psychology and peace building. There are many differences between the two but there are also important similarities: both disciplines intend to improve dysfunctional behaviour. While clinical psychology studies abnormal behaviour of individuals, peace building looks at the functioning of post-war societies. Concepts such as learning, reflection and interpersonal interactions are important topics in both disciplines. The idea for this study is based on the conviction that improving mental health of the members of a given society will lead to a better functioning of the society as a whole. A mentally healthy individual is better prepared to deal with stress and contributes to a society that can handle conflicts more constructively.

This study develops ideas about how mental health influences reconciliation using the example of Lebanon. It must also be understood as an attempt to explore the potential of clinical psychology to make a contribution to peace building. The insights gathered in this study can be a starting point to explore the impact of mental health on reconciliation in other contexts.

Studies like this one can provide knowledge useful for humanitarian and development experts, government organizations and academics working in post-conflict societies. It enables them to review and adjust the reconciliation efforts taking mental health issues into account. Additionally, humanitarian NGOs providing psychosocial care and national mental health service providers could use this knowledge to gain awareness of the impact of their work on the reconciliation process.

1.1 Intent of the study

This study contributes to filling a literature gap in the interface between mental health and reconciliation. In this section, the existing literature gap is described before developing a set of research questions.

People involved in war run the risk of facing a wide range of traumatic situations. They might have to deal with the loss of a beloved person, live in fear of being harmed, and lacking food and shelter. Many witness violence or death with their own eyes or are a victim of violence themselves.

These are war experiences which cause psychological stress. If coping mechanisms of a person are not sufficient to deal with this stress, mental health problems can develop. Depression and Posttraumatic Stress Disorder (PTSD) are two mental health disorders often observed in survivors of humanitarian emergencies. Studies carried out after natural disasters in Greece, Thailand and China found that about 13% of survivors met the criteria for depression (Goenjiana et al., 2011; Jia et al., 2010; Thienkrua, 2006). A study on PTSD in post-conflict areas found prevalence rates ranging from 15.8% for Ethiopia to 37.4% for Algeria (de Jong, Komproe & Ommeren, 2003). Substance abuse is also a mental health disorder which can develop after conflict. A study undertaken in Kosovo after the war indicated that drug addiction among young people is a serious problem (World Bank, 2001). Moreover, alcohol abuse is strongly linked to family disruption (Garrett & Landau, 2007).

Not all people who experience trauma in a conflict situation develop mental health problems. How somebody copes with stress can be determined by factors such as their economic situation or family support. For example, having a regular occupation and permanent private accommodation contributes to better mental health in refugees (Porter & Haslam, 2005). For children, support from peers and a good parent-child relationship might protect the child from developing PTSD (de Young, Kenardy & Cobham, 2011).

When people suffer from mental health problems, psychosocial care from professionals might be needed. However, the World Health Organization (WHO) recognises that resources to prevent and treat mental health problems are globally insufficient and unequally distributed (2011). Low-income countries have much less mental health legislation and services compared to high-income countries. Consequently, for people in low-income countries, access to mental health services is lower than in other countries (Peters et al., 2008). Thus, many people with mental health problems who live in post-conflict societies have insufficient access to mental health services.

International humanitarian actors have only recently realised that coordinated mental health interventions are needed in the context of humanitarian emergencies. The Interagency Standing Committee (IASC) has published guidelines on mental health and psychosocial support in emergency settings (2007). This initiative was based on the observation that psychosocial problems in emergencies are not limited to post-traumatic stress disorder but are very diverse and multi-sectoral. Interventions ranging from basic psychosocial support to specialised mental health care need to be coordinated under the leadership of mental health professionals. Humanitarian actors too often only focus on

their own very specific target group, leaving other vulnerable groups such as severely mentally ill without support. The IASC recognises that promoting mental health and psychosocial well-being is an obligation rooted in international human rights law such as the right to health, to education and freedom from discrimination.

While the IASC guideline is mostly focussed on natural disasters, Rubenstein and Kohli (2010) consider it to be a promising approach to address better mental health needs during conflict situations as well. They observe a lack of interest from donors and other humanitarian actors in mental health needs and a lack of evidence for efficient interventions. Humanitarian actors often focus on reinforcing the national mental health system which, in a post-conflict setting, might be out-dated and discriminatory. Psychosocial interventions need to be coordinated and based on individual needs and capacities of the beneficiaries.

A society that has experienced civil war and enters a state of peace faces major challenges related to peace building. Governmental structures set out in the peace agreement have to be put in place, economic structures need to be revitalized, and the judicial system has to address the crimes that had been committed. However, studies show that restoring justice and reforming political structures are not enough to achieve reconciliation on the community level (Clark, 2009; Babo-Soares, 2004). By reviewing psychological studies on post-conflict justice, Mendeloff (2009) concludes that there is only little evidence that truth telling and justice dampens the desire for vengeance among victims of conflict. While peace building experts assume that post-conflict justice reduces emotional suffering of victims, minimises the risk for retributive violence and encourages reconciliation among warring groups, there actually is no conclusive evidence for it (Mendeloff, 2009). A recent report on Northern-Ireland confirms that peace building on political and justice level is not enough to restore the social fabric of society (Community Relations Council, 2012). While many indicators regarding security and political stability have improved in Northern-Ireland, on the social level there are still significant problems including division of society and sectarianism.

To achieve reconciliation on social level, bottom-up approaches which allow communities to be owners of the process are better suited than external and top-down interventions (Japan International Cooperation Agency (JICA), 2006). Reconciliation is a voluntary act and cannot be imposed (Bloomfield, Barnes & Huyse, 2005); people need to be able and willing to actively engage in reconciliation. A good mental health is necessary for that. As demonstrated above, mental health is often disturbed among people who have experienced war. Hence, a large group of people living in post-conflict societies are probably not able to contribute to the reconciliation process.

There is an apparent need for research on the impact of mental health problems on reconciliation in post-conflict societies. However, most existing research only indirectly addresses the ability of war-affected people to engage in reconciliation. For example, research shows that people suffering from depression and PTSD due to war believe to a lesser extent in peaceful solutions to a conflict compared to people not suffering from mental health problems (Vinck, Pham, Stover & Weinstein, 2007). A study among former child soldiers in Uganda and the Democratic Republic of the Congo shows that symptoms of PTSD are associated with a decreased openness to reconciliation and more

feelings of revenge (Bayer, Klasen & Adam, 2007). Also, research on drug-related violence in Mexico indicates that individuals who experience anxiety or depression due to the conflict engage less in productive work (Michaelsen, 2012). This in turn has negative consequences for Mexico's social development and economic growth, which are two potential promoting factors for peace and stability in the country.

While this indirect evidence is useful, there remains a gap in the academic literature regarding the influence of mental health problems on reconciliation. This study uses Lebanon as a case example for making a first step towards filling the literature gap. The following research questions are guiding this study:

Overall research question:

How does mental health influence reconciliation in Lebanon?

Specific research questions:

1 How has war affected the mental health of people living in Lebanon?

This research question aims at describing the nature and extent of war-related mental health problems in Lebanon. As demonstrated in the literature review, war has shown to impact mental health of people in many complex ways, with resilience and vulnerability factors playing a significant role. Answering this question helps to understand the context specific challenges for the psychosocial well-being of war affected people in Lebanon, as well as common resilience and vulnerability factors. This section also attempts to answer if war has affected mental health of people in different ways depending on their role during the conflict. It will serve as a starting point for a discussion on the impact of mental health problems on reconciliation in Lebanon.

2 How accessible is mental health service in Lebanon?

In order to be able to estimate the impact of mental health problems on society, it is crucial to understand how affected people are cared for. The different types of psychosocial services and the quality of those will be described in this section. Also, this question seeks to answer to what extent Lebanese people are able or willing to use these services. Answering this research question is necessary for drawing conclusion about the potential impact of mental health problems on the reconciliation process because it shows how well mentally ill people are cared for. If mental health care is widely accessible and of high quality, mental health problems will be less severe and of shorter duration.

3 In what ways does mental health of individuals influence the reconciliation process within Lebanese society?

After having established research question one and two, the foundation is set to proceed to the main question of the research. The different ways in which people with mental health problems influence the reconciliation process within Lebanese society will be described in this section. Different actors will be analysed because impact of mental

health on reconciliation might be different depending on the role the affected person has within the post-conflict society.

1.2 Defining reconciliation and mental health

The research objectives contain several concepts which need clarification.

The term reconciliation can be understood as part of the wider concept of peace building. There is no generally accepted definition of peace building (Bercovitch & Jackson, 2009, p.171). The term was first used by the United Nations (UN) Secretary General Boutros-Ghali in the “agenda for peace” (1992). Seventeen years later, Bercovitch and Jackson (2009, p.172) extracted from the literature that it can be understood as a set of political and development strategies from international third parties to support activities ranging from short term recovery from war to creating the conditions for long-term human security. Redesigning state institutions to guarantee power sharing and improving minority rights are examples of common peace building measures.

The term reconciliation refers to peace building measures on the inter-personal level. After a civil war, restoring relationships is important for achieving peaceful co-existence (JICA, 2006). People whose relationships might have been dominated by distrust and hatred during the conflict are supposed to live and work together after the conflict has ended. Reflection on the past is necessary to recognize what had divided society to prevent the same issues from causing conflict in the future (Assefa, 2001; Bloomfield et al., 2005). Reconciliation requires that several activities take place simultaneously: people from opposing parties come together to create a vision of an interdependent and fair society, they acknowledge and explore the past, build positive relationships, promote cultural and attitudinal change and transform social, economic and political structures that gave rise to the conflict (Hamber & Kelly, 2004). More generally, Hamber and Kelly state that reconciliation is a “process of addressing conflictual and fractured relationships” (2004, p.3). The definition of Hamber and Kelly (2004) is the most comprehensive and will therefore be used in this study.

Another core concept of this study is mental health. The WHO defines mental health as being “a state of complete physical, mental and social well-being, and not merely the absence of disease” (2012). According to this definition, physical, mental and social aspects of human functioning are interdependent. The notion that social well-being is part of mental health is of particular interest for this study because it suggests that living in a post-war society might also affect mental health of people. In line with the diagnosis of physical diseases, there is a classification system for mental disorders. The most commonly used categorisation system for mental disorders is the Diagnostical and Statistical Manual of Mental Disorders (DSM) created by the American Psychological Association (APA). The DSM is reviewed and updated regularly. At the time of writing, the text revised edition of the fourth DSM (DSM-IV-TR, APA, 2000) is the most recent completed edition.

Certain mental disorders from the DSM will be mentioned in this study. Here, a short description of the most important ones is given.

One group of disorders is called anxiety disorders. There is one sub-type of anxiety disorders called generalised anxiety disorder. People with that condition experience anxiety in most circumstances and worry about “practically anything” (Comer, 2007, p.116). They show several distressing behavioural symptoms such as restlessness, easy fatigue, irritability, muscle tension and sleep disturbance (APA, 2000).

Another sub-type of anxiety disorders is PTSD. This condition is marked by anxiety and depression as a response to a threatening situation well after the situation is over (Comer, 2007, p.158). Affected people re-experience the traumatic event in thoughts, dreams and flashbacks, get distressed when facing reminders of the event, and feel numb and emotionally detached. They avoid situations that remind them of the traumatic event, might experience concentration problems and a strong feeling of guilt for having survived the threatening situation (APA, 2000).

People suffering from depression experience a state marked by sadness, lack of energy, low self-worth and guilt (Comer, 2007, p.224). Concentration problems, sleep problems and suicide ideation are also common symptoms of depressions (APA, 2000). The DSM distinguishes a major depression which is characterised by two weeks of very severe symptoms and a dysthymic disorder where people suffer from lighter symptoms for at least two years (APA, 2000).

The last mental disorder with a frequent mentioning in this study is substance abuse. They are marked by the physical, psychological or social problems caused by recurring use of a substance. There are several groups of substances: depressants, slowing down the activity of the central nervous system; stimulants, increasing it; hallucinogens, causing sensory changes; and cannabis (Comer, 2007, p.339ff). Examples of depressants are alcohol, barbiturates, benzodiazepines and heroin. The most common stimulants are cocaine, amphetamines and caffeine. Lysergic Acid Diethylamide (LSD), mescaline and MDMA (Ecstasy) are hallucinogens. People can also get addicted to a combination of substances of different groups and substance abuse often goes hand in hand with other mental health problems like mood disorders and PTSD (Comer, 2007, p.363).

The international validity of the DSM has not been without criticism. Several mental disorders which are described in the DSM have been found to be culturally dependent. Research on mental health problems is mostly performed in western countries with western patients. Because behaviour is also defined by our cultural background, it has been argued that behavioural symptoms of mental health problems do differ between cultures. For example, PTSD has been criticised for being bound to Western culture (Hinton & Roberto Lewis-Fernandez, 2011). Grievance about a traumatic event might be longer and more intense in non-western cultures and wrongfully characterised as PTSD in the western context. For a more elaborated discussion on the intercultural validity of the DSM-IV-TR see Dadlani et al. (2012). To avoid a cultural bias in the understanding of mental health in this study, I tried to prevent talking about mental health solely in terms of mental disorders. To understand what the interviewees think mental health means within the specific Lebanese context became part of the research objectives. Without analysing the accounts of the interviewees in detail at this point, it should be sufficient to say that the difference in the definition of mental health between interviewees was remarkable.

The notion of the WHO that mental health is a combination of mental, physical and social factors also influence the meaning of mental health care. Aside from psychotherapists and psychiatrists, all types of physical and social interventions can influence mental health. Social workers, religious authorities and general physicians are therefore also part of mental health care. Mental health care in this study is understood as a coordinated effort of all these services to alleviate mental health problems.

One research question relates to how accessible mental health care in Lebanon is. Accessibility can be defined in terms of geographic accessibility, acceptability, availability, and financial accessibility (Peters et al., 2008). Geographic accessibility depends on the users' location and the location of the services. Acceptability refers to the users' attitude and expectations and how responsive providers are to these features. Availability means that the right type of service is available within an appropriate waiting time. Finally, financial accessibility depends on the costs of care and the ability and willingness of users to pay those costs. Thus, accessibility has elements on the side of the suppliers as well as the demanders of mental health services.

1.3 The Lebanese context

In order to explore the link between mental health and reconciliation, this research project will use Lebanon as a case study. The country is home to four million inhabitants of eighteen different religious groups, with the Christian Maronites, Muslim Shia and Muslim Sunni (around thirty per cent each) and Druse and Catholics being the largest religious groups (Corstange, 2012). Because of its geopolitical position amidst powerful players like Israel, Iran and Syria, Lebanon has been called the “battleground of the Middle-East” (Hirst, 2010).

From 1975 to 1990 Lebanon suffered from one of the most devastating wars of modern times. An internal duel between the Christian Maronite Phalange party and the Arabic Lebanese National Movement in 1975 led to military attacks against civil targets in Beirut. The capital was split into two parts with severe fighting taking place around the demarcation line and in Palestinian refugee camps. An international peace accord in 1977 was followed by killings of political leaders, a 100 days battle in East Beirut and a violent coup-d'état. After the Christian president was murdered in 1982, Israel invaded West-Beirut and mass atrocities against Muslims were committed (Traboulsi, 2007; Hirst, 2010). Militant resistance movements, of which Hezbollah was the most effective one, launched frequent attacks on Israeli occupiers in West-Beirut and other parts of the country. In 1985, Israeli forces withdrew from a large part of Lebanese territory and cleared the way for more Syrian influence on Lebanese politics. The Lebanese government, led by a Christian president, opposed Syrian involvement in internal political affairs, while Islamic groups in the country welcomed Syrian support. Political instability and war led to economic problems and increased sectarianism. Lebanon between 1985 and 1990 lived under domination of armed militias controlling their particular sectarian territories (Traboulsi, 2007). The state's effective control of the country was reduced to a minimum. The war was sustained by drug trafficking, arm trades and pillages (Traboulsi, 2007).

The war between 1975 and 1990 took its toll on Lebanese society. A survey from the WHO (2010) indicates that 49 per cent of the Lebanese population experienced a war-related event of some type. An estimated 20 per cent of the Lebanese population (810,000) was displaced [United Nations Development Programme (UNDP), 1997]. In 2006, Israeli forces occupied parts in the south of Lebanon with the intention to defeat Hezbollah. Research shows that in these regions, more than 86 per cent of the population has experienced a war-related traumatic event (Farhood, Dimassi & Lehtinen, 2006). At the time of writing, the civil war in Syria caused severe security problems in Lebanon: in the city of Tripoli, supporters and contesters of the Syrian government engaged in armed conflict [British Broadcasting Corporation (BBC), 2012]. A car bomb in central Beirut killed a Lebanese intelligence official and seven other people (Reuters, 2012). Additionally, more than 100,000 Syrian refugees have fled into Lebanon and draw on the resources of the country [United Nations Refugees Agency (UNHCR), 2012].

Figure 1: Map of Lebanon



Source: worldmapsinfo.com 2013

2 Methods

This is a qualitative field study using a grounded theory approach. This approach is explained in more general terms before elaborating on the specific methods used in this study.

2.1 Grounded theory approach

Grounded theory was first developed by Glaser and Strauss in the 1960s as a method to study the interaction between dying patients and their caregivers in a Californian hospital (O'Callaghan, 2012). They argued that the aim of many social scientists was to confirm a pre-defined hypothesis instead of starting by looking openly at the information available. By applying grounded theory the researcher examines data through an inductive analytical process, discovering themes and issues as they emerge. There is not one way of employing grounded theory. Rather, grounded theory should be viewed as a family of methods for which researchers have developed their own interpretation depending on the context to be studied (Bryant & Charmaz, 2007). Charmaz (2006) also distinguishes between objectivist and constructivist grounded theory, the latter of which will be used here.

Constructivist grounded theory is a qualitative approach which is marked by multiple realities, the construction of data during collection, a subjective analysis, and context-bound findings. The methodology of the present study is predominantly informed by the work of Strauss and Corbin (2008) who, using a constructivist grounded theory approach, recognise that cultural personal experiences of the researcher can influence the way the data is viewed. Instead of trying to suppress personal or cultural bias, the researcher should clarify his or her pre-existing values (Amir, 2005).

Coming from a European background, the cultural context in Lebanon was new to me when first collecting data. During the two-and-a-half months I tried to learn as much as possible about the different Lebanese lifestyles. As my understanding of the culture deepened, interpretation of the data became more embedded in the context. On the other hand, having the perspective of a foreigner offers the advantage of looking at data in a more neutral fashion. In grounded theory, data consists of interview transcripts, questionnaires, newspapers, observations, historical documents, among others (Corbin et al., 2008). In the present study, interviews were the main data source, but observations, informal conversations and news articles were also included. When undertaking interviews within a grounded theory framework, it is important to avoid leading questions and give interviewees the space to answer freely and openly.

Grounded theory uses theoretical sampling. With this process, sampling runs parallel to data collection and theory generation. In contrast to quantitative methods, the researcher does not aim to acquire a representative sample of a larger population in order to make statistical generalisations. In theoretical sampling, after an initial sample is drawn, data analysis determines future data collection.

Coding, category development and theory development are the tools of data analysis in grounded theory. During the process of coding, concepts are attached to chunks of

information. In interviews, concepts are a theoretical interpretation of words, sentences or larger parts of the account. Concepts are also qualified in terms of properties and dimensions (the range of variations). By extracting the most common concepts and organizing them structurally, categories are developed. Through identifying common patterns in groups of concepts, categories explain certain ideas in the data. Categories are constantly refined as new data is gathered and new concepts are identified. When gathering fresh data fails to generate new categories, categories are considered saturated. Theories can then be developed by formulating the interrelationship between identified categories. Notes taken during data collection and reflection can be used to refine the theories. The outcome of this entire process of data analysis is called a grounded theory. How the different steps in grounded theory approach have been applied in the context of the present study will be explained in the following sections.

2.2 Research sample

The initial sample in the present study was drawn from the University Saint-Joseph in Beirut and the NOHA network. Experts from local, national and international NGOs as well as state institutions, and international organizations were included in the sample. People with the most relevant experience were approached first. Interviewees were asked to provide new contacts to be included in the sample. The choice to include both experts in mental health and peace building in the sample was based on the assumption that both groups witness the influence of mental health on reconciliation in their respective work field. Considering that total theoretical saturation can never be reached (Corbin et al., 2008, p. 149) and the given constraints regarding time and resources, I realised after fourteen interviews and 115 pages of material that enough data had been collected to develop a grounded theory. The interviews were supported by literature, news articles and numerous off-the-record conversations with people I met during my stay in Lebanon. Table 1 provides an overview of the interview sample, with reference numbers for each interviewee to hide identifying information.

Table 1: Research sample interviews

Ref	Professional background	Area
INT1	International NGO, mental health project	Lebanon
INT2	International organization, missing people project	Lebanon
INT3	National NGO, reconciliation children and youth	Tripoli
INT4	Psychotherapist (psychoanalysis) private clinic and NGO	Beirut
INT5	Psychotherapist (psychoanalysis and systemic therapy) private clinic and NGO	Beirut
INT6	Professor in displacement and cross-sectarian dialogue	Mount Lebanon
INT7	Psychiatrist and researcher in mental health	Beirut
INT8	Psychologist (cognitive psychology) and researcher in peace building	Beirut
INT9	Psychiatrist and researcher	Beirut
INT10	National NGO and former government advisor in peace building and displacement	Mount Lebanon
INT11	Psychiatrist, human rights and public health work at NGO	Beirut
INT12	Local NGO, reconciliation and socio-economic needs	outskirts Beirut
INT13	National NGO, psychosocial care for torture victims	Tripoli
INT14	International organization peace-building	Lebanon

Source: own composition

There are ethical problems attached to interviewing people who have been directly affected by war. Recalling painful experiences for the sake of research could open wounds which distress the interviewee long after the researcher has left. Hence no patients or victims of violence were interviewed for this study. The interviewees were professionals who work very closely with those affected by violence and were therefore in the position to speak on their behalf. Two of the interviewees had been displaced themselves and many of them had certainly witnessed fighting with their own eyes. But they had talked about their war experience many times in the context of their work and felt comfortable to tell me about them without placing an emotional burden on themselves. Personal information about the interviewees will not be shared with third parties and informed consent from all interviewees was ensured.

2.3 Interview guideline

In the beginning of every interview, the purpose of the study was explained and consent for recording and processing the data was asked. Interviews were open-ended and non-directive, between one and two hours in duration and conducted at the work places or homes of interviewees. The interview guideline used for the first set of interviews had an open and non-directive character. In accordance with the idea of grounded theory, the interview guideline was adjusted towards more closed and directive questions in later sets of interviews to allow a deeper exploration of emerging categories and hypotheses. The initial interview guideline contained sixteen questions and was split into three sections.

Section one referred to the first research question and contained elements about mental health problems that might be linked to war experience. To be as non-directive as possible, names of specific mental disorders and references to specific war events were avoided. The interviewee was asked to describe a typical example of someone who has experienced war and consequently developed mental health problems. To explore the level of integration of such a person into a post-conflict society, questions about coping and the level of community support were included.

Section two of the interview guideline contained questions about access to mental health care. The four questions in this section referred to the four dimensions of accessibility to health care as described in Peters et al. (2008), namely geographic accessibility, acceptability, availability, and financial accessibility. Exploring accessibility is useful for this study to be able to place statements about the impact of mental health on reconciliation into a wider context. It tells us what is already done to care for people with mental health problems and could point to possible improvements.

The third and last section of the interview guideline addressed the main objective of this study: the impact of mental health on reconciliation. The different elements of reconciliation as defined in Hamber and Kelly (2004) were used as a framework for this set of questions. They addressed the elements “acknowledge and dealing with the past”, “significant cultural and attitudinal change”, “building positive relationships” and “developing a shared vision of an interdependent and fair society”.

The interview guideline was understood as a framework for the interviews which was open for adjustment to the specific needs and expertise of the interviewees. If interviewees had troubles understanding the questions, I paraphrased and offered probes. I sometimes posed extra questions to get a deeper understanding of the topic. The interview was also adjusted based on the professional experience of the interviewee. An expert in peace building could discuss more about reconciliation than access to mental health care, while a psychiatrist had more to offer on the latter topic. The interview guideline can be found in the annex.

2.4 Coding and hypothesis creation

In this section, the process of creating a grounded theory on the relationship between mental health and reconciliation is described giving examples of concepts, categories

and hypotheses. Analysis of the material took place in three research circles following three sets of interviews.

After transcribing the first set of interviews (INT₁ - 6), material relevant for the research questions was coded and a first set of concepts evolved. First concepts related to mental health problems found in people who have experienced war. PTSD, depression and alcohol abuse are common problems related to war experience. But also the notion that internationally recognised mental health disorders are unsuited to describe the mental health situation in Lebanon was frequently mentioned. Regarding the question of accessibility of mental health services, the evolving concepts related to location, cost and people's perception of mental health services. Interviewees mentioned that mental health services are highly centralised within Beirut and also very expensive. Additionally, many Lebanese carry prejudices against people with mental health problems, calling them 'crazy'. Concerning the third research question, the influence of mental health on reconciliation, the concepts pointed in various directions. For example, some interviewees said that patients do not like to talk about the past; others said they would dwell on the past. Relationships between concepts were not obvious at this early stage and categories therefore showed significant gaps.

The next set of interviews (INT₇ - 12) suggested saturation of categories concerning the second research question (access to mental health services). People using mental health service are frequently disrespected by their social environment and the national mental health system is too expensive for large parts of the population. Mental health services in Lebanon are therefore perceived as widely unaccepted and inaccessible. New material also shed more light on the nature and extent of mental health problems by drawing attention towards individual characteristics of war-affected people, for example family background and pre-existing conditions. Categories describing vulnerability and resilience were developed. Regarding the third question, influence of mental health on reconciliation, the new material helped to group concepts in terms of relationships with the past, cognitive skills and social behaviour. Additionally, the material showed that the problems are evident on two levels of society: community and politics. The new categories were corroborated with the material from the first set of interviews.

Finally, two interviewees (INT₁₃; INT₁₄) supported and refined the existing categories. Mental health problems were said to differ in severity and sometimes are not pathological, supporting a hypothesis of accumulating war trauma. Regarding accessibility, one interviewee added a dimension to an existing category by mentioning an overburdened NGO system. This category was then tested on material from previous interviews and included in the hypothesis on accessibility. The NGO level was also included in the theory on the third research question, leading to the hypothesis that poor mental health decreases the ability of Lebanese society to engage in reconciliation on the community, political and NGO level by diminishing cognitive skills, trust and shared responsibility.

The code trees one, two and three (figure 2, 3 and 4) show a selection of codes for all three research questions and how those codes led to concepts, categories and hypotheses. The following chapter analyses the outcome of the grounded research approach in more detail.

Figure 2: Code tree I. How has war affected the mental health of people living in Lebanon?

Codes	Concepts	Categories	Hypothesis
Depression	DSM disorders	Mental health problems go beyond the prevalence of clinical disorders	The accumulation of traumatic events in combination with vulnerability factors and protective factors determine the impact of war on the mental health of an individual
Alcohol Abuse			
PTSD			
Fear	Subclinical problems		
Uncertainty			
Acute Stress			
Family Bond	Resilience	People react differently to war trauma depending on personal and social features	
Common enemy			
Preparation			
Influence from parents	Vulnerability		
Family pressure			
Pre-existing disorders			
Economic consequences	Delayed impact	People experience negative consequences long after war event	
Reminders			
Injustice			

Figure 3: Code tree 2. How accessible is mental health service in Lebanon?

Codes	Concepts	Categories	Hypothesis	
Centralised in Beirut	Ineffectiveness	The national mental health system is insufficient	Mental health service in Lebanon is widely inaccessible and unaccepted.	
Few public hospitals				
Public mental hospitals use out-dated treatment				
No social security	High costs			
No insurance coverage				
No free care				
Mentally ill people are 'crazy' or 'weakly willed'	Taboo	Mental health carries a significant stigma		
Patients keep treatment secret				
Shame				
Religion preferred to treatment	Mental health care as last resort			
Medication preferred to treatment				
Physical health more accepted				
More media attention in last 10 years	Small positive changes			
Family members lack knowledge	Lack of knowledge among society			
Teachers lack knowledge				
GP lack knowledge				
NGO projects are too short	NGO's face financial insecurity			NGO working in psychosocial care are overburdened
Funding problems				
Donor interests shift				
No national system to connect to	Unsustainable NGO system			
Corruption and political challenges				

Figure 4: Code tree 3. In what ways does mental health of individuals influence the reconciliation process within Lebanese society?

Codes	Concepts	Categories	Hypothesis
Some people avoid talking about the past	Traumatized people are unable to learn from the past	Mental health problems disturb reconciliation on community level	Poor mental health decreases the ability of Lebanese society to engage in reconciliation on the community, political and NGO level by diminishing cognitive skills, trust and shared responsibility.
Other people dwell on past grievances			
Stuck in victim role			
People are afraid to face their fears	Traumatized people are socially passive		
Frustration and no engagement in politics			
Traumatized people are socially isolated			
Unable to see opportunities	Cognitive skills are disturbed through trauma		
Lack of problems solving skills			
No perspective taking			
Dualistic thinking	Traumatized people do not trust others		
Need for revenge			
Need to protect oneself against new betrayal			
Politicians are traumatised	Peace negotiations take place without confidence and trust	Mental health problems among politicians disturb reconciliation	
No recognition of each other's victim role			
Fear of new violence			
Aggressive political communication	Politicians apply war like communication during peace		
Politicians lie and ignore problems			
No psychosocial care for NGO field staff	High mental pressure on NGO staff	Mental health problems among NGO staff and beneficiaries diminish effectiveness of reconciliation activities	
NGO Outreach workers have not yet recovered from trauma			
NGO Management does not understand realities on the ground			
Beneficiaries are tired of talking	Beneficiaries are not motivated to engage in projects		
Beneficiaries only want to hear apology			

3 Analysis

Before the main question of this study regarding the influence of mental health on reconciliation can be answered, one implicit assumption must first be addressed. The assumption is that war causes significant mental health problems among the population. This statement is formulated in research question one which is the topic of the following section. After the impact of war on mental health has been described, the study sets out to investigate how well mental health services are able to accommodate people with mental health problems. This aspect is reflected in research question two which addresses the access to mental health care for Lebanese people. The first two research questions set the ground for the main question of this research: what is the impact of mental health on reconciliation? The third section will try to answer that question.

3.1 The impact of war on mental health

Research question 1: How has war affected the mental health of people living in Lebanon?

Hypothesis 1: The accumulation of traumatic events through time in combination with vulnerability and resilience determine the impact of war on the mental health of an individual.

3.1.1 Mental health is more than the absence of disorders

Prevalence and types of mental disorders in Lebanon are the same as in European countries when using the DSM IV-TR criteria for assessment. Research using representative surveys is very exceptional in Lebanon. Two studies on the prevalence of mental health disorders have found prevalences ranging from 17 per cent (Karam et al., 2006) to 25 per cent (Eurojar, 2010). The most common disorders appearing in both studies were anxiety disorders, mood disorders and substance abuse disorders. According to these studies the prevalence of mental disorders in Lebanon is not different from those found in European countries (Alonso, Angermeyer, & Lépine, 2004). There might be small cultural differences which are limited to very specific symptoms of certain disorders. For example, Lebanese people with depression are generally more anxious than Europeans and Europeans experience more lack of energy (INT9).

Shortcomings of diagnostic tools. Assessing the mental health impact by using internationally recognised diagnostic tools simplifies the real psychological impact of the Lebanese wars. Interviewees argued that labelling people with mental disorders hides much more important socio-political problems caused by the war (INT11; INT13). Also, the psychological reactions to war might be too complex to be covered by the DSM. For example, people show increased impulsivity and aggressiveness which are not mental disorders as such (INT9). Acute stress which disappears after a few weeks is also a common reaction to war experience (INT13). Another argument against using international guidelines is that they are not suited to assessing mental health problems in a specific cultural context (INT11). Many complaints after war are psychological

reactions to loss and grief that might be considered normal in that particular environment (INT1). Culture also influences how people answer questionnaires, making the application of international diagnostic tools in a specific cultural context problematic (INT7). Many interviewees showed particular dissatisfaction with the way PTSD is assessed in the Lebanese context. What is labelled as PTSD might in fact be a healthy reaction to stress (INT1; INT11). Another argument is that the concept of PTSD is not suited to the Lebanese context because there is no real end of the war, making the “post” in PTSD not applicable (INT11). These points all lead to an over-diagnosis of PTSD (INT9). The popularity of the DSM among some psychologists and psychiatrists might be based on its international recognition and how it facilitates the receipt of funding for research (INT11). Furthermore, finding evidence against the international applicability of diagnostic instruments is very difficult because conditions which do not appear in the instrument are systematically ignored. Hence, diagnostic instruments promote themselves (INT11).

Consequently, several interviewees have refused to measure the psychological impact of war based on the prevalence of mental disorders (INT4; INT5). According to them, the number of people who are traumatised by the war is much higher than statistics on mental disorders would suggest: “[...] every single Lebanese person is still until today traumatised by the war. Every single decision that he makes is influenced by this past that we had.” (INT5). Most people refuse to talk about war experience and do not express their trauma. They therefore do not seek mental health care and do not appear on statistics. Even those who go to mental health service do not realise that their problems are caused by the war. Evidence for a collective war trauma can be found by looking at behavioural patterns in everyday life. Aggressiveness in traffic, a lack of self-reliability in housekeeping and an inability to delay satisfaction are part of Lebanese lifestyle. Those behavioural patterns are all consequences of war experience (INT4; INT5; INT11).

Mental health problems might in fact be normal reactions to abnormal situations. Constant fear and uncertainty is a common psychological reaction to war experience (INT1; INT5; INT7; INT4). Uncertainty about the future and fear of another outbreak of violence dominates the life of many Lebanese. In some areas the permanent threat of conflict is very real. An eruption of violence could destroy livelihoods in an instant. Being in constant anticipation of war can therefore be considered functional. For example, in the south of the country people show paranoid traits which could be considered “useful” for the environment they live in (INT7). Children who live in these areas run the risk of being delinquent and impulsive (INT3; INT7). Is it justifiable to talk about mental health problems if the psychological reaction is useful for survival? Many interviewees answered this question with no. But they were quick in adding that these people still need care, be it psychological, social or spiritual, so that they can reduce stress to a minimum and lead a healthier life (INT11; INT5)

The suffering of perpetrators. In a conflict where brothers and neighbours fight against each other, there is a thin line between perpetrators and victims. Joining the fighting is not always a matter of free choice. A psychotherapist demonstrated this point by telling how one of his patients became a fighter:

“So after a few months his father was killed. And he had many sisters. [...] He started thinking, okay, my sisters are at home, there is no one to protect them, we are all afraid. But the only people who are not afraid are the villains on the street who have arms and who are raping the others and killing the others. So if I want to get rid of my fear there is only one way: that is to become like these people. So he decided when 11 years old to go to the street to bring arms and to start killing people and to rape people. Because for him this was the only way to give an image about himself that he is someone that everybody has to fear. And with this image he would be able to protect his family” (INT5).

This case is typical for the situation many fighters are in. Joining the battles is a strategy to survive. Committing violence puts these fighters under high psychological stress. Feelings of guilt and regret haunt them. Images of the cruelties they have committed intrude their dreams. To deal with this psychological stress, many fighters start taking drugs. When the battles are over, they have troubles adapting to the peaceful situation. The strategy that has helped them survive during war now makes them isolated and mentally disturbed. They are left behind traumatised and often develop a drug addiction (INT7; INT5). One interviewee described the social downturn of ex-warriors:

“Most of the ex-warriors are now people who live in the streets. Who sleep in the streets, they don’t have homes because they didn’t receive any. They didn’t go to school or university. During the war they were addicted to drugs, so now they are drug users. And because of that they live in the streets, nobody takes care of them. Most of the people that you see in the streets are ex-warriors” (INT5).

Authorities do not see perpetrators of violence as the ones who need care. But perpetrators can get traumatised as much as victims. They also need care but their needs are very often overlooked (INT7).

Families of missing people. In Lebanon, thousands of people who went missing during the war between 1975 and 1990 are still unaccounted for [International Committee of the Red Cross (ICRC), 2012]. One interviewee was able to report extensively on the psychosocial stress family members of the missing experience (INT2). First of all, the status of missing is not accepted by the community. Mourning the death of a loved one generates more community support than living in uncertainty about the destiny of a family member. Authorities have no support mechanism for families of missing people. They are left alone by the state and socially isolated. Secondly, if the breadwinner went missing, the family faces economic downturn. They receive no pension funds and they cannot sell family property without the consent of the missing owner. They spend large amounts of time and money to find out about the fate of the beloved one: driven by feelings of guilt they try all within their power. Sometimes they fall prey to fraudsters who sell fake information for large sums of money. Searching for the missing becomes a task for life and they lose interest in social activities. They often report physical problems because of the high level of psychosocial stress. Yet, they do not want psychosocial support because it would distract them from finding what in their eyes is the only possible solution to the problem: finding their missing family member.

Summary: Mental health not measurable. The abovementioned cases demonstrate that the impact of war on mental health is more complex than the categorisation of mental disorders would suggest. Psychological reactions to war have many forms and mental

disorders such as depression, anxiety disorder and substance abuse are only one part of the story. Consequently, quantification of the real psychological impact of war is impossible.

3.1.2 The accumulation of war trauma

Considering the diversity of psychological reactions to war, I am confronted with the problems of bringing together mental health disorders including depression, anxiety disorders and substance abuse with the idea of more subtle psychological reactions like aggressiveness and social isolation. The suggested hypothesis that might explain the different reactions includes the notion of accumulation of war trauma. In the perception of the Lebanese, the war had neither a clear beginning nor end. Tensions, threats, conflicts, violence and ceasefires follow each other in unpredictable, endless loops. Therefore, experience of war builds up through time. The combination, order and severity of war events might determine the psychological reaction to war.

Financial resources matter. After somebody has experienced a painful loss during war, the impact on mental health depends on the existing resources to deal with the loss. For example, it is not uncommon for rich Lebanese to own two houses, one in Beirut and one on Mount Lebanon. If their main house in Beirut is destroyed, those people can move to their second house until the violence is over and rebuild their main home. They have the chance to escape the violence and recover from the war event in a secure environment. The financial resources are sufficient to rebuild the house, which means no loss in socio-economic status. Additionally, they receive support from the state because the government has a strong interest in rebuilding the capital city. Looking at the case of a typical middle class citizen in the countryside reveals another picture. He may have worked his whole life to build a house, and if it is shelled he loses everything. He moves to a camp for internally displaced people with his family, where he has to stay for many years because he receives no support to restore his old home. Moving to the camp, worrying about his family, losing his socio-economic status and the feeling of powerlessness add to the initial trauma of the shelling. This accumulation of trauma leaves this person with a much higher risk of developing a severe mental health problem compared to the first example. The first one might suffer from sleep problems for a short period of time, while the second one might develop a major depression. Thus, the same war event can have a different impact on two people depending on what they have to live through after the event and the resources they have at their disposal before the event (INT7; INT13).

The stress of displacement and resettlement. Not only can the traumatising nature of the war events but also environmental factors after the traumatic event cause psychological stress. Many people in Lebanon have been displaced during the war. Displacement is a distressing event in itself. One interviewee described how armed warriors arrived at her village and took over all the homes, forcing the families to depart unprepared; leaving all their belongings behind (INT6). In the village of Darmur in the south of Lebanon, the displacement led to a massacre. Besides being displaced, settling into the new environment poses numerous challenges. For example, people who lived in small

villages in the mountains had to move to the city of Beirut. This meant a significant change in their lifestyles. One interviewee explained:

“Because the source of income during that time [before displacement] was just on agriculture and having some cows... they were living like peasants. Most of them. But nowadays they are living in cities and they are relying much more on either industry or companies, having jobs. So the economic life totally changed.”(INT10)

When resettlement plans were put into action years or decades after the displacement, people faced the choice of returning to their old villages and living a farmer’s life again. Consequently, displacement and resettlement means not only moving from one place to the other, but also changing from a rural to an urban lifestyle and vice versa. These major changes in life style can cause psychological stress, adding to the trauma of the war event itself (INT10; INT6).

New conflicts open old wounds. Recent political events remind people of the war events they have been through which can cause psychological stress. During my stay in Lebanon, a civil war was raging in neighbouring Syria. One psychologist observed:

“The past two or three months I have seen people, in their 40s and 50s, telling me about their experiences in war. They were fighting in Lebanon in the mid-70s. They didn’t fight for the last 30 to 40 years. How come when we have dinner they come up with these stories? And then I realised that they were watching TV about Syria. So it opened the same kind of data bank. Because that is how it started in Lebanon. You know, people fighting here and there and then it went into chronic war, [...] so they were living it. And the same kind of geography. The same houses and machine guns. So it just opened up the data source.”(INT7)

In Lebanon, the talking about war never stops. Speculations about a possible new outbreak of violence occupy people’s minds. The consequences of the last conflict are discussed in the media. And conflicts in neighbouring countries are followed with an eagle eye. Furthermore, the names and faces of politicians in power have not changed much since the long war between 1975 and 1990. Either they are the same people, or their sons, grandsons or cousins. This evokes a strong feeling of injustice in people who are suffering from the consequences of war (INT2). The language of the political leaders has also not changed. They speak with the same aggressive, stereotyping and sectarian language they used 30 years ago (INT14). This daily confrontation with war talk causes fear and uncertainty, forcing people to relive their own traumatic war experiences. The psychological stress builds up over time and can lead to mental health problems many years after the war experience (INT7; INT1).

Summary: Mental health problems as an end product of war stress. It is difficult to differentiate between mental health problems caused by war and those created through time. Adapting to stress might be within the capacities of many, but stressful events often leave a psychological scar. It can have a subconscious impact. Lebanese people are psychologically weakened because of all the confrontation with war and violence in everyday life. They become more and more fragile until the trauma breaks out. This can take the form of different mental health problems in various severities. Whichever the

severity of the psychological complaint, they are only the end products of a long process of accumulating war traumas (INT4; INT14; INT10).

3.1.3 Vulnerabilities increase the risk of mental health problems

The first ones who suffer during war are those who are already weak when the conflict starts. The same way physically fragile people struggle with the effects of a humanitarian crisis, psychological vulnerability have an increased risk of being negatively affected by it. There are many reasons why somebody would be less prepared to deal with the consequences of war.

Cross-generational war trauma. One of the topics most intriguing to learn about during the interviews was the concept of cross-generational trauma. Children who were not victimised themselves during the last episode of violence can suffer from war trauma. The war trauma is transferred to them by their parents. An interviewee recounted a case in which a woman was traumatised because of a bomb explosion next to her car. The NGO of the interviewee wanted to offer her psychosocial care.

“In the first few months she refused to come to our centre. She wanted to be provided with the services inside her home. And she was also very irritated at the government because nobody helped her. And she was not provided with any kind of services, or free of charge services. You can only see her case in the magazine; the news was reported to everybody but no kind of services were provided to her. So she was really irritated at the government, she was really mad. She could not work anymore and she felt very victimised about herself. And it was obvious that she didn’t want to come out of this victimisation. In her case, of course it also affected her child big time, she could not deal with her child anymore. She wanted to be treated all the time.[...] she was used to work as a teacher, [...] but also I know in school she couldn’t treat the children in a good way after this traumatic event. She couldn’t handle the teaching” (INT3).

The traumatic experience caused the woman to neglect her own child and the children she was responsible for in school. After many months she received the psychosocial care she needed and the situation improved. But most parents who suffer from war trauma are not so lucky to have an NGO reaching out to them to offer support. When the trauma is not managed it affects their ability to care for their children. It can cause communication problems and violent behaviour towards the child. Sometimes parents use alcohol and drugs to cope with their trauma which diminishes their child rearing skills. If the breadwinner was killed during the war, the entire family faces an economic downturn which leads to more psychological stress for the children. They hear stories of killing and fighting and experience the negative consequences of war. This makes children who were not even born at the time of conflict act as if they had lived through these horrific episodes themselves (INT3, INT4, INT5, INT7).

Besides the direct line from parents through children, there is also an indirect transfer of trauma through genetic predisposition. Parents who are most affected by the trauma are genetically more vulnerable. They have a more anxious personality which makes them more worried in life compared to others. The war trauma confirms and further increases their fear. Their children share the same genes and are therefore also more anxious. When they are confronted with their parents’ trauma, their risk of developing a

secondary trauma is thus increased by their genetic predisposition. The age of children is an important factor in secondary trauma. The risk of developing mental health problems due to a secondary trauma seems to be highest between the ages of 3 and 12. This also applies to other negative childhood events, such as divorce, death of a parent etc. (INT7).

Pre-existing mental health problems. In addition to children of traumatised parents, there is another vulnerable group: people with pre-existing mental health problems. After every violent period, Lebanese psychiatrists see numerous patients with pre-existing conditions seeking support. A traumatic war event can trigger the manifestation of a sub-clinical mental health problem. They have a psychological vulnerability which makes them prone to severe mental health problems during war. People with anxiety problems or depression who have been able to manage their life very well in a peaceful environment suffer from a reoccurrence of their symptoms during conflict. They have troubles adapting to the new situation. This group has an external locus of control, meaning that they feel their life is influenced by the outside world rather than by themselves. The instability during conflict increases their fears and depression, they for example experience sleep problems, extreme passivity and social isolation. Similarly, children who were born with Attention Deficit and Hyperactivity Disorder (ADHD) or learning disabilities face an aggravation of their problems during conflict. Their support systems break down: schools are closed due to insecurity and parents are occupied with protecting the family livelihood. The psychological stress that comes with the conflict worsens the symptoms of ADHD and learning disabilities (INT1; INT7; INT8; INT9; INT3).

3.1.4 Resilience protects against mental health problems

During my stay in Lebanon I saw peaks in political tensions on several occasions. A hostage situation in Syria triggered abductions in Beirut. Militias blocked the road to the airport and there were shootings near a Palestinian refugee camp in the south of the city. What astonished me most was that people could live with the permanent threat of violence so well. Public life did seem to go on no matter what. The reason for this could be that Lebanese people in general got used to a permanent threat of conflict in their country. They became resilient. One interviewee explained this point by referring to recent clashes in her city:

INT13: “A few days ago you couldn’t go to certain areas in Tripoli. [...] But we still go to work and we continue our life like nothing has happened. So we have been trained to deal with the war so long. We have experience with it. We have a vaccination against trauma.”

Some areas more resilient. Interestingly, the vaccination described by this interviewee seems to be stronger for certain parts of the Lebanese population. Comparing the south with other parts of the country suggests interesting differences in terms of resilience. After the war events in the south of Lebanon in 2006, the extent of trauma-related mental health problems was lower than expected given the atrocities committed in this region (INT9). Many communities in the south live in permanent anticipation of violent conflict. Children are raised with the conflict in their minds. They join training sessions

of local militia groups and observe every move of their enemies. Consequently, they are prepared when violent conflict arises. There is a strong social connectedness among people. They are convinced the enemy comes from outside and the community is determined to go through this together. They feel strongly connected with their land and are determined to protect it. This ideology protects them from war trauma-related mental health problems like PTSD (INT11; INT3; INT12).

Even after very extreme war events like torture, people with this ideology are in a better mental state than others (INT13). Living with a war ideology is a survival strategy which enables them to move on after violent conflict. However, it seems that this ideology only offers protection against certain types of mental health problems, such as anxiety disorders. Personality disorders and certain behavioural problems might be more frequent in the south of Lebanon (INT1; INT13).

Community support as coping strategy. Resilience to war trauma depends to a large part on the personal strategy somebody employs to deal with the traumatic situation. People employing more positive coping strategies are better protected against war trauma. One example of a positive coping strategy is to connect with family and community members to talk about the war trauma. The community can provide strong psychosocial support. However, the family can only provide support if family cohesion was already strong before the war event. In families where support structures are weak, the war trauma can even be aggravated. For example, children who are beaten by their parents suffer more from war trauma (INT7). If family support is weak, the one who is traumatised tries to hide his mental health problems because of feelings of guilt and the fear of showing weakness. An additional problem is that in Lebanon sometimes entire communities were affected by war trauma. Family members who are traumatised themselves are not prepared to offer psychological support. In that case, the war trauma actually prevents support networks from working. Thus, an important part of mental health care is to investigate how much support the own community can offer to the traumatised person (INT1; INT7; INT5).

3.1.5 Summary

As demonstrated in this section, war-related mental health problems in Lebanon are very complex. Interviewees from different psychological schools hold very different opinions, ranging from “all Lebanese people are traumatised by the war” (INT5; INT4) to “the wars did not cause any mental health problems” (INT9; INT7). On the one hand there is the medical perspective of psychiatrists which follows a classification system of internationally accepted criteria to determine whether or not a patient has a mental disorder. Measuring them in terms of internationally defined mental disorders may leave many cases unnoticed. Mental health problems build up over time. Sometimes, the consequences of war are more challenging than the war trauma itself. Vulnerable people show particularly strong psychological reactions. However, there is also a strong resilience in the Lebanese society; many have learned to live with the permanent threat of conflict. Vulnerability factors, protective factors as well as frequency and severity of traumatic experiences have to be considered to estimate the psychological impact of war on an individual.

When own support systems are weak, mental health care might be necessary. Before proceeding to the question of how mental health problems affect reconciliation in Lebanon, it is useful to investigate to what degree mental health services are able to offer support to those affected by war. For this reason the next section will explore the accessibility of mental health services in Lebanon.

3.2 Access to mental health service

Research question 2: How accessible is mental health service in Lebanon?

Hypothesis 2: Mental health service in Lebanon is widely inaccessible and unaccepted.

3.2.1 A lacking national system

The national mental health system refers to the coordinated functioning of psychiatric hospitals, private and public clinics for psychotherapy, and psychosocial care in community centres and schools. A reoccurring theme in all of my interviews was that the national mental health system is unable to offer the level of care that is needed in Lebanon. The mental health system can be characterised by three features: centralised, private and unaffordable.

Centralisation. Most Lebanese mental health facilities are concentrated in the capital of Beirut. In rural areas, the number of mental health services is very low, forcing people to travel long distances to the nearest clinic. In the mountain villages there is almost no mental health service at all. Even in the second largest city of Tripoli, access to therapy or counselling is very low. For example, there is only one school for children with special needs which is accessible for free in Tripoli, a city of 200,000 inhabitants (INT1; INT11; INT3; INT5).

Privatisation. The majority of mental health services are private and therefore unaffordable. Clinics for psychotherapy and psychiatry ask high fees for counselling. Private psychotherapists provide their services for a minimum of 60 US\$ per hour. Private psychiatrists ask up to 120 US\$ per hour plus high additional costs for psychotropic medication. For Lebanese middle class families therapy is therefore unaffordable, not to mention for families with low income. If a person still decides to take sessions, feelings of guilt for paying so much money often arise. Consequently, the high costs force many clients to stop the therapy after a few sessions, leading only to frustration and no improvement in mental health. There is no insurance or social security covering psychological consultation. Social security for civil servants only covers a small segment of psychiatric services (INT1; INT4; INT5; INT11).

Lacking public care. Public psychiatric hospitals offer free services which are of low quality, potentially doing more harm than good (INT9; INT5). Psychiatric hospitals are for severe mental disorders like schizophrenia or bipolar disorder with severe psychotic symptoms. These symptoms can be treated very effectively with new anti-psychotic medication. Taking this medication would allow patients to lead a normal life; they could stay at home and even go to work. However, in public psychiatric hospitals these new drugs are not used because they are expensive. Patients are treated with old methods and stay hospitalised for many months, years and often for the rest of their lives. They

become socially isolated and their disorders become more chronic. Patients cannot afford better treatment, because other psychiatric treatment is not covered by the government. Thus, the psychiatric hospitals are their only option for receiving any treatment at all (INT9).

There is no national system caring for vulnerable groups. Homeless people with mental health problems like drug addiction or depression do not receive any kind of outreach service (INT5). In elementary schools, children do rarely receive the support they would need based on their mental capacities. Teachers are poorly educated about how to deal with children with mental health problems. One interviewee explained that elementary school teachers often do not know how to handle a child with ADHD. They might beat the child because they do not know how else to discipline them. Parents are little involved in education and also lack information about the mental health status of their children. And when communities are displaced, all information about the specific vulnerabilities of a child is lost because there is no national system which social services can use to share information about mental health issues (INT3).

Summary: good mental health care largely inaccessible. The Lebanese mental health service is not accessible for a large part of the population. The gap between the number of people who need care and those receiving care is 85 per cent (Karam et al., 2006), one of the highest rates in the world. This is striking considering that Lebanon has the most qualified psychologists and psychiatrists in the region. Their services are reserved for the rich. NGOs try to fill this gap by offering mental health services to less advantaged parts of the population (INT9; INT11).

3.2.2 An overburdened NGO system

In Lebanon, there are many NGOs working in the mental health sector. They offer care to vulnerable groups such as drug addicts, children and the displaced. All of the psychologists I interviewed work part time with NGOs because there they can support people who cannot afford costly therapy sessions. There is clearly a strong dedication among mental health professionals to fill the gaps of the national health system. However, many of the interviewees pointed out that NGOs face enormous challenges in the area of mental health because of chronic shortcomings of the non-profit sector.

Limited funding duration. One interviewee described a common dilemma in mental health projects:

“Lebanese Addiction Center (SKOUN) is an NGO for treating addiction problems for people. SKOUN is free of charge because it is supported by maybe French supporters. Suppose SKOUN one day does not have budget to continue. What do you do with all these people followed by SKOUN? It is a big problem. If you take the same situation for disabilities. You have a great number of NGOs working on disabilities, autistic people, mental retardation. They are all supported by some people by some government. Suppose one day they stop. Who will follow all these people?” (INT9).

NGOs receive funding for a project for a very limited period of time. They must apply for new funding on a regular basis, at least once a year. Often funds last for only six to nine months. Mental health projects are no exception to this rule. However mental health

projects need much more time to deliver sustainable results. First, NGOs need to win the trust of the people to cooperate in psychosocial activities. Whether the NGO offers psychosocial interventions on a group level or individual therapy sessions, it requires months of preparation before traumatised people are ready to take part in the sessions. Then, in the first weeks of the intervention, progress is naturally very slow. Expectations have to be managed and the therapist has to win the trust of the client. Beneficiaries have to confront their fears, which can be a painful process; frustrations and doubts are inevitable parts of psychological interventions. When the initial difficulties are overcome, working on the roots of the psychological trauma can begin. It can take years of therapy to achieve a sustainable improvement in mental health. Only if enough time is invested in building a relationship of trust, the client stays committed to the intervention. If the therapy ends early, the intervention will be counterproductive. However, the short-term nature of the funding makes a genuine commitment to psychosocial interventions impossible. Because of the permanent insecurity about the continuation of the project beyond the next funding round building a relationship of trust is very difficult. The short project period is just enough to improve basic daily functioning of the beneficiaries without having the time to work on the psychological trauma itself (INT3; INT4; INT1).

Limited target groups. Funding for NGOs is often accompanied by strict criteria concerning the target group of the project. In mental health, often the criteria are so specific that they do not include the social environment of the beneficiary. Including family and friends in interventions is crucial for a lasting recovery from mental health problems. For example, one NGO received funding to work with traumatised children. In some cases they discovered that the parents were the source of the trauma because they abused or neglected the child. However, they had no funding to work with the parents. Restricting psychosocial interventions to children without being able to address the problems of the parents is ineffective and unsustainable (INT3).

Shifting donor interests. An additional problem with NGO projects is the political nature of the funding. The international donor community allocates more money to humanitarian crises that attract the most media attention and that are high on political agendas. Projects meeting the needs of beneficiaries from such high-profile crises receive funding until the international attention shifts to another crisis. An interviewee explained the recent shifts in money flow from one refugee community to the other:

“A few years ago the money was coming for working with Iraqis. Now the interest of the international funders starts going to Syrians. That means less money for the Iraqi people. Does it mean that the Iraqi people don’t need help? No. Does it mean that the Lebanese people don’t need help? No. But the funds go through” (INT4).

The sudden shifts in donor involvement are incompatible with mental health projects. The interest of donors for a humanitarian emergency is strongest during the first months of the crises. Yet, the role of mental health interventions is limited at the early stage. Priorities lie with life-saving activities and basic physical needs. Those who have lost a loved one engage in a normal process of grief. It is too early to assess war trauma in this early stage of the crisis. It is months later that mental health professionals can identify those who suffer from lasting mental health problems. Mental health projects are most needed during the years following the traumatic event. But the focus from

donors on new crises makes it difficult for mental health NGOs to collect funding for addressing the psychological aftermath of a humanitarian crisis (INT₃; INT₉; INT₄).

Emotional burden on care providers. Not only beneficiaries but also NGO workers feel the consequences of the structural difficulties of the sector. Working in mental health projects poses great psychosocial challenges to the care providers. It requires emotional engagement with people who have been through horrible war events. Doing this on a daily basis naturally draws on the mental well-being of workers. Emotional preparation, psychological support and peer supervision are therefore essential for mental health care providers. However, in the NGO system, these activities are very low in priority. Most of the money goes to implementation and administration. One NGO I visited organized peer supervision in their leisure time because of lack of funding (INT₁₃). Even in powerful humanitarian organizations, psychological support for mental health care providers is rarely available. The management does not see the importance of it because they are too far away from the field level. The absence of psychological support for employees negatively affects the performance of mental health care providers and can lead to negative project outcomes. Furthermore, many mental health projects rely on outreach workers who are part of the target community. They are more suited to address the needs of the community because they have lived through the same events. Before outreach workers are able to work for a mental health project, they must have completely recovered from the war trauma. Otherwise the outreach worker will negatively affect the beneficiaries. Yet, NGOs rarely provide proper psychological support to outreach workers due to a lack of funds (INT₁₄; INT₁₂).

Summary: structural challenges for mental health NGOs. NGOs in Lebanon generally do quite well at addressing the psychological needs of the population affected by war. However, they have to work within a system that makes it difficult to achieve a sustainable improvement in mental health. Politics complicates the actions of NGOs and can destroy the fruits of their hard work in an instant if new violent conflict erupts. For mental health projects to be more effective they have to be carried out in cooperation with the authorities. The state has to ensure that the beneficiaries are cared for after the project has ended. Without an effective national mental health system, the impact of NGO projects is short-lived and limited to very small parts of the population.

3.2.3 Mental health: a stigmatised topic

In Lebanon, access to mental health care is hampered by stigma and a lack of awareness among a large part of the population. The consequence is that after a war event, victims who have suffered a psychological trauma rarely seek help at mental health services. As demonstrated in previous sections of this paper, access to mental health care is low due to a limited supply of adequate services. In this section I will analyse what the interviewees discussed about accessibility from the demander point of view.

Common misconceptions. The stigma of mental health can take many forms. A widespread opinion is that people with mental health problems are “crazy” (INT₁; INT₂; INT₄) or “weakly willed” (INT₁₁). Good mental health is not seen as complementary to physical health. While physical health is accepted as a part of human well-being that needs care, there is no such understanding about mental health. Consequently,

problems in mental health are thought to be caused by something lying in the personality of a person. The consequences of this stigma can be quite dire: for example, a man with sleeping problems due to PTSD is blamed by his family for not being able to work (INT_I). Or a woman with depression would never find a husband because the depressed mood is thought of being in her genes and will be passed on to her children (INT_{II}).

There is a misconception that people with mental health problems are not able to lead a normal life; that they have to stay in a hospital and need constant care. It is not considered a problem that can be managed well with the right support (INT₄; INT₉; INT₁₃).

In certain areas of Lebanon, the taboo attached to mental health is stronger than in others. Especially in the south of the country and in the Beqaa Valley the taboo is significant, in the city of Beirut it is less profound. The stigma exists especially among people from a lower socio-economic class (INT_I, INT₂, INT_{II}).

More accepted forms of care. Shame and fear lead people to seek mental health care as a last resort. They search for help at other more accepted care providers. Going to a religious authority such as a sheikh or priest is a common step. Many believe they can recover by praying more and faithfully attending religious services. Adhering to god can help manage feelings of guilt because it makes people aware that there is something greater than them. But religion can rarely do enough to manage more severe mental health problems. There are even cases of people with schizophrenia receiving only religious support. There is also a risk of ending up with a charlatan who takes advantage of the need for spirituality by selling dubious services (INT₄; INT_{II}; INT₉).

Going to the family doctor is also more accepted than the mental health service. However the awareness of mental health problems among general practitioners is very low. If a patient presents mental health problems they are often treated for the physical symptoms instead of being referred to a mental health professional. For example, patients with sleeping problems due to nightmares about a traumatic event often receive tranquillizers (INT_{II}). While treating the symptoms is important it is not an effective intervention on its own. (INT₄; INT₅).

The overreliance on medical solutions for psychological problems opens doors from fraud and misuse. The pharmaceutical business is poorly regulated in Lebanon. Patients can buy strong medicine on their own account and risk suffering from side effects or becoming addicted (INT₅). Some companies make substantial amounts of money selling fake herbal medicine on the street or on the internet to people with serious psychological symptoms (INT_{II}).

In reaction to the existing stigma, mental health care providers have learned to keep a low profile. NGOs cannot call their interventions mental health care or psychological care because the stigma attached to mental health would prevent people from coming. So NGOs try to avoid this stigma by naming their facilities differently. An interviewee explained that a certain centre for children with mental disorders is called “family guidance centre” (INT_{II}) to make it less stigmatising. Another common strategy to make mental health care less recognisable as such is to link it to existing primary health care

facilities. They offer mental health care in the same familiar setting. Beneficiaries are afraid that people they know might see them going to psychological treatment. They keep it a secret from their family and go through all kinds of trouble to avoid being seen. Patients often prefer to see a psychotherapist in a different region and they disguise themselves with sunglasses to hide their tears after crying during therapy. (INT1; INT11; INT4)

General awareness is slowly improving. Lack of knowledge is an important reason for the stigma around mental health care. Families do not know what to do if they see behavioural reactions to a psychological trauma. Accordingly, the community cannot provide adequate support to a traumatised person. Physical health and spiritual guidance are well known to be important for a person's well-being. Awareness about the potential contribution of mental health care is very low. Consequently, many traumatised people will never find adequate treatment or only after many months have passed. (INT13)

However, many interviewees stressed that awareness about mental health has been improving in the last decade. In the media there are more items about psychological well-being. Psychologists and psychiatrists appear on radio and TV discussing everyday topics like good parenting or the importance of talking about personal problems (INT5). Campaigns from NGOs also had a positive effect. People go more often directly to a psychologist and doctors more often refer patients to mental health providers (INT1). This is certainly a positive trend that should be pushed forward not only by NGOs and the media but also by the national authorities.

3.2.4 Summary

Access to mental health care in Lebanon is limited due to a centralised and expensive national system. As a result, psychotherapy and other mental health services are only available to the rich part of the population. People with severe psychological disorders can be treated in public psychiatric hospitals which offer an out-dated standard of care. NGOs are limited in their ability to deliver sustainable results because they mostly work in isolation and have to deal with significant structural challenges, such as insecure funding. The limited use of mental health care service is further restricted by the prevailing stigma and lack of knowledge among the public, although awareness is slowly improving thanks to increasing media attention to mental health topics. Improving access to mental health care should be in the interest of the state because - besides improving the well-being of its citizens - it would help to build lasting peace. How better mental health care would help to build peace is the topic of the next section of this paper.

3.3 The influence of mental health on reconciliation

Research question 3: In what ways does mental health of individuals influence the reconciliation process within Lebanese society?

Hypothesis 3: Poor mental health decreases the ability of Lebanese society to engage in reconciliation by diminishing cognitive skills, trust and shared responsibility. These processes affect the community, political leaders and NGO staff alike.

3.3.1 How mental health problems affect reconciliation

According to a working definition of reconciliation (Hamber and Kelly, 2004), there are several psychological capacities which are necessary to contribute to reconciliation. First, a person must be able to learn from the past and envision a peaceful future for his environment. Further, the person should act within his social network based on that vision. Finally, groups of people who were the enemy during war should be encountered in a constructive way to generate social inclusion.

Interviewees were asked how war-related mental health problems affect these capacities. Soon it became obvious that engaging in reconciliation is an enormous challenge for every Lebanese whether or not suffering from mental health problems. However, it was also very clear that war trauma makes reconciliation even more challenging.

For reconciliation to be successful, a feeling of shared responsibility for the war is necessary. Fears that have been created in the past have to be acknowledged by all parties. A collective reflection on the past is followed by a shared duty to build a future. That way learning from the past and building peace is possible. (INT14; INT10)

Disturbed relation with past and future. People with war trauma are less able to learn from the past (INT4; INT6; INT13). Their view of the past is disturbed by the psychological trauma they have experienced. They are unable to let go of the past emotionally. Despite that fixation many refuse to talk about personal suffering. They would pretend to live a normal life and deny their involvement in the war, thinking that by not talking about the war they will forget everything that has happened. When in a comfortable setting in which they feel confident enough to talk, they can become very emotional. An interviewee gave an account of a man who was a fighter during war. Later he lived a life full of self-blame and guilt. He interpreted every negative life event – his wife’s miscarriage, his child being sick - as punishment for his war activities (INT6).

Also, people might dwell on past injustices. They are trapped in the victim role. They are so obsessed with demanding compensation that they are unable to deal with everyday life. Somebody who has been harmed in the war can develop very strong feelings of anger and spend his days planning vengeance. (INT6, INT3, INT13)

People with mental health problems lack the ability to plan for the future (INT5; INT7; INT9). Because of permanent political instability it is hard for all Lebanese to create a vision of a peaceful future. People with anxiety problems suffer even more from the instability. They feel very insecure about their own future and they take any negative event as confirmation of their fears. They are very convinced that their fears are justified: “People who worry too much don’t think they worry, they think they are right” (INT7).

Consequently, they think about the future of the country in very negative terms. Some live in a constant anticipation of war, preparing themselves and their families to fight for their land. This anticipation can develop into a severe paranoia. (INT5; INT7; INT9).

Due to this disturbed view on the past and the future, people with mental health problems are less able to contribute to the creation of a peaceful future (INT1, INT4, INT10). The fixation on the own victimhood makes them unable to recognise a shared suffering among all Lebanese. A realistic view of everybody's contribution to the war would be a starting point for reconciliation in Lebanon. It would set the ground for a future which is based on mutual respect and trust. This process has to start at the community level. Civil society can challenge political leaders and take initiatives for new laws. They can influence political discourse away from sectarianism towards a constructive dialogue. People who have been traumatised during war cannot contribute to this process because their perception about the past and the future is disturbed by the war trauma. Their view is limited to personal misery and if they contribute to the political discourse it is only in a destructive way. They do not want to get hurt again, so they avoid taking any risk. It is a way to protect oneself from more suffering. Without the appropriate care, they pass the trauma on to the next generation who will have the same negative bias about the future. (INT1; INT4; INT10).

Disturbed cognitive skills. Perspective taking and problem solving are two cognitive skills that are important for reconciliation. Starting a process of reconciliation requires the ability to take the perspective of an opponent group. Sharing views and interests creates a level of identification between enemies. The awareness that there is more than one truth about the war is a crucial experience. It allows people to appreciate each other's similarities and respect the differences. After this awareness is created, there is a need to find creative solutions that serve all interests. With a common cause in their minds they are willing to compromise without revisiting extreme viewpoints. It is important that this experience is made on a community level because that makes the people resistant to dangerous rhetoric from political or religious leaders. If the number of Lebanese who say no to sectarian politics reaches a critical mass, the political discourse will move from a power struggle between ethnic groups towards the creation of a unified national identity (INT6; INT10).

People with mental health problems lack the cognitive skills necessary to promote a dialogue of reconciliation. An interviewee described the perspective of a person with mental health problems as follows:

“A person with a mental health problem might be facing a wall, with their nose to the wall, so they cannot see anything beyond that. [...] Depending on what their issues are they are very much focused and cannot see anything beyond it. A person without a mental health problem might be able to see things from a different angle. They might be able to take a step back, to look at other options that they might have for their own life and for the life of their family and for the future of the country” (INT1).

The preoccupation with one's own problems limits the ability to solve every day problems effectively. The rumination disturbs the ability to take a step back and find creative solutions. A person with depression is trapped in a spiral of negative thinking that sucks up all his cognitive resources. He avoids social contacts and lives a passive life

because he feels a constant lack of energy. When confronted with a social situation he is unable to engage in constructive dialogue. Taking the perspective of the other and solving conflicts is impossible. A person with anxiety problems is preoccupied by fear. Avoiding stimuli that remind him of the traumatic war event becomes a daily challenge. Social situations mean insecurity and are avoided as much as possible. Meeting people from opponent groups generates fear and can trigger extreme emotional reactions. They therefore prefer to stay in a secure environment and to engage in well-structured activities. Engaging in a dialogue of reconciliation means taking a leap of faith; it requires courage to step forward and confront fears. A good portion of optimism is needed to be able to accept the differences between parties and find a fair solution to the conflict. People with mental health problems are unable to take that risk and do not show the necessary optimistic bias. Consequently, they are unable to contribute to the process of reconciliation (INT8; INT7; INT14).

Limited social interaction. For reconciliation to be successful, social segregation needs to be addressed. In Lebanon, the political system mirrors the social division across sectarian lines. The sectarian segregation has caused armed conflict in the past and can easily do so again in the future. Relations between the groups have frequently changed during the war. Depending on time and place the conflict was between Christians and Muslims, between Druses and Christians or between Sunni and Shia. Because relationships between groups can change easily from friend to foe, it is safest to stay with one's own people. Belonging to a group is very important for Lebanese people in general. Group belonging protects them from being attacked by another group. This is learned behaviour which is a consequence of a history of conflict. Consequently, meaningful interactions between groups are rare. People do not know much about the needs and interests of the other group. Stereotyping and suspicion dominate intergroup relations. Unequal national laws treating one sect differently from the others maintain the sectarian thinking. Instead of a national Lebanese identity, there is merely a co-existence of communities. To build sustainable peace it is crucial to break through this social segregation. This process starts at the local level. Interaction in social activities builds trust and respect. Civil society organizations can take initiatives to bring people from different sects together which would promote a national identity. If communities work on an inclusive society they can take away the breeding ground for sectarian politics (INT5; INT10; INT11).

People with war trauma sustain the segregation of society. They have experienced a severe violation of trust. For example, in the Shouf mountains in certain villages, Druse and Christian people were living together as friends. When the Christian population turned against the Druze and forced many to leave their homes, former friends started to harm and kill each other. The fighting and displacement alone are severe traumatic experiences, but the violation of trust leaves a very particular psychological scar. They learned not to rely on another sectarian group again. Accordingly, they prefer to live and work with their own people (INT10).

If another sectarian group is the source of the trauma, interaction with that group becomes extremely difficult. Someone who witnessed violence might experience fear of anything associated with the source of the trauma. Not only the individual who was the perpetrator is seen as the source of the trauma, a generalisation to the social group the

perpetrator belongs to takes place. Accordingly, a traumatised person tries to avoid interactions with a member of that group because an encounter triggers fear. Although interaction is often necessary in everyday life, it remains superficial. The traumatised person takes all kind of irrational precautions because of his fear. Comparable to somebody with a phobia against a specific object, for example snakes, the fear is stronger than any rational argument. A man who is afraid of snakes might avoid going to the forest even though an ecologist might explain to him that it is not dangerous. In the same vein, a man who has been shot by a Christian militia avoids talking to any Christian even after an NGO advises him to meet with the group in the name of reconciliation. If he agrees to talk to them, his traumatic experience forces him to be careful and distanced to protect himself from being harmed. This superficial interaction is not enough to build the mutual trust that would prevent conflicts in the future. The psychological trauma has to be treated first before a sincere and meaningful dialogue is possible (INT7).

Losing trust in a better future prevents constructive interactions between groups. An interviewee working with victims of torture recounted the strong feelings of personal revenge they harbour. Torture is an experience that is very traumatising. Almost all victims of torture develop mental health problems. Often they lose all trust in society, isolate themselves and refuse to talk to anybody about their experience. In many cases they develop a strong need to take revenge, ready to destroy the life of the one who destroyed theirs. To do this they may even go to the prison to harm and kill the perpetrator (INT13).

Also among displaced people, the absence of trust and confidence is too strong to allow reconciliation. Often the families who have been most traumatised decide to leave the country. Others who have stayed in Lebanon and returned to their villages refuse to reconcile. Many regard themselves as victims and demand compensation and revenge. In reconciliation projects, they do not engage in constructive dialogue with the other group, instead presenting endless lists of accusations and demands (INT10). The psychological state needed to overcome these strong feelings of revenge has been called “negative revenge” (INT10), in other words transforming the need to do harm into a peaceful action. This promotes the idea that the real revenge is to not surrender to that need and instead show that one is strong and positive. For a victim of torture that means to accept that their life has been destroyed and to “build a new life” (INT13) and for a displaced person it means to “look for more love in those who have destroyed my village” (INT10). This is a difficult cognitive task for anyone who has experienced war and violence.

Summary: Reconciliation among the community is prevented by a lack of positive thinking and disturbed cognitive skills caused by psychological trauma. A genuine attitude of working and building is needed on all social levels for successful reconciliation. It takes time and effort to accept the other even if you do not trust them. A certain positive bias is needed to engage with the group that has hurt you in the past. People with mental health problems do not have the necessary positive attitude. And without adequate psychological support they will pass their trauma on to the next generation who will harbour the same stereotypes and fears that prevent reconciliation (INT7).

3.3.2 Mental health problems among politicians

Many interviewees were convinced that reconciliation is a process that has to take place on the community level. Overcoming one's fears, listening to each other's needs and becoming an active citizen can start the peace building process (INT14; INT6; INT10). In addition to that, the government has to provide a framework in which reconciliation can take place. Formally accepting that everybody was a victim of war can create a common ground for moving forward. It is important to listen to the needs of all social groups and grant them civil rights. Next to material compensation for losses, everyone's suffering needs to be recognised. In Lebanon, an agreed upon history of the war does not exist yet. Political negotiations keep failing in essential matters for peace building. Sectarian laws exist in areas of marriage, divorce and inheritance. In all these matters, politicians need to take the lead. But political leaders lack confidence and trust in their own peace building negotiations. (INT7; INT6; INT10).

There is no reason to believe that politicians have been less affected by war than other citizens. On the contrary, many politicians were in the military during the war and faced numerous traumatic war events. Many politicians are known for having fought important battles and many have lost family members during war. At the same time, politicians never seek psychological support because they think that makes them look weak. An interviewee stated strikingly that he has heard many members of the Lebanese parliament declare that they need an open heart surgery but never of one who admitted needing psychotherapy (INT9). Hence, politicians are at least as much affected by anxiety problems and depression as the general population.

Fear drives sectarian politics. Fear of violence dominates their political actions. Fear impairs a realistic view on the relationship between parties. In the view of one interviewee:

“[Mental health affects] your capacity to listen to the other and to know that the other is an enemy and might become an enemy again. But that other could be anyone. Because you are a human being, given the right circumstances he might become an enemy. And in view of that profound consciousness that human beings are capable of bad stuff, do whatever what is best to prevent this bad stuff from happening. And not be under the illusion that you are [...] my friend and we love each other. Let's sit down and work together from our own experience, what has traumatised us the most and how we can avoid it. And respect you profoundly. But if I am somebody who is depressed and I am at the negotiating table, or if I had PTSD, or if I am impulsive, and if I am sitting around a table to test you. Not with the intention to strike a deal with you. It is disastrous” (INT7).

Because of the fear of violence politicians need to protect themselves from harm. They get the protection from their own sect or party. So they enter the negotiations with extreme caution, unwilling to leave their own position and approach the other party with an honest intention to reach a compromise. Fear makes it impossible to recognise each other's victim role. Everyone sees himself as a victim of the conflict. So they are not at the negotiation table to reconcile, but to ask for an apology (INT7).

Political leaders lack confidence and trust which should be the starting point for every kind of dialogue, negotiations and consultation. Before a meeting, a thorough

preparation to build trust and confidence is necessary. Often it is the task of a mediator to build that foundation. During this preparation, parties need to talk about their feelings, needs and interests. “They need to enter the hearts and minds of the other” (INT10). They need the ability to take the perspective of the other and accept the fact that there are several truths to the same conflict. It requires cognitive effort to do that. Politicians who are traumatised by the war are unable to make that cognitive effort because their thinking is blurred by emotions. Feelings of victimhood, anger and revenge dominate their thinking. They are looking at today’s political problems with the emotions of the past. According to one interviewee, during public speeches it becomes visible that politicians are stuck in the past emotionally:

“If you compare 1981 or 1986 what the speech was and now, you see that it is almost the same person. Talking during the war and talking now. Maybe sometimes the words are different or the context is different. But from the non-verbal communication, the way they use their hands and their face, usually it is a speech of aggression” (INT14).

Summary: politicians with unresolved trauma fuel the conflict. The psychological trauma does not allow politicians to let go of the past emotionally. Even though they might talk and behave as if they are ready to negotiate as partners, their emotional load is too strong to really engage in reconciliation. They are unable to understand the needs of the former opponent and cannot accept a mutual victimhood. With the psychological trauma unresolved, every meeting just becomes another layer in the conflict.

3.3.3 Problems among NGO staff

NGOs play an important role in the reconciliation process. In Lebanon, the government is not pushing forward the reconciliation process. They are pre-occupied with restoring the economy and the current political tensions in the region and, as discussed above, they lack the trust and confidence that is needed to engage in peace building. NGOs might be in a better position to push forward the reconciliation process. They are neutral in political issues and they are close to the community. They can build “microenvironments where reconciliation is encouraged” (INT7). On a small scale, they bring people from different sects together, listen to all the fears and needs and promote capacity building. At the same time they can produce tangible results: building schools, hospitals and community centres (INT14). In this way the community becomes more resistant to conflict in the future. However, the work of NGOs is also affected by war-related mental health problems.

Community workers are not ready for reconciliation. NGO workers need a healthy mental state to be able to deal with the conflicts arising in reconciliation projects. They need to be highly motivated and skilled to handle competing interests and convince beneficiaries to contribute to the project. At the same time they must be emotionally engaged in order to understand the suffering of the people. They are subjected to a lot of pressure. Working in this environment with compassion and professionalism requires good mental health.

NGO workers run the risk of suffering from mental health problems. NGOs often recruit community workers from the target community because they are more accepted by the beneficiaries and they “speak the same language” (INT14). Thus, community

workers have experienced the same traumatic events as the beneficiaries. The external workers working in a conflict area also face permanent psychological stress. However, as described above in the context of mental health projects, there is no adequate psychological support for NGO workers in reconciliation projects. Consequently, often NGO workers who suffer from mental health problems enter the field and engage with the population. What happens if a field worker with mental health problems works in reconciliation?

“We have had many examples, [...] how they deal with the community and sometimes they are dealing with them in a negative way. Because they are under pressure and they are in this bad mental health situation, so they get angry, they get upset or they treat the beneficiaries in a very negative and not adequate way” (INT14).

One-size-fits-all solutions lead to frustrations. Project outcomes suffer from the challenging mental health status of NGO workers. Field workers are not able to build the trust and confidence needed for a constructive dialogue with the beneficiaries. The psychological stress prevents them from engaging emotionally with the target community. This situation leads to frustrations among NGO workers and beneficiaries.

Yet, there is no awareness of the importance of psychological support for NGO workers. It should be a part of training and preparation for every field worker. But the design of projects is not based on cultural realities on the ground. There is little understanding of the sufferings of the particular sub-groups of the community. “Instead of designing something which responds to the needs of the target community, they design something responding to the needs of the donor” (INT14). Because of the need to react quickly on calls for proposals, NGOs offer one-size-fits all interventions. There is a lack of time and money to undertake sufficient preparation in which the particular needs of the target population can be assessed. Success is measured by outputs like capacity building workshops and community centres instead of the genuine commitment of beneficiaries. With this attitude, the mentality of beneficiaries has been ruined. The following might be expressed by beneficiaries in reaction to a new reconciliation project:

“Bring us money and this is what we want. Give money for computers or make a playground or whatever, [...] we are fed up with speaking and the whole blablabla we need something tangible.” (INT14)

Summary: psychological support for NGO staff needed. Reconciliation starts with trust and confidence. Preparation of beneficiaries and NGO workers on the psychosocial level must be the foundation for peace building projects. Good mental health of field workers should be a high priority for project design and implementation. Without good mental health there is no trust and confidence in a successful reconciliation process. If NGO workers lack confidence and trust they are unable to evoke these qualities in the beneficiaries.

3.3.4 Summary

Mental health problems disturb social and cognitive skills which are necessary for reconciliation. On a social level, affected people lack trust and confidence that is needed to engage in positive interactions with former opponent groups. Reflection on past

conflicts is either marked by an extreme preoccupation with the past or the refusal to talk about the past at all. The fixation on one's own victimhood disturbs cognitive skills such as problems solving and perspective taking. These symptoms limit the capacity of people to plan the future and contribute to a peaceful society. Political leaders are also affected and, as a result, are largely incapable of pushing forward the reconciliation process. In NGO's which are working on reconciliation, it has been observed that community workers lack confidence and trust in the success of their own projects.

4 Conclusion

This thesis started with the myth of the Phoenix. The bird that is getting itself burned by the sun serves as an analogy for Lebanon, a country that has been dragged into war over and over again in the course of its history. Experts in peace building try to find ways of ending this cycle of destruction. My angle on this challenge was to explore the influence of war-related mental health problems on reconciliation. The outcome of this study is a grounded theory which will be presented in the first part of this section. Based on the grounded theory, several lessons-learned for humanitarian actors have been formulated in the second part of this section. Because of the explorative nature of this study, all outcomes have the character of a working hypothesis. More research is needed to confirm, adapt or reject the outcomes of this study. Suggestions for possible directions for future research are formulated in the last part of this section.

4.1 Developing a grounded theory

Many Lebanese people feel that their country is in a permanent state of war. Periods of threats, conflict, violence, and recovery follow each other in endless loops. Consequently, war-related stress can have many different forms, ranging from fear of conflict and the experience of actual violence, to adaptation problems in the aftermath of conflict. The accumulation of several of these stressors in combination with individual vulnerability and resilience factors can lead to mental health problems. The more severe these stressors are, the more severe the mental health impact will be. Vulnerability factors such as pre-existing mental health problems or cross-generational trauma increase the impact of war stress. Parts of the Lebanese population show a strong resilience to war trauma due to habituation, strong social bonding or financial resources.

Despite the evident need for adequate mental health care, access to mental health services is very limited. Psychotherapy and psychiatry in private clinics is unaffordable to the majority of the population. Public mental health services are of poor quality and only for severe mental disorders. NGO's offer free services around the country, but their capacities are limited due to insecure funding. Because of a stigma around psychological problems, people with mental health problems refrain from seeking psychological support or prefer to seek more accepted forms of care such as medical or religious counselling.

Poor mental health caused by the war in combination with a lacking mental health care services has disturbed the reconciliation process in Lebanon in several ways. Interactions between social or religious groups are marked by a lack of trust and irrational fears.

People with mental health problems lack a positive thinking and are stuck in a victim role, which prevents them from initiating constructive contact with former opponents. Their mental capacity to solve conflict-related problems is limited by depression, anxiety or drug-abuse. These negative thinking patterns are passed on from one generation to the next. Official peace building efforts are failing because political leaders are also affected by war-related mental health problems. Additionally, NGO staff working in peace building needs psychological support to be better prepared for the implementation of reconciliation projects.

4.2 Lessons learnt for humanitarian actors

Humanitarians working in post-conflict areas should develop an understanding of the most common types of mental health problems that are caused by war experience. People have different needs according to their particular condition. Hence, they also need to be approached differently when integrated into reconciliation projects. Their individual fears have to be assessed in order to restore trust and confidence. Beneficiaries who might negatively affect the project because of mental health problems need to be identified and cared for.

People with generalised anxiety have learned to look everywhere for signs of danger. They develop irrational assumptions about the risks of engaging with other people. They retreat to their own groups and avoid meaningful interactions with others. Thus, before reconciliation can take place, the exaggerated fear has to be addressed.

Symptoms of PTSD prevent reconciliation because they decrease the ability to deal with the past. They fear the repetition of a certain war event and avoid being reminded of it. This fear disturbs a constructive reflection and learning process. Additionally, due to lack of sleep and emotional unrest they suffer from poor concentration and memory decrease. This affects general problem solving skills which are necessary to achieve economic and social improvement, such as finding a job or solving family problems.

Depression is marked by structurally negative thinking patterns. Thoughts about personal failures occupy the minds of those affected. The negative thinking prevents them from developing a constructive attitude in interpersonal interactions. They lack confidence in a positive outcome of the peace process and drag others into a negative thinking pattern. These negative thinking patterns have to be addressed before they can contribute to the reconciliation process.

People addicted to substances such as alcohol and heroin use the drugs to ease feelings of anxiety which come up when being reminded of traumatic war situations. They lack problems-solving skills, social skills and are less active in public because their lives are pre-occupied with the addiction. Often, they have started using drugs during the war as a negative coping strategy. Those root cause have to be addressed simultaneously with the physical consequences of substance abuse before addicted people can be integrating into reconciliation projects.

In addition to the mental health disorders described above, people with pre-existing mental health problems are a group which needs special attention from humanitarians and mental health care providers working in a post-conflict situation. The structure and

support needed to manage their condition in everyday life breaks apart during conflict. Humanitarians working in post-conflict areas should therefore devote special attention to people with pre-existing mental health problems. Parallel to physical vulnerability, vulnerable groups in terms of mental health should be identified before implementing a humanitarian project.

Children are a vulnerable group that suffer from war through the transfer of trauma. The confrontation with negative effects of war through their caregivers can impact their mental health long after the war is over. Humanitarian projects should therefore integrate the wider social environment of a child. Linking with parents and schools is crucial to have a lasting positive influence.

The dysfunctional behaviour associated to mental health problems lead to a disruption of the reconciliation process on several levels of society. Humanitarian organisations have to be aware of the consequences for beneficiaries, the political context they are working in, and their own staff.

Beneficiaries might show a lack of commitment to reconciliation projects because of mental health problems. They might only participate because of material incentives or social pressure but actually lack the trust in a positive outcome. They might take part because they want to hear an apology from former enemies instead of working on the root or the conflict. Blame and stereotyping dominates their thinking. Because of a fixation on one's own victimhood, listening to the fears and needs of others is impossible. Hence, the motivation of beneficiaries has to be addressed before the start of the project. Restoring trust and confidence is more important than organizing actual activities. Achieving this requires large amounts of time and resources for the preparation of a reconciliation project.

The same destructive attitude makes negotiations with politicians difficult. Mental health problems interfere with their ability to push forward the peace process. They might be unable to truly engage with opponent groups because of fear to lose the protection of their own group. Their statements are marked by stereotyping and aggressiveness. Making communities aware of the destructive attitude and working towards an inclusive society can take away the breeding ground for sectarian politics.

Organizations working in reconciliation have to take good care of their own staff to help them performing well. Working with the personal sufferings of people in a post-conflict environment puts field workers under psychological pressure. To be able to function well, they need tools to restore their own psychological well-being, such as supervision, counselling and therapy. Local staff needs to have fully recovered from own traumas before they can engage with beneficiaries.

Because working on trust and confidence requires good mental health, humanitarian organizations have to integrate psychosocial support into their reconciliation projects. The support has to be culturally sensitive and informed by the local history. Cooperation with mental health experts can deliver valuable insight into critical challenges for a particular target group. There are no one-size-fits-all solutions to reconciliation.

Humanitarian organizations offering psychosocial care can learn from this study that mental health is a complex concept which requires thorough analysis on an individual

level. Vulnerabilities and resilience of beneficiaries influence how a humanitarian crisis impacts mental health of an individual. Vulnerabilities should be identified in the needs assessment. Interventions should aim to strengthen resilience. Understand all these factors and providing a tailored care requires long term commitment of resources.

Humanitarian donors need to understand that mental health projects need long-term funding and flexible implementation rules. They should give psychosocial projects the space to address the wider social causes of mental health problems. A sustainable psychological recovery from war experience takes time. They have to continue long after life-saving operations have ended and need to be reactive to changing circumstances.

Working together with local actors such as religious authorities, clan leaders, general practitioners and psychologists is crucial because they are all part of mental health care. In a post-conflict environment, mental health services may be inadequate and an understanding of its importance might be lacking. There should be open communication about each other's role and expectations and a willingness to complement each other's actions.

This study demonstrated that national authorities, NGOs and international organizations which work on the development of a national health system should promote an accessible mental health service. Not only does poor mental health cause individual suffering, it disrupts the reconciliation process and decreases the chances for sustainable peace. A political framework is needed that enables cooperation of social services and physical and mental health care. After a civil war, all national care providers should reach out to those affected by conflict and make good mental health care accessible to them. Mental health care should not rely too much on the private sector or the NGO sector. National health care has to step in when NGOs projects end.

Fighting the stigma attached to mental health also is part of the responsibility of the national authorities. Because of an existing stigma, people rarely take the initiative to seek mental health services in an early stage of their suffering. Seeing mental health care as a measure of last resort delays interventions and increases the risk of being subjected to more stressful war events.

The main lesson from this study is that if we want to fix the cracks that war leaves on society, we need to address the psychological wounds first.

4.3 Directions for future research

The aim of this study was to explore the impact of mental health problems on reconciliation. An important observation was that there was a very low level of communication between mental health professionals and experts in peace building. There was little appreciation of each other's field of expertise. Mental health was understood as an issue reserved for psychiatrists and psychologists, while mental health professionals lacked a concern for wider sociological challenges of peace building. This shows that the public discussion about these topics is at a very early stage. This research puts forward a good case for the importance of a dialogue between professionals of both domains. Joint research efforts could be a starting point for this dialogue. The findings of this explorative study can stimulate research in several directions.

There is a need for more research on the prevalence of mental health disorders in Lebanon. Next to disorders as defined in clinical instruments, research should also focus on subclinical behavioural symptoms of mental health problems. Efforts should be made to create diagnostic criteria which are tailored to the culture of the people. Investigating vulnerabilities and resilience is necessary to understand the impact of war on different parts of the population. Longitudinal studies can generate a better understanding of the link between mental health and war.

The process of transferring war trauma from one generation to the next should be subject of more systematic research. We need to understand why stereotyping, aggressiveness and sectarianism persist across generations to prevent that those processes fuel old conflicts.

This study has found a significant stigma attached to mental health. The stigma prevents people from receiving the care they need. Studies on health perception and behaviour are necessary to pinpoint the root of the stigma. Those studies could guide inform schools, social services and the media to improve health educational on a national scale.

Experts in peace building should perform qualitative research on the effectiveness of reconciliation projects. They should focus on long-term commitment and trust instead of short-term outputs. They have to draw on the knowledge of social scientists to understand how fractured relationship can be repaired.

Lebanon was the context of this study on the influence of mental health on reconciliation. The country has no yet managed to integrate the different social groups in order to build a solid foundation for sustainable peace. Although the cultural backgrounds of different post-conflict areas are very different, many still have to deal with the social consequences of past wars. Studying the influence of mental health on the reconciliation process in other post-conflict societies would provide new insights into those peace building efforts as well.

5 References

- Alonso, J., Angermeyer, M. C., & Lépine, J. P., 2004. The European Study of the Epidemiology of Mental Disorders (ESEMED) project: an epidemiological basis for informing mental health policies in Europe. *Acta Psychiatrica Scandinavica. Supplementum 109*(Supplement 420), pp. 5-7.
- Amir, D., 2005. Grounded theory. In B. Wheeler (Ed.), *Music therapy research* (2nd ed.) Gilsum, NJ: Barcelona Pub, pp. 364-378.
- APA:Task Force on DSM-IV., 2000. *Diagnostic and statistical manual of mental disorders: DSM-IV-TR* (4th ed.). Washington, DC: APA.
- Assefa, H., 2001. Reconciliation. In L. Reyhler & T. Paffenholz (Eds.), *Peacebuilding - A field guide*. Boulder, Colorado: Lynne Rienner Publishers.
- Babo-Soares, D., 2004. Nahe biti: The philosophy and process of grassroots reconciliation (and justice) in East Timor. *The Asia Pacific Journal of Anthropology* 5(1), pp.15-33.
- BBC, 2012. Lebanon clashes: Fresh clashes breach truce in Tripoli. Available at: <http://www.bbc.co.uk/> [Accessed November 13, 2012].

- Bercovitch, J. & Jackson, R., 2009. Conflict resolution in the twenty-first century: Principles, methods, and approaches. Ann Arbor: University of Michigan Press.
- Bloomfield, D., Barnes, T., & Huyse, L., 2005. Reconciliation after violent conflict: A handbook (Reprint.). Stockholm: International Institute for Democracy and Electoral Assistance. Available at: <http://www.idea.int/publications/reconciliation/>
- Bryant, A., & Charmaz, K., 2007. Introduction. In L. H. Bryant & K. Charmaz (Eds.), *The Sage handbook of grounded theory*. Los Angeles: Sage Publications.
- Charmaz, K., 2006. *Constructing grounded theory: A practical guide through qualitative*. London: Sage Publications.
- Clark, J. N., 2009. From Negative to Positive Peace: The Case of Bosnia and Hercegovina. *Journal of Human Rights* 8(4), pp. 360–384.
- Comer, R. J., 2007. *Abnormal psychology* (6th ed.). New York, N.Y: Worth Publishers.
- Community Relations Council, 2012. *The Northern Ireland Peace Monitoring Report*. Available at: www.community-relations.org.uk [Accessed September 1, 2012].
- Corbin, J. M., Strauss, A. L. & Strauss, A. L. B. o. q. r., 2008. *Basics of qualitative research: Techniques and procedures for developing grounded theory* (3rd ed.). Thousand Oaks, Calif: Sage Publications.
- Corstange, D., 2012. Religion, Pluralism, and Iconography in the Public Sphere: Theory and Evidence from Lebanon. *World Politics* 64(01), pp. 116–160.
- Dadlani, M. B., Overtree, C. & Perry-Jenkins, M., 2012. Culture at the Center: A Reformulation of Diagnostic Assessment. *Professional Psychology: Research and Practice* 43(3), pp. 175–182.
- Eurojar., 2010. Plus de 25% de Libanais ont souffert de troubles psychologiques. Available at: www.eurojar.org [Accessed August 1, 2012].
- Farhood, L., Dimassi, H., & Lehtinen, T., 2006. Exposure to War-Related Traumatic Events, Prevalence of PTSD, and General Psychiatric Morbidity in a Civilian Population From Southern Lebanon. *Journal of Transcultural Nursing* 17(4), pp. 333–340.
- Garrett, J. & Landau, J., 2007. Family Motivation to Change: A major factor in engaging alcoholics in treatment. *Alcohol Treatment Quarterly* 24(1/2), pp. 65–83.
- Goenjiana, A. K., Roussosc, A., Steinberga, A. M., Sotiropouloud C., Walling D., Kakakie M. & Karagiannif S., 2011. Longitudinal study of PTSD, depression, and quality of life among adolescents after the Parnitha earthquake. *Journal of Affective Disorders* 133(3), pp. 509–515.
- Hamber, B. & Kelly, G., 2004. A working definition of reconciliation. *Democratic Dialogue*. Available at: <http://cain.ulst.ac.uk> .
- Hinton, D. E. & Roberto Lewis-Fernandez, L., 2011. The cross-cultural validity of posttraumatic stress disorder: implications for DMS-5. *Depression and Anxiety* 28(9), pp. 783–801.
- Hirst, D., 2010. *Beware of small states: Lebanon, battleground of the Middle East*. New York: Nation Books.
- IASC, 2007. *IASC Guidelines on Mental Health and Psychosocial Support in Emergency Settings*. Geneva: IASC.
- ICRC, 2012. *ICRC/ Red Crescent, 2012. Lebanon: ICRC calls for data on missing persons*. Available at: www.icrc.org. [Accessed November 22, 2012].

- Jia, Z., Tian, W., He, X., Liu, W., Jin, C., & Ding, H., 2010. Mental health and quality of life survey among child survivors of the 2008 Sichuan earthquake. *Quality of Life Research* 19(9), pp. 1381–1391.
- JICA., 2006. Handbook for Transition Assistance. Available at: <http://gwweb.jica.go.jp> [Accessed June 1, 2012].
- Jong, J. de, Komproe, I., & Ommeren, M., 2003. Common mental disorders in postconflict settings. *The Lancet* 361, pp. 2128–2130.
- Karam, E. G., Mneimneh, Z. N., Karam, A. N., Fayyad, J. A., Nasser, S. C., Chatterji, S., & Kessler, R. C., 2006. Prevalence and treatment of mental disorders in Lebanon a national epidemiological survey. *The Lancet* 367, pp. 1000–1006.
- Mendeloff, D., 2009. Trauma and Vengeance: Assessing the Psychological and Emotional Effects of Post-Conflict Justice. *Human Rights Quarterly* 31, pp. 592–623.
- Michaelsen, M. M., 2012. Mental Health and Labour Supply: Evidence from Mexico's Ongoing Violent Conflicts. Households in Conflict Network (HiCN) Working Paper No. 117.
- O'Callaghan, C., 2012. Grounded Theory in Music Therapy Research. *Journal of Music Therapy* 49(3), pp. 236–277.
- Peters, D. H., Garg, A., Bloom, G., Walker, D. G., Brieger, W. R., & Hafizur Rahman, M., 2008. Poverty and Access to Health Care in Developing Countries. *Annals of the New York Academy of Sciences* 1136(1), pp. 161–171.
- Porter, M., & Haslam, N., 2005. Predisplacement and postdisplacement factors associated with mental health of refugees and internally displaced persons. *Journal of the American Medical Association* 294(5), pp. 602–612.
- Reuters , 2012. Beirut bomb kills anti-Syrian intelligence official. Available at: <http://www.reuters.com>. [Accessed November 13, 2012].
- Rubenstein, L. & Kohli, A., 2010. Mental Health Services During and After Armed Conflict: The State of Knowledge and Practice. United States Institute of Peace: Peacebrief 57. Available at: www.usip.org.
- Scarpa, A., 2003. Community violence exposure in young adults. *Trauma Violence Abuse* 4, pp. 210–227.
- Thienkrua, W., 2006. Symptoms of Posttraumatic Stress Disorder and Depression Among Children in Tsunami-Affected Areas in Southern Thailand. *JAMA: The Journal of the American Medical Association* 296(5), pp. 549–559.
- Traboulsi, F., 2007. A history of modern Lebanon. London: Pluto.
- UNDP, 1997. A Profile of Sustainable Human Development in Lebanon: The displaced and development.
- United Nations High Commissioner for Refugees (UNHCR), 2012. Number of Syrian refugees in Lebanon passes 100,000 mark. Available at: <http://www.unhcr.org>. [Accessed November 3, 2012].
- Vinck, P., Pham, P., Stover, E., & Weinstein, H., 2007. Exposure to War Crimes and Implications for Peace Building in Northern Uganda. *JAMA* 298(5), pp. 543–554.
- WHO, 2010. WHO-AIMS Report on Mental Health System in Lebanon. Available at: <http://www.who.int>.

WHO, 2012. Mental Health. Available at: <http://www.who.int> [Accessed June 1, 2012].

WHO, 2011. Mental Health Atlas. Available at: www.who.int [Accessed June 1, 2012].

World Bank, 2001. Kosovo poverty assessment report: Vol. 1. Main report. Washington D.C.:
World Bank Poverty Reduction and Economic Management Unit Europe and Central Asia
Region.

Worldmapsinfo.com. Available at: <http://www.worldmapsinfo.com/mapimage/lebanon.jpg>
[Accessed March 8, 2013].

6 Appendix: Interview guideline

Interview guideline: Research on mental health and reconciliation

Background: My name is Heiko Fabian Königstein and I am currently conducting research within the European Master's programme in International Humanitarian Action at Bochum University, Germany. The data collection takes place in cooperation with the Université Saint-Joseph de Beyrouth. Before this master I graduated in psychology. Thank you very much for receiving me for doing this interview. Before we start with the questions, I would like to explain to you what the research is about and inform you about some practical issues. The interview should take no more than one hour and all personal information will be made anonymous. To make the analysis of the information easier, I would like to record the interview. Nobody else will hear the recordings and the audio file will be deleted after the project. Are you fine with that? O YES O NO

Now I would like to tell you a little more about this research. It looks at three aspects which are all related to Lebanese people who have experienced war. The first aspect is mental health problems of people who have suffered from war. The second aspect is the accessibility of mental health services. And the third aspect is social reconciliation, which I understand as being the process of addressing fractured relationships in the community to build lasting peace. These are the general topics of the interview. The aim of this interview is to explore these topics as openly as possible. My questions will be open and you are encouraged to speak freely about everything which comes to your mind. If we are getting short on time, I will have to interrupt you to speed up the interview.

Have you understood the procedure and the topic of the interview or do you want me to clarify something? Some things might get clearer when you hear the questions. Can we start the interview now? (Any remarks?)

Date:

Place:

Name interviewee:

Organisation and function interviewee:

Short description of the interviewees work: who are the clients? How do they come to the organisation? How frequent and how long are the sessions?

Topic One: mental health problems among Lebanese people affected by war.

People affected by war run risk of experiencing a wide range of traumatic situations. In your experience, what are the most common psychological problems resulting from war

related experiences? (probe: do people who witnessed violence or who lost a family member during war suffering from mental problems?)

If you think of the people who benefit from your services, how would you describe the development of the psychological problems that resulted from the traumatic experiences during war?

Can you talk about one specific case to give an example? (medical history)

What do people you are working with generally do to address their problems?

How do they decide whether or not to seek professional psychosocial services?

How are they supported in dealing with mental health problems? By whom? (probe: are they supported by family, community, NGOs?)

Topic Two: accessibility of mental health services

What kind of professional mental health service is available to people who suffer from war related mental health problems?

How accessible are mental health services in different regions of the country?

How high do you estimate the level of acceptance of professional mental health service by the people?

How do the patients pay for the mental health services?

Topic Three: social reconciliation

In Lebanon, different religious and political groups have fought against each other during the civil war. Now, these groups have to live and work together peacefully.

In your experience, what position do the war experiences take in the lives of people suffering from mental health problems?

How do these people refer to and think about groups who have been the enemy during the war?

How does this way of thinking influence the interaction with the other group in everyday life?

How do they envision a future together with all the different political and religious groups?

How are they acting on this vision in everyday life?

Can you tell about a specific case to give an example?

Thank you very much. This was the interview. Do you have any other things to say or specific remarks about the interview?

Acknowledgements

This paper was realised with support of several academics connected to the Network of Humanitarian Action (NOHA). First and foremost, I want to thank Ms Rosenow-Williams from Ruhr University Bochum for her trust, assistance and advice as well as for her editorial support. My gratitude also goes to the NOHA staff around Mr Gibbons of University College Dublin, who helped me in the preparation of this project. During the stay in Lebanon, I received tremendous support from Ms Bou-Ramia from University of Saint-Joseph in Beirut, who supported me in the preparation of the interviews and made me feel welcome in her country. I would like to thank her and her colleague Ms Tannous Jomaa, as well as Ms Gourbin from the Catholic University of Louvain for introducing me to the Lebanese context. Finally, this study would not have been possible without the fantastic cooperation of all the interviewees in Lebanon, who were willing to invest their time and energy to answer all my questions. Special thanks to you all!



URL: <http://www.rub.de/ifhv/6-publications/6-workingpapers.html>

ISSN: 2199-1367

List of published IFHV Working Papers

- Vol. 1, No. 1** *Huseyn Aliyev*
03/2011 **Aid Efficiency in an Armed Conflict**
The Role of Civil Society in the Escalation of Violence in the North
Caucasus
http://www.rub.de/ifhv/documents/workingpapers/wp1_1.pdf
- Vol. 1, No. 2** *Matteo Garavoglia*
08/2011 **Germany's Humanitarian Aid and Media Reporting on Natural
Catastrophes**
An Investigation of the Relationship between Issue Salience and the
Provision of Humanitarian Aid at the Beginning of the 21st Century
http://www.rub.de/ifhv/documents/workingpapers/wp1_2.pdf
- Vol. 2, No. 1** *Jan Wulf*
05/2012 **A Balanced Scorecard for the Humanitarian Sector?**
Adaptability of the Balanced Scorecard Model to Sector-Wide
Performance Management in Humanitarian Aid – Feasibility and
Implications
http://www.rub.de/ifhv/documents/workingpapers/wp2_1.pdf
- Vol. 2, No. 2** *Johannes Beck*
08/2012 **Contested Land in the Eastern Democratic Republic of the Congo**
Anatomy of the Land-Related Intervention
http://www.rub.de/ifhv/documents/workingpapers/wp2_2.pdf
- Vol. 3, No. 1** *Markus Koth*
10/2013 **Civil-Military Cooperation and Its Impact on Human Security – Chances
and Limits**
The Example of the Australian Defence Forces in East Timor (1999
and 2006)
http://www.rub.de/ifhv/documents/workingpapers/wp3_1.pdf
- Vol. 3, No. 2** *Heiko Fabian Königstein*
10/2013 **The Influence of Mental Health on Reconciliation in Post-War Lebanon**
An Explorative Field Based Study Using Grounded Theory Research
http://www.rub.de/ifhv/documents/workingpapers/wp3_2.pdf

Manuscripts can be submitted to the editors:

Prof. Dr. Pierre Thielbörger, ifhv@rub.de

Dr. Kerstin Rosenow-Williams, ifhv@rub.de



URL: <http://www.rub.de/ifhv/6-publications/6-workingpapers.html>

ISSN: 2199-1367

Institute for International Law of Peace and Armed Conflict (IFHV)

The Institute for International Law of Peace and Armed Conflict (Institut für Friedenssicherungsrecht und Humanitäres Völkerrecht, IFHV) was established in 1988 by decision of the University Senate as a central research unit ('Zentrale Wissenschaftliche Einrichtung') of the Ruhr University Bochum. The IFHV is responsible directly to the Rector and the Senate of the Ruhr University Bochum, but works in close cooperation with the different faculties, in particular the faculties of law, social science, geosciences and medicine.

The IFHV carries out research and teaching on the problems of peace and armed conflict from an inter-disciplinary perspective. Based on its strong international humanitarian law tradition, the IFHV is the only institute in Germany, and one of very few in Europe and the world, which is dedicated to the discipline of humanitarian studies. The IFHV combines its strong emphasis on international humanitarian law, the law of peace and human rights law with sociological and political perspectives on humanitarian crises, actors and activities.

IFHV Working Paper Series

In 2011, the IFHV and the Ruhr University Bochum decided to set up an IFHV Working Paper Series in humanitarian studies. In line with the IFHV's multidisciplinary profile, we intend to publish a broad range of papers in the field of humanitarian studies. Our Working Paper Series publishes 'work in progress'. The Working Paper Series intends to stimulate the humanitarian discourse, contribute to the advancement of the knowledge and understanding of the practices, policies and norms of humanitarian action, and last but not least seeks to attract comments, which improve the content of the working paper for further publications.

The Working Paper Series allows IFHV staff and students, and like-minded researchers in the field of humanitarian studies to bring their work and ideas to the attention of a wider audience. In order to publish high level working papers, the papers offered for publication will be technically screened by the editors of the working paper series and subjected to an internal blind peer review process.

Contact:

Institute for International Law of Peace and Armed Conflict (IFHV)

NA 02/33

Ruhr University Bochum

Universitätsstraße 150

44780 Bochum

Germany

Telephone: +49(0)234 32 27366

Fax: +49(0)234 32 14208

Email: ifhv@rub.de

Web: www.ifhv.de

Facebook: www.facebook.com/rub.ifhv