Article

Journal of Interpersonal Violence
Volume 24 Number 11
November 2009 1835-1848

10.1177/0886260508325491
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Darfur Refugees in Cairo

Mental Health and Interpersonal Conflict in the Aftermath of Genocide

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Hundreds of thousands of Darfur people affected by the Sudanese genocide have fled to Cairo, Egypt, in search of assistance. Collaborating with Africa and Middle East Refugee Assistance (AMERA), the authors conducted a mental health care needs assessment among Darfur refugees in Cairo. Information was collected using individual and focus group interviews to identify gaps in mental health care and develop understandings of emotional and relationship problems. The refugee mental health care system has a piecemeal structure with gaps in outpatient services. There is moderate to severe emotional distress among many Darfur refugees, including symptoms of depression and trauma, and interpersonal conflict, both domestic violence and broader community conflict, elevated relative to pregenocide levels. Given the established relationships between symptoms of depression/traumatic stress and interpersonal violence, improving mental health is important for both preventing mental health decompensation and stemming future cycles of intra- and intergroup conflict.

Keywords: *refugee; trauma; violence; Sudan; Darfur*

Introduction

The ongoing Sudanese genocide, in which Darfur people are being attacked by government-backed militias, has resulted in the displacement of

Authors' Note: This research was funded by the UCSF Psychiatry Residency Research Track Funds. We are grateful for the help of Dr. Barbara Harrell-Bond and the Cairo Office of African and Middle East Refugee Assistance (AMERA). Please address correspondence to Susan M. Meffert, VAMC Building 8, Box 116P, Department of Psychiatry, University of California, San Francisco, San Francisco, CA 94143; e-mail: smeffert@lppi.ucsf.edu.

approximately 2.5 million Darfur people and the death of at least 200,000 (Polgreen, 2007). Many Darfur civilians have fled to the adjacent country of Egypt. Although the United Nations High Commission for Refugees (UNHCR) has officially registered approximately 24,000 Darfur refugees, estimates of the total numbers of Darfur refugees in Egypt are in the hundreds of thousands. Many Darfur refugees have undergone intense traumatic exposure, including rape, murder of family members, and narrow escape from death. Africa and Middle East Refugee Assistance (AMERA), which provides pro bono legal and psychosocial aid services to refugees in Cairo, saw a strong need for improved mental health services in the Darfur refugee community and collaborated with this study as part of an effort to improve and expand their mental health care services.

Although many people recover from traumatic stressors spontaneously, in the aftermath of ethnic conflict, there often remains a significant group who develop chronic mental health sequelae, including depression, anxiety, and traumatic stress symptoms (De Jong et al., 2001). A study of 799 adults with physical disabilities living in Afghanistan showed rates of depression at 67.7% and 71.7% for disabled and nondisabled, respectively. Rates of posttraumatic stress disorder (PTSD) were 42.1% and 42.2% for disabled and nondisabled, respectively (Cardozo et al., 2004). A study of Cambodian refugees two decades after resettlement found high comorbidity between depression and PTSD, with a rate of major depression at 51% and PTSD at 62% (Marshall, Schell, Elliott, Berthold, & Chun, 2005). Across postconflict settings in four different countries (Algeria, Cambodia, Ethiopia, Gaza), the percentage of people meeting criteria for PTSD on the Composite International Diagnostic Interview (CIDI) was 15.8% to 37.4% (De Jong et al., 2001). A meta-analysis of 7,000 resettled refugees in "Western" countries (Australia, United States, United Kingdom, Italy, Norway, Canada, New Zealand), based primarily on studies using semi-structured interviews, found 1 in 10 to have PTSD, 1 in 20 to have major depression, and 1 in 25 to have generalized anxiety disorder (Fazel, Wheeler, & Danesh, 2005). The authors noted the low rate of depression found in their meta-analysis, relative to other reports. It is possible that using studies in which participants meet criteria for major depression, rather than a more general and perhaps less culturally specific diagnosis such as "depression not otherwise specified," could contribute to the low representation of depression symptoms in this article.

Research on the interpersonal effects of depression has shown a significant effect of depression on family relationships. Depression in one or both marital partners was associated with increased marital conflict and the

absence of positive conflict resolution strategies (Du Rocher Schudlich, Papp, & Cummings, 2004).

To date, the bulk of studies of depression and parenting have focused on the effects of depression in mothers. Compared to nondepressed controls, depressed mothers displayed more flat affect, provided less stimulation, and were more negative, more unsupportive, and less able to sustain social interaction with their children (Burke, 2003). Depressed mothers were also more irritable, more critical, and had a higher risk of displaying hostility and aggressive behavior toward their children.

There has been extensive research on the interpersonal impact of psychological trauma symptoms. Early findings come from the National Vietnam Veterans Readjustment Study (NVVRS), which surveyed a national random probability sample of Americans who served in Vietnam and included a focus on family functioning. Male Vietnam veterans with PTSD had lower quality of intimate relationships and were more likely to be separated or divorced than those without PTSD. The degree of relationship distress correlated with the veteran's PTSD severity (Riggs, Byrne, Weathers, & Litz, 1998). Veterans with PTSD had poorer family functioning, more interpersonal problems, and poorer dyadic adjustment relative to combat-exposed veterans without PTSD (Jordan et al., 1992). The spouses or partners of veterans with PTSD were less happy and less satisfied than the spouses or partners of veterans without PTSD (Kulka et al., 1990). On parental measures of childhood adjustment, 35% of the children of veterans with PTSD were rated as having an average behavioral problem score in the clinical range (using the Child Behavior Checklist), compared with only 14% for those without a PTSD positive parent (Jordan et al., 1992; Kulka et al., 1990).

Veterans with PTSD were more likely than those without PTSD to collect firearms and engage in more potentially dangerous activities with the firearms (Freeman & Roca, 2001). They were more likely to engage in verbal, psychological, and physical aggression toward intimate female partners (Bryne & Riggs, 1996). Importantly, the tendency toward violence extended beyond veterans to spouses and partners. For male veterans, family violence, both by the veteran and by the significant other, was found to be more prevalent among those families in which the veteran had PTSD than in families in which the veteran did not have PTSD (Jordan et al., 1992; Kulka et al., 1990). Furthermore, veterans' reports of PTSD were positively associated with reports of hostility and violence among children, including adult children of veterans (Glenn et al., 2002). Jordan and colleagues (1992) discussed possible explanations for the elevated rates of spousal violence among PTSD positive veterans. They noted Straus and

Gelles's (1990) finding that the spouses of husbands who exhibit higher-than-average levels of violence also tend to exhibit higher-than-average levels of violence and described his three hypotheses to explain this phenomenon:

> (1) Women who are assaulted by their partners may incorporate violence in their own behavioral repertoire. (2) Some women may follow the norm of reciprocating violence. . . . (3) The use of violence in one sphere, for example, child care, may carry over to other spheres, specifically, interaction with one's mate. (p. 162)

Although the NVVRS provides a large, representative sample allowing population estimates to be drawn about the relationships among trauma, interpersonal relationships, and violence, the findings have also been supported by research on nonveteran women and men. A study of women who use violence in interpersonal relationships examined the relationship between PTSD, anger type ("in," "out," or "control"), and violence (Swan, Gambone, Fields, Sullivan, & Snow, 2005). The study found that symptoms of PTSD were negatively predictive of anger control and positively predictive of anger out. PTSD symptoms predicted aggression indirectly through anger out. A study of civilian men from university campuses showed that men who had been exposed to a traumatic life event and reported symptoms of PTSD had more trait anger, internal anger, hostility, aggression, and violent behavior than men who did not report symptoms of PTSD (Jakupcak & Tull, 2005). The men with symptoms of PTSD reported committing twice as many acts of aggression and violence in the context of romantic relationships as compared to their trauma-exposed asymptomatic counterparts.

As described earlier, the association between interpersonal conflict and depression/trauma symptoms has been clearly delineated in Euro-American studies. Although mental illness is defined by many biological, universal features, emotional expression is also informed by cultural context (Kleinman, 1977; Mollica et al., 1992). Thus, Euro-American studies provide support for the idea that a universal association between interpersonal relationships and trauma/depression symptoms may exist, but the concept must be evaluated in cultural context before applying it to a different society. The goal of this study is to perform a mental health needs assessment of a specific population, with particular attention to the relationship between interpersonal conflict and mood symptoms. This information provides the basis on which interventions will be designed to improve mental health care services for Darfur refugees in Cairo.

Method

General Study Design

The study was invited by and done in collaboration with the AMERA-Egypt. The qualitative work was full-time for 2 months. Study participants represent a convenience sample and were recruited through tribal community leaders, local nongovernmental organization (NGO) workers, and "word of mouth" within the Darfur refugee community. The study consisted of 22 key informant interviews and 10 focus groups. All participating members gave verbal informed consent. All interviews were conducted with a Sudanese translator. Most interviews took place in Darfur tribe community centers located near the dwellings of Darfur refugees in Cairo, Egypt. Some interviews took place in the homes of Darfur refugees, the homes of Darfur refugee community leaders, or at the office of the collaborator.

Participants

Participants were not always certain of their exact age, and estimates ranged from 25 to 45 years of age. Key informant interview participants consisted of 9 women and 13 men. Key informants were generally in positions of community leadership. Slightly more than half (12) were of Darfur or other Sudanese background. These included individuals such as the Zhagawa and Fur tribe leaders and local employees of psychosocial NGOs. Of the key informant participants, 10 were of non-Sudanese descent and were heavily involved with psychosocial care of refugees in Cairo. Examples include directors of NGO organizations, crisis mental health services, and local psychiatrists who had extensive contact with refugees. Focus group participants consisted of 31 women and 7 men and group size ranged from 2 to 12. Participants were generally local Darfur refugee community members. They volunteered for the study through various routes, including discussion with their community leader and participating in a focus group as a break in an ongoing class at the community center.

Procedures

Key informant and focus group interviews were done with study participant(s), a translator, and the first author. Interviews with key informants generally took place in an office setting, either at the informant's or the interviewer's location, whichever was more convenient for the informant.

Focus group interviews generally took place at the tribal community centers or in the homes or workplaces of participants. The decision about the location of the interview was left to the participants and their comfort in the environment was double-checked at the beginning of the focus group.

Interviews were audio-recorded and notes were taken during the interviews, with the consent of study participants. Interview questions for both focus groups and individual interviews consisted of open-ended questions regarding the general emotional problems of Darfur refugees in Cairo and the quality of family and Darfur community relationships since the genocide, including the current level of discord or violence (e.g., "What has life been like for you in Egypt?" "What community problems do Sudanese refugees have in Cairo?" "What family problems do Sudanese refugees have in Cairo?" "What emotional problems do Sudanese refugees have in Cairo?"). Please see the appendix for a full list of focus group and key informant interview questions.

Data Collection and Analysis

Interview audio-recordings were saved in protected digital format and used after the interviews to fill in details and gaps in the notes. After the completion of the study, between-subjects interview themes were identified and representative quotes were grouped. Themes were classified based on social, relational, or emotional topic. Topics were explored by analyzing the content of interview quotes. Given the limits of study personnel for a pilot project, we were not able to assess interrater reliability for data extraction; this work was completed primarily by the lead author.

Results

The refugee mental health care system in Cairo has developed in an ad hoc manner with contribution from multiple nonprofit NGOs, dedicated to providing different aspects of refugee care. For refugees with very severe emotional distress, such as extreme psychosis or suicidality, there are limited inpatient services. Treatments in these acute situations generally consist of short-term hospitalizations focused on the development of a stabilizing medication regime. There are a number of nonprofit social groups, community centers, and church-based institutions designed to support the general recovery of the community by providing a space where refugees can socialize together in a healthy setting, continue primary schooling, take

courses in English, learn occupational skills, and/or discuss the many problems faced by their community, all in a group format. Although the available services fill important niches in the mental health needs of the population, they seem to leave out an essential aspect of mental health recovery having to do with the many nonacute but extremely distressed individuals whose mental health symptoms interfere with their functioning and limit their ability to benefit from general community recovery programs but are not so extreme as to require hospitalization. Community leaders are overwhelmed by the number of these individuals needing individualized and intensive mental health care.

Participants described many depression symptoms among Darfur refugees in Cairo, including hopelessness, tearfulness, apathy, decreased concentration, decreased or increased sleep, low appetite, weight loss, low mood, decreased energy, and guilt. Participants described the mood of Darfur refugees as: "depressed," "desperate," "very sad," "very upset," "blocked," "hopeless," "frustrated," "cannot sleep," "wish for dying," "guilt," "worthlessness," "everyday will be worse," "I am dead but I am alive," "stays in bed," "looking at the wall," "thinking too much," "exhausted." Participants described numerous traumatic stress symptoms among Darfur refugees in Cairo, including flashbacks, intrusive thoughts, irritability, outbursts of anger, avoidance, emotional numbing, sense of foreshortened future, survivor guilt, poor memory, poor concentration, feeling of detachment from others, and difficulty sleeping. In discussing the problems of the Darfur community, participants noted both their own emotional difficulties and those of others, including: "I have the memories all of the time;" "speak loudly;" "no place that is safe;" "no clear image of the future;" "pain in my heart, disaster in Sudan;" "war came and destroyed everything;" "can't sleep;" "four times per week I am very sad and very upset . . . the main reason is because my oldest brother disappeared;" "not feel relaxed, comfortable;" "stressed."

Unfortunately, Darfur refugees living in Cairo are often discriminated against on the basis of race. They are often denied health care, education for their children, work permits, and housing and receive daily verbal and frequent physical abuse based on racism. Study participants consistently described certain social and emotional problems arising in concert with classic depression and traumatic stress symptoms. One possible corollary of the discrimination they experience included a sense of betrayal: "We came here [Cairo] seeking peace and safety." "We were shocked and disappointed [by the UNHCR, Cairo]." "We are frustrated and hopeless." "Everything is destroyed." "We are confused." "We don't know what to do." "Feel lost." "What's the end of this situation? We feel that the UNHCR

doesn't do anything." "I am coming here escaping from the war and nothing changed and nothing became better than the past."

In addition, Darfur refugees in Cairo had great difficulty maintaining traditional social/moral norms secondary to financial constraints: "The Sudanese ethic is 'whenever you have something, you share it,' but now there is less of everything to go around, so you must be very selective about your relationships." "One tries to avoid social relationships because this incurs financial responsibility." "Unable to provide culturally required gifts when visiting others and visiting requires the host to provide, so . . . you may help the most by staying away." In Cairo, Sudanese refugees were confronted with new cultural and moral norms: "In Sudan, people are more linked to each other." "In Sudan, the life is very simple and here it is much busier." "Sudanese can visit each other any time they want, Egyptians have schedules." "In Sudan, people cooperate, and here everyone is in their own world." "There is no relationship between neighbors, here [in Cairo]."

In discussing these social stresses, Darfur refugees noted associated emotional problems, including confusion, disorientation, shock, demoralization, shame, and perseveration on unfulfilled duties. Descriptors included "feeling lost," "confused," "turned upside down," "our children become confused and also we are confused," "like a lost goat," "not able to be a mother the way we used to be," "not able to fulfill my mandate as a father," "not enough time for family," "shame," "time here is not useful," "wasting time," "all your dreams never come true."

Interpersonal Conflict

Conflict between husbands and wives was often described as related to gender role changes and shifts in family power structure secondary to male unemployment: "If the husband doesn't have a good day, he talks badly to his wife. Takes these problems into the home and they have violence, hitting or punching." "Arguments are bigger in Cairo than they were in Darfur." "My husband behaves like this according to the conditions . . . my husband is completely different since coming to Cairo. In the past, he had no hard words." "Male/husband changes include decreased eating and more aggression with the children, they cause problems by speaking loudly, women/wives have to accept this." Conflicts between parents and children, particularly teenage children, were prevalent. The collapse of family and community authority structures and decreased ability of parents to protect and provide were often cited as reasons for the increased conflict: "Now, I feel like I'm not doing my mandate as a father, not enough time and not

enough money." "I can't sleep and keep thinking according to how to provide." "Now they [children] don't get any help from mothers and elders. This makes them angry and disobey mothers and elders." "Kids argue for things and you have to beat them." Youth violence was common, often directed within the refugee community, although the reason for obtaining weapons was described as self-protection against Egyptians: "They got knives to protect themselves against Egyptians, now they turned the knives against themselves." Tribal-based adult violence was also common: "The Khartoum government created these problems by favoring one tribe over another and creating hatreds that persist in Cairo." "Everyone thinks their tribe is better."

Discussion

Although this is a small convenience sample and does not estimate true rates of emotional or interpersonal problems in the Darfur community of Cairo, the ethnographic work does support the idea that emotional distress, including depression and traumatic stress symptoms as well as social fragmentation and interpersonal violence, may be significant problems for Darfur refugees in Cairo. These findings resonate with earlier research findings, including both the high prevalence of depression and traumatic stress symptoms in postconflict populations as well as the associations found between depression/trauma and interpersonal discord.

There is a growing recognition of the role of individual psychiatric symptoms, particularly traumatic stress symptoms, in the social pathogenesis of communities exposed to intrastate conflict. In northern Uganda, those reporting PTSD symptoms were more likely to favor violent over nonviolent means of ending warfare (Ross, 2007; Vinck, Pham, Stover, & Weinstein, 2007). In a study of postconflict Rwanda, those with PTSD symptoms were less likely to have positive attitudes toward the Rwandan national trials, belief in community, and interdependence with other ethnic groups (Pham, Weinstein, & Longman, 2004). Among former Ugandan and Congolese child soldiers, PTSD symptoms were associated with more feelings of revenge and less openness to reconciliation (Bayer, Klasen, & Adam, 2007).

Our results support the idea that interpersonal discord exists not only on broad levels between conflicting or previously conflicting groups but also within the affected group(s) at the level of community and family. Although care must be taken to avoid inappropriate generalization across cultures,

these study findings do appear to share themes with some Euro-American studies of depression and trauma, as discussed earlier.

Limitations

As mentioned earlier, this study was unable to check the interrater reliability of the data extraction approach, given the limits of personnel. Interrater reliability is a technique used by qualitative data researchers that involves an assessment of the consistency with which multiple researchers extract similar content from the database. Some believe that convergent views from two or more researchers strengthen the analysis: "The reliability of the analysis of qualitative data can be enhanced by organizing an independent assessment of transcripts by additional skilled qualitative researchers and comparing agreement between the raters" (Mays & Pope, 1995, p. 1). However, there is disagreement on the value of independent, convergent opinions, with some researchers taking a relativist position and arguing that consistency is not meaningful and that "all accounts have some validity" (Armstrong, Gosling, Weinman, & Marteau, 1997). In a study that evaluated whether or not different researchers identified the same codes or themes in a transcript, it was determined that although the six researchers identified the same basic themes, they "packaged" the themes into a different context, perhaps reflective of the researcher's academic field and personal experience (Armstrong et al., 1997).

Regardless of whether the purpose of multiple evaluators of qualitative data is seen as supporting the development of a convergent analysis or whether it is viewed as part of a process of generating multiple, valid interpretations, this study was unable to benefit in either way as the limits of research personnel prevented the use of multiple, independent analyses. Given the debate in the field, it is unclear whether this shortcoming of the study causes it to suffer from lack of convergence, lack of divergence, or both: On the one hand, the bias inherent in the interpretation presented here might be moderated by combining it with the convergent aspects of other interpretations; on the other hand, our interpretation may suffer from a lack of diversity that might have been obtained through the use of multiple evaluators.

Conclusions: A Way Forward

Outcome-focused treatment of depression and trauma symptoms with attention to local/domestic interpersonal context triggers and consequences

may be a logical starting point for exploring the utility of mood-violence concepts developed in Euro-American research for the Darfur refugee population of Cairo. The overall goal of such work would be to promote individual mental health and to rebuild the interpersonal relations necessary for creating and sustaining peace. Treatment could take the form of either group or individual work. Based on this study, an argument can be made for either the group or individual modality. Group-level treatment might be favored by the fact that maintaining their predisplacement level of social contact has been difficult for Darfur refugees in Cairo and that social interaction is both central to their cultural norms and likely to promote emotional healing. On the other hand, Cairo is fortunate to have a wealth of NGOs currently providing various types of support/counseling groups for refugees and Darfurians have created their own community centers that facilitate increased social interaction. As indicated by Darfur community leaders, there are many refugees who have such severe mood symptoms that they isolate themselves and are unable to effectively participate and "self-heal" using the available group formats. This suggests that some Darfur refugees are in need of more intensive, individually based interventions to catalyze their own recovery so that they can better use community and group programs.

Guided by the findings from our interviews and focus groups, we have selected interpersonal therapy (IPT) as a starting point for a subsequent treatment intervention. IPT provides a way of treating individual Darfur refugees suffering from moderate-severe depression and trauma symptoms while maintaining a focus on the interpersonal sequeale in a time limited manner. IPT has been shown to be effective in treating depression, there is promising preliminary data for treatment of PTSD (Bleiberg & Markowitz, 2005), and IPT has been successfully adapted for use in Uganda (Verdeli et al., 2003). It is important to note that IPT has been shown to be successful with Ugandans and has not been tested or results replicated with other African populations to our knowledge. It is also important to underline that the IPT results with PTSD are preliminary only. However, when confronted with (a) a call from local psychosocial NGOs for better mental health care interventions, (b) multiple statements of emotional distress from the Darfur refugee community, and (c) indications from Darfur community leaders that current psychosocial interventions are inadequate for many emotionally distressed individuals, we believe that the risks of intervention may now be outweighed by the potential benefits of culturally informed efforts to assist with local capacity building. Although IPT has not been tested for its ability to reduce levels of interpersonal conflict, it is an evidence-based strategy that allows for a tight focus on mood and interpersonal events and

from this perspective provides reasonable hope for success in addressing the neglected aspects of individual and interpersonal mental health care in the Darfur population of Cairo in a culturally syntonic, inclusive manner, without sacrifice of practicality.

The next step will be training of several Sudanese community members living in Cairo to conduct IPT and a pilot trial of IPT for Darfur refugees. Information from the pilot will be used to refine training, therapy, measures, and overall study design in preparation for a randomized controlled clinical trial of IPT for Darfur refugees in Cairo.

Appendix
Focus Group and Key Informant Interview Questions

Question Asked to Focus Groups

Asked to each individual:

1. What part of Sudan are you from?
2. When did you leave Sudan?
3. How long have you been in Cairo?

Asked to the group:

1. What has life been like for you in Egypt?
2. How have people been affected by events in Sudan and the flight to Egypt?
3. Have relationships changed? How?
4. How do you determine that people are having problems?
5. How is your health?
6. Are there other things that you would like to share? If yes, what are they?
7. Are there important things that have not been talked about? If yes, what are they?

Questions Asked to Key Informants:

1. What part of Sudan are you from?
2. When did you leave Sudan?
3. How long have you been in Cairo?
4. What problems do Sudanese refugees have in Cairo?
5. What community problems do Sudanese refugees have in Cairo?
6. What family problems do Sudanese refugees have in Cairo?

(continued)

Appendix (continued)

7. Are there relationship problems (e.g., family, friends) for Sudanese refugees in Cairo?
8. Are there problems with anger for Sudanese refugees in Cairo?
9. Are there problems with violence for Sudanese refugees in Cairo?
10. Are there problems with violence within the Sudanese community?
11. Are there problems with disagreements or violence in Sudanese families in Cairo?
12. What health problems do Sudanese refugees have in Cairo?
13. What emotional problems do Sudanese refugees have in Cairo?
14. What mental health problems do Sudanese refugees have in Cairo?
15. Are there other things that you would like to share?
16. Are there important things that I have not asked about?

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