American Journal of Orthopsychiatry
2006, Vol. 76, No. 4, 409–422

0002-9432/06/$12.00 DOI: 10.1037/0002-9432.76.4.409

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Beyond Trauma-Focused Psychiatric Epidemiology: Bridging Research and Practice With War-Affected Populations

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This article examines the centrality of trauma-focused psychiatric epidemiology (TFPE) in research with war-affected populations. The authors question the utility of the dominant focus on posttraumatic stress disorder and other disorders of Western psychiatry, and they identify a set of critical research foci related to mental health work with communities affected by political violence. Core assumptions of TFPE and its roots in logical positivism and the biomedical model of contemporary psychiatry are explored. The authors suggest that an alternative framework—social constructivism—can serve as a bridge between researchers and practitioners by helping to refocus research efforts in ways that are conceptually and methodologically more attuned to the needs of war-affected communities and those working to address their mental health needs.

Keywords: PTSD, war, refugees, violence, mental health

The past 25 years have witnessed a remarkable increase in research on the mental health effects of political violence and forced migration. This surge of interest began in the 1980s, with studies documenting the prevalence of psychiatric disorders among Southeast Asian refugees who had fled their homelands in the wake of the Vietnam War and the Cambodian genocide (Felsman et al., 1990; Harding & Looney, 1977; Kinzie et al., 1986). Other conflicts heightened the growing interest in the pathogenic nature of war and other forms of organized violence. Such conflicts included, for example, the "dirty wars" of Chile, Argentina, Guatemala, and El Salvador (Aron, Corne, Fursland, & Zelwer, 1991; Bowen, Carscadden, Beighle, & Fleming, 1992; CODEPU [Corporation for the Promotion and Defense of Human Rights of the People], 1989; Padilla & Comas-Diaz, 1987); civil wars in Lebanon, Sri Lanka, and the Sudan (Baron, 2002; Bryce et al., 1989; Somasundaram, 1996); ethnic cleansing and genocide in Bosnia and Rwanda (de Jong et al., 2001; Weine et al., 1998); and the Israeli occupation and Palestinian *intifadas* in Gaza and the West Bank (Punamäki, 1989).

We have accumulated by now a substantial body of literature on the mental health of refugees and other war-affected populations; in fact, a literature search conducted for this article identified over a thousand empirical studies, book chapters, and clinical reports that focused specifically on this topic. It is not our purpose here to review that extensive body of research and clinical observation. Although partial in scope, several published reviews collectively bring together much of what is known about the mental health problems experienced by survivors of political violence and forced migration (Boothby, 1996; de Jong, 2002; Miller & Rasco, 2004; van der Veer, 1998). As those reviews make clear, important strides have been made in documenting the ways in which exposure to organized violence significantly increases the risk of both acute and enduring psychological distress.

Despite these critical first steps toward documenting the impact of armed conflict, however, we believe that a problematic gap has emerged between research and practice with survivors of war and other forms of political violence. More specifically, we are concerned that research with war-affected populations has too often failed to provide practitioners with the sort of useful information that could support the development of culturally appropriate, empirically sound mental health interventions. Although notable exceptions exist (and are discussed later), the modal study in this field is focused on assessing the prevalence of psychiatric symptomatology, primarily symptoms of posttraumatic stress disorder (PTSD), and to a lesser extent, other disorders of Western psychiatry. We suggest that this approach, referred to here as *trauma-focused psychiatric epidemiology* (TFPE), is of limited value to community-based mental health and psychosocial organizations, which are concerned with a number of pressing questions that go well beyond the prevalence of PTSD symptoms in the communities they serve.

These organizations need to know about local idioms of distress—the particular ways in which psychological distress is experienced, expressed, and understood in specific cultural contexts. They need to understand culturally specific patterns of help-seeking behavior and traditional ways of coping with emotional

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The authors wish to thank Lisa Rasco and Clark McCain for their helpful comments on an earlier version of this article.

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distress and impaired functioning and to be able to identify locally available resources within communities that can promote healing and adaptation. They also need to learn about the mental health problems and psychosocial stressors that community members identify as most salient and about the impact that other forms of violence (e.g., the structural violence of poverty, institutionalized racism, gender-based discrimination, and the acute violence of spouse and child abuse) may have on mental health in contexts of political violence and forced migration. They need to understand how healthy and impaired psychosocial functioning are defined locally and how these definitions vary by factors such as age, gender, ethnicity, and marital status. Finally, they need to know what sorts of interventions have been shown to be effective in similar settings, so that they can adapt elements of those interventions rather than continually reinvent the wheel or rely on programs that may have intuitive appeal but lack empirical support.

It is curious that such a broad range of critical issues has received comparatively little attention in the research literature despite more than 25 years of scholarship on the mental health of communities affected by organized violence. To understand this phenomenon, it is helpful to consider the pervasive influence of TFPE on the conduct of research in this area. TFPE, with its roots in the biomedical model of psychiatry and the increasingly popular field of traumatology, has shaped the agenda for research with survivors of political violence in profound, although seldom acknowledged, ways. It has defined the appropriate focus of empirical study (i.e., the prevalence and correlates of PTSD and related psychiatric syndromes) and has legitimized a particular set of methodologies for carrying out research (i.e., quantitative methods using symptom checklists or structured clinical interviews). Consistent with its biomedical roots, it has defined the individual as the appropriate unit of analysis; thus, we see few studies examining the impact of political violence on social systems such as families, communities, and communal institutions. Reflecting its strongly positivist underpinnings, the TFPE framework has prioritized the identification of universal patterns of distress, emphasizing findings that can be generalized across diverse settings (e.g., PTSD as a universal human response to traumatic events) while minimizing the exploration of local variations in the ways that people understand, react to, and are affected by their experiences of violence and displacement.

It is not our contention that psychiatric epidemiology and traumatology have no roles to play in research with war-affected populations. As we discuss later, psychiatric epidemiology, where conceptually and methodologically appropriate, can play a critical role in documenting the mental health problems and associated risk and protective factors within a population. Also, the study of trauma certainly has a role in research with communities that have survived the terrifying events that organized violence entails. Our concern is with the way in which these two fields have combined so as to unnecessarily narrow the both the focus and methods of research on mental health and psychosocial well-being in conflict and postconflict settings (and with refugees in settings of resettlement), to the point where several critical areas of inquiry—all highly germane to the work of practitioners—have been largely overlooked.

In emphasizing the lack of attention to a number of clinically salient issues affecting war-affected communities, we are mindful of wanting to avoid painting too broad a stroke by overlooking important exceptions to the trend of TFPE-influenced research. We recognize that a nascent trend has emerged among researchers who have begun to critique the dominance of TFPE (Buitrago Cuellàr, 2004; Jenkins, 2004; Kagee & Naidoo, 2004; Phan, Steel, & Silove, 2004; Summerfield, 1995, 1999; Wessells & Monteiro, 2004). They are questioning the presumed universality and cultural relevance of PTSD as a response to traumatic stress and are drawing attention to culturally specific syndromes of trauma-related distress. They are also asking whether the current focus on the traumatic sequelae of previously experienced war-related violence may cause us to inadvertently overlook ongoing stressors that exert a significant influence on people's mental health (Breslau, 2004; Dawes & Donald, 1994; Miller et al., 2006a; Silove, 1999). Paralleling these critiques—and in response to them—a growing number of researchers are broadening their empirical focus, moving beyond a narrow focus on PTSD to examine a broader range of questions, and making use of an increasingly diverse range of methods in their research. A second aim of this article, therefore, is to highlight some of the important work being done outside of the TFPE framework.

To date, however, efforts at transcending the limitations of the TFPE framework have had a limited impact on the popularity of that framework among researchers working with communities affected by armed conflict. The assessment of PTSD and its correlates remains a primary focus of research efforts in this area; meanwhile, insufficient attention continues to be paid to other issues of critical concern to practitioners. We believe there is, therefore, a need to more effectively bridge the currently disparate worlds of research and practice with communities affected by political violence. In this article, we propose that an alternative scientific framework, social constructivism, can serve as such a bridge by helping to refocus research efforts in ways that are both conceptually and methodologically more attuned to the needs of war-affected communities and the organizations working to address their mental health needs. It is not our position that all research with war-affected populations should be guided by a constructivist perspective; rather, we hope that familiarity with key constructivist ideas may offer researchers a broader conceptual and methodological toolbox from which to draw.

We begin by discussing the basic tenets and paradigmatic roots of TFPE and social constructivism, taking care to note the potentially useful roles that epidemiology and the study of trauma can play when utilized appropriately. We also consider the historical context in which the study of PTSD came to be prioritized in research with survivors of political violence. We then examine specific limitations of the TFPE model as a framework for research with populations affected by armed conflict. Finally, we examine several core areas of inquiry that are particularly relevant to practitioners yet have received comparatively little attention in the literature thus far. Case examples from our own research and clinical experience are used to illustrate these core issues; in addition, we present constructivist approaches to each area of inquiry, using exemplars drawn from the small but growing number of studies that have been informed by a constructivist perspective.

TFPE

TFPE is itself neither a scientific paradigm nor a formally recognized field of study. Rather, it represents an integration of

two fields: (a) psychiatric epidemiology—the study of the prevalence, correlates, and causes of psychiatric disorders within a population; and (b) traumatology—the study of psychological trauma. Each of these fields has its own set of conceptual and methodological priorities, yet both share a common set of paradigmatic roots in the biomedical model of contemporary psychiatry, and more fundamentally, in the scientific framework of logical positivism. To understand the influence of TFPE on research with war-affected populations, it is therefore helpful to consider not only the basic tenets of each field but also the influence on both fields of the biomedical perspective and the basic axioms of logical positivism regarding the nature and purpose of scientific inquiry.

Logical Positivism

Logical positivism is the dominant scientific framework within which research in the behavioral and social sciences has been conducted for over 400 years (Gergen, 2001; Guba & Lincoln, 1994). The primary purpose of positivist science is to discover the nature of reality and to identify those universal laws by which it is governed. Applied to the behavioral and social sciences, positivist research aims to discover the underlying laws that govern and explain human behavior (Guba & Lincoln, 1994). With regard to method, positivism emphasizes deductive, hypothesis-driven research in which the truthfulness of a priori assumptions is tested through experimental designs that control (to the extent possible) for confounding influences. The prescribed stance of the scientist is one of neutrality and objectivity, in order to minimize the impact of investigator bias on the research process. Legitimate research methods are primarily quantitative, although there is a growing recognition that qualitative methods may play a useful role within positivist inquiry (Banyard & Miller, 1998; de Jong & van Ommeren, 2002; Dumka, Gonzales, Wood, & Formoso, 1998).

The Biomedical Model of Contemporary Psychiatry

The positivist influence on contemporary psychiatry and related disciplines is evident in both the aims and methods of psychiatric research, which prioritizes the use of hypothesis-driven designs utilizing quantitative methods in the search for universal patterns of psychiatric disorder and their underlying causal mechanisms. Since its inception as a discipline in the mid-1800s, psychiatry has been guided primarily by a biomedical model that emphasizes the study of psychopathology in terms of dysfunctional or abnormal intrapersonal processes and structures (Cohen, 1993).[1] Although the biomedical model clearly specifies the individual as the critical unit of analysis, factors external to the individual may be relevant to the extent that they affect core intrapersonal processes. The model implies an essentialist conceptualization of psychological distress: Although the social context may exert some influence on the expression of psychiatric disorders, the same underlying mechanisms are assumed to be at work within individuals across contexts, and careful assessment should be able to identify roughly the same core patterns of psychiatric symptomatology largely independent of the social context.

Psychiatric Epidemiology and Traumatology

The field of psychiatric epidemiology is a natural extension of biomedically oriented clinical research. It entails assessing the prevalence of psychiatric disorders within a given population, as well as risk and protective factors for those disorders. Psychiatric epidemiology may be viewed as a form of needs assessment, providing practitioners with data that allow for the development of mental health interventions tailored to the specific needs, vulnerabilities, and resources of a particular population. For epidemiological studies of mental health disorders to be useful, however, they must assess categories of disorder that are empirically valid and culturally meaningful; ideally, they should also assess problems that are of primary concern to community members. It is, unfortunately, precisely on these two points that psychiatric epidemiology with war-affected populations has been problematic. The emphasis has been on assessing the prevalence of Western diagnostic categories without first examining the construct validity of those categories, the degree to which they are culturally meaningful, or the extent to which they are viewed as mental health priorities by community members. It is critical to bear in mind that the great majority of war-affected populations live in (or have been displaced from) non-Western societies with highly diverse cosmologies. Here we see the essentialism of the biomedical model and its positivist underpinnings—the a priori assumption of the universal validity and cross-cultural salience of Western psychiatric diagnoses.

Moreover, we see the powerful influence of the rapidly growing field of traumatology, with its emphasis on the study of PTSD. To understand the genesis of the assumption that PTSD should be the primary focus of research with war-affected populations, it is helpful to bear in mind the *zeitgeist* within Western psychiatry during the early 1980s, when clinicians and researchers in the industrialized nations were confronted by a massive influx of refugees from Southeast Asia and Latin America (Haines, 1997; Holtzman & Bornemann, 1990). The American Psychiatric Association had recently incorporated the newly developed diagnosis of PTSD into the third edition of its *Diagnostic and Statistical Manual of Mental Disorders* (*DSM–III*; American Psychiatric Association, 1980), and there was considerable enthusiasm for exploring the utility of the diagnosis among victims of a diverse range of potentially traumatic events (e.g., child abuse, rape, violent crime, natural disasters). Although the PTSD construct was originally developed on the basis of research and clinical experience with American veterans of the Vietnam War, the diagnostic criteria stated clearly that the same constellation of symptoms could be expected to appear among survivors of *any* event that was sufficiently terrifying.

For researchers interested in the mental health of recently arrived refugees, whose histories were replete with exposure to frightening experiences of violence, the PTSD construct was un-

[1] Clinical psychology has expanded the biomedical focus to include psychological as well as biological factors as underlying causes of mental disorder; however, it has generally retained the focus on factors internal to the individual (e.g., internal conflicts, maladaptive working models of attachment, and distorted cognitions). Therefore, we refer collectively to psychiatry and clinical psychology when discussing psychiatric research and the biomedical model.

derstandably compelling. Grounded firmly in the acultural essentialism of the biomedical model, PTSD was presumed to represent a universal response to traumatic events. Thus, there was no need to examine local idioms of trauma-related distress among culturally diverse refugees, as the human response to traumatic stress was assumed to be universal. It is noteworthy, however, that this focus on PTSD among refugees quickly became predominant specifically within the mental health disciplines (psychiatry, clinical psychology, and clinical social work) where the influence of the biomedical model was most evident; in contrast, among researchers studying refugee well-being from the vantage of other disciplines (e.g., medical anthropology, sociology), more contextually grounded views of mental health and the effects of war-related violence were evident (e.g., Farias, 1994; Hitchcox, 1990; Manz, 1988).

Any critique of the cross-cultural validity and utility of the PTSD construct must take into account the reality that symptoms of PTSD, as well as the full syndrome, have in fact been documented—although with marked variability—in numerous studies of war-affected populations (e.g., de Jong et al., 2001; Kinzie et al., 1986; Weine et al., 1998). There can be little doubt at this point that elements of the PTSD diagnosis—particularly symptoms entailing the intrusive re-experiencing of traumatic events (e.g., nightmares, flashbacks, intrusive images) and symptoms of hyperarousal (e.g., heightened startle response, sleep disturbances)—are found in diverse cultural contexts (Marsella, Friedman, & Spain, 1996). Moreover, there is growing evidence, based primarily on research with American war veterans, of numerous psychophysiological changes associated with the experience of psychological trauma (e.g., reduced cortisol levels, increased opiod response to trauma-associated stimuli; van der Kolk, 1996). Although these data do not permit generalization across cultural contexts, there is no reason to assume that trauma-related psychophysiological alterations would not also be found among non-Western trauma survivors.

However, findings suggesting the cross-cultural occurrence of PTSD symptoms must be interpreted cautiously for several reasons. First, leading trauma researchers—including those with a strong grounding in the psychophysiology of trauma responses—have cautioned that the 17 items that constitute the PTSD diagnosis fail to capture to the complexity and variability that characterize the ways in which people are affected by traumatic experiences (Briere, 1998; Marsella et al., 1996; van der Kolk & McFarlane, 1996). Although evidence suggests that reactions to traumatic stress include certain psychophysiological correlates that may transcend cultural context, there is a growing recognition that cultures exert a powerful influence on the ways in which underlying psychopathology is expressed and experienced (van der Kolk & McFarlane, 1996). As Briere (1998) has noted, expressions of trauma-related psychopathology that differ significantly from PTSD have been documented in numerous cultural contexts. Jenkins (1996) and Farias (1994), for example, have described the salience of *calor* and *nervios* among Salvadoran refugees, indigenous idioms of distress clearly linked to the experience of traumatic events that entail a combination of somatic and emotional symptoms that overlap only moderately with PTSD.

Findings of PTSD among survivors of political violence must also be tempered by a consideration of what Kleinman (1987) has termed the *category fallacy*, which involves the erroneous assumption that a diagnostic category developed in one cultural context is meaningful in a different cultural context simply because the symptoms that comprise it can be identified in both settings. Cultural variations in the experience and expression of trauma are very unlikely to be identified if one assesses only those symptoms that are assumed a priori to comprise the trauma response. Although symptoms of PTSD, and indeed the full syndrome, may be found in a given culture, we cannot assume that the diagnosis has the same meaning or salience as it does in the West; nor can we can we presume to know how traumatic stress is understood and experienced in that culture simply because people endorse items on a measure of PTSD.

For example, one can readily identify symptoms of PTSD among indigenous Guatemalans (Aron et al., 1989; Light, 1992); however, rural Guatemalans are more likely to understand war-related distress in terms of *susto* and the aforementioned *nervios*, indigenous idioms of distress that share some symptomatic overlap with PTSD, yet are also distinct from it (Guarnaccia & Farias, 1988; Miller, 1994; Zur, 1996). Similarly, in Afghanistan, people will generally report symptoms of PTSD when asked specifically about them (Lopes Cardozo et al., 2004; Malekzai et al., 1996); however, the construct has little meaning within Afghan culture, and Afghans—who have survived more than 23 years of war and repression—are much more likely to describe their war-related distress in terms of *jigar khun* (dysphoria associated with experiences of loss and other hardships), *asabi* (a combination of nervousness and anger), and *fisha-e-bala* (feeling highly pressured or stressed) than PTSD (Miller et al., 2006).

Finally, regardless of how psychological trauma is conceptualized, there is reason to question its assumed primacy as a mental health concern within war-affected communities. In the small number of studies that have allowed survivors of political violence to voice their own mental health priorities, numerous other concerns have been identified as being more urgent than symptoms of trauma. Such concerns include impaired psychosocial functioning, family conflict, sadness and isolation resulting from the loss of social networks, spouse abuse, distress related to the experience of poverty and the inability to provide for one's family, psychosis, substance abuse, sadness due to separation from loved ones, grief associated with the death or disappearance of family members, and distress regarding the lack of opportunity to engage in culturally important rituals of bereavement (Bracken et al., 1995; de Jong, 2002; Englund, 1998; Miller et al., 2002; Summerfield, 1999). It is interesting, however, that when researchers are queried regarding the mental health priorities of war-affected communities, they often assume, incorrectly, that trauma related to political violence is the most urgent problem (see de Jong, 2002, for an excellent discussion of this phenomenon); consequently, the study of PTSD is prioritized while other problems of equal or greater concern to community members are inadvertently overlooked.

An Alternative Framework: Social Constructivism

Social constructivism is one of several "critical theories" (Gergen, 1985; Guba & Lincoln, 1994) that have gained popularity during the past few decades. In contrast to logical positivism, with

its emphasis on knowing the way things "really are," constructivism emphasizes the socially constructed nature of reality; it shifts attention away from the search for universal truths and toward an exploration of what is considered real within particular social contexts. This does not negate the value of examining the way similar phenomena may occur across diverse settings, but it does represent a genuine shift toward understanding how people in particular cultural contexts understand their world. With specific regard to mental health, a constructivist perspective eschews the search for universally valid definitions of mental health and disorder, focusing instead on exploring the variety of ways psychological well-being and distress are understood and expressed across and within diverse cultural settings.

There are two key elements to this definition of constructivism that distinguish it quite clearly from the positivist approach. First, it suggests a conceptual and methodological shift from an etic (outsider) to an emic (insider) approach; that is, exploring the ways in which reality is constructed or understood in specific contexts is prioritized over examining the universal validity of psychological phenomena originally identified in a particular cultural context. This implies a shift toward a greater use of exploratory research methods that allow for the identification of culturally specific values, beliefs, and behavioral systems. Hence, we see a much greater utilization of inductive, qualitative methods in constructivist research, such as focus groups, narrative analysis, and ethnography.

However, there is a common misperception that constructivist inquiry relies exclusively on qualitative methods, and that constructivism is essentially synonymous with the ethnographic approach commonly used by anthropologists. In fact, quantitative methods can play a critical role in constructivist research, and a constructivist perspective can inform research that is primarily quantitative and hypothesis-driven. For example, Miller et al. (2006b) used narrative data gathered from interviews with 20 residents of Kabul to construct the Afghan Symptom Checklist, a 22-item measure that was subsequently administered to 320 adults throughout the city. The interview data revealed several categories of psychological disorder, including those caused by biological factors (e.g., schizophrenia), those related to spirit possession (*jinns*), and those resulting from painful life experiences. The narrative data also revealed several indigenous indicators of distress (e.g., *jigar khun, asabi,* and *fishar*), as well as symptoms common to Western psychiatry (e.g., insomnia, crying, lack of appetite). The survey subsequently confirmed the researchers' hypothesis that women were at higher risk than men of psychological distress and impairment and highlighted the particular vulnerability of widows who had lost their husbands during the war.

Similar mixed-methods designs using free-listing techniques, ethnography, and questionnaire-based surveys have been used to examine psychological distress among refugees from Sierra Leone in the refugee camps of Guinea (Hubbard & Pearson, 2004), Vietnamese refugees in Great Britain (Phan, Steel, & Silove, 2004), and psychosocial functioning among survivors of civil war and genocide in Rwanda and Uganda (Bolton & Tang, 2002). Interested readers are referred to de Jong and van Ommeren (2002), who have provided a useful framework for integrating qualitative and quantitative methods in the development of culturally grounded psychiatric epidemiology studies with war-affected populations.

The point, then, is not that one set of methodologies should be prioritized over another; on the contrary, a diversity of methods allows us to examine a greater range of research questions. Our concern here is with the limitations of relying primarily on etic approaches that inappropriately assume a universally shared set of meanings regarding important psychosocial phenomena. The potential hazards of an exclusively etic approach can be seen in a questionnaire-based study of delinquency and social integration among Palestinian youth in Gaza and the West Bank (Barber, 2001). The study was unique in its emphasis on development and adaptation among adolescents in a conflict zone. However, rather than starting by exploring the ways in which delinquent behavior is understood and expressed locally, Barber used a four-item delinquency measure containing items such as cigarette smoking that have been associated with delinquency among youth in the United States. The use of North American criteria for delinquency ignores some rather critical questions: What does smoking mean to Palestinian youth living under the Israeli occupation? Does it reflect delinquency, or is it a normative behavior? How is delinquency itself defined in a context where "normal" behavior (e.g., secretly attending classes when education has been banned) is criminalized and criminal behavior is legitimized by the corruption of the local authorities and the frequent violation of civil and human rights by the occupying power? Inductive methods are essential precisely because they allow community members to inform us about the meaning and indicators of core constructs (e.g., delinquency) in particular social contexts. By failing to attend to such local variations in the understanding and expression of psychosocial phenomena, we risk imposing our own cultural definitions on these phenomena, thereby potentially undermining the validity of our findings.

The second key point in the definition of constructivism offered above is the explicit emphasis on human agency in the creation of meaning and on the centrality of the meaning-making process in mediating our responses to life experiences. This emphasis on the social construction of meaning, and on the active way in which we make sense of life events, has gained recognition among researchers in a number of areas, including research on stress and coping (Lazarus & Folkman, 1984). Interest in appraisals reflects the recognition that human beings do not respond automatically or reflexively to challenging life experiences, including experiences of organized violence (Dawes, 1990).

This point has significant implications for our how we view the stressors associated with organized violence and their impact on the human psyche. Implicit in much of the PTSD literature, including the literature on political violence, is a fairly mechanistic conceptualization of how people are affected by their exposure to organized violence. Researchers measure exposure to stressful events and assess their association with levels of PTSD symptomatology, implying (within the constraints imposed by correlational designs) a direct causal relationship. It is important to note, however, that the strength of this association has varied markedly across studies, suggesting that (a) many people exposed to organized violence do not develop elevated or enduring levels of PTSD symptoms, and (b) a variety of factors likely moderate and mediate

the relationship between exposure to violence and the development of trauma symptoms.

Although several recent studies with war-affected communities have examined the stress-moderating role of environmental factors such as instrumental and affective social support (e.g., Gorst-Unsworth & Goldenberg, 1998), to date little attention has been paid to the role of individual appraisals and socially shared belief systems in protecting people from (or leaving them more vulnerable to) the adverse effects of political violence.[2] A constructivist perspective redirects our attention to this meaning-making process and its potentially powerful role in shaping responses, including the development of PTSD, to experiences of violence and forced migration. Also, because constructivism emphasizes the inherently interpersonal origins of individual appraisals, our attention is drawn to the study of shared belief systems within communities and their expression in the individual appraisal process.

Finally, constructivism emphasizes the fundamentally interpersonal nature of the research relationship and suggests that data invariably reflect the quality of that relationship. Efforts to gather valid data are framed within an understanding that research participants are not rats in a Skinner box, reflexively completing symptom checklists without critical reflection on the purpose of the research or the perceived intentions of the researchers. We gather data within a relational context, which itself is embedded within the larger social context of the community where the research takes place. A constructivist perspective considers the influence of these multiple contexts on the data gathering process. Anthropologist Patricia Omidian, in her work with Afghan refugees in Northern California, noted that women in the community initially presented as happy and well-adjusted to their new environment; however, when she was able to gain their trust over a period of time, they often revealed a deep, hidden grief at all they had left behind and the enormous challenges of creating meaningful lives in exile (Omidian, 1996). Clearly, the social context may exert a significant effect on which aspects of their realities people choose to share with us and which aspects they keep hidden (Miller, 2004).

Having presented the basic tenets of trauma-focused psychiatric epidemiology and its underlying biomedical and positivist roots, as well as several key elements of an alternative scientific framework—social constructivism—we turn now to an examination of several domains of inquiry that have been comparatively neglected in research with war-affected populations. The set of issues presented here is meant to be illustrative rather than exhaustive; we have sought to prioritize topics of particular relevance to practitioners working in the field. To illustrate each issue, we provide vignettes drawn from our research and clinical work with war-affected communities in Afghanistan, Mexico, and Guatemala, and with Bosnian and Afghan refugees in the United States. We also draw on the exemplary work of the growing number of individuals whose research has been informed by a constructivist perspective.

Some Critical Areas of Inquiry With War-Affected Populations

1. Examining Local Idioms of Distress

The experience of emotional distress occurs within specific cultural contexts that shape the ways in which suffering is experienced, expressed, and understood (Rogler, 1989). As suggested earlier, however, the essentialism of the biomedical model has led researchers to presume that core elements of psychopathology are expressed in similar ways across cultures, thereby legitimizing the emphasis on Western psychiatric constructs such as PTSD, regardless of the cultural context. Unfortunately, this approach is of limited value to practitioners who work in communities where the PTSD construct and other disorders of Western psychiatry are either unfamiliar or simply less salient than local idioms of distress. To communicate effectively and intervene appropriately, practitioners must be familiar with locally meaningful mental health constructs and culturally salient explanatory models of suffering. Distress may be understood in spiritual or religious terms and may be expressed in psychosomatic syndromes unfamiliar to Western clinicians. Moreover, symptoms of PTSD may be present, but they may less salient than other manifestations of distress.

Case 1: Jigar Khun in Afghanistan

Samed Khan was a member of our research team during a recent study of mental health in Kabul (Miller et al., 2006b). An elected leader of his community, Samed is a large, powerful man of 45 years, with a long beard, a turban, and a warm, infectious laugh, and he is the patriarch of a large family on the outskirts of Kabul. During one of our research team meetings, he told the following story. One day during the war against the Soviet Union, he was driving a small truck carrying his sister and her family along a steep, windy mountain road. At a military roadblock, *mujahedin* commanders forced the truck to stop and asked Samed to get out of the truck and show his papers. In his haste to comply, he forgot to set the hand brake and watched in horror as the truck rolled over the side of a cliff and crashed hundreds of feet below. Everyone in the truck was killed, their bodies mangled in the wreckage of the truck. Samed Khan collected the remains of his sister's family and brought them back to Kabul for burial. He described becoming *jigar khun* (literally "bloody liver," or melancholic) for about 6 months, during which he was socially withdrawn, felt deeply sad, and struggled with feelings of hopelessness. Eventually, however, he made a decision to reengage with life, feeling that God had given him the resources to cope—inner strength, a supportive family, and patience (*saber*) in the knowledge that he could not know God's will. When asked about symptoms of PTSD, he said that he initially experienced some intrusive imagery related to the accident but added that "the images fade, they don't last long. We Afghans, we stop remembering the images after a while; it's the *jigar khun* that stays with you, sometimes forever." The other members of the research team, all of whom had lived through the war, lost family members to the violence, and endured the destruction of their neighborhoods, nodded in agreement.

[2] Important exceptions include the work of Victor Frankl (1963), a survivor of the Auschwitz concentration camp, who noted the protective function of religious faith among Jewish camp inmates; the work of South African psychologists who have documented the stress-buffering capacity of shared ideological conviction among Black youth detained and tortured by the authorities (Dawes, 1990); and the work of Punamäki (1989), who noted lower levels of distress among Palestinian women who reported deeply held political beliefs.

An assessment of PTSD following Samed Khan's accident would likely have revealed various symptoms of psychological trauma. However, it was the experience of *jigar khun* that he focused on, describing his PTSD symptoms as comparatively transient and of secondary concern. The agreement of the other Afghans who were present while Samed Khan related his experience, all of whom had suffered traumatic stress during the war, suggests the greater cultural salience of *jigar khun* relative to PTSD as an expression of war-related distress in Afghanistan. These initial observations were subsequently borne out in the previously cited research by Miller et al. (2006a, 2006b), in which PTSD symptoms were less salient than other forms of distress in detailed narratives of war-related suffering and in two questionnaire-based surveys of mental health among adults in Kabul.

These findings have important implications for practitioners: Afghans are more likely to engage in mental health interventions when they address culturally salient idioms of distress such as *jigar khun* than when they target symptoms that are of secondary concern. This does not mean that symptoms of trauma should not be addressed among Afghans but that a primary focus on healing PTSD is likely to be perceived as out of sync with people's actual priorities.

As noted earlier, exploring the nature and salience of local idioms of distress initially entails the use of qualitative methods such as free-listing techniques, participant observation, semistructured interviews, and focus groups that generate descriptions and explanations of common forms of distress and impairment. Once these indicators of distress are identified, culturally grounded assessment tools can be created for use in population surveys and mental health screening; in addition, a variety of methods may be used to identify clusters of related symptoms (e.g., pile sorts, factor analysis), permitting comparison of indigenous syndromes with western diagnostic constructs.

2. Identifying Local Mental Health Concerns and Priorities

We have already discussed the seeming mismatch between the current emphasis on PTSD in the literature and the actual mental health concerns of war-affected communities. As suggested earlier, this lack of fit does not negate the potential value of studying trauma, but it does underscore the importance of broadening our scope to ensure that we are examining those problems that community members themselves perceive as most pressing. Mental health services are far more likely to be perceived as relevant when they target priorities that communities themselves have articulated.

With its explicit emphasis on prior exposure to traumatic events, the assessment of PTSD directs our attention to past experiences and their traumatic sequelae. We are not questioning the importance of focusing on the impact of war-related violence; clearly, such a focus is justified by the distressing nature of such violence and its etiological link to emotional suffering and psychosocial disability. There is, however, a growing recognition that a considerable amount of the variance in reported distress within war-affected communities is related not to violence experienced in the past but to ongoing stressors in people's day-to-day lives (Gorst-Unsworth & Goldenberg, 1998; Miller et al., 2006a; Silove, 1999). In our experience, survivors of political violence, particularly when displaced from their homes and communities, are often more concerned about such daily stressors as social isolation, a lack of basic resources, difficulties negotiating their new environment, and separation from loved ones.

For example, during interviews we conducted with Guatemalan women in refugee camps in southern Mexico, the women readily acknowledged having recurrent nightmares of the violence they had experienced in Guatemala; however, they were generally more distressed by the poverty that prevented them from providing for their children's basic nutritional and medical needs and, for those who had left family members behind in Guatemala, a painful sense of social isolation and loss of social support (Miller & Billings, 1994). Guatemalan refugees were not allowed to own land in Mexico, leaving them impoverished and dependent on outside food and medical assistance—both of which were scarce in the camps. One woman, the mother of six children, described her poverty-related distress in this way:

> I want to work and plant crops and we can't. How are we going to eat? I feel sad because of our poverty. Sometimes I'd rather die because I can't work. I can't buy medicine. I can't earn money to buy medicine (Miller & Rasco, 2004, p. 20).

Another woman, who had been separated from her family when she went into exile, struggled with intense feelings of loneliness and their impact on her daily functioning:

> I have difficulty doing my work in the home because of desperation. I have no one to talk with. I am lonely. I cry when I am alone in my house. I don't have parents or siblings who help me and visit me. (Miller & Rasco, 2004, p. 20).

Similar concerns about poverty, isolation, and other displacement-related stressors were mentioned frequently during interviews we conducted with Bosnian refugees living in Chicago (Miller et al., 2002; Miller & Rasco, 2004) and with Afghan refugees living in northern California (Zahir, Kakar, & Miller, 2001). Such concerns underscore the importance of mental health interventions that transcend a narrow focus on PTSD by focusing not only on the resolution of psychological trauma but also on fostering new social support networks, enhancing access to critical resources, and promoting the development of locally relevant skills and knowledge (Hubbard & Pearson, 2004; Tribe et al., 2004).

Another largely unexamined mental health concern among women in war-affected communities is spouse abuse. Despite anecdotal evidence suggesting the epidemic nature of domestic violence in many low-income countries affected by political violence (Desjarlais, Eisenberg, Good, & Kleinman, 1995), few empirical studies have assessed the contribution of spouse abuse to the high levels of distress so often documented among war-affected communities. In focusing so heavily on the traumatic impact of previously experienced war-related violence, we may be overlooking the highly distressing nature of the ongoing violence occurring within people's own homes. In our experience with victims of spouse abuse in diverse war-affected communities, war-related violence in the past may seem of secondary importance relative to their ongoing experience of victimization. Furthermore, for refugee women who do not speak the language of their host society and who are isolated from the support of family members, the experience of abuse may transform their home into a prison from which escape seems all but impossible.

Case 2: Spouse Abuse of a Bosnian Refugee Woman and Her Daughter in the United States

Mrs. K, a 45-year-old Bosnian Muslim, was a client at a refugee mental health clinic in the United States where the first author worked as a clinician. Mrs. K, who spoke no English and had no other family in the United States, was being seen for depression and PTSD by a Bosnian paraprofessional counselor. She was always accompanied to the clinic by her husband, who would wait anxiously while his wife was being seen. Although there was some suspicion of spouse abuse by her husband, Mrs. K. denied being abused, and the primary focus of treatment was on the traumatic experiences Mrs. K had endured during the war in Bosnia. One week she did not attend her counseling session, and we learned that she had been hospitalized for a brief psychotic reaction at a nearby community hospital. When we interviewed her in the hospital, we found no evidence of psychosis; however, Mrs. K. was highly agitated and anxious, crying heavily, and worried about her 5-year-old daughter, who was at home with her husband. We asked what had happened and she initially grew silent. However, when she was asked whether her husband had beaten her, she became highly animated, describing a 3-year pattern of imprisonment in her apartment, during which she was raped daily in front of her daughter and endured recurrent threats by her husband that she and her daughter would be killed if they ever tried to leave him. She described the physical and sexual violence at home as far worse than the war she had lived through in Bosnia. We arranged for the police to escort Mrs. K and her daughter to a shelter, where over a period of several months Mrs. K's mood and anxiety level improved markedly, and her daughter, who had been completely mute, enuretic, and withdrawn, began talking, stopped wetting the bed, and started playing with other children. As we could not identify a long-term safety solution for Mrs. K locally (her husband was free within 3 days and could easily have found her in the city's small Bosnian community), she decided to return to Bosnia with her daughter to live with family members there.

Given the severe and adverse impact of spouse abuse on women's mental and physical health (Pico-Alfonso, 2005; Sutherland, Bybee, & Sullivan, 2002), there is a pressing need to examine the prevalence of domestic violence within war-affected communities. Beyond the assessment of prevalence, however, it is important identify the ways in which political violence and forced migration, together with specific cultural beliefs and practices, may affect the occurrence of abuse and the types of interventions that are most likely to be effective in particular sociocultural contexts.

A constructivist perspective suggests the importance of inquiring about the relative salience of different mental health concerns within particular communities rather than assuming that we already know the most pressing variables on which to focus our research and intervention efforts. Englund (1998), for example, used ethnographic methods to study the psychological difficulties experienced by Mozambican refugees in Malawi. He found that their greatest concern was the lack of opportunity—because of their experience of displacement—to engage in traditional rituals of burial and bereavement. In contrast to cultures that emphasize the continuity of relations with deceased ancestors (e.g., Cambodian or Khmer culture), traditional Mozambican culture eschews such continuity between the living and the dead; consequently, Mozambicans have developed a variety of rituals meant to ensure the smooth and complete transition of the spirits of the deceased to a different realm. The inability to enact those rituals thus became an ongoing source of acute psychological distress.

Studies of refugee children, like those of adults, have generally shared a similar focus on the prevalence of PTSD and other disorders of Western psychiatry (e.g., Arroyo & Eth, 1986; Kinzie et al., 1986; Mghir & Raskin, 1999). However, it is interesting that, in the few studies in which parents of war-affected children were asked to identify their own concerns regarding their children's mental health, problems other than psychological trauma were mentioned. For example, in a recent study of Afghan families in the capital city of Kabul, de Berry and her colleagues found that parents were most concerned about the impact of political violence and displacement on children's *tarbia*, or moral development as reflected in their social behavior (de Berry et al., 2003). They were also worried about their children's lack of access to education and about their becoming sad or worried as a result of other life stressors such as poverty and experiences of family loss. Similar concerns were voiced by the children, who also noted that family violence was a source of significant sadness and worry for them.

3. Understanding the Effects of Organized Violence on Multiple Levels

Perusing the literature on the psychological effects of organized violence, one could easily get the impression that violence exerts its effects primarily or exclusively on individual well-being. This is untrue, of course, but the focus on individual psychopathology does reflect the biomedical emphasis on the individual as the essential unit of analysis. In reality, political violence takes its toll on every level of society, affecting not only individuals but also families, communities, and social institutions.

Latin American researchers have been at the forefront of efforts to address the lack of knowledge regarding the multilevel impact of organized violence. At the familial level, for example, psychologists in Chile (CODEPU, 1989) and Mexico (Bottinelli et al., 1990) have documented the adverse impact of repressive violence and forced migration on the structure and functioning of nuclear and extended families. Among their findings are heightened family conflict as familial roles change in the wake of parental detention and the premature assumption of adult roles and responsibilities by young people when a parent is killed or abducted.

At the community and societal levels, researchers in Colombia and El Salvador have noted that civil war and political repression generate *psychosocial* trauma, in which the networks of social relations and institutions that form the basis of civil society are shattered. Profound distrust develops within formerly harmonious communities; animosity and wariness develop toward social institutions whose original mission to protect social well-being has been corrupted; and violence is legitimized as an approach to solving social conflicts (Buitrago Cuellár, 2004; Martín Baró, 1989).

Other reports have noted (a) the devastating impact of wartime rape, not only on women and girls, but also on their families and communities (Aron et al., 1991; Landesman, 2002; Petevi, 1996); (b) the presence of former child soldiers who must be reintegrated into the same communities against whom they caused terrible harm (Boothby, 1990); and (c) in nearly every society affected by organized violence, the creation of large numbers of widows,

orphans, and people with disabilities (e.g., land mine victims), whose survival depends on the availability of scarce community resources. Finally, ongoing violence may destroy the very social fabric that binds communities together—the social ties and patterns of interaction that create the basis for a sense of community and that allow community institutions to function effectively.

The effects of organized violence on levels beyond the individual are not matters of concern solely to sociologists and political scientists. On the contrary, they are highly relevant to the work of mental health practitioners. There is a growing recognition that individual mental health is intimately linked to the health of the larger social ecology in which it is embedded (Bronfenbrenner, 1979; Kelly, 1986). To understand the effects of organized violence solely in terms of psychiatric symptomatology such as PTSD ignores the social context in which individual distress occurs and which mediates and moderates the impact of violence on individual well-being. It also presumes the primacy of individual distress (i.e., psychiatric symptomatology) as a concern of community members, when in fact, people may be more concerned about family conflict or the dissolution of communal ties and social networks. Furthermore, a narrow focus on individual psychopathology and intrapersonal explanatory variables is likely to suggest interventions that ameliorate distress by altering internal psychological factors while failing to address aspects of the social environment that could promote healing and adaptation; thus, we see a reliance on psychotherapy and psychiatric medication stemming from the emphasis on PTSD and other psychiatric disorders.

In contrast, an ecological analysis is more likely to emphasize comprehensive interventions that strengthen families and communities while also working directly to support the recovery of distressed individuals. Such an approach is premised on the reciprocally influencing relationships that are presumed to exist between individuals and the multiple settings in which they live. That is, just as healthy individuals are likely to positively influence the functioning of their families and communities, so too can healthy communities and well-functioning families facilitate individual healing and adaptation. From this ecological perspective, therefore, mental health interventions with war-affected communities are ideally multilevel in their focus. An illustrative example can be found in the work of Corporación AVRE in Colombia (Buitrago Cuellár, 2004). On the basis of an ecological analysis of the psychosocial impact of violence in Colombian society, AVRE staff developed a diverse array of interventions ranging from individual and group counseling to social integration programs for displaced families, conflict resolution programs to mend the rifts in divided communities, and psychosocial support programs, including occupational therapy, for women widowed by armed conflict.

With its emphasis on understanding how reality is socially constructed in specific contexts, a constructivist approach encourages us to ask (rather than assume we already know) how communities are affected by their experiences of organized violence and what their priorities are in terms of mental health and psychosocial assistance. In any given context, there may be a greater emphasis on individual trauma, on the difficulties faced by families adjusting to the disappearance or death of loved ones, on the distrust that has arisen within communities where neighbors have betrayed each other, or on the challenge of integrating former child soldiers.

4. Understanding Local Patterns of Help-Seeking Behavior and Identifying Local Resources That Can Promote Healing and Adaptation

The development of sound mental health interventions requires an understanding of culturally sanctioned help-seeking behaviors. It is of limited use to create professionally staffed psychiatric clinics in communities where emotional distress is generally ameliorated by traditional healers or religious leaders and where discussion of individual and family problems with strangers is strongly discouraged. Nonetheless, the cornerstone of the mental health community's response to war-affected populations has been the development of mental health clinics offering psychotherapy and psychopharmacology (Miller, 1999; Summerfield, 1999). This response, although well-intentioned, is fundamentally ethnocentric in its presumption that people in distress, regardless of their cultural background, will seek out (and be helped by) Western mental health services wherever they are made available. It is also consistent with the assumptions of the biomedical model of Western psychiatry; for if psychopathology is expressed universally across diverse cultures and stems from the same underlying causal mechanisms, then logically the same clinical interventions should be appropriate, regardless of the cultural background of the affected population.

The study of help-seeking behaviors entails documenting the sources of assistance to which people turn when they are distressed and the various conditions under which they use different types of helping resources. For refugee communities, this may mean identifying resources that were previously utilized but which have been disrupted or become unavailable in exile. Such resources may include religious leaders, as well as traditional healers such as *Kruu Khmer* in Cambodia or the spiritually oriented herbalists known as *curanderos* who are popular throughout much of Latin America. Spiritual belief systems, including religious rituals and physical spaces such as churches, temples, and mosques, may also play a critical role in helping people cope with distress, and although Western mental health professionals generally steer clear of religion, an understanding of local religious beliefs and practices as resources for healing may be very useful. This is especially true when working in communities where religious leaders have traditionally played a primary role in helping community members cope with stressful life events.

Case 4: Using a Religious Leader to Help With Complicated Bereavement

Mrs. J, a deeply religious 46-year-old Bosnian Serb refugee living in a large Midwestern city in the United States, lost her son, a young man of 20, during the war in Bosnia. She had been grieving deeply for 5 years when she came to the refugee mental health clinic at the urging of other family members. She presented as deeply depressed, with her primary symptoms consisting of an intensely dysphoric mood, insomnia, a lack of appetite, low motivation, and anhedonia. In light of the clear link between her presenting symptoms and the loss of her son, she was diagnosed with complicated bereavement and was started on antidepressant medication and weekly supportive counseling. During her counseling sessions, Mrs. J expressed intense feelings of guilt at the idea of ending her grieving for her lost son and insisted that ending

her bereavement would dishonor him and make her a bad mother. No amount of reassurance that she had grieved sufficiently to honor his memory seemed to lessen her sense of guilt and her experience of being "stuck" in the grieving process. After several months of counseling, as well as trials of several antidepressant medications, her symptoms of unresolved grief had not abated. At this point, the clinic staff thought that Mrs. J. might benefit from meeting with a local Serb Orthodox priest, whose influence might be greater than that of a counselor, even one who shared Mrs. J's religion and ethnic background. Unfortunately, the local Bosnian Serb priest was regarded as a nationalist whose sentiments Mrs. J did not share, and she declined to meet with him. However, she agreed to meet with the head of the local Greek Orthodox Church, who was sympathetic to her experience of war-related loss and her struggle with the bereavement process. One meeting with this priest accomplished what months of psychotherapy and medication had failed to achieve: After hearing the priest's declaration that she had grieved long enough for her son and had honored his memory sufficiently, she finally felt liberated to move on with her life and emerge from her state of prolonged grief. Her depression lifted, and she subsequently terminated her individual therapy.

Valuing traditional help-seeking behaviors among war-affected populations does not mean that mental health interventions must be wholly consistent with those behaviors or that they must actively involve religious leaders or traditional healers in their implementation. As Hubbard and Pearson (2004) have noted, the scope and severity of war-related distress may overwhelm traditional coping resources and exceed the knowledge and skills of traditional healers. Nonetheless, an understanding of culturally specific help-seeking behaviors and coping resources allows for the development of interventions that fit within the value system of local communities, even as they introduce culturally unfamiliar approaches to managing psychological distress. This can be seen in the approach developed by Jon Hubbard and his colleagues in their work with Sierra Leoneans in the refugee camps of Guinea (Hubbard & Pearson, 2004). The identification of traditional help-seeking behaviors and healing rituals informed the development of a trauma-focused intervention that combined Western group therapy techniques and traditional rituals such as cleansing ceremonies. Communal discussion and resolution of social problems was a culturally accepted practice; consequently, although trauma-focused group therapy was unfamiliar in the community, the group discussion format was regarded as sufficiently consistent with cultural norms to be accepted by community members.

5. Identifying Effective Intervention Strategies

There is a striking paucity of evaluation data regarding the effectiveness of mental health interventions with war-affected populations, whether clinical or community-based. Although there is a fairly substantial body of published clinical recommendations regarding the psychotherapeutic and psychopharmacological treatment of refugees, the empirical basis for such recommendations is lacking (i.e., there is scant evidence for the effectiveness of the clinical treatment of psychological distress among refugees). Furthermore, although a few community-based programs have documented their effectiveness through sound evaluations (e.g., Hubbard & Pearson, 2004; Weine et al., 2004), most programs have limited their efforts to process evaluations, which document levels of participation and fidelity of implementation but not effectiveness—the extent to which programs have achieved their intended goals.

There has also been a tendency for programs that utilize mental health paraprofessionals, a common approach in conflict and post-conflict situations, to evaluate the quality of the training experience (e.g., Was the training well-received? Did participants acquire the desired knowledge and skills?) but not the extent to which trainees were able to successfully implement their newly acquired capacities in their home communities. In fact, although such programs are highly promising, they often face numerous obstacles to successful implementation (Hubbard & Miller, 2004; Kostleny & Wessells, 2004).

Case 5: Evaluating Obstacles to Implementing a Mental Health Program in Guatemala

Working in the highlands of Guatemala, a collaborative team of psychologists, teachers, and actors adapted an expressive arts-based mental health intervention for children in war-affected communities developed in Buenos Aires during the "Dirty War" in Argentina. For a period of 2.5 years, members of rural communities throughout Guatemala's devastated highlands—which had borne the brunt of the army's scorched earth campaign between 1978 and 1982—came together in a central location for week-long trainings in the intervention. The trainings created a safe space in which participants could learn experientially, sharing and reflecting on their experiences of oppression, suffering, and resilience while mastering a set of culturally relevant group-based intervention concepts and strategies. The ultimate aim of the intervention was for the participants to develop group interventions with children in their home communities, fostering a process of healing and adaptation by implementing what they had learned in the centralized trainings. However, when we evaluated the extent to which participants had actually put their newly acquired knowledge and skills into practice in their own communities, we were surprised to find that after 2.5 years, none of the trainees had implemented the intervention in their villages. A 3-day workshop was held during which trainees were invited to share the obstacles they had encountered in working with the intervention. Numerous barriers were identified, including a need for on-site supervision, the lack of a written intervention manual, discomfort with some of the intervention activities, threats by local military commanders to punish anyone participating in mental health activities, and threats by local evangelical leaders to report group participants to the army as Communist subversives. This evaluation workshop enabled the program staff to address the numerous barriers that trainees had encountered and led to an adaptation of the intervention for use with Guatemalan refugees in the refugee camps of southern Mexico.

We simply do not have sufficient evaluation data to justify the development of a set of empirically informed "best intervention practices" at this point, yet that is precisely what is needed: a list of intervention strategies with well-documented effectiveness to which practitioners can turn. At first glance, this advocacy of best practices may seem to contradict our emphasis on interventions that are tailored to specific cultural contexts. Indeed, a constructivist perspective reminds us that interventions shown to be effective in one sociocultural context are likely to require some adap-

tation for use in other settings; absolute fidelity to the program's original design is neither necessary nor desirable (Schorr, 1997).

However, it is important to recall that constructivism acknowledges the possibility of similar phenomena occurring across highly diverse contexts; thus, for example, former child soldiers in different countries may face similar stressors as they struggle to reintegrate in their communities (e.g., rejection by community members, shame at whatever atrocities they may have committed, fear of being re-abducted). Practitioners in one setting can benefit greatly from the experiences of colleagues working under similar circumstances elsewhere, bearing in mind the need to adapt intervention strategies in ways that ensure their contextual fit.

Responsibility for the lack of sound evaluation data clearly cannot be laid solely on researchers; practitioners have relied heavily on clinical impression and intuition as the basis for evaluating the effectiveness of their interventions. On the other hand, the empirical focus on TFPE has meant that researchers have not lent sufficient time and energy to helping practitioners develop and evaluate their work. Although we recognize the myriad difficulties inherent in conducting sound evaluations in conflict and postconflict situations, a variety of resources are available to help overcome these obstacles (Hubbard & Miller, 2004). As researchers work together with practitioners to identify which elements of their interventions are effective and which require modification, communities will be better served and a growing body of knowledge about intervening effectively with war-affected populations will develop.

Discussion

Our aim in this article has been to explore the continued dominance of trauma-focused psychiatric epidemiology in research with war-affected populations. It is our contention that researchers influenced by the TFPE framework have tended to focus on an overly narrow set of questions—namely, those regarding the prevalence and correlates of PTSD—while paying insufficient attention to a number of other critical issues that are of paramount concern to practitioners. Consequently, research with communities affected by organized violence has made itself less useful than it has the potential to be.

We have presented social constructivism as an alternate conceptual and methodological framework that can help us become more attuned to precisely those issues of greatest concern to war-affected populations and the organizations working to address their mental health concerns. A constructivist perspective broadens the range of what are considered legitimate methods of scientific inquiry, according greater import to inductive methodologies that allow communities to identify their mental health needs and priorities for us (rather than our deciding for them).

There are a number of objections that might be raised to our position. First, it might be argued that at least some of the responsibility for the gap between research and practice lies with practitioners, who may underutilize the existing research literature in the design and implementation of their interventions. In our view, this line of argument begs the question of *why* the research literature is being underutilized. We suggest that practitioners make limited use of the available research precisely because it is not sufficiently useful or relevant to their work. By focusing so heavily on the assessment of psychiatric symptomatology, we have failed to provide practitioners with the kind of data that could inform development of mental health interventions tailored to the particular sociocultural contexts in they work.

A second objection to our emphasis on social constructivism is that we are inappropriately minimizing the value of positivist research and its potential contribution to understanding the mental health needs of war-affected populations. In fact, our concern is not with logical positivism per se as an approach to studying the effects of organized violence; rather, we are concerned specifically with the undue influence of trauma-focused psychiatric epidemiology, a particular manifestation of positivist inquiry that has borne limited fruit for those working with war-affected communities. There are without question elements of positivist science that hold considerable potential for research in this area. Hierarchical linear modeling, using culturally appropriate indicators of well-being and distress, can be used to test the short- and long-term effectiveness of mental health interventions (Goodkind, Hang, & Yang, 2004) and to study the natural course of recovery (or lack thereof) among war-affected individuals. Quasi-experimental designs and between-groups comparisons that make use of naturally occurring groups (e.g., those who choose to participate in an intervention and those who choose not to or who drop out midcourse) are similarly useful also for assessing the effectiveness of mental health interventions and their constituent components (Hubbard & Miller, 2004). Also, structural equation modeling, if applied to latent constructs that are contextually meaningful, can be helpful in the identification of variables that either moderate or mediate the impact of war-related violence and daily stressors on mental health, in effect laying out conceptual roadmaps for empirically based interventions (Rasco & Miller, 2004).

In addition, we recognize that the positivist emphasis on identifying universal laws that govern human behavior may lead to meaningful research with war-affected populations. It seems reasonable to suppose that there are common patterns that may be identified in the ways that people respond to experiences of violence and forced migration. We have already discussed certain elements of posttrauma reactions that are evident across diverse cultural contexts. With specific regard to forced migration, Eisenbruch's (1990) identification of the *cultural bereavement syndrome* among refugees lends itself to empirical study to see whether, in fact, cultural bereavement is meaningful construct among diverse refugee populations and in what ways it differs across different resettlement contexts (e.g., refugee camps, informal settlements, and countries of permanent resettlement).

Finally, it could be argued (and we agree) that there are additional factors not considered in this article that have likely contributed to the ongoing popularity of the TFPE framework. For example, growing interest in psychological trauma, particularly since the terrorist attacks of September 11, 2001, has elevated scholarly and popular interest in PTSD to unprecedented levels. Although the available evidence, including several studies cited above, suggests that factors other than war-related violence account for much of the psychological distress among people exposed to armed conflict, suffering related to poverty, displacement, poor health, spouse abuse, and social isolation simply does not draw the same level of international interest and concern as war-related trauma. Moreover, for researchers, there is considerable kudos accorded to scholarship on PTSD; several professional journals are dedicated specifically to the study of psychological

trauma, and funding for trauma-related research and interventions is substantial. Our analysis of factors contributing to the continuing dominance of TFPE is by necessity partial; rather than provide a comprehensive analysis that is beyond the scope of this article, our aim has simply been to contribute to an ongoing discussion of the limits of the TFPE framework and to further legitimize the consideration of alternative approaches to the study of war-affected populations and their mental health needs.

Our emphasis on the utility of a constructivist framework is not meant to further polarize the already contentious debate between advocates of positivism and those of critical theories such as social constructivism. Although such debate may have a useful role to play in academic discourses, our concern here is simply with increasing the familiarity of researchers with the range of conceptual frameworks available to guide their empirical efforts. Moreover, we hope to foster a greater degree of intentionality among researchers in this area with regard to their selection of research topics and methodologies. To the extent that researchers focus their efforts based on a critical consideration of cultural context and take into account those domains of inquiry of greatest concern to practitioners and the communities they serve, a much needed bridge between research and practice with war-affected populations will be constructed.

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Received August 22, 2005
Revision received May 2, 2006
Accepted August 1, 2006 ■