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# Cost of Trauma in Sub-Saharan Africa: Review of Origins, Estimation Methods, and Interventions

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# Executive Summary

The purpose of this report is to review the empirical peer-reviewed literature on the cost and consequences of trauma in sub-Saharan Africa. Trauma is a widely acknowledged problem facing individuals and communities in developing countries. Sub-Saharan Africa—a region that is home to some of the world's worst human rights violations, ethnic and civil conflicts, disease epidemics, and conditions of poverty—trauma is an all-too-common experience in citizens' daily lives. In order to address these conditions effectively, the impact of trauma must be understood. This includes investigating how trauma is measured and determining whether evaluation methods are appropriate for quantifying and monitoring the cost of trauma.

In this report, trauma is limited to manmade events, specifically those which occur on a large scale and as a result of some major disruption to a community, society, or region. However, it is essential to understand the context for trauma because the lack of infrastructure, including lack of healthcare, violence against the vulnerable, and high rates of disease all compound the consequences of trauma. For example, disease is discussed because of the sociopolitical factors that contribute to its spread and the resulting impact it has on communities and regions.

The economic evaluation of physical health consequences, while informative and relevant, represents a limited dimension of the cost of trauma. Little effort has been made to describe and evaluate the psychological and social costs of trauma. This report reviews current literature describing the emotional and interpersonal effects of trauma, as well as interventions that have been employed to mitigate those effects.

This report begins with an explanation of the bidirectional contributors that precede and perpetuate trauma in sub-Saharan Africa, followed by a description of the impact of trauma on services, infrastructure, and productivity, and the economic and financial cost analyses of trauma in sub-Saharan Africa. Interventions that have been employed to mitigate the psychosocial effects of trauma and recommendations are then reviewed. Implications are raised based on the literature reviewed, as are recommendations for addressing the cost of trauma. Finally, numerous resources, including an annotated bibliography, follow as appendixes.

## Introduction

The European colonization of the African continent, which began in the last half of the nineteenth-century, had devastating repercussions. In a scramble for African resources, European powers vied over land and imposed arbitrary boundaries that divided ethnic groups and clans, naming members of the same tribe as residents of different nations (Lawson & McCormic, 2006; Heath, 2010; Oliver & Fage, 1988). In addition to forcibly imposing colonial states, European powers maintained control by exploiting linguistic, ethnic and cultural differences to create unstable political and economic environments for native people (Lawson & McCormic, 2006; Oliver & Fage, 1988). The volatile context created by colonial rule resulted in continuing instability for individuals, communities, and systems that comprise sub-Saharan Africa today (Turner, Duignan, & Gann, 1971).

The effort to determine the human and economic cost of trauma in sub-Saharan Africa is complicated by the continuing legacy of this colonization. Lack of infrastructure, tribal conflict, disease, and general lack of economic progress not only not only form the stage for trauma, but exacerbate its consequences. In this report we characterize the sources of trauma, describe its consequences and also portray the extent to which these consequences are compounded by the unique context of sub-Saharan Africa. This is followed by describing the limits of what is currently known and recommendations for further study on this important and complicated topic.

## Purpose

In this review of the literature we investigate the cost and consequences of trauma in sub-Saharan Africa. We begin with an overview of bidirectional contributors to trauma. Then we describe the psychosocial and physical health outcomes of trauma, followed by the impact on services, infrastructure, and productivity, and the economic and financial cost analyses of trauma. Finally, we focus on interventions to address these areas in order that we may provide a substantive perspective on how trauma affects individuals, communities, and organizations. It is important to note, however, that estimating the cost of trauma is a complex endeavor. Thus, the purpose of this review is to inform the effort to determine a method for measuring the impact of trauma in sub-Saharan Africa and the efficacy of trauma interventions in the region.

## Method

For this study, we used the United Nation's definition of sub-Saharan Africa as "all of Africa except northern Africa, with the Sudan included in sub-Saharan Africa" (United Nations, 2012). Specifically, the countries included for this study were: Angola, Benin, Botswana, Burkina Faso, Burundi, Cameroon, Cape Verde, Central African Republic, Chad, Comoros, Congo, Cote d'Ivoire, Democratic Republic of the Congo, Djibouti, Equatorial Guinea, Eritrea, Ethiopia, Gabon, Gambia, Ghana, Guinea, Guinea-Bissau, Kenya, Lesotho, Liberia, Madagascar, Malawi, Mali, Mauritania, Mauritius, Mayotte, Mozambique, Namibia, Niger, Nigeria, Réunion, Rwanda, Saint Helena, Sao Tome & Principe, Senegal, Seychelles, Sierra Leone, Somalia, South Africa, South Sudan, Sudan, Swaziland, Togo, Uganda, United Republic of Tanzania, Zambia, and Zimbabwe.

Since PsycINFO, EconLit and MedLine most fully encompass the topic of economic costs associated with trauma, the searches

were limited to these three databases. Search results were further limited to peer-reviewed, empirical studies.

Trauma or costs associated with HIV/AIDS in sub-Saharan Africa were considered outside the scope of this review, as these issues are complex, the literature is extensive, and warrants a separate study. Similarly, literature dealing with trauma-related issues in South Africa is incorporated only to the extent that it represents that country within the broader context of sub-Saharan Africa. Once again it was felt that an in-depth study of trauma-related issues in this area would be beyond the scope of the present study, and would not do justice to the complexity of those topics. Rather this review seeks to provide an in-depth review and analyses of literature on the cost of trauma in sub-Saharan Africa.

## Context of Trauma

### Poverty

Poverty in sub-Saharan Africa includes economic, social, political, and cultural facets. The World Bank (2012) defines poverty as living under the international poverty line of $1.25 per day. Sub-Saharan Africa has the highest percentage of people living in poverty, as much as 47.5 percent of the region's population in 2008 (World Bank, 2012). The first of the United Nations' (UN) Millennium Development Goals is to halve the proportion of people living in poverty worldwide by 2015 because combating poverty is essential for the overall growth and development of nations, (United Nations Summit, 2010). Chronic poverty, as defined by the Chronic Poverty Research Center, describes those who benefit least from economic growth and development (Grant, Hulme, Moore, & Shepherd, 2005). These individuals and their children will comprise the majority of the 800 million people who are projected to still be in poverty by 2015, suggesting that those who are in poverty remain in poverty (Grant et al., 2005). Sub-Saharan Africa not only has the highest percentage of people living under the poverty line, but it is also home to approximately 25% of the world's "chronically poor," or those who will never, or very rarely, be found above the international poverty line(Grant et al., 2005).

Political and social factors have been found to compound and exacerbate poverty. Political corruption is endemic in sub-Saharan Africa due to weak separation of the public and private spheres and the private appropriation of public resources (Handley, Higgins, Sharma, Bird, & Cammack, 2009; Ikejiaku, 2009). Government decisions are often made by informal networks of influential people, and policies that are contrary to elite interests are often stalled or thwarted completely (Handley et al., 2009). Angola, an oil-rich country on the western coast of sub-Saharan Africa, provides one example. The country's gross domestic product has increased by more than 400 percent in the last six years, yet millions of Angolans continue to lack access to basic social services (Human Rights Watch, 2010). Similarly, the Democratic Republic of Congo is a mineral-rich country with the potential to be one of the wealthiest in the world. Despite these resources, the DRC is ranked last on the United Nations Development Programme's (2012) Human Development Index, which is a composite measure of health, education, and income. Unfortunately these examples of systemic maintenance of poverty are more often the rule than the exception.

Trauma is compounded by poverty in sub-Saharan Africa. Those in the lowest socioeconomic classes are the most vulnerable when exposed to trauma due to limited or no access to health care, impoverished nutrition, little or no education, and limited job opportunities (Onyut et al., 2009). In a recent study, Somali and Rwandese refugees in Uganda, whose possessions totaled less than ten dollars in worth, were at extreme risk for post-traumatic stress disorder and depression (Onyut et al., 2009). Another study on impoverished youth in Kenya found that 6 months after being exposed to the 2007 post-election violence, 21 percent were diagnosable for post-traumatic stress disorder (Harder, Mutiso, Khasakhala, Burke, & Ndetei, 2012). These types of mental health problems appear to occur in a cyclical pattern: lack of basic human services leads to lessened resiliency to trauma which leads to deeper levels of poverty and weaker resiliency to trauma.

## War and Conflict

In addition to widespread, chronic poverty, sub-Saharan Africa has also been the site of extensive armed conflict in the past few decades. Some argue that conflict in the region has been "the single most important determinant of poverty and human misery in sub-Saharan Africa" (Luckham, Ahmed, Muggah, & White, 2001, p. 1). Armed conflict is not an isolated occurrence; it has impacted over half of the countries on the continent of Africa in the past two decades alone (Luckham et al., 2001). Conflict occurs within, as well as between, countries. Civil wars have become one of the most common forms of conflict in the region (Justino, 2012). Due to the damage inflicted on infrastructure, social institutions, industrial production, local communities, and social networks, civil war has been named one of the main causes of persistent poverty in this region (Justino, 2012). In addition to immediate damage, the residual impact of these conflicts can last years and spread across social groups. People are often displaced and forced to leave their homes, which interferes with social support networks that are important for coping. Those who remain in their communities are not necessarily in a better position than those who flee. Distrust between neighbors creates conditions of fear that further disrupt communities (Justino, 2012). Thus, the capacity for rebuilding diminishes when people lack the stability of a permanent home and the ability to trust those who live in their communities.

One proposed explanation for the persistence of conflict in sub-Saharan Africa is the lack of a clear objective for which to fight; terrorizing civilian populations appears to be the only outcome of conflict (Gettleman, 2010). Most armed conflicts in sub-Saharan Africa today are between soldiers, national or rebel, and civilians. In sub-Saharan Africa conflicts most often revolve around control of resources, especially resources that can easily be taken, such as diamonds. Rebel forces as well as outside nations cross borders in order to obtain natural resources, often to increase their personal wealth and for political gain (Lujala, Gledistch, & Gilmore, 2005). Once these resources are stripped away, the fighting parties exit and the local people are left with physical and emotional damage and few resources to help them rebuild and recover (Lujala et al., 2005).

The Democratic Republic of Congo provides an example of how far-reaching conflict can be in sub-Saharan Africa. Since 1998, over 5 million people have died in the Democratic Republic of Congo due to armed conflict, and one in three combatants is under the age of 18 (Gettleman, 2010). This ongoing conflict is the deadliest since WWII and includes three Congolese rebel movements, 14 armed foreign groups, and numerous militias. This has led to the destabilization of the entire region (Autesserre, 2008).

According to Gettleman (2010), due to the instability, and often corruption, of governments in the region, as well as the wealth that is forcibly accumulated by rebel forces in certain areas, the prospect for change in the near future looks bleak. The effects of conflict do not stay on the battlefield nor do they end when the battle is over. The impact is felt across societies and leads to years of hardship that foster lasting poverty and trauma.

## Disease

High rates of disease are commonly associated with sub-Saharan Africa, and play a distinct role in the types of trauma

suffered by citizens of this region (World Health Organization, 2006). Accordingly, the following section will begin with a description of disease as trauma, following with details of several prevalent diseases that this region faces: cholera, tuberculosis, malaria, and HIV/AIDS. General remarks of disease within sub-Saharan Africa will conclude this section.

When addressing trauma, it is necessary to account for the impact of disease, since disease shapes the experience of trauma by affecting personal and public health in multiple ways. First, Lando, Williams, Sturgis, & Williams (2006) found that chronic diseases have significant impacts on mental health. Caregivers who attend to the needs of loved ones affected by disease have been found to experience negative psychological consequences. Overall, the trauma of disease has been found to lead to increased chronic stress, which in turn affects physical health, creating a cyclical downward spiral pattern (Schaefer et al., 2007). Further, worsened physical health is associated with less access to health care, increased depression, and greater insecurity (Vinck & Pham, 2010). More specifically, researchers have assessed "life threatening illness" as trauma and have found in one study that 12.7% of South African respondents have encountered this trauma (Williams et al., 2007). The decision by researchers of this study to include illness as trauma was based on precedent from prior research. Similarly, research in Nigeria also characterized disease as trauma and reported that 17.1% of the sampled population had experienced trauma from "health problems/sickness" (Omigbodun, Bakare, & Yusuf, 2008, p. 248). These examples strongly suggest that a discussion of disease is critical in order to elucidate the impact of trauma in sub-Saharan Africa.

Turning now towards specific diseases, cholera, which is spread due to the lack of clean water and poor sanitation, has swept the region in several waves. For example, the seventh cholera epidemic began in the 1960s, reaching Africa in 1970 (Griffith, Kelly-Hope, & Miller, 2006). While cholera has decreased in Asia and Latin America, the incidence of cholera in sub-Saharan Africa has risen over the past decades; since 2001, sub-Saharan Africa has accounted for over 94% of worldwide cholera cases and fatalities related to cholera remain highest worldwide (Gaffga, Tauxe, & Mintz, 2007). Countries with the highest number of cases include Democratic Republic of Congo, Mozambique, and eastern South Africa. Researchers have attributed these high rates of cholera to a lack of infrastructure and the lack of economic development (Griffith et al., 2006).

Tuberculosis (TB) has also plagued the region. Pallangyo (2001) describes the situation as "bad and getting worse (p. 43)" and explains that TB has been a major public health concern since the early twentieth century. Sub-Saharan Africa currently has the highest prevalence (number of cases in an area) and incidence (number of new cases in a period of time) of TB infection worldwide and over the past two decades, TB incidence has doubled (Stuckler, Basu, McKee, & Luric, 2011). Between 2000 and 2007, rates of TB declined in only 10 sub-Saharan countries. These consistently high levels of TB are likely due to the HIV epidemic, population growth, urbanization, and poverty (Pallangyo, 2001).

Malaria is also a concern within sub-Saharan African countries, with both incidence rates and death rates associated with malaria increasing in these nations (Korenromp et al., 2005). Of all the worldwide malaria

cases, over 90% occur in Africa (World Health Organization, 2006). Effective medication campaigns are now used in this area, with 33 countries adopting anti-malarial medication regimes. Of these 33, however, only 9 countries have actually implemented these plans. Generally, at-risk populations in sub-Sahara Africa still lack access to effective prevention and treatment (World Health Organization, 2006).

Of all the health problems faced by those living in sub-Sahara Africa, HIV/AIDS has been one of the most challenging and widespread threats. Though a worldwide problem, sub-Saharan Africa carries the "largest burden" associated with HIV/AIDS: more than two-thirds of all cases worldwide are found in this region, as well as76% of the world's HIV/AIDS-related deaths (Ndjakani, Ceesay, & Wilson, 2010). HIV/AIDS has also been found to be the leading cause of death for adults within the WHO Africa Region, which includes most of the African continent, despite the rise of antiretroviral medication use (World Health Organization, 2006). Within sub-Saharan Africa, different areas are affected differently by this epidemic: highest rates of HIV/AIDS occur in southern Africa, moderate rates occur in eastern Africa, and lowest rates occur in western Africa. Additionally, poverty rates do not correlate with incidence rates, and urban areas tend to be more greatly impacted (Heimer, 2007). Of particular relevance to this review, gender-based violence is also a known factor that has increased the risk of HIV infection, particularly among women throughout the region (Andersson, Cockcroft, & Shea, 2008).

In conclusion, it is important to remember that this overview has focused on major disease pockets, and that many other less common ailments are also endemic to this area. Additionally, a trend of the "double health burden" is rising with sub-Saharan Africa, in which high rates of infectious disease are compounded by increasing rates of chronic disease (diabetes, cancer, etc.) (World Health Organization, 2006). Overall, the potential for trauma related to incidence levels and effects of disease persist in sub-Saharan Africa, and many millions of individuals are impacted by these factors.

## Gender-Based Violence

Broadly speaking, gender-based violence in sub-Saharan Africa may encompass experiences of abuse in the form of domestic violence, sexual exploitation, female genital mutilation and rape or sexual assault. The victims of such abuses are usually young women and adolescents, though the traumatic effects of gender-based violence are immense on families and communities as well (Wood & Jewkes, 1997). A study by Madu, Ndom, and Ramashia (2010) included women up to the age of 65, demonstrating that the problem affects women of all ages. The United Nation Population Fund's definition of gender-based violence captures the complicated and multifaceted nature of this type of trauma, which includes an interaction of gender, culture, and state powers:

> *...violence involving men and women, in which the female is usually the victim; and which is derived from unequal power relationships between men and women. Violence is directed specifically against a woman because she is a woman, or affects women disproportionately. It includes violence which is perpetrated or condoned by the state*

(Borwankar, Diallo, Goings, Sommerfelt, & Oluwole, 2009, p. 1)

Though gender-based violence disproportionately affects women and girls, little attention has been given to sexual violence against men and boys. Limited data suggests that sexual violence against men and boys may often take the form of sexual torture, including castration, rather than forced sexual encounters (Human Security Report, 2012). Further investigation is needed to understand the violence inflicted on men and boys as well as the role of women and girls as perpetrators. Given that gender-based violence is multifaceted and widespread in many countries of sub-Saharan Africa (Delano, 1998), it is important to consider it as a significant source of trauma.

Domestic violence against women is a widespread issue for many sub-Saharan African countries. It is reported that 46 percent of Ugandan women, 60 percent of Tanzanian women, 42 percent of Kenyan women, and 40 percent of Zambian women endorse experiences of domestic abuse (Wood & Jewkes, 1997). A study in Namibia found that 81.7 percent of women endorsed experiencing financial abuse, defined as being denied access to money or sufficient funds to provide for the family (Nangolo & Peltzer, 2003). In Kenya, one third of married women have been physically abused, while one tenth have been sexually abused by their husbands (Kimuna & Djamba, 2008). In the Democratic Republic of Congo, over 3 million women have reported experiencing *intimate partner sexual violence*, which may be attributable to increases in society's exposure to and tolerance of violence in different forms (Peterman, Palermo, & Bredenkamp, 2011). Physical and sexual abuse may be deeply imbedded in the culture fabric of society in developing countries, as evidenced by large numbers of women endorsing a belief that their partners have the right to have sex with them (regardless of whether they want to) and that it is acceptable for women to suffer physical consequences for denying sex to their partners (Human Security Report, 2012).

The long-term psychological effects of domestic violence are not only detrimental to the health of the victim, but also to the health of families and societies. Rates of depression and suicide attempts have also been shown to be higher for women who have been abused (Madu et al., 2010; Heise, 1993). Children are especially vulnerable to the effects of domestic violence, whether as victims or witnesses. Studies have shown that children who witness violence may experience many of the same emotional and behavioral problems as children who are victims of the violence. Such problems include depression, aggression, nightmares, physical health problems and poor school performance (Heise, Pitanguy, & Germain, 1994).

Rape and sexual assault are commonly inflicted in both domestic and societal conflicts. Several countries in sub-Saharan Africa, specifically the Democratic Republic of Congo, Rwanda, Sierra Leone, Liberia, and South Sudan, have received wide attention for *conflict-related sexual violence*, which refers to sexual violence perpetrated by combatants (Human Security Report, 2012). However, the pervasiveness of the problem in those contexts should not be generalized to all conflict areas or all of sub-Saharan Africa because they are the "exceptions, not the rule" (Human Security Report, 2012, p. 4).

Where sexual violence occurs on any scale, the effects may permeate across several domains, from an individual woman to her family to her community. When large-scale rape occurs in a society, it disrupts perceptions of honor and family unity. In

such cases, rape serves the purpose of instilling fear in communities, humiliating women and men into submission, and degrading women by "spoiling" their identities (Mullins, 2008). The after-effects are prolonged by the birth of mixed ethnic children, who are viewed as reminders of the fear, humiliation, and degradation of their parents (Mullins, 2008). For example, rape as a weapon of war has been and continues to be widespread in the Democratic Republic of Congo (Gettleman, 2007; Peterman, Palermo, & Bredenkamp, 2011). The term *weapon of war* suggests that rape is conducted systematically, carried out with strategic military aims, and endorsed by military leaders. This assumption is challenged based on findings that suggest, specifically in the Democratic Republic of Congo, that rape occurs more often in the form of "opportunistic behavior of undisciplined armed combatants" (Human Security Report, 2012, p. 30). Whether rape is systematically ordered by military leaders or opportunistically executed by armed individuals, the misuse of power to dominate civilians sexually or otherwise is symptomatic of the imbalanced power relations that characterize some conflict areas of sub-Saharan Africa and threatens the most vulnerable members of those populations.

Female Genital Mutilation or Cutting (FGM/C) is another example of gender-based violence that continues to be a widespread practice with debilitating consequences for women's health. FGM/C is the practice of cutting the external genital areas or closing the genital area, leaving a small opening only for urinating and menstrual flow. Associated physical health concerns as a result of FGM/C may include prolonged bleeding, infection, sepsis, infertility and even death (Abor, 2006). In Sudan, doctors estimate that 10 to 30 percent of young girls die as a result of FGM/C, particularly in areas where access to antibiotic medications is limited (Heise, Pitanguy, & Germain, 1994). Psychological consequences have been described as "mental torture" due to the pain of the procedure as well as ongoing fear about contact with the sexual organs (Abor, 2006).

Discussions of consequences resulting from FGM/C often overlook the effects on men. Studies have found that men in communities where FGM/C is practiced also experience physical and psychosocial complications. Almroth et al. (2001) found that consequences include problems with intercourse due to difficulty with penetration and male preference for wives who have not undergone FGM/C. This knowledge is being used to promote opposition to the practice (Almroth et al., 2001).

More than an estimated 60 million girls and women between the ages of 15 and 49 are subjected to FGM/C in 28 African countries (Keele, 2007). Although FGM/C is regarded as a cultural and religious practice, it is also viewed as a violation of the rights of girls and thus another source of trauma in sub-Saharan Africa (Adeyinka, Oladimeji, & Aimakhu, 2009).

Gender-based violence in its myriad forms unarguably contributes to a context of trauma in sub-Saharan Africa. To understand the context more fully, the 2012 Human Security Report challenges tenets of the prevailing mainstream narrative regarding sexual violence in areas of conflict. As previously stated, conflict regions such as the Democratic Republic of Congo, Liberia, and the Sudan have been home to widespread conflict-related sexual violence. However, the pervasiveness of the problem in these regions should not be generalized to all areas of conflict or all of sub-Saharan Africa, where data is lacking. In addition, data that suggests substantial increases in the incidence of sexual violence in conflict areas should be investigated

further, as the increased rates may be due to an increase in reporting rather than an increase in violence (Human Security Report, 2012). Finally, we began this section by naming domestic violence as a form of gender-based violence. Despite the overshadowing impact of conflict-related sexual violence, the majority of gender-based violence in conflict areas occurs in the context of intimate relationships (Human Security Report, 2012).

## Cost of Trauma

### Psychosocial Outcomes

Psychosocial outcomes and physical health outcomes comprise the majority of the research on the cost of trauma in sub-Saharan Africa. The impact of trauma is primarily measured according to the incidence and prevalence of particular mental and physical health problems among certain populations. Each study is context-specific, such as focusing on post-genocide Rwanda or civil war-torn Liberia. While the outcomes should not be generalized to all sub-Saharan African contexts, the similar findings across contexts illustrate the pervasiveness of psychosocial and physical health problems in the region that are the result of large-scale, man-made trauma.

The most common measurements of psychological distress in the aftermath or the midst of trauma are posttraumatic stress symptoms and posttraumatic stress disorder (PTSD). Commonly reported posttraumatic stress symptoms include difficulty concentrating, irritability and outbursts of anger, intrusive thoughts, nightmares, and hypervigilance (Liebling & Kiziri-Mayengo, 2002). Studies reviewed show prevalence rates of PTSD ranging from 24.8% of the adult population surveyed to 74% (Pham, Weinstein, & Longman, 2004; Vinck, Pham, Stover, & Weinstein, 2007). A variety of self-report instruments were used to measure PTSD. The most extreme low and high rates of PTSD were both measured using the PTSD Symptom Checklist – Civilian Version (PCL-C), which has been correlated with the Clinician-Administered PTSD Scale (CAPS). Perhaps most notably, the actual and assumed number of participants who met criterion A of the DSM-IV PTSD classification, exposure to a traumatic event, was at or near 100% across studies. This suggests that entire communities are at significant risk of posttraumatic stress symptoms and PTSD.

Two studies focused particularly on the experiences of women and girls in attempts to fill a gap in the literature regarding the suffering of traumatized women in contexts of war (Igreja, Kleijn, & Richters, 2006; Amone-P'Olak, 2005). The participants were Mozambican women living in a former war-zone in the center of Mozambique and formerly abducted adolescent girls receiving treatment at a trauma center in northern Uganda. All of the women and girls had experienced traumatic circumstances such as being in the midst of combat, lacking food/water, lacking shelter, and being close to death. Ninety-three percent of the Mozambican women reported a particularly distressing, specific form of forced labor called *gandira*, which usually included captivity and rape, in addition to carrying food, weapons, and other goods to remote locations. A salient, ongoing psychological consequence of the trauma was possession by "war spirits" that were said to prevent the women from returning to their normal lives. About one-third of the women reported this type of possession, and 88% of that subset met criteria for PTSD. This manifestation of symptoms reflects a unique cultural response to trauma. All but one of the Ugandan girls demonstrated clinically significant PTSD symptoms.

Exposure to sexual violence correlated with higher levels of PTSD among both men and women in a study examining gender and combatant status among Liberians (Johnson et al., 2008). Among all adults surveyed, 44% met symptom criteria for PTSD. One-third of those surveyed were former combatants, and one-third of those were female. While rates of exposure to sexual violence were higher among former

combatants, specifically female former combatants, male former combatants were exposed to sexual violence as well. The prevalence of PTSD was higher among both male and female former combatants who experienced sexual violence than those who did not. Soldiers and rebels were reported to be the perpetrators of sexual violence experienced by both women and men who had been involved in combat.

Vinck et al. (2007) focused on northern Uganda provides a perspective on patterns of exposure to traumatic events. Participants were divided into four groups, and comparisons were made among each group's level of exposure to violence and rate of PTSD. Group 1 reported low exposure to war-related violence; Group 2 reported witnessing violence but did not personally suffer threat of death or physical injury; Group 3 reported suffering threat of death or physical injury; and Group 4 reported being abducted. As would be expected, traumatic exposure increased across groups, ranging from less than 1 traumatic event for Group 1 to almost 7 traumatic events for Group 4. Despite their comparatively low levels of exposure, respondents in Group 1 still had a PTSD rate of 47%. This rate nearly doubled for Groups 3 and 4, in which respondents were more than 6 times as likely to have PTSD symptoms. Similar studies in Rwanda and South Africa examined cumulative traumatic exposure as well as demographic characteristics and proximity to conflict as predictors of PTSD symptoms (Pham et al., 2004; Williams et al., 2007). Women were more likely to have PTSD symptoms, as were individuals who were residing in Rwanda at the time of the genocide. In South Africa, individuals with the highest number of cumulative traumatic events were at significantly greater risk of distress. A study examining exposure to traumatic events for aid workers and missionaries found a similar pattern of exposure and posttraumatic stress (Schaefer et al., 2007).

In addition to providing information about demographics and patterns of exposure, studies in Rwanda and Uganda attempted to connect exposure to trauma with attitudes toward community rebuilding, specifically justice, reconciliation, and peace-building (Vinck et al., 2007; Pham et al., 2004; Bayer, Klasen, & Adam, 2007). Across contexts, those with PTSD symptoms were less likely to have faith in others, including local and national judicial proceedings, were more likely to view violence as a viable means to achieve peace, and were generally less open to reconciliation. Conceptions of peace varied depending on exposure and proximity to violence, as well as level of education and ethnicity. This applied focus provides useful correlations that may help other researchers and community-based workers make projections about attitudes of individuals and communities toward reconciliation and may help tailor interventions accordingly.

PTSD was not the only indicator of poor psychosocial outcomes in traumatized settings. Depression, poor social functioning, and anxiety have also been examined (Johnson et al., 2008; Vinck et al., 2007; Vinck & Pham, 2010; Roberts, Ocaka, Browne, Oyok, & Sondorp, 2008; Roberts, Damundu, Lomoro, & Sondorp, 2009). Prevalence rates for depression and Major Depressive Disorder (MDD) range from 40% in Liberia to 55.3% in the Central African Republic (CAR). While the prevalence rates do not parallel the variance found in PTSD, they suggests that depression is a consistent psychosocial outcome. Greater exposure to traumatic events, specifically gender-based violence, increases rates of depression, and this may

be attributed to stigma (Gelaye, Arnold, Williams, Goshu, & Berhane, 2009; Betancourt, Agnew-Blais, Gilman, Williams, & Ellis, 2010). Rates of suicidal ideation and unsuccessful suicide attempts also have been found to increase among those who have experienced domestic violence, and specifically sexual violence (Devries et al., 2011; Esere, Idowu, & Omotosho, 2009). One study examined perceptions of mental health outcomes using local terms for common symptoms and found a "depression-like" illness, suggesting both the need for contextual investigation of mental health problems as well as the universality of certain symptoms (Bolton, 2001; Vinson & Chang, 2012). Anxiety in the form of panic attacks and panic disorder were found among Rwandan widows who survived the 1994 genocide (Hagengimana, Hinton, Bird, Pollack, & Pitman, 2003). In addition to exposure to traumatic events, other stressful life events, such as food insecurity and living in refugee camps, were found to be associated with depression, anxiety, and posttraumatic stress (Hadley, Tegegn, Tessema, Cowan, Asefa & Galea, 2008; Fox & Tang, 2000).

All of the studies discussed so far have focused on the psychosocial outcomes of adults who have been exposed to trauma. The literature concerning children is scarcer, presumably because of the methodological challenges of working with that population. However, there are some significant findings to be highlighted from the existing literature. Similar to the adult population, it can be assumed that virtually all children living in or near contexts of trauma are significantly at risk of experiencing posttraumatic stress symptoms and PTSD (Magwaza, Killian, Petersen, & Pillay, 1993; Neugebauer et al., 2009). One study in the Darfur region of southern Sudan found that 75% of the children interviewed met PTSD criteria (Morgos, Worden, & Gupta, 2007). Young lives that are characterized by experiences of death, disease, violence, and poverty are bound to exhibit heightened levels of emotional distress.

Akello, Reis, and Richters (2010) found that despite their high levels of exposure to trauma, children in northern Uganda did not readily express their distress verbally. From a developmental perspective, it is reasonable that children lack the cognitive ability to translate their emotions into words. This limited developmental capacity may account for the finding by Morgos et al. (2007) that while 75% of children met symptom criteria for PTSD, only 20% endorsed significant grief symptoms. However, it should be noted that children's distress does not go unexpressed entirely. Akello et al. found that children appear to primarily express their emotional suffering through somatic complaints, which frequently lead to pharmacological and medical interventions for emotional and psychological problems. Another study asked children to draw pictures of things they had experienced in their lives. Those who were able to express themselves and their trauma through the drawings were less likely to suffer from PTSD (Magwaza et al., 1993).

Werner (2012) conducted a literature review exploring the effects of war on children across the globe. Several of the findings are substantiated in the literature on adults reviewed above. Children at the greatest risk of developing posttraumatic stress symptoms include child soldiers, who would qualify as Group 4 per Vinck et al. (2007) (Derluyn, Broekaert, Schuyten, & Temmerman, 2004); children who were raped, similar to the victims of sexual violence per Johnson et al. (2008); and children who had been forcibly displaced. In addition, vicarious trauma is a significant

risk for children and adolescents. A study in the Democratic Republic of Congo found that 92% of the children interviewed knew a young person who had been forcefully recruited by rebel forces, and the children endorsed an accompanying feeling of inferiority to those children (Masinda & Muhesi, 2004).

A study by Seedat et al. (2004) compared rates of trauma exposure and posttraumatic stress symptoms among male and female adolescents in Kenya and South Africa. Findings showed a similar rate of exposure to severe trauma, more than 80% in both contexts, but the South African youth reported significantly higher levels of PTSD and posttraumatic stress symptoms. No significant gender differences were found.

Long-term physical health consequences have been identified for children exposed to war trauma; however more longitudinal research is needed to identify the long-term psychosocial outcomes. One potential area of further exploration is neurocognitive functioning, where impairment as a result of PTSD has been found (Schoeman, Carey, & Seedat, 2009). In addition, the role of perceived social support warrants additional exploration, as one study suggested that it moderated the impact of traumatic exposure and posttraumatic stress on AIDS-orphaned children in South Africa (Cluver, Fincham, Dylan & Seedat, 2009).

## Physical Health Outcomes

Though not the primary focus of this review, physical health outcomes are relevant to the degree that they influence or are influenced by psychosocial outcomes. Studies have shown several indicators of poor physical health in communities affected by war, including reduced stature and increased mortality, specifically mortality of children under 5, and lifelong disabilities and associated pain (Akresh, Lucchetti, & Thirumurthy, 2012; Akresh, Bhalotra, Leone, & Osili, 2011; Baez, 2011; Simon, 2001; Vinck et al., 2010; Denov, 2010).

One study particularly examined the physical health impact of hosting refugees, a common occurrence across sub-Saharan Africa (Baez, 2011). Hosting refugees brought an increase in infectious diseases, which are potentially fatal, especially for children. Rape as a weapon of war has been shown to increase incidence of HIV among victims, which in turn increases depressive symptoms and leads to gynecological complains, such as chronic lower abdominal pain and abnormal bleeding (Cohen et al., 2009; Murray et al., 2006; Kinyanda et al., 2010). Formerly abducted girls reported sexually-related concerns, including abdominal pains and a variety of sexually transmitted diseases (Amone-P'Olak, 2005). Other commonly reported physical symptoms include headaches, ulcers, and hernias, as well as increased heart rate 7-9 months after experiencing trauma (Liebling & Kiziri-Mayengo, 2002; Obilom & Thacher, 2008).

## Services/Infrastructure/Productivity Outcomes

The impact of trauma on communities is examined in the literature in terms of vulnerability, human productivity, community cohesion, and community rebuilding. Vulnerability to trauma is influenced by a myriad of factors, including psychological, social, and economic. A common assumption from an economic perspective is that civil unrest, which contributes to trauma in communities, is rooted in the greed of individuals. One study explored the determinants and consequences of civil strife and found that civil strife

increases as education levels and access to infrastructure decrease (Deininger, 2003). Therefore, strengthening a society's access to "assets" may decrease its vulnerability to civil strife and consequently its vulnerability to trauma.

The World Health Organization conducted World Mental Health surveys in 24 countries to examine the impact of commonly occurring mental and physical disorders on society (Alonso et al., 2011). The disorders were predetermined and reflected the highest-prevalence disorders worldwide. PTSD had the third largest impact on productivity, with individuals reporting an average of 15.2 days in which they could not carry on their usual activities due to illness. Major depression was the most commonly reported mental health problem, affecting between 4.9 and 6.2 percent of those surveyed and resulting in 34.4 "days out of role". The data specific to lower income countries, which would have included the majority of countries in sub-Saharan Africa, are even more severe. The prevalence rate for depression was 4.9%, but the average number of "days out of role" was 35.8. Prevalence for PTSD is even lower, at 0.7%, but the average number of days lost was 44.9. Clearly, impact should be examined in terms of depth as well as breadth.

Other studies used the unfortunate but naturally occurring laboratory of northern Uganda to examine the impact of trauma in terms of community cohesion through the reintegration of perpetrators of violence into their communities (Annan, Blattman, Mazurana, & Carlson, 2011; Blattman & Annan, 2010). Contrary to what may be a logical assumption, studies suggest that perpetrators of violence gain acceptance into their communities that is similar to the acceptance of non-combatant peers. However, these studies focus on males; females are believed to experience more difficulty reintegrating, particularly those who were sexually assaulted (Annan et al., 2011). Also contrary to popular assumption, women and girls do indeed become combatants; evidence suggests that overall social acceptance is high for women as well as men. However, despite these exceptions to the assumption, research also suggests difficulty reintegrating due to various forms of stigma attached to former combatants (Denov, 2010; Akello, Richters, & Reis, 2006).

Another study looking at reintegration in Uganda found that former child soldiers often report battling with *cen*, which are the avenging spirits of the people killed by the child soldier (Akello et al., 2006). Communities sometimes ask questions of former child soldiers seeking reintegration to ascertain the degree to which they are troubled by *cen.* The cultural assumption is that if a person has made every effort to alleviate *cen* but has been unable to do so, then the person is truly guilty for their actions. However, the common symptoms of *cen* mirror common symptoms of depression and anxiety, including difficulty sleeping, threatening and disturbing images, and feelings of guilt, fear, or sadness. Reintegration into a community may help alleviate some common symptoms through the presence of social support and a sense of purpose and belonging. Whether a former combatant is reintegrated or remains ostracized from the community, culturally-manifested psychological distress must be understood and addressed to promote healing and health for them.

Community rebuilding constitutes more than the reintegration of communities; the very people and structures that constitute a society must be reconstructed. Though

reintegration is possible, the ongoing impact of conflict on the individuals involved creates a context of long-term effects. Ghobarah, Huth, and Russett (2004) found increased incidence of infectious diseases and other ailments such as cancer, with women and children being disproportionately affected. Rates of death and disability climb as a result of these complications, and communities are forced to respond to the ongoing disruption that threatens their efforts to rebuild.

In Uganda and Sudan, the economic cost of civil war led to redistribution of resources toward military spending and away from essential services, such as healthcare (Dodge, 1990). The pervasiveness of poor psychosocial and physical outcomes in conflict-ridden communities has been illustrated, and therefore the importance of essential services cannot be underestimated. The difficulty of providing such services is further exacerbated by the relocation of healthcare providers away from areas of conflict. Some flee for their own safety, while others leave because they are unable to provide services due to insufficient infrastructure and resources. Once again, communities face concomitant complications of trauma that must be overcome. However, despite the challenge of allocating resources, there is evidence that training and employing community workers to address mental health needs in rural areas with limited access to hospitals and other infrastructure can promote mental health and manage psychological problems (Byaruhanga, Cantor-Graae, Maling, & Kabakyenga, 2008).

## Financial Cost Analyses/Economic Outcomes

The prevalence of negative psychosocial and physical outcomes necessitates an outpouring of resources, both human and capital, in response. Needs for these resources have been calculated according to the associated costs, such as scaling up essential mental healthcare services (Chisholm, Lund, & Saxena, 2007; Lund, Boyce, Flisher, Kafaar, & Dawes, 2009). The Chisholm et al. (2007) study used national epidemiological survey data to estimate prevalence rates of select ICD-10 mental disorders in 12 low- and middle-income countries. Needs assessments revealed how much scaling up would be required to address the prevalence of the disorders, and the US dollar amount was computed. The results indicated that, while new resource allocation is essential, the total amounts are not large, particularly when compared to the funding requirements of other major global disease contributors. This suggests a potentially high return on investment through scaling up mental healthcare resources; however the scope of psychosocial outcomes included was very limited and did not include the disorders identified previously as being the most destructive for communities that have experienced trauma (e.g. PTSD).

The Lund et al. (2009) study specifically focused on estimating service needs for a population of 100,000 people in South Africa, according to number of daily patient visits, number of hospital beds required for acute and medium to long-term care, and number of staff needed. This study also excluded PTSD, so the results are likely underestimated. Additionally, the study attempted to measure service requirements for the current level of need. Due to ongoing conflict throughout sub-Saharan Africa, and the frequency of displacement and refugee movement among countries, the established levels may not be accurate. Nonetheless, the model for calculating service needs may be

useful in other contexts where such assessment would assist in service provision. Another South African study reviewed inpatient mental healthcare services at a particular hospital and found that the hospital was significantly understaffed and also underfunded (van Rensburg & Jassat, 2011). The majority of patients receiving care were seeking treatment for schizophrenia, substance-related disorders, and bipolar mood disorder, and the study did not specifically examine trauma in any form.

Finally, a study by Bishai et al. (2010) estimated the financial cost and loss of life resulting from FGM and resulting obstetric complications among 15-year-old girls who lived to the age of 45 in six countries. The level of risk of obstetric complications was based on a former study. Findings suggest that, based on a population of 2.8 million 15-year-old girls across the six countries, the anticipated loss of life is 130,000 years, or approximately half a month from each girl's life. The financial cost of obstetric complications in these countries was estimated at $3.7 million purchasing power parity dollars (Bishai et al., 2010). The cost of investing in FGM prevention is projected to offset the cost of caring for obstetric complications.

## Summary

The literature suggests that the cost of trauma is measured according to several outcomes: psychosocial, physical health, services/infrastructure/productivity, and financial/economic outcomes. The next section will review the literature on efforts to address these outcomes, specifically psychosocial interventions and religious interventions.

## Addressing the Cost of Trauma

Efforts to address the cost of trauma in sub-Saharan Africa take multiple forms in the literature. Some studies evaluate the effectiveness of new and established interventions in the sub-Saharan African context; others do not address interventions directly but rather include general recommendations for improving the lives of individuals impacted by trauma. Both are included, with an emphasis on reviewing psychological and religious intervention outcomes.

### Psychosocial Interventions

Several interventions have been directed at reducing posttraumatic stress symptoms and PTSD with favorable outcomes. Neuner et al.'s (2008) study on Rwandan and Somali refugees in Uganda found that both narrative exposure therapy and trauma counseling interventions significantly decreased the likelihood of meeting PTSD criteria when compared to the control group. Similarly, a rumination-focused cognitive and behavioral intervention with adolescent genocide survivors in Rwanda found lower levels of PTSD symptoms following treatment and at follow-up (Sezibera, Van Broeck, & Philippot, 2009).

In Mozambique, Igreja, Kleijn, Schreuder, Van Dijk, & Verschuur (2004) conducted an intervention study of the efficacy of the testimony method of psychotherapy to relieve posttraumatic stress symptoms. The testimony method is a relatively simple intervention in which the survivor of trauma tells his or her story of traumatic events and is helped by the interviewer to write a narrative account. This process is believed to help the survivor develop a coherent account of the trauma which enables the survivor to function. The purpose of this study was two-fold: to evaluate the efficacy of this method to reduce posttraumatic stress symptoms and to determine the viability of this method in a poor, rural, war-stricken African context. Participants randomly assigned to the intervention group did not demonstrate a significant difference in posttraumatic stress symptoms from those in the control group, though both groups demonstrated significant decreases in symptoms. Explanations for this are only conjecture, and further exploration is needed. Although the intervention results were not robust, the intervention was demonstrated to be feasible. If anything is to be learned from this study with regard to reducing posttraumatic stress symptoms, it is perhaps that time begins to heal psychological wounds inflicted by trauma.

Exposure-based therapies are commonly used to address anxiety disorders and trauma. The Rewind Technique is an intervention in which the participant recalls the trauma as two movies. In the first movie, the participant is a detached observer of the trauma; in the second movie, the participant is an active participant who sees and feels the content of the first movie as it is rewound, but the rewinding happens too quickly for the participant to re-experience its intensity. The process starts and ends in the safe space before the trauma occurred. Utuza, Joseph, and Muss (2012) applied this intervention in a group setting with Rwandan genocide survivors. The simplicity of the technique, combined with the decreased potential for re-traumatization through telling one's story and the capacity to reach many people with a single, one-time intervention, makes it appealing for contexts in which mental healthcare is scarce. Results from the Impact of Events Scale (IES) demonstrate significantly decreased symptom levels following the Rewind Technique at a two-week follow-up. This

suggests the Rewind Technique may be a viable intervention in traumatized sub-Saharan African contexts.

Two studies investigated the effectiveness of Thought Field Therapy (TFT) in reducing PTSD symptoms (Sakai, Connolly, & Oas, 2010; Connolly & Sakai, 2011). The participants were adult and adolescent survivors of the 1994 genocide in Rwanda, respectively. TFT is a brief treatment that focuses on a specific traumatic event and uses self-tapping of select acupuncture points. The treatment is initially taught by the therapist and can then be enacted by the participant in the context of treatment or on his or her own. Trauma symptoms significantly decreased for both samples, and gains were maintained at follow-up one and two years later for adolescents and adults, respectively. Among the adolescent group, several offered unsolicited reports of self-treatment using TFT at the time of the follow-up. One possible limitation of these studies is their reliance on self-report measures of PTSD symptoms.

In addition to exposure-based therapies, psychoeducation has been shown to have a normalizing effect which reduces PTSD symptoms. Yeomans, Forman, Herbert, and Yuen (2010) examined the effects of PTSD psychoeducation by comparing the efficacy of an intervention delivered with and without PTSD psychoeducation to a sample in Burundi. Compared to the control group, both intervention groups demonstrated decreased posttraumatic stress symptoms; however, the group that did not receive PTSD psychoeducation saw greater decreases. Yeomans proposes that this effect may be due to 1) the exacerbation of symptoms based on new, trauma-focused information, or 2) the effect of additional content used in the non-psychoeducation group to make up the time difference of the psychoeducation group. Further research is needed to examine the effect of psychoeducation.

Community-based education has been shown to be effective in promoting behavior change regarding female genital mutilation/cutting (FGM/C) in Senegal (Diop & Askew, 2009). The intervention was developed locally in Senegal and involved dissemination of information about FGM/C within the intervention villages, with no intervention taking place in the comparison villages. Effectiveness was measured by pre- and post-test responses concerning knowledge and attitudes toward FGM/C, as well as through reported decreases in FGM/C activity among young girls in the intervention villages. Similar decreases were not reported among young girls in the comparison villages. Another study that specifically looked at issues affecting women measured the effectiveness of two interventions, one providing counseling and one that offered support groups and skills training (Lekskes, van Hooren, & de Beus, 2007). Compared to the control group, both interventions were helpful in decreasing PTSD scores, though counseling had a more significant effect.

Adapting interventions for cross-cultural contexts is important for providing the most relevant and sensitive care possible. One of the elements of sub-Saharan African culture that stands out as a potential avenue for adaptation is the use of rituals. Harris (2007) moved beyond adapting traditional Western therapy to conceptualizing creative therapeutic processes that combine the essence of Western trauma treatment with the rituals of the culture of Sierra Leone. The capacity of dance/movement therapy to promote emotional expression through the body resonates with the culture of Sierra Leone, in which unity of mind and body is

strong. This therapy, combined with the disruption of traditional rituals due to ongoing, pervasive war, created an opportunity to conduct creative therapy with former boy combatants. An attendance rate of 90% suggests a commitment to the process that likely facilitated progress. Gradual reduction in symptoms of aggression, depression, and anxiety suggests that each session contributed in a cumulative way to the improved psychosocial outcomes overall.

The influence of trauma is measured in the absence of appropriate daily functioning as well as the presence of posttraumatic stress symptoms. Therefore, it is appropriate for interventions to move beyond the reduction of symptoms toward improved functioning. Stepakoff et al. (2006) implemented a program for Liberian and Sierra Leonean refugees that primarily consisted of relational, supportive, group counseling. The counseling process followed 3-stages of recovery, from safety to mourning to reconnection. Follow-up assessments demonstrated improved daily functioning and social support in addition to trauma symptom reduction. Social support was likely enhanced by the departure from a traditional, Western group therapy expectation that precludes contact between members outside of therapy. Participants were encouraged to interact with one another outside of the group. Promoting positive self-talk as a technique presumably contributed to the enhanced capacity for daily functioning.

In Uganda, the EMPOWER program is a culturally sensitive intervention based in the cognitive-behavioral tradition that seeks to help war-affected individuals deal with and move on from traumatic experiences (Sonderegger, Rombouts, Ocen, & McKeever, 2011). A pilot evaluation of this program found that it was successful in decreasing depression and anxiety symptoms and in promoting prosocial behaviors when compared to the control group. The primary assessment instrument, the Acholi Psychosocial Assessment Instrument (APAI) was selected for its broader scope of functioning, rather than focusing narrowly on PTSD. It was developed in consultation with community members in the region of Uganda that shares its name.

Despite the preceding affirmative results, not all interventions produce favorable outcomes. Akello, Richters, and Reis (2006) investigate why reintegration processes in northern Uganda have failed by examining three perspectives on the process: a Christian non-governmental organization called World Vision, formerly abducted child soldiers, and the communities where the children attempt to reintegrate. World Vision's perspective on reintegration is rooted in Christian values of repentance, forgiveness, and the belief that formerly abducted children were taken advantage of in their vulnerability and are innocent of their crimes. Interventions are based traditional, Western conceptions of one-on-one psychotherapy and group psychotherapy, with the ultimate goal of talking about one's experiences. The communities where children attempt to reintegrate have a different perspective. Formerly abducted children are not viewed as innocent of their crimes and face harassment, verbal abuse, and stigma based on the community's previous experience with other formerly abducted children, specifically those who rejoined the rebel forces. Formerly abducted children describe a perspective that combines the influences of the NGO and the community. They are aware of the negative attitudes toward them and do not endorse that they are innocent.

The previous discussion of *cen*, which are the avenging spirits of people killed by the child soldier, emerges in the myriad of symptoms endorsed by the children. The presence of *cen* increases the hostility with which communities regard former child soldiers.

The inconsistencies in these three perspectives illuminate the challenge of reintegration. Akello et al. (2006) recommends considering the desires of formerly abducted children with regard to reintegration. Children may diverge from the NGO model in any number of places, including whether they desire to reintegrate at all. In addition, the problem of *cen* must be addressed in light of the cultural and religious context in which it takes place. To restate a foundational concern, culturally-manifested psychological distress must be understood for any intervention with formerly abducted children, whether or not they desire to reintegrate.

Reintegration status aside, many formerly abducted children in northern Uganda suffer from PTSD. Ertl, Pfeiffer, Schauer, Elbert, & Neuner (2011) assessed the effectiveness of three interventions – narrative exposure therapy, an academic catch-up plan with supportive elements, and a wait list – in reducing PTSD symptoms one year following treatment. Therapy was carried out by trained lay therapists without mental health or medical backgrounds and took place over the course of 8 sessions. As hypothesized, narrative exposure therapy produced the most significant improvement as measured by the Clinician-Administered PTSD Scale.

Due to the efficacy of narrative exposure therapy for adults, Onyut et al. (2004) designed and evaluated a child-friendly version. Symptom reduction was evident following treatment and at the nine-month follow-up assessment. The pilot involved only six children, so further validation is needed. In addition to established therapeutic interventions, Uguak (2010) promotes the use of normal, childhood activities in a therapeutic way. Such activities may include, dance, drawings, and play with the objective of meeting psychosocial needs.

Wessells and Monteiro (2006) focused on Angola, where decades of war have wreaked havoc on the local people. One ongoing challenge of rebuilding from a context of violence is offering young people alternatives to violence, including prosocial behaviors. Wessells evaluated a community-based program intervention that focused on skill building, peer support, and education about nonviolence among young people. Favorable outcomes included increased awareness of the needs of young people (including increased awareness for adults), decreased levels of conflict among young people, and increased perceptions and actualizations of young people contributing to the community. Developing a joint focus on young people and post-conflict rebuilding contributed to positive community-wide changes, such as disrupting the cycle of violence. This is especially important because many young people fought in Angola's war and were otherwise victims of the structural violence that pervaded the country.

The case for social support as a protective factor against posttraumatic stress is strong, but it had not been examined specifically in children orphaned by AIDS in South Africa until Cluver, Fincham, & Seedat (2009) found that participants with high levels of perceived social support had significantly lower levels of PTSD symptoms than those with low levels of perceived social support.

This was found across levels of trauma exposure.

## Religious Interventions

Studies have shown that religion and spirituality are often used to cope with negative life events (Harrison, Koenig, Hays, Eme-Akwari, & Pargament, 2001; Ano & Vasconcelles, 2004). Various studies in sub-Saharan Africa build on this foundational knowledge. Approximately 85 percent of Ugandan women living with HIV/AIDS in one study endorsed employing some form of spirituality to cope, including prayer, worship, and God or Jesus (Hodge, 2010). Another Ugandan study focused specifically on the experience of "born-again" Christians, or those belonging to the Pentecostal church (Tankink, 2007). The elements of the Pentecostal faith that were particularly helpful were a hopeful perspective on the future based on biblical teachings, a public space in which to express suffering, and an experience of trust and solidarity through the church. A third Ugandan study found that forgiveness as a form of religious coping contributed to personal empowerment among a population that had long been regarded as victims (Finnegan, 2010).

Putman, Lea, and Eriksson (2011) investigated religious coping methods that have been established in the United States for applicability in Guatemala and Kenya. Their findings demonstrated consistent constructs for religious coping across cultures, as well as unique responses in different cultures. *Human responsibility*, which entailed attributing negative events to human beings rather than God, was common among Kenyans. Finally, the most frequently reported coping method unique to Kenya was the act of prayer, followed by *solidarity through shared experience*, which was also common in Guatemala (Putman et al., 2011).

Though religion and spirituality have been shown to be helpful in dealing with trauma, there are documented exceptions. A Sierra Leonean study examining the experiences of local people with the Truth and Reconciliation Commission found that religious beliefs impeded the reconciliation process (Millar, 2012). This is attributed to their subjective perceptions of agency and the truth-telling process. A study in Burkina Faso found that religious beliefs integrating the cultural practice of FGM/C led to higher rates of female circumcision, despite the health risks associated with the practice (Hayford & Trinitapoli, 2011). Another example of how religion and spirituality has been misused, and has been linked to trauma, can be found in the Democratic Republic of the Congo. The Lord's Resistance Army (LRA) in Uganda is rooted in Christian, Muslim, and indigenous beliefs, adhering to practices such as baptism and daily prayers to promote in-group cohesion (Adam, de Cordier, Titeca, & Vlassenroot, 2007). However, a study by Manca (2008) found that the LRA specifically exploits traditional Acholi belief in spirit possession to promote obedience to LRA leader Joseph Kony, who claims to be possessed by various divine spirits (Adam et al., 2007). Thus, religious and spiritual beliefs have been misconstrued for personal and political gain, as a way of influencing obedience and as a way for justifying violence.

## Discussion

### Context of Trauma

Overall, researchers have documented a wide-range of atrocities that have helped create an environment that lends itself to trauma. One of the overarching findings from this review is that trauma in sub-Saharan Africa is complexly intertwined with a wide-range of contextual factors. Gender-based violence, which may be thought to occur on a personal level, is applied systematically in communities. Disease is endemic, affecting entire populations and being exacerbated by migration and other population trends. Conditions of poverty promote instability that contribute to conflict, which further destabilizes communities and promotes the spread of disease and interpersonal violence. Complex trauma, a term that encompasses this complexity, describes how pervasive and cumulative traumatic circumstances impact individuals and communities.

### Cost of Trauma

Efforts to measure the cost of trauma have focused on more tangible and quantifiable constructs, such as: cost for healthcare service providers based on incidence rates of physical and mental disorders and lost productivity cost from individuals being unable to perform normal functions. Minimal effort has been made to consider preventative costs, such as psychoeducation and social support efforts. This is perhaps attributable to the reality that in many communities, services are already inadequate to deal with existing problems, making it difficult to consider investing personnel and resources into prevention. Financial costs are a very real consequence of trauma; however, current efforts to measure the psychosocial costs are limited in quantity and scope. This is partly attributable to the application of interventions that have been validated in a western context. Western definitions and accepted manifestations of trauma may or may not be culturally appropriate in non-western contexts. If trauma is being measured in one culture according to norms from another culture, the results may be inaccurate or misleading. In addition, there may be positive relational and communal impacts of trauma that also warrant exploration. Current research has also brought attention to the need for broader definitions and conceptualizations of trauma to be considered when developing quantitative formulations for calculating cost.

### Addressing the Cost of Trauma

Efforts to address the cost of trauma have largely aimed to decrease rates of posttraumatic stress and related symptoms and have mirrored traditional forms of treatment. For example, Edwards (2005) sought to summarize a myriad of approaches for addressing vulnerability and building resilience in the aftermath of trauma in regions of sub-Sahara Africa. Despite the nuances of each case highlighted, they generated largely predictable recommendations, including traditional psychotherapy, family therapy, psychoeducation, and empowerment-oriented interventions. There is also burgeoning body of research on religion/spirituality and trauma in sub-Sahara Africa that suggests that religion/spirituality appear to help buffer against trauma experienced by those living in sub-Saharan Africa. At the same time, researchers have brought attention to misuses of religion/spirituality to perpetuate personal and political gain that actually led to traumatic events (e.g., civil unrest).

## Recommendations

Based on this review, we draw several conclusions about the state of research in this field and outline a series of next steps to measure and address the cost of trauma in sub-Saharan Africa. The following recommendations fall broadly into the following categories: methodological issues, community-wide perspectives, contextualization, interaction of trauma domains, and alternative measurement and outcome models:

- Greater attention needs to be given to methodological design issues. Askew (2005) emphasizes the importance of quasi-experimental design and appropriate sample sizes to draw valid conclusions about the effectiveness of interventions. Bolton (2001) highlights the need for and the feasibility of validating instruments prior to using them in a particular context through the collection of supporting evidence from the specific context. Overall, more sophisticated designs are needed to provide greater evidence of support for efforts to understand and address trauma in sub-Sahara Africa.

- Develop standardized, culturally appropriate metrics that assess for culture- and context-specific expressions of trauma. For example, a Kenyan woman living in the city of Nairobi and experiencing domestic violence may have more access to services than a woman who was raped by militants who invaded her village. Both these women fall under the domain of gender-based violence, however the appropriate assessment of and interventions for her trauma will largely depend on the resources available, the cultural norms for dealing with this type of trauma and the occurrence of other sources of trauma such as poverty or war. A standardized metric to assess for the specific impacts of trauma is needed to inform culturally and contextually appropriate interventions.

- In order to develop standardized, culturally appropriate metrics, it would be helpful to identify locally run entities, such as religious organizations, educational institutions, non-governmental organizations or public service organizations, which are familiar with the cultural context of the specific community, nation or people group in which an intervention would take place. Partner with these entities and utilize their knowledge and experience to inform the creation or adaptation of standardized assessment measures.

- It is important to note that many of the measures used among treatment studies reviewed utilized PTSD measures normed on Western population. Greater efforts are needed to validate the efficacy of PTSD measures sub-Sahara Africa. More detailed validity and reliability reports are also needed in future research, as current reports among treatment focused studies were spotty at best.

- Develop assessment tools that measure community-wide trauma impact and not strictly PTSD or other individual, pathological responses to trauma. This includes

developing community-based interventions that may provide healing to an entire community, rather than select members. Constructs of trauma should be derived from the community itself, rather than imposed based on accepted Western definitions and manifestations of trauma.

- More attention is also needed on community-based interventions. For example, Amone-P'Olak (2005) found support programs, such as training in entrepreneurial skills and teaching coping skills to formerly abducted girls in northern Uganda, as effective approaches to help buffer against trauma.
  .
- Steps should be taken to ensure interventions are culturally contextualized. Attempts to validate psychological constructs and interventions in cultures other than the one in which they were developed should adopt an anthropological bent, in which observed behaviors and practices are integrated into the intervention. This is exhibited by the dance/movement therapy used in Sierra Leone (Harris, 2007). By taking into account community, tribal, and religious differences, addressing the cost of trauma through interventions becomes a much more robust endeavor.

- Consider the interaction of domains of trauma, rather than attempting to only measure or address the cost of trauma on a domain-specific basis. For example, Alonso (2011) looked at how many work days an individual misses due to psychological or physical illness, but how does this interact with a lack of infrastructure, living in chronic poverty, or the absence of social support? Efforts should be made to understand the interaction between domains of trauma to inform development and implementation of interventions, as interactions may actually increase cost that may not otherwise go unobserved.

- Only a handful of empirical articles have attempted to quantify the economic cost of trauma in sub-Saharan Africa. More research is needed with this area of focus to help guide future efforts. Specific foci might include estimating the cost of trauma to assist with: maximizing resources, assisting with fundraising efforts, enhancing fiscal accountability of service delivery, and improving sustainability and scale-ability of services.

- Alternative models for quantifying and estimating the cost of trauma are needed in sub-Sahara Africa. Building on the current available research, future studies ought to expand quantitative models that will incorporate a wider range of contextual and trauma factors. Researchers should also look beyond the current literature to identify novel measurement models from other fields of study (e.g., healthcare) for quantifying the cost of trauma, such as rating, categorical, or ranking systems (e.g., report card systems).

- Consider alternative trauma outcome measures, such as resilience measures. Exploring individual

differences and community perspectives and practices that contribute to positive outcome trajectories following trauma is essential to help strengthen sub-Saharan Africa from within. This may also assist with breaking down the victim/helper mentality with which many well-meaning individuals and organizations approach interventions.

## Conclusion

Despite being widely acknowledged and researched, trauma in sub-Saharan Africa remains a complex problem affecting individuals and communities in complex ways. Effectively addressing trauma in this context requires combining an anthropologist's observational abilities with a scientist's methodological integrity, infused with a counselor's compassion for suffering. This multi-faceted perspective helps to broaden and deepen the current approaches to conceptualizing trauma, evaluating its cost, and intervening on behalf of those impacted by trauma.

Rather than being overwhelmed by the task that lies ahead, the authors of this report assert that the greatest resources for addressing trauma in sub-Saharan Africa are the sub-Saharan African communities themselves. Merging the best of Western psychology with the best of sub-Saharan community knowledge and experience will yield more effective approaches to understanding and addressing the cost of trauma.

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Vinck, P., & Pham, P. N. (2010). Association of exposure to violence and potential traumatic events with self-reported physical and mental health status in the Central African Republic. *JAMA: Journal Of The American Medical Association, 304*(5), 544-552. doi:10.1001/jama.2010.1065

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# APPENDIXES

# APPENDIX A

## Annotated Bibliography Of Research Reviewed

**Abor, P. A. (2006). Female genital mutilation: Psychological and reproductive health consequences. The case of Kayoro traditional area in Ghana. *Gender & Behaviour, 4*(1), 659-684.**

The study examined the reproductive health and psychological effects of female genital mutilation, in one traditional area in the Upper East region (i.e. Kayoro Traditional Area) of Ghana. The results of the study revealed that, the practice of FGM actually affects the physical (deforming the female genitalia), psychological (the mental torture due to pain experienced during the circumcision and also the fear of the unknown which includes medical examination which will involve touching of the genitalia as well as sexual intercourse), and the reproductive health consequen ces ranging from various forms, including immediate complications such as bleeding, sepsis, and to later complications such as child birth complications and even death. Recommendations were made to the public, policy makers and NGOs with the aim of reducing and if possible eradicate the practice. (PsycINFO Database Record (c) 2012 APA, all rights reserved) (journal abstract)

**Adam, J., De Cordier, B., Titeca, K., & Vlassenroot, K. (2007). In the name of the father? Christian militantism in Tripura, Northern Uganda, and Ambon. *Studies in Conflict & Terrorism, 30*(11), 963-983. doi: 10.1080/10576100701611288**

Although armed groups and political violence referring to Islam have attracted increasing attention since the start of the global war against terror, one particular religion can hardly be described as the main source of inspiration of what is commonly referred to as "terrorist acts of violence." Faith-based violence occurs in different parts of the world and its perpetrators adhere to all major world faiths including Christianity. As such, this article treats three cases of non-state armed actors that explain their actions as being motivated by Christian beliefs and aimed at the creation of a new local society that is guided by religion: the National Liberation Front of Tripura, the Lord's Resistance Army, and the Ambonese Christian militias. It analyzes the way by which they instrumentalized religion against respective backgrounds of conflict rooted in social change, the erosion of traditional identities, imbalances of power, and widening communautarian faultlines. (PsycINFO Database Record (c) 2012 APA, all rights reserved) (journal abstract)

**Adeyinka, D. A., Oladimeji, O., & Aimakhu, C. (2009). Female genital cutting: Its perception and practice in Igbo-Ora community, Nigeria. *International Journal of Child Health and Human Development, 2*(2), 143-150.**

Female genital cutting (FGC) or female circumcision is a human right violation that prevents girls from enjoying optimal health and maturation. Despite international agreements, it is still common worldwide and affects millions especially in the developing countries. Objective. To assess the knowledge, prevalence, practice and attitudes to FGC and its health implication in Igbo-Ora Community. Methods. A survey was conducted among 280 people above the age 18 years in Igbo-Ora town using a multi-staged sampling technique with an appropriate interviewer administered semi-structured questionnaire. Results. More than 78.7% girls and women in Igbo-

Ora had undergone FGC. Despite high awareness (97.5%), only a few (30.7%) knew about the health consequences. It was practiced by people from all social classes and women with more education were less likely to practice FGC. There was strong adherence to tradition and beliefs and the patriarchal nature of the society as many disapproved its abolition especially people of younger age group (58.1%) with more men than women. More practiced among Muslims, 63.8%. The traditional doctors did not have health training, use anesthesia or sterilize the circumcision instruments. A majority (84.8%) had no knowledge about the enacted legislation regarding FGC in Nigeria. Conclusion. This suggests that the younger generations may have lesser access to FGC information and are more influenced by tradition. Hence, efforts to end it require understanding and changing their beliefs. Focusing largely on gathering information and speaking out about FGC at international, regional and national levels is critical in encouraging its abandonment. (PsycINFO Database Record (c) 2012 APA, all rights reserved) (journal abstract)

**Akello, G., Reis, R., & Richters, A. (2010). Silencing distressed children in the context of war in northern Uganda: An analysis of its dynamics and its health consequences.** ***Social Science & Medicine, 71*****(2), 213-220. doi: 10.1016/j.socscimed.2010.03.030**

Children in northern Uganda who are the focus of this article were born and raised in the context of war. The research presented here is based on a one-year ethnographic study (2004-2005) with children aged 9-16 years. Various qualitative and quantitative methods used in this study were geared to this age group. A grounded theory approach was followed to trace the reasons for the silencing of their distress. Throughout the study a child actor perspective was implemented: children were approached as social actors capable of processing social experience and devising ways of coping with life. We found that their lives were characterized by high rates of exposure to extreme events, such as deaths, child abductions, disease epidemics, gender-based violence and poverty. As a consequence, their level of emotional distress was high. However, they did not readily speak about their distress. The article identifies and analyses a complex set of reasons for children's distress and its silencing by the children themselves and other members of society. A distinction is made between the processes of victim blaming, self blaming, mimetic resilience and mirroring resilience. In addition, the consequences of the silencing children are presented. Children expressed their emotional suffering primarily in physical aches and pains and used pharmaceuticals and herbal medicines to minimize their distress. The result was a medicalization of psychological distress. In conclusion, we reflect on the necessity of a multi-pronged approach to address children's distress. (PsycINFO Database Record (c) 2012 APA, all rights reserved) (journal abstract)

**Akello, G., Richters, A., & Reis, R. (2006). Reintegration of former child soldiers in northern Uganda: Coming to terms with children's agency and accountability.** ***Intervention: International Journal of Mental Health, Psychosocial Work & Counselling in Areas of Armed Conflict, 4*****(3), 229-243. doi: 10.1097/WTF.0b013e3280121c00**

Reintegration processes of formerly abducted children have yielded limited success in northern Uganda. The article seeks answers to the question why reintegration processes in the area have failed. The approach of one Christian non-governmental organization towards reintegration is compared with the ideas and strategies of formerly abducted child soldiers and people in their communities on how best to deal with their violent past. (PsycINFO Database Record (c) 2012 APA, all rights reserved) (journal abstract)

**Akresh, R., Bhalotra, S., Leone, M., & Osili, U. (2011). *War and Stature: Growing Up During the Nigerian Civil War*. Department of Economics, University of Bristol, UK, The Centre for Market and Public Organisation. Retrieved from http://ezproxy.wheaton.edu/login?url=http://search.ebscohost.com/login.aspx?direct=true&db=ecn&AN=1290393&site=ehost-live http://www.bristol.ac.uk/cmpo/publications/papers/2011/wp279.pdf**

**Akresh, R., Lucchetti, L., & Thirumurthy, H. (2012). Wars and child health: Evidence from the Eritrean–Ethiopian conflict. *Journal of Development Economics, 99*(2), 330-340. doi: 10.1016/j.jdeveco.2012.04.001**

Conflict between and within countries can have lasting health and economic consequences, but identifying such effects can be empirically challenging. This paper uses household survey data from Eritrea to estimate the effect of exposure to the 1998–2000 Eritrea–Ethiopia war on children's health. The identification strategy exploits exogenous variation in the conflict's geographic extent and timing and the exposure of different birth cohorts to the fighting. The unique survey data include details on each household's migration history, which allows us to measure a child's geographic location during the war and without which war exposure would be incorrectly classified. War-exposed children have lower height-for-age Z-scores, with similar effects for children born before or during the war. Both boys and girls who are born during the war experience negative impacts due to conflict. Effects are robust to including region-specific time trends, alternative conflict exposure measures, and mother fixed effects.

**Almroth, L., Almroth-Berggren, V., Hassanein, O. M., Al-Said, S. S. E., Hasan, S. S. A., Lithell, U.-B., et al. (2001). Male complications of female genital mutilation. *Social Science & Medicine, 53*(11), 1455-1460. doi: 10.1016/S0277-9536(00)00428-7**

The objectives of this study were to explore male complications and attitudes with regard to female genital mutilation (FGM). Interviews were carried out in a village in Sudan according to a pretested questionnaire, using structured questions with open-answer possibilities. Married men of the youngest parental generation and grandfathers were randomly selected from up-to-date election lists. 59 men were interviewed (29 young men, aged 26–43, and 30 grandfathers, 50–82 yrs old) as to their attitudes regarding FGM and their own physical and psychological complications. Male complications resulting from FGM, such as difficulty in penetration, wounds/infections on the penis and psychological problems were described by a majority of the men. Most men were also aware of the female complications. More young than old respondents would have accepted a woman without FGM to become their daughter-in-law ($p<0.03$). A majority of the young men would have preferred to marry a woman without FGM. This proportion was significantly higher than among the grandfathers ($p<0.01$). FGM can no longer be considered to be only an issue for women. The acknowledged male complications and attitudes described may open new possibilities to counteract the practice of FGM. (PsycINFO Database Record (c) 2012 APA, all rights reserved)

**Alonso, J., Petukhova, M., Vilagut, G., Chatterji, S., Heeringa, S., Üstün, T. B., et al. (2011). Days out of role due to common physical and mental conditions: Results from the WHO World Mental Health surveys.** ***Molecular Psychiatry, 16*****(12), 1234-1246. doi: 10.1038/mp.2010.101**

Days out of role because of health problems are a major source of lost human capital. We examined the relative importance of commonly occurring physical and mental disorders in accounting for days out of role in 24 countries that participated in the World Health Organization (WHO) World Mental Health (WMH) surveys. Face-to-face interviews were carried out with 62971 respondents (72.0% pooled response rate). Presence of ten chronic physical disorders and nine mental disorders was assessed for each respondent along with information about the number of days in the past month each respondent reported being totally unable to work or carry out their other normal daily activities because of problems with either physical or mental health. Multiple regression analysis was used to estimate associations of specific conditions and comorbidities with days out of role, controlling by basic socio-demographics (age, gender, employment status and country). Overall, 12.8% of respondents had some day totally out of role, with a median of 51.1 a year. The strongest individual-level effects (days out of role per year) were associated with neurological disorders (17.4), bipolar disorder (17.3) and post-traumatic stress disorder (15.2). The strongest population-level effect was associated with pain conditions, which accounted for 21.5% of all days out of role (population attributable risk proportion). The 19 conditions accounted for 62.2% of all days out of role. Common health conditions, including mental disorders, make up a large proportion of the number of days out of role across a wide range of countries and should be addressed to substantially increase overall productivity. (PsycINFO Database Record (c) 2012 APA, all rights reserved) (journal abstract)

**Amone-P'Olak, K. (2005). Psychological impact of war and sexual abuse on adolescent girls in Northern Uganda.** ***Intervention: International Journal of Mental Health, Psychosocial Work & Counselling in Areas of Armed Conflict, 3*****(1), 33-45.**

In this article, war experiences, psychological symptoms, post traumatic stress disorder (PTSD) symptomatology, and the physical and sexual abuses of formerly abducted girls in Northern Uganda were assessed. In a cross-sectional self-report design, questionnaires were administered to 123 formerly abducted girls. Data originating from records at three rehabilitation centres were analysed. The girls had been exposed to horrific war events, participated in shocking atrocities, were physically and sexually abused, and diagnosed with diseases resulting from their abduction. As a result, many are psychologically distressed. There are child mothers and a few were pregnant at the time of the study. Training in entrepreneurial skills and teaching better coping skills are suggested as activities in psychosocial intervention. (PsycINFO Database Record (c) 2012 APA, all rights reserved) (journal abstract)

**Andersson, N., Cockcroft, A., & Shea, B. (2008). Gender-based violence and HIV: Relevance for HIV prevention in hyperendemic countries of Southern Africa.** ***AIDS, 22*****(Suppl4), S73-S86. doi: 10.1097/01.aids.0000341778.73038.86**

Gender-based violence (GBV) is common in southern Africa. Here we use GBV to include sexual and non-sexual physical violence, emotional abuse, and forms of child sexual abuse. A sizeable literature now links GBV and HIV infection. Sexual violence can lead to HIV infection directly, as trauma increases the risk of transmission. More importantly, GBV increases HIV risk indirectly. Victims of childhood sexual abuse are more likely to be HIV positive, and to

have high risk behaviours. GBV perpetrators are at risk of HIV infection, as their victims have often been victimised before and have a high risk of infection. Including perpetrators and victims, perhaps one third of the southern African population is involved in the GBV-HIV dynamic. A randomised controlled trial of income enhancement and gender training reduced GBV and HIV risk behaviours, and a trial of a learning programme reported a non-significant reduction in HIV incidence and reduction of male risk behaviours (primary prevention). Interventions among survivors of GBV can reduce their HIV risk (secondary prevention). Various strategies can reduce spread of HIV from infected GBV survivors (tertiary prevention). Dealing with GBV could have an important effect on the HIV epidemic. A policy shift is necessary. HIV prevention policy should recognise the direct and indirect implications of GBV for HIV prevention, the importance of perpetrator dynamics, and that reduction of GBV should be part of HIV prevention programmes. Effective interventions are likely to include a structural component, and a GBV awareness component. (PsycINFO Database Record (c) 2012 APA, all rights reserved) (journal abstract)

**Annan, J., Blattman, C., Mazurana, D., & Carlson, K. (2011). Civil war, reintegration, and gender in Northern Uganda.** ***Journal of Conflict Resolution, 55*****(6), 877-908. doi: 10.1177/0022002711408013**

What are the impacts of war on the participants, and do they vary by gender? Are ex-combatants damaged pariahs who threaten social stability, as some fear? Existing theory and evidence are both inconclusive and focused on males. New data and a tragic natural quasi-experiment in Uganda allow us to estimate the impacts of war on both genders, and assess how war experiences affect reintegration success. As expected, violence drives social and psychological problems, especially among females. Unexpectedly, however, most women returning from armed groups reintegrate socially and are resilient. Partly for this reason, postconflict hostility is low. Theories that war conditions youth into violence find little support. Finally, the findings confirm a human capital view of recruitment: economic gaps are driven by time away from civilian education and labor markets. Unlike males, however, females have few civilian opportunities and so they see little adverse economic impact of recruitment. (PsycINFO Database Record (c) 2012 APA, all rights reserved) (journal abstract)

**Ano, G. G., & Vasconcelles, E. B. (2005). Religious Coping and Psychological Adjustment to Stress: A Meta-Analysis.** ***Journal Of Clinical Psychology*****,** ***61*****(4), 461-480. doi:10.1002/jclp.20049**

A growing body of literature suggests that people often turn to religion when coping with stressful events. However, studies on the efficacy of religious coping for people dealing with stressful situations have yielded mixed results. No published studies to date have attempted to quantitatively synthesize the research on religious coping and psychological adjustment to stress. The purpose of the current study was to synthesize the research on situation-specific religious coping methods and quantitatively determine their efficacy for people dealing with stressful situations. A meta-analysis of 49 relevant studies with a total of 105 effect sizes was conducted in order to quantitatively examine the relationship between religious coping and psychological adjustment to stress. Four types of relationships were investigated: positive religious coping with positive psychological adjustment, positive religious coping with negative psychological adjustment, negative religious coping with positive psychological adjustment, and negative religious coping with negative psychological adjustment. The results of the study generally

supported the hypotheses that positive and negative forms of religious coping are related to positive and negative psychological adjustment to stress, respectively. Implications of the findings and their limitations are discussed. (PsycINFO Database Record (c) 2012 APA, all rights reserved)

**Askew, I. (2005). Methodological issues in measuring the impact of interventions against female genital cutting. *Culture, Health & Sexuality, 7*(5), 463-477. doi: 10.1080/13691050410001701939**

With increasing efforts being made to introduce systematic interventions for encouraging abandonment of female genital cutting (FGC) comes the need to better understand how such interventions work and what effects they have. Many interventions are based on theoretical models of behaviour change and so studies to evaluate them should develop indicators appropriate to the type of behaviour change anticipated. Systematic evaluations need also to use some form of quasi-experimental design to be able to attribute change to the intervention and not to any 'natural' change in FGC behaviour or other activities that may be concurrent. A sustained change in the prevalence of FGC is the ultimate indicator and there are several ways this can be measured, although with many limitations given the intimate nature of the practice. Moreover, appropriate sample sizes must be calculated and used to be able to draw valid conclusions. Many of those implementing FGC interventions are not familiar with such basic research principles and so there is an urgent need to ensure that projects are well designed so that valid conclusions concerning their effectiveness can be drawn. (PsycINFO Database Record (c) 2012 APA, all rights reserved) (journal abstract)

**Baez, J. E. (2011). Civil Wars beyond Their Borders: The Human Capital and Health Consequences of Hosting Refugees. *Journal of Development Economics, 96*(2), 391-408. doi: http://www.elsevier.com/wps/find/journaldescription.cws_home/505546/description#description**

In early 1994, Kagera--a region in northwestern Tanzania--was flooded by more than 500,000 refugees fleeing from the genocides of Burundi and Rwanda. I use this population shock and a series of topographic barriers that resulted in variation in refugee intensity to investigate the short- and long-run causal effects of hosting refugees on outcomes of local children. This strategy provides evidence of adverse impacts over one year after the shock: a worsening of children's anthropometrics (0.3 standard deviations), an increase in the incidence of infectious diseases (15-20 percentage points) and an increase in mortality for children under five (7 percentage points). I also find that intra- and inter-cohort variation in childhood exposure to the refugee crisis reduced height in early adulthood by 1.8 cm (1.2%), schooling by 0.2 years (7.1%) and literacy by 7 percentage points (8.6%). Designs using the distance to the border with Rwanda as an alternative identification strategy for refugee intensity support the findings. The estimates are robust across different samples, specifications and estimation methods and provide evidence of a previously undocumented indirect effect of civil wars on the well-being of children and subsequent economic growth in refugee-hosting communities.

**Bayer, C. P., Klasen, F., & Adam, H. (2007). Association of trauma and PTSD symptoms with openness to reconciliation and feelings of revenge among former Ugandan and Congolese child soldiers. *JAMA: Journal of the American Medical Association, 298*(5), 555-559. doi: 10.1001/jama.298.5.555**

Context: Tens of thousands of the estimated 250,000 child soldiers worldwide are abused or have been abused during the last decade in Africa's Great Lakes Region. In the process of rebuilding the war-torn societies, it is important to understand how psychological trauma may shape the former child soldiers' ability to reconcile. Objective: To investigate the association of posttraumatic stress disorder (PTSD) symptoms and openness to reconciliation and feelings of revenge in former Ugandan and Congolese child soldiers. Design, Setting, and Participants: Cross-sectional field study of 169 former child soldiers (aged 11-18 years) in rehabilitation centers in Uganda and the Democratic Republic of the Congo, conducted in 2005. Main Outcome Measures: Potentially traumatic war-related experiences assessed via a sample-specific events scale; PTSD symptoms assessed using the Child Posttraumatic Stress Disorder Reaction Index (CPTSD-RI), with a score of 35 or higher indicating clinically important PTSD symptoms; and openness to reconciliation and feelings of revenge assessed via structured questionnaires. Results: Children participating in this study were a mean of 15.3 years old. These former child soldiers reported that they had been (violently) recruited by armed forces at a young age (mean [SD], 12.1 [2] years), had served a mean of 38 months (SD, 24 months), and had been demobilized a mean of 2.3 months before data collection (SD, 2.4 months). The children were exposed to a high level of potentially traumatic events (mean [SD], 11.1 [2.99]). The most commonly reported traumatic experiences were having witnessed shooting (92.9%), having witnessed someone wounded (89.9%), and having been seriously beaten (84%). A total of 54.4% reported having killed someone, and 27.8% reported that they were forced to engage in sexual contact. Of the 169 interviewed, 59 (34.9%; 95% confidence interval, 34.4%-35.4%) had a PTSD symptom score higher than 35. Children who showed more PTSD symptoms had significantly less openness to reconciliation (p=-0.34, P< .001) and more feelings of revenge (p=0.29, P<.001). Conclusions: PTSD symptoms are associated with less openness to reconciliation and more feelings of revenge among former Ugandan and Congolese child soldiers. The effect of psychological trauma should be considered when these children are rehabilitated and reintegrated into civilian society. (PsycINFO Database Record (c) 2012 APA, all rights reserved) (journal abstract)

**Betancourt, T. S., Agnew-Blais, J., Gilman, S. E., Williams, D. R., & Ellis, B. H. (2010). Past horrors, present struggles: The role of stigma in the association between war experiences and psychosocial adjustment among former child soldiers in Sierra Leone. *Social Science & Medicine, 70*(1), 17-26. doi: 10.1016/j.socscimed.2009.09.038**

Upon returning to their communities, children formerly associated with armed forces and armed groups-commonly referred to as child soldiers-often confront significant community stigma. Much research on the reintegration and rehabilitation of child soldiers has focused on exposure to past war-related violence and mental health outcomes, yet no empirical work has yet examined the role that post-conflict stigma plays in shaping long-term psychosocial adjustment. Two waves of data are used in this paper from the first prospective study of male and female former child soldiers in Sierra Leone. We examined the role of stigma (manifest in discrimination as well as lower levels of community and family acceptance) in the relationship between war-related experiences and psychosocial adjustment (depression, anxiety, hostility and

adaptive behaviors). Former child soldiers differ from one another with regard to their post-war experiences, and these differences profoundly shape their psychosocial adjustment over time. Consistent with social stress theory, we observed that post-conflict factors such as stigma can play an important role in shaping psychosocial adjustment in former child soldiers. We found that discrimination was inversely associated with family and community acceptance. Additionally, higher levels of family acceptance were associated with decreased hostility, while improvements in community acceptance were associated with adaptive attitudes and behaviors. We found that post-conflict experiences of discrimination largely explained the relationship between past involvement in wounding/killing others and subsequent increases in hostility. Stigma similarly mediated the relationship between surviving rape and depression. However, surviving rape continued to demonstrate independent effects on increases in anxiety, hostility and adaptive/prosocial behaviors after adjusting for other variables. These findings point to the complexity of psychosocial adjustment and community reintegration in these youth and have a number of programmatic and policy implications. (PsycINFO Database Record (c) 2012 APA, all rights reserved) (journal abstract)

**Bishai, D., Bonnenfant, Y.-T., Darwish, M., Adam, T., Bathija, H., Johansen, E., . . . Organization, F. G. M. C. S. G. o. W. H. (2010). Estimating the obstetric costs of female genital mutilation in six African countries. *Bulletin of the World Health Organization, 88*(4), 281-288.**

OBJECTIVE: To estimate the cost to the health system of obstetric complications due to female genital mutilation (FGM) in six African countries.; METHODS: A multistate model depicted six cohorts of 100,000 15-year-old girls who survived until the age of 45 years. Cohort members were modelled to have various degrees of FGM, to undergo childbirth according to each country's mortality and fertility statistics, and to have medically attended deliveries at the frequency observed in the relevant country. The risk of obstetric complications was estimated based on a 2006 study of 28,393 women. The costs of each complication were estimated in purchasing power parity dollars (I$) for 2008 and discounted at 3%. The model also tracked life years lost owing to fatal obstetric haemorrhage. Multivariate sensitivity analysis was used to estimate the uncertainty around the findings.; FINDINGS: The annual costs of FGM-related obstetric complications in the six African countries studied amounted to I$ 3.7 million and ranged from 0.1 to 1% of government spending on health for women aged 15-45 years. In the current population of 2.8 million 15-year-old women in the six African countries, a loss of 130,000 life years is expected owing to FGM's association with obstetric haemorrhage. This is equivalent to losing half a month from each lifespan.; CONCLUSION: Beyond the immense psychological trauma it entails, FGM imposes large financial costs and loss of life. The cost of government efforts to prevent FGM will be offset by savings from preventing obstetric complications. (journal abstract)

**Blattman, C., & Annan, J. (2010). The Consequences of Child Soldiering. *Review of Economics and Statistics, 92*(4), 882-898. doi: http://www.mitpressjournals.org/loi/rest**

Little is known about the impacts of military service on human capital and labor market outcomes due to an absence of data as well as sample selection: recruits are self-selected, screened, and selectively survive. We examine the case of Uganda, where rebel recruitment methods provide exogenous variation in conscription. Economic and educational impacts are widespread and persistent: schooling falls by nearly a year, skilled employment halves, and

earnings drop by a third. Military service seems to be a poor substitute for schooling. Psychological distress is evident among those exposed to severe war violence and is not limited to ex-combatants.

**Bolton, P. (2001). Local perceptions of the mental health effects of the Rwandan genocide. *Journal of Nervous and Mental Disease, 189*(4), 243-248. doi: 10.1097/00005053-200104000-00006**

Investigated how Rwandans perceive the mental health effects of the 1994 genocide, examined the local validity of western mental illness concepts, and (if the concepts were valid) provided data to adapt mental health assessment instruments for local use. Three ethnographic methods were used to interview people in 2 rural areas in Rwanda: 1st, free listing provided a list of local terms for mental symptoms and disorders; 2nd, key informant interviews then provided more detailed information about these disorders; and finally, pile sorts confirmed the relationships among symptoms and disorders that emerged from the other methods. It was found that Ss described the diagnostic symptoms of depression and posttraumatic stress disorder as results of the genocide and also described associated "local" symptoms not included in the established diagnostic criteria. Ss divided symptoms into a "mental trauma" syndrome that included the posttraumatic stress disorder (PTSD) symptoms and some depression and local symptoms, and a grief syndrome including other depression and local symptoms. In the pile sorts, 4 of the locally described symptoms formed part of a local depression-like illness. Results suggest that depression occurs in this population and support the local content validity of depression assessment instruments. (PsycINFO Database Record (c) 2012 APA, all rights reserved)

**Byaruhanga, E., Cantor-Graae, E., Maling, S., & Kabakyenga, J. (2008). Pioneering work in mental health outreach in rural southwestern Uganda. *Intervention: International Journal of Mental Health, Psychosocial Work & Counselling in Areas of Armed Conflict, 6*(2), 117-131. doi: 10.1097/WTF.0b013e328307ed56**

In Uganda, the rates of mental illness are high due to poverty, high prevalence of HIV/AIDS and long-term exposure to civil wars and armed rebellion. The cost of mental health services in urban hospitals remains prohibitive for the rural poor who resort to traditional healers, and many mental health workers prefer working in urban areas. In response, a community outreach program has been developed in rural, southwestern Uganda to deliver effective mental health care. The programme was aimed at improving access to psychiatric care by taking services to communities where the majority of the rural population live, yet where services were non-existent. Baseline information on the training needs was collected by interviewing health workers in rural health units, and the need for a mental health service was assessed by interviewing members of the community and local leaders. Records of local health units were also reviewed. The result of the programme has shown that marginalized and neglected people with mental disorders have been able to access mental health care. Through increasing knowledge and access to psychiatric services in the community, mental health problems and psychological problems can be managed effectively with little need for referral to larger hospitals. (PsycINFO Database Record (c) 2012 APA, all rights reserved) (journal abstract)

**Chisholm, D., Lund, C., & Saxena, S. (2007). Cost of scaling up mental healthcare in low- and middle-income countries. *The British Journal of Psychiatry, 191*(6), 528-535. doi:**

**10.1192/bjp.bp.107.038463**

Background: No systematic attempt has been made to calculate the costs of scaling up mental health services in low- and middle-income countries. Aims: To estimate the expenditures needed to scale up the delivery of an essential mental healthcare package over a 10-year period (2006-2015). Method: A core package was defined, comprising pharmacological and/or psychosocial treatment of schizophrenia, bipolar disorder, depression and hazardous alcohol use. Current service levels in 12 selected low- and middle-income countries were established using the WHO-AIMS assessment tool. Target-level resource needs were derived from published need assessments and economic evaluations. Results: The cost per capita of providing the core package at target coverage levels (in US dollars) ranged from $1.85 to $2.60 per year in low-income countries and $3.20 to $6.25 per year in lower-middle-income countries, an additional annual investment of $0.18-0.55 per capita. Conclusions: Although significant new resources need to be invested, the absolute amount is not large when considered at the population level and against other health investment strategies. (PsycINFO Database Record (c) 2012 APA, all rights reserved) (journal abstract)

**Cluver, L., Fincham, D. S., & Seedat, S. (2009). Posttraumatic stress in AIDS-orphaned children exposed to high levels of trauma: The protective role of perceived social support. *Journal of Traumatic Stress, 22*(2), 106-112. doi: 10.1002/jts.20396**

Poor urban children in South Africa are exposed to multiple community traumas, but AIDS-orphaned children are at particular risk for posttraumatic stress. This study examined the hypothesis that social support may moderate the relationship between trauma exposure and posttraumatic stress for this group. Four hundred twenty-five AIDS-orphaned children were interviewed using standardized measures of psychopathology. Compared to participants with low perceived social support, those with high perceived social support demonstrated significantly lower levels of PTSD symptoms after both low and high levels of trauma exposure. This suggests that strong perception of social support from carers, school staff, and friends may lessen deleterious effects of exposure to trauma, and could be a focus of intervention efforts to improve psychological outcomes for AIDS-orphaned children. (PsycINFO Database Record (c) 2012 APA, all rights reserved) (journal abstract)

**Cohen, M. H., Fabri, M., Cai, X., Shi, Q., Hoover, D. R., Binagwaho, A., et al. (2009). Prevalence and predictors of posttraumatic stress disorder and depression in HIV-infected and at-risk Rwandan women. *Journal of Women's Health, 18*(11), 1783-1791. doi: 10.1089/jwh.2009.1367**

Objective: During the 1994 Rwandan genocide, rape was used as a weapon of war to transmit HIV. This study measures trauma experiences of Rwandan women and identifies predictors associated with posttraumatic stress disorder (PTSD) and depressive symptoms. Methods: The Rwandan Women's Interassociation Study and Assessment (RWISA) is a prospective observational cohort study designed to assess effectiveness and toxicity of antiretroviral therapy in HIV-infected Rwandan women. In 2005, a Rwandan-adapted Harvard Trauma Questionnaire (HTQ) and the Center for Epidemiologic Studies Depression Scale (CES-D) were used to assess genocide trauma events and prevalence of PTSD (HTQ mean > 2) and depressive symptoms (CES-D ≥ 16) for 850 women (658 HIV-positive and 192 HIV-negative). Results: PTSD was common in HIV-positive (58%) and HIV-negative women (66%) ( p = 0.05). Women with HIV had a higher prevalence of depressive symptoms than HIV-negative women

(81% vs. 65%, p < 0.0001). Independent predictors for increased PTSD were experiencing more genocide-related trauma events and having more depressive symptoms. Independent predictors for increased depressive symptoms were making <$18 a month, HIV infection (and, among HIV-positive women, having lower CD4 cell counts), a history of genocidal rape, and having more PTSD symptoms. Conclusions: The prevalence of PTSD and depressive symptoms is high in women in the RWISA cohort. Four of five HIV-infected women had depressive symptoms, with highest rates among women with CD4 cell counts <200. In addition to treatment with antiretroviral therapy, economic empowerment and identification and treatment of depression and PTSD may reduce morbidity and mortality among women in postconflict countries. (PsycINFO Database Record (c) 2012 APA, all rights reserved) (journal abstract)

**Connolly, S., & Sakai, C. (2011). Brief trauma intervention with Rwandan genocide-survivors using Thought Field Therapy. *International Journal of Emergency Mental Health, 13*(3), 161-172.**

This randomized waitlist control study examined the efficacy of Thought Field Therapy (TFT) in reducing Posttraumatic Stress Disorder symptoms in survivors of the 1994 genocide in Rwanda. Participants included 145 adult genocide survivors randomly assigned to an immediate TFT treatment group or a waitlist control group. Group differences adjusted for pretest scores and repeated measures anovas were statistically significant at p < .001 for 9 of 10 TSI trauma subscales and for both severity and frequency on the MPSS, with moderate to large effect sizes. Reduced trauma symptoms for the group receiving TFT were found for all scales. Reductions in trauma symptoms were sustained at a 2-year follow-up assessment. Limitations, clinical implications, and future research are discussed. (PsycINFO Database Record (c) 2012 APA, all rights reserved) (journal abstract)

**Deininger, K. (2003). Causes and Consequences of Civil Strife: Micro-level Evidence from Uganda. *Oxford Economic Papers, 55*(4), 579-606. doi: http://oep.oxfordjournals.org/**

To bridge the gap between case studies and highly aggregate cross-country analyses of civil unrest, we use data from Uganda to explore determinants of civil strife (as contrasted to theft and physical violence) at the community level, as well as the potentially differential impact of these variables on investment and non-agricultural enterprise formation at the household level. We find that distance from infrastructure (a proxy for scarcity of economic opportunities and government investment), asset inequality (social tension), presence of cash crops (expropriable wealth), and lower levels of human capital (ability to take advantage of opportunities in the "regular" economy) all increase the propensity for civil strife. Furthermore, civil strife, in marked contrast to violence and theft, reduces investment and non-agricultural enterprise startups.

**Denov, M. (2010). Coping with the trauma of war: Former child soldiers in post-conflict Sierra Leone. *International Social Work, 53*(6), 791-806. doi: 10.1177/0020872809358400**

Children across the globe have been implicated in armed conflict as both victims and participants. During Sierra Leone's decade-long civil war, thousands of children, both boys and girls, participated directly in armed conflict or were recruited for labour or sexual exploitation in armed groups. Drawing upon in-depth interviews with 80 children formerly associated with Sierra Leone's Revolutionary United Front, this paper explores children's experiences of violence during the armed conflict, traces the realities that children faced in the aftermath of the war, and examines the ways in which participants attempted to cope with the war's profound

after-effects. The paper concludes with a discussion of the implications for social work. (PsycINFO Database Record (c) 2012 APA, all rights reserved) (journal abstract)

**Derluyn, I., Broekaert, E., Schuyten, G., & Temmerman, E. D. (2004). Post-traumatic stress in former Ugandan child soldiers. *The Lancet, 363*(9412), 861-863. doi: 10.1016/S0140-6736(04)15734-6**

Worldwide, 300,000 children are currently used as child soldiers in armed conflicts. We interviewed 301 former child soldiers who had been abducted by the northern Ugandan rebellion movement Lord's Resistance Army. All the children were abducted at a young age (mean 12.9 years) and for a long time (mean 744 days). Almost all the children experienced several traumatic events (mean six events); 233 (77%) saw someone being killed, and 118 (39%) had to kill someone themselves. 71 children also filled in the impact of event scale--revised to assess their post-trauma stress reactions. 69 (97%) reported post-traumatic stress reactions of clinical importance. The death of a parent, especially of the mother, led to an important increase in score for avoidance symptoms (mother alive 16.4, mother not alive 21.6; p=0.04), with a high increase for girls (from 15.1 to 25.8), but almost no change for boys (from 17.7 to 17.4; p=0.02). Our findings shed light on the nature of severe trauma experienced by this group of children, and show a high rate of post-traumatic stress reactions. (PsycINFO Database Record (c) 2012 APA, all rights reserved) (journal abstract)

**Devries, K., Watts, C., Yoshihama, M., Kiss, L., Schraiber, L. B., Deyessa, N., et al. (2011). Violence against women is strongly associated with suicide attempts: Evidence from the WHO multi-country study on women's health and domestic violence against women. *Social Science & Medicine, 73*(1), 79-86. doi: 10.1016/j.socscimed.2011.05.006**

Suicidal behaviours are one of the most important contributors to the global burden of disease among women, but little is known about prevalence and modifiable risk factors in low and middle income countries. We use data from the WHO multi-country study on women's health and domestic violence against women to examine the prevalence of suicidal thoughts and attempts, and relationships between suicide attempts and mental health status, child sexual abuse, partner violence and other variables. Population representative cross-sectional household surveys were conducted from 2000-2003 in 13 provincial (more rural) and city (urban) sites in Brazil, Ethiopia, Japan, Namibia, Peru, Samoa, Serbia, Thailand and Tanzania. 20967 women aged 15-49 years participated. Prevalence of lifetime suicide attempts, lifetime suicidal thoughts, and suicidal thoughts in the past four weeks were calculated, and multivariate logistic regression models were fit to examine factors associated with suicide attempts in each site. Prevalence of lifetime suicide attempts ranged from 0.8% (Tanzania) to 12.0% (Peru city); lifetime thoughts of suicide from 7.2% (Tanzania province) to 29.0% (Peru province), and thoughts in the past four weeks from 1.9% (Serbia) to 13.6% (Peru province). 25-50% of women with suicidal thoughts in the past four weeks had also visited a health worker in that time. The most consistent risk factors for suicide attempts after adjusting for probable common mental health disorders were: intimate partner violence, non-partner physical violence, ever being divorced, separated or widowed, childhood sexual abuse and having a mother who had experienced intimate partner violence. Mental health policies and services must recognise the consistent relationship between violence and suicidality in women in low and middle income countries. Training health sector workers to recognize and respond to the consequences of violence may substantially reduce the health burden associated with suicidal behaviour. (PsycINFO Database Record (c) 2012 APA, all rights

reserved) (journal abstract)

**Diop, N. J., & Askew, I. (2009). The effectiveness of a community-based education program on abandoning female genital mutilation cutting in Senegal. *Studies in Family Planning, 40*(4), 307-318. doi: 10.1111/j.1728-4465.2009.00213.x**

A pre - and post-test comparison-group design was used to evaluate the effect of a community education program on community members' willingness to abandon female genital mutilation/cutting (FGM/C) in rural areas of southern Senegal. Developed by TOSTAN (a Senegalese nongovernmental organization), the education program aimed to empower women through a broad range of educational and health-promoting activities. Our findings suggest that information from the program was diffused widely within the intervention villages, as indicated by improvements in knowledge about and critical attitudes toward FGM/C among women and men who had and had not participated in the program, without corresponding improvement in the comparison villages. The prevalence of FGM/C among daughters aged ten years and younger decreased significantly over time as reported by women who were directly and indirectly exposed to the program, but not among daughters in the comparison villages, suggesting that the program had an impact on family behaviors as well as attitudes. Findings from this study provide evidence-based information to program planners seeking to empower women and discourage a harmful traditional practice. (PsycINFO Database Record (c) 2012 APA, all rights reserved) (journal abstract)

**Dodge, C. P. (1990). Health implications of war in Uganda and Sudan. *Social Science & Medicine, 31*(6), 691-698. doi: 10.1016/0277-9536(90)90251-m**

Civil war disrupted agriculture and trade in Uganda and Sudan. This reduced tax revenues and drained scarce resources away from health budgets to finance increased military expenditures. Hundreds and thousands of people were driven from their homes either as internally displaced people or as refugees. Normal health service delivery systems were broken down forcing doctors, nurses and other health professionals into towns, cities or neighbouring countries in search of peace and employment. Scores of hospitals, health centres and dispensaries were abandoned, destroyed or looted, rendering even the limited physical facilities useless. Preventive public health services such as immunization and provision of potable drinking water were discontinued leaving huge populations susceptible to controllable infections diseases and epidemics.

**Edwards, D. (2005). Post-traumatic stress disorder as a public health concern in South Africa. *Journal of Psychology in Africa; South of the Sahara, the Caribbean, and Afro-Latin America, 15*(2), 125-134.**

This article briefly surveys the extent to which traumatic events are a feature of life all over Africa and provides a comprehensive review of research that documents the pervasiveness of traumatic events in South Africa and the prevalence of PTSD symptoms. The material reviewed includes statistics on crime, violence and accidents, research from clinical settings, and surveys. Several provide evidence for the causal link between traumatic events and the development of PTSD. These studies show that PTSD has been and continues to be a significant problem for public health in South Africa, affecting individuals in all sectors of society and as much a concern with respect to children as to adults. (PsycINFO Database Record (c) 2012 APA, all rights reserved) (journal abstract)

**Ertl, V., Pfeiffer, A., Schauer, A., Elbert, T., & Neuner, F. (2011). Community-implemented trauma therapy for former child soldiers in Northern Uganda: A randomized controlled trial. *JAMA: Journal of the American Medical Association, 306*(5), 503-512. doi: 10.1001/jama.2011.1060**

Context: The psychological rehabilitation of former child soldiers and their successful reintegration into postconflict society present challenges. Despite high rates of impairment, there have been no randomized controlled trials examining the feasibility and efficacy of mental health interventions for former child soldiers. Objective: To assess the efficacy of a community-based intervention targeting symptoms of posttraumatic stress disorder (PTSD) in formerly abducted individuals. Design, Setting, and Participants: Randomized controlled trial recruiting 85 former child soldiers with PTSD from a population-based survey of 1113 Northern Ugandans aged 12 to 25 years, conducted between November 2007 and October 2009 in camps for internally displaced persons. Participants were randomized to 1 of 3 groups: narrative exposure therapy (n = 29), an academic catch-up program with elements of supportive counseling (n = 28), or a waiting list (n = 28). Symptoms of PTSD and trauma-related feelings of guilt were measured using the Clinician-Administered PTSD Scale. The respective sections of the Mini International Neuropsychiatric Interview were used to assess depression and suicide risk, and a locally adapted scale was used to measure perceived stigmatization. Symptoms of PTSD, depression, and related impairment were assessed before treatment and at 3 months, 6 months, and 12 months postintervention. Intervention: Treatments were carried out in 8 sessions by trained local lay therapists, directly in the communities. Main Outcome Measures: Change in PTSD severity, assessed over a 1-year period after treatment. Secondary outcome measures were depression symptoms, severity of suicidal ideation, feelings of guilt, and perceived stigmatization. Results: PTSD symptom severity (range, 0-148) was significantly more improved in the narrative exposure therapy group than in the academic catch-up (mean change difference, −14.06 [95% confidence interval, −27.19 to −0.92]) and waiting-list (mean change difference, −13.04 [95% confidence interval, −26.79 to 0.72]) groups. Contrast analyses of the time × treatment interaction of the mixed-effects model on PTSD symptom change over time revealed a superiority of narrative exposure therapy compared with academic catch-up (F[sub]1,234.1[/sub] = 5.21, P = .02) and wait-listing (F[sub]1,228.3[/sub] = 5.28, P = .02). Narrative exposure therapy produced a larger within-treatment effect size (Cohen d = 1.80) than academic catch-up (d = 0.83) and wait-listing (d = 0.81). Conclusion: Among former Ugandan child soldiers, short-term trauma-focused treatment compared either with an academic catch-up program including supportive counseling or with wait-listing resulted in greater reduction of PTSD symptoms. (PsycINFO Database Record (c) 2012 APA, all rights reserved) (journal abstract)

**Esere, M. O., Idowu, A. I., & Omotosho, J. A. (2009). Gender-based domestic violence against children: Experiences of girl-children in Nigeria. *Journal of Psychology in Africa, 19*(1), 107-112.**

This study investigated the dynamics of gender-based domestic violence against children in Nigeria. This qualitative study explored the experiences of 20 purposively selected girl-children (age range = 12 to 15 years) from two SOS Children's Village who have been victims of Domestic Violence (DV). Qualitative data on DV experiences and associated factors were collected through 6 Focus Group Discussions (FGDs). Physical violence was reported by 90% of

the participants; psychological abuse by 80% and violent sexual abuse (rape) by 10%. Major factors associated with last episode of DV experiences included: inability to finish selling wares that were being hawked, late preparation of food, getting home late from the market, burning of the employer's cloth while ironing, refusal to be genitally cut and refusal to be raped by the man of the house. Self-reported consequences of DV by victims included amongst others: constant headaches (30%) physical injury (25%), sleep disturbances (20%), excessive fear and anxiety (10%), hatred for men (10%) and suicidal ideation (5%). These findings suggest that DV may be playing significant but salient role in the poor state of health of Nigerian children and effective intervention processes at all levels are needed to address it. (PsycINFO Database Record (c) 2012 APA, all rights reserved) (journal abstract)

**Finnegan, A. C. (2010). Forging forgiveness: Collective efforts amidst war in Northern Uganda. *Sociological Inquiry, 80*(3), 424-447. doi: 10.1111/j.1475-682X.2010.00341.x**

This paper is a case study analysis of the sociological phenomena of forgiveness occurring in an ongoing two-decade war in northern Uganda. Building on a long-term relationship with the region and utilizing the methods of participant observation, semi-structured interviews, and a qualitative questionnaire, I identify two especially important social mechanisms that correlate with the prevalence of forgiveness discourse amongst the Acholi people of northern Uganda: (1) a communal sense of war fatigue and (2) a sense of Acholi collective identity, which the religious and cultural leaders have emphasized to promote a pervasive public dialogue of forgiveness. While recognizing that forgiveness in northern Uganda is contested, findings from my study point to how forgiveness opens a space for some Acholi to assert power and express agency in their lives after years of being portrayed largely as victims. Furthermore, forgiveness also offers the opportunity for some Acholi to experience interpersonal empowerment by maintaining a locus of control through meaning-making. (PsycINFO Database Record (c) 2012 APA, all rights reserved) (journal abstract)

**Fox, S. H., & Tang, S. S. (2000). The Sierra Leonean refugee experience: traumatic events and psychiatric sequelae. *The Journal of nervous and mental disease, 188*(8), 490-495. doi: 10.1097/00005053-200008000-00003**

Although a number of studies address the mental health status of refugees from a variety of regions in the world, there are no studies of the mental health status of West African refugees. It was the purpose of this study to determine the prevalence of various traumatic events to which a sample of Sierra Leonean refugees have been exposed as well as psychiatric sequelae associated with such exposure. A procedure of probability sampling was used to identify and assess a sample of 55 Sierra Leonean refugees residing in a UNHCR-sponsored camp in The Gambia, West Africa. The Harvard Trauma Questionnaire and the Hopkins Symptom Checklist-25 served as survey instruments. The findings clearly indicate the presence of disturbingly high prevalence rates for various traumatic experiences and psychiatric sequelae. It appears that a significant mental health problem exists that begs to be addressed. (journal abstract)

**Gelaye, B., Arnold, D., Williams, M. A., Goshu, M., & Berhane, Y. (2009). Depressive symptoms among female college students experiencing gender-based violence in Awassa, Ethiopia. *Journal of Interpersonal Violence, 24*(3), 464-481. doi: 10.1177/0886260508317173**

Little epidemiologic research has focused on the mental health effects of gender-based violence among sub-Saharan African women. The objective of this study was to assess risk of

depression and depressive symptoms among 1,102 female undergraduate students who were victims of gender-based violence. Students who reported experience of any gender-based violence were nearly twice as likely to be classified as having moderate depression during the academic year (OR = 1.98, 95% CI = 1.39-2.82) as compared with non abused students. Compared with non abused students, those who had experienced both physical and sexual abuse were 4 times more likely to report either moderately severe (OR = 4.32, 95% CI = 2.00-9.31) or severe depressive symptoms (OR = 4.19, 95% CI = 1.01-17.43). Our findings, consistent with previous studies, support the thesis that women's mental health status is adversely affected by exposure to gender-based violence. (PsycINFO Database Record (c) 2012 APA, all rights reserved) (journal abstract)

**Ghobarah, H. A., Huth, P., & Russett, B. (2004). The post-war public health effects of civil conflict. *Social Science & Medicine, 59*(4), 869-884. doi: 10.1016/j.socscimed.2003.11.043**

Civilian suffering from civil war extends well beyond the period of active warfare. We examine longer-term effects in a cross-national analysis of World Health Organization data on death and disability broken down by age, gender, and type of disease or condition. We find substantial long-term effects, even after controlling for several other factors. We estimate that the additional burden of death and disability incurred in 1999 alone, from the indirect and lingering effects of civil wars in the years 1991–1997, was nearly double the number incurred directly and immediately from all wars in 1999. This impact works its way through specific diseases and conditions, and disproportionately affects women and children.

**Hadley, C., Tegegn, A., Tessema, F., Cowan, J. A., Asefa, M., & Galea, S. (2008). Food insecurity, stressful life events and symptoms of anxiety and depression in east Africa: evidence from the Gilgel Gibe growth and development study. *Journal of epidemiology and community health, 62*(11), 980-986. doi: 10.1136/jech.2007.068460**

OBJECTIVES: Common mental disorders are a major contributor to the burden of disease in developing countries. An assessment was carried out of whether food insecurity and exposure to stressful life events, two common features of life in sub-Saharan Africa (SSA), are associated with symptoms of mental disorders among adults.; METHODS: The Gilgel Gibe Growth and Development Study (GGGDS) is an ongoing cohort study in rural Ethiopia. Participants of the GGGDS were randomly selected from households from a complete census of persons living in the area. The Hopkins Symptom Checklist and the Harvard Trauma Questionnaire were used to assess anxiety and depression and post-traumatic stress symptoms.; RESULTS: Among 902 adult participants, food insecurity, stressful life events and symptoms of common mental disorders were highly prevalent. In separate multivariate models adjusting for potential confounders, food insecurity and stressful life events were independently associated with high symptoms of depression, anxiety and post-traumatic stress.; CONCLUSIONS: Potentially modifiable stressors may influence variation in common mental disorders in Ethiopia, and SSA more generally. These findings suggest that the negative effects of food insecurity extend beyond nutritional outcomes and that interventions that promote food security may also positively influence adult mental health in the region. (journal abstract)

**Hagengimana, A., Hinton, D., Bird, B., Pollack, M., & Pitman, R. K. (2003). Somatic panic-attack equivalents in a community sample of Rwandan widows who survived the 1994 genocide. *Psychiatry Research, 117*(1), 1-9. doi: 10.1016/S0165-1781(02)00301-3**

The present study is the first to attempt to determine rates of panic attacks, especially 'somatically focused' panic attacks, panic disorder, symptoms of post-traumatic stress disorder (PTSD), and depression levels in a population of Rwandans traumatized by the 1994 genocide. The following measures were utilized: the Rwandan Panic-Disorder Survey (RPDS); the Beck Depression Inventory (BDI); the Harvard Trauma Questionnaire (HTQ); and the PTSD Checklist (PCL). Forty of 100 Rwandan widows (aged 18-50 years old) suffered somatically focused panic attacks during the previous 4 weeks. Thirty-five (87%) of those having panic attacks suffered panic disorder, making the rate of panic disorder for the entire sample 35%. Rwandan widows with panic attacks had greater psychopathology on all measures. Somatically focused panic-attack subtypes seem to constitute a key response to trauma in the Rwandan population. Future studies of traumatized non-Western populations should carefully assess not only somatoform disorder but also somatically focused panic attacks. (PsycINFO Database Record (c) 2012 APA, all rights reserved)

**Harder, V. S., Mutiso, V. N., Khasakhala, L. I., Burke, H. M., & Ndetei, D. M. (2012). Multiple traumas, postelection violence, and posttraumatic stress among impoverished Kenyan youth. *Journal of Traumatic Stress, 25*(1), 64-70. doi: 10.1002/jts.21660**

Research on posttraumatic stress disorder (PTSD) among youth has focused on specific subgroups from developed countries. Most of the world's youth and war-like violence, however, is concentrated in developing countries, yet there is limited mental health data within affected countries. This study focused on a random community-based sample of 552 impoverished youth ages 6–18 within an informal settlement in Nairobi, Kenya, which experienced war-like violence for a month following the contested presidential election of 2007. Six months after the violence ended, 99 (18%) had PTSD according to the UCLA PTSD Reaction Index (Steinberg, Brymer, Decker, & Pynoos, 2004), and an additional 18 (3%) were found to have partial PTSD due to high overall scores. Kenyan psychologists conducted diagnostic interviews and found the positive predictive value of the assessment tool to be 72% in this sample; the confirmed prevalence was 12%. Similar to other studies worldwide, Criterion C (avoidance) was the limiting factor for diagnosing PTSD according to the DSM-IV-TR, and parent–child agreement was at best fair. The number of traumatic experiences was strongly associated with PTSD outcomes. Differences due to age or sex were not found. The findings indicate the need for universal mental health services for trauma-exposed youth and their families in the impoverished informal settlements of Nairobi, Kenya. (PsycINFO Database Record (c) 2012 APA, all rights reserved) (journal abstract)

**Harris, D. A. (2007). Pathways to embodied empathy and reconciliation after atrocity: Former boy soldiers in a dance/movement therapy group in Sierra Leone. *Intervention: International Journal of Mental Health, Psychosocial Work & Counselling in Areas of Armed Conflict, 5*(3), 203-231. doi: 10.1097/WTF.0b013e3282f211c8**

A time limited dance/movement therapy group, facilitated by adult males, provided creative movement opportunities and other embodied healing activities for adolescent orphans who, as boys, had been involved in wartime atrocities. This fusion of Western trauma treatment and ritual proved transformative in helping the youths overcome violent impulses and rediscover the pleasure of collective endeavour. Engaging in symbolic expression through attunement and kinaesthetic empathy enabled the teenagers to reflect on their personal involvement in armed conflict in a way that encouraged enhanced awareness of belonging to the broader humanity. The

intervention therefore fostered conditions that led participants to create a public performance highlighting their dual roles as both victims and perpetrators in the war. This, in turn, advanced their reconciliation within the local community. (PsycINFO Database Record (c) 2012 APA, all rights reserved) (journal abstract)

**Harrison, M. O., Koenig, H. G., Hays, J. C., Eme-Akwari, A. G., & Pargament, K. I. (2001). The epidemiology of religious coping: A review of recent literature. *International Review Of Psychiatry*, *13*(2), 86-93. doi:10.1080/09540260120037317**

Studies of religious coping have increased dramatically over the past few years. This review summarizes recent findings concerning the prevalence, predictors, and outcomes of religious coping. In studies employing a wide variety of methods, religious coping was found to be common across samples, and is predicted by social, personal, and situational factors. Religious coping has implications for physical health, psychological well-being, health behaviors, and feelings of efficacy. Implications for future research are reviewed. (PsycINFO Database Record (c) 2012 APA, all rights reserved)

**Hayford, S. R., & Trinitapoli, J. (2011). Religious differences in female genital cutting: A case study from Burkina Faso. *Journal for the Scientific Study of Religion, 50*(2), 252-271. doi: 10.1111/j.1468-5906.2011.01566.x**

The relationship between religious obligations and female genital cutting is explored using data from Burkina Faso, a religiously and ethnically diverse country where approximately three-quarters of adult women are circumcised. Data from the 2003 Burkina Faso Demographic and Health Survey are used to estimate multilevel models of religious variation in the intergenerational transmission of female genital cutting. Differences between Christians, Muslims, and adherents of traditional religions are reported, along with an assessment of the extent to which individual and community characteristics account for religious differences. Religious variation in the intergenerational transmission of female genital cutting is largely explained by specific religious beliefs and by contextual rather than individual characteristics. Although Muslim women are more likely to have their daughters circumcised, the findings suggest the importance of a collective rather than individual Muslim identity for the continuation of the practice. (PsycINFO Database Record (c) 2012 APA, all rights reserved) (journal abstract)

**Hodge, D. R., & Roby, J. L. (2010). Sub-Saharan African women living with HIV/AIDS: An exploration of general and spiritual coping strategies. *Social Work, 55*(1), 27-37. doi: 10.1093/sw/55.1.27**

From a global perspective, the typical person living with HIV/AIDS is likely a sub-Saharan African woman. Yet despite calls from NASW to adopt a global outlook on the HIV/AIDS crisis, little research has examined how such women cope. In this study, the authors used a mixed-methods approach to explore how one sample of sub-Saharan African women (N = 162) attending an AIDS clinic in Entebbe, Uganda, cope with their circumstances. The results reveal the importance of indigenous service providers, spirituality, and, to a lesser extent, social support. Approximately 85 percent of the women reported that spirituality played some role in their ability to cope. Among these, 43 percent indicated that spirituality was the most important factor that kept them going. The most widely used spiritual coping strategies consisted of support from other believers, prayer, and trusting in God. (PsycINFO Database Record (c) 2012 APA, all rights reserved) (journal abstract)

**Human Security Report. (2012). Human security report 2012: Sexual violence, education, and war: Beyond the mainstream narrative. Vancouver, BC: Human Security Research Group. Retrieved from http://www.hsrgroup.org/human-security-reports/2012/overview.aspx**

The *Human Security Report 2012* challenges a number of widely held assumptions about the nature of sexual violence during war and the effect of conflict on education systems. Both analyses are part of the Human Security Report Project's ongoing investigation of the human costs of war. Part I: Sexual Violence, Education, and War first reviews the fragmentary data on sexual violence against adults and children in wartime. It finds, among other things, that the mainstream narrative exaggerates the prevalence of combatant-perpetrated sexual violence, while largely ignoring the far more pervasive domestic sexual violence perpetrated in wartime by family members and acquaintances. This bias has unfortunate implications for policy. Turning to the impact of war on education, the Report shows that—surprisingly—education outcomes actually *improve* on average during wartime. It confirms that conflict-affected countries generally have substantially lower educational outcomes than nonconflict countries, but it challenges the widely held notion that this is *because* of war. It points out that educational outcomes were also low—or lower— during the prior periods of peace. They could not, therefore, have been caused by warfare. The *Report* offers the first explanation for the apparent paradox of education outcomes that improve in wartime. Part II of the *Report* reviews global and regional trends in the incidence and severity of organized violence. It highlights new research on the deadliness of external military intervention in civil wars, challenges the notion that conflicts are becoming more persistent, and shows that even "failed" peace agreements save lives.

**Igreja, V., Kleijn, W., & Richters, A. (2006). When the War Was Over, Little Changed: Women's Posttraumatic Suffering After the War in Mozambique. *Journal of Nervous and Mental Disease, 194*(7), 502-509. doi: 10.1097/01.nmd.0000228505.36302.a3**

This article explores the psychosocial effects of women's prolonged exposure to civil war in the center of Mozambique. Using a combination of quantitative and qualitative methods, 91 women were assessed for posttraumatic stress symptoms and psychosocial indicators of ill health. The results indicate that for the majority of the women in this study, traumatic experiences are sequential processes. Their ill health ranges from symptoms of posttraumatic stress to episodes of spirit possession (gamba), affecting women's capacities to conceive and raise children, and marginalizing their social position. A careful analysis of the specific problems and needs of women in postwar contexts is recommended, along with a systematic examination of the effectiveness of the available resources that may play a role in boosting trauma recovery in this group of women. (PsycINFO Database Record (c) 2012 APA, all rights reserved) (journal abstract)

**Igreja, V., Kleijn, W. C., Schreuder, B. J. N., Van Dijk, J. A., & Verschuur, M. (2004). Testimony method to ameliorate post-traumatic stress symptoms: Community-based intervention study with Mozambican civil war survivors. *The British Journal of Psychiatry, 184*(3), 251-257. doi: 10.1192/bjp.184.3.251**

Background: The effectiveness of the testimony method has not been established in rural communities with survivors of prolonged civil war. Aims: To examine the effectiveness and feasibility of a testimony method to ameliorate post-traumatic stress symptoms. Method:

Participants (n=206) belonged to former war zones in Mozambique. They were divided into a case (n=137) and a non-case group (n=69). The case group was randomly divided into an intervention (n=66) and a control group (n=7l). Symptoms were measured during baseline assessment, post-intervention and at an 11-month follow-up. Results: Post-intervention measurements demonstrated significant symptom reduction in both the intervention and the control group. No significant differences were found between the intervention and the control group. Follow-up measurements showed sustained lower levels of symptoms in both groups, and some indications of a positive intervention effect in women. Conclusions: A remarkable drop in symptoms could not be linked directly to the intervention. Feasibility of the intervention was good, but controlling the intervention in a small rural community appeared to be a difficult task to accomplish. (PsycINFO Database Record (c) 2012 APA, all rights reserved) (journal abstract)

**Johnson, K., Asher, J., Rosborough, S., Raja, A., Panjabi, R., Beadling, C., et al. (2008). Association of combatant status and sexual violence with health and mental health outcomes in postconflict Liberia. *JAMA: Journal of the American Medical Association, 300*(6), 676-690. doi: 10.1001/jama.300.6.676**

Context: Liberia's wars since 1989 have cost tens of thousands of lives and left many people mentally and physically traumatized. Objectives: To assess the prevalence and impact of war-related psychosocial trauma, including information on participation in the Liberian civil wars, exposure to sexual violence, social functioning, and mental health. Design, Setting, and Participants: A cross-sectional, population-based, multistage random cluster survey of 1666 adults aged 18 years or older using structured interviews and questionnaires, conducted during a 3-week period in May 2008 in Liberia. Main Outcome Measures: Symptoms of major depressive disorder (MDD) and posttraumatic stress disorder (PTSD), social functioning, exposure to sexual violence, and health and mental health needs among Liberian adults who witnessed or participated in the conflicts during the last 2 decades. Results: In the Liberian adult household-based population, 40% (95% confidence interval [CI], 36%-45%; n = 672/1659) met symptom criteria for MDD, 44% (95% CI, 38%-49%; n = 718/1661) met symptom criteria for PTSD, and 8% (95% CI, 5%-10%; n = 133/1666) met criteria for social dysfunction. Thirty-three percent of respondents (549/1666) reported having served time with fighting forces, and 33.2% of former combatant respondents (182/549) were female. Former combatants experienced higher rates of exposure to sexual violence than noncombatants: among females, 42.3% (95% CI, 35.4%-49.1%) vs 9.2% (95% CI, 6.7%-11.7%), respectively; among males, 32.6% (95% CI, 27.6%-37.6%) vs 7.4% (95% CI, 4.5%-10.4%). The rates of symptoms of PTSD, MDD, and suicidal ideation were higher among former combatants than noncombatants and among those who experienced sexual violence vs those who did not. The prevalence of PTSD symptoms among female former combatants who experienced sexual violence (74%; 95% CI, 63%-84%) was higher than among those who did not experience sexual violence (44%; 95% CI, 33%-53%). The prevalence of PTSD symptoms among male former combatants who experienced sexual violence was higher (81%; 95% CI, 74%-87%) than among male former combatants who did not experience sexual violence (46%; 95% CI, 39%-52%). Male former combatants who experienced sexual violence also reported higher rates of symptoms of depression and suicidal ideation. Both former combatants and noncombatants experienced inadequate access to health care (33.0% [95% CI, 22.6%-43.4%] and 30.1% [95% CI, 18.7%-41.6%], respectively). Conclusions: Former combatants in Liberia were not exclusively male. Both female and male former combatants who experienced sexual violence had worse mental health outcomes than

noncombatants and other former combatants who did not experience exposure to sexual violence. (PsycINFO Database Record (c) 2012 APA, all rights reserved) (journal abstract)

**Kimuna, S. R., & Djamba, Y. K. (2008). Gender based violence: Correlates of physical and sexual wife abuse in Kenya. *Journal of Family Violence, 23*(5), 333-342. doi: 10.1007/s10896-008-9156-9**

This study explored factors associated with physical and sexual wife abuse on a sample of 4,876 married women aged 15-49 years in the 2003 Kenya Demographic Health Survey. Results indicate that 40% of married women reported at least one type of violence; 36% were physical and 13% were sexual. Multivariate analysis showed that living in poorer households, being Christian, being in a polygamous marriage, having a husband who drinks alcohol, and being in sales, agricultural, or unskilled jobs significantly increased the wife's risk of physical and sexual abuse. Wife's education had significant effect on both physical and sexual abuse, but the relationships were not linear. Wife's age and number of children were significantly associated only with physical abuse; husband's education had a marginal but significant effect only on sexual abuse. Research implications are discussed. (PsycINFO Database Record (c) 2012 APA, all rights reserved) (journal abstract)

**Kinyanda, E., Musisi, S., Biryabarema, C., Ezati, I., Oboke, H., Ojiambo-Ochieng, R., . . . Walugembe, J. (2010). War related sexual violence and it's medical and psychological consequences as seen in Kitgum, Northern Uganda: A cross-sectional study. *BMC international health and human rights, 10*, 28. doi: 10.1186/1472-698x-10-28**

BACKGROUND: Despite the recent adoption of the UN resolution 1820 (2008) which calls for the cessation of war related sexual violence against civilians in conflict zones, Africa continues to see some of the worst cases of war related sexual violence including the mass sexual abuse of entire rural communities particularly in the Great Lakes region. In addition to calling for a complete halt to this abuse, there is a need for the systematic study of the reproductive, surgical and psychological effects of war related sexual violence in the African socio-cultural setting.This paper examines the specific long term health consequences of war related sexual violence among rural women living in two internally displaced person's camps in Kitgum district in war affected Northern Uganda who accessed the services of an Isis-Women's International Cross Cultural Exchange (Isis-WICCE) medical intervention.; METHODS: The study employed a purposive cross-sectional study design where 813 respondents were subjected to a structured interview as part of a screening procedure for an emergency medical intervention to identify respondents who required psychological, gynaecological and surgical treatment.; RESULTS: Over a quarter (28.6%) of the women (n = 573) reported having suffered at least one form of war related sexual violence. About three quarters of the respondents had 'at least one gynaecological complaint' (72.4%) and 'at least one surgical complaint' (75.6%), while 69.4% had significant psychological distress scores (scores greater than or equal to 6 on the WHO SRQ-20). The factors that were significantly associated with war related sexual violence were the age group of less than or equal to 44 years, being Catholic, having suffered other war related physical trauma, and having 'at least one gynaecological complaint'. The specific gynaecological complaints significantly associated with war related sexual violence were infertility, chronic lower abdominal pain, abnormal vaginal bleeding, and sexual dysfunction. In a multivariable analysis the age group of less than or equal to 44 years, being Catholic and having 'at least one gynaecological complaint' remained significantly associated with war related sexual violence.; CONCLUSION: The results

from this study demonstrate that war related sexual violence is independently associated with the later development of specific gynaecological complaints. (journal abstract)

**Lekskes, J., van Hooren, S., & de Beus, J. (2007). Appraisal of psychosocial interventions in Liberia. *Intervention: International Journal of Mental Health, Psychosocial Work & Counselling in Areas of Armed Conflict, 5*(1), 18-26. doi: 10.1097/WTF.0b013e3280be5b47**

This article presents the methodology and results of a study on the effectiveness of two psychosocial interventions targeting female victims of war-related and sexual violence in Liberia. One intervention provided counselling, the other offered support groups and skill training. Qualitative research suggests that the participants of both interventions were positive with regard to the help provided. Quantitative analyses revealed that counselling was effective in reducing trauma symptoms as compared to the support and skill training and to a waiting list control group. Taking into account the number of women with a high post traumatic stress disorder score, both interventions were effective compared to the control group. (PsycINFO Database Record (c) 2012 APA, all rights reserved) (journal abstract)

**Liebling, H., & Kiziri-Mayengo, R. (2002). The psychological effects of gender-based violence following armed conflict in Luwero District, Uganda. *Feminism & Psychology, 12*(4), 553-560. doi: 10.1177/0959353502012004015**

The current study aimed to investigate the long-term psychological effects resulting from traumatic experiences during the civil war in Uganda some 13 yrs after the end of the war, to discuss implications for treatment based on these findings, and to make suggestions about how to address women's needs. The study used both survey research using questionnaires, and qualitative data collection through semi-structured interviews. The authors found that the group of women studied are still suffering from an extremely high level of psychological distress 13 yrs after the civil war and they have some of the symptoms usually indicative of Post-Traumatic Stress Disorder, along with several other psychological needs. The authors state that it is essential that women's war experiences are documented because this knowledge can assist one to challenge existing structures that are preventing women gaining access to the assistance they require. Additionally, interventions need to be gender-sensitive with a focus on the empowerment of women and enhancement of local initiatives. (PsycINFO Database Record (c) 2012 APA, all rights reserved)

**Lund, C., Boyce, G., Flisher, A. J., Kafaar, Z., & Dawes, A. (2009). Scaling up child and adolescent mental health services in South Africa: Human resource requirements and costs. *Journal of Child Psychology and Psychiatry, 50*(9), 1121-1130. doi: 10.1111/j.1469-7610.2009.02078.x**

Background: Children and adolescents with mental health problems have poor service cover in low- and middle-income countries. Little is known about the resources that would be required to provide child and adolescent mental health services (CAMHS) in these countries. The purpose of this study was to calculate the human resources and associated costs required to scale up CAMHS in South Africa. Methods: A spreadsheet model was developed to calculate mental health service resources, based on an estimation of the need for services in a given population. The model can be adapted to specific settings by adjusting population size, age distribution, prevalence, comorbidity, levels of coverage, service utilisation rates, workloads, length of consultations and staff profile. Steps in the modelling include population identification; estimates

of prevalence, service utilisation and staffing; and costing. Results: Using a nominal total population of 100,000 (of which 43,170 would be children and adolescents under 20 years of age), the following full-time equivalent staff are required at minimum coverage level: 5.8 in PHC facilities, .6 in general hospital outpatient departments (OPDs), .1 in general hospital inpatient facilities, 1.1 in specialist CAMHS OPDs, .6 in specialist CAMHS inpatient facilities, .5 in specialist CAMHS day services, and .8 in regional CAMHS teams. This translates into roughly $21.50 and $5.99 per child or adolescent per annum nationally for the full coverage and minimum coverage scenarios respectively. When comparing the results of this model with current realities in South Africa, there remains a substantial shortfall in existing levels of CAMHS provision. Conclusions: The model can be used as an advocacy tool to engage with planners and policy makers on a rational basis. It can also be adapted for use in other countries, and is intended to support wider calls for a global scaling up of mental health services. (PsycINFO Database Record (c) 2012 APA, all rights reserved) (journal abstract)

**Magwaza, A. S., Killian, B. J., Petersen, I., & Pillay, Y. (1993). The effects of chronic violence on preschool children living in South African townships. *Child Abuse & Neglect, 17*(6), 795-803. doi: 10.1016/s0145-2134(08)80010-5**

Investigated the psychological sequelae of civil conflict and violence on preschool children in South Africa. Using a combination of participatory and empirical methods, 5 teachers (also trained as field workers) took a random sample of 148 children. The Post Traumatic Stress Disorder Questionnaire for Children was completed by the teachers for each of the children under their care. Children were asked to draw pictures of things they had experienced in their life. Children's drawings were not good predictors of posttraumatic stress disorder (PTSD). The more a child was able to express emotional trauma through drawings, the less likely he or she would suffer from PTSD. (French & Spanish abstracts) (PsycINFO Database Record (c) 2012 APA, all rights reserved)

**Manca, T. (2008). Innocent murderers? Abducted children in the Lord's Resistance Army. *Cultic Studies Review, 7*(2), 129-166.**

For over twenty-one years, a guerrilla force known as the Lord's Resistance Army (LRA) has been terrorizing the people of northern Uganda. The LRA abducts children to help it fight against local civilians and the Ugandan government. LRA commanders use extreme violence to control these children. The LRA justifies the use of this violence with its secretive spiritual and political ambitions. Many of the children in the LRA commit horrendous acts, such as mutilations and murders, against civilians in a effort to survive while they await the opportunity to escape. Some of these children eventually internalize the violence that the LRA subjects them to and become willing participants in the movement. In this article, I discuss how the LRA's organization, its use of religious doctrine, and its use of physical coercion manipulate children in an effort to create obedient members of the LRA. (PsycINFO Database Record (c) 2012 APA, all rights reserved) (journal abstract)

**Masinda, M. T., & Muhesi, M. (2004). Children and adolescents' exposure to traumatic war stressors in the Democratic Republic of Congo. *Journal of Child and Adolescent Mental Health, 16*(1), 25-30. doi: 10.2989/17280580409486560**

This study focuses on post-traumatic reactions of children and adolescents in the Democratic Republic of Congo. The study was conducted in Butembo between April 2001 and

May 2001 during the ongoing war that started on 2 August 1999. Semi-structured interviews combining a mix of open- and closed-ended questions were used to collect data from 88 children (44 girls and 44 boys) and 91 schoolteachers (40 women and 51 men) in 24 elementary and 20 secondary schools. The results show that both children and adolescents, and schoolteachers, are traumatised by war-related traumatic events such as shooting, loss of family members and forced recruitment into the armed forces. For example, 72.59% children and adolescents said they had lost a family member, 95.45% had experienced shooting, and 75% reported high levels of insecurity leading to a decline in school performance. The research suggests that international agencies devoted to protecting young people should provide assistance even during war, because the cost of healing may be too high if action is only taken later. Special attention should be given to teachers, arming them with skills that will equip them in supporting traumatised children. (PsycINFO Database Record (c) 2012 APA, all rights reserved) (journal abstract)

**Millar, G. (2012). "Ah lef ma case fo God": Faith and agency in Sierra Leone's postwar reconciliation.** ***Peace and Conflict: Journal of Peace Psychology, 18*****(2), 131-143. doi: 10.1037/a0028094**

This article describes a qualitative ethnographic analysis of local experiences of truth-telling performances within Sierra Leone's Truth and Reconciliation Commission. Whereas proponents of truth commissions claim that such processes promote postwar reconciliation, this study found that local religious belief impeded such effects. While belief did enhance the local willingness to reconcile, in tandem with postwar insecurity, it also promoted a reliance on secondary control mechanisms wherein individuals subjugated their own agency in reconciliation to the power of God. Within this context, the man-made processes of truth-telling were experienced by local people as redundant at best and provocative at worst. (PsycINFO Database Record (c) 2012 APA, all rights reserved) (journal abstract)

**Morgos, D., Worden, J. W., & Gupta, L. (2008). Psychosocial effects of war experiences among displaced children in Southern Darfur.** ***Omega: Journal of Death and Dying, 56*****(3), 229-253. doi: 10.2190/OM.56.3.b**

This study focused on assessing the psychosocial effects of the long standing, high intensity, and guerrilla-style of warfare among displaced children in Southern Darfur. The goal was to better understand the etiology, prognosis, and treatment implications for traumatic reactions, depression, and grief symptoms in this population. Three hundred thirty-one children aged 6-17 from three IDP Camps were selected using a quota sampling approach and were administered a Demographic Questionnaire, Child Post Traumatic Stress Reaction Index, Child Depression Inventory, and the Expanded Grief Inventory. Forty-three percent were girls and 57% were boys. The mean age of the children was 12 years. Results found that children were exposed to a very large number of war experiences with no significant differences between genders for types of exposure, including rape, but with older children (13-17 years) facing a larger number of exposures than younger children (6-12 years). Out of the 16 possible war experiences, the mean number was 8.94 (SD = 3.27). Seventy-five percent of the children met the DSM-IV criteria for PTSD, and 38% exhibited clinical symptoms of depression. The percentage of children endorsing significant levels of grief symptoms was 20%. Increased exposure to war experiences led to higher levels of: 1) traumatic reactions; 2) depression; and 3) grief symptoms. Of the 16 war experiences, abduction, hiding to protect oneself, being raped, and being forced to kill or hurt family members were most predictive of traumatic reactions. Being raped, seeing others

raped, the death of a parent/s, being forced to fight, and having to hide to protect oneself were the strongest predictors of depressive symptoms. War experiences such as abduction, death of one's parent/s, being forced to fight, and having to hide to protect oneself were the most associated with the child's experience of grief. In addition to Total Grief, Traumatic Grief, Existential Grief, and Continuing Bonds were measured in these children. Although trauma, depression, and grief often exist as co-morbid disorders, the mechanisms and pathways of these is less understood. In this study we used Structural Equation Modeling to better understand the complex interaction and trajectories of these three symptoms evolving from war exposure and loss. This study is the first of its kind to assess the psychosocial effects of war experiences among children currently living in war zone areas within Sudan. It identifies some of the most prevalent war-related atrocities and their varying impact on the children's psychological well-being and overall adjustment. Implications for planning mental health interventions are discussed. (PsycINFO Database Record (c) 2012 APA, all rights reserved) (journal abstract)

**Murray, L. K., Haworth, A., Semrau, K., Singh, M., Aldrovandi, G. M., Sinkala, M., et al. (2006). Violence and Abuse Among HIV-Infected Women and Their Children in Zambia: A Qualitative Study. *Journal of Nervous and Mental Disease, 194*(8), 610-615. doi: 10.1097/01.nmd.0000230662.01953.bc**

HIV and violence are two major public health problems increasingly shown to be connected and relevant to international mental health issues and HIV-related services. Qualitative research is important due to the dearth of literature on this association in developing countries, cultural influences on mental health syndromes and presentations, and the sensitive nature of the topic. The study presented in this paper sought to investigate the mental health issues of an HIV-affected population of women and children in Lusaka, Zambia, through a systematic qualitative study. Two qualitative methods resulted in the identification of three major problems for women: domestic violence (DV), depression-like syndrome, and alcohol abuse; and children: defilement, DV, and behavior problems. DV and sexual abuse were found to be closely linked to HIV and alcohol abuse. This study shows the local perspective of the overlap between violence and HIV. Results are discussed in relation to the need for violence and abuse to be addressed as HIV services are implemented in sub-Saharan Africa. (PsycINFO Database Record (c) 2012 APA, all rights reserved) (journal abstract)

**Nangolo, L. H. N., & Peltzer, K. (2003). Violence against women and its mental health consequences in Namibia. *Gender & Behaviour, 1*, 16-33. doi: 10.4314/gab.v1i1.23310**

The aim of this study is to explore or elicit the experiences of battered women; their menial health consequences and their attempts to deal with their battering in Namibia. The sample consisted of 60 battered women who were seen at the Woman and Protection Units. Results indicate that women had experienced financial abuse (81.7%), emotional abuse (60%), physical abuse (53.3%), and sexual abuse (26.6%). Three quarters of the women reported various forms of relationship disability and psychological dysfunction, half reported life restrictions and impairment of their health status, and a few abused alcohol, drugs or smoked excessively. As a last resort all respondents approached the Women and Child Protection Unit for help, many kept quiet or went to a priest, a quarter went to legal authorities and only a few to neighbours or psychosocial professionals (social workers). Results are discussed in terms of violence characteristics and contributing factors as well as psychosocial impact of women battering. (PsycINFO Database Record (c) 2012 APA, all rights reserved) (journal abstract)

Neria, Y., Galea, S., & Norris, F. H. (2009). *Mental health and disasters*. Cambridge; New York: Cambridge University Press.

**Neugebauer, R., Fisher, P. W., Turner, J. B., Yamabe, S., Sarsfield, J. A., & Stehling-Ariza, T. (2009). Post-traumatic stress reactions among Rwandan children and adolescents in the early aftermath of genocide. *International journal of epidemiology, 38*(4), 1033-1045.**

BACKGROUND: Epidemiological investigations of post-traumatic stress reactions in Sub-Saharan Africa, where atrocious violence against civilians is endemic, are rare. This article is the first complete report of the key community-based findings of a 1995 psychiatric epidemiological survey of young survivors of the 1994 Rwandan Genocide.; METHODS: The National Trauma Survey (NTS) of Rwandans aged 8-19 measured traumatic exposures using an inventory of possible war time experiences and post-traumatic stress reactions with a checklist of symptoms of Post-traumatic stress disorder (PTSD). Individuals meeting assessed PTSD diagnostic criteria are classified as cases of 'probable PTSD'. The NTS interviewed youth residing in the community and others institutionalized in unaccompanied children's centres; the former (n = 1547) are the subject of the present report. Instrument change midway into the study divides respondents into two samples.; RESULTS: Among respondents, over 90% witnessed killings and had their lives threatened; 35% lost immediate family members; 30% witnessed rape or sexual mutilation; 15% hid under corpses. In Sample 1, 95% of respondents reported one or more re-experiencing symptom, 95% reported three or more avoidance/blunting symptoms and 63% reported two or more arousal symptoms; in Sample 2, these figures were 96%, 95% and 56%, respectively. The overall rate of 'probable PTSD' was 62% and 54% in Samples 1 and 2, respectively, and exhibited a dose-response relationship with exposure. Among the most heavily exposed individuals the rate was 100%. Rates of 'probable PTSD' were higher among females than among males. Results for age were inconsistent.; CONCLUSION: In industrialized societies, most survivors of traumatizing violence experience symptoms only transiently. In the Rwanda survey, symptom levels and rates of 'probable PTSD' were exceptionally elevated, suggesting that at the limits of catastrophic man-made violence, psychological resilience among youth is all but extinguished. (journal abstract)

**Neuner, F., Onyut, P. L., Ertl, V., Odenwald, M., Schauer, E., & Elbert, T. (2008). Treatment of posttraumatic stress disorder by trained lay counselors in an African refugee settlement: A randomized controlled trial. *Journal of Consulting and Clinical Psychology, 76*(4), 686-694. doi: 10.1037/0022-006X.76.4.686**

Traumatic stress due to conflict and war causes major mental health problems in many resource-poor countries. The objective of this study was to examine whether trained lay counselors can carry out effective treatment of posttraumatic stress disorder (PTSD) in a refugee settlement. In a randomized controlled dissemination trial in Uganda with 277 Rwandan and Somalian refugees who were diagnosed with PTSD the authors investigated the effectiveness of psychotherapy administered by lay counselors. Strictly manualized narrative exposure therapy (NET) was compared with more flexible trauma counseling (TC) and a no-treatment monitoring group (MG). Fewer participants (4%) dropped out of NET treatment than TC (21%). Both active treatment groups were statistically and clinically superior to MG on PTSD symptoms and physical health but did not differ from each other. At follow-up, a PTSD diagnosis could not be established anymore in 70% of NET and 65% TC participants, whereas only 37% in MG did not meet PTSD criteria anymore. Short-term psychotherapy carried out by lay counselors with

limited training can be effective to treat war-related PTSD in a refugee settlement. (PsycINFO Database Record (c) 2012 APA, all rights reserved) (journal abstract)

**Obilom, R. E., & Thacher, T. D. (2008). Posttraumatic stress disorder following ethnoreligious conflict in Jos, Nigeria. *Journal of Interpersonal Violence, 23*(8), 1108-1119. doi: 10.1177/0886260507313975**

In September 2001, ethnoreligious rioting occurred in Jos, Nigeria. Using a multistage cluster sampling technique, 290 respondents were recruited in Jos 7 to 9 months after the riots. Data were collected regarding demographics, exposure to traumatic events, and psychological symptoms. Resting pulse and blood pressure were recorded. A total of 145 (52.5%) witnessed or were victims of personal attacks, 165 (59.6%) lost their possessions, 56 (20.7%) had their homes burned, 44 (16.2%) witnessed relatives' deaths, and 8 (2.9%) were robbed. A total of 252 (89.7%) of the respondents met reexperiencing criteria, 138 (49.1%) met avoidance criteria, and 236 (84.0%) met arousal criteria for posttraumatic stress disorder (PTSD). A total of 116 (41%, 95% confidence interval [CI] = 36% to 47%) met all three categories for PTSD. Only personal attacks (adjusted odds ratio = 2.8, 95% CI = 1.7 to 4.7) and a heart rate of 90 beats/min or more (adjusted odds ratio = 2.8, 95% CI = 1.4 to 5.8) were significantly related to PTSD in a multivariate model. (PsycINFO Database Record (c) 2012 APA, all rights reserved) (journal abstract)

**Omigbodun, O., Bakare, K., & Yusuf, B. (2008). Traumatic events and depressive symptoms among youth in southwest Nigeria: A qualitative analysis. *International Journal of Adolescent Medicine and Health, 20*(3), 243-253. doi: 10.1515/IJAMH.2008.20.3.243**

Traumatic experiences have dire consequences for the mental health of young persons. Despite high rates of traumatic experiences in some African cities, there are no reports for Nigerian youth. Objective: To investigate the pattern of traumatic events and their association with depressive symptoms among youth in Southwest Nigeria. Methods: This is a descriptive cross-sectional study of randomly selected youth in urban and rural schools in Southwest Nigeria. They completed self-reports on traumatic events and depressive symptoms using the Street Children's Project Questionnaire and the Youth DISC Predictive Scale (DPS). Results: Of the 1,768 responses (88.4% response rate) entered into the analysis, 34% reported experiencing a traumatic situation. Following interpretative phenomenological analysis, 13 themes emerged. Frequently occurring traumatic events were 'road traffic accidents' (33.0%), 'sickness' (17.1%), 'lost or trapped' (11.2%) and 'armed robbery attack' (9.7%). A bad dream was described by 3.7%. Traumatic experiences were commoner in males (36.2%) than in females (31.6%) ($X^2 = 4.2$; $p = .041$). Experiencing a traumatic event was associated with depressive symptoms ($X^2 = 37.98$; $p < .001$), especially when the event directly affected the youth as in sexual assault or physical abuse. Conclusions: One-third of youth in Southwest Nigeria have described an experienced traumatic event. Road traffic accidents, armed robbery attacks, and communal disturbances depict the prevailing social environment, whereas 'bad dreams' revealed the influence of cultural beliefs. Policy makers must be aware of the social issues making an impact on the health of youth. Multi-agency interventions to improve the social environment and provide mental health services for traumatized young people are essential. (PsycINFO Database Record (c) 2012 APA, all rights reserved) (journal abstract)

**Onyut, L. P., Neuner, F., Schauer, E., Ertl, V., Odenwald, M., Schauer, M., et al. (2004).**

**The Nakivale Camp Mental Health Project: Building local competency for psychological assistance to traumatised refugees.** ***Intervention: International Journal of Mental Health, Psychosocial Work & Counselling in Areas of Armed Conflict, 2*****(2), 90-107.**

Little is known about the usefulness of psychiatric concepts and psychotherapeutic approaches for refugees who have experienced severe traumatic events and continue to live in stressful and potentially dangerous conditions in refugee settlements. The central goal of the Nakivale Camp Mental Health Project is to establish the usefulness of short-term treatment approaches when applied by local paramedical personnel in a disaster region. In a randomized controlled clinical trial, the efficacy of Narrative Exposure Therapy (NET) vis-à-vis Supportive Counselling has been tested, when applied by trained paramedical personnel from within the same refugee community. Here we demonstrate the feasibility of such an approach and detail the methods and strategy for it. The project also included an epidemiological survey to ascertain the prevalence of PTSD among refugee adolescents and adults alike. Consistent with other investigations, the demographic survey revealed a high prevalence of chronic PTSD ranging from 31.1% in the Rwandan to 47% in the Somali population; even though traumatic events had on average taken place more than 9 and 11 years earlier in each case respectively. Diagnostic validity was assured using expert clinical interviews. The significant social and work-related dysfunction, a disabling consequence of PTSD, does not only impact on the life of the affected individual. Communities where a significant percentage of members, are psychologically affected by past human rights violations, atrocities and war, are held back in their recovery process at many levels. Therefore mental health programmes with workable guidelines on how to treat posttraumatic symptoms, based on solid scientific research with proven effectiveness and feasibility, in particular cultural settings, must become a humanitarian priority. (PsycINFO Database Record (c) 2012 APA, all rights reserved) (journal abstract)

**Peterman, A., Palermo, T., & Bredenkamp, C. (2011). Estimates and determinants of sexual violence against women in the Democratic Republic of Congo.** ***American Journal of Public Health, 101*****(6), 1060-1067. doi:10.2105/AJPH.2010.300070**

Objectives. We sought to provide data-based estimates of sexual violence in the Democratic Republic of Congo (DRC) and describe risk factors for such violence. Methods. We used nationally representative household survey data from 3436 women selected to answer the domestic violence module who took part in the 2007 DRC Demographic and Health Survey along with population estimates to estimate levels of sexual violence. We used multivariate logistic regression to analyze correlates of sexual violence. Results. Approximately 1.69 to 1.80 million women reported having been raped in their lifetime (with 407 397–433 785 women reporting having been raped in the preceding 12 months), and approximately 3.07 to 3.37 million women re- ported experiencing intimate partner sexual violence. Reports of sexual violence were largely independent of individual-level background factors. However, compared with women in Kinshasa, women in Nord-Kivu were significantly more likely to report all types of sexual violence. Conclusions. Not only is sexual violence more generalized than previously thought, but our findings suggest that future policies and programs should focus on abuse within families and eliminate the acceptance of and impunity sur- rounding sexual violence nationwide while also maintaining and enhancing efforts to stop militias from perpetrating rape. (Am J Public Health. 2011;101: 1060–1067. doi:10.2105/AJPH.2010.300070)

**Pham, P. N., Weinstein, H. M., & Longman, T. (2004). Trauma and PTSD Symptoms in Rwanda: Implications for Attitudes Toward Justice and Reconciliation. *JAMA: Journal of the American Medical Association, 292*(5), 602-612. doi: 10.1001/jama.292.5.602**

Context: The 1994 genocide in Rwanda led to the loss of at least 10% of the country's 7.7 million inhabitants, the destruction of much of the country's infrastructure, and the displacement of nearly 4 million people. In seeking to rebuild societies such as Rwanda, it is important to understand how traumatic experience may shape the ability of individuals and groups to respond to judicial and other reconciliation initiatives. Objectives: To assess the level of trauma exposure and the prevalence of posttraumatic stress disorder (PTSD) symptoms and their predictors among Rwandans and to determine how trauma exposure and PTSD symptoms are associated with Rwandans' attitudes toward justice and reconciliation. Design, Setting, and Participants: Multistage, stratified cluster random survey of 2091 eligible adults in selected households in 4 communes in Rwanda in February 2002. Main Outcome Measures: Rates of exposure to trauma and symptom criteria for PTSD using the PTSD Checklist-Civilian Version; attitudes toward judicial responses (Rwandan national and gacaca local trials and International Criminal Tribunal for Rwanda [ICTR]) and reconciliation (belief in community, nonviolence, social justice, and interdependence with other ethnic groups). Results: Of 2074 respondents with data on exposure to trauma, 1563 (75.4%) were forced to flee their homes, 1526 (73.0%) had a close member of their family killed, and 1472 (70.9%) had property destroyed or lost. Among the 2091 total participants, 518 (24.8%) met symptom criteria for PTSD. The adjusted odds ratio (OR) of meeting PTSD symptom criteria for each additional traumatic event was 1.43 (95% CI, 1.33-1.55). More respondents supported the local judicial responses (90.8% supported gacaca trials and 67.8% the Rwanda national trials) than the ICTR (42.1 % in support). Respondents who met PTSD symptom criteria were less likely to have positive attitudes toward the Rwandan national trials (OR, 0.77; 95% CI, 0.61-0.98), belief in community (OR, 0.76; 95% CI, 0.60-0.97), and interdependence with other ethnic groups (OR, 0.71; 95% CI, 0.56-0.90). Respondents with exposure to multiple trauma events were more likely to have positive attitudes toward the ICTR (OR, 1.10; 95% CI, 1.04-1.17) and less likely to support the Rwandan national trials (OR, 0.90; 95% CI, 0.84-0.96), the local gacaca trials (OR, 0.80; 95% CI, 0.72-0.89), and 3 factors of openness to reconciliation: belief in nonviolence (OR, 0.92; 95% CI, 0.87-0.97), belief in community (OR, 0.92; 95% CI, 0.87-0.98), and interdependence with other ethnic groups (OR, 0.86; 95% CI, 0.81-0.92). Other variables that were associated with attitudes toward judicial processes and openness to reconciliation were educational level, ethnicity, perception of change in poverty level and access to security compared with 1994, and ethnic distance. Conclusions: This study demonstrates that traumatic exposure, PTSD symptoms, and other factors are associated with attitudes toward justice and reconciliation. Societal interventions following mass violence should consider the effects of trauma if reconciliation is to be realized. (PsycINFO Database Record (c) 2012 APA, all rights reserved) (journal abstract)

**Putman, K. M., Lea, J. C., & Eriksson, C. B. (2011). Cross-cultural comparison of religious coping methods reported by native Guatemalan and Kenyan faith-based relief providers. *Journal of Psychology and Theology, 39*(3), 233-243.**

Guatemala and Kenya are both countries that have recently experienced political violence in the context of long histories of colonialization, oppression and poverty. The current study examines focus group responses of indigenous faith-based relief providers in Guatemala and

Kenya describing how they utilized religion to cope with their own experience of political violence as well as to cope with stress related to providing relief services to others. In an effort to study both emic and etic dimensions of religious coping, the study also analyzes these responses within the framework of Pargament and colleagues' (1998; 2000) religious coping constructs to determine responses that are consistent with findings across other cultures (etic) and to identify and describe responses that are culturally specific to Guatemala and Kenya (emic). Guatemalan and Kenyan themes consistent with North American literature were: Religious Helping, Seeking Spiritual Support, Benevolent Religious Reappraisal, Spiritual Connections and Collaborative Religious Coping. Themes unique to Guatemala and Kenya included Acceptance and Engagement of Suffering, Cosmic Balance, Living Better, Prayer, Human Responsibility, Communal Spiritual Traditions, and Finding Solidarity Through Shared Experience. Finally, this article examines emic and etic responses within the context of literature on African and Central American theologies. (PsycINFO Database Record (c) 2012 APA, all rights reserved) (journal abstract)

**Roberts, B., Damundu, E. Y., Lomoro, O., & Sondorp, E. (2009). Post-conflict mental health needs: A cross-sectional survey of trauma, depression and associated factors in Juba, Southern Sudan. *BMC Psychiatry, 9*. doi: 10.1186/1471-244X-9-7**

Background: The signing of the Comprehensive Peace Agreement in January 2005 marked the end of the civil conflict in Sudan lasting over 20 years. The conflict was characterized by widespread violence and large-scale forced migration. Mental health is recognized as a key public health issue for conflict-affected populations. Studies revealed high levels of post-traumatic stress disorder (PTSD) amongst populations from Southern Sudan during the conflict. However, no studies have been conducted on mental health in post-war Southern Sudan. The objective of this study was to measure PTSD and depression in the population in the town of Juba in Southern Sudan; and to investigate the association of demographic, displacement, and past and recent trauma exposure variables, on the outcomes of PTSD and depression. Methods: A cross-sectional, random cluster survey with a sample of 1242 adults (aged over 18 years) was conducted in November 2007 in the town of Juba, the capital of Southern Sudan. Levels of exposure to traumatic events and PTSD were measured using the Harvard Trauma Questionnaire (original version), and levels of depression measured using the Hopkins Symptom Checklist-25. Multivariate logistic regression was used to analyze the association of demographic, displacement and trauma exposure variables on the outcomes of PTSD and depression. Multivariate logistic regression was also conducted to investigate which demographic and displacement variables were associated with exposure to traumatic events. Results: Over one third (36%) of respondents met symptom criteria for PTSD and half (50%) of respondents met symptom criteria for depression. The multivariate logistic regression analysis showed strong associations of gender, marital status, forced displacement, and trauma exposure with outcomes of PTSD and depression. Men, IDPs, and refugees and persons displaced more than once were all significantly more likely to have experienced eight or more traumatic events. Conclusion: This study provides evidence of high levels of mental distress in the population of Juba Town, and associated risk-factors. Comprehensive social and psychological assistance is urgently required in Juba. (PsycINFO Database Record (c) 2012 APA, all rights reserved) (journal abstract)

**Roberts, B., Ocaka, K. F., Browne, J., Oyok, T., & Sondorp, E. (2008). Factors associated**

**with post-traumatic stress disorder and depression amongst internally displaced persons in northern Uganda. *BMC Psychiatry, 8*. doi: 10.1186/1471-244X-8-38**

Background: The 20 year war in northern Uganda between the Lord's Resistance Army and the Ugandan government has resulted in the displacement of up to 2 million people within Uganda. The purpose of the study was to measure rates of post-traumatic stress disorder (PTSD) and depression amongst these internally displaced persons (IDPs), and investigate associated demographic and trauma exposure risk factors. Methods: A cross-sectional multi-staged, random cluster survey with 1210 adult IDPs was conducted in November 2006 in Gulu and Amuru districts of northern Uganda. Levels of exposure to traumatic events and PTSD were measured using the Harvard Trauma Questionnaire (original version), and levels of depression were measured using the Hopkins Symptom Checklist-25. Multivariate logistic regression was used to analyse the association of demographic and trauma exposure variables on the outcomes of PTSD and depression. Results: Over half (54%) of the respondents met symptom criteria for PTSD, and over two thirds (67%) of respondents met symptom criteria for depression. Over half (58%) of respondents had experienced 8 or more of the 16 trauma events covered in the questionnaire. Factors strongly linked with PTSD and depression included gender, marital status, distance of displacement, experiencing ill health without medical care, experiencing rape or sexual abuse, experiencing lack of food or water, and experiencing higher rates of trauma exposure. Conclusion: This study provides evidence of exposure to traumatic events and deprivation of essential goods and services suffered by IDPs, and the resultant effect this has upon their mental health. Protection and social and psychological assistance are urgently required to help IDPs in northern Uganda re-build their lives. (PsycINFO Database Record (c) 2012 APA, all rights reserved) (journal abstract)

**Sakai, C. E., Connolly, S. M., & Oas, P. (2010). Treatment of PTSD in Rwandan child genocide survivors using Thought Field Therapy. *International Journal of Emergency Mental Health, 12*(1), 41-49.**

Thought Field Therapy (TFT), which utilizes the self-tapping of specific acupuncture points while recalling a traumatic event or cue, was applied with 50 orphaned adolescents who had been suffering with symptoms of PTSD since the Rwandan genocide 12 years earlier. Following a single TFT session, scores on a PTSD checklist completed by caretakers and on a self-rated PTSD checklist had significantly decreased ($p < .0001$ on both measures). The number of participants exceeding the PTSD cutoffs decreased from 100% to 6% on the caregiver ratings and from 72% to 18% on the self-ratings. The findings were corroborated by informal interviews with the adolescents and the caregivers, which indicated dramatic reductions of PTSD symptoms such as flashbacks, nightmares, bedwetting, depression, isolation, difficulty concentrating, jumpiness, and aggression. Following the study, the use of TFT on a self-applied and peer-utilized basis became part of the culture at the orphanage, and on one-year follow-up the initial improvements had been maintained as shown on both checklists. (PsycINFO Database Record (c) 2012 APA, all rights reserved) (journal abstract)

**Schaefer, F. C., Blazer, D. G., Carr, K. F., Connor, K. M., Burchett, B., Schaefer, C. A., et al. (2007). Traumatic events and posttraumatic stress in cross-cultural mission assignments. *Journal of Traumatic Stress, 20*(4), 529-539. doi: 10.1002/jts.20240**

In addition to cross-cultural and environmental stressors, aid workers and missionaries are frequently exposed to trauma. We explored the frequency of traumatic events, their mental

health impact, and factors associated with posttraumatic stress in two groups of missionaries, one representing a predominantly stable setting (Europe) and the other an unstable setting (West Africa). The 256 participants completed self-report measures assessing lifetime traumatic events, current posttraumatic stress, depressive and anxiety symptoms, resilience, and functioning. The rate of traumatic events was significantly higher in the unstable setting. More-frequent traumatic events were associated with higher posttraumatic stress. Factors associated with the severity of posttraumatic stress were depression, functional impairment, subjective severity and number of traumatic events, and the level of resilience. (PsycINFO Database Record (c) 2012 APA, all rights reserved) (journal abstract)

**Schoeman, R., Carey, P., & Seedat, S. (2009). Trauma and posttraumatic stress disorder in South African adolescents: A case-control study of cognitive deficits. *Journal of Nervous and Mental Disease, 197*(4), 244-250. doi: 10.1097/NMD.0b013e31819d9533**

Despite the prominence of neuropsychological deficits in memory, attention and learning in adults exposed to trauma and those who develop posttraumatic stress disorder (PTSD), few studies have explored these cognitive deficits in adolescents. This study aimed to assess the impact of PTSD on various neurocognitive functions in South African adolescents. In a case-control study, 40 traumatized adolescents (20 with PTSD and 20 without) were evaluated for the presence of PTSD and were then referred for neuropsychological evaluation using a standardized neuropsychological test battery. The presence of PTSD itself, rather than trauma exposure, was associated with cognitive deficiencies in attention, visual memory and nonverbal concept formation. This study highlights the impact of PTSD itself—and particularly current symptoms—on the cognitive development of adolescents. As this effect appears to be stronger than the impact of trauma alone, more studies on the long-term consequences of PTSD on youth cognitive development are crucial. (PsycINFO Database Record (c) 2012 APA, all rights reserved) (journal abstract)

**Seedat, S., Nyamai, C., Njenga, F., Vythilingum, B., & Stein, D. J. (2004). Trauma exposure and post-traumatic stress symptoms in urban African schools. Survey in CapeTown and Nairobi. *The British journal of psychiatry : the journal of mental science, 184*, 169-175. doi: 10.1192/bjp.184.2.169**

BACKGROUND: There is a lack of comparative data on the prevalence and effects of exposure to violence in African youth.; AIMS: We assessed trauma exposure, post-traumatic stress symptoms and gender differences in adolescents from two African countries.; METHOD: A sample of 2041 boys and girls from 18 schools in CapeTown and Nairobi completed anonymous self-report questionnaires.; RESULTS: More than 80% reported exposure to severe trauma, either as victims or witnesses. Kenyan adolescents, compared with South African, had significantly higher rates of exposure to witnessing violence (69% v. 58%), physical assault by a family member (27% v. 14%) and sexual assault (18% v. 14%). But rates of current full-symptom post-traumatic stress disorder (PTSD) (22.2% v. 5%) and current partial-symptom PTSD (12% v. 8%) were significantly higher in the South African sample. Boys were as likely as girls to meet PTSD symptom criteria.; CONCLUSIONS: Although the lifetime exposure to trauma was comparable across both settings, Kenyan adolescents had much lower rates of PTSD. This difference may be attributable to cultural and other trauma-related variables. High rates of sexual assault and PTSD, traditionally documented in girls, may also occur in boys and warrant further study. (journal abstract)

**Sezibera, V., Van Broeck, N., & Philippot, P. (2009). Intervening on persistent posttraumatic stress disorder: Rumination-focused cognitive and behavioral therapy in a population of young survivors of the 1994 genocide in Rwanda. *Journal of Cognitive Psychotherapy, 23*(2), 107-113. doi: 10.1891/0889-8391.23.2.107**

This study assessed the outcome of a brief rumination-focused cognitive and behavioral intervention in treating posttraumatic stress disorder (PTSD) symptoms among Rwandan adolescent survivors of the 1994 genocide. All participants (54.5% female, N=22) aged between 15 and 18 years (M=16.55, SD=0.96) met criteria for PTSD as assessed by the PTSD self-rating scale (UCLA PTSD index). Measures included questionnaires assessing PTSD, depression, and somatization. Data were obtained at four points: (1) 11 years after the genocide (baseline), (2) 13 years after the genocide (pretreatment), (3) posttreatment (2 weeks after the treatment), and (4) follow-up (2 months after the treatment). PTSD symptoms increased between baseline and pretreatment. The intervention was associated with a reduction in PTSD symptoms, with gains maintained at follow-up. (PsycINFO Database Record (c) 2012 APA, all rights reserved) (journal abstract)

**Simon, D. (2001). The Bitter Harvest of War: Continuing Social and Humanitarian Dislocation in Angola. *Review of African Political Economy, 28*(90), 503-520. doi: http://www.tandf.co.uk/journals/titles/03056244.asp**

Angola's seemingly endless civil war has generated untold human suffering through death, injury, displacement and destruction. The social cost of the return to war after the elections in 1992, and again after the abandonment by UNITA of the Lusaka Accords in late 1998 has arguably been greater than previously. This paper examines the human cost of this latest period of fighting, focusing on the scale and nature of displacement, the collapse of infrastructure and services, and the very costly international humanitarian operation. Paradoxically, the crisis has worsened since the Angolan army's dramatic territorial gains against UNITA, as more displaced people become accessible and resources are stretched yet further. Economic dislocation is profound, health and educational indicators are alarming, while poverty is pervasive in both urban and rural areas. Resettlement and rehabilitation efforts are slow and limited; even if a durable and effective peace is eventually secured, the long-term challenges of human recovery, social reconstruction and participatory development will be immense. Critical questions are raised about the likely nature of this process.

**Sonderegger, R., Rombouts, S., Ocen, B., & McKeever, R. S. (2011). Trauma rehabilitation for war‐affected persons in northern Uganda: A pilot evaluation of the EMPOWER programme. *British Journal of Clinical Psychology, 50*(3), 234-249. doi: 10.1348/014466510X511637**

Objectives: This study evaluated the impact of a culturally sensitive cognitive behaviour therapy (CBT)-based intervention (the EMPOWER programme) for war-affected persons in northern Uganda. Design: The study conducted a pilot evaluation with a convenience sample of participants from internally displaced persons (IDPs) camps (i.e., a treatment camp and waitlist control camp). This was done to avoid treatment effects spreading from the intervention to control conditions. Methods: A total of 202 participants (N = 90 treatment participants and N = 112 control participants) were included as a convenience sample. The Acholi Psychosocial Assessment Instrument (APAI), a culturally appropriate measure of psychosocial functioning,

was administered to participants residing in two IDP camps at pre-treatment, post-treatment, and at 3-month follow-up. Participants in the treatment camp received the EMPOWER programme – a culturally sensitive CBT-based intervention teaching emotional resiliency and promoting forgiveness. Results: Participants in the treatment condition reported (a) significantly lower scores on the depression-like syndromes and the anxiety-like syndrome and (b) significantly more prosocial behaviours, than participants in the control condition. Conclusions: The results of this study provide initial support for the application of structured CBT interventions in war-affected areas, illustrating that the EMPOWER programme could be utilized by humanitarian agencies to address the psychosocial needs of war-affected displaced persons. (PsycINFO Database Record (c) 2012 APA, all rights reserved) (journal abstract)

**Stepakoff, S., Hubbard, J., Katoh, M., Falk, E., Mikulu, J.-B., Nkhoma, P., et al. (2006). Trauma healing in refugee camps in guinea: A psychosocial program for Liberian and Sierra Leonean survivors of torture and war.** ***American Psychologist, 61*****(8), 921-932. doi: 10.1037/0003-066x.61.8.921**

From 1999 to 2005, the Minneapolis-based Center for Victims of Torture (CVT) served Liberian and Sierra Leonean survivors of torture and war living in the refugee camps of Guinea. A psychosocial program was developed with 3 main goals: (a) to provide mental health care, (b) to train local refugee counselors, and (c) to raise community awareness about war trauma and mental health. Utilizing paraprofessional counselors under the close, on-site supervision of expatriate clinicians, the treatment model blended elements of Western and indigenous healing. The core component consisted of relationship-based supportive group counseling. Clinical interventions were guided by a 3-stage model of trauma recovery (safety, mourning, reconnection), which was adapted to the realities of the refugee camp setting. Over 4,000 clients were provided with counseling, and an additional 15,000 were provided with other supportive services. Results from follow-up assessments indicated significant reductions in trauma symptoms and increases in measures of daily functioning and social support during and after participation in groups. The treatment model developed in Guinea served as the basis for CVT's ongoing work with survivors in Sierra Leone and Liberia. (PsycINFO Database Record (c) 2012 APA, all rights reserved) (journal abstract)

**Tankink, M. (2007). 'The moment I became born-again the pain disappeared': The healing of devastating war memories in born-again churches in Mbarara district, southwest Uganda.** ***Transcultural Psychiatry, 44*****(2), 203-231. doi: 10.1177/1363461507077723**

In southwest Uganda, many people who suffer from devastating war experiences become born-again Christians. This article describes the therapeutic functions of the churches and the experiential transformations associated with becoming born-again. The discourse of the born-again churches gives people another orientation toward the future, based on the Bible, that also provides them with a different perception of the past. Whereas people remain silent about their war experiences in everyday life, the churches offer their members a public space to express their suffering. In these churches, feelings of trust and solidarity are restored. Many aspects of the churches' activities can also be found in western trauma therapies. (PsycINFO Database Record (c) 2012 APA, all rights reserved) (journal abstract)

**Uguak, U. A. (2010). The importance of psychosocial needs for the post traumatic stress disorder (PTSD) and displaced children in schools.** ***Journal of Instructional Psychology,***

***37*(4), 340-351.**

The study targets children in especially difficult circumstances from 8-14 years; and explores the importance of psychosocial needs for the PTSD and displaced children in schools. Out of 235 participants, descriptive statistics indicated that 63 children are traumatized. Based on ANOVA findings, the result revealed that there is significant effect of war on children from 10-14 years since N = 63; F = 3.421; p = .006. Psycho Therapy activities are used to identify and treat those maladjusted children under their noses. The main objective of this paper is to recognize and reduce the ill-effects and adverse consequences of trauma among the affected children and integrate them into social institutions to lead a normal life. (PsycINFO Database Record (c) 2012 APA, all rights reserved) (journal abstract)

**Utuza, A. J., Joseph, S., & Muss, D. (2012). Treating traumatic memories in Rwanda with the rewind technique: Two-week follow-up after a single group session. *Traumatology, 18*(1), 75-78. doi: 10.1177/1534765611412795**

The Rewind Technique (RT) is an exposure based therapy for the treatment of PTSD. The RT is most often used in one to one clinical settings but it also has the potential to be used in a group setting. To date it has not been evaluated in a group setting. The results of a single intervention group therapy session with the RT applied to 21 survivors of the genocide in the East of Rwanda are reported. Results show a statistically significant reduction in scores for clients at 2 weeks. It is concluded that the RT could be a useful tool to incorporate where vast numbers of traumatized people are beyond reach on a one to one basis. (PsycINFO Database Record (c) 2012 APA, all rights reserved) (journal abstract)

**van Rensburg, A. B. R. J., & Jassat, W. (2011). Acute mental health care according to recent mental health legislation. Part II. Activity-based costing. *African Journal of Psychiatry, 14*(1), 23-29.**

Objective: This is the second of three reports on the follow-up review of mental health care at Helen Joseph Hospital (HJH), Objectives for the review were to provide realistic estimates of cost for unit activities and to establish a quality assurance cycle that may facilitate cost centre management Method: The study described and used activity-based costing (ABC) as an approach to analyse the recurrent cost of acute in-patient care for the financial year 2007-08 Fixed (e.g. goods and services, staff salaries) and variable recurrent costs (including laboratory', 'pharmacy') were calculated Cost per day per user and per diagnostic group was calculated. Results: While the unit accounted for 4.6% of the hospital's total clinical activity (patient days), the cost of R8.12 million incurred represented only 2.4% of the total hospital expenditure (R341.36 million). Fixed costs constituted 90% of the total cost. For the total number of 520 users that stayed on average 15.4 days, the average cost was Rl ,023 00 per day and Rl 5748.00 per user. Users with schizophrenia accounted for the most (35%) of the cost, while the care of users with dementia was the most expensive (R23.360 68 per user). Costing of the application of World Health Organization norms for acute care staffing for the unit, projected an average increase of 103% m recurrent costs (R5.1 million), with the bulk (a 267% increase) for nursing. Conclusion: In the absence of other guidelines, aligning clinical activity with the proportion of the hospital's total budget may be an approach to determine what amount should be afforded to acute mental health m-patient care activities m a general regional hospital such as HJH. Despite the potential benefits of ABC, its continued application will require time, infrastructure and staff investment to establish the capacity to maintain routine annual cost analyses for different cost

centres. (PsycINFO Database Record (c) 2012 APA, all rights reserved) (journal abstract)

**Vinck, P., & Pham, P. N. (2010). Association of exposure to violence and potential traumatic events with self-reported physical and mental health status in the Central African Republic. *JAMA: Journal of the American Medical Association, 304*(5), 544-552. doi: 10.1001/jama.2010.1065**

Context: For decades, the Central African Republic (CAR) has experienced violence, economic stagnation, and institutional failure. The latest wave of violence erupted in 2001 and continues to this day in some areas. Yet there has been little attention to the conflict and even less research to document and quantify the conflict's human cost. Objective: To study levels of violence in CAR, including mortality levels, and the association between exposure to violence and traumatic events with self-reported physical and mental health status. Design, Setting, and Participants: Multistage stratified cluster random survey of 1879 adults 18 years or older in selected households conducted in 5 administrative units of CAR (3 in the south, which has been free from recent violence, and 2 in the north, in which violence continues) between October and December 2009. Main Outcome Measures: Mortality, morbidity, exposure to potential traumatic events, sense of insecurity, and meeting of symptom criteria for depression and anxiety using the Hopkins Symptom Checklist-25 with a cut-off score of 1.75. Results: The crude mortality rate (CMR) was 4.9 deaths (95% confidence interval [CI], 4.6-5.1) per 1000 population per month and self-reported CMR due to violence was 0.8 deaths (95% CI, 0.6-1.0) per 1000 population per month. Thirty-five percent reported their physical health status as being good or very good while 29% described it as bad or very bad. Respondents in northern prefectures reported higher rates of mortality, exposure to trauma, and insecurity and lower levels of physical health and access to health services compared with those in the south. The estimated prevalences of symptoms of depression and anxiety were 55.3% (95% CI, 51.6%-59.0%) and 52.5% (95% CI, 48.1%-56.8%), respectively. Exposure to violence and self-reported physical health were statistically associated with mental health outcomes ($P < .001$). Anxiety symptom scores were higher for respondents in the northern prefectures than those in the south ($t = 2.54$, $P = .01$). Conclusion: A high proportion of adult respondents in CAR reported witnessing or having personally experienced traumatic events over the course of the conflicts, and more than half met symptom criteria for depression and anxiety. (PsycINFO Database Record (c) 2012 APA, all rights reserved) (journal abstract)

**Vinck, P., Pham, P. N., Stover, E., & Weinstein, H. M. (2007). Exposure to war crimes and implications for peace building in Northern Uganda. *JAMA: Journal of the American Medical Association, 298*(5), 543-554. doi: 10.1001/jama.298.5.543**

Context: Since the late 1980s, the Lord's Resistance Army has waged war against the Ugandan People's Democratic Army and the people of northern Uganda. Ending the conflict and achieving peace have proven to be challenges. In this context, it is important to examine population-based data on exposure to war crimes to understand how survivors perceive mechanisms aimed at achieving a lasting peace. Objectives: To assess the level of exposure to war-related violence and the prevalence of posttraumatic stress disorder (PTSD) and depression symptoms in northern Uganda and to determine how these variables are associated with respondents' views about peace. Design, Setting, and Participants: Multistage, stratified, random cluster survey of 2585 adults aged 18 years or older conducted in villages and camps for internally displaced persons in 4 districts of northern Uganda in April and May 2005. Main Outcome Measures: Rates and patterns of exposure to trauma; symptom criteria for PTSD,

assessed via the PTSD Checklist-Civilian Version with a total severity score of 44; symptoms of depression, assessed via the Johns Hopkins Depression Symptom Checklist with a cutoff of 42; and opinions and attitudes about peace. Results: Among the respondents, 1,774 of 2,389 (74.3%) met PTSD symptom criteria and 1,151 of 2,585 (44.5%) met depression symptom criteria. Four patterns of exposure to trauma were distinguished: those with low exposure (group 1; 21.4%), witnesses to war-related violence (group 2; 17.8%), those threatened with death and/or physically injured (group 3; 16.4%), and those abducted (group 4; 44.3%). Respondents in groups 3 and 4, who experienced the most traumatic exposures, were more likely to have PTSD symptoms compared with group 1 (group 3 vs group 1: odds ratio [OR], 7.04 [95% confidence interval {CI}, 5.02-9.87]; group 4 vs group 1: OR, 6.07 [95% CI, 4.77-7.71]). Groups 3 and 4 were also more likely to meet depression symptom criteria (group 3 vs group 1: OR, 5.76 [95% CI, 4.34-7.65]; group 4 vs group 1: OR, 4.00 [95% CI, 3.16-5.06]). Respondents who met the PTSD symptom criteria were more likely to identify violence as a means to achieve peace (OR, 1.31; 95% CI, 1.05-1.65). Respondents who met the depression symptom criteria were less likely to identify nonviolence as a means to achieve peace (OR, 0.77; 95% CI, 0.65-0.93). Conclusions: Our study found high prevalence rates for symptoms of PTSD and depression in a conflict zone. Respondents reporting symptoms of PTSD and depression were more likely to favor violent over nonviolent means to end the conflict. (PsycINFO Database Record (c) 2012 APA, all rights reserved) (journal abstract)

**Vinson, G. A., & Chang, Z. (2012). PTSD symptom structure among West African war trauma survivors living in African refugee camps: a factor-analytic investigation. *Journal of traumatic stress, 25*(2), 226-231. doi: 10.1002/jts.21681**

We examined the factor structure of measured posttraumatic stress disorder (PTSD) symptoms in a sample of West African civilian refugees who had fled the civil war in Sierra Leone between 2001 and 2006. Given that such war-affected populations are common but understudied in trauma research, our objective was to examine the similarities and differences in this factor structure compared to prevailing models of PTSD symptom structure. As part of treatment services provided in refugee camps, refugees (2,140 women, 1,662 men, 1 unknown) from Sierra Leone, Liberia, and Guinea completed the 17 symptoms portion of the Posttraumatic Stress Diagnostic Scale (PDS). We used exploratory and confirmatory factor analyses to investigate whether there was a factor structure unique to this population, and made comparisons with the numbing, dysphoria, and aroused intrusion models. Results from the confirmatory analyses showed that the dysphoria model best fit the data (root mean square error of approximation [RMSEA] = .062); however, exploratory analyses revealed that 3 items loaded differently than theoretically expected. Psychological distress cross-loaded on reexperiencing and avoidance factors and physiological reactivity loaded on the avoidance factor instead of the reexperiencing factor. The sleep difficulties item was not well explained, generally; the highest loading (lambda = .22) was on the dysphoria factor. Copyright 2012 International Society for Traumatic Stress Studies. (journal abstract)

**Werner, E. E. (2012). Children and war: Risk, resilience, and recovery. *Development and Psychopathology, 24*(2), 553-558. doi: 10.1017/S0954579412000156**

This article reviews and reflects on studies that have explored the effects of war on children around the world. Most are cross-sectional and based on self-reports. They describe a range of mental health problems, related to dose effects and to the negative impact of being a

victim or witness of violent acts, threats to and loss of loved ones, prolonged parental absence, and forced displacement. The more recent the exposure to war, and the older the child, the higher was the likelihood of reported posttraumatic stress disorder symptoms. Especially vulnerable to long-term emotional distress were child soldiers, children who were raped, and children who had been forcibly displaced. In adulthood, war-traumatized children displayed significantly increased risks for a wide range of medical conditions, especially cardiovascular diseases. Among protective factors that moderated the impact of war-related adversities in children were a strong bond between the primary caregiver and the child, the social support of teachers and peers, and a shared sense of values. Among the few documented intervention studies for children of war, school-based interventions, implemented by teachers or locally trained paraprofessionals, proved to be a feasible and low-cost alternative to individual or group therapy. More longitudinal research with multiple informants is needed to document the trajectories of risk and resilience in war-affected children, to assess their long-term development and mental health, and to identify effective treatment approaches. (PsycINFO Database Record (c) 2012 APA, all rights reserved) (journal abstract)

**Wessells, M., & Monteiro, C. (2006). Psychosocial Assistance for Youth: Toward Reconstruction for Peace in Angola. *Journal of Social Issues, 62*(1), 121-139. doi: 10.1111/j.1540-4560.2006.00442.x**

Following decades of war, Angolan youth are at risk of continuing cycles of violence and need support in developing positive behaviors and social roles. Accordingly, a community-based program, conducted in Angola 1998-2001, taught youth life skills, provided peer support and peace education, educated adults about youth, and engaged youth as workers on community development projects. The main results included increased adult awareness of the situation and needs of youth, improved youth-adult relations, reduced perceptions of youth as troublemakers, reduced fighting between youth, increased community planning, and increased perceptions that youth make a positive contribution to the community. The results suggest that a dual focus on youth and community development contributes to peacebuilding and the disruption of cycles of violence. (PsycINFO Database Record (c) 2012 APA, all rights reserved) (journal abstract)

**Williams, S. L., Williams, D. R., Stein, D. J., Seedat, S., Jackson, P. B., & Moomal, H. (2007). Multiple traumatic events and psychological distress: The South Africa Stress and Health Study. *Journal of Traumatic Stress, 20*(5), 845-855. doi: 10.1002/jts.20252**

Using nationally representative data from South Africa, we examine lifetime prevalence of traumas and multiple traumas (number of events). Employing multiple regression analysis, the authors study the sociodemographic risk of trauma, and the association between trauma and distress. Results indicate most South Africans experience at least one traumatic event during their lives, with the majority reporting multiple. Consistent variation in risk is evident for gender and marital status, but not other sociodemographics. Trauma is positively related to high distress, and findings also support a cumulative effect of trauma exposure. Individuals with the most traumas (6+) appear at 5 times greater risk of high distress. This study highlights the importance of considering traumatic events in the context of other traumas in South Africa. (PsycINFO Database Record (c) 2012 APA, all rights reserved) (journal abstract)

**Yeomans, P. D., Forman, E. M., Herbert, J. D., & Yuen, E. (2010). A randomized trial of a reconciliation workshop with and without PTSD psychoeducation in Burundian sample.**

***Journal of Traumatic Stress, 23*(3), 305-312.**

Posttraumatic stress disorder (PTSD) psychoeducation is increasingly offered in diverse cultural settings. As the literature offers theoretical arguments for why such information might be normalizing and distress-reducing, or might risk morbid suggestion of greater vulnerability, a two-sided hypothesis was proposed to examine the specific effect of PTSD psychoeducation. Participants of a trauma healing and reconciliation intervention in Burundi were randomized to conditions with and without PTSD psychoeducation, or to a waitlist control. Both interventions reduced symptoms more than the waitlist. Participants in the condition without psychoeducation experienced a greater reduction in PTSD symptoms relative to other conditions. Findings are discussed in relationship to intervention development for traumatic stress in nonindustrialized and culturally diverse settings. (PsycINFO Database Record (c) 2012 APA, all rights reserved) (journal abstract)

# APPENDIX B

## Annotated Bibliography of Recommended Books & Chapters on Addressing Trauma in Global Contexts

**Agger, I. (2006). Approaches to Psychosocial Healing: Case Examples from Lusophone Africa. In G. Reyes & G. A. Jacobs (Eds.),** ***Handbook of international disaster psychology: Practices and programs (Vol. 2).*** **(pp. 137-155). Westport, CT US: Praeger Publishers/Greenwood Publishing Group.**

(from the chapter) This chapter is based on a study that was part of a multidisciplinary research program: "Conflict and its aftermath: Health and social consequences of a complex emergency in Guinea-Bissau; preconditions and long-term consequences." The research program, which started in June 1999, ran over a three-year period and was funded by the Danish Council for Development Research/Danish International Development Agency. The objective of the study was to contribute to the understanding of complex emergencies in Africa by analyzing psychosocial aspects of armed conflict and humanitarian interventions exemplified by case studies from Lusophone Africa (Angola, Mozambique, and Guinea-Bissau). The material for the study was collected and elaborated during a one-year period (from June 1, 1999, to June 2000) that included language studies and fieldwork among nongovernmental organizations (NGOs) in Lisbon in June 1999, fieldwork in Guinea-Bissau in October 1999, and work in Angola in June 2000. Additionally, the chapter concerns a specific type of assistance, namely, psychosocial interventions for war-affected people. Through case examples, various discourses of healing are examined--with special emphasis on two main approaches that are currently widely disputed in the aid community: the protection-oriented rights approach, associated with interventions that respect and protect the "rights" of local culture and traditions, versus the more treatment-oriented trauma approach, associated with the application of Western, "medical" intervention modes in developing countries. (PsycINFO Database Record (c) 2012 APA, all rights reserved) (chapter)

**de Jong, J. (2002).** ***Trauma, war, and violence: Public mental health in socio-cultural context.*** **New York, NY US: Kluwer Academic/Plenum Publishers.**

(from the preface) Describes a variety of programs to address mental health and psychosocial problems in low-income countries and conflict and post-conflict areas in Africa, Asia and the Middle East. Examples from 9 programs started or supported by the Transcultural Psychosocial Organization clarify how mental health can be approached within different sociocultural contexts, while also providing the historical, political and sociocultural background of different conflicts. The book focuses on the public mental health aspects of complex humanitarian and political emergencies. These emergencies combine several features: (1) they violate human rights; (2) involve the use of both state and non-state terror; (3) they often occur within a country rather then across state boundaries; (4) they include expressions of political, economics and sociocultural divisions; (5) they promote competition for power and resources and result in predatory social formations; (6) they affect large, displaced and mostly poor populations; and (7)

they often are protracted in duration and accompanied by cycles of violence. Governments, non-governmental organizations, and United Nations agencies will find this book useful when setting up community mental health and psychosocial services. (PsycINFO Database Record (c) 2012 APA, all rights reserved) (preface)

**Fairbank, J. A., Ebert, L., & Zarkin, G. A. (1999). Socioeconomic consequences of traumatic stress. In P. A. Saigh & J. D. Bremner (Eds.), *Posttraumatic stress disorder: A comprehensive text.* (pp. 180-198). Needham Heights, MA US: Allyn & Bacon.**

(from the chapter) One purpose of this chapter is to provide an introduction to research on mental health and labor market outcomes and to communicate the relevance of this topic to researchers in the field of traumatic stress. A primary goal is to provide an analytic review of the existing research on relationships between traumatic stress exposure, mental health, and labor market outcomes. Given the limited scope of research in this area, another key aim is to guide and inform future research on the economic outcomes of exposure to traumatic stress. (chapter)

First we introduce the labor market outcome variables and analytic approaches that are standard practice in economics research. Next, we review the major general population studies that use such approaches to examine associations between mental health and labor market outcomes. We then provide a detailed review of studies which have specifically examined relationships between traumatic stress exposure and labor market outcomes. In reviewing this research we offer a framework that emphasizes the manner in which traumatic stress exposure is measured and the extent to which relevant sociodemographic variables and mental health indicators are utilized in evaluating associations between trauma and labor market outcomes. (PsycINFO Database Record (c) 2012 APA, all rights reserved) (chapter)

**Kamya, H. (2009). Healing from refugee trauma: The significance of spiritual beliefs, faith community, and faith-based services. In F. Walsh (Ed.), *Spiritual resources in family therapy (2nd ed.).* (pp. 286-300). New York, NY US: Guilford Press.**

(from the chapter) The challenges of addressing trauma among refugee populations require that all who are involved in their care gain a deeper understanding of the role of faith in refugees' healing process. This chapter explores the interface of faith-based services, pastoral counseling, and clinical practice, and suggest ways of tapping spiritual resources in therapy through linkages with faith communities, the practice of prayer, and the use of metaphors. I offer clinical illustrations from my therapeutic work with Mot, a young refugee, one of the "Lost Boys" from Sudan. (PsycINFO Database Record (c) 2012 APA, all rights reserved) (chapter)

**Miller, K. E., & Rasco, L. M. (2004). *The mental health of refugees: Ecological approaches to healing and adaptation*. Mahwah, NJ US: Lawrence Erlbaum Associates Publishers.**

(from the preface) There is a gradual recognition occurring among mental health professionals who work with refugees and internally displaced people that the old paradigm of clinical intervention, though certainly useful, cannot be the cornerstone of our response to the mental health needs of these communities. The authors in this book

share a common vision, a commitment to an alternative conceptual framework within which culturally appropriate refugee mental health programs can be developed. As the various chapters illustrate, such programs empower communities to take greater control over their own mental health and the conditions that affect it. Guided by an ecological model that combines elements of public health, empowerment theory, community psychology, clinical psychology, psychiatry, and anthropology, ecological mental health programs have been developed for refugees in highly diverse settings. The diverse projects described in this book are innovative, empowering, and far-reaching in their impact. Importantly, the contributing authors have not been asked to present models of fully polished, flawless intervention strategies. Instead, the goal has been to share a wealth of innovative and impactful intervention experiences that illustrate a new way of thinking about how we can best support the healing and adaptation of communities displaced by violence--communities that are struggling to heal from the wounds of the past. (PsycINFO Database Record (c) 2012 APA, all rights reserved) (preface)

**Norris, F. H., Galea, S., Friedman, M. J., & Watson, P. J. (2006). *Methods for disaster mental health research*. New York, NY US: Guilford Press.**

(from the jacket) Understanding the psychological consequences of natural or technological disasters and terrorism--and measuring the effectiveness of postdisaster interventions--are critical tasks for contemporary researchers and practitioners. This practical volume assembles leading experts to consider large-scale traumatic events from different perspectives and to translate their chaotic aftermath into feasible research ideas and approaches. It provides an in-depth introduction to disaster mental health research, together with invaluable guidance for overcoming logistical and scientific challenges. The book begins with a review of key concepts and findings pertaining to disasters and their effects on individuals and communities. A framework is presented for formulating appropriate research questions and selecting the design and methods that best meet the investigators needs. Approaches to sampling and data collection are detailed, including face-to-face, telephone, Web-based, and school-based strategies. A rationale and techniques for collecting qualitative data are also described. Subsequent chapters take a closer look at program evaluation and public mental health planning, emphasizing how ethical, high-quality research can improve the quality and availability of clinical services for mass trauma survivors. Rounding out the volume is a section on the nuts and bolts of studying specific populations--children and adolescents, military personnel, and culturally diverse communities--and of conducting international research. The concluding chapter identifies high-priority directions for future work in the field. Throughout, many examples from recent studies are used to illustrate the points discussed. Timely, authoritative, and user friendly, this is an important reference for researchers in clinical psychology, psychiatry, social work, public health, and related disciplines. It may serve as a primary or supplemental text in graduate-level courses, and will also be of interest to clinicians specializing in disaster mental health or treatment of psychological trauma. (PsycINFO Database Record (c) 2012 APA, all rights reserved) (jacket)

**Peddle, N., Monteiro, C., Guluma, V., & Macaulay, T. E. A. (1999). Trauma, loss, and resilience in Africa: A psychosocial community based approach to culturally sensitive healing. In K. Nader, N. Dubrow & B. H. Stamm (Eds.), *Honoring differences: Cultural issues in the treatment of trauma and loss.* (pp. 121-149). Philadelphia, PA US: Brunner/Mazel.**

Presents a synthesis of backgrounds, cultural beliefs, and values found in many areas of Africa. Two African countries, Sierra Leone and Angola, are examined in-depth in an effort to encourage expatriates' use of culturally sensitive, community based approaches that respect the local culture and community and avoid historic patterns of Western domination and derogation of traditional African practices. This chapter begins with the personal experience of one of the authors in Sierra Leone. Next, background information is provided. Language, history, cultural beliefs and rituals are detailed. Political and economic factors, and religion are discussed. It describes health and healing in Africa in terms of Western and traditional forms. The community based strategy for healing is presented and recommendations for interventionists are also provided. (PsycINFO Database Record (c) 2012 APA, all rights reserved)

**Peltzer, K., & Chongo, A. (2000). Trauma and the rehabilitation of torture and violence victims in Mozambique. In S. N. Madu, P. K. Baguma & A. Pritz (Eds.), *Psychotherapy and African reality.* (pp. 95-119). Sovenga South Africa: UNIN Press.**

(from the chapter) Identifies trauma and rehabilitation needs of torture and violence victims in Mozambique. On the basis of consultative meetings, pilot studies in two provinces and literature review the following target populations of torture and violence were identified: (1) political torture victims under colonial rule; (2) religious torture and violence under colonial and post-colonial rule; (3) war victims; (4) ex-soldiers; (5) victims of "operation production"; (6) torture victim in police custody and prison; (7) refugees; (8) children, unaccompanied minors; (9) war amputees; (10) disappearances; and (11) women. The pilot studies included a sample of 71 Political Prisoners of the colonical system, Jehovah's Witnesses and demobilized soldiers. A high incidence of psychotrauma was found. Specialized health and psychosocial services for victims of torture and violence are reviewed in Mozambique, and it is concluded that the creation of treatment and rehabilitation centers for these target groups are recommended. (PsycINFO Database Record (c) 2012 APA, all rights reserved) (chapter)

**Pynoos, R. S., Nader, K., Black, D., Kaplan, T., Hendriks, J. H., Gordon, R., et al. (1993). The impact of trauma on children and adolescents. In J. P. Wilson & B. Raphael (Eds.), *International handbook of traumatic stress syndromes.* (pp. 535-657). New York, NY US: Plenum Press.**

(from the book) [book section covering several chapters] (book)

"Issues in the Treatment of Posttraumatic Stress in Children and Adolescents" / Robert S. Pynoos and Kathi Nader / discuss issues in the treatment of posttraumatic stress reactions in children and adolescents (book)

"Father Kills Mother: Effects on the Children in the United Kingdom" / Dora Black, Tony Kaplan and Jean Harris Hendriks / study the psychiatric sequelae of an intrafamilial homicide [on children in the United Kingdom] (book)

"Responses of Children and Adolescents to Disaster" / Rob Gordon and Ruth Wraith /

discuss the responses of children and adolescents to disaster (book)
"Childhood Sexual and Physical Abuse" / Arthur Green / develop a theoretical framework to help us understand the nature of the trauma associated with the physical and sexual abuse of children and its relationship to posttraumatic stress disorder (PTSD) (book)
"Father–Daughter Incest" / Judith Lewis Herman / discusses father–daughter incest, a traumatic event that ruptures the bond of trust between a parent and a child and the family system as well (book)
"Bitter Waters: Effects on Children of the Stresses of Unrest and Oppression" / Michael A. Simpson / explores the effects of political repression, chronic unrest, and civil violence on children and adolescents, as well as their families, who live in South Africa (book)
"Traumatic War Experiences and Their Effects on Children" / Mona S. Macksoud, Atle Dyregrov and Magne Raundalen / examine the nature of childhood war traumata and their potential deleterious effects on children (book)
"Transgenerational Transmission of War-Related Trauma" / Laurie Leydic Harkness / review the various ways PTSD can affect family life from a systems perspective as well as extending to the impact of PTSD on daily family life (book)
"Apartheid: Disastrous Effects of a Community in Conflict" / Derrick Silove and Robert Schweitzer / explore the effect of apartheid on children and adolescents in South Africa (book)
"Psychotherapy with Young Adult Political Refugees: A Developmental Approach" / Guus van der Veer / present some of the possibilities which developmental theories of adolescence provide for understanding the problems of young adult political refugees and . . . show that this approach also provides a point of departure for intervention and therapy (PsycINFO Database Record (c) 2012 APA, all rights reserved) (book)

**Thielman, S. B. (2011). Religion and spirituality in the description of posttraumatic stress disorder. In J. R. Peteet, F. G. Lu & W. E. Narrow (Eds.),** ***Religious and spiritual issues in psychiatric diagnosis: A research agenda for DSM-V.*** **(pp. 105-113). Washington, DC US: American Psychiatric Association.**

(from the chapter) In this chapter the author discusses the diagnostic description of PTSD and the inclusion of spiritual and religious considerations. He cautions against creating a biased, Westernized view. Rather, recommendations include cross-cultural considerations that may differ significantly in interpretation of symptoms and treatment. Unlike a Westernized orientation, many cultures place little emphasis on individual psychological experiences, focusing instead on issues of family, religion, and meaning within a larger social context. Clinicians working in settings involving war, political uncertainty, or natural catastrophe should be circumspect when educating survivors about the emergence of PTSD and proposed remedies for traumatic stress. PTSD may not be as prevalent in non-Western settings as in the West, and the intact extended social networks that often exist in non-Western settings may be protective against the development of PTSD. The DSM-V presentation of PTSD might profitably be framed in such a way that it does not facilitate the exportation to other cultures of a purely technological worldview that describes experiences of distress in technical terms and offers a technical solution. Such an approach will avoid draining local narratives of their meaning and will try to preserve

alternative approaches to understanding that are steeped in local tradition and promote connectedness. In this way DSM will promote a way of understanding that helps those who have been traumatized to use readily available resources to grapple with and grow through the stressful circumstances. Although DSM focuses on the symptoms of the individual, these larger social considerations should also enter into the weight a clinician places on the likelihood of the PTSD diagnosis and the effectiveness of proposed treatments (i.e., securing basic needs such as food and shelter may be much more important than a decision on pharmacological treatment in some situations). Future research directions in the relationship of PTSD to religious and spiritual concerns will need to include a focus on contextual factors that shape PTSD, use cross-cultural comparisons to highlight how divergent world views might affect the presentation and course of PTSD, and explore how religious and spiritual factors might ethically be included in treatment strategies. (PsycINFO Database Record (c) 2012 APA, all rights reserved) (chapter)

**Walker, E. A., Newman, E., & Koss, M. P. (2004). Costs and health care utilization associated with traumatic experiences. In P. P. Schnurr & B. L. Green (Eds.),** ***Trauma and health: Physical health consequences of exposure to extreme stress.*** **(pp. 43-69). Washington, DC US: American Psychological Association.**

(from the chapter) This chapter is an overview of the issues facing the next generation of research in trauma treatment. It summarizes the economic consequences of the detection and nondetection of trauma status in health care settings, associated costs and impacts on utilization, and how research and policy barriers might be overcome by targeted health services research designs. We review core concepts of service utilization, cost analysis, and the potential impact of disclosure of trauma histories on eligibility for insurance. We also examine statistical issues regarding the proper interpretation of cost data with particular focus on analytic methods and study design that are appropriate to account for the large variability in service utilization and medical system design. (PsycINFO Database Record (c) 2012 APA, all rights reserved) (chapter)

**Wessells, M., & Monteiro, C. (2001). Psychosocial interventions and post-war reconstruction in Angola: Interweaving Western and traditional approaches. In D. J. Christie, R. V. Wagner & D. D. N. Winter (Eds.),** ***Peace, conflict, and violence: Peace psychology for the 21st century.*** **(pp. 262-275). Upper Saddle River, NJ US: Prentice Hall/Pearson Education.**

(from the chapter) The purpose of this chapter is twofold. First, it aims to show that psychosocial reconstruction is an integral part of wider, multidisciplinary processes of post-war reconstruction. Second, it examines a national program for psychosocial reconstruction in Angola conducted by Christian Children's Fund (CCF), an international NGO. The program addresses two main elements of psychosocial reconstruction: healing the wounds of war and demobilizing and social reintegrating former child soldiers. The focus on Angola is timely because the scale of human needs there is immense and because Angola remains trapped in recurrent cycles of violence. To make its maximum contribution, psychological methods must be shown to apply under the most dire conditions. The program discussed here fits within the definition of peace psychology since it aims to help prevent violence. Further, Angolan cosmology and traditional

practices challenge the assumptions of Western peace psychology, offer an opportunity for intercultural learning and integration, and work in a partnership mode. (PsycINFO Database Record (c) 2012 APA, all rights reserved) (chapter)

**Wessells, M., & Monteiro, C. (2003). Healing, social integration, and community mobilization for war-affected children: A view from Angola. In S. Krippner & T. M. McIntyre (Eds.),** ***The psychological impact of war trauma on civilians: An international perspective.*** **(pp. 179-191). Westport, CT US: Praeger Publishers/Greenwood Publishing Group.**

(from the chapter) Over the past several decades, the nature of armed conflict has changed and the consequences for children have been catastrophic. In complex emergencies such as that in Angola's 40-year-old war, trauma is only a small part of a much larger set of psychosocial burdens carried by war-affected children and families. For psychologists interested in supporting children and preventing further abuses of children, it is important to examine strategies for more comprehensive, integrated psychosocial assistance in war zones. The purpose of this chapter is to illustrate a community-based strategy for providing psychosocial assistance involving elements pertaining to healing, reintegration of underage soldiers, and youth development. Because the purpose is to illustrate the application of a wider approach to psychosocial assistance, the emphasis will be on summarizing diverse program strategies and elements, and their connection with the core issue of preventing violence. The importance of respecting local culture will be emphasized throughout. (PsycINFO Database Record (c) 2012 APA, all rights reserved) (chapter)

**Wessells, M., & Monteiro, C. (2004). Internally Displaced Angolans: A Child-focused, Community-based Intervention. In K. E. Miller & L. M. Rasco (Eds.),** ***The mental health of refugees: Ecological approaches to healing and adaptation.*** **(pp. 65-94). Mahwah, NJ US: Lawrence Erlbaum Associates Publishers.**

For children, who comprise approximately half the population of Angola, the war has imposed heavy emotional and social burdens. Internally displaced children, for example, have suffered the loss of their homes and the stable routines that provide a sense of security, support, and continuity. Many children have lost parents or family members, and experience profound grief, insecurity, and uncertainty about how their needs will be met. Amidst the daily challenges of survival in Angola, there may be little space for grieving and coming to terms with what has happened. Traumatic distress is prevalent, as recent research indicates 70% to 90% rates of post-traumatic stress disorder among Angolan teenagers who have had extensive exposure to war (Eyber, 2002; Mclntyre & Ventura, in press). This chapter describes an intervention project, which was part of a much larger program focused on youth and addressed five key problems: community disruption and destabilization; material deprivation; weak supports for children in camps and settlement areas; destructive conflict between displaced groups and relatively stable communities; and inappropriate supports for orphans. (PsycINFO Database Record (c) 2012 APA, all rights reserved)

**Wessells, M. G. (1999). Culture, power, and community: Intercultural approaches to psychosocial assistance and healing. In K. Nader, N. Dubrow & B. H. Stamm (Eds.), *Honoring differences: Cultural issues in the treatment of trauma and loss.* (pp. 267-282). Philadelphia, PA US: Brunner/Mazel.**

Aims to integrate main insights into a broad conceptual framework centered around the issues of context, culture, power, and community. This chapter begins with the idea that loss of hope, meaning, and perceived control are pivotal aspects of trauma (J. Herman, 1992). Recovery from trauma and loss is argued to require the reconstruction of meaning, the rebuilding of hope and the sense of empowerment needed to regain control of one's being and life. The author contends that the imposition of Western, decontextualized views marginalizes local voices and cultural traditions, disempowers communities, and limits healing. Conversely, the use of consultants' power to situate problems in historic context and to learn about and valorize local cultural traditions, when appropriate, is viewed as empowering the community and bringing into play culturally appropriate sustainable healing resources. Implications for how one works as a consultant, views and works with local people in need, and disposes oneself toward other cultures are considered. (PsycINFO Database Record (c) 2012 APA, all rights reserved)

**Wessells, M. G. (2007). Post-conflict healing and reconstruction for peace: The power of social mobilization. In J. D. White & A. J. Marsella (Eds.), *Fear of persecution: Global human rights, international law, and human well-being.* (pp. 257-278). Lanham, MD US: Lexington Books/Rowman & Littlefield.**

(from the chapter) The purpose of this paper is to expand the discourse on psychosocial assistance to refugees and displaced people beyond the trauma frame toward more holistic approaches enabling movement toward peace, conceived systemically to include nonviolence and social justice at multiple levels. Drawing on work from the field, much of it conducted by U.N. agencies and nongovernmental organizations (NGOs), it argues that narrow, clinical approaches are less well suited than are community-based approaches to the tasks of sustainable healing on a wide scale and of building peace. Examining community-based work in Angola, it illustrates the potential power of healing based on social mobilization that builds local capacities, uses local resources, and activates communities for economic development and social action on behalf of peace and the well-being of future generations. (PsycINFO Database Record (c) 2012 APA, all rights reserved) (chapter)

**Wessells, M. G., & Monteiro, C. (2004). Healing the wounds following protracted conflict in Angola: A community-based approach to assisting war-affected children. In U. P. Gielen, J. M. Fish & J. G. Draguns (Eds.), *Handbook of culture, therapy, and healing.* (pp. 321-341). Mahwah, NJ US: Lawrence Erlbaum Associates Publishers.**

(from the chapter) This chapter describes a large-scale program of psychosocial assistance to war-affected children conducted in Angola by an international nongovernmental organization (NGO), Christian Children's Fund (CCF). Focusing on the period 1995 to 1998, during which there were hopes for peace in the aftermath of the Lusaka Protocol, the program places culture and community participation at the center of psychosocial reconstruction. Having described the Angolan war and its impact on civilians, we outline the local cosmologies and cultural practices that color the

interpretation of people's war experiences and provide the foundation for culturally relevant methods of healing and social integration. Against this cultural background, we analyze the implications for psychosocial intervention on a mass scale. In particular, we describe two concurrent community-based projects that focus on healing and on the reintegration of former child soldiers, respectively. Although the results of these projects are discussed, we emphasize the process of integrating Western and traditional methods because this process has implications for the conduct of psychosocial work in other regions. (PsycINFO Database Record (c) 2012 APA, all rights reserved) (chapter)

**Worthington, E. R., & Aten, J. D. (2010). Forgiveness and reconciliation in social reconstruction after trauma. In E. Martz (Ed.) , *Trauma rehabilitation after war and conflict: Community and individual perspectives* (pp. 55-71). New York, NY US: Springer Science + Business Media.**

(from the chapter) We examine social reconstruction after human-caused trauma—with a focus on warfare, civil disquiet, or conflict. Specifically, we examine the roles of forgiveness and reconciliation in social reconstruction. Forgiveness promotes both trustworthy and trusting behavior, which can lead to reconciliation. Forgiveness and reconciliation help heal past memories, restore present trust, and thus pave the way for breaking future cycles of trauma. Forgiveness and reconciliation happen in the present but affect the future. They arise from the crucible of conflict and trauma in which people's hopes can be squashed. Yet,forgiveness and reconciliation can also renew crushed spirits, which can lead not only to inner peace within an individual but to peace within a country torn apart by conflict. We suggest a model of aggression and related model of peacemaking and reconciliation. We also offer a series of societal and diplomacy recommendations that are meant to facilitate forgiveness and reconciliation following social traumas. In this chapter, and in the present book, the focus is on recovery and rehabilitation after armed conflict, which in most cases, involve people within a country killing, maiming, and harming their fellow citizens—not perpetrating harm on citizens of a different country. (PsycINFO Database Record (c) 2012 APA, all rights reserved)

# APPENDIX C

## Recommended Websites for Further Reading and Resources

**Africa Mental Health Foundation:** www.africamentalhealthfoundation.org/

**Africa Mental Health Programme:** http://www.aho.org.uk/africa_mental_health.html

**APA Division 52 International Psychology:** http://www.apa.org/about/division/div52.aspx

**APA Division 56 Trauma Psychology:** http://www.apatraumadivision.org/

**Centre for Public Mental Health (South Africa):** http://www.cpmh.org.za/

**Cost of War:** http://costsofwar.org/

**Human Rights Watch:** http://www.hrw.org/

**Institute of Development Studies:** http://www.ids.ac.uk/

**International Society for Traumatic Stress Studies:** http://www.istss.org/

**International Trauma-Healing Institute:** http://www.traumainstitute.org/

**United Nations Development Program:** http://www.undp.org/

**USAID:** http://www.usaid.gov/

**World Bank:** http://www.worldbank.org/

**World Health Organization Africa:** http://www.afro.who.int/

**World Health Organization Mental Health:** http://www.who.int/mental_health/en/

**World Federation for Mental Health Africa Initiative Online Resource Directory:** http://www.wfmh.org/PDF/PSYCHOSOCIAL%20BEST%20PRACTICE%20FOR%20WEB%20v2.pdf

www.wheaton.edu/HDI