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Cultural Consensus Model of Depression Beliefs Among Afghan Refugees

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Cultural Consensus Model of Depression Beliefs among Afghan Refugees

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ABBREVIATIONS

APA	American Psychiatric Association
ASCL	Afghan Symptom Checklist
ASI	Acculturation Stress Index
AUDIT	Alcohol Use Disorders Identification Test
AWES	Afghan War Experiences Scale
BDI	Beck Depression Inventory
BSI	Bradford Somatic Inventory
CAPS-1	Clinician Administered PTSD Scale
CCM	Cultural Consensus Model
CCT	Cultural Consensus Theory
CIA	Central Intelligence Agency
CIDI	Composite International Diagnostic Interview
CES-D	Center for Epidemiologic Studies Depression Scale
CMI	Cornell Medical Index
DHHS	Department of Health and Human Services
DSM	Diagnostic and Statistical Manual of Mental Disorders
EU	European Union
FGD	Focus Group Discussion
GP	General Practitioner
HSCL	Hopkins Symptom Checklist
HTQ	Harvard Trauma Questionnaire
ICD	Informed Consent Document

IDP	Internally Displaced Person
IES-R	Impact of Events Scale-Revised
IOM	International Organization for Migration
KII	Key Informant Interview
LSNS	Lubben Social Network Scale
MAP	Maudsley Addiction Profile
NAMI	National Alliance on Mental Illness
NIMH	National Institute of Mental Health
NATO	North Atlantic Treaty Organization
OECD	Organization for Economic Development and Cooperation
OSR	Office of Sponsored Research
PPV	Permanent Protection Visa
PRWORA	Personal Responsibility and Work Opportunity Reconciliation Act
PTSD	Post-traumatic Stress Disorder
RA	Research Assistant
SASS	Social Adaptation Self-Evaluation Scale
SB	Senate Bill
SF	San Francisco
TBDI	Talbieh Brief Distress Inventory
TPV	Temporary Protection Visa
WHO	World Health Organization
UNDESA	United Nations Department of Economic and Social Affairs
UNHCR	United Nations High Commissioner for Refugees

US	United States
UK	United Kingdom

ABSTRACT OF THE DISSERTATION

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Dr. Sigrid James, Chairperson

This study describes gender-specific beliefs about depression among Afghan refugees, a population shown to be highly distressed. A 73-item questionnaire covering causes, symptoms, and treatments of depression, developed through free-listing techniques and supplemented with items from existing scales, was administered to a non-random sample of 50 men and 43 women in San Diego County. Demographic information and data on baseline distress levels were also collected. The Cultural Consensus Model was used to estimate the culturally correct answer for each question, and to assess the proportion of shared beliefs within and between groups. Results from consensus analysis indicated a homogenous response pattern present for each group, and collectively when groups were combined. The proportion of shared beliefs across all depression domains was significantly ($p < .05$) higher among women (.52) than in men (.46). Women also reported significantly higher agreement in terms of depression causality (women = .54, men = .42). Equal agreement (.45) was observed in groups regarding symptoms. Items relating to treatments were the most widely recognized by men (.53) and women (.57); however, significant differences in agreement were not observed. Results did not vary by demographic characteristics or by distress experiences for either group. Causes were associated with cultural conflicts and social isolation;

women classified more somatic items, and both groups believed that treatments for depression included seeking professional help as well as lay techniques such as engaging in religious activities and exercise. Understanding cultural beliefs about depression among Afghan refugees could provide insights into the cultural and social reasons that influence help-seeking behaviors and the presentation of depressive symptoms in clinical settings, in turn, leading to improvements in service provision and depression care.

CHAPTER 1

INTRODUCTION

Problem Statement

Background

Migration is defined as "the movement of a person or a group of persons, either across an international border, or within a State…it includes migration of refugees, displaced persons, economic migrants, and persons moving for other purposes, including family reunification" (IOM, 2011). Migration involves an origin, a destination, and an intervening set of obstacles regardless of the distance or degree of difficulty (Lee, 1966). Inherent in the migration process, according to Djuretic, Crawford, and Weaver (2007) is the loss and gain of "land, language and law" (p. 743). Causes for human migration are vast; however, they can be categorized into two distinct, sometimes co-occurring circumstances that developing countries often endure. These include economic deprivation, and war, which tend to produce two classes of migrants, *voluntary* and *involuntary*, respectively. These classifications are included in the IOMs definition of 'migration.'

The first, voluntary or economic migration occurs as a result of one's own desire to relocate within or across borders to improve his/her economic prospects (Chiswick, 2000). The UNDESA (2008) indicates that the total number of international migrants has grown substantially within the past 10 years as numbers have increased from 150 million in 2000 to 214 million persons. The underlying factors for the growth of migrants can be partly attributed to globalization, which refers to the "widening, deepening, and speeding up of global interconnectedness" (Held, McGrew, Goldblatt, & Perraton, 1999, p. 14).

This has generated unprecedented movements of people across borders (both legally and unlawfully) given demands for cheap labor.

In addition to the demand for cheap labor on which the United States (US) progressively became dependent, migration to the US was spurred by the signing of the 1965 Immigration Act. The law placed higher ceilings on entry numbers, and as a result, the foreign-born population has grown considerably given large-scale immigration from Latin America and Asia. Moreover, this policy abolished laws calling for immigrant entry quotas based on racial preferences, and also created generous ordering of preferences in the distribution of visas (Gerber, 2011). Also, Gerber (2011) suggests that modernizing forces have created opportunities for prosperity and security to the point where many people may consider permanently changing their residence.

It is estimated that over 40 million people currently living in the US are foreign born, accounting for nearly 13% of the total population (US Census Bureau, 2011c). The time period between 1990 and 2000 marked a significant foreign-born growth rate as the total number of foreign-born residents in the US increased by 57% with more undocumented than legal immigrants arriving each year (Nandi et al., 2008). Nandi and colleagues suggest that an estimated 10 million undocumented immigrants are currently living in the US. Of this figure it has been estimated that 8.4 million are Latino (Ortega et al., 2007). Perpetual economic deprivation in Mexico and other Latin countries has served as a push factor in motivating these populations to unlawfully enter the US for work.

Policies intended on curbing the illegal immigration problem in the US have raised human rights concerns and have also consequently drawn much criticism from the

public. For example, Arizona recently passed the *Safe Neighborhoods Act* or *SB 1070* (2010), which aims to "identify, prosecute and deport illegal immigrants" (Archibold, 2010). In the 1990s, fiscal conservatives (in collaboration with the Clinton administration) passed the *Personal Responsibility and Work Opportunity Reconciliation Act or PRWORA*, commonly referred to as *Welfare Reform* (Sawhill, 1995). One objective of this law was to significantly change the provisions of welfare benefits for both unlawful as well as lawful immigrants (Kullgren, 2003). In creation of the law, Congress's basic intent was to reduce the national deficit by lowering federal expenditures. This meant setting restrictions on welfare benefits for *all* immigrants by "encouraging economic self-sufficiency through work" (Kaushal & Kaestner, 2005, p. 698).

Furthermore, the social forces underlying economic migration, both lawful and unlawful, are explicated through various theories posited within the disciplinary area of 'migration.' Reference is made to the *Neoclassical, Dual Labor Market, New Economics of Migration, World Systems* theories (Jennissen, 2007). Neoclassical economic theory posits that wage differences between two regions are the reason why people migrate (Jennissen, 2007). People transcend borders from low to high capital regions in spite of their being a shortage of labor (yet high wages) in these regions; hence, making movement an "individual decision for income maximization" (Massey et al. 1993, p. 432). Dual Labor Market theory asserts that industrialized nations pull migrants due to labor demands (Jennissen, 2007). The New Economics of Migration theory asserts that families migrate to minimize risks to family income or to overcome capital constraint (Jennissen, 2007). Similarly, Wallerstein's (2004) World Systems theory cites migration

as “a natural outgrowth of disruptions and dislocations that inevitably occur in the process of capitalist development” (Massey, 1993, p. 445). Essentially economic migrants have been incorporated in the world market due to pull factors in Western nations and push factors occurring in developing countries.

Lee’s Model and Forced Migration

Lee’s (1966) *push-pull* model extends Wallerstein’s concept by lending itself to the notion of forced migration. Push factors, or non-favorable social and economic occurrences in the country of origin, which can range from financial hardship and unemployment to persecution and war are reasons why people simply flee their homelands. In contrast, pull factors take place in the country of destination and include benefits such as education, employment and healthcare to religious freedom and security, all of which attract a diverse array of people. Lee (1966) alludes to the fact that migration is selective in that “persons respond differently to the sets of plus and minus factors at origin and at destination” (p. 56). Selection can be positive or negative. Positive selection refers to the immigration of *high quality migrants* or individuals that are able-bodied, aggressive, educated, and who are able to overcome various obstacles in order to reach the host country (Lee, 1966).

This is evidenced by concepts such as the *healthy migrant effect*, which asserts that immigrants resettling in industrialized nations are often healthier than their native-born counterparts (Fennelly, 2007). Jasso, Massey, Rosenzweig, and Smith’s (2004) argument supports the position that migration is selective with regard to health, namely that individuals who migrate are a *self-selected group* who are much healthier than

individuals in their home countries. Gushulak (2007) indicates that such positive factors can be seen in the incidence and outcomes of several chronic diseases and conditions. In their analysis of population data including over 300,000 immigrants resettled in the US, Singh and Siahpush (2001) observed that foreign born men and women had a significantly lower risk of overall mortality (from cardiovascular diseases) than their US-born counterparts when controlling for socio-economic characteristics.

In contrast, negative migrant selection refers to forced migration and occurs when minus factors such as war forces individuals who are socio-economically disadvantaged to seek refuge elsewhere, usually affecting the "uneducated or the disturbed" (Lee, 1966, p. 56). War has a catastrophic effect on the health and well-being of nations as studies have shown that conflict situations cause more mortality and disability than any major disease (Murthy & Lakshminarayana, 2006). Throughout history, war has consequently led to the displacement of millions of people globally. At the end of 2009 there were 43 million displaced people worldwide and of this number 15 million were deemed *refugees* (UNHCR, 2010). The 1951 UN Convention (UNHCR, 2011) indicates that a refugee is a person who:

> "owing to a well-founded fear of persecution for reasons of race, religion, nationality, membership of a particular social group or political opinion, is outside the country of his nationality and is unable or, owing to such fear, is unwilling to avail himself of the protection of that country."

Of the remaining 28 million forced migrants, roughly 26 million were IDPs or persons who have been forced to flee their homes but have not crossed an internationally recognized border. The remaining two million are *asylum seekers* or "persons seeking to be admitted into a country as refugees and awaiting decision on their application for refugee status under relevant international and national instruments" (IOM, 2004, p. 8).

The Afghan Refugee Crisis

As Afghanistan enters its fourth decade of armed conflict, it stands as one of few countries to have observed a drastic decline in its population (Nyrop & Seekins, 1986). The country's humanitarian crisis is a direct result of socio-political events dating back to the revolution that sparked the Afghan-Soviet war. Soviet forces invaded the country in 1979 in order to support the fragile Afghan communist regime in power at the time (CIA, 2012). The regime was under intense pressure from Afghans who rejected decrees that violated the cultural and religious norms that people had lived by for centuries (Nyrop & Seekins, 1986). The Soviet invasion was met with strong resistance from Afghans, particularly from populations residing in rural areas, rebel groups who were armed through various foreign sources and who identified themselves as *Mujahidin* (US Department of State, 2010), or "holy warriors." This opposition sparked a nine-year long war between the Mujahidin and Soviet forces along with their Afghan counterparts, which subsequently led to their withdrawal from Afghanistan in1989. Furthermore, remnants of the communist regime remained in power until their fall in 1992, leaving a power vacuum. This triggered a barrage of civil wars among warlords who sought control of Kabul, and ultimately led to an "extraordinary degree of destruction and loss of life" (Miller et al., 2006, p. 424).

The general indifference displayed by the global community towards humanitarian and political events taking place in Afghanistan ushered in the Taliban regime in 1994, a foreign-backed student militia who eventually rose to power in 1996 (Johnson & Leslie, 2008). The Taliban were initially welcomed by Afghans as they sought to bring order to war-torn Afghanistan. They gained prominence through quelling

much of the violence given their effective ability in usurping power from warlords responsible for a multitude of human rights violations against their own people. However, the Taliban came under criticism from the global community for their strict rule, which mostly affected women who were held under "virtual house arrest" (Palmer, 1998, p. 734) due to laws forbidding them to leave the home without male accompaniment. The Taliban announced a policy of segregating men and women, which further impeded women's access to healthcare and employment (Cardozo et al. 2005). At this time, Afghanistan also became vulnerable to the exploitation from foreign elements that covertly used the country as a training ground for terrorism, ultimately resulting in the current US/NATO intervention (US Department of State, 2010).

The wars and conflicts taking place over the years have forced millions of Afghans to seek refuge in neighboring and foreign countries. During the 1980s, Afghans represented the largest refugee population globally as over six million people sought international protection (UNHCR, 2010). A majority resettled in neighboring Iran and Pakistan. A fraction of this figure resettled in India, the EU, and particularly the US, which witnessed an unprecedented growth of refugees from Afghanistan as numbers bordered on 40,000 newcomers mainly concentrated in the SF Bay Area (Lipson, 1993). The USDHHS (2012) Office of Refugee Resettlement indicates that since 9/11 nearly 8,000 Afghan refugees have been resettled in the US with nearly 10% (990) resettling in California. The US Census Bureau (2011b) indicates that in total there are nearly 90,000 people of Afghan ancestry residing in the US of which 65,000 are foreign born (2011a). The US Department of State (2011) considers the Afghan refugee crisis a *protracted*

refugee situation as nearly 2.6 million Afghans continue to seek international protection in Iran and Pakistan despite millions already repatriated to Afghanistan.

Resettlement Stressors and Mental Health Issues

The traumatic events taking place during Afghanistan's modern history continue to expose millions of Afghans to violence. As mentioned, these events have displaced millions, both internally within Afghanistan's borders, as well as externally to neighboring and foreign countries. Afghans, akin to other war refugee groups present with a host of *pre-migration traumas* and *post-migration stressors* upon host country resettlement – all of which have been shown to have detrimental effects on *mental health*, which is defined as one's ability to cope with normal daily stressors (WHO, 2010). Pre-migration traumas include loss of family members due to displacement and death, fear for personal safety, imprisonment, and being subjected to physical and emotional torture (Mollica, Wyshak, de-Marnaffe, Khuon, & Lavelle, 1987). Upon and thereafter host country resettlement, post-migration stressors take various forms including financial and unemployment challenges, which are inextricably linked to linguistic barriers (e.g. English language proficiency) and other adaptation difficulties related to the process of *acculturation.*

The process of acculturation presents life changes that could potentially benefit or harm an individual (Abraido-Lanza, Armbrister, Florez, & Aguirre, 2006). Acculturation, according to Clark and Hofsess (1998) and LaFromboise, Coleman, and Gerton (1993), can be described as "the process by which individuals adopt the attitudes, values, customs, beliefs, and behaviors of another culture" (as cited in Abraido-Lanza et al.,

2006, p. 1342). Prominent acculturation models such as Berry's *Bidimensional model* (Berry, 1997, 1989, 1980) assert "acculturation entails two orthogonal behavioral changes for minorities, 1) losing behaviors, beliefs, practices, and values specific to their minority culture, and simultaneously 2) gaining behaviors, beliefs practices, and values of the Anglo host culture, thereby resulting in four possible outcomes" (Landrine & Klonoff, 2004, p. 528). These four outcomes suggest that ethnic minorities may 1) remain immersed in their indigenous culture, 2) fully adopt the Anglo culture, 3) be immersed equally in both cultures, or 4) immersed in neither culture (Landrine & Klonoff, 2004).

Also, Berry (1989) suggests that acculturation entails three phases: *contact, conflict,* and *adaptation*, which are necessary, probable, and inevitable, respectively. Contact is free and voluntary for immigrants, hence their higher propensity to *assimilate* or give up cultural identity and mix with the mainstream culture; yet for refugees because contact is forced, this causes conflict or some degree of resistance to change and adapt – leading to acculturative stress, according to Berry (1989). Migrant adaptation refers to the "process through which persons reorganize or rebuild their lives after relocating to a new socio-cultural context" (Ryan, Dooley, Benson, 2008, p. 2), which Afghans and other refugees alike may have difficulty responding to given the involuntary nature of their resettlement against a backdrop of war-related traumatic experiences and ongoing social stressors. Much of this can be attributed to the notion of *culture shock* or the normal stress response induced by the realization that former patterns of behavior are ineffective (Furnham & Bochner, 1986; Oberg, 1960). Bhugra and Ayonrinde (2004) assert that the perceived sense of culture shock may bring about feelings of cultural confusion, alienation and isolation, and depression.

Another major source of distress includes the loss of *social support* or as suggested by Keyes (2000), "separation from family and friends" (p. 398). Simich, Beiser, and Mawani (2003) suggest that the lack of meaningful supportive relationships within the ethnic community adversely affects refugee health and well-being. Cultural groups have consistently been shown to cope with stressors through seeking social support. Social support is considered a post-migration protective factor and important for psychological adjustment as people have others to depend on when they need help (Birman & Tran, 2008). Studies with various refugee groups exemplify the influence of social support on health and well-being. Among a sample of Iraqi refugees resettled in the UK, investigators found that psychological morbidity was associated with a lack of social support with poor social support being a much stronger predictor of depression in the long term than the severity of trauma (Gorst-Unsworth & Goldenberg, 1998). In an ethnically diverse group of asylum seekers, Silove et al. (1997) shows that feelings of loneliness resulting from social support loss were exclusively associated with depression.

An inability to cope with these types of stressors is the very reason why refugee groups including Afghans are highly vulnerable to suffering from *psychological distress*, which encompasses sadness, frustration, anxiety, and symptoms related to normal emotional responses to adversity (Carney & Freedland, 2002). Psychological distress manifests itself in unique ways; though, many studies have aligned it with mood and anxiety disorders including depressive and posttraumatic symptomatology, respectively. Carney and Freedland (2002) cite depression as being a variety of psychological distress. Depression is a common disorder characterized by feelings of sadness, reduced interest in activities that used to be enjoyed, loss of energy, sleep disturbances, difficulty

concentrating, and suicidal thoughts and is usually treated with medications such as anti-depressants and psychotherapy, according to the NIMH (2012a). Kleinman (2004) argues that "among refugees, depressive affect and disorder are common aspects of collective and personal experiences of loss and trauma" (p. 951).

PTSD, a form of trauma, occurs as a result of an intense traumatic event which causes intense fear in a person as well as flashbacks, bad dreams and frightening thoughts and in some avoidance symptoms (e.g. such as staying away from places, events, or objects that are reminders of the experience) as well as hyper-arousal symptoms (e.g. being easily startled, having angry outbursts). The NIMH (2012b) indicates that PTSD is treatable through medication and psychotherapy by providers experienced in treating such disorders. Studies published in this area have found a large proportion of refugees and asylum seekers that have resettled in industrialized nations (defined as member countries of the OECD, 2012) reporting high depressive and posttraumatic symptomatology associated with the aforementioned pre- and post-migration stressors.

Porter and Haslam's (2005) meta-analysis of over 59 research studies published within the migrant health arena, indicates that refugees reported significantly impaired mental health than non-refugees. Lindert, Ehrenstein, Priebe, Mielck, and Brahler's (2009) systematic review confirms these findings through comparing mental health outcomes between immigrants (economic migrants) and refugees and shows that disease (depression, anxiety, and PTSD) prevalence rates were significantly higher for refugees. Studies suggest that asylum seekers are at even greater risk of psychological distress as the process of seeking asylum in Western countries "places additional demands on this group," according to Robjant, Hassan, and Katona (2009, p. 306). This is often due to

stressful legal processes, in addition to being denied access to work, education, and health services.

Mental health problems have been discovered mainly through exploratory research (cross-sectional in design). Investigators have utilized prominent distress scales such as the HSCL-25 for measuring depressive symptoms (Mollica et al., 1987), and HTQ (Mollica et al., 1992) for measuring PTSD symptoms. The HSCL-25 was originally adapted for use in refugee populations while the HTQ was developed specifically for refugee research (Hollifield et al., 2002). These instruments along with many others (e.g. BDI, CAPS-1, etc.) have been administered in studies with Afghans as well.

In contrast, qualitative studies have contextualized in-depth descriptions of lived experiences with the migration process, post-migration living difficulties, and coping mechanisms for resulting stressors (described in further detail in 'Chapter 2. Literature Review'). While previous studies imply underutilization of mental health services among Afghan refugees (Lipson, Omidian, & Paul, 1995; Stempel, 2009), investigators have not formally investigated help-seeking behaviors and cultural beliefs about mental illness. Research with refugees is limited; however, studies with Asian and Latino immigrants (also described in further detail in the 'Chapter 2. Literature Review') indicate that mental health and help-seeking are generally influenced by traditional beliefs about mental health. Additionally, language and levels of acculturation, religious beliefs and spirituality, as well as social stigma and shame have been found to influence professional help-seeking (Kramer, Kwong, Lee, & Chung, 2002)

Culture, Depression, and Mental Health Care

Culture can be defined as "a person's beliefs, norms, values, and language, which dictates how people perceive and experience mental illness, whether or not they seek help, what type of help they seek, what coping styles and supports they have, and what treatments might work" (NAMI, 2007). It has been found that underutilization of mental health care among refugees is influenced by multiple factors, such as refugees' perceptions or lay beliefs with regard to suffering and illness etiology, distrust of Western medicine, unfamiliarity with Western medical methods, communication issues between physicians and patients, and cultural ignorance on the part of practitioners (Uba, 1992). The latest Surgeon General's supplemental report on mental health indicates that practitioners also maintain a culture in which perceptions regarding symptoms, diagnoses, and treatments are grounded in scientific evidence (USDHHS, 2001). The Surgeon General's report indicates that these perceptions at times diverge with clients' views, and as a result create barriers to effective care.

By viewing patients through a *biomedical* (or *biopsychiatric*) lens, refugees could be prevented from articulating their own experiences, views on mental health, and needs in terms of psychotherapy and other service provisions. This ultimately makes them "vulnerable to institutional responses that generalize refugees into a single pathologized identity" (Watters, 2001, p. 1710), which can lead to patient harm, according to Kleinman (2004). Chen and Mak (2008) argue that "understanding how people attribute mental health problems may illuminate whether and where they solicit professional care" (p. 448). To improve mental health treatment programs and increase utilization, Keyes (2000) suggests that programs should be designed in a culturally appropriate manner.

Among Afghans and many other refugee groups, cultural barriers have been found to affect utilization of mental health services as "stigma and lack of understanding of what mental health conditions are have made it difficult to serve the refugee population" (Morris, Popper, Rodwell, Brodine, & Brouwer, 2009, p. 535).

Bal and Cochrane (1993) argue that practitioners should be aware of the difference in symptomatology in ethnic groups, and of the cultural and social reasons that affect the presentation of their symptoms. Kleinman (2004) asserts "symptoms that represent a depressive disorder for the practitioner may not denote a medical problem to the patient, his or her family, or their clergy, for whom depression may be a sign of the moral experience of suffering" (p. 952). Jacob, Bhugra, Lloyd, and Mann (1998) show that while Western societies may view disorders such as depression as a medical problem, traditional groups conceptualize depressive symptoms as social problems or as emotional reactions to situations. For example, Asians may perceive physical problems as the cause for emotional problems, which can be conceivably cured through addressing physical ailments (Sue, Nakamura, Chung, & Yee-Bradbury, 1994). This is explained by the *somatization hypothesis* (Ryder, Yang, & Heine, 2002), which asserts that "people from traditional cultural backgrounds either deny psychological distress, interpret such distress as somatic illness, or present distress as physical illness in medical settings" (Karasz, 2005, p. 1625).

Somatization, which is defined as the "the expression of personal and social distress in an idiom of bodily complaints and medical help-seeking" (Lin et al., 1985, p. 1080) could very well be understood as "culturally coded expressions of distress" (Kirmayer & Young, 1998, p. 420). Therefore, it has been suggested that therapists treat

somatic complaints as real problems that can be distressing rather than viewing them as defense mechanisms and also developing therapeutic strategies based on clients' lay beliefs about mental illnesses (Wong, Tran, Kim, Van Horn Kerne, & Calfa, 2010). This means understanding the patient's "explanatory models of causality, disease, and desired treatments" (Kleinman, 2004, p. 952). Thereby, the clinician can gather a better understanding of the subjective experience of illness, which in turn can promote collaboration and improve clinical outcomes and patient satisfaction (Bhui & Bhugra, 2002; Kleinman, 1988). In an earlier report, Kleinman (1978) asserts that the lack of concordance in patient-provider explanatory models of illness may be an important determinant of adherence to medical regimens. It was also suggested that understanding patients' beliefs (about depression) may improve satisfaction with services.

Such information could provide practitioners a sense of how to respond to culturally salient family conflicts and issues of self-care that patients engage in that may affect their prognosis in terms of the biomedical regimen used in treating depression (Kleinman, 2004). Therefore, proper assessment, diagnosis, and treatment in a culturally relevant manner may be contingent on the practitioners' understanding of cultural aspects of mourning, expressions of distress, and other responses to traumatic events (Keyes, 2000). By overlooking cultural factors that influence symptom expressions, Leong and Lau (2001) indicate that "lack of cultural validity in diagnosis" (p. 206) can occur. Previous research on culture-specific lay beliefs about depression have been conducted with an array of cultural groups; however, Furnham (1988) indicates that studies assessing lay beliefs do not explore possible reasons for individual or group differences in the structure and content of beliefs, in addition to a small number of studies examining

beliefs about cures and treatments (Cinnirella & Loewenthal, 1999). Previous research has been limited to studies with non-Afghan migrant groups focusing mainly on beliefs about the causes of mental illnesses (such as depression) rather than a comprehensive range of beliefs (Wong et al., 2010).

Significance

Understanding beliefs about the causes, symptoms, and treatments of depression among Afghan refugees should be considered for a number of reasons. First, studies with Afghan refugees show elevated levels of depressive symptomatology due to the abrupt separation from their land and loved ones. These traumas are exacerbated by ongoing social stressors and daily hassles that affect many even after long-term resettlement. Secondly, Afghans continue to resettle to Western nations with virtually no prior psychological support given Afghanistan's weak mental health infrastructure (WHO, 2005). This is evidenced by community-based studies conducted in Afghanistan that have shown elevated levels of anxiety, depression, PTSD, and impaired psychosocial functioning especially among women due to prolonged exposure to conflict (Cardozo et al., 2005; Miller et al., 2008). Thirdly, mental health services are underutilized partly due to the stigma (of being labeled as "crazy" as suggested by qualitative interviews discussed in 'Chapter 3') or perceived discrimination associated with having a mental disorder, linguistic barriers to mental health care (Morris et al., 2009), as well as gender inappropriate ways in which care is rendered (Lipson, 1992).

For these reasons, understanding beliefs about depression could assist mental health professionals working with Afghan refugees in addressing this pervasive and

serious problem. Such insight could provide clinicians the tools to align clinically derived explanatory models of disease causality, symptomatology, and treatments with those that Afghans possess. Concordance between patient-provider models of depression could lead to better treatment adherence, in turn, improved mental health outcomes. Knowledge in this area could also assist with more gender-specific treatment modalities as depression etiology, emotional and physical responses to depression, and anti-depressive/help-seeking behaviors may be approached in unique ways by gender group. Responses to depression could generally be influenced by a multitude of factors that are rooted in Afghans' Islamic faith and cultural traditions, as well as social factors such as acculturation, educational attainment, and available social supports.

The purpose of this study is to estimate intra-cultural beliefs (cultural competency) about the causes, symptoms, and treatments of depression among Afghan men and women using the *Cultural Consensus Model or CCM.* Additionally, we assessed various demographic characteristics as well as baseline distress levels in order to correlate these outcomes with cultural competency scores. We also describe how Afghans view depression causality, symptomatology, and treatment.

Theoretical Approach: Cultural Consensus Theory

Cultural Consensus Theory (*CCT*) (Romney et al., 1986) or CCM (the terms will be used interchangeably) will be used to examine how depression is conceptualized among Afghan refugees residing in San Diego County, California. CCT is both a theory and a method, which includes "a collection of analytical techniques and models that can be used to estimate cultural beliefs and the degree to which individuals know or report

those beliefs" (Weller, 2007, p. 339) in an objective way (Romney et al. 1986). The central idea of the theory is to use "the pattern of agreement or consensus among informants to make inferences about their differential competence in knowledge of the shared information pool constituting culture" (Romney et al., 1986, p. 316).

Although knowledge can be inferred from consensus, not all consensus or sharing of beliefs among a group on a given domain of knowledge always indicates *cultural knowledge*, or knowledge that has arisen from human inventions (e.g. language) passed from one generation to the next, according to Romney (1999). Culture is essentially shared knowledge with regard to some cultural domain, and the aspect of culture that CCM accounts for is the knowledge stored in the minds of its members (Romney et al., 1986). The consensus model allows investigators to measure knowledge with a degree of accuracy comparable to that obtained with traditional test theory without knowing the correct answers in advance (Weller, 1987).

Unlike test theory or knowledge tests that determine whether answers to questions are 'correct' or 'incorrect' in terms of biomedical or in this case biopsychiatric models, consensus analysis provides the ability to center variation and patterning of responses around the cultural norm (Baer, Weller, De Alba Garcia, & Salcedo Rocha, 2004). CCT uses "an aggregation of responses to estimate the answers to questions and to see how much each person's responses deviate from it" (Weller, 2007, p. 363). The model provides an estimate of the cultural knowledge or competence of each informant and an estimate of the correct answer to each question asked of the informants (explained in further detail in 'Chapter 4. Methods section).

There are two versions of CCM – the *formal* and *informal* models. Weller (2007) indicates that the informal model can be run with a factor analysis procedure (*principal components analysis*) in programs such as *SPSS* for obtaining estimated answers and individual accuracy estimates. The data is transposed from its usual structure so that questionnaire items become the rows or units of analysis and people become the variables or columns in the data matrix. However, this study applies the formal model, which is a family of models that is similar to a reliability analysis (Weller, 2007). It corrects for guessing in answers to questions, which is assumed to occur without bias. The formal model accommodates for categorical-type data (dichotomous or 'yes/no', 'true/false'; multiple choice; and open-ended short-answers) and can only be run in *ANTRHOPAC* (version 4.98) software (Borgatti, 1996) (explained in further detail in 'Chapter 4. Methods').

Additionally, the formal model rests on three assumptions or ground rules (Romney, 1999; Romney et al., 1986; Weller, 2007). These include: 1) *Common Truth.* Informants all come from a common culture, i.e., that whatever the cultural reality is, it is the same for all informants in the sample, meaning that CCT is applicable only if there is a single set of answers to the questions or that there must be a high level of consistency (agreement) in responses among informants; 2) *Local Independence.* Each informant's answers are given independently of each other informant, meaning that answers should be provided by individuals (not groups) and without consultation with others; 3) *Homogeneity of Items.* Questions should all be on a single topic, at the same difficulty level, and there should be a single set of answers to the questions.

Consensus theory/modeling has been used to study various health concerns including: Latino beliefs about asthma (Pachter et al., 2002), depression (Martinez Tyson, Castañeda, Porter, Quiroz, & Carrion (2011), diabetes (Weller et al., 1999), HIV/AIDS (Trotter et al., 1999); cancer (Chavez, Hubbell, McMullin, Martinez, & Mishra, 1995); as well as culture-bound syndromes such as *susto* (Weller et al., 2002) and *empacho* (Weller, Pachter, Trotter, & Baer, 1993). To the best of our knowledge, the model has not been used in research with a refugee group for understanding explanatory models about depression. According to Romney et al. (1986), the model's use has many implications. Most relevant to this study, Romney and colleagues (1986) indicate that the consensus model provides the ability to objectively test the cultural knowledge of different subgroups of informants without knowing the answers to the questions. Secondly, the model opens the opportunity for possibilities of studying intra-cultural variability, for example, differences in beliefs between men and women, subgroups that may have access to certain types of cultural knowledge (Romney et al., 1986).

This study focuses on achieving the following aims listed below. Aims 1-3 relate to CCT while Aim 4 was added for descriptive purposes:

Specific Aims:

Aim 1: Assess the degree to which there is a shared set of beliefs about depression (i.e. causes, symptoms, and treatments) among Afghan refugee men and women.

Aim 2: Investigate differences in models about depression between gender subgroups.

Aim 3: Classify responses to questions about the causes, symptoms, and treatments for depression among genders with a high degree confidence.

Aim 4: To obtain a baseline measure of acculturation, social support, and psychological distress for descriptive purposes.

CHAPTER 2

LITERATURE REVIEW

Overview

As indicated in the previous chapter, there are many practical implications with regard to understanding cultural conceptions about mental illness (including depression) among Afghan refugees and asylum seekers. The knowledge base, although sparse, currently consists of studies that investigate the severity, types and sources of psychological distress. Specifically, qualitative studies have described lived experiences with mental health problems, coping strategies and help-seeking behaviors, and to a limited extent, issues surrounding culturally sensitive mental health care. In contrast, quantitative research studies have reported findings related to the degree of depressive and posttraumatic symptomatology using culturally validated instruments. However, regardless of design, empirical investigations with Afghans have mainly described mental health problems in the context of two general domains.

The first domain includes cultural adjustment challenges, and the second relates to social support loss. The following section sets out to synthesize studies related to each of the two domains. Where findings from studies allow, linkages between the various sources and responses to psychological distress and their relationship with gender subgroups will be highlighted. In the final or third section of this chapter we describe empirical findings related to beliefs about depression and other forms of distress. Given the dearth of knowledge with regard to studies systematically investigating depression beliefs among the Afghan population, our knowledge is informed by research conducted among other migrant groups (e.g. Asian and Latino immigrants).

Post-Migration Stressors

Psychological Distress, Cultural Adjustment, and Acculturation

Ground-breaking research (e.g. first studies to document mental health problems among Afghans resettling in the West) with Afghan refugees has been initiated through qualitative studies conducted in the San Francisco Bay Area. As mentioned, this is the region with the highest concentration of Afghans in the US, and perhaps globally outside of Asia. The first published (qualitative) mental health-related study with this population dates back to Lipson's research (1991). Lipson aimed to describe social and cultural stressors among a relatively new group of 29 Afghans (17 women, 12 men) residing in the US for an average of slightly over three years. Through ethnographic methods (e.g. in-depth interviews and participant observation), Lipson (1991) discovered that antecedents to stress included pre-migration war traumas, which entailed being imprisoned, observing atrocities, and losing family members.

Effects of these experiences included nightmares, depression, and being mute – sequelae observed among women. Moreover, post-migration stressors, which were a particularly serious problem for women, included loss of social support. For men conflicts with the acculturation process such as learning English, linked to financial difficulties and unemployment, were found to be major factors for psychological distress. In this study we define acculturation in this context as related to 'English language proficiency' given its precedence in previous research with Afghans, and salience in influencing post-migration stress. Secondly, we define cultural adjustment according to accounts from lay qualitative interviews (discussed in 'Chapter 3'), which operationalize this term as '(not) overcoming or adapting to the stress induced by culture shock, i.e.

stress associated with former patterns of behavior being rendered ineffective in a new environment (as defined in 'Chapter 1').

For example, in the Netherlands, Gernaat, Malwand, Laban, Komproe, and de Jong (2002) show that poor language skills, in addition to lower education and unemployment were associated with the prevalence of psychiatric disorders in a sample of 51 Afghans suffering from depressive disorder (57%) and PTSD (35%). Distress for Afghan men is compounded by perceived losses of social status, according to Lipson's original article and subsequent larger-scale qualitative studies conducted by the same author (e.g., Lipson, 1993; Lipson & Omidian, 1997), which consisted of 60 participants, of which 32 were women. Status loss is explicated by the fact that credentials/degrees acquired at institutions such as Kabul University are not recognized in the US and other western nations. As a result, a majority of men lose their "traditional breadwinner role" (Lipson & Omidian, 1997, p. 116), which has forced Afghan men to end up seeking public assistance to support their families, undermining their self-esteem and self-respect.

In relation to this, Porter and Haslam's (2005) meta-analysis observed that higher levels of education and socioeconomic status before displacement were associated with worse mental health outcomes among refugees from various regions. The authors assert that "greater predisplacement intellectual and economic resources may imply a greater subsequent loss of status rather than a protective effect on refugees against their predicament" (p. 610). Gender role reversals can have a deep impact on the family as tensions between spouses, and have been shown to contribute to domestic violence. A recent study conducted among Somali refugee women in the US (Nilsson, Brown, Russell, & Khamphakdy-Brown, 2008) showed that as women increased their English

language proficiency and in turn gained work opportunities, their distress levels increased as their (unemployed) male-counterparts resorted to domestic violence to reclaim perceived losses of control and power.

Intergenerational conflicts have been reported to occur between parents and children as well. Children may acculturate more readily and subsequently become indifferent to parental authority as they adopt new values that contradict Afghan familial values (Lipson & Omidian, 1997). A seminal cross-sectional household survey inclusive of a convenience sample of 196 Afghans (59% female) in the Bay Area confirms these findings (Lipson et al., 1995). In addition to assessing the (high) rate of stress problems (63%) and (low) mental health care utilization (17%), the authors cite that factors predictive of distress included concerns over raising children in the US. Also, conflicts related to acquiring the English language, lower education, concerns over money, length of residence in the US, and worry over family in Afghanistan were all found to have direct or indirect effects on psychological well-being.

These findings are validated in a more recent (unpublished) study by Stempel (2009) conducted in the same region among a convenience sample of 261 Afghans (52% female). Stempel discovered that a high proportion of Afghans suffered from PTSD symptoms (45% according to an ad hoc trauma questionnaire), with posttraumatic symptomatology more likely in women (58%) than in men (31%). As indicated through the TBDI (Ritsner, Rabinowitz, & Slyuzberg, 1995), women were also more likely to suffer from psychological distress (42%) as compared to men (24%). Higher levels of psychological distress were related to arrival to the US after 2000, concerns with regard

to discrimination (for both men and women), loss of identity and the preservation of cultural values (more so for men), and social isolation (a greater problem for women).

Consistent findings are reported in a study examining the prevalence of PTSD, depression, and other psychiatric disorders among a relatively limited sample of 38 young Afghan refugees in the SF Bay Area (Mghir et al., 1995). Study findings indicate that higher degrees of distress were reported among respondents arriving to the US at an older age and having mothers with lower English proficiency. It was suggested that English proficient children served as buffers between their mothers and the migration process; hence, leading to Mghir's et al. (1995) position that "limited educational background or resistance to acculturation may be indirect risk factors for the development of psychiatric symptoms" (p. 29). A later study using the same sample compared distress levels among two distinct ethnic groups (i.e. Pashtuns and Tajiks) (Mghir & Raskin, 1999). Results supported Mghir and colleagues' previous findings that failure to acculturate may increase one's risk for psychiatric symptoms. Pashtuns who spoke little English and spent less time in the US were found to report significantly higher scores on HSCL-25 as compared to their Tajik counterparts.

Mghir and colleagues' position that one's 'resistance to acculturation leads to psychiatric symptoms has been recently tested in a study assessing cultural resistance and the occurrence of depressive symptomatology (Iqbal, 2006). Iqbal shows a small but significant positive relationship between cultural resistance and level of somatization among 60 Afghan women in the SF Bay Area. This suggests that lower levels of somatization were found to be associated with cultural incorporation and cultural shift among these women. Based on these findings and earlier studies with Afghans noted

above, the prospect of acculturation could possibly bring a great degree of improvement to an individual's overall mental health, in addition to some level of harm. Berry (1989) indicates that less stress could indeed occur when ethnic minorities are somewhat similar to the mainstream. For example, in a study comparing depression and trauma in Somali, Vietnamese, and Yugoslavian refugee men and women resettled in the US (Stutters and Ligon, 2001), the authors argue that refugees from the former Yugoslavia tended to be more expressive than comparison groups with regard to mental health challenges, open to mental health services, and able to assimilate easier given their cultural similarities with the mainstream culture.

Similarly, authors (e.g. Steel, Silove, Phan, & Bauman, 2002) have suggested that "mental health symptoms improve over time for the majority but remain a significant risk factor for a minority in the long term" (cited in Schweitzer, Melville, Steel, & Lacharez, 2006, p. 180). This is exemplified by Carlson and Rosser-Hogan's (1994) study with Cambodian refugees, which documents extremely high rates of anxiety (78%), depression (80%), and PTSD (86%) among a sample of 50 participants. The authors cite that "even ten years after they had left their homes in Cambodia, these refugees are still suffering considerable mental distress, yet have not sought mental health treatment" (p. 229).

Inconsistencies in findings with regard to the influence of one's acculturation level and/or acculturative stress on mental health outcomes necessitate further empirical investigations within this domain. The effect of acculturation and acculturative stress on the mental health of Afghans has not been definitively evaluated. Haasen and colleagues (2008) provide an informative yet inconclusive account with regard to this. Among a non-representative sample of 50 Afghan refugees largely made up of men (92%) residing

in Germany, the authors found a significant correlation between mental health complaints (assessed through the MAP mental illness sub-scale) (Marsden et al., 1998) and acculturative stress ($r = 0.45$, $p < 0.05$) as measured by the ASI (Nicassio, Solomon, Guest, & McCullough, 1986). The authors also discovered that alcohol use was significantly correlated with mental health complaints ($r = 0.29$, $p < 0.05$) as assessed through the AUDIT (Babor, Higgins-Bittle, Saunders, & Monteiro, 2001). Alcohol use as a coping mechanism for mental health problems has been understudied among this population possibly due to cultural taboos with regard to the admission of its use.

This is a factor that may require further investigation, especially among younger, more culturally assimilated Afghans born or raised in Western nations who often face identity challenges. Studies with Afghan children and young adults are limited; however, a recent qualitative study sheds light on coping mechanisms among an even distribution of 16 adolescent (age range: 13 to 17) Afghan boys and girls residing in Australia (de Anstiss & Ziaian, 2010). Adolescents reported seeking help for psychosocial problems from friends more often than from any other source. They also noted that they would not venture beyond their informal networks for professional help due to low priority placed on mental health, poor mental health and service knowledge, distrust of services, and stigma or perceived discrimination associated with psychosocial problems and help-seeking. Studies conducted with adult Afghans have traditionally implied that close family ties are integral in mitigating problems related to social support, factors that are addressed in the following section.

Psychological Distress and Social Support

Family is perhaps the most significant institution in Afghan culture (Lipson, 1992) and source of social support, which Keyes (2000) operationalizes as 'the loss of family and friends.' A notable difference, between Afghan and American cultures is "family interdependence versus individualism," with "family being the core of Afghan culture and psychological well-being" (Lipson, 1992, p. 272). Renner, Salem and Ottomeyer (2008) put the role of family into context among people from collectivistic societies by asserting "the mere separation from families and support groups constitutes a traumatic event conducive to clinical symptoms" (p. 244). Among a sample of 50 Afghans resettled in Austria, of which 39 were male, Renner et al. (2008; 2006) gives an account of culture-specific aspects of traumatic stress and of posttraumatic symptomatology, and the pathogenic impact that societies have on individuals and coping styles.

Through diagnostic interviews Renner and colleagues showed that 44% of Afghans suffer from symptoms of posttraumatic stress. Furthermore, discriminant analysis indicated that posttraumatic symptomatology was defined by complaints about faintness, tiredness, nervousness/feeling jumpy, irritability, sleep disturbances, trouble concentrating. Within the context of social support, factors considered helpful for coping with trauma included family reunion and keeping in touch with family at home. Moreover, factors considered unhelpful included, but were not limited to worrying about relatives and friends back home, not having a job, conversations about Afghanistan, and getting news from home.

Other studies corroborate the importance of family in the coping process. For example, emotional social support sought primarily from family members was described as a coping mechanism by a convenience sample of eight Afghan women in the East coast-US who took part in a focus group discussion (Welsh & Brodsky, 2010). Welsh and Brodsky (2010) aimed to understand how *psychological mediators* such as coping skills and *situational mediators* (e.g. community resources and cultural traditions) affect stress reactions and support adaptive mental health outcomes among a relatively small sample of Afghan women at the US East coast. Difficult aspects of social support, according to Welsh and Brodsky (2010), entailed discussing war traumas with others, "which often resulted in sadness" (p. 169). Kim, Sherman, and Taylor (2008) found that unlike European Americans, Asian Americans are more likely to utilize and benefit from social support than European Americans so long as discussion do not involve explicit discussions of stressful events.

Welsh and Brodsky (2010) note that Afghan women resorted to involvement in religious activities and faith in God for coping with stressors. However, Rintoul's (2010) (unpublished) findings contradict Welsh and Brodsky's as religion in the former study was not an important part of dealing with distress among a sample of Afghans resettled in Australia. Though consistent with other studies noted in this review, the authors explained that Afghan women were particularly vulnerable to poor mental health. Family conflict and separation from family members were perceived as being major concerns affecting mental health (Rintoul, 2010).

The elderly are also disproportionately affected by mental illness as many face a great deal of isolation and loneliness. This may stem from the fact that many find

themselves communicatively disconnected (in their host environment) from their children and grandchildren who fail to maintain their mother tongue. Qualitative studies assert a general theme with regard to the elderly, which suggests that psychological distress is associated with their expectations of respect, attention and socialization from family not being met. Moreover, stress reactions for the elderly may be more severe than younger generations given the strong links to their homeland, as well as the loss of identity, property, and social status. Their levels of impairment may deter cultural adjustment. Hence a valid cause for distress among elderly Afghans could be associated with the rumination and introspection that occurs as a result of their seclusion and confinement to their homes. Netherlands-based Afghan refugees categorize this rumination and introspection as *thinking too much*, and have also suggested that this serves as a great source of stress through qualitative interviews (Feldmann, Bensing, de Ruijter, & Boeije, 2007). Respondents, who consisted of varying age and gender subgroups, associated their physical ailments to rumination and loneliness, and suggested that stressors were best reduced by *keeping oneself busy*.

In an earlier quantitative study with a relatively small sample of 30 Afghan refugees residing in the West coast-US, Malekzai et al. (1996) confirms the severity of distress in older Afghans. While 50% of participants met CAPS-1 criteria for a current diagnosis of PTSD, the incidence of PTSD increased from 10% in the 19 to 30 years age group to 100% in the 61 to 75 years age group (age and PTSD incidence: $r = 0.65$, $p < .005$). The authors suggest that the lower incidence of PTSD in the younger age group could be due to a strong protective effect of parental support. Furthermore, Malekzai et al. (1996) indicates that participants did not consider their symptoms extraordinary within

the Afghan community. This is consistent with elderly Afghan women's views of depression as being known to the Afghan society and regarded as natural phenomena (Morioka-Douglas, Sacks, & Yeo, 2004). Based on findings from a focus group conducted with nine elderly women residing in the SF Bay Area, Morioka-Douglas et al. (2004) indicates that the most effective treatment for disorders such as depression (common in elders) includes mitigating feelings of isolation. In addition, it was suggested that English proficiency ought to be increased among the elderly as it could increase access to mental health services given the potential reduction in communication barriers between providers and patients.

Apart from the issue of social support, Malekzai and colleagues' findings suggest a dose-response relationship between traumatic experiences and psychological distress. Support for this interpretation comes from Jamil et al. (2007) who show a comorbid relationship between PTSD symptomatology and depressive symptoms among 116 Iraqi refugee men and women resettled in Michigan shortly after the first Gulf War. Similarly, among 490 Cambodian refugees in California, Marshall et al. (2005) reported 51% of participants being depressive and 62% with posttraumatic symptomatology. Furthermore, Omeri et al. (2006; 2004) provides context for this relationship in a qualitative study of Afghans resettled in Australia. Contributory factors identified for the sadness brought about by their emotional responses to trauma included, but were not limited to isolation from family and friends, no sense of belonging in their host environment, and feelings of loss of their country and identity (Omeri et al., 2006; 2004). Respondents associated sadness and depression with loss and breakdown of family support, being unemployed and facing language barriers. Respondents suggested the need for health services to

reflect Islamic teachings and culturally acceptable coping strategies. Afghans described adherence to the Islamic code as a way of coping with feelings of sadness and depression.

Other subgroups affected by deficiencies in social support include asylum seekers. EU-based studies with Afghan refugees and asylum seekers residing in the Netherlands indicate high severity of depressive and traumatic symptomatology. In a seminal Netherlands-based study, Gerritsen et al. (2006) compared refugees and asylum seekers from Afghanistan, Bosnia, and Somalia across various mental health outcomes including anxiety, depression, and PTSD. Among the 206 Afghans taking part in this study, 17% of respondents were deemed symptomatic for PTSD on the HTQ, with high rates of depression (36.6%) and anxiety (32.3%) as well, according to the HSCL-25. The authors provided a limited description of the Afghan population given the study's aims of comparing symptoms across ethnic groups. Therefore, relationships with distress are provided collectively for the entire sample. The authors found that legal status or 'being an asylum seeker,' enduring post-migration stress, female gender, and lower social support levels were shown to predict PTSD and depression/anxiety symptoms. Considerably higher rates for PTSD (25.4%), depression (54.7%), and anxiety (39.3%) were reported for the asylum seeker group.

Consistent findings are reported in a fairly recent study (not included in the aforementioned review) investigating the adverse effects of detention among a convenience sample of 55 Afghan male asylum seekers resettled in Japan (Ichikawa et al., 2006). The authors compared asylum seekers who had once been detained (n = 18) and those that had never been detained (n = 37) through administering the HSCL-25 and HTQ accordingly. Mean symptomatology scores for anxiety, depression, and PTSD were

considerably higher for asylum seekers detained than those never detained. Significant predictors for these outcomes included post-migration detention, the number of traumatic events experienced, and living arrangement or "living alone."

Ichikawa's findings parallel results from Robjant, Hassan, and Katona's (2009) systematic review, which pools data from a sample of 10 studies examining distress levels among asylum seekers previously detained. Results indicated that individuals detained for more than six months "met diagnostic cut-offs for PTSD, depression and moderate to severe health-related disability than those who had been detained for shorter periods or who had not been detained" (p. 308). Despite the consistency in findings, Ichikawa's study ought to be interpreted with caution given the relatively small and disproportionate comparative groups. However, lack of social support or in the context of this study – 'living alone' – has been shown to negatively impact mental health outcomes.

Steel et al. (2011) corroborate higher distress levels among Afghan asylum seekers holding TPVs and those holding PPVs through a two-year longitudinal study in Australia. TPVs are for asylum seekers without valid visas that have been awarded refugee status, and have been released from immigration detainment into communities on a temporary basis. These individuals, like asylum seekers in general, face barriers to employment, English language training, health and other social services, and are barred from leaving Australia to reunite with family (Steel et al., 2011). In contrast, PPVs enjoy the protections and unrestricted services given the legality of their claims through bona-fide refugee resettlement programs.

Steel and colleagues (2011) report higher scores on the HTQ's PTSD symptom scale, the HSCL-25, and the GHQ at baseline and also increasing anxiety, depression, and PTSD at follow-up. The authors suggest that the growing levels of distress are likely due to social isolation. Moreover, Renner, Laireiter, and Maier (2012), in a controlled study testing the effects of sponsorship on traumatized and non-traumatized Afghan (n = 21) and Chechen (n = 42) refugees and asylum seekers in Austria found that for the traumatized group social support provided by sponsors consistently reduced anxiety, depression, and psychological symptoms over time. However, the authors indicate that the results are only helpful for those with posttraumatic symptoms prior to intervention. Schweitzer et al. (2006) also observed a moderating effect of social support on psychological distress among a sample of 63 Sudanese refugees in Australia. The authors indicate that concerns about family not living in Australia were associated with increased depression, anxiety, and somatization. They cite the presence of family and social support from the Sudanese community as significant determinants of psychological well-being for the sample under study.

Table 1 summarizes findings from qualitative published mental health-related studies that report results specifically for Afghan refugees and asylum seekers resettled in western nations. Results are presented by theme. Table 2 includes published quantitative studies using standardized instruments that report psychological distress levels (e.g. depression, anxiety, and PTSD) specifically for Afghan refugees and asylum seekers. The studies listed in each table are presented in chronological order.

Table 1.

Summary of peer-reviewed [qualitative] studies conducted with Afghan refugees and asylum seekers[a]

Reference & Setting	Purpose/Aims	Design & Data Sources	Sampling Method	Sample Size and Characteristics	Results
Sulaiman-Hill & Thompson (2011, 2010)	To explore resettlement experiences and mental health outcomes, and to examine ongoing sources of stress	Mixed-method (qualitative portion) In-depth interviews	Snowball: Use of multiple community entry points	N = 90 refugees; Age range: 18 to 60+; Education: 43 secondary school, 33 university, 9 primary, 5 none; English language proficiency: 76% proficient; Gender: 50% male; Time in host country: *M* = 2.8yrs (*SD* = 1.2)	Themes (sources of distress): 1. 'Thinking too much' due to past experiences and current reminders; 2. Separation from past lifestyle, feeling homesick; 3. Feeling overwhelmed due to hopelessness; 4. Relationship challenges due to family tensions and acceptance into host society; 5. Status dissonance as a result of unemployment and social position; 6. Disempowerment due to welfare dependency; 7. Social isolation due to language barriers and old age; 8. Cultural/social change due to cultural literacy; 9. Other, e.g. cultural clashes, economic hardship
de Anstiss & Ziaian (2010)	To describe use of informal supports, as well as actual and perceived barriers to mental health services	Focus group discussions	Convenience and snowball: Community organizations and social gatherings	N = 16 refugees; Age range: 14 to 17; Gender: 8 males	Themes: 1. Informal help-seeking: adolescents more likely to seek help for psychosocial problems from friends than from any other source; 2. Formal help-seeking: adolescents not willing to venture beyond informal networks for professional help given low priority placed on mental health, distrust and poor knowledge of mental health services, stigma associated with help-seeking
Welsh & Brodsky (2010)	To contextualize coping skills and situational mediators that affect transient stress reactions and support adaptive mental health outcomes	In-depth interviews	Snowball: Recruitment through key informants	N = 8 refugees; Age: *M* = 43 (*SD* = 15.5); Age at displacement: *M* = 21.6 (*SD* = 14.1); Education: 6 college and beyond; Gender: all female; Marital	Themes (related to coping): Coping strategies include: helping others including family members, seeking social support through family, maintaining hope, shifting present difficulties to future, expressing gratitude for current situation, engaging in religious activities, searching in

				status: 6 married	meaning in adversity
Feldmann et al. (2007)	To elicit refugees' views on the way the healthcare system serves them, in order to learn about their frames of reference, expectations and experiences concerning health and healthcare	In-depth interviews	Convenience: Participants approached through refugee agencies, personal networks	N = 36 refugees; Age range: 18 to 66; Education: 16 secondary or lower vocational training; Employment status: 16 unemployed; Gender: 15 females; Legal status: 23 Dutch nationals, 13 humanitarian residence permit; Time in host country: 3 to 13yrs	Themes: 1. Causes of illness a result of mental worries, which include 'thinking too much' due to loneliness, unemployment, war experiences, loss of family members, being separated from family; 2. Strategies for coping with worries and bad memories include indulging in activities, praying, physical activity, talking with friends or family; 3. GPs primarily expected to address physical complaints, onus on individual to fight stress by keeping oneself busy
Omeri et al. (2006, 2004)	To explore and describe health and resettlement issues and barriers; To investigate access to, and appropriateness of, mental and physical health services for the Afghan community	Focus group discussions and semi-structured interviews	Convenience: Recruitment through community-based agency and informants in community	N = 38 refugees; Age range: 20 to 80; Gender: 16 female and 9 male general informants, 7 female and 6 male key informants; Time in host country: 1 to 16yrs	Themes: 1. Emotional Responses to Trauma: shame, sadness, guilt, anger, fear, grief and loss, hopelessness, frustration, dispossession, and displacement; 2. Contributory factors identified: gender role and career changes, isolation from family and friends, loss of country and identity, financial and housing difficulties, discrimination, culturally incongruent health care services, lack of health related information in Dari and Pashtu languages, lack of familiarity with the health care system in Australia
Morioka-Douglas et al. (2004)	To increase the information available for clinicians and educators to care for, and educate others to care for, elders from Afghan backgrounds more effectively	Focus group discussion	Convenience: Recruitment through community senior center	N = 9 refugees; Gender: all female; Time in host country: 10 to 21yrs	Themes: 1. Conceptions of health: health status and effective treatments identified with faith in, and practice of Islam (e.g. Afghans seek prayer for good health); 2. Lifestyle and health: subjects noted enduring depression and boredom – suggested the creation of elderly organization and day care; 3. Mental illness: subjects suggested no shame or negative association with depression as mental health problems known to Afghan society and considered natural phenomena

Lipson & Omidian (1997); Lipson (1993)	To describe mental health problems, their antecedents, ongoing everyday hassles that characterize interactions between community members and service providers	Ethnography-participant observation and open-ended interviews	Network sampling techniques: Initiated by two Afghan research assistants	N = 60 refugees; Age range: 21 to 73; Gender: 32 females; Education: none to doctorate; Marital status: 53% married; Time in host country: 5mos to 14yrs	Themes: 1. Antecedents for mental health problems/stress include experiences in Afghanistan, i.e. imprisonment, observing atrocities, losing family members; 2. Escape/transit experiences while fleeing homeland and in refugee camps; 3. Continuing stressors in the US include: survivor guilt, news from media, telephone, and mail from friends and family in Afghanistan; 4. Views on health care more positive than views on social services, problems of access and communicating needs persist due to lack of language and culturally-appropriate mental health services
Lipson (1991)	To describe social and cultural stressors experienced and health problems and patterns	Ethnography-participant observation and open-ended interviews	Convenience: Recruitment through pre-established community contacts	N = 29 refugees; Age: *M* = 40; Age range: 16 to 70; Gender: 17 females; Education: *M* = 10yrs, range: none to high school; Employment status: 24% employed; Time in host country: *M* = 3.4yrs, range: 4mos to 6yrs	Themes: 1. Community and Resettlement Stressors: lack of social support particularly affect women and elderly; elderly face severe isolation, depression; 2. Culture Conflict, Language, & Employment Stressors: men endure stressors associated with loss of social status, unemployment, dependency on public assistance – a source of self-esteem problems and depression; 3. Mental Health Sequelae: informants reported recurrent nightmares, becoming easily upset

Note. [a]Table adapted from Alemi, James, Cruz, Zepeda, & Racadio (2013)

Table 2.

Summary of peer-reviewed [quantitative] studies conducted with Afghan refugees and asylum seekers[a]

Reference & Setting	Purpose/Aims	Design & Data Sources	Sample Size and Characteristics	DVs (Instruments), and IVs	Results
Bronstein et al. (2012)	To provide an estimate for probable PTSD and to investigate relationship of PTSD symptom levels with pre-migration cumulative trauma, immigration status, social care living arrangements	Quantitative: Cross-sectional Sampling Method: Convenience-participants recruited through local authority social services	N = 222 unaccompanied asylum-seeking children (UASC); Age: *M* = 16.3 (*SD* = 1.0); Age range: 13 to 18; Gender: all male; Living arrangement: 62.6% in foster care, 37.4% in semi-independent accommodation, 3.2% emergency accommodation; Time in host country: *M* = 572 days (*SD* = 391), range: 3 to 1,776 days	DV: Pre-migration traumatic experiences or cumulative stress (SLE), and PTSD symptoms (RATS) IVs: Age, number of years in host country, and living arrangement, pre-migration traumatic events	Prevalence: Cumulative stress (*M* = 6.6, *SD* = 2.7), 34.3% reported scores above the suggested cutoff for probable PTSD; RATS (*M* = 45.7, *SD* = 10.9), subscale means of 12.7 (*SD* = 4.0) for intrusion, *M* = 20.0 (*SD* = 5.0) for numbing, and *M* = 13.0 (*SD* = 4.3) for hyperarousal Risk Factors: Cumulative trauma correlated with higher levels of PTSD symptoms (ρ = .40, $p < .001$); PTSD symptoms correlated with semi-independent accommodation compared to those living in foster care, $F(1, 217) = 11.08$, $p = .001$; *M* = 48.75, *SD* = 11.04 vs. *M* = 43.83, *SD* = 10.33; Multivariate analysis: SLE total score and living in foster care predictive of higher RATS scores
Sulaiman-Hill & Thompson (2011, 2010)	To explore resettlement experiences and mental health outcomes, and to examine ongoing sources of stress	Mixed-method (quantitative portion) Sampling Method: Snowball- use of multiple community entry points	N = 90 refugees; Age range: 18 to 60+; Education: 43 secondary school, 33 university, 9 primary, 5 none; English language proficiency: 76% proficient; Gender: 50% male; Time in	DV: Psychological Distress (Kessler-10) IVs: Gender, English proficiency, education, employment status, marital status	Prevalence: *M* = 19.8 (*SD* = 7.6) indicating moderate levels of distress consistent with a diagnosis of moderate depression and/or anxiety disorder Risk Factors: Female gender, inability to speak English, lower education, previously married, unemployment

			host country: *M* = 2.8yrs (*SD* = 1.2)		
Seglem et al. (2011)	To investigate depressive symptom levels	Quantitative: Longitudinal Sampling Method: Convenience-participants approached through community locations familiar with youth	N = 116 refugee minors (demographics not provided)	DV: Depressive symptomatology (CES-D) IVs: Not provided	Prevalence: *M* = 21.51 (*SD* = 8.44) falling below cut-off score of 24, suggesting less than moderate levels of depressive symptoms Risk Factors: Specific sub-group relationships not provided for Afghan subsample
Haasen et al. (2008)	To investigate a potential correlation between acculturation stress and alcohol use prior to accessing treatment	Quantitative: Cross-sectional Sampling Method: Snowball-recruitment through 2nd author contacts	N = 50 migrants; Age: *M* = 42.6 (*SD* = 9.2); Age range: 22 to 64; Age at migration: *M* = 31.7 (*SD* = 9.2); Education: all high school diploma; Gender: 92% male; Marital status: 88% married; Time in host country: *M* = 10.9yrs	DV: Mental complaints (MAP- mental health subscale) IVs: Acculturative stress and alcohol use	Prevalence: Mental complaints: *M* = 9.5 (*SD* = 4.9); Range = 2 to 23; Acculturation stress: *M* = 11.3 (*SD* = 3.2) Risk Factors: Significant correlation between mental distress and problematic alcohol use ($r = 0.29$, $p < 0.05$), and acculturation stress ($r = 0.45$, $p < 0.05$)
Gerritsen et al. (2006)	To estimate prevalence rates of depression/anxiety, and PTSD symptoms, and to identify the risk factors for these complaints	Quantitative: Cross-sectional Sampling Method: Random-recruitment via sampling frame	N = 206, 90 refugees and 116 asylum seekers; Time in host country: *M* = 2.8yrs (*SD* = 1.2)	DVs: Depressive symptoms/anxiety (HSCL-25), traumatic experiences and symptomatology (HTQ) IVs: Legal status, gender, stress, and social support	Prevalence: Depression reported in 54.7% of respondents; Anxiety: 39.3%; PTSD: 25.4%; Depression/anxiety (Adjusted Odds Ratio): 2.89; PTSD symptoms (Adjusted OR): 3.08; *M* = 7.1 (*SD* = 3.5) traumatic events experienced by asylum seekers out of 17 events Risk Factors: Legal status (asylum seekers),

		from refugee reception center			female gender, post-migration stress, and lower social support
Ichikawa et al. (2006)	To examine the adverse effects of post-migration detention on mental health by comparing asylum seekers who had once been detained and those never detained	Quantitative: Cross-sectional Sampling Method: Convenience-recruitment through attorneys representing asylum seekers HSCL-25: depressive symptomatology/ /anxiety; HTQ: traumatic experiences and symptom-atology	N = 55 asylum seekers (18 previously detained); Age: *M* = 30.2 (*SD* = 6.9); Education: 31 secondary/high school, 18 primary school or none, 6 university; Ethnicity: 78% Hazara; Gender: 96% male; Marital status: 35 unmarried; Time in host country: *M* = 24.4mos (*SD* = 15.6)	DV: Depression and PTSD diagnosis (CIDI) IVs: Age, education, ethnicity, having a confidant, living arrangement, marital status, time in host country, traumatic events	Prevalence: 1. Detained: Anxiety (*M* = 2.91), Depression (*M* = 2.75), PTSD (*M* = 2.90); 2. Non-detained: Anxiety (*M* = 2.30), Depression (*M* = 2.41), PTSD (*M* = 2.34) Risk Factors: Post-migration detention and trauma exposure significantly associated with anxiety, depression, and PTSD with estimated score increase (*B* coefficients) of 0.68, 0.43, and 0.47, respectively; Living alone also significantly associated with higher anxiety (0.54) and depression (0.50)
Gernaat et al. (2002)	To assess the prevalence of psychiatric disorders and help-seeking behaviors	Quantitative: Cross-sectional Sampling Method: Snowball	N = 51 refugees; Employment: 88% unemployed; Language proficiency: 92% moderate to poor language skills; Time in host country: *M* = 4yrs	DVs: Depression, PTSD, Anxiety IVs: Education, employment, and language proficiency	Prevalence: Psychiatric disorders prevalence 65%; Depressive disorder diagnosis: 57%; PTSD diagnosis: 35%; Anxiety diagnosis: 12% Risk Factors: Poor language skills, lower education level, and unemployment
Mghir et al. (1999, 1995)	To determine the prevalence of PTSD, depression, and other	Quantitative: Cross-sectional	N = 38 refugees; Age: *M* = 18 (*SD* = 3.14); Age range: 12 to 24;	DVs: Depressive symptoms (BDI), PTSD diagnosis (CAPS-1), traumatic	Prevalence: 45% met criteria for life-time diagnosis of depression; 1/3 met criteria for major depression, PTSD, or both; Being

	psychiatric disorders among adolescents and young adults by ethnic group and other socio-demographic variables	Sampling Method: Convenience-recruitment through Afghan community leader BDI: depressive symptomatology; CAPS-1: PTSD diagnosis; HTQ: traumatic experiences; SCID	Ethnicity: 60% Tajik, 40% Pashtun; Gender: 55% male; Father's education: 60% some college, mothers education: 78% less than high school; No. of months in Afghanistan during war: Pashtuns: 72mos, Tajiks: 53mos; Time in host country: *M* = 4.6yrs (*SD* = 2.7)	experiences (HTQ); major depression, dysthymia, generalized anxiety disorder, panic disorder, phobia (SCID) IVs: Age, age arrived to US, amount of English spoken by mother, ethnicity, gender, mothers' distress levels, parents' level of education, and traumatic events experienced	close to death most common war trauma reported (59.5%), followed by forced separation of family members (29.7%); Pashtuns showed greater evidence of PTSD and depression than Tajiks Risk Factors (PTSD, depression, or both) : Pashtun ethnicity, age (r = .47, p < 0.01), age arrived in US (r = 0.52, p < 0.01), amount of English spoken by mother (r = 0.44, p < 0.01), mothers' HSCL-25 total score (r = 0.35, p < 0.05), total number of traumatic events experienced (r = 0.48, p > 0.05)
Malekzai et al. (1996)	To develop a diagnostic instrument for assessment of PTSD and to provide baseline assessment of need	Quantitative: Validation study Sampling Method: Snowball	N = 30 refugees; Age: *M* = 42; Age range: 19 to 75; Gender: 50% male	DV: PTSD diagnosis (CAPS-1) IVs: Age (briefly described but not part of study' purpose)	Prevalence: 50% met CAPS-1 criteria for a current diagnosis of PTSD, including 52% of the male participants and 44% of the female participants Risk Factors: Age (incidence of PTSD increased from 10% in the 19 to 30 years age group to 100% in the 61 to 75 years age group) (r = 0.65, p < 0.005)
Lipson et al. (1995)	To assess the health concerns and needs for health education	Quantitative: Cross-sectional Sampling Method: Snowball	N = 196 refugee families, representing 951 individuals; Age: *M* = 43.5 (*SD* = 13); Gender: 59% female; Education: *M* = 15.3yrs (*SD* = 2.7) for males, *M* = 10.3yrs (*SD* = 5.6) for females; English proficiency: 61% poor to no English ability; Household	DV: Psychosocial distress (ad-hoc 96-item survey)	Prevalence: 63% of families reported stress problems; 17% mental health utilization rate Risk Factors: Stress in family members significantly associated with inadequate income, occupational problems, and loss of culture and traditions (p < 0.00l); Current stressors significantly related to work problems, property loss, and status loss

					size: *M* = 4.9 (*SD* = 1.8); Time in host country: *M* = 8.2yrs (*SD* = 4.1), range: 6mos to 17yrs

Note. [a]Table adapted from Alemi et al. (2013)

Beliefs about Depression and other Forms of Distress

Studies describing explanatory models of depression and other forms of distress specifically among refugees are limited. However, Kokanovic et al.'s (2010) study among a clinical sample of 24 East Timorese and Vietnamese refugees residing in Melbourne provides some evidence despite generalizability being limited. Qualitative interviews with respondents revealed that causes of depression and distress were inseparable from pre-migration traumas. Additionally, beliefs about causes included the sense of cultural and physical displacement and distance, changes in family structures and relations, and issues of structural disadvantage upon settlement in Australia.

Similar findings are described in an earlier qualitative study by Kokanovic et al. (2008), which compared conceptions about depression between Anglo-Australian with Somali and Ethiopian accounts. Refugees indicated not having a term for 'depression' in their respective languages. However, they did express feeling emotional distress, but did not relate this to a medical problem. Instead distress was related to the collective experiences of being a refugee such that women explained separation from family as a source of stress and men indicated social structural factors related to unemployment, economic disenfranchisement, and racism as sources. Social networks were described as a protective factor against depression.

With relation to these beliefs, Karasz (2005) hypothesized that for more traditional groups depression could very well be an emotional reaction to interpersonal, financial, isolation-related and social problems, aligned with a *situational model* (Patel, 1995). Karasz (2005) argues that for acculturated groups depression may be characterized as a disease resembling the biopsychiatric model where causes stem from chemical

imbalances and genetic factors. Karasz (2005) confirmed these notions through a qualitative study comparing views about depression between 36 South Asian (SA) and 37 European American (EA) women. A vignette methodology was used to elucidate conceptual models through semi-structured interviews. With respect to the perceived causes of depression, EAs perceived depression to be caused by chemical imbalances (Karasz, 2005) while SAs were likely to focus on ongoing problems such as marital and family/home problems. Cabassa, Hansen, Palinkas and Ell (2008) presented similar results in a qualitative study of Latino immigrants in Los Angeles. Participants did not endorse biological causes of depression, instead they described depression resulting from loss of employment and functioning, failing health, economic strains, domestic violence, and care-giving burdens. Moreover, somatic complaints (e.g. headaches, chest pains, feeling tired, and the lack of energy), and disinterest in pleasurable activities were some of symptoms associated with having depression.

A situational model was also supported in a consensus analysis of depression beliefs among 120 Latino immigrants representing various nationalities residing Florida (Martinez Tyson). Causes included but were not limited to the following categories: interpersonal problems (e.g. family problems, problems with children), psychosocial and intrapersonal issues (e.g. loneliness, stress), health-related issues (e.g. health problems/illness), as well as economic problems (e.g. lack of money). Additionally, symptoms included but were not limited to emotional as well as somatic expressions. Treatments were related to the following categories: seeking care from a biomedical practitioner, social support, distracting oneself, taking personal initiative, thinking positive, as well as engaging in religious activities such as prayer and going to church.

Cinnirella and Loewenthal (1999) have found that religious beliefs also play a role in determining help-seeking and attitudes toward depression. Among a diverse sample of respondents, these authors investigated the degree to which "beliefs about religion were seen to intertwine with lay beliefs about depression and schizophrenia, including the degree to which religious beliefs and practices were perceived to be a factor in interactions with professionals such as GPs or social workers" (p. 507). Qualitative data suggested that Muslim respondents felt that depression might be caused by lack of faith and failure to pray regularly, and that such illnesses could be treated through ethnically similar practitioners, as well as support from family and friends. Similarly, the role of faith in coping with depression was discovered in a cross-sectional study conducted among a sample of 95 Latino immigrants largely made up of women (Cabassa, Lester, & Zayas, 2007). Additionally, the majority of participants endorsed positive attitudes towards counseling, but 61% of respondents described their ambivalence towards anti-depressants as they were perceived to be addictive while 38% "thought that they made people feel drugged" (p. 10). Overall, men had more positive attitudes towards these interventions; however, these attitudes were not associated with characteristics such as higher acculturation.

Luu, Leung, and Nash (2009) recently posed the question, "How does acculturation affect attitudes about seeking mental health services?" (p. 478). In a study surveying 210 Vietnamese Americans, Luu et al. (2009) examined the influence of acculturation, as well as cultural barriers, and spiritual beliefs on attitudes toward seeking professional psychological help. Results suggest that acculturation was significantly associated with positive attitudes toward seeking psychological help. This corroborates

findings from previous studies with Southeast Asian refugees (Chung & Lin, 1994) who reported higher tendencies to use Western health care services as predicted by levels of exposure to Western practices and culture, higher English proficiency, and more formal education.

Other cross-sectional studies also show that more traditional groups have unique conceptualizations of anti-depressive behaviors. For example, a study among native- and foreign-born Britons residing in the UK (Furnham & Malik, 1994) suggests that views of depressive symptomatology differed drastically among the two groups and were influenced by age and exposure to Western education. Angel and Thoits (1987) suggest that education is a major source of acculturation and that medicalized models of depression found among educated lay people represent a form of acculturation that occurs as a function of exposure to biopsychiatric models learned through psychiatric discourse. Moreover, Furnham and Malik (1994) assert that traditional groups placed a strong emphasis on family as a source of social support in the therapeutic process. Dow (2011) argues that it is imperative for mental health providers to really consider and understand family dynamics, as it serves as a form of cultural knowledge that could assist in the implementation of culturally appropriate therapeutic interventions.

Similarly, in a study among 223 Asian Americans largely made up of women (Wong et al., 2010), respondents who believed in biological and situational causes of depression were more likely to endorse professional help-seeking as compared to those maintaining Asian values and interpersonal causes for depression. Also, Wong and colleagues suggest that the maintenance of Asian values leads many to believe that depression results in somatic complaints, which has been associated with a greater

likelihood of endorsing professional help-seeking given culturally-bound notions that it is socially acceptable to seek help for problems related to physical illnesses. According to Renner, Salem, and Ottomeyer (2007), "to non-Westerners, somatic symptoms may seem more acceptable and easier to communicate than psychological symptoms" (p. 243).

Other studies have also examined the relationship between cultural beliefs about the causes of mental distress and attitudes associated with seeking help for psychological problems. Among 287 British Asians, Western Europeans, and Pakistanis, Sheikh and Furnham (2000) found that culture as a variable was not a significant predictor of positive attitudes towards seeking professional help. However, causal beliefs of mental distress were significant in shaping views on seeking professional help. Particularly among the Pakistani group, "the more traditional beliefs of supernatural causes of mental illness predicted a less positive attitude towards help-seeking, while beliefs in Western physiological causes predicted a more positive attitude" (Sheikh & Furnham, 2000, p. 332). Such findings are supported in a study aimed at investigating the relationship between psychological distress, acculturation, and help-seeking attitudes among 130 individuals of African descent (Obasi & Leong, 2009). The authors suggest that survey respondents who maintained cultural beliefs about mental illness reported poor confidence in mental health practitioners as their levels of psychological distress increased.

Among individuals of Chinese descent, Chen and Mak (2008) examined the contributions of cultural beliefs about the etiology of mental illness to help-seeking behaviors among Chinese-Americans. The authors confirmed through analysis of written responses to open-ended questions that individuals exposed to and influenced by the

Western culture held more positive perceptions toward seeking professional psychological help and actually used more mental health services. Nevertheless lay beliefs of illness differed widely among cultural groups, between levels of education and socioeconomic strata (Helman, 1991), which according to Kirmayer (2006) are not stable within the same individual as traditional and modern concepts mix. According to Ho (2002) "health care providers can deal with their clients more competently if they are knowledgeable of their clients' cultural beliefs, their interpretation of mental illness and mental well-being, their help seeking patterns, and choice of traditional alternative health practices" (p. 51).

A recent qualitative study conducted in Southern California among refugee health and resettlement professionals identified language and communication, acculturation difficulties, and cultural beliefs regarding health care to be major barriers to accessing mental health services (Morris et al., 2009). This confirms Afghan respondents' perceived concerns described by Lipson and Omidian (1997) surrounding the inaccessibility to mental health care. It has been suggested that culturally relevant clinical services for Afghans could be provided through clinicians who are sensitized to the refugee experience and cultural characteristics, settlement patterns, and health beliefs (Lipson, 1991).

Summary

In conclusion, we find that depressive and posttraumatic symptomatology is widespread in Afghan communities in the US and other western nations. The primary sources of psychological distress appear to be cultural adjustment and loss, which come

in various forms. Investigators have operationalized cultural adjustment as difficulties in acquiring the English or mainstream language, which are inextricably linked to employment and financial problems particularly for men whose stress is compounded by gender-role reversals and loss of status. Moreover, Afghans persistently show concern with regard to their children's eroding cultural values resulting from exposure to Western society, along with isolation and social exclusion found mostly in women and the elderly. The elderly are an understudied group; however, some findings do suggest that the elderly appear to be disproportionately affected by mental illness. Abrupt changes in lifestyle, loss of family, property, and status greatly affect this population given their stronger bonds with their homelands. Social support is necessary for Afghans as overcoming disorders such as depression are practically contingent on seeking help from family as indicated by various studies conducted with Afghans.

While these findings are supported by a few studies, current conclusions cannot be regarded as definitive for various reasons. First, there is a paucity of research conducted among Afghans resettling in the US in recent years. Secondly, studies conducted with Afghans resettling in earlier refugee waves may be outdated. Finally, studies have been limited in scope given methodological constraints inherent in this type of community-based research (e.g. small/non-representative samples). Also, a major void of existing knowledge includes the systematic investigation of beliefs about depression, which is a disorder that is highly prevalent among Afghans in exile.

For this reason, we sought data from studies conducted with other migrant groups including Asian and Latino immigrants to inform our knowledge. We observed that more traditional groups tend to view depression as resulting from family conflicts, loss of

social support, or weak religious faith. Many also hold negative views about professional help-seeking. It may very well be that traditional groups believe that emotional reactions to problems such as family conflicts and financial difficulties are normal. However, some of the studies reviewed above show the saliency of family and other sources of social support as integral to coping with distress. More acculturated groups or groups exposed to Western education tend to view depression from biopsychiatric models of disease etiology and therefore endorse professional help-seeking. Findings from the studies documented in this section are essential in guiding the interpretation of this study's findings.

CHAPTER 3

PRELIMINARY RESEARCH

Overview

This chapter provides an in-depth review of preliminary qualitative work carried out with the Afghan refugee community in San Diego County. This research was essential foundational work for the subsequent dissertation research and as such is described in this document. Two qualitative studies, both approved by the IRB of Loma Linda University (OSR# 5100251 and 5110152) were carried out. These include a feasibility/pilot study (Phase-I) entitled "Identifying strategies of gaining access to the Afghan refugee population: a qualitative study" (Alemi & James, 2011). The second qualitative study, (Phase-II) is entitled "An era of sacrifice: resettlement stressors and views of depression among Afghan refugees" (Alemi & James, 2012). This second study was necessary for obtaining culturally relevant views about depression, which later informed the development of our structured questionnaire for this dissertation research.

Methods: Phase-I

Purpose

The purpose of this study was to identify culturally-sensitive strategies of gaining access to the Afghan refugee population, needed for conducting future mental health surveys. Specifically, we aimed to conduct in-depth interviews with key informants from the refugee community in order to elicit responses to open-ended questions on the Afghan refugee populations' characteristics, factors surrounding mental health-related issues, and their perceptions on strategies of gaining access to potential study

participants. Our secondary aim was to conduct focus group discussions with members from the Afghan community for the purpose of data triangulation.

Sample

An initial purposive sample of seven key informants participated in this qualitative study. Inclusionary criteria were: a) credibility with, and knowledge of the Afghan community in terms of its size, demographics, and social issues; b) experience working with Afghans (and other refugees) in delivering health and resettlement services. Participants ranged in age from 32 to 71 years (m = 51; sd = 12). Of this sample five were Afghan of which two reported being community leaders, one a religious leader/clergy, one individual was a licensed psychiatrist, and another a Dari-Pashto linguist experienced in working with Afghan refugees. All participants were male with the exception of one non-Afghan health care provider; our other non-Afghan participant reported being a health care provider as well. With exception of the religious leader who had obtained theological training, education levels for the rest of the sample ranged from a master's to a doctoral degree (medicine/philosophy). We obtained the number of years engaged with refugee communities for only five of seven participants, which ranged from two to 14 years (m = 6.8; sd = 5.1). Table 3 below summarizes key-informant demographic characteristics.

Table 3

Key-informant characteristics (n = 7)

	Age (m = 51, sd = 12)	Education	Specialty	Nationality	Profession	Yrs. Contact with Refugees
R1	51	Seminary	-	Afghan	Clergy	-
R2	55	Master's	Information Technology	Afghan	Community Leader	14
R3	52	Master's	-	Non-Afghan	Health Care Provider	9
R4	43	Master's	Education	Afghan	Community Leader	7
R5*	32	PhD	Public Health	Non-Afghan	Health Care Provider	2
R6	50	MD	Psychiatry	Afghan	Health Care Provider	2
R7	73	MD	General Medicine	Afghan	Community Leader	-

Note. *Female key-informant

Inclusion criteria for the two focus groups included adult Afghans originally resettled in the US as either refugees or asylum seekers. Our convenience sample of Afghans participating in our first focus group, grouped as "FGD-1", included seven men, ranging in age from 39 to 68 years of age (m = 56.4; sd = 14.6), who were recruited through the local mosque (described below in the 'Procedure' subsection). Educational levels included two participants completing high school, one participant completing military training, two with bachelor degrees, and the remaining two with master's degrees. Six of the seven participants reported being married; four were of Pashtun ethnicity while three were Tajik. With the exception of one participant arriving to the US as an asylum seeker, all other participants arrived as refugees. Six of seven participants reported being US citizens while one reported being a permanent resident. Length of residence in the US ranged from 12 to 25 years with many reporting relatively short stays

in the Afghanistan before fleeing (range: 4 months to 5 years; *m* = 2.7; *sd* = 1.9). Many participants fled to neighboring Pakistan upon the wake of the Soviet invasion.

The second focus group, grouped as "FGD-2", consisted of eight young Afghan adult males ranging in age from 21 to 31 years of age (*m* = 23.9; *sd* = 3.2) representing diverse ethnic groups. As expected most participants (five of eight) reported never being married; six individuals reported obtaining a high school diploma, while one did not complete high school, with the remaining individual not providing a response to this question. The number of years resided in the US ranged from 8 to 12 years (*m* = 9.8; *sd* = 1.3), indicating that most arrived after 9/11. The number of years spent in Afghanistan during war ranged from none to 12 years (*m* = 3.7; *sd* = 4.4). Similar to our first focus group cohort all participants spent a portion of their lives in Pakistan. Table 4 below summarizes general-informant demographic characteristics.

Table 4.

General-informant characteristics (n = 15)

Variables	FGD-1 (*n* = 7)	FGD-2 (*n* = 8)
Mean Age (SD) [years]	*m* = 56.4; *sd* = 14.6	*m* = 23.9; *sd* = 3.2
Education		
HS or below	2	7
College and beyond	5	0
Employment		
Employed	4	8
Unemployed	3	0
Ethnicity		
Pashtun	5	1
Tajik	2	2
Hazara	-	3
Nuristani	-	2
Marital Status		
Married	6	3
Unmarried	1	5
Mean Time in US (SD) [years]	*m* = 22.0; *sd* = 4.9	*m* = 9.8; *sd* = 1.3
Mean Time in Afg. (SD) [years]	*m* = 2.7; *sd* = 1.9	*m* = 3.7; *sd* = 4.4

Note. *One participant in FGD-2 did not provide response to question on educational attainment. All participants fluent in Dari.

Procedure

Entry into the Field

The author approached a prominent Afghan religious figure for purposes of gaining entry into the Afghan community as this was determined the most appropriate method of establishing rapport. Therefore, this religious figure was asked to serve as a reference to other key informants in the community, a strategy suggested by Lipson and Meleis (1989). This strategy, along with the student-investigator's fluency in Dari may have influenced the expeditious recruitment of Afghan key informants for interviews. Furthermore, key informants were also recruited through a local refugee health forum mainly attended by resettlement personnel where the author announced the study and its purpose. This provided access to the two non-Afghan health care providers experienced in serving refugees as well as a referral by a resettlement professional to an Afghan linguist who formerly served as a refugee resettlement provider.

Participants were contacted telephonically and by e-mail upon request, and were met at times and locations convenient for them. This included home and office visitations lasting anywhere from 45 to 75 minutes. Standard procedures for getting consent were considered before interviews commenced. Three of the five initial Afghan participants refused to be audio-recorded while two refused to sign the ICD, which prompted the need to take notes during interviews and to gain verbal consent from Afghans participating in future studies. We later found that a seminal cross-sectional study conducted with displaced Afghans in the Netherlands used and recommended a similar strategy, i.e. the use of verbal consent (Gerritsen et al., 2006).

Rapport with Afghan key informants, who essentially served as gatekeepers to the larger community, facilitated access to a local Mosque/community center attended by Afghans for recruitment in future focus group discussions. We foresaw the use of focus group discussions as a necessary tool in efficiently obtaining data despite our reluctance in employing this method given the possible stigma associated with participants having to vocalize mental health-related issues before peers. However, our efforts were encouraged and informed by focus group discussions that have taken place in recent studies with Afghans in the US (Morioka-Douglas et al., 2004) and abroad (Omeri et al., 2006, 2004). Community leaders advertised the focus group in the least obtrusive fashion possible by announcing the study after Friday religious services as a student-initiated project that seeks to "understand the life experiences and life difficulties of Afghans," a suggestion from key informants. The author approached and obtained individuals' names and phone numbers immediately after advertisements were made. It was crucial for the first author to consistently attend Friday sermons at the center in order to gain the trust of the community and increase receptivity of potential participants toward the research project.

Attempts to recruit women were subsequently facilitated through the appointment of a female Afghan RA from the local community, who through her personal social network coordinated a time and place for approximately five women to meet at a potential participant's home. However, the focus group discussion was not executed as all women opted not to participate given the fact that it was later discovered through debriefings that the aim of the discussion was conveyed as one that seeks to understand "depression in Afghan women." However, the RA was able to coordinate the recruitment of eight young-adult Afghan males involved in a local soccer team representing

understudied minority groups (e.g. Hazaras), providing a potential link to these sub-groups for surveys to be distributed in the future. It has been demonstrated that utilization of multiple-entry points in the community are necessary with "hard to reach" groups such as this (de Anstiss & Ziaian, 2010).

Focus group members were contacted telephonically. The purpose and aims of the study were carefully explained to the participants; we obtained verbal consent, and displayed caution in audio-recording focus group discussions. Contrary to our beliefs, focus group participants allowed for the discussion to be audio-recorded. While one individual in our first focus group protested the use of audio-recordings, other participants convinced this individual to allow it. The first focus group was held at the center where recruitment took place while the second was held at a participant's home. Both sites were deemed the most accessible, neutral, and private for discussions to be carried out. Interview and focus group data were collected over a six month period from November 2011 to April 2012.

Data Sources

Data collection techniques included in-depth interviews with key informants using an interview guide (see 'Appendix A') to ensure consistency across interviews. The interview guide was informed by Morris et al. (2009) and included three general topic areas and probes: 1) the Afghan refugee populations' size and socio-demographic characteristics; 2) the stressors and mental health conditions affecting Afghan refugees; and 3) suggestions on effective strategies for sampling, recruiting and gauging the receptivity of Afghans for participating in a prospective mental health study. We

triangulated this original data source with our two focus groups using the same guide used in our interviews. Socio-demographic characteristics were collected using a paper-and-pencil questionnaire in each approach.

In focus groups, after the ICD was read to participants, the discussion's aims were stated, with a statement that the author was seeking to learn from the participants (Morgan, 1997). Each focus group began with an "ice-breaker" by providing each participant an opportunity to give a brief self-introduction and synopsis of their experiences fleeing Afghanistan and resettling in the US. The fact that the student-investigator and RA were both of Afghan descent and fluent in Dari may have been the cause for the candid discussion that took place, which drew on individuals' lived experiences and emotions. However, given age differences between the student-investigator and participants, with the latter being visibly older in age, a challenge arose in moderating the group discussion as adherence to cultural norms in respect for elders superseded efforts in disallowing certain individuals from monopolizing the conversation. Consequently, this took away much needed time allotted for responses with relation to mental health issues.

Data Analysis

Data was analyzed using *Qualitative Description* techniques as informed by Sandelowski (2000). This technique was most suitable as the study was not guided by a specific qualitative paradigm, data was non-theorized and presented in no other terms but its own (Neergaard, Olesen, Andersen, & Sondergaard, 2009; Sandelowski, 2000). Sandelowski describes qualitative descriptive techniques as the method of choice when

straight descriptions of phenomena are required. Qualitative content analysis (the analysis strategy in qualitative descriptive studies), according to Sandelowski (2000) is "data-derived" in that codes are systematically applied, but they are generated from the data themselves in the course of the study. Thus qualitative descriptive methods can carry overtones from grounded theory such as constant comparison. But the end result of counting is not a quasi-statistical rendering of the data, but rather a description of the patterns or regularities in the data that have, in part, been discovered and then confirmed by counting.

Preliminary Results: Phase-I

Data analysis focused on three domains, which included in-depth information about San Diego County's Afghan refugee population characteristics, contextual information about the mental health issues affecting Afghans, and strategies for conducting culturally-sensitive mental health research with Afghans.

Domains

Domain 1: San Diego County's Afghan Refugee Population

With respect to the larger population's size, a majority of participants taking part in both focus groups and in-depth interviews asserted that an estimated 4000 to 6000 Afghans currently reside in the San Diego area with roughly half being adults. However, estimates are debatable according to one Afghan key-informant (KII-R2) as tracking of arrivals was discontinued many years ago, which was confirmed by KII-R3 who asserted that county-wide data is not provided for this sub-group. It was suggested that Afghans

arrived in two waves with the majority arriving during the 1980s and a sparse number arriving post 9/11. Afghans residing in Western nations are those that once lived in the urban areas or capitals of their respective provinces (KII-R2). Lipson and Omidian (1991) also found that most Afghans in the SF Bay area reported coming from urban areas of Afghanistan and were highly educated (cited in Morioka-Douglas et al., 2004; Lipson et al., 1995). These individuals were afforded opportunities to leave Afghanistan and to seek refuge in Iran and Pakistan, which in turn facilitated their resettlement in Western nations. The 1980s cohort represents much variation in gender and age categories given their larger size; however, those arriving post 9/11, although few, are more unique as the population is comprised of widows with children, and those belonging to the Hazara and Tajik ethnic groups due to escape from Taliban repression. It was asserted that many Hazaras have resettled in a specific subdivision of the county, i.e. East County/El Cajon (KII-R1). This was validated by the demographic makeup of the young adults taking part in our second focus group discussion. This group was mainly composed of Hazaras currently residing in El Cajon with single parent families during the previous 10 years.

Domain 2: Mental Health Issues

An Afghan psychiatrist (KII-R6) noted that Afghans suffer mental illnesses including depression and PTSD and present with symptoms common to these conditions. Causative factors for psychological distress according to Afghans are not merely rooted in traumatic experiences, but are exacerbated by difficulties related to cultural adjustment, social support, loss of social status, and a lack of education. This seems to be

supported by Lipson and colleagues' previous work with Bay Area Afghans that describes everyday hassles and annoyances as more contributory to psychological distress than major life events. A drawback to our convenience sample of young adults (FGD-2) was their limited experience and knowledge in this particular domain. This exemplifies a limitation of convenience sampling such that some participants may not be fit to provide adequate information on a given topic (Berg, 2009; Creswell, 2007). However, the (paraphrased) statement posited by one of our key informants puts mental health problems into context.

> '…a survey measuring stress is not needed because it is obvious that stress is high in our community'…'no Afghan exists that does not have stress, depression due to loss is never erased from ones memory- loss of family, property, identity and is made worse by the current war.' –KII-R1

In terms of cultural adjustment difficulties, parents perceive their resettlement to the US as a sacrifice for their children to prosper. Yet, they are challenged with instilling the culture in their children who often do not meet their expectations due to newly adopted values. An exchange between two focus group respondents (FGD-1-R2 and -R5) occurred as disagreements between accepting and rejecting the Western culture for their children were expressed. However, it was suggested that children or younger generations therefore endure identity issues and face much discrimination from non-Afghans. Participants in FGD-2 also noted discrimination as a source stress, and recounted on various occasions where they nearly engaged in physical altercations with non-Afghans. Furthermore, the elderly were noted as the most at-risk for mental health problems given their ties back home, their stronger perceived sense of loss, and isolation as "they have no one to socialize with…and are in exile" –FGD-1-R1. The loss of social status was related to the recognition not given to professional degrees, gender role changes that many face,

and the detrimental effects of living on public assistance, which was also documented in a study by Lipson and Omidian (1997) among Bay Area Afghans. Role reversal has a deep impact on the psychological wellbeing of men who feel they are losing control, often leading to domestic/family violence for reclaiming dominance in the family. Moreover, informants noted news of the protracted violence in Afghanistan as a major stressor as many still do have family living in Afghanistan and cannot fulfill their longing for wanting to return home. The (paraphrased) statement below exemplifies some of the hardships that Afghans face upon and thereafter resettlement.

> '…those that took the welfare route never get back, those that chose to work, they go through hell. For example, I drove taxi, I was a dishwasher, and I worked in McDonalds. But I never accepted welfare even though I had to support five people. But those who went the welfare route stayed on welfare, welfare doesn't allow you to develop and it ruins a person.' –FGD-1-R1

> '…in Afghanistan the leader of the home is the father, but after becoming refugees these people became the homemakers (or *khana neesheen*) and food was just handed to them. And many of our women, who come from a strict society, now have many freedoms. And the law system here favors women over men, this has caused even more stress in men, and because they have lost their identity within their family.' –FGD-1- R2

Health care providers alluded to a "honeymoon" (KII-R3, -R5) period experienced by refugees upon arrival to the US, referring to the fact that refugees feel a sense of security upon resettlement to the US through receiving social assistance from refugee agencies. However, after approximately one year refugees tend to become "homesick" as refugee agencies cutoff support and practically leave refugees to fend for themselves in terms of finding jobs and navigating social services systems.

Domain 3: Harnessing Methods for Establishing Study Feasibility

With respect to harnessing methods for establishing study feasibility, key- and

general-informants noted the following in terms of advertising, gaining credibility in the community, as well as sampling and recruiting strategies: 1) ensuring buy-in from religious leaders/gatekeepers who could facilitate recruitment efforts, according to one key-informant: "The people don't trust outsiders, especially after 9/11, many things going on" –KII-2; 2) the purpose of the study must be very clear and also explicitly portrayed as an activity to understand the life challenges of Afghans rather than a study on mental health, according to a focus group participant: "Don't touch the subject (mental health)…once you get to their house let them know, for now tell them you want to learn about their life difficulties" –FGD-1-R3, "Make sure that people understand that your research will not lead to the formation of a mental health clinic" –KII-R5, -R3), avoid use of direct monetary incentives given its negative connotation as a form of bribery as indicated by Afghan (KII-R2) and two non-Afghan key informants (KII-R2, 3, 5), instead incentivize participation by donating money on their behalf to a local mosque to also build a sense of a "good deed being committed" (KII-R2) by taking part in the study; 4) when recruiting females, male counterparts of women should be notified first; 5) use of Afghan youth groups in local universities who could facilitate recruitment of their parents, possibly rendering more valid responses to survey questions (KII-R2, -R4, and -R6; various focus group participants); 6) using locally held events for advertising such as *Nowruz* or New Year's holidays and post-Ramadan prayers held at local centers; 7) use of mail-in surveys sent on behalf of local religious or community leaders, while elders would need home visitations given transportation issues as cited by various focus group informants; however, some FGD-2 respondents advised against using mail-in surveys by alluding to Afghans possibly not being responsive to letters or not knowing how to return

a questionnaire via postal service; 8) use of broadcast media such as commercials by prominent figures in the community or appearing on talk shows to discuss study through Afghan satellite television networks located in southern California; 9) obtaining verbal rather than written consent; and 10) to avoid the use of audio-recording devices during interviews.

Our qualitative work has corroborated perceived difficulties in gaining access and trust to this population and the level of rapport needed before actually conducting mental health related surveys on Afghans (Lipson, 1991; Lipson et al., 1995; Smith, 2009). Afghans are a "hard-to-reach" subgroup in that trust with them comes with many complexities. Miller et al. (2005) acknowledges that (in general) refugees have a diminished capacity for trust given their history of persecution. For Afghans, problems with trust may stem back to the traumatic events that took place in Afghanistan's modern history. Politically-motivated Afghans persecuted their own country-men, leading to major disruptions in the continuity of regular Afghans' relations with the very people they were familiar with, potentially bearing a deep impact on their ability to trust others. Miller's (2004) reference to the late sociologist Erving Goffman's concept of "frontstage" and "backstage" behaviors (Goffman, 1959) puts the importance of trust into perspective. Essentially *frontstage* behaviors imply illusory interpersonal access to individuals while *backstage* behaviors imply authentic interpersonal access (Miller, 2004). As cited by Miller (2004):

> "By frontstage behaviors, Goffman (1959) referred to self-protective, often manipulative modes of behavior used with strangers, societally defined superiors, and others with whom one feels a limited degree of interpersonal trust and intimacy. Backstage behavior, in contrast, occurs when there is no longer any need to perform, for example, when an individual is alone, or finds him or herself in the company of trusted companions" (p. 222)

By developing trusting relationships with community members one can increase the "likelihood of gaining interpersonal or backstage access," according to Miller (2004, p. 224). Trust and rapport building are critical in working with refugee communities (Miller, 2004), especially where there is a tendency for interview respondents to provide answers to questions in socially desirable ways. Upon gaining trust, an investigator's similar cultural background to the participants can serve to help respondents navigate their way through difficult topics in surveys and will have a greater likelihood of being sensitive to core cultural issues that may impact data collection (e.g. interviewing of women).

Methods: Phase-II

Purpose

The overall purpose of this study was to understand Afghans' lived experiences with the migration process as they fled Afghanistan, the stressors and challenges faced upon resettlement to the US, and to elicit Afghans' views of depression. The ultimate aim was to inform the development of a survey instrument to be used in the subsequent dissertation research.

Sample

A convenience sample of 18 Afghans was recruited as this provided sufficient saturation of responses to the interview protocol (through an iterative process of data collection and analysis). It included 11 males and seven females ranging in age from 36 to 71 years (M = 55.6; SD = 9.8) (see Table 5 for sample characteristics). Fourteen

participants reported being married with two women reporting being widowed and one male never being married. Educational attainment ranged from 'less than high school' to a doctorate of medicine, reported by three females and two males, respectively. Five of the remaining 12 participants reported obtaining a bachelor's degree while the remainder obtained a high school diploma. Of the seven individuals with college degrees, only two were employed in areas outside their fields of study, which exemplifies the lack of recognition given to foreign education here in the US. The majority of the sample (n = 12) reported being unemployed, three reported being employed full-time, and one employed part-time. All participants were fluent in Dari.

Eight participants described themselves as Pashtun, five Nuristani, two Hazara, and three Tajik. With the exception of three individuals who reported being asylees all others were refugees. One individual who was born in the US and returned to Afghanistan when he was an infant fled the country when he was 17 years of age in 1979 as the Soviets invaded. Therefore, because he was born a US citizen he technically did not meet our inclusion criteria as a refugee or asylum seeker; however, we categorized him as a refugee merely based on the coercive nature of his departure from the country.

We employed maximum variation sampling techniques in order to obtain a relatively heterogeneous sample of individuals in terms of time resided in the US. Time in the US ranged from two months to 30 years (M = 18.2 years; SD = 10.3) with four individuals spending between two months to two years in the US. The time spent in Afghanistan during war (includes all conflicts from 1979 to present) ranged from two months to 35 years (M = 7.5 years; SD = 8.6). The time in between fleeing Afghanistan and resettling in the US was generally spent in Pakistan. Only three individuals reported

spending a considerable amount of time in Germany, Iran, or Russia in addition to spending some time in Pakistan. With the exception of two participants residing in the US for less than a year, all other individuals reported being US citizens who usually communicate with family in Afghanistan but seldom send remittances abroad. Inclusionary criteria included: a) being an adult of Afghan ancestry; b) originally resettled in the US as either a refugee or asylum seeker.

Table 5

Sample characteristics (Phase-II)

	Number of Respondents		
Variable	Total (N = 18)	Females (n = 7)	Males (n = 11)
Mean Age (SD) [years]	55.7 (9.5)	56.7 (9.8)	55.0 (9.7)
Educational Attainment			
High school diploma or below	11	7	4
Bachelor's degree/equivalent or higher	7	0	7
Ethnicity			
Pashtun	8	3	5
Tajik	3	1	2
Hazara	2	1	1
Nuristani	5	2	3
Marital Status			
Married	15	5	10
Other (never married, separated, widowed)	3	2	1
Mean Time in US (SD) [years]	17.3 (10.7)	15.9 (9.6)	18.3 (11.7)
<1 year to 20 years	8	4	4
>20 years	10	3	7
Mean Time in Afghanistan During War (SD) [years]	7.4 (8.3)	8.7 (5.2)	6.6 (10)
<1 year to over 20 years	17	7	10
>20 years	1	0	1

Procedure

Entry into the Field

The initial feasibility study (Phase-I) set the stage for recruitment of individuals at the Mosque/community center used in Phase-I as advertisements had already been carried out for recruiting focus group participants. Therefore a sense of credibility and familiarity in the eyes of potential participants had already been established. Convenience sampling techniques not only permitted the inclusion of participants at this site, but from our RA's personal social network as well. The utilization of personal networks along with referrals to potential participants from key informants has been used for sampling purposes in previous qualitative studies with Afghans (Lipson, 1991; Lipson et al., 1995). These sampling techniques have proven effective in recent studies with Afghans (de Anstiss & Ziaian, 2010; Feldmann et al., 2007; Ichikawa et al., 2006; Omeri et al., 2006, 2004). For this study, this specific technique facilitated rapport with unique ethnic subgroups (e.g. Hazaras and Nuristanis) and women who are generally guarded by cultural boundaries, groups which would have otherwise been virtually inaccessible by merely recruiting through the mosque/community center described in Phase-I.

Participants included Afghans living in Afghanistan anytime during the wake of the Soviet invasion and beyond, hence providing for a more eclectic set of responses on views of depression from individuals conceivably having suffered from depressive symptoms in the past and also those never personally experiencing depression. Study participants were initially contacted telephonically. The student-investigator introduced himself as a student and informed participants of the study's purpose. To avoid the potential stigma of being associated with a study on mental illness, the study was

presented as one that 'seeks to understand the life experiences of Afghans.' This reflects suggestions posited during our first focus group discussion in terms of the manner in which such a study ought to be advertised.

Most interviews were conducted in the homes of participants and lasted about one hour. Two interviews were conducted at the local center used for recruitment. Verbal consent was obtained from participants after the ICD was interpreted in Dari to all participants; however, the author further assured them of their rights by providing them a signed copy of the ICD. Participants were informed that a $10 cash donation would be made on their behalf to a mosque of their choosing as previously advised by key informants. After obtaining consent participants were asked for permission to audio-record the interview. Attempts to audio-record were dismissed after the first three interviewees refused to be recorded, corroborating assumptions formulated in Phase-I. As a result, notes were taken during interviews, which were conducted in Dari, and later transcribed in English.

Data Sources

Data was collected through in-depth interviews (see 'Appendix B' for the interview guide). The interview contained two general topic areas including migration experiences and views about depression. Because Afghans guard personal information, a less intrusive approach was taken as the student-investigator introduced himself as a student. We started interviews asking a general open-ended question about participants' experiences and memories while living in a theater of war. We used probes when necessary for clarification purposes. Also, responses to questions provided for subtle

transitions in topic areas. For example, responses with relation to fleeing Afghanistan usually ended with the participant providing an account of their resettlement to the US, which prompted questions relating to 'difficulties faced upon resettlement.' Most respondents described the effects of post-resettlement stressors as detrimental to their health and well-being. As we probed for more in-depth information in these areas we arrived at our final question on their perceptions about depression. Data collection lasted from July through October 2011.

Data Analysis

Qualitative Description techniques as described above in 'Phase-I Data Analysis' were employed.

Preliminary Results: Phase-II

Themes

We uncovered three major themes in Phase-II, all of which are briefly presented in the following subsection. These included one theme, the "diminished sense of safety and security" brought about by pre-migration stressors including horrific encounters with traumatic events while living in Afghanistan. Two themes were related to post-migration stressors, which included "cultural adjustment and acculturation challenges" and "perceived gains/benefits of resettlement," which really provided insights into how Afghans cope with depression and distress. Finally, we describe participants' explanatory models of depression through free-listing techniques.

Pre-migration Stressors: Diminished Sense of Safety and Security

Afghans described their lives in Afghanistan after the Soviet invasion as being fraught with arbitrary home invasions and searches, imprisonment of family members, house arrests, and interrogations. Many expressed fears of being killed. Moreover, many witnessed atrocities, in addition to hearing of people they knew being kidnapped or killed because of political affiliation or religious beliefs. During the Soviet occupation, escape experiences to neighboring Pakistan entailed traversing through mountain passes on foot and horseback, seeking shelter in villages, facing hunger, and the threat of being killed along the way. Some were actually separated from their spouses and children for months, while in some cases many years. Only one participant described living in Iran as a refugee where she and her family faced extreme discrimination, while all others essentially described a life in limbo after illegally entering Pakistan and awaiting refugee status elsewhere as offered through relief organizations.

Moreover, traumatic war experiences were not limited to one era (e.g. Soviet invasion) as many lived in Afghanistan through the civil war that took place after the Soviets withdrew. The in-fighting that took place between Afghan warlords and later years encroached more on urban areas and city centers as opposed to the Soviet invasion in which violence was mostly limited to rural areas. Thus, post-Soviet conflicts exposed a high-density of the populace to war-related traumatic events. However, as indicated by lay community members, during the Soviet-era, Kabul was plagued by government-supported clandestine efforts in rooting out Afghans opposing the current regime in power at the time. This exposed many to arbitrary home invasions and interrogations by

communist Afghans. The responses below, translated from Dari to English, exemplify participants' wartime experiences.

> "Anyone that has come to the US with any memory of life experiences in Afghanistan is emotionally scarred" –Male, 51

> "I could never forget my memory of seeing a person's (amputated) hands and feet hung off a light post (for allegedly committing a crime during the Taliban era)" –Male, 36

Post-migration Stressors: Cultural Adjustment and Loss

Many expressed that life was hardest in America during the first year of resettlement. English language proficiency problems along with having little money and no means of transportation were major sources of stress for many, while for some they continue to be a problem. However, regardless of the time since resettlement, both newly resettled refugees and those arriving decades ago indicated stress being associated with the perceived loss of culture, identity as an Afghan, and value shifts such as children's disrespect towards elders due to their newfound sense of individualism. The statements below, translated from Dari to English, exemplify some of the sentiments shared among many participants regarding cultural conflicts.

> "Many households have lost their children due to children having boyfriends and girlfriends, getting involved with using drugs and alcohol, which leads to depression" –Male, 60

> "Many suffer from not being able to control children…they let go of who they are and that lifestyle doesn't fit with us" –Male, 49

In relation to the many cultural changes, many men in particular related loss to their 'diminished authority within the family', and also the loss of their professions in the US. All participants expressed grief resulting from the loss of family bonds and the resulting isolation and loneliness. Also, unemployment and financial hardships were common

experiences, and making matters worse for some, this included having to depend on welfare benefits and to constantly deal with public assistance programs that were described as impersonal and insensitive and an affront to their dignity. The statements below, translated from Dari to English, exemplify some of the post-migration resettlement challenges and daily hassles experienced by many participants.

> "I miss very much sitting together with 30 people on the floor and eating around one *dastarkhan* (cloth spread out on ground where food is traditionally eaten)" – Male, 36
>
> "I couldn't find work…and what really prevented me from getting a job was being overqualified, and not having a resume" – Male, 63
> "God protect us from welfare…they would just place us in jobs that we couldn't do" –Female, 54

Gains/Benefits of Resettlement (Coping Mechanisms)

Despite expressing great losses in terms of country, culture, and belongings, as well as a longing to return to Afghanistan, many participants noted being grateful for Allah's protection. For example, many articulated their gratitude for escaping war and violence and eventually having a greater sense of safety and security in the US. These sentiments of faith in Allah, and the fact that many described experiencing great hardships brought about by the resettlement process, which were later overcome (for some through financial stability) spoke for their resilience. These descriptions along with the fact that many defined their (forced) migration to the US as a "sacrifice for their children's (academic and financial) future/prosperity" also portrayed a means of coping with ongoing stressors. However, these positive sentiments of life in the US with concurrent feelings of culture loss brought to surface a conflict. For example, while children were given the opportunity to prosper in terms of education, money, and jobs,

parents and elders alike often find they succumb to the stress of not being able to control their children given the liberties gained in the US. Such liberties include drinking alcohol, eating pork, and wearing clothing that is considered too revealing. The statements below asserted by participants exemplify the "sacrifice" that many participants alluded to.

> "Here it is good for the children, but I can't work, I can't talk to anyone, I can't have friends" –Female, 53
>
> "I sacrificed my profession so my children could find a way in life" – Male, 71
> "Here our children can gain an education and have health care, but then again it's not a good place for us" –Male, 58

Explanatory Models of Depression

Views of depression. Table 6 below provides a detailed account of free-listed responses regarding views of depression. Views regarding causality were essentially related to the social predicaments that many Afghans commonly endure, some of these being known to Western models (e.g. financial and marital problems), and those common to refugees related to cultural conflicts. Views regarding symptoms include Western-recognized indicators of depression such as insomnia and loss of interest in activities, indigenous idioms such as *jigar khuni* or sadness as a result of interpersonal loss (Miller et al., 2006), and somatic complaints such as headaches and abdominal pain. Treatments were associated with seeking psychiatric care and use of anti-depressants along with more lay approaches such as being around family and taking part in religious activities.

Table 6

Views of depression (N = 18)

What are the causes and risk-factors?	What are the symptoms?	What are the treatments?	What are the consequences?
11 Older age	11 *Asabi*/irritability[b]	8 Medicine	6 Going crazy
10 Distance from family/not having family around	8 *Goshagiry*/self-isolation	6 Being together with family	5 Disease gets worse
9 War-related traumatic experiences	5 Thinking too much	4 Prayer	5 Suicide
7 Cultural adjustment[a]	4 Concentration difficulty	3 Keeping oneself busy	3 Dementia
7 Loss of culture and identity	2 Abdominal pain	2 Acceptance	2 Alcohol/drug use and abuse
6 Financial hardship	2 Crying	2 Children's educational success	2 Chronic diseases
6 Children losing cultural values/not listening to parents	2 Dizziness	2 Leisure	1 Chemical imbalances
5 Not being able to drive	2 *Ghamgeen*/sadness	2 Socialization w/people of same age and language	1 *Goshagiry*/self-isolation
4 Female gender	2 Headaches	2 Stable income	1 Diminished sense of respect towards others
4 Marital problems	2 Insomnia	1 Being calm	1 Hospitalization (psychiatric)
4 Thinking too much	2 Pale complexion	1 Counseling	1 Ineffective disease defenses
3 Male Gender	2 Overeating	1 Getting out and about	1 Laziness
2 Living situation/inability to accommodate space for large family	1 Fearfulness	1 Good environment	
2 Uncertainty about future	1 Inconsiderate towards others	1 Self-efficacy	
1 Gender role reversals	1 Inflicting self-harm	1 Self-sufficiency	
1 Counseling emotional problems	1 Impatience	1 Traditional healing	
1 Children wearing western/revealing clothing	1 Mute		
1 Stressful lifestyle	1 Talking to oneself		

Note. [a]Cultural adjustment, according to open-ended interviews refers to not overcoming culture shock. [b]Asabi is an interchangeable (indigenous) term relating here (in the context of depression) to "irritability" and not to "nervous/stressed" as reported by Miller et al. (2006).

Conclusion

Qualitative data from Phase-I suggested unique socio-demographic shifts in Afghan refugee arrivals since 9/11. Also, the data showed that mental health issues are highly prevalent in all arrival waves as a result of various pre- and post-migration stressors common to Afghans and other refugee groups cited in previous research. Participants cited the need for building trust with the community through gaining buy-in from religious leaders, the need to clearly communicate one's purpose, and the use of multiple outlets for sampling and recruitment purposes. Results also indicated that standard research procedures for gaining informed consent, offering incentives, tape recording of face-to-face interviews, and recruitment of women require adaptation to make them culturally fitting. Results from this study expose the various dynamics needing consideration before attempting to conduct larger studies.

With respect to Phase-II, we found that resettlement stressors were associated with cultural conflicts, as well as loss of family, identity, and status. Depressive symptomatology was conceptualized as emotional reactions to these social problems; however, despite these challenges Afghans expressed gratitude for their children prospering in the US. Findings also suggest that in developing a structured questionnaire assessing beliefs about depression, survey items ought to include idioms and indicators of distress that are defined by social situations, cultural values, and traditional beliefs. In both studies, qualitative descriptive techniques were found to be useful for conceptual clarification underlying scale development, and for answering the "who," "what," and "where" of experiences (Sandelowski, 2000, p. 338).

CHAPTER 4

METHOD

Overview

This chapter begins with an overview of our study aims, as described in our introductory chapter ('Chapter 1'), followed by a listing of our research hypotheses. This will be followed by a discussion of the methodology employed in this study. Figure 1 below illustrates the research activities that have lead to the development of this stand-alone quantitative study.

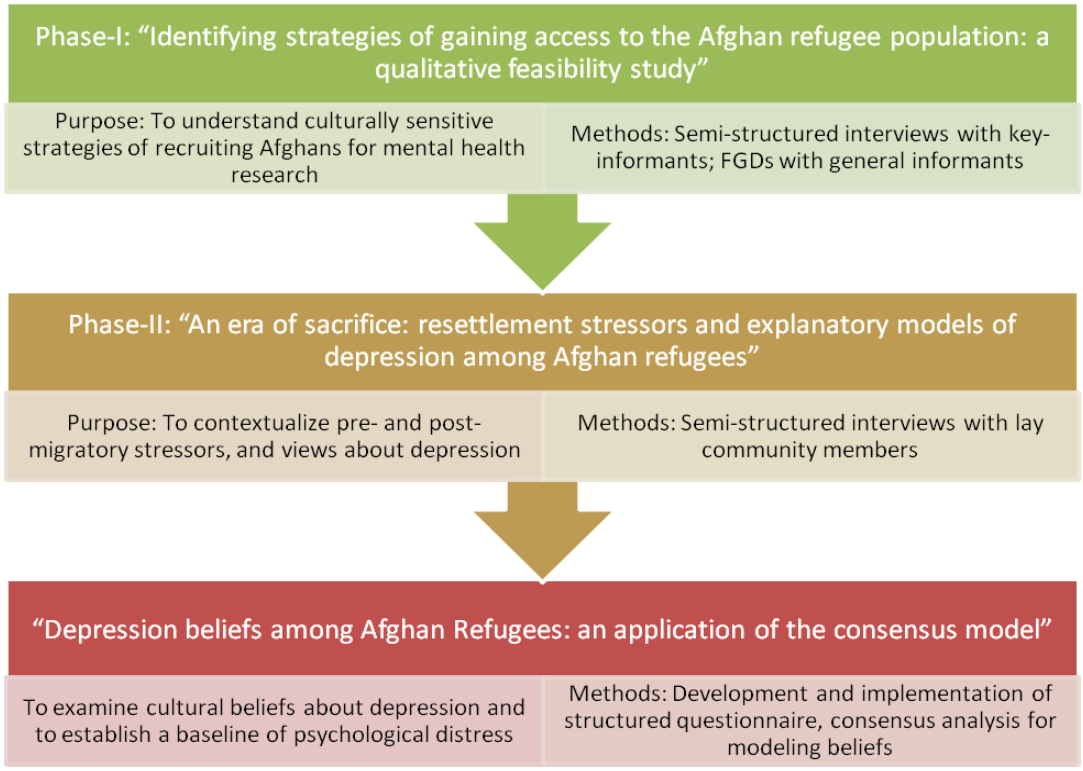

Figure 1. Research activities.

Research Hypotheses

Findings from the second phase about Afghans' views on depression served as the foundation for the development of a structured questionnaire systematically measuring cultural beliefs about this disorder among the larger population. This was needed in order to carry out this CCT-driven study, which aims to 1) assess the degree to which there is a shared set of beliefs about depression (i.e. causes, symptoms, and treatments), 2) investigate differences about models of depression between gender groups, 3) classify answers to questions about depression with a high degree of confidence for gender groups, and 4) to obtain baseline indices of acculturation, social support, psychological distress, and perceived stress. Table 7 below displays the hypotheses that were tested in this study, which were formulated based on insights gained through preliminary qualitative research described in 'Chapter 3' along with previously published studies conducted with the Afghan refugee population.

Table 7.

Summary of Aims and Research Hypotheses

Study Aims	Hypotheses
Aim 1: Assess the degree to which there is a shared set of beliefs about depression (i.e. causes, symptoms, and treatments) among Afghan refugee men and women	Hypothesis 1: There will be a single set of shared beliefs about depression within and between Afghan refugees across gender groups
Aim 2: Investigate differences in models about depression between gender groups	Hypothesis 2: Because of separation of gender roles in this population, men and women may have significantly different models of depression
	Hypothesis 3: Within genders, cultural competency will be significantly associated with socio-demographic variables (e.g. age, education, marital status) as well as with outcomes from standardized measures of acculturation, social support, psychological distress, and perceived stress
Aim 3: Classify responses to questions about the causes, symptoms, and treatments for depression among genders with a high degree confidence	Not applicable.
Aim 4: To obtain a baseline measure of acculturation, social support, and psychological distress for descriptive purposes	Not applicable.

Sampling

The population of interest for this study included adult Afghans resettled in the US as refugees, asylum seekers, or individuals who originally fled Afghanistan due to an element of coercion to resettle elsewhere and who were later sponsored to the US as immigrants. We excluded individuals who were under 18 years of age, not born in Afghanistan, or those who voluntarily immigrated to the US from Afghanistan on a student or work visa. Sample size estimations were guided by conservative estimates of shared levels of agreement among participants as indicated in various CCT-guided studies. The standard method of determining sample size in CCT studies includes the following procedures: 1) assuming low levels of 'sharing of beliefs' or 'group

competence levels' (regarding depression) to be 0.50 or 50%, 2) to require a high accuracy/correct classification of answers (0.95 validity), and 3) to classify answers to questions with a high degree of confidence, i.e. Bayesian posteriori probability of 0.99 (Romney et al., 1986; Weller, 2007).

These criteria warranted a sample size of approximately 23 participants per subgroup (Romney et al., 1986; Weller, 2007). Because our main analysis focuses on competency within and between gender groups, a total sample of 46 participants (23 females and 23 males) was theoretically required. However, to ensure that adequate subgroup comparisons could be made with respect to competence levels, we oversampled by seeking to recruit ≥40 individuals per gender group. This approach ultimately rendered an overall sample of 93 respondents (43 females, 50 males).

Instrumentation

Demographics

The first part of the survey consists of a section entitled "Demographics," which is divided into three subsections (see 'Appendix C. Questionnaire'). The first subsection entails questions aimed at providing a comprehensive account of respondents' age, gender, marital status, education in years and level of attainment, ethnicity, legal status upon arrival to the US (e.g. refugee, asylum seeker), year of arrival to US, years resided in Afghanistan during war, employment status, and income. Given potential inaccuracies in obtaining estimates of annual income (possible confusion between pre- and post-tax income as well as other supplementary sources), we adapted a proxy measure informed by Song et al. (2010), "Can you make a comfortable living with your current household

income?" (p. 515) by stating "Can you comfortably pay your bills every month with your current household income?"

In the second subsection we assessed language acculturation or "language preference." For practicality and for gaining a viable measure of acculturation we used a scale developed and validated by Deyo, Diehl, Hazuda, and Stern (1985) in a clinical study with Mexican-Americans. The scale's (eight) questions mainly focus on language use and preference and demonstrate a coefficient of reproducibility and scalability of 0.97 and 0.90, respectively (Deyo et al., 1985). Deyo and colleagues indicate that language ability provides a strong marker for other aspects of acculturation (e.g. behaviors) while others have asserted that language is the most important indicator of acculturation (Olmeda & Padilla, 1978).

The first question in our acculturation measure queries respondents on the first language they learned to speak through four response choices (1 = *English*, 2 = *English and Dari/Pashto simultaneously*, 3 = *Dari or Pashto*, 4 = *other*). We substituted the terms "Spanish" with the terms "Dari/Pashto" to reflect Afghanistan's (prominently spoken) national languages. This first question is followed by three items that assess respondents' perceptions on their ability to 1) speak Dari or Pashto, 2) speak English, and 3) read English where response choices are also provided on a four-point scale (1 = *very well* and 4 = *not at all*). This is followed by four questions that elicit responses with relation to one's language use or preference with one's 1) spouse, 2) children, 3) parents, and 4) in family gatherings.

For example, we asked, "What language do you usually use with your spouse?" with response choices provided on a four-point scale (1 = *only English*, 2 = *mostly*

English, 3 = *both equally*, 4 = *mostly Dari/Pashto*, 5 = *only Dari/Pashto*). For gaining valid assessments of language preference, we inserted the following statements in parentheses at the end of each respective question for those not having a 'spouse': "or with your fiancée or a best friend if you are not married"; 'children': "or with family members who are children, if you have no children"; 'parents': "or with older family members if you have no parents."

The third subsection entitled "Social Network" assesses social support levels. The *Lubben Social Network Scale-6* (*LSNS-6*) (Lubben et al., 2006), a shortened version of original social support scale developed for use with older adults was used as a general measure of social support. The scale consists of six items used to measure the size, closeness, and frequency of contacts in an individual's social network. Family or people who are related by birth or marriage, and friends or people living within one's neighborhood define social networks. Questions relate to the number of relatives (and friends) seen or heard from in the context of a one-month period, as well as the number of relatives (and friends) one can discuss private matters with, and who can be called on for help. The measure's ease of use is exemplified by its organization as questions are subdivided by social network type (e.g. relatives, and friends), and solicited using the same verbiage with six numerical response choices provided for all questions (e.g. *0, 1, 2, 3-4, 5-8, 9 or more*).

Cultural Beliefs about Depression

The second part of the survey assesses cultural beliefs about depression. In developing our questionnaire, we used free-listed responses elicited on Afghans' views of

depression obtained through open-ended interviews. This approach has essentially been the method of choice for questionnaire development in CCT-driven studies assessing beliefs regarding asthma (Pachter et al., 2002), diabetes (Weller et al., 1999), HIV/AIDS (Trotter et al., 1999), and culture-bound syndromes (Weller et al., 2002; Weller et al., 1993). This method helps provide culturally relevant responses about disease, and according to Weller (2007) can be supplemented by items "from existing sources such as scientific publications, archival records, or previous questionnaires and tests" (p. 348).

As such, we diversified our initial pool of questions gleaned from our qualitative work by incorporating items from the HTQ, BDI, BSI, and the CMI. Some overlap was found between free-listed items and items noted in the BDI and CMI. We added two items relating to mild traumatic experiences from Part-I of the HTQ to the section on 'causes.' These items were related to whether depression was caused by 'having had one's home searched for people or things,' and 'experiencing a lack of food and clean water.' The BSI is a 46-item somatic symptom questionnaire validated through research with Pakistani and indigenous British patients with a diagnosis of anxiety, depression, hysteria or hypochondriasis (Mumford et al., 1991). We incorporated the following items strictly from the BSI: bitter taste in the mouth, burning and itching of the skin, buzzing noises in ears or head, constipation, darkness or mist in front of the eyes, diarrhea, difficulty breathing even when resting, difficulty swallowing, excessive belching, excessively sweaty palms, feelings of a hot or burning head, feelings of pins and needles all over the body, having cold hands or feet, pain in the heart or chest, pain or burning in the eyes, and tension in the neck and shoulders.

We used a 'yes-no' response choice format, and as suggested by Weller (2007) carefully constructed questionnaire items to balance positive and negative items to keep the proportion of true items between 30% and 70%. This meant sparingly including free-listed responses to avoid a response set with mainly 'yes' responses. We therefore reversed some items to force a negative response in addition to supplementing our survey with uncommon to more reasonable indicators or symptoms of depression and distress. For simplicity of analysis, participants' open-ended responses on the causes, risk-factors, symptoms, treatments and disease consequences of depression were collapsed into three categories, including 1) causes, 2) symptoms, and 3) treatments. Although a potential threat for response-set bias, questionnaire items were presented in a non-randomized format, which allowed for recall and for the interview to flow in a reasonable way (Weller et al., 1999).

General Psychological Distress

The ASCL or Afghan Symptom Checklist (see 'Appendix C, Questionnaire') was used for measuring general psychological distress. The ASCL was originally developed and culturally validated for use with Afghans living in Kabul, Afghanistan (Miller, Omidian, Rasmussen, Yaqubi, & Daudzai, 2008; Miller et al., 2006). In developing the ASCL, Miller and colleagues recruited a convenience sample of 10 men and 10 women in two districts of Kabul to identify indicators of distress through in-depth interviews. For demonstrating its utility, Miller et al. (2006) subsequently conducted a validation study inclusive of 100 Afghans (50 men and 50 women) in which the ASCL showed excellent internal consistency for both men and women (*Cronbach's α* coefficient = 0.89 for men,

0.94 for women). Adequate construct validity was also displayed as scores on the ASCL showed a strong correlation ($r = .70$, $p < .001$) with scores on a measure of war experiences and loss (i.e., AWES).

The ASCL consists of 23 items or distress indicators presented in the context of the previous two weeks. Response choices are offered on a five point scale (1 = *never* and 5 = *everyday*). Dr. Ken Miller (the ASCL's author) provided the Dari version of the survey at our request (Dr. Ken Miller, personal communication, 2011). Both versions of the measure were presented to one key-informant from the Afghan community and a few lay community members for purposes of assessing face validity. Feedback from these individuals rendered positive feedback regarding the measure's potential for accurately assessing psychological distress in a Southern California context. However, minor adjustments were made to questions 20 and 21 relating to *fishar bala* and *fishar payin,* respectively. In pilot testing, fishar bala was interpreted as "high blood pressure" while fishar payin was viewed as "low blood pressure," when in reality the former relates to "internal agitation" and the latter to "low energy and motivation." We accordingly attached these phrases in parentheses at the end of each question.

Perceived Stress

We assessed perceived stress levels using the 10-item *Perceived Stress Scale or PSS* (Cohen, Kamarck, & Mermelstein, 1983). The PSS is the most widely used psychological instrument for measuring the perception of stress. According to Cohen and colleagues, items were designed to tap how unpredictable, uncontrollable, and overloaded respondents find their lives. The questions are asked in the context of the previous month

and for each question responses are elicited on how often respondents felt a certain way. Response choices are provided on a five-point scale (0 = *not at all* and 4 = *very often*). In a normative sample of 2,387 respondents in the US, mean scores for men (m = 12.1, sd = 5.9) were slightly lower than scores for women (m = 13.7, sd = 6.6), (Cohen, 1994).

A systematic translation and back-translation technique informed by Beaton et al. (2000) was used for ensuring semantic, conceptual and normative equivalency across English and Dari versions of the survey instrument (see 'Appendix D' for Dari version of questionnaire). This included the following steps: one independent forward translation of the instrument from English to Dari; back translation (from Dari to English) by a person blind to the original survey (this led to slight grammatical adjustments to the original version); pilot testing with one male and one female from the Afghan community to identify discrepancies indicative of ambiguous wording. After pilot testing, minor grammatical, spelling, and punctuation revisions were made to the original surveys.

Procedures

Data collection activities were limited to San Diego County where non-random sampling techniques (e.g. convenience and snowball sampling) had been previously used for recruiting Afghans as described earlier. This approach was deemed most feasible given the hard-to-reach nature of this population. Recruitment challenges stem from the perceived stigma/discrimination associated with mental health problems and/or being associated with a mental health study. Indications of this stigma are given in lay accounts of depression's consequences such that persons with mental disorders may be viewed as "crazy." In order to reduce fears of taking part in this study and for increasing receptivity

of potential participants, the study was dubbed as a "student project seeking to assess the health and life experiences of Afghans." This was motivated by suggestions from key informants from our preliminary qualitative work who essentially advised 'to not touch the subject of mental health' when approaching Afghans in the context of assessing psychological problems. Also, as there is currently no sampling frame available for Afghans living in San Diego County, our non-random sampling techniques provided flexibility in accessing individuals through multiple community entry points (Sulaiman-Hill & Thompson, 2011a).

Such entry points included one local mosque/community center (used for recruitment purposes in preliminary qualitative work) consisting of a congregation of approximately 75 to 100 Afghans, most of who were Sunni Muslims. Besides being highly accessible to the student-investigator, rapport and familiarity had already been established with the religious/community leaders who managed the center along with various attendees of Friday prayers. A prominent community/religious leader advertised this study on three consecutive occasions immediately after Friday prayers concluded. The community leader was asked to encourage the women in attendance to participate, who were not visible given the partition created in order to separate men and women during prayers. After announcements were made, a relatively small number of men approached the student-investigator for survey copies to complete at home and return it the following week, while others completed the survey on site. Some individuals asked for additional copies of the survey to distribute to their family members.

To comply with CCT assumptions, the student-investigator explained the study and consent form to the individuals and emphasized that survey responses were not to be

completed through consultation with others. For ensuring cultural sensitivity the female RA who assisted with our preliminary qualitative work accompanied the student-investigator and approached the small group of women in attendance for recruitment purposes. Approximately 12 women completed surveys on-site. Most completed the Dari version through self-administration. A small number of respondents completed English versions of the survey; one woman and an elderly man (not proficient in English) were interviewed by the RA. Recruitment of both men and women essentially took place on the first visit. Subsequent visits were ineffective in providing new participants despite continued announcements by the community leader, and the fact that the student-investigator and RA approached individuals with surveys. However, these subsequent visits allowed for the collection of a few returned surveys distributed to individuals during prior visits.

Recruitment of women mainly took place through the RAs personal social network in which home visitations were made for administering surveys. The majority of women were interviewed. Many of these women referred their relatives, friends, and neighbors to the study by providing their phone numbers. Women were contacted telephonically by the RA where the study was briefly explained, which was followed by a home visitation for data collection. Other techniques included surveying individuals in the student-investigator's personal social network, re-contacting individuals taking part in preliminary qualitative work (given readily available contact information), frequenting a local café where many Afghan cab drivers convened during evenings, and setting up a booth at an Eid prayer that took place at a public venue where data was collected on-site.

Thirteen Afghans completed the survey through self-administration, of which only two were completed by women.

The ethical merits of this study and all informed consent documents were reviewed and approved by Loma Linda University, School of Behavioral Health IRB. The ICD was used for gaining verbal consent from participants (see 'Appendix E'); however, a copy signed by the student-investigator was provided to each participant. We informed participants that a small cash incentive of $10 would be donated to a local mosque or charity of their choice in exchange for their participation. The author, along with the RA clarified each survey section. Efforts were made to assist those who had trouble reading and writing and navigating through hard-to-understand questions.

Data Analysis

SPSS, version 20.0 was used for all descriptive and correlation analyses as well as scoring and generating reliability coefficients for all standardized measures. For describing the demographic characteristics of our sample, we report the total number and proportion of respondents for categorical variables, and means and standard deviations for continuous variables. Chi-square tests of independence (χ^2) along with independent sample *t*-tests were applied accordingly in order to assess significant differences in characteristics between men and women. Few categorical items consisting of more than two response choices were dichotomized by combining disparately reported response choices in order to achieve even distributions in frequencies. For example, in the question assessing marital status, we combined the "never married", "separated", and "widowed" response choices and presented this as one single response, i.e. "not married." The same

procedure was carried out for questions relating to educational attainment, employment status, ethnicity, and legal status.

The following paragraphs provide details in terms of scoring our standardized instruments (i.e. language acculturation scale, LSNS-6, ASCL, and PSS). For our language acculturation scale we used a scoring algorithm suggested by Deyo et al. (1985) as presented in Table 8 below. This allows for assessing the degree to which an individual has acculturated based on mean acculturation scores. Scores range from 0 to 4 with higher scores indicating higher levels of acculturation. For our entire sample, the

Table 8

Language acculturation items and scoring procedures[a]

Item and response choices	Method of transforming responses (scoring)
First language you learned to speak? 1 = English 2 = English and Dari/Pashto simultaneously 3 = Dari or Pashto	English = 1 All other responses = 0
In your opinion how well do you speak Dari or Pashto? ... English? 1 = very well 2 = pretty well 3 = not too well 4 = not at all	English response less than Dari/Pashto response = 1 English response equal to or greater than Dari/Pashto response = 0
What language do you usually use with your spouse? … your children? … your parents? … at family gatherings? 1 = only English 2 = mostly English 3 = both equally 4 = mostly Dari/Pashto 5 = only Dari/Pashto	This represents 4 separate questions. The 4 items will be summed: A total of less than or equal to 13 will be scored as 1; a total greater than 13 will be scored 0
In your opinion, how well do you read English? 1 = very well 2 = pretty well 3 = not too well 4 = not at all	Answers 1 to 3 = 1, answer 4 = 0

Note. [a]Table adapted from Deyo et al. (1985)

acculturation scale shows adequate reliability (*Cronbach's α* coefficient = 0.71); however, this coefficient was inadequate for men (0.61), and sufficient for women (0.79) when compared to standard benchmarks of 0.70 Houser (2008).

The total score for our social support measure, the LSNS-6, is an equally weighted sum of six items. Scores range from 0 to 30 with higher scores indicating higher levels of social support. Based on our data, the LSNS-6 shows adequate reliability for both men and women (*Cronbach's α* coefficient = 0.85 overall, 0.89 for men, 0.77 for women). Moreover, in terms of our general psychological distress questionnaire, the ASCL, scores are an equally weighted sum of 23 items that range from '23 to 115' with higher scores indicative of higher levels of distress symptoms. The ASCL shows excellent reliability for the entire sample and for both gender groups (*Cronbach's α* coefficient = 0.93 overall, 0.89 for men, 0.94 for women). Additionally, PSS scores are obtained by reversing responses (e.g., 0 = 4, 1 = 3, 2 = 2, 3 = 1, 4 = 0) to negatively stated items (4, 5, 7, and 8), and then summing across all scale items. Scores range from '0 to 40' with higher scores indicating higher levels of perceived stress. The PSS shows adequate reliability for the entire sample and for each gender group (*Cronbach's α* coefficient = 0.81 overall, 0.84 for men, 0.76 for women).

Responses were analyzed with CCT to see if there were shared beliefs. ANTHROPAC software, version 4.98 (Borgatti, 1996) was used to run the formal version of consensus analysis (as discussed in 'Chapter 1. Introduction'). This software readily provides goodness-of-fit criteria, competency scores for each respondent, item classifications, and indication if there is high agreement among respondents. The data was initially entered into SPSS, converted into a Microsoft Excel® file, which was then

converted into a '.txt' file and imported into ANTHROPAC software. The analysis consists of various steps, which is initiated by checking whether a consistent pattern is present in the response data as demonstrated by goodness-of-fit criteria. This is determined by assessing *eigenvalue* ratios and ensuring that the first eigenvalue is larger than the second with ratios of ≥3:1 being the standard (Weller, 2007). Higher ratios are indicative of a *unidimensional* model or that a single response pattern is present in the data (Weller, 2007).

Estimates of individual knowledge or competency can be estimated from the agreement between people. These answers are estimated by the factor scores on the first factor. Weller et al. (1999) indicates that competency is the extent to which an individual agrees with the aggregated responses of the group. The greater an individual's competency score (ranging from 0 to 1), the more culturally knowledgeable or competent the person is believed to be (Romney et al. 1986). The culturally correct answers were then estimated by weighting the responses of each person by their competency and aggregating responses across people. For this study, agreement between pairs of respondents' dichotomous responses was measured using the *covariance* method (due to its lack of sensitivity to response bias) and the proportion of positive ('yes') responses was assumed to be 50%. These probabilities were revised after examining the pattern of positive responses provided by item classifications. For classifying responses, a conservative Bayesian classification rule was used; and only answers classified at the $p \geq 0.99$ confidence level were considered classified.

Additionally, gender groups were compared in terms of their cultural competency scores. Competency scores were also correlated with all demographic variables using

Pearson correlation coefficients ('*r*') for continuous variables. Effect sizes or the mathematical equivalent, *eta* (η), was calculated for categorical variables (e.g. Trotter et al., 1999; Weller et al., 1999). Statistical significance was measured at $\leq .05$ level. Data cleaning consisted of omitting respondents with more than 10% of responses missing. Because the formal consensus model corrects for guessing or assumes that people will guess a response when they do not know the answer (Weller, 2007), missing responses were guessed for respondents by randomly imputing a '0' or a '1.'

CHAPTER 5

RESULTS

Participant Characteristics

A total sample of 96 Afghans was interviewed or filled out the survey over a 22-day recruitment period during September 2012. Table 9 provides descriptive statistics of the sample subdivided by gender group. Three respondents with over 10% missing data were dropped from the sample, yielding a final sample of 93 respondents of which 43 (46.2%) were women. Respondents ranged in age from 21 to 85 years with a mean of 44.8 years (*SD* = 16.27). Significant differences in age between gender subgroups were not found ($t(91) = -0.016$, $p = .987$) as roughly equal values in age were reported in men ($m = 44.8$, $sd = 16.6$) and women ($m = 44.7$, $sd = 16.08$). Chi-square tests of independence indicated a significant relationship between marital status and gender ($\chi^2(1) = 6.23$, $p = .013$) as men were more likely (76%) than women (51.2%) to report being married. This is due in part to a considerably higher number of women ($n = 12$) who reported being widowed than men. Responses elicited on educational attainment indicate major differences as men were significantly more likely (62%) to report completing a bachelor's degree (or higher) as compared to women (37.2%) with differences being significant ($\chi^2(1) = 5.47$, $p = .019$). Furthermore, slightly over half of women (51.2%) reported being of Pashtun ethnicity, while men were more likely to report being of non-Pashtun (i.e. mostly Tajik) ethnic background (58%). The relationship between gender and ethnicity was not statistically significant ($\chi^2(1) = 0.781$, $p = .377$).

Respondents resided in the US for approximately 16 years (*SD* = 8.18, range: <1 to 32 years); however, differences in mean years of US residence were not statistically

significant ($t(91) = -1.46$, $p = .149$) among men ($m = 17.46$, $sd = 8.2$) and women ($m = 15.00$, $sd = 8.04$). Additionally, the majority of respondents (76%) reported refugee status upon arrival to the US with similar proportions in legal status observed between gender subgroups. Thus, chi-square tests indicated no significant relationship between gender and legal status ($\chi^2(1) = 0.007$, $p = .933$). A large proportion of women (69.8%) reported being unemployed as opposed to a large proportion of men who reported being employed (78%), hence the relationship between gender and employment status was statistically significant ($\chi^2(1) = 23.42$, $p = .000$). Such differences could be explained by the significant association observed between employment and education (eta = .314, $p = .003$), which as mentioned above is higher in men compared to women.

Non-significant differences ($t(90) = -1.40$, $p = .166$) in language acculturation were observed between men ($m = 1.24$, $sd = 0.59$) and women ($m = 1.02$, $sd = 0.74$). Acculturation scores for both groups ranged from zero to three. This could be due to our acculturation measures' low reliability as reported in the previous chapter. Also, the relationship between gender and comfort in paying monthly bills (our proxy measure for income) was not statistically significant ($\chi^2(1) = 1.00$, $p = .316$). Additionally, differences observed in social support levels were not significant ($t(90) = -0.059$, $p = .953$) with relatively minor differences observed between men ($m = 16.24$, $sd = 6.4$) and women ($m = 16.7$, $sd = 5.25$). Significant differences in general psychological distress scores were found between gender subgroups ($t(66.6) = 2.850$, $p = .006$), according to the ASCL. Women were more distressed ($m = 47.67$, $sd = 18.17$, range: 23 to 88) than men ($m = 38.62$, $sd = 10.75$, range: 23 to 77).

Distress scores for women were associated with various factors that could explain subgroup differences, which include: lower language acculturation (r = -.378, p = .013), being unmarried (eta = -.383, p = .011), and being unemployed (eta = -.396, p = .009). Notably, ASCL scores in this sample are much lower than a sample based on a validation study conducted in Kabul (Miller et al., 2006) – perhaps due to the comparative safety and stability of life in the US (Ken Miller, personal communication, 2012). The most frequently cited item between both groups was *thinking too much* as 41 (82%) men and 38 (88%) women reported experiencing this at least once a week during the last two weeks. A higher proportion of women reported experiencing distress symptoms with the exception of the following items: 'quarreling with a neighbor', *asabi*, 'memory loss,' and 'concentration difficulty.' However, a higher proportion of women reported experiencing indigenous indicators of distress such as *jigar khuni* and *ghamgeen*. In contrast, the PSS showed no significant differences in perceived stress between gender subgroups (t(88) = 1.60, p = .114). However, PSS scores for this sample were higher on average (M = 15.16, SD = 6.7, range: 0 to 27) in comparison to a normative US population, which reported a mean score of approximately 13 (Cohen, 1994).

Table 9

Sample characteristics

	Number (%) of Respondents[a]			Statistic	*p*
Variable	Total (*N* = 93)	Females (*n* = 43)	Males (*n* = 50)		
Mean Age (SD) [years]	44.8 (16.27)	44.7 (16.08)	44.8 (16.6)	*t* = -.016	.987
Educational Attainment					
High school diploma or below	46 (50.5)	27 (62.8)	19 (38)	χ^2 = 5.47	<.05
Bachelor's degree/equivalent or higher	44 (47.3)	15 (34.9)	29 (58)		
Ethnicity					
Pashtun	43 (46.2)	22 (51.2)	21 (42)	χ^2 = .781	.377
Tajik (and all others)	50 (53.8)	21 (48.8)	29 (58)		
Marital Status					
Married	60 (64.5)	22 (51.2)	38 (76)	χ^2 = 6.230	<.05
Not married (never married, separated, widowed)	33 (35.5)	21 (48.8)	12 (24)		
Employment Status					
Employed	51 (55.9)	12 (30.2)	39 (78)	χ^2 = 23.42	<.001
Unemployed (includes retired and disabled)	42 (44.1)	31 (69.8)	11 (22)		
Income (able to comfortably pay monthly bills) ‡					
Yes	71 (76.3)	35 (81.4)	36 (72)	χ^2 = 1.00	.316
No	22 (23.7)	8 (18.6)	14 (28)		
Legal Status					
Refugee	71 (76.3)	33 (76.7)	38 (76)	χ^2 = .007	.933
Asylum seekers (and others)	22 (23.7)	10 (23.3)	12 (24)		
Mean Time in US (SD) [years]	16.3 (8.37)	14.93 (8.24)	17.50 (8.37)	*t* = -1.46	.149
Mean Time in Afghanistan During War (SD) [years]†	10.6 (8.63)	12.11 (10.04)	9.20 (7.04)	*t* = 1.57	.120
Acculturation (SD) (0–4) ‡	1.15 (0.66)	1.05 (0.73)	1.24 (0.59)	*t* = -1.40	.166
Social Support (SD) (0–30) ‡	16.21 (5.88)	16.12 (5.25)	16.24 (6.4)	*t* = -.06	.952
Mean Sum Score for Afghan Symptom Checklist (SD) (23–115) ‡	42.9 (15.33)	47.67 (18.17)	38.62 (10.75)	*t* = 2.850	<.01
Mean Sum Score for Perceived Stress Scale-10 (SD) (0–40)	15.16 (6.7)	16.33 (6.25)	14.09 (7.00)	*t* = 1.60	.114

Note. [a]Total number of respondents per subgroup unless otherwise indicated; †Based on 91 respondents; ‡ Based on 92 respondents

Consensus Analysis

Hypothesis 1: Assessing Model Fit

A cultural consensus analysis using the covariance method assessed group agreement on beliefs about depression. Analysis showed that the data met goodness-of-fit criteria to use the consensus model to represent the group's responses with a single set of answers. The first and second factor eigenvalues exceeded the recommended 3:1 ratio for gender groups (4.1 among men, and 3.6 among women). This suggests there is a shared set of beliefs about the causes, symptoms, and treatments of depression within each subsample, which supports our first research hypothesis. Furthermore, the cultural consensus model fit well (eigenvalue ratio: 3.7:1) when data was analyzed collectively from both samples.

Hypotheses 2: Assessing Gender Differences in Cultural Competency

The degree to which respondents share beliefs is defined by cultural competency scores (1^{st} factor loadings) that range from 0 to 1. When all respondents were considered together, the analysis showed that men and women shared beliefs regarding depression ($m = 0.48$, $sd = 0.14$); however, the average competency level was significantly different between genders. As reported in Table 10 below, women reported significantly higher average cultural competency scores ($m = 0.52$, $sd = 0.13$) than men ($m = 0.46$, $sd = 0.14$) ($t(91) = 2.159$, $p = .033$). This supports our second research hypothesis asserting that significant differences in depression models would be observed between groups due to separation of gender roles. Responses were more heterogeneous for men as exhibited by

lower average competency scores. For men, lowest agreement was observed in responses regarding causes (m = 0.42, sd = 0.27), which was significantly lower than the proportion observed in women (m = 0.54, sd = 0.23) (t(91) = 2.248, p = .027). An equal level of agreement (m = 0.45) was observed in responses regarding symptoms with non-significant differences between groups (t(91) = -.032, p = .974); however, this represented the lowest level of agreement for the female sample. Agreement was highest for responses regarding 'treatments' within both gender groups. However, in terms of this domain, significant differences in mean cultural competency scores were not observed (t(91) = 1.071, p = .287) between men (m = 0.53, sd = 0.22) and women (m = 0.57, sd = 0.21).

Table 10

Proportion of shared beliefs by gender group and domain[a]

	Causes*	Symptoms	Treatments	Overall*
Females (n = 43)	0.54±0.23	0.45±0.18	0.57±0.21	0.52±0.13
Males (n = 50)	0.42±0.27	0.45±0.19	0.53±0.22	0.46±0.14

Note. [a]Indices are indicative of the average proportion of shared beliefs (± one standard deviation).
*Significant at p < .05.

Hypothesis 3: Examining Variation in Beliefs within Samples

Individual cultural knowledge scores (1st factor loadings) were compared with demographic variables to assess variability within samples (refer to Table 11). Gender was negatively correlated with cultural knowledge scores, reaffirming that women possessed higher competence than men (r = -.221, p = .033). No other variables were correlated with competency. Because women and men differed in agreement and competence (the first factor), the two groups were analyzed in separate cultural consensus

analyses as displayed here. However, after subdividing the sample by gender, no significant correlations were observed with cultural competency. These findings are not supportive of our third research hypothesis.

Table 11

Correlations between competency scores (1st factor loadings) and demographic variables

Variables	Overall (*N* = 93)		Females (*n* = 43)		Males (*n* = 50)	
	Correlation (*r*)	*p*	Correlation (*r*)	*p*	Correlation (*r*)	*p*
Gender (η^2)	-.221	<.05	–	–	–	–
Age	-.003	.975	.025	.872	-.024	.869
Education (η^2)	.013	.904	.076	.633	.070	.636
Ethnicity (η^2)	.138	.189	.071	.652	.160	.267
Marital Status (η^2)	-.116	.268	-.089	.569	-.040	.784
Employment (η^2)	.070	.503	.290	.059	.154	.284
Income (η^2)	-.001	.995	-.041	.799	-.016	.911
Legal Status (η^2)	-.039	.714	-.106	.500	.007	.963
Years Resided in US	-.100	.350	-.025	.875	-.107	.468
Years Lived in Afg. During War	.151	.152	.021	.897	-.165	.105
Acculturation	-.087	.408	.065	.683	-.172	.232
Social Support	-.178	.090	-.186	.237	-.179	.214
Psychological Distress	-.043	.683	-.104	.509	-.165	.263
Perceived Stress	-.081	.450	-.109	.485	-.129	.388

Note. η^2 indicates eta-squared or effect size for dichotomous variables.

We further examined variation in beliefs within samples by examining scores from the residual agreement factor (2nd factor loadings). For the entire sample, we observed a significant correlation between gender and residual agreement (r = -.277, p = .007). This further suggested that men and women had some systematic differences in their understanding of depression, and that the two groups differed in some of their beliefs about depression. This indicated the possible presence of a cultural sub-model of depression based on gender.

Descriptions of Depression

Overall, depression was described similarly between men and women. There was a strong similarity between genders in the classification of answers. The answer to each question was classified as "Yes" or "No" at the .99 confidence level or was unclassified. Men and women classified 55 of the total 73 questions identically (kappa = .57, $p < .001$).

Beliefs about Causes

Agreement was high regarding the causes and risk-factors for depression as 86% (18/21) of the questions in this section were answered identically (refer to Table 12). Of the 21 items, nine were classified as "Yes" by both men and women, and nine were classified as "No." Two items were not agreed upon, i.e., women believed that depression was more likely in people with a lot of children, and men believed that both genders were at risk for depression as opposed to women who only thought women were more likely to be depressed. Additionally, women viewed depression as being caused by children wearing western clothing while this item was positively classified at the 0.78 Bayesian level for men.

Table 12

Comparison of item classifications by gender group (causes)

		Males		
		No	Yes	Total
Females	No	9	1	10
	Yes	1	10*	11
Total		10	10	21

Note. 86% match; $\chi^2 = 13.78(2)$, $p < .001$' *One item negatively classified below 0.99 confidence level.

Men and women indicated that not being able to adjust to the American culture was a cause for depression (adjustment here is indicative of adapting to the stress associated with former patterns of behavior rendered ineffective in a host environment, which normally ensues as a result of culture shock). They also suggested that those unable to drive or speak English were at higher risk for depression. By the same token, respondents did not believe that depression was caused by preserving ones culture and identity. Respondents indicated that depression is caused when children leave their parents' home after marriage. However, respondents believed that depression is not caused by children receiving a college degree, suggesting that their children's success could serve as a coping mechanism for dealing with depression.

With regard to challenges surrounding isolation and loneliness, respondents did not believe that depression was more likely in those with close family around them, or in people who have others their age to socialize with. The elderly and women were believed to be at-risk for depression; though, respondents did not believe that depression was likely in children nor in people who are certain of their future. Respondents did not believe that depression is inherited; however, they did believe that depression is caused by having a depressed family member, and that it could stem from having a chronic disease. Mild traumatic experiences such as arbitrary searches of one's home, and experiencing a lack of food or clean water were classified as causes for depression. Negative memories while residing in Iran or Pakistan as a refugee before resettling in the US was also believed to be a cause of depression. Table 13 presents findings on item classifications with regard to causes.

Table 13

Causes agreed upon between gender groups

Affirmative Response (classified with a 'Yes' response)	Negative Response (classified with a 'No' response)
Is depression more likely in people who cannot adjust to the American culture?	Is depression more likely in people who have close family around them?
Is depression more likely in people who have a chronic disease?	Is depression more likely in people who are able to drive?
Is depression more likely in people who have had their home searched for people or things?	Is depression more likely in people who learn to speak English?
Is depression more likely in people who have experienced a lack of food or clean water?	Is depression more likely in people who have preserved their culture and identity?
Is depression more likely in people who have a depressed family member?	Is depression more likely among young children?
†Is depression more likely in people who have a lot of children?	Is depression more likely in people whose children receive a college degree?
Is depression more likely in people who are elderly?	Is depression inherited?
‡Is depression more likely in men?	Is depression more likely in people who are certain of their future?
Is depression more likely in women?	Is depression more likely in people who have people their age to talk to?
Is depression more likely in people whose children leave the home after being married?	
†Is depression more likely in people whose children wear Western clothing?	
Is depression more likely in people with negative memories of being a refugee in Iran or Pakistan?	

Note. †Item classified by women only, and positively classified at 0.78 confidence level by men; ‡Item classified by men only.

Beliefs about Symptoms

Beliefs regarding the symptoms of depression varied greatly as only 58% (18/31) were classified identically by men and women (refer to Table 14). Of the 31 items, 10 were classified as "Yes" by our samples, and nine were classified as "No." Of the remaining 12 items, three were not agreed upon between men and women, seven items were unclassified for men only, and two were unclassified for women.

Table 14

Comparison of item classifications by gender group (symptoms)

		Males		
		No	Yes	Total
Females	No	16*	0	16
	Yes	5**	10	15
Total		21	10	31

Note. 58% match; $\chi^2 = 20.70(4)$, $p < .001$; *7 items negatively classified below 0.99 confidence level by men; **2 items positively classified below 0.99 level by women

Data on symptom classifications revealed 12 thematic differences in models as women reported more than twice as many symptoms as men. As expected, men and women positively classified indigenous indicators of distress, i.e. *asabi* (irritable or temperamental), *goshagiry* (self isolation or avoiding people and places), *ghamgeen* (sadness), and *jigar khuni* (form of sadness following interpersonal loss or reaction to a painful experience) as symptoms of depression. Symptoms of depression also included: not being able to concentrate normally, nor being able to make decisions, feeling low in energy, and not having a normal appetite. Anxiety-related symptoms such as having recurrent nightmares were positively classified by both groups. Additionally, women positively classified being suddenly scared for no reason as a symptom of depression (this item was unclassified for men).

Furthermore, four somatic items were believed to be symptoms of depression by men and women: feelings of tingling (pins and needles) all over the body, headaches, tension in the neck and shoulders, and pains in the heart or chest. Somatic items not believed to be symptoms of depression among samples include: burning and itching of the skin, excessive belching, diarrhea, constipation, and pain or burning in the eyes.

Somatic items endorsed by women only included excessively sweaty palms, feelings of a hot or burning head, having a bitter taste in the mouth, and indigestion; however, two items remained unclassified for women (e.g. abdominal pain and having cold hands and feet) that men on the other hand classified negatively. Additionally, items classified positively by women that were unclassified for men included: dizziness, difficulty breathing even when resting, hearing buzzing noises in the ears, and paleness. Table 15 presents findings on item classifications with regard to symptoms within groups and across both samples.

Table 15

Symptoms of depression

	Response		
	Females	Males	Overall
Is being *asabi* (irritable/temperamental) a symptom of depression?	Y	Y	Y
Is *goshagiry* (isolating oneself from people and places) a symptom of depression?	Y	Y	Y
Is being *ghamgeen* (sadness) a symptom of depression?	Y	Y	Y
Is paleness a symptom of depression?	Y	N**	Y
Is a person able to concentrate normally with depression?	N	N	N
Are people with depression able to make decisions?	N	N	N
Is tension in the neck and shoulders a symptom of depression?	Y	Y	Y
Is burning and itching of the skin a symptom of depression?	N	N	N
Do people with depression feel energetic?	N	N	N
Is excessive belching a symptom of depression?	N	N	N
Are headaches a symptom of depression?	Y	Y	Y
Is diarrhea a symptom of depression?	N	N	N
Is constipation a symptom of depression?	N	N	N
Is having a bitter taste in the mouth a symptom of depression?	Y	N	N
Is dizziness a symptom of depression?	Y	N**	Y
Is abdominal pain a symptom of depression?	Y**	N	N
Are excessively sweaty palms a symptom of depression?	Y	N	Y
Is difficulty breathing, even when resting a symptom of depression?	Y	N**	Y
Is hearing buzzing noises in the ears a symptom of depression	Y	N**	Y
Is loss of appetite a symptom of depression?	Y	Y	Y
Are feelings of a hot or burning head a symptom of depression?	Y	N	N
Is difficulty swallowing a symptom of depression?	N	N	N
Are experiences of darkness and mist in front of the eyes a symptom of depression?	Y	N**	Y
Is being suddenly scared for no reason a symptom of depression?	Y	N**	Y
Are feelings of pain or burning in the eyes a symptom of depression?	N	N	N
Is indigestion a symptom of depression?	Y	N*	Y
Are feelings of tingling (pins and needles) all over the body a symptom of depression?	Y	Y	Y
Are pains in the heart or chest a symptom of depression?	Y	Y	Y
Are recurrent nightmares a symptom of depression?	Y	Y	Y
Are having cold hands and feet a symptom of depression?	Y**	N	N
Is *jigar khuni* (sadness resulting from painful experience) a symptom of depression?	Y	Y	Y

Note. "Y" refers to a positive response, and "N" refers to a negative response. **Item classified below 0.99 confidence level. *Item classified between 0.99 and 0.95 confidence level.

Beliefs about Treatments

Agreement was high regarding the treatments for depression as 81% (17/21) of the questions in this section were answered identically (refer to Table 16). Of the 21

items, nine were classified as "Yes" by men and women, and nine others were classified as "No." Of the three remaining items, one item relating to whether depression could be treated by eating right was unclassified by men and women; listening to Afghan music was unclassified for women only, and visiting a Tabib (herbal specialist) as well as speaking with an Imam (about one's personal problems) was unclassified for men only.

Table 16

Comparison of item classifications by gender group (treatments)

		Males		
		No	Yes	Total
Females	No	6*	1	6
	Yes	1	13**	13
Total		7	14	21

Note. 81% match; $\chi^2 = 20.45(4)$, $p < .001$

Our samples believed that there was a cure for depression, and that a psychiatrist was the best person to treat it. Additionally, respondents believed that depression could be treated through treating other illnesses, taking herbal medicines and anti-depressants, exercise, rest, and visiting Afghanistan. Women believed that consulting a Tabib (herbal specialist) could help treat depression. Moreover, both groups believed that depression could not be treated by drinking tea, taking sleeping pills, wearing *taweez* (amulet including Islamic scripture), or visiting the grave of a martyr (shrine of a noble person). Moreover, men and women believed that *namaaz* or prayer and reciting Qur'an could help treat depression. Additionally, women believed that seeking counsel from an Imam could help treat depression. Respondents believed that if depression goes untreated it

would not get better by itself and could make one vulnerable to other diseases. Table 17 presents findings on item classifications with regard to treatments.

Table 17

Treatments agreed upon between gender groups

Affirmative Response (classified with a 'Yes' response)	Negative Response (classified with a 'No' response)
Is there a cure for depression?	Can depression be treated by drinking tea?
Is a psychiatrist the best person to treat depression?	Can depression be treated with sleeping pills?
†Can a Tabib (herbal specialist) help treat depression?	Can depression be treated with aspirin?
‡Can depression be treated by listening to Afghan music?	Can depression be treated by visiting the grave of a martyr?
Can depression be treated by treating other illnesses?	Can depression be treated by wearing *taweez* (amulet)?
Can depression be treated with herbal medicines?	If not treated, will depression get better by itself?
Can depression be treated with anti-depressants?	
*Can depression be treated by eating right?	
Can depression be treated with exercise?	
Can depression be treated with rest?	
Can depression be treated by visiting Afghanistan?	
Can depression be treated with *namaaz* (prayer)?	
Can depression be treated by reciting Qur'an?	
††Can depression be treated by speaking with an Imam?	
If not treated, does depression make one more vulnerable to other diseases?	

Note. *Item classified below 0.99 confidence level by both groups (men = .98, women = .68);†Item classified by women only, classified with 'No' response by men at .89 confidence level; ††Item classified by women only, classified with 'Yes' response by men at .87 confidence level; ‡Item classified by men only, classified with 'Yes' response by women at .76 confidence level.

Summary

Women possessed significantly greater average cultural competency than men. By domain, the proportion of shared beliefs was higher with regard to causality among women than in men. The model shared by men and women had nine causes generally relating to cultural conflicts and pre-migration traumas. Because we reversed various items in the 'causes' subsection of our questionnaire, various items were identically

classified with ‘No’ responses by both groups. These items were indicative of nine acculturation and social support factors as causes of depression. In separate analyses, we analyzed the relationship between each of our distress measures (ASCL and PSS) with indices from our acculturation and social support scales. Results corroborate some aspects of causality models as we found a significant negative relationship (eta = -.207, p = .05) between acculturation and ASCL scores. Significant relationships with social support indices were not observed with either the ASCL or PSS.

Groups reported equal values in terms of competency regarding symptoms. Ten items were classified identically with positive responses, which were related to various indigenous idioms, western indicators, and some somatic complaints. Notably, men and women primarily differed in their classifications of 12 somatic items, which women positively classified as symptoms. Treatments were the most widely recognized between both groups. Significant differences were not observed in competency scores within this domain. Treatment models for both groups related to seeking professional care to more lay techniques such as prayer, exercise, and taking herbal medicines. We also assessed relationships between competency scores for each gender with demographic variables as well as distress indices, and observed no significant relationships.

CHAPTER 6

DISCUSSION

A Brief Overview of Our Approach

The purpose of this study was to examine cultural beliefs about the causes, symptoms, and treatments of depression among Afghan refugees residing in San Diego County, and to test for perceived associations with standardized scales. We collected data from men and women in order to examine intra-cultural variation in beliefs about depression between these groups using the cultural consensus model. We initially developed and administered a structured questionnaire to all respondents that solicited questions pertaining to each disease domain in a dichotomous ('yes-no') response format. In developing this questionnaire, we incorporated items free-listed in open-ended interviews with lay community members; additionally, for the section on symptoms we added items from validated scales.

Affirming Research Hypotheses

Assessing Model Fit

With regard to examining cultural beliefs about depression, consensus modeling allowed for the development of hypotheses. Our first hypothesis consisted of a rudimentary procedure to determine if our data was sufficient for carrying out further analyses needed for asserting valid and reliable estimates of cultural beliefs. With regard to our first hypothesis, we assessed goodness-of-fit criteria to determine whether a single response pattern was present in the data in order to present each group's responses with a single set of answers. Consensus analysis revealed a homogenous response pattern

present among the entire sample when analyzed collectively, and within gender groups as eigenvalue ratios exceeded recommended fit indices (≥3:1). This pattern of responses is indicative of a shared belief system within and across gender groups and therefore supports our first research hypothesis.

Assessing Cultural Models of Depression

Favorable findings noted above allowed for testing of our second hypothesis, which proposed that significant overall differences in cultural knowledge would exist between men and women. To describe those differences, we systematically estimated and aggregated individual competency scores for each group (note: cultural competence relates to the pattern of answers of one individual to the aggregate pattern of answers). Parametric tests suggested a higher overall level of cultural competency among women as this group essentially agreed on more questionnaire items when analyzed broadly across all domains. These findings supported our second research hypothesis asserting significant differences between groups. After subdividing competence scores by domain for each group, we found that women only reported significantly higher cultural competence with relation to causes. Significant between-group differences in competence were not observed in terms of symptoms and treatments. Therefore, the data partially supports our second hypothesis.

Examining Knowledge about Causality

Higher levels of agreement regarding causality were observed among women. This could be explicated by the fact that women may be more inclined to socialize and

express their (common) life stressors and problems to one another in contrast to their male counterparts. However, despite higher agreement, a high proportion of items (86%) were classified similarly at the 0.99 confidence level by both groups. Causality was essentially viewed in the context of intra- and inter-personal, social and cultural conflicts. This is consistent with East African refugee accounts of depression described by Kokanovic et al. (2008), who describes causality being viewed as an emotional reaction to host-country life difficulties relating to cultural conflicts, disruptions in family ties, and problems between parents and children. Martinez Tyson et al.'s (2011) consensus analysis of depression beliefs among Latino immigrants is also consistent with our findings. Study participants aligned causes of depression with family problems, problems with children, loneliness, being far away from family, and health problems/illnesses. Similarly, 'having a chronic disease' was attributed as a cause of depression among our sample. Chronic conditions or physical health problems such as heart disease and diabetes have been found to be of high concern among Afghan refugees in the SF Bay Area as documented in Lipson et al.'s (1995) large scale family survey. The belief that having a chronic disease causes depression is explicated by Cabassa et al.'s (2008) study examining explanatory models of depression among diabetic Latinos. Participants attributed their depression to the loss of functioning associated with their diabetes, e.g. the capacity to work and engage in daily activities.

Causality models among Afghans are also consistent with East Timorese and Vietnamese refugee models described in a more recent study by Kokanovic et al. (2010). Causes were linked to a sense of cultural displacement and changes in family structures, as well as pre-migration war traumas and ensuing escape and transit experiences.

Specifically, this is supported by the positive classifications attributed to items relating to traumatic experiences including 'arbitrary searches,' 'enduring hunger,' and 'negative memories of being a refugee in Iran or Pakistan' by our sample. Additionally, like our sample, refugees in Kokanovic' study included recent arrivals as well as individuals living in their respective host environment for over 20 years. Current knowledge about depressive and posttraumatic symptomatology levels in Afghan refugees gives credence to beliefs regarding this comorbid relationship (Ichikawa et al., 2006; Malekzai et al., 1996; Mghir et al., 1999; 1995).

Because depression causality was associated with factors related to social and interpersonal issues, beliefs coincide with the tenets of a 'situational' explanatory model (as described in 'Chapter 2'), and show consistency with various studies describing depression beliefs among other migrant groups such as Latinos (Cabassa et al., 2008). Additionally, our findings with relation to causality converge with previously published qualitative mental health-related studies conducted with Afghans that describe experiences with depression and distress. Our data along with findings from previous studies with Afghans support the notion that a biopsychiatric model was not endorsed. Nor does our data support the coexistence with a situational model, mainly for two reasons, 1) one item suggestive of a biopsychiatric model, 'whether depression is inherited,' was negatively classified by both samples, and 2) no such items relating to this explanatory model (e.g. chemical imbalances) were endorsed in lay accounts of depression in qualitative interviews. Karasz (2005) cites similar findings among EA women who endorsed biological causes of depression as compared to SA women who described depression as stemming from social factors such as marital and family

problems. An item on ‘marital problems’ in the ‘causes’ subsection of our questionnaire was not included due to data variability concerns; however, several respondents taking part in lay qualitative interviews indicated marital problems as a cause of depression.

The prolonged nature of depression affecting Afghans is apparently a consequence of ‘not culturally adjusting’ or not recovering from the culture shock that normally ensues after resettlement. This can be extended to acculturation challenges such as (not) learning English and driving a vehicle, both positively classified by men and women here. Our data is consistent with evidence from published studies with Afghans showing an inextricable link between learning English and the stressors associated with unemployment (Gernaat et al., 2002), economic hardships, and social isolation (Sulaiman-Hill & Thompson, 2011b; 2010). Those at-risk for depression may include both gender groups, according to the men in our sample. However, women did not believe that men were more likely to be depressed. This belief coincides with higher ASCL scores observed in women, and the predictive relationship in depression levels documented in a seminal quantitative study with Afghan refugees and asylum seekers in the Netherlands (Gerritsen et al., 2006).

Moreover, the belief that woman are at higher risk for depression could be a reflection of the burdens of having the responsibility of caring for many children (as positively classified by women as a cause of depression), and the sense of isolation and lack of mainstream cultural integration they perceive. However, the elderly were recognized by both groups as being particularly at risk for depression given their isolation and loneliness. In our pilot study (Phase-I), general informants suggested that the elderly were most susceptible to distress, explicated by their ties to the homeland, sense of

identity as Afghans, and the perceived loss of status and lack of authority within the household.

The erosion of core cultural values occurring within families is partly responsible for the isolation that many subgroups endure, especially the elderly, which may be rooted in intergenerational problems (Lipson, 1993). Data from larger scale cross-sectional studies conducted with SF Bay-Area Afghans also support this (Lipson et al., 1995). This is also consistent with Stempel's (2009) (unpublished) cross-sectional study of SF Bay Area Afghans that shows depression being associated with losing cultural values (mainly for men), as well as social isolation, which was a greater problem for women.

Strikingly, despite viewing depression essentially as a result of one's inability to adjust and acculturate, our sample did not believe that causality was linked to maintaining or 'preserving one's culture and identity.' In our data, these seemingly contradictory views would appear to be supported by the (culturally-oriented) beliefs that depression is caused by 'children who move out of their parents' home after marriage,' or the fact that women believed depression was caused by 'children wearing western clothing.' These items reflect Afghan cultural values, which hold that children are responsible for their parents, and women, who may have "less moral control than men…must be kept out of harm's way" (Krieger, 1986, p. 126). Consensus modeling confirms this conflict, which was originally observed in lay qualitative interviews portraying post-resettlement life for many Afghans as a challenge in balancing their children's prosperity with their liberties. Moreover, as described by lay community members in qualitative interviews, younger generations' intentional disassociation from family and language are important factors in causing depression, as well as their newfound sense of individualism. Bhugra and Becker

(2005) indicate that "individuals who migrate from collectivistic or socio-centric societies, who themselves are socio-centric, into individualist or egocentric societies may experience feelings of alienation and mental distress, with consequent difficulty in settling into the new society" (p. 19).

Examining Knowledge about Symptoms

Many of the negative circumstances related to ongoing stressors described above were shared by lay community members during qualitative interviews. Many linked their social predicaments and resulting social stressors to indigenous (*asabi*/irritability, *goshagiry*/self-isolation, *ghamgeen*/sadness, and *jigar khuni*/grief following interpersonal loss) and western (concentration difficulty, indecisiveness, loss of appetite) idioms and indicators of distress and depression, respectively. As such, our data affirms these sentiments as all abovementioned (indigenous and western) symptoms were positively classified among men and women. Such an outcome was expected, especially for the indigenous items as they affirm findings from Miller et al.'s (2006) study with Afghans in Kabul who attributed distress symptoms to these items. Moreover, our general psychological distress measure (ASCL) gives credence to these beliefs as over half of all men and women reported experiencing these symptoms at least once a week.

In addition, few lay community members indicated that *thinking too much* was not only a symptom of depression but also a cause; however, this item was omitted in our questionnaire to ensure variability in responses. Approximately 46% of men reported 'thinking too much' at least *2-3 times/week*, while 68% of women reported these feelings anywhere from 2-3 times/week to *everyday*. Previously published studies with Afghans in

Australia and New Zealand have cited the notion of ruminative behaviors or 'thinking too much' (due to past experiences and current reminders) as a major source of distress (Sulaiman-Hill & Thompson, 2010). Results from studies with Afghans in the Netherlands confirm these findings as 'thinking too much' has been associated with loneliness, unemployment, war experiences, which result in mental worries (Feldmann et al., 2007).

Various somatic symptoms were also classified similarly between groups (e.g. tension in the neck and shoulders, feelings of tingling all over the body, headaches, low energy, pains in the heart or chest). Some of these findings are affirmed by our distress symptoms measure, which also included an item for headaches and one for low energy. Nearly half of all men and approximately 60% of women reported experiencing headaches. A slightly higher proportion of women (46.5%) than men (43.7%) reported experiencing low energy at least once a week during the last two weeks. Notably, several somatic items including having 'a bitter taste in the mouth', 'excessively sweaty palms', as well as 'labored breathing' and 'hearing buzzing noises' were associated with depressive symptoms by women only. Somatized presentations are what Kirmayer (2001) refers to as "ticket behavior" (p.24) or an appropriate and nonstigamitized reason to seek help from a biomedical practitioner (Epstein, Quill & McWhinney, 1999). In consistency with this notion, Asian immigrants who believed that depression resulted in somatic consequences were associated with a greater likelihood of endorsing professional help seeking given the perceived social acceptance of seeking care for physical ailments. While somatic complaints may serve as a push factor for seeking care, for some Afghans stigma may pose a barrier to seeking professional care from either a primary care

physician or a psychiatrist for treating depression; however, this area remains understudied. However, stigma, or "going crazy" as exemplified in free-listed responses regarding views on depression's consequences may be a cursory explanation as to why professional help-seeking may be limited.

Examining Knowledge about Treatments

Underutilization can be explained by many factors. For example, it may resonate from the expectation that Afghans have of primary care physicians, which is to treat physical problems as discovered in a previously published study with Netherlands-based Afghans (Feldmann, et al., 2007). Additionally, Afghan refugees taking part in qualitative studies in Australia have described mental health care as culturally incongruent (Omeri et al., 2006, 2004). Similarly, Afghans in the SF Bay Area shared more positive views on health care than on social services given problems of access, and communicating needs due to culturally inappropriate care stemming from communication challenges between providers and patients (Lipson, 1993; Lipson & Omidian, 1997). Among younger Afghans in Australia 'limited mental health services knowledge' was found to be one of many deterrents to seeking treatment (de Anstiss & Ziaian, 2010).

Furthermore, according to Afghans in the East Coast US, professional help-seeking may be deterred by coping mechanisms adopted for dealing with depression and distress such as engaging in religious activities (Feldmann et al., 2007; Welsh & Brodsky, 2010). Our findings show consistency with this as both groups did indicate that prayer and reciting Qur'an were treatments for depression. These findings also show consistency with findings regarding beliefs shared among other Muslim groups (Cinnirella &

Loewenthal, 1999). In relation to this, lay community members in qualitative interviews suggested that their very presence in the US was preordained by Allah. The general sentiment expressed with regard to fleeing their homelands and their subsequent resettlement was one of 'sacrifice for their children's prosperity' as suggested by our qualitative data. One key-informant suggested that for some Afghans faith in God may serve as a form of "emotional protection" against depression and distress.

Given these convictions exemplified through lay accounts, limited help-seeking could be limited due to notion that depression is not entirely viewed as an illness for some Afghans; rather, a normal emotional response to ongoing social stressors. Pincay and Guarnaccia's (2007) study of depression beliefs among Latino immigrants lends support to this notion. Respondents referred to disruptions in social structures caused by the immigration process leading to isolation and loneliness as causes of depression, and suggested that although a serious disorder, depression did not warrant mental health care. However, in contrast with Pincay and Guarnaccia's findings, our sample attributed positive views to psychiatrists and anti-depressants for treating depression. However, we could not ascertain the perceived effectiveness of these positively classified items in comparison to more lay treatment techniques given the 'yes-no' response choice format used. However, informal conversations with survey respondents suggested that anti-depressants were "good for temporary use", and that self-efficacy and bonds with family and relatives were more effective.

Although not assessed directly in our questionnaire's 'treatments' subsection due to concerns surrounding data variability, classification of items relating to depression causality provide support for lay helping seeking methods. Respondents suggested that

'having close family members around' (to possibly discuss emotional problems) and 'people of similar age and language to socialize with' as being protective against depression. For many, these approaches may indeed be more practical than having to resort to antidepressants, and potentially more therapeutic than seeking counseling from psychiatrists and therapists. Similarly Furnham and Malik's (1994) study comparing depression views between foreign- and native-born Britons in the UK shows that the former placed a strong emphasis on family as a source of social support. Moreover, in our study, such views may have been supported in the context of the pervasive problem of isolation and loneliness that vulnerable groups such as women and the elderly endure.

Unexpectedly, despite women having lower education and possibly limited experience with psychotherapy or other western treatment modalities, they negatively classified various non-traditional treatments. These included drinking tea, taking aspirin and sleeping pills, and wearing a *taweez* or amulet (containing religious scripture). Interestingly, while agreeing on western modalities in treating depression as noted above, women also suggested that visiting or consulting a *Tabib* (herbal specialist) was helpful, and that discussing problems with an Imam could help treat depression. Feldmann et al. (2007) describes that Afghans living in rural as well as urban areas would often consult a Tabib or help themselves with herbs for different complaints, more religious families from the villages would seek counsel from a Mullah or Imam, and were asked to read the Qur'an and pray for God's blessing for the sick.

Additionally, other items including 'exercise' was classified positively by both groups in our sample, which strikingly coincides with Renner et al.'s (2008, 2006) study of Afghans in Austria that describes exercise as a way of coping with posttraumatic

symptomatology. This strategy was also suggested by three individuals in our lay qualitative interviews as well. In relation to this, socially and culturally meaningful forms of leisure and recreation were salient factors in coping with distress in a qualitative study conducted among Afghans resettled in Canada (Stack & Iwasaki, 2009). The authors indicate that leisure and recreation could serve as a catalyst for social connections and networks with Afghan families and friends as well as with non-Afghan Canadian friends – facilitating cultural adjustment.

Examining Associations with Cultural Competence

Lastly, we tested whether cultural competency would vary by demographic or distress-related outcomes within and between groups. Despite observing significant differences in distress levels as well as demographic characteristics such as education, employment, and marital status, our data did not support this hypothesis. These nonsignificant findings were unexpected considering the impact that higher educational attainment may potentially have on belief models. Angel and Thoits (1987) suggest that individuals with higher levels of education may be more exposed to western discourse about mental illness than those less educated, in turn aligning their beliefs with the mainstream culture. Also, higher education may invariably provide for higher English proficiency. Cabassa et al. (2007) noted that the use of and proficiency in English "may expose individuals through media (e.g. television, radio) and interactions with members of the dominant culture to the medical terms and labels used to describe depression" (p. 13).

Consistency with this notion is observed in Iqbal's (2006) study of Afghan women residing in the SF Bay Area. Results indicate a small but significant positive relationship between cultural resistance and level of somatization. While we did not observe significant differences in acculturation between groups, we did observe a significant negative relationship between acculturation and current distress levels. Current experiences with a select number of somatic complaints measured through the ASCL coincided with the positive classifications attributed to somatic items. Moreover, two plausible explanations for these nonsignificant findings include 1) that our sample is not representative, or 2) "that there truly are no differences," (Weller, 1993, p. 116). Although it may be that groups differ on key characteristics that can potentially influence knowledge, the very fact that this population is generally highly distressed as a result of stressors common to both groups ultimately renders the entire sample more homogenous.

Practice Implications

Improving Depression Care and Service Provision

Healthcare professionals treating depression among refugees in primary care and in mental health services settings should recognize the need to understand their clients' views about such disorders. Here we examined beliefs about depression in a population that has been found to be highly distressed with seemingly limited professional help-seeking experience. While our data shows promise for seeking professional care given positive views attributed to psychiatrists and psychotropic medicines, it is uncertain whether Afghans would generally be inclined to "act upon specific culturally oriented beliefs during a particular illness episode" (Weller et al., 2002, p. 131). For Afghans, the

concept of treatment through psychotherapy may simply be viewed as culturally incongruent, stigmatizing, and obsolete in light of the overwhelming degree of interpersonal, familial and cultural conflicts that may only be resolvable through more practical methods, for example, improving social bonds with family and friends.

Nonetheless, mental health services need to be tailored to those that are inclined to seek professional care as well as individuals that would be more receptive to lay techniques that are employed through ecological models. The belief system documented in this study is not suggestive of an approach that completely defies conventional wisdom in treating depression. In essence, what it suggests are adjustments in care/manualized therapy through improving cultural competence of providers for ultimately improving treatment adherence. Primarily, assuring concordance in client explanatory models and provider biopsychiatric models could facilitate this. We suggest, in consistency with Pachter et al.'s (2002) study of asthma beliefs, "attempts should be made to negotiate or combine concordant aspects of the personal/cultural model with biomedical practice" (p. 131).

At the clinical level, it points towards the need to understand the subjective views of clients and cultural aspects of mourning that are undergirded by ongoing social problems. For Afghans, and like many other refugee groups the loss of a culture and home can have a similarly dramatic impact on mental health as traumatic experiences. Therefore, clinicians should be cognizant to not limit the discussions with Afghans and other refugee groups to pre-migration traumas (Williams & Thompson, 2010). However, Murray, Davidson, and Schweitzer (2010) suggest that understanding flight experiences is critically important for tailoring mental health services in the postflight context despite

practice recently shifting emphasis on resettlement factors as this approach provides "a practical target for preventive interventions" (p. 578). Moreover, Lim and Koike (2010) state that "therapists attempting psychotherapy with refugee populations must not make the assumption that Western-based models of psychotherapy will be appropriate without modifications, since the clients will not share the same beliefs, values, and customs as the therapists" (p. 162). These authors allude to Bemak, Chung, and Pedersen's (2003) multilevel model of psychotherapy for meeting the mental health needs of refugees, which consists of four phases.

The first phase promotes 'mental health education,' which calls on therapists to educate clients about mainstream mental health practices and to discuss with clients their cultural beliefs and values. The second phase includes 'applying individual, group, and/or family therapy' with the latter possibly being most effective given the fact that Afghans, like many other refugee groups come from collectivistic societies where there is a sense of shared responsibility among family members. Renner (2009) suggests that "group interventions are of obvious use in assisting refugee and asylum seekers provided that such interventions are sensitive with respect to cultural and to gender issues" (p. 105). The third phase calls for 'culturally empowering refugees' by instilling a sense of environmental mastery in order to find employment, or most relevant in this context, to become proficient in English. In relation to this, mental health clinicians working with Afghan refugee clients could incorporate into their standards of practice cultural orientation lessons (especially beneficial for newer refugee arrivals). The fourth phase calls on therapists working with refugees to treat distress by incorporating into treatment protocols religious leaders (such as Imams) who can provide counseling in terms of

helping clients make meaning of their life in exile, and indigenous healers that can prescribe herbs and teas.

In combination with the above mentioned approach, standard clinical evaluations could be supplemented by highlighting the effect of culture on explanatory models of illness, symptoms, help-seeking preferences through the application of the *Cultural Formulation* model proposed by DSM-IV (APA, 1994), as suggested by the Surgeon General's supplemental report on mental health (USDHHS, 2001). Components of the Cultural Formulation model, according to Lewis-Fernandez and Diaz (2002) include consideration of: the cultural identity of the individual, cultural explanations of the individual's illness, cultural factors related to psychosocial environment and levels of functioning, cultural elements of the relationship between the individual and the clinician, and overall cultural assessment for diagnosis and care. The Surgeon General's report encourages clinicians to embrace all five components for ensuring proper diagnosis and treatment.

Moreover, because psychotherapists may not be fluent in Dari or Pashto, mental health services agencies need to ensure that proper linkages are in place within mental health provider networks that include trained medical interpreters who are age and gender-matched with clients (Grey, Lab, & Young, 2010). Renner and Salem (2009) suggest that in spite of therapeutic work being efficient, therapeutic relationships may lack immediateness and emotionally laden subtleties that are difficult to communicate. Miller, Martell, Pazdirek, Caruth, and Lopez (2005) indicate that the nature of the relationships interpreters have with clients can significantly impact the therapy process as interpreters provide cultural guidance to therapists who lack familiarity with their clients'

cultural background – cultures in which therapy is unfamiliar or viewed negatively. Also, ethnically similar mental health professionals would potentially be indispensable in terms of accurately diagnosing and treating depression. Such practitioners could incorporate Islamic teachings and culturally acceptable coping strategies that have been cited by Afghans as necessary in treating mental health problems (Omeri et al., 2006, 2004). To this end, more collaboration is needed between local mental health agencies, refugee resettlement organizations, and leadership within the Afghan community.

Mental health professionals, and especially primary care physicians who have a tendency to focus on psychological complaints when diagnosing depression should acquire skills for recognizing somatic complaints in order to avoid misdiagnosis, according to Tylee and Gandhi (2005). These authors suggest that primary care physicians could also teach patients to reattribute somatic symptoms to psychological problems by making them feel understood and by fully explaining the link between somatic complaints and psychological and lifestyle factors. Moreover, Kung and Lu (2008) suggest that better recognition of somatic complaints among medical doctors and nurses who work with clients with historically low underutilization of psychological services may provide for referrals to mental health services.

Local mental health agencies ought to appropriate resources for training health professionals who commonly work with Afghan refugees in these areas. Another strategy that could have much practical significance includes developing a glossary of cultural terms where practitioners could easily define explanations of words used to express signs and symptoms of specific mental disorders (Escobar & Gureje, 2007). Improvements in

primary care services are of utmost importance as such settings are "a critical portal to mental health treatment for ethnic and racial minorities" (USDHHS, 2001, p. 32).

With consultation from local mental health clinics, Afghan community and religious leaders could also help reduce stigma in professional help-seeking by instilling attitudinal changes about mental disorders and psychological care. Psychoeducation in terms of medicalizing depression as a disease (and not as a result of moral weakness or madness) could help reduce fears related to expressing the need for care. This approach, coupled with psychoeducation about existing mental health services and treatments could also be helpful (Pincay & Guarnaccia, 2007). Additionally, to further encourage professional help-seeking and to ensure that mental health promotion efforts are far-reaching, awareness about managing one's own stress along with real-life accounts of treatment effectiveness could be disseminated through various methods.

This would require televised broadcasts with (Afghan) physicians and psychiatrists through Afghan satellite television networks. Broadcasts ought to include real time question-and-answer sessions as well as live counseling with anonymous callers. Testimonials from Afghans seeking mental health care that exemplify positive experiences with providers as well as favorable disease outcomes/functioning could also be beneficial. Also, leaflets and brochures written in Dari and Pashto languages distributed at mosques as well as religious and cultural events could serve as a practical means of instilling knowledge on managing stress. Consideration should be given to instilling knowledge in terms of the social implications of not seeking treatment (e.g. unemployment and marital problems), and sequelae including cardiovascular disease and dementia.

Among more recent refugee arrivals, resettlement agencies ought to heighten awareness of the availability of psychological care provided through state-sponsored health insurance programs. More targeted efforts should focus on those who could benefit most from treatment such as widows and the elderly. This more targeted approach could help avoid medicalizing the refugee experience (Colic Peisker & Tilbury, 2004) among a larger refugee population that may already internalize a sense of victimization. More attention could then be paid to improving English language ability at a faster rate (Corvo & Peterson, 2005) for the larger population, and also providing job training consistent with skills to improve long-term employment prospects. Other strategies that community-based organizations could adopt include focusing on social capital building as this can not only lead to improvements in emotional well-being, but could also facilitate gainful job opportunities where members of their cultural group are concentrated.

Combining an emphasis on employment with opportunities for developing skills – a strategy supported by recent research on welfare recipients – could be an especially effective model for limited English speakers, who could combine part-time work with language training (Tumlin & Zimmerman, 2003). Because job placement programs mandated by Welfare Reform legislation fail to understand the populations that policies target (Schneider, 2006), community-based organizations should be cognizant of those with child care responsibilities, transportation challenges, and the cultural taboos against women taking part in manual labor. Also, it has been argued that the psychological effects of war traumas could render someone unable to work (Keigher, 1997), and that strict job placement requirements take away from refugees' abilities to seek treatment for mental health problems.

At the community level, Afghan religious leaders who possess credibility should initiate prevention and intervention efforts. Lay community members in this study suggested that community leaders and the local government ought to establish a communal place where vulnerable groups such as the elderly could congregate. Miller (1999) proposes a similar approach, and elaborates on the need for promoting social activities such as 'drinking tea or talking politics' to take place between attendees. Miller (1999) also suggests that within community settings, mental health professionals could address adaptation issues, while refugees who have some history of residence in the host setting could lead orientation programs, and Imams could address distress in sermons and informal interactions with congregation members. These are just some of Miller's suggestions of employing complimentary and lay strategies in meeting the mental health needs of refugee communities in light of the magnitude of the problems inadequately addressed by psychotherapy in stigmatizing psychiatric clinics. Miller and Rasco (2004) cite "whenever possible, ecological interventions should be integrated into existing community settings and activities, in order to enhance participation in and long-term sustainability of the interventions" (p. 45).

Limitations

There are several limitations to this study, which also suggest directions for future research. First, the use of convenience sampling may have introduced selection bias. Our sample reflected little variation in age as young people and the elderly were underrepresented (also a challenge in our lay qualitative interviews). Nevertheless, a random sample was unfeasible given the fact that no sampling frame exists for this

population as discovered during our interviews with key informants. Although a sizeable number of Afghans may reside in the San Diego area, they are spread throughout the county and not centralized in one geographic region as observed in the SF Bay Area. Additionally, places of congregation are limited and attendance at these venues is generally small in size. Community-wide events are rare, and as we have learned, large turnover at such events did not guarantee participation in research.

Some of this can be attributed to the general mistrust that Afghans have in outsiders (as discussed in 'Chapter 3'), the lack of interest in research, and unfamiliarity with completing surveys, and with the research process altogether. Cultural sensitivity issues also presented a compelling challenge in terms of recruiting women, who at times are guarded by their male counterparts. To mitigate this challenge, we appointed a female RA in order to gender-match surveys. We were also uncertain as to how long respondents would be engaged in thoroughly completing a survey composed of over 100 questions presented across 15 sheets of paper, which lead to weaknesses in measurement.

For brevity we resorted to acculturation and social support measures based on the fact that they were limited in length and seemingly easy to complete. Our acculturation measure was unidimensional as it was limited to assessing language preference, albeit a strong indicator for acculturation, it may have not been as accurate in assessing this variable when compared to more comprehensive measures. Future studies should consider gauging behavioral and identity preferences, in addition to language (preferences) as demonstrated in a recent study with Vietnamese refugees (Birman & Tran, 2008). Also, measures reflective of Berry's bi-dimensional acculturation

framework used with Arab immigrants (Amer & Hovey, 2007) could provide accurate results.

Moreover, several questionnaire items in the 'causes' subsection of our belief questionnaire were stated in a "double-negative" format in order to achieve variation in responses as per consensus analysis guidelines, which made comprehension of such questions for some difficult. A similar issue was observed in four of the questions in our scale measuring perceived stress. This may have introduced some degree of systematic error/low quality data as respondents who completed the questionnaire through self-administration may have responded to questions by satisficing. Furthermore, we applied a dichotomous ('yes-no') question-answer response format. This approach may have not captured "mixed feelings" regarding certain questionnaire items as suggested by respondents themselves. The use of a Likert-type scale was considered during our survey development phase; though, key informants discouraged the use of such a response format for ensuring ease of survey completion.

Lastly, de Munck (2009) cites various criticisms of consensus analysis such as the reliance on interview data for constructing cultural models. Weller and Mann (1997) indicate that systematic bias is a weakness in consensus analysis as data is based on survey responses that gauge what respondents know and what they can remember. Aunger (1999) makes a similar claim, in addition to questioning whether culture can be found only in the minds of individuals, and whether or not culture is comprised of mental constructs (in de Munck, 2002). In relation to this, Garro (2000) suggests that culture is always contextualized and that "questionnaires have little to do with context and

everything to do with the answer that seems reasonable at that time and when that person is in a hurry" (cited in de Munck, 2009, p. 137).

However, the objective here was not to ultimately determine whether beliefs were correct or incorrect in terms of the biomedical, or in this case a biopsychiatric model. Instead, consensus analysis provided the power to center variation and patterning of responses around the cultural norm (Baer et al., 2004). While acknowledging the fact that culture is more complicated in practice, de Munck (2009) suggests that there is a reason for the emergence of a pattern when many people answer a set of questions the same way. Nonetheless, Bhui and Bhugra (2002) suggest that "methodological issues facing researchers need to be developed before the weight of research evidence is sufficiently compelling for clinicians routinely to explore their patients' explanatory models of distress" (p. 7).

Our consensus analysis raises questions for future research. Consensus models of depression should be examined among newly resettled Afghan refugees and asylum seekers who may be disproportionately impaired. Additionally, it is necessary to compare differences between Afghan and health provider explanatory models of depression and distress. Not only can this potentially promote concordance in disease models between Afghans and mental health professionals, it could lead to improvements in patient-provider communication, culturally sensitive care, and treatment adherence.

While this study also assessed psychological distress levels among Afghans (mostly after long-term resettlement) using a scale validated in Afghanistan, we did not collect data on current or past mental health care utilization/treatment. As suggested by Marshall et al. (2005), future research is needed to determine whether (in our case)

psychological distress rates are due to low service utilization or ineffective treatments. With relation to this, other avenues for research include qualitative studies describing Afghan refugees' lived experiences with mental health professionals. Contextualizing the experience of clinicians working with Afghan clients is equally imperative. This could help shed light on the symptoms that Afghans with depression commonly present with, along with their adherence, receptivity, and prognosis in terms of manualized therapies. In relation to this, published evaluations of programs and interventions utilized with other refugee groups could further inform practice and policy. Murray et al. (2010) cites practice-based evidence in the area of refugee-related (psychological) interventions is still in its emerging stages" (p. 578), which (as indicated by these authors) is exemplified by sparse accounts of efficacy trials using rigorous study designs.

Secondly, cross-sectional studies ought to investigate the ecological barriers and facilitators for mental health care utilization. This can be achieved by using well-grounded conceptual frameworks (Andersen & Newman, 2005). Moreover, future research should consider examining determinants of cultural adjustment, or the factors explicating why some groups fare better than others after resettlement. Consideration should also be given to regions where there is a high density of Afghans that enjoy strong social networks within ethnic enclaves. Lastly, longitudinal cohort studies that include newly resettled Afghan refugees that are followed years after resettlement could be effective in identifying the various socio-cultural and -economic factors related to the long-term impact of depression and trauma. The challenge with this research design as well as those noted above rests in engaging Afghans in the research process in a culturally sensitive manner.

Conclusion

Depression is a pervasive problem among refugee groups exposed to war-related violence and the subsequent stressors that are brought about by the resettlement process. Specifically, mental health-related studies conducted with Afghan refugees in the US and other western nations indicate a high degree of depressive symptomatology. As discussed in chapter one, Afghans have endured many atrocities resulting from a conflict that is nearing four decades. A growing body of empirical data shows that anxiety disorders resulting from war traumas are exacerbated by ongoing hardships and stressors of post-resettlement life. Stressors for Afghans come in various forms, which are not merely limited to jobs and money. Research with Afghan refugees has shown that depression stems from the abrupt separation from family, loss of social support, status and identity, as well as adjustment challenges and cultural conflicts. Depression does not only affect newer refugee resettlement groups. Studies with Afghans show that stressors are ongoing as a result of the loss of social structures, cultural values, and self-identity, what Eisenbruch (1991) defines as "cultural bereavement." Our data lends much support to this notion.

Continued resettlement of Afghans in the US with prolonged exposure to war and little to no prior psychological support, ongoing stress, in addition to limited mental health service provision are factors that necessitate furthering research with Afghans. Other than the discussion of stigma as a barrier to mental health care (Lipson, 1992), little is known about professional help-seeking among the Afghan refugee population. Understanding conceptions about the etiology of depression, symptoms, and treatments may provide some insight as to whether professional help-seeking is even a viewed as a

viable treatment method. Furthermore, knowledge about their depression models could culturally sensitize clinicians to the various emotional and physical symptoms that depressed Afghans may present with in clinical settings, and also how they cope with their problems.

Such knowledge could also provide clinicians and mental health providers working with Afghans insights for reformulating treatment efforts that are not bound to traditional western methods. This is because explanatory models relating to sources of distress, symptomatology, and help-seeking are influenced by culture (Kirmayer, 2001). Explanatory models also help embrace the authentic view of the patient's world (Bhui & Bhugra, 2002).

This study has gone some way towards understanding beliefs about depression among Afghan refugees. The use of consensus modeling, borrowed from cognitive anthropology, provided a sophisticated means of systematically aggregating and estimating beliefs within each disease domain. We discovered a consistent pattern in responses among both samples, indicating that despite slight differences between models, men and women share similar beliefs about depression. Overall, women possessed more cultural knowledge or shared more of the beliefs than men. We also learned that beliefs regarding causes of depression among our samples are aligned with a situational model, rather than a biopsychiatric model. This was affirmed through data suggesting intra- and inter-personal as well as social factors in depression causality models, and not biological ones. In contrast, a high degree of heterogeneity was observed between samples regarding depressive symptom classifications. Although both samples positively classified indigenous and western idioms and indicators of distress and depression, higher

agreement was observed regarding somatic items among women. Treatments were similarly classified for most items as both samples suggested the use of western and non-traditional techniques for treating depression.

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APPENDIX A

INTERVIEW GUIDE FOR PHASE-I (FEASIBILITY/PILOT STUDY)

1. In your experience, what are the mental health conditions affecting the Afghan refugees that you are working with?

Probes:

Do (Afghan) refugees often complain of feeling down, or depressed, or express anxiety or traumatic experiences?

What populations or age groups are most affected (e.g. men, women, children, elderly)?

Is there any difference between those who have been in the U.S. 1 year versus those who have already been here 5 or 10 years?

2. Do you have any suggestions on how to get in contact with recent Afghan refugee arrivals (e.g. door-to-door surveys, through refugee service organizations)?

Probe:

What times of the day would this population be most available?

What days of the week are best to reach this population?

What types of locations are best to reach this population?

3. What advice would you give to someone planning to conduct a survey of Afghan refugees in San Diego?

Probe:

Do you think the Afghan refugee community would be receptive to the idea of a mental health/mental health status survey/health status survey?

Are there any topics that might be difficult to discuss?

Are there any settings/places in which it might be difficult to ask mental health related questions?

Are there any special difficulties in reaching women or talking about these subjects with women?

Are there any special difficulties in reaching men or talking about these subjects with men?

4. What agencies, organization, or health care providers do you recommend we talk to about San Diego County Afghan refugee health needs?

APPENDIX B

INTERVIEW GUIDE FOR PHASE-II (PRELIMINARY RESEARCH)

A. Migration Experiences

1. Tell me about your journey in relation to fleeing Afghanistan and becoming a refugee?

Probes:

How did you escape and what did you experience along the way?

What factors were responsible in your decision for leaving (Did you fear for your life?)

Did you witness first hand or know of people who were kidnapped, killed or tortured?

2. Tell me about your experiences upon resettling in the US?

Probes:

What hardships did you face upon resettling in the US and thereafter?

What made it easier/harder for you to adjust?

What are some of the hardships, if any, that you currently face?

3. How have these (migration) experiences shaped your life?

Probe:

Do you feel that these (pre- and post-migration) experiences are a cause of distress for many Afghans, including yourself?

B. Mental Illness Beliefs

4. Based on your knowledge and experience, and in the context of Afghan refugees how exactly would you define mental illness?

5. In terms of depression, what is your view on the 1) causes; 2) symptoms; 3) risk factors, 4) treatments, and 5) disease consequences if left untreated?

APPENDIX C

QUESTIONNAIRE (ENGLISH VERSION)

LOMA LINDA
UNIVERSITY

Afghan Health & Life Experience Survey

Principal Investigator:
Qais Alemi, PhD©

Loma Linda University
Department of Social Work & Social Ecology

Survey Number: _____

I. DEMOGRAPHICS

We are interested in learning a little about you. Please answer the following questions to the best of your ability.

1. How old are you? _____

2. Gender:
    a. Female
    b. Male

3. Marital status:
    a. Married
    b. Divorced or Separated
    c. Widowed
    d. Never Married

4. Years of education completed: _____

5. What is the highest level of education that you've attained?
    a. Less than high school
    b. High school diploma
    c. Bachelor's degree or equivalent
    d. Master's/Doctoral degree or equivalent

6. To what ethnic group do you belong to?
    a. Hazara
    b. Nuristani
    c. Pashtun
    d. Tajik
    e. Uzbek
    f. Other, please specify: _____

7. What was your legal status upon arrival to the US?
    a. Refugee
    b. Asylum-seeker
    c. Other, please specify: _____

8. Year of arrival in the United States: _____

9. How many years did you live in Afghanistan during war? _____

10. What is your current employment status?
    a. Employed
    b. Unemployed
    c. Retired
    d. Disabled

11. Can you comfortably pay your bills every month with your current household income?
    a. Yes
    b. No

LANGUAGE PREFERENCE

We are interested in learning about your language speaking abilities and preferences. Please circle the answer that best corresponds with you.

1. What was the first language you learned to speak?

English English and Dari/Pashto simultaneously Dari/Pashto Other

2. In your opinion, how well do you speak Dari/Pashto?

Very Well Pretty Well Not too well Not at all

3. In your opinion, how well do you speak English?

Very Well Pretty Well Not too well Not at all

4. In your opinion, how well do you read English?

Very Well Pretty Well Not too well Not at all

5. What language do you usually use with your spouse (or your fiancée or a best friend if you are not married)?

Only English Mostly English Only Dari/Pashto Mostly Dari/Pashto Both Equally

6. What language do you usually use with your children (or with family members who are children, if you have no children)?

Only English Mostly English Only Dari/Pashto Mostly Dari/Pashto Both Equally

7. What language do you usually use with your parents (or with older adult family members if you have no parents)?

Only English Mostly English Only Dari/Pashto Mostly Dari/Pashto Both Equally

8. What language do you usually use during family gatherings?

Only English Mostly English Only Dari/Pashto Mostly Dari/Pashto Both Equally

SOCIAL NETWORK

We are interested in learning about your relationships with your relatives and friends. Please circle the answer that fits best.

Considering the people to whom you are related either by birth or marriage…

1. How many of your relatives do you see or hear from at least once a month?

0 1 2 3-4 5-8 9 or more

2. How many of your relatives do you feel at ease with that you can talk about private matters?

0 1 2 3-4 5-8 9 or more

3. How many of your relatives do you feel close to, such that you could call on them for help?

0 1 2 3-4 5-8 9 or more

Considering all of your friends including those who live in your neighborhood…

4. How many of your friends do you see or hear from at least once a month?

0 1 2 3-4 5-8 9 or more

5. How many of your friends do you feel at ease with that you can talk about private matters?

0 1 2 3-4 5-8 9 or more

6. How many of your friends do you feel close to such that you could call on them for help?

0 1 2 3-4 5-8 9 or more

II. VIEWS ABOUT DEPRESSION

We are interested in learning about your views on the *Causes* for depression. Please indicate whether you agree or disagree with the following statements by circling your response.

1. Is depression more likely in people who cannot adjust to the American culture?

   Yes **No**

2. Is depression more likely in people who have a chronic disease?

   Yes **No**

3. Is depression more likely in people who have close family around them?

   Yes **No**

4. Is depression more likely in people who have had their home searched for people or things?

   Yes **No**

5. Is depression more likely in people who have experienced a lack food or clean water?

   Yes **No**

6. Is depression more likely in people who are able to drive?

   Yes **No**

7. Is depression more likely in people who have a depressed family member?

   Yes **No**

8. Is depression more likely in people who learn to speak English?

   Yes **No**

9. Is depression more likely in people who have preserved their culture and identity?

   Yes **No**

10. Is depression more likely in people with a lot of children?

Yes **No**

11. Is depression more likely in people who are elderly?

Yes **No**

12. Is depression more likely among young children?

Yes **No**

13. Is depression more likely in people whose children receive a college degree?

Yes **No**

14. Is depression more likely in women?

Yes **No**

15. Is depression more likely in men?

Yes **No**

16. Is depression inherited?

Yes **No**

17. Is depression more likely in people who are certain of their future?

Yes **No**

18. Is depression more likely in people who have people their age to talk to?

Yes **No**

19. Is depression more likely in people whose children leave the home after being married?

Yes **No**

20. Is depression more likely in people whose children wear Western clothing?

Yes **No**

21. Is depression more likely in people with negative memories of being a refugee in Iran or Pakistan?

Yes **No**

Now we are interested in learning about your views on the *Symptoms* for depression. Please indicate whether you agree or disagree with the following statements by circling your response.

22. Is being *asabi* a symptom of depression?

Yes **No**

23. Is *goshagiry* a symptom of depression?

Yes **No**

24. Is being *ghamgeen* a symptom of depression?

Yes **No**

25. Is paleness a symptom of depression?

Yes **No**

26. Is a person able to concentrate normally with depression?

Yes **No**

27. Are people with depression able to make decisions?

Yes **No**

28. Is tension in the neck and shoulders a symptom of depression?

Yes **No**

29. Is burning and itching of the skin a symptom of depression?

Yes **No**

30. Do people with depression feel energetic?

Yes **No**

31. Is excessive belching a symptom of depression?

Yes **No**

32. Are headaches a symptom of depression?

Yes **No**

33. Is diarrhea a symptom of depression?

Yes **No**

34. Is constipation a symptom of depression?

Yes **No**

35. Is having a bitter taste in the mouth a symptom of depression?

Yes **No**

36. Is dizziness a symptom of depression?

Yes **No**

37. Is abdominal pain a symptom of depression?

Yes **No**

38. Are excessively sweaty palms a symptom of depression?

Yes **No**

39. Is difficulty breathing, even when resting a symptom of depression?

Yes **No**

40. Is hearing buzzing noises in the ears or head a symptom of depression?

Yes **No**

41. Is loss of appetite a symptom of depression?

Yes **No**

42. Are feelings of a hot or burning head a symptom of depression?

Yes **No**

43. Is difficulty swallowing a symptom of depression?

Yes **No**

44. Are experiences of darkness or mist in front of the eyes a symptom of depression?

Yes **No**

45. Is being suddenly scared for no reason a symptom of depression?

Yes **No**

46. Are feelings of pain or burning in the eyes a symptom of depression?

Yes **No**

47. Is indigestion a symptom of depression?

Yes **No**

48. Are feelings of tingling (pins and needles) all over the body a symptom of depression?

Yes **No**

49. Are pains in the heart or chest a symptom of depression?

Yes **No**

50. Are recurrent nightmares a symptom of depression?

Yes **No**

51. Are having cold hands or feet a symptom of depression?

Yes **No**

52. Is *jigar khuni* a symptom of depression?

Yes **No**

Now we are interested in learning about your views on the *Treatments* and *Consequences* for depression if not treated. Please indicate whether you agree or disagree with the following statements by circling your response.

53. Is there a cure for depression?

Yes **No**

54. Is a psychiatrist the best person to treat depression?

Yes **No**

55. Can a Tabib (herbal specialist) help treat depression?

Yes **No**

56. Can depression be treated by drinking tea?

Yes **No**

57. Can depression be treated by listening to Afghan music?

Yes **No**

58. Can depression be treated by treating other illnesses?

Yes **No**

59. Can depression be treated with sleeping pills?

Yes **No**

60. Can depression be treated with herbal medicines?

Yes **No**

61. Can depression be treated with anti-depressants?

Yes **No**

62. Can depression be treated with aspirin?

Yes **No**

63. Can depression be treated by eating right?

Yes **No**

64. Can depression be treated with exercise?

Yes **No**

65. Can depression be treated with rest?

Yes **No**

66. Can depression be treated by visiting Afghanistan?

Yes **No**

67. Can depression be treated with namaaz (prayer)?

Yes **No**

68. Can depression be treated by reciting Qur'an?

Yes **No**

69. Can depression be treated by speaking with an Imam?

Yes **No**

70. Can depression be treated by visiting the grave of a martyr?

Yes **No**

71. Can depression be treated by wearing taweez?

Yes **No**

72. If not treated, does depression make one more vulnerable to other diseases?

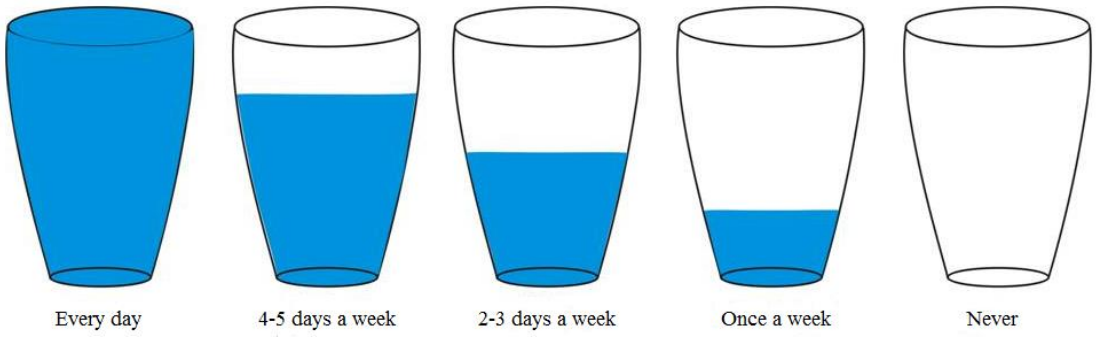
Yes **No**

73. If not treated, will depression get better by itself?

Yes **No**

III. EXPERIENCES WITH DISTRESS

Please think about the last 2 weeks for each of the following questions. For each question, please select the best answer. You can point to the cup that best describes your answer. The empty cup means "Never", the next cup means 1 day each week, the middle cup means 2-3 days each week, the next cup means 4-5 days each week, and the full cup means "Everyday".



1. During the last 2 weeks, how many times have you cried?

   Never **1 day/week** **2-3 days/week** **4-5 days/week** **Everyday**

2. During the last 2 weeks, how many times have you had a lack of appetite?

   Never **1 day/week** **2-3 days/week** **4-5 days/week** **Everyday**

3. During the last 2 weeks, how many times have you had difficulty falling asleep?

   Never **1 day/week** **2-3 days/week** **4-5 days/week** **Everyday**

4. During the last 2 weeks, how many times have you had a quarrel with a family member?

   Never **1 day/week** **2-3 days/week** **4-5 days/week** **Everyday**

5. During the last 2 weeks, how many times have you had a quarrel with a neighbor or friend?

   Never **1 day/week** **2-3 days/week** **4-5 days/week** **Everyday**

6. During the last 2 weeks, how many times have you felt hopeless?

Never **1 day/week** **2-3 days/week** **4-5 days/week** **Everyday**

7. During the last 2 weeks, how many times have you beat someone in your family?

Never **1 day/week** **2-3 days/week** **4-5 days/week** **Everyday**

8. During the last 2 weeks, how many times have you isolated yourself socially?

Never **1 day/week** **2-3 days/week** **4-5 days/week** **Everyday**

9. During the last 2 weeks, how many times have you felt sad?

Never **1 day/week** **2-3 days/week** **4-5 days/week** **Everyday**

10. During the last 2 weeks, how many times have you become *jigar khun*?

Never **1 day/week** **2-3 days/week** **4-5 days/week** **Everyday**

11. During the last 2 weeks, how many times have you had a headache?

Never **1 day/week** **2-3 days/week** **4-5 days/week** **Everyday**

12. During the last 2 weeks, how many times have you had a nightmare?

Never **1 day/week** **2-3 days/week** **4-5 days/week** **Everyday**

13. During the last 2 weeks, how many times have you felt irritable?

Never **1 day/week** **2-3 days/week** **4-5 days/week** **Everyday**

14. During the last 2 weeks, how many times have you felt easily startled? For example, how many times have you become afraid when you've heard a sudden noise?

Never **1 day/week** **2-3 days/week** **4-5 days/week** **Everyday**

15. During the last 2 weeks, how many times have you experienced bad memories you can't get rid of?

Never **1 day/week** **2-3 days/week** **4-5 days/week** **Everyday**

16. During the last 2 weeks, how many times have you been thinking too much?

Never **1 day/week** **2-3 days/week** **4-5 days/week** **Everyday**

17. During the last 2 weeks, how many times have you experienced *asabi*?

Never **1 day/week** **2-3 days/week** **4-5 days/week** **Everyday**

18. During the last 2 weeks, how many times have you had trouble remembering things?

Never **1 day/week** **2-3 days/week** **4-5 days/week** **Everyday**

19. During the last 2 weeks, how many times have you beaten or hurt yourself?

Never **1 day/week** **2-3 days/week** **4-5 days/week** **Everyday**

20. During the last 2 weeks, how many times have you felt *fishar e bala* (internal agitation)?

Never **1 day/week** **2-3 days/week** **4-5 days/week** **Everyday**

21. During the last 2 weeks, how many times have you felt *fishar e payin* (low energy)?

Never **1 day/week** **2-3 days/week** **4-5 days/week** **Everyday**

22. During the last 2 weeks, how many times have you had difficulty meeting your responsibilities at home or at work because of *jigar khuni, fishar,* or *asabi?*

Never **1 day/week** **2-3 days/week** **4-5 days/week** **Everyday**

23. During the last 2 weeks, how many times have you had trouble concentrating?

Never **1 day/week** **2-3 days/week** **4-5 days/week** **Everyday**

1. In the last month, how often have you been upset because of something that happened unexpectedly?

Never **Almost Never** **Sometimes** **Fairly Often** **Very Often**

2. In the last month, how often have you felt that you were unable to control the important things in your life?

Never **Almost Never** **Sometimes** **Fairly Often** **Very Often**

3. In the last month, how often have you felt nervous and "stressed"?

Never **Almost Never** **Sometimes** **Fairly Often** **Very Often**

4. In the last month, how often have you felt confident about your ability to handle your personal problems?

Never **Almost Never** **Sometimes** **Fairly Often** **Very Often**

5. In the last month, how often have you felt that things were going your way?

Never **Almost Never** **Sometimes** **Fairly Often** **Very Often**

6. In the last month, how often have you found that you could not cope with all the things that you had to do?

Never **Almost Never** **Sometimes** **Fairly Often** **Very Often**

7. In the last month, how often have you been able to control irritations in your life?

Never **Almost Never** **Sometimes** **Fairly Often** **Very Often**

8. In the last month, how often have you felt that you were on top of things?

Never **Almost Never** **Sometimes** **Fairly Often** **Very Often**

9. In the last month, how often have you been angered because of things that were outside of your control?

Never **Almost Never** **Sometimes** **Fairly Often** **Very Often**

10. In the last month, how often have you felt difficulties were piling up so high that you could not overcome them?

Never **Almost Never** **Sometimes** **Fairly Often** **Very Often**

APPENDIX D

Questionnaire (Dari Version)

LOMA LINDA
UNIVERSITY

سروی صحی و تجربه زنده گی افغانان

قیـــس عالمی، کاندید (PhD)

پوهنتون لومه لندا

شماره سروی: _____

تلیفون: (619) 212-1275
ایمل: qalemi05p@llu.edu

I. آمار نفوس

میخواهم در باره شما بدانم. لطفآ به سوالات زیر تا حد امکان پاسخ ارایه بدارید:

1. چند ساله استید؟ _____

2. جنس:
الف. مذکر
ب: مونث

3. حالت مدنی:
الف: متاهل
ب: طلاق و یا جدا شده
ج: بیوه
د: هیچگاه ازدواج نکرده

4. چند سال مکتب خوانده اید؟ _____

5. بلندترین درجه تحصیل:
الف: کمتر از لیسه
ب: دوازه پاس
ج: درجه لیسانس
د: مافوق لیسانس/ دوکتورا ویا معادل آن

6. به کدام گروه قومی تعلق میگیرید؟
الف: هزاره
ب: نورستانی
ج: پشتون
د: تاجک
و: ازبک
ه: دیگر، لطفآ مشخص سازید: _____

7. حالت حقوقی تان در زمان ورود به امریکا:
الف: محاجر
ب: پناهجو
ج: دیگر، لطفآ مشخص سازید: _____

8. سال ورود به امریکا: _____

9. چند سال در دوران جنگ در افغانستان زنده گی نموده اید: _____

10. وضعیت شغلی تان چگونه است؟
الف: مستخدم (مشغول کار)
ب: بیکار
ج: متقاعد
د: معزور (غیرفعال)

11. آیا میتوانید به راحتی مصارف ماهانه خود را با درآمد خانواده گی که دارید بپردازید؟
الف: بلی
ب: نخیر

الویت زبان

علاقه دارم درابطه به قابلیت های مکالماتی و الویت های زبانی تان بدانم. لطفآ بهترین جواب را دررابطه بخود حلقه نماید.

1. اولین زبان را که یادگرفتـــید تا صحبت نماید، کدام بود؟

انگلیسی **انگلیسی و دری/پشتو بطور هم زمان** **دری/پشتو** **دیگر**

2. به نظر شما چگونه بخوبی میتوانید دری/پشتو صحبت نماید؟

خیلی خوب **تا حدی خوب** **خیلی خوبه نه** **هیچ**

3. به نظر شما چگونه بخوبی میتوانید انگلیسی صحبت نماید؟

خیلی خوب **تا حدی خوب** **خیلی خوبه نه** **هیچ**

4. به نظر شما چگونه بخوبی میتوانید انگلیسی بخوانید ؟

خیلی خوب **تا حدی خوب** **خیلی خوبه نه** **هیچ**

5. با همسر تان معمولآ
به کدام زبان صحبت مینماید؟
(یا نامزاد ویا نزدیکترین دوست تان، اگر ازدواج نکردید)

تنها انگلیسی **اضافتر انگلیسی** **تنها دری/پشتو** **اضافتر دری/پشتو** **بطور مساویانه**

6. با اطفال تان معمولآ
به کدام زبان صحبت مینماید؟
(ویا با اعضای فامیل که اطفال استند، اگر شما خودتان اولاد ندارید)

تنها انگلیسی **اضافتر انگلیسی** **تنها دری/پشتو** **اضافتر دری/پشتو** **بطور مساویانه**

7. با والدین تان معمولآ
به کدام زبان صحبت مینماید؟
(یا با اعضای سالمند فامیل، اگر خودتان والدین ندارید)

تنها انگلیسی **اضافتر انگلیسی** **تنها دری/پشتو** **اضافتر دری/پشتو** **بطور مساویانه**

8. در تجماعات فامیلی معمولآ به کدام زبان صحبت مینمای

تنها انگلیسی اضافتر انگلیسی تنها دری/پشتو اضافتر دری/پشتو بطور مساویانه

ارتباط یا شبکه اجتماعی

علاقه دارم در باره ارتباطات تان با اقارب و دوستان تان بدانم. لطفآ بهترین جواب را حلقه نماید.

با در نظرداشت اشخاص که با آنها روابط خانواده گی و یا خوایشاوندی دارید

1. تعدادی اقاربی تان که با آنها کم از کم یکبار در ماه به تماس هستید.

0 1 2 4-3 8-5 9 و یا اضافه

2. تعدادی اقاربی تان که میتوانید با احساس راحتی مسایل شخصی تان را با ایشان شریک نماید.

0 1 2 4-3 8-5 9 و یا اضافه

3. تعدادی اقاربی تان که با آنها احساس نزدیکی نموده و در وقت ضرورت بالای شان حساب کنید؟

0 1 2 4-3 8-5 9 و یا اضافه

با درنظرداشت دوستان تان بشمول آنهای که در همسایگی تان زندگی می نمایند

4. تعدادی دوستانی تان که با آنها کم از کم یکبار در ماه به تماس هستید.

0 1 2 4-3 8-5 9 و یا اضافه

5. تعدادی دوستانی که میتوانید با احساس راحتی مسایل شخصی تان با ایشان شریک نماید.

0 1 2 4-3 8-5 9 و یا اضافه

6. تعدادی دوستانی که با آنها احساس نزدیکی نموده و در وقت ضرورت بالای شان حساب کنید؟

0 1 2 4-3 8-5 9 و یا اضافه

II. نظرات در رابطه به افسرده گی

میخواهم نظر تان را در باره علل افسرده گی بدانم. لطفآ جواب مطلوب تان را در باره اظهارات ذیل حلقه نماید:

1. آیا افسرده گی به احتمال زیاد در مردمانی است که نمیتوانند در فرهنگ امریکایی عادت کنند؟

بلی نخیر

2. آیا افسرده گی به احتمال زیاد در مردمانی است که مرض مزمن دارند؟

بلی نخیر

3. آیا افسرده گی به احتمال زیاد در مردمانی است که خانواده نزدیک در اطراف خود داردند؟

بلی نخیر

4. آیا افسرده گی به احتمال زیاد در مردمانی است که خانه های شان بخاطر افراد یا اشیا تلاشی شده است؟

بلی نخیر

5. آیا افسرده گی به احتمال زیاد در مردمانی است که نداشتن غذا یا آب آشامیدنی را تجربه نموده اند؟

بلی نخیر

6. آیا افسرده گی به احتمال زیاد در مردمانی است که قابلیت راننده گی را دارند؟ ؟

بلی نخیر

7. آیا افسرده گی به احتمال زیاد در مردمانی است که یک عضو فامیل افسرده دارند؟

بلی نخیر

8. آیا افسرده گی به احتمال زیاد در مردمانی است که می آموزند انگلیسی صحبت کنند؟

بلی نخیر

9. آیا افسرده گی به احتمال زیاد در مردمانی است که فرهنگ و شناخت خود را حفظ نموده اند ؟

بلی نخیر

10. آیا افسرده گی به احتمال زیاد در مردمانی است که اطفال زیاد دارند؟

بلی نخیر

11. آیا افسرده گی به احتمال زیاد در مردمانی است که مسن استند؟

بلی نخیر

12. آیا افسرده گی به احتمال زیاد در بین اطفال است؟

بلی نخیر

13. آیا افسرده گی به احتمال زیاد در مردمانی است که اطفال شاه دیپلوم کالج دریافت میکنند؟

بلی نخیر

14. آیا افسرده گی به احتمال زیاد در خانما است؟

بلی نخیر

15. آیا افسرده گی به احتمال زیاد در مرد ها است ؟

بلی نخیر

16. آیا افسرده گی به ارث برده میشود؟

بلی نخیر

17. آیا افسرده گی به احتمال زیاد در مردمانی است که از آینده خود مطمین هســتند؟

بلی نخیر

18. آیا افسرده گی به احتمال زیاد در مردمانی است که افرادی به سن و سال خود دارند تا با آنها صحبت کنند؟

بلی نخیر

19. آیا ترک خانه توسط اطفال به علت های مانند ازدواج باعث افسرده گی میگردد؟

بلی نخیر

20. آیا پوشیدن لباس های غربی توسط جوانان باعث افسرده گی می شود؟

بلی نخیر

21. آیا داشتن خاطرات بی وطنی در ایران ویا پاکستان علامت افسرده گی است؟

بلی نخیر

فعلاً میخواهم نظرتان را درباره علایم افسرده گی بدانم. لطفاً جواب مطلوب تان را در باره اظهارات ذیل حلقه نماید:

22. *عصبی* علامه افسرده گی است؟

بلی نخیر

23. *گوشه گیری* علامه افسرده گی است؟

بلی نخیر

24. آیا غمگین بودن علامه افسرده گی است ؟

بلی نخیر

25. آیا رنگ پریده گی علامه افسرده گی است؟

بلی نخیر

26. آیا یک شخص با افسرده گی قادر به تمرکز فکری بشکل عادی است؟

بلی نخیر

27. آیا مردم با افسرده گی میتوانند که تصمیم بگیرند؟

بلی نخیر

28. آیا تشنج در گردن و شانه ها علامت افسرده گی است؟

بلی نخیر

29. آیا سوزش و خارش جلد علامت افسرده گی است؟

بلی نخیر

30. آیا مردم با افسرده گی احساس انرژی مینمایند؟

بلی نخیر

31. آیا آروق زدن بیش از حد علامت افسرده گی است؟

بلی نخیر

32. آیا سردردی علامه افسرده گی است؟

بلی نخیر

33. آیا اسهال علامت افسرده گی است؟

بلی نخیر

34. آیا قبظیت علامت افسرده گی است؟

بلی نخیر

35. آیا داشتن مزه تلخ در دهن علامت افسرده گی است؟

بلی نخیر

36. آیا سرگیچی علامه افسرده گی است؟

بلی نخیر

37. آیا درد شکم علامه افسرده گی است؟

بلی نخیر

38. آیا کف های دست بیش از حد عرق پر علامت افسرده گی است؟

بلی نخیر

39. آیا مشکلات تنفسی حتی در وقت استراحت علامت افسرده گی است؟

بلی نخیر

40. آیا شنیدن صدا های (بزبز) در گوش یا سر علامت افسرده گی است؟

بلی نخیر

41. آیا از دست دادن اشتها علامت افسرده گی است؟

بلی نخیر

42. آیا احساس گرمی یا سوزش در سر علامت افسرده گی است؟

بلی نخیر

43. آیا مشکلات در بلع یا قرت کردن علامت افسرده گی است؟

بلی نخیر

44. آیا تجربه داشتن غبار یا تاریکی جلو چشم ها علامت افسرده گی است؟

بلی نخیر

45. آیا دفعتآ بدون کدام موجب ترسیدن علامت افسرده گی است؟

بلی نخیر

46. آیا احساس درد یا سوزش در چشم ها علامت افسرده گی است؟

بلی نخیر

47. آیا سو، هاضمه علامت افسرده گی است؟

بلی نخیر

48. آیا احساس سوزن سوزن شدن در تمام بدن علامت افسرده گی است؟

بلی نخیر

49. آیا درد در قلب ویا سینه علامت افسرده گی است؟

بلی نخیر

50. آیا باربار دیدن خواب های ناراحت کننده علامت افسرده گی است؟

بلی نخیر

51. آیا داشتن دست ها یا پا های سرد علامت افسرده گی است؟

بلی نخیر

52. آیا جگرخونی علامت افسرده گی است؟

بلی نخیر

حالا میخواهم نظرتان را در رابطه به علاج و عواقب افسرده گی، اگر علاج نشود، بدانم. لطفآ جواب مطلوب تان را در باره اظهارات ذیل حلقه نماید:

53. آیا افسرده گی علاج دارد؟

بلی نخیر

54. آیا روانشناس بهترین کسی است که افسرده گی را تداوی می نماید؟

بلی نخیر

55. آیا طبیب (متخصص گیاهی) میتواند افسرده گی را تداوی کند؟

بلی نخیر

56. آیا افسرده گی با نوشیدن چای تداوی شده میتواند؟

بلی نخیر

57. آیا افسرده گی با گوش دادن به موسیقی افغانی تداوی شده میتواند؟

بلی نخیر

58. آیا افسرده گی با تداوی بیماری های دیگر تداوی شده میتواند؟

بلی نخیر

59. آیا افسرده گی با خوردن قرص های خواب آور تداوی شده میتواند؟

بلی نخیر

60. آیا افسرده گی با دوا های گیاهی تداوی شده میتواند؟

بلی نخیر

61. آیا افسرده گی با دواهای ضد افسرده گی تداوی شده میتواند؟

بلی نخیر

62. آیا افسرده گی با اسپرین تداوی شده میتواند؟

بلی نخیر

63. آیا افسرده گی با خوردن غذا های درست تداوی شده میتواند؟

بلی نخیر

64. آیا افسرده گی با سپورت نمودن تداوی شده میتواند؟

بلی نخیر

65. آیا افسرده گی با استراحت تداوی شده میتواند؟

بلی نخیر

66. آیا افسرده گی با دیدار از افغانستان تداوی شده میتواند؟

بلی نخیر

67. آیا افسرده گی با دعا و خواندن نماز میتواند تداوی شود؟

بلی نخیر

68. آیا افسرده گی با تلاوت قران تداوی شده میتواند؟

بلی نخیر

69. آیا افسرده گی با صحبت نمودن با امام تداوی شده میتواند؟

بلی نخیر

70. آیا افسرده گی با دیدار از مزار شهدا تداوی شده میتواند؟

بلی نخیر

71. آیا افسرده گی با پوشیدن تاویز تداوی شده میتواند؟

بلی نخیر

72. اگر تداوی نشود، آیا افسرده گی یک شخص را آسیب پذیر در مقابل امراض دیگر میسازد؟

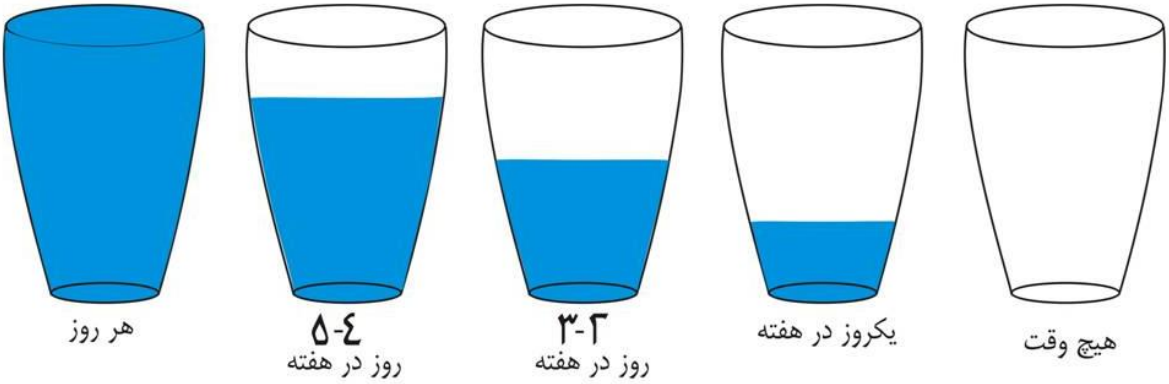
بلی نخیر

73. اگر تداوی نشود، آیا افسرده گی خود بخود بهبود میابد؟

بلی نخیر

III. پرسشنامه صحت رواني

سوالهاي ذيل را به اساس سرگذشت دو هفته گذشته ات جواب بدهيد.



1. در دوهفته گذشته خودت چند بار گريه كردي؟

هيچوقت يكروزدرهفته 2-3 روز درهفته 4-5 روز درهفته هرروز

2. در دو هفته گذشته خودت چند بار اشتها نداشتي؟

هيچوقت يكروزدرهفته 2-3 روز درهفته 4-5 روز درهفته هرروز

3. در دو هفته گذشته شمارا چندبارخواب نميبرد ؟

هيچوقت يكروزدرهفته 2-3 روز درهفته 4-5 روز درهفته هرروز

4. در دو هفته گذشته شما چند بار همراى فاميل تان جنجال نموده ايد؟

هيچوقت يكروزدرهفته 2-3 روز درهفته 4-5 روز درهفته هرروز

5. در دوهفته گذشته شمام چندبار با همسايه هاويا دوستان تان جنجال نموده ايد؟

هيچوقت يكروزدرهفته 2-3 روز درهفته 4-5 روز درهفته هرروز

6. در دو هفته گذشته شما چند بار خود را نا اميد احساس نموده ايد؟

هيچوقت يكروزدرهفته 2-3 روز درهفته 4-5 روز درهفته هرروز

7. در دو هفته گذشته خودت چند بار اعضاي فاميل تان را لت كردي؟

هيچوقت يكروزدرهفته 2-3 روز درهفته 4-5 روز درهفته هرروز

8. در دو هفته گذشته خودت چند بار گوشه گیری اختیار نموده ای؟

هيچوقت يكروزدرهفته 2-3 روز درهفته 4-5 روز درهفته هرروز

9. در دو هفته گذشته خودت چند بار غمگين بودي؟

هيچوقت يكروزدرهفته 2-3 روز درهفته 4-5 روز درهفته هرروز

10. در دو هفته گذشته خودت چند بار جگر خون شدي؟

هيچوقت يكروزدرهفته 2-3 روز درهفته 4-5 روز درهفته هرروز

11. در دو هفته گذشته خودت چند بار سر دردي داشتي؟

هيچوقت يكروزدرهفته 2-3 روز درهفته 4-5 روز درهفته هرروز

12. در دو هفته گذشته خودت چند بار خواب خراب ديدي و ترسيدي؟

هيچوقت يكروزدرهفته 2-3 روز درهفته 4-5 روز درهفته هرروز

13. در دو هفته گذشته خودت چند بار زود آزرده شدي؟

هيچوقت يكروزدرهفته 2-3 روز درهفته 4-5 روز درهفته هرروز

14. در دو هفته گذشته خودت چند باروارخطاشدي؟ مثلاً از صداي بلند؟

هيچوقت يكروزدرهفته 2-3 روز درهفته 4-5 روز درهفته هرروز

15. در دو هفته گذشته خودت چند بار خاطرات بد كه ميخواستی فراموش كنی باز هم بيادت آمد ؟

هيچوقت يكروزدرهفته 2-3 روز درهفته 4-5 روز درهفته هرروز

16. در دو هفته گذشته خودت چند بار چرتی بودي؟

هيچوقت يکروزدرهفته 2-3 روز درهفته 4-5 روز درهفته هرروز

17. در دو هفته گذشته خودت چند بار عصبي شدي؟

هيچوقت يکروزدرهفته 2-3 روز درهفته 4-5 روز درهفته هرروز

18. در دو هفته گذشته خودت چند بار ياد فراموشي کردي؟

هيچوقت يکروزدرهفته 2-3 روز درهفته 4-5 روز درهفته هرروز

19. در دو هفته گذشته خودت چند بار خودرا لت کردي؟

هيچوقت يکروزدرهفته 2-3 روز درهفته 4-5 روز درهفته هرروز

20. در دو هفته گذشته چند بار فشارت پايين (کسالت) رفته؟

هيچوقت يکروزدرهفته 2-3 روز درهفته 4-5 روز درهفته هرروز

21. در دو هفته گذشته چند بار فشارت بالا (بی قراری) رفته؟

هيچوقت يکروزدرهفته 2-3 روز درهفته 4-5 روز درهفته هرروز

22. در دو هفته گذشته خودت چند بار به نسبت جگرخوني به کارهاي خود در خانه يادر محل کار رسيدگي کرده نتوانستي؟

هيچوقت يکروزدرهفته 2-3 روز درهفته 4-5 روز درهفته هرروز

23. در دو هفته گذشته چند بار فکرت جمع نبود؟

هيچوقت يکروزدرهفته 2-3 روز درهفته 4-5 روز درهفته هرروز

1. در ماه گذشته، چند بار بخاطر کدام اتفاق غیرمترقبه ناراحت بوده اید؟

هیچگاه تقریباً هیچگاه بعضاً نسبتاً اغلب اغلب

2. در ماه گذشته، چند بار شما احساس کرده اید که قادر به کنترول کردن چیزهای مهم در زنده گی تان نبوده اید؟

هیچگاه تقریباً هیچگاه بعضاً نسبتاً اغلب اغلب

3. در ماه گذشته، چند بار خود را عصبی و "زیر فشار" احساس نموده اید؟

هیچگاه تقریباً هیچگاه بعضاً نسبتاً اغلب اغلب

4. در ماه گذشته، چند بار با اطمینان احساس نموده اید که قابلیت رسیده گی به مشکلات شخصی تان را دارید؟

هیچگاه تقریباً هیچگاه بعضاً نسبتاً اغلب اغلب

5. در ماه گذشته، چند بار احساس نموده اید که چیزها طبق خواهش شما اتفاق افتاده است؟

هیچگاه تقریباً هیچگاه بعضاً نسبتاً اغلب اغلب

6. در ماه گذشته، چند بار دریافتید که نتوانسته اید با تمام چیزها که میخواستید مقابله نماید؟

هیچگاه تقریباً هیچگاه بعضاً نسبتاً اغلب اغلب

7. در ماه گذشته، چند بار قابلیت کنترول نمودن ناراحتی را در زنده گی تان داشته اید؟

هیچگاه تقریباً هیچگاه بعضاً نسبتاً اغلب اغلب

8. در ماه گذشته، چند بار شما احساس نموده اید که به کار های تان بصورت شاسته رسیده گی نموده اید؟

هیچگاه تقریباً هیچگاه بعضاً نسبتاً اغلب اغلب

9. در ماه گذشته، شما چند بار بخاطریکه چیزها از کنترول شما خارج بوده، قهر شده اید؟

هیچگاه تقریباً هیچگاه بعضاً نسبتاً اغلب اغلب

10. در ماه گذشته، چند بار احساس نموده اید که مشکلات افزود شده و شما نتوانسته اید که با آنها مقابله نماید؟

هیچگاه تقریباً هیچگاه بعضاً نسبتاً اغلب اغلب

APPENDIX E

Informed Consent Document

LOMA LINDA
UNIVERSITY

School of Science and Technology
Department of Social Work & Social Ecology
1898 Business Center Drive, San Bernardino, CA 92408

(909) 379-7570
FAX: (909) 379-7594
Email: sowk@llu.edu

Informed Consent Document

Afghan Health and Life Experiences Survey

Dear Friend,

Purpose

My name is Qais Alemi. I'm a doctoral student at Loma Linda University in the Social Policy & Social Research program. The purpose of this research study is for me to learn about your beliefs about depression and some of your experiences with stress. You are being invited to take part in this research study because you are an adult Afghan who came to this country as a refugee or asylum seeker.

Procedures

You will be asked to take part in a survey for about 20 minutes on one occasion. The survey will take place at a local mosque/community center or at a time and place of your choice. You can either complete the survey on your own, or I can read the questions to you and you could give me an answer to each question. Also, a female Afghan research assistant will join me during the interview. The survey asks questions about your beliefs on the causes, symptoms, and treatments for depression. Some questions that will be asked in the survey include: 1) "Is depression more likely in those who are able to drive?" 2) "Are headaches a symptom of depression?" 3) "If not treated, can depression lead to diabetes?"

Risks

There are minimal risks to you in taking part in this study. This means there is the possibility that confidentiality could be breached. In order to protect your identity the information you provide on the survey will be kept private. This means that your name/identity will not be revealed in any papers, presentations, and reports coming out of this study. Also, for further protecting your identity, I will assign a unique code to your particular survey. Data from this study will be stored in a locked cabinet in a locked room in the Department of Social Work and Social Ecology at Loma Linda University. Information from surveys will be entered into a computer data file, linked to the unique code assigned to you, will be password protected, and only members of the research team will have access to it.

Benefits

You will not benefit personally from completing the survey, but your participation in this study might help in better understanding cultural views about depression among Afghans, which could lead to more effective prevention and intervention programs for Afghans who seek care.

Loma Linda University
Adventist Health Sciences Center
Institutional Review Board
Approved 8/27/12 Void after 8/27/2013
5120217 Chair R L Rugleymd

Rights

Participation in this survey is entirely voluntary. This means that if at any time during the interview or while completing the survey you find that you do not wish to take part you may refuse to continue. If you do not want to answer a certain question you may decline. Your decision of whether or not to take part in this study or end the survey will not affect your present or future relationship with Qais Alemi, his research advisor, or any related organization.

Additional Costs/Reimbursements

There will be no cost to you for taking part in this study. As a sign of appreciation for your participation a $10 donation will be made on your behalf to a local mosque of your choice after the interview is completed.

Impartial 3rd Party Contact

If you want to contact an impartial third party not part of this study about any questions or complaints you may have about this study, you may contact the Office of Patient Relations, Loma Linda University Medical Center, Loma Linda, CA 92354, phone (909) 558-4647, patientrelations@llu.edu for information and assistance.

Informed Consent Statement

If your questions about this research study have been answered, and you do not have any more questions after Qais Alemi's explanation of the consent form – you can simply provide a verbal response to him regarding your agreement to complete the survey. But please understand that by agreeing to take part in this research study, you are not waiving your rights. Also, your willingness to take part in this study does not release Qais Alemi, his institution or sponsors from their responsibilities. You may call Qais Alemi during routine office hours at (909) 379-7572 or contact him by e-mail at qalemi05p@llu.edu if you have additional questions or concerns. You may also contact his research advisor, Sigrid James, PhD, MSW at (909) 379-7591 during routine office hours or by e-mail at ssjames@llu.edu. You may keep this consent form for your records, which has been signed by Qais Alemi.

Investigator's Attestation

I have reviewed the contents of this consent form with the person signing above. I have explained potential risks and benefits of the study. A signed copy of the consent form has been provided to the participant, and I have also kept a copy for myself, which includes a unique code that identifies the individual – written at the top of the first page.

_____ _____

Signature of Investigator Date

Qais Alemi, PhD©, MPH, MBA
Dept. of Social Work & Social Ecology
School of Behavioral Health
Loma Linda University

Loma Linda University
Adventist Health Sciences Center
Institutional Review Board
Approved 8/27/12 Void after 8/22/2013
5120217 Chair R L Rigsby MD