

The Concept of Depression in Afghan Refugees

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Introduction

Depression is one of the most common issues for which patients from any population are seen by primary care providers.¹ For patients with a refugee background, depression is especially prevalent, along with other psychological conditions such as post-traumatic stress disorder (PTSD) and anxiety. Refugees experience displacement and disruption of life during the resettlement process, and many refugees are also exposed to trauma and violence, which play a role in the development of depression. People from Afghanistan comprise a significant portion of the refugee population in Charlottesville, VA, who receive care at the University of Virginia International Family Medicine Clinic. This paper provides an overview of the conceptualization, symptoms, and treatment of depression in the cultural context of refugees from Afghanistan using a patient case and published literature, and includes an appendix of a validated, culturally-adapted symptom checklist for mental health assessment research.

Case Presentation

Ms. N is a 32 year old Dari-speaking woman from Afghanistan who arrived in the United States three years ago under a Special Immigrant Visa with her husband, a former interpreter for the U.S. military. Her past medical history is significant for iron deficiency anemia and uterine fibroid *status post* myomectomy. She presents to clinic reporting that for the past few months she feels weak and tired every day, with associated “beeping” throughout her body. She also endorses constant pressure in her left ear. Each day, she develops a “beeping” on the right side of her head with a black screen coming down over her right eye, which quickly resolves. She has associated numbness around her mouth and pounding in her chest wall at times. She experiences whole body weakness, dizziness, and worsening headache with the episodes and must lie down, which improves her symptoms. Although she does not lose

consciousness during these episodes, she describes the experience as being “knocked out”. Ms. N believes her symptoms are related to the sedation she received during her recent surgery. Additionally, she reports a persistently low mood, with frequent crying, poor sleep, no appetite, and feelings of helplessness. She had tried taking citalopram for one week but stopped because it caused her to be “like a zombie” without expression. She has not seen her family in many years. Recently, she received news that her nephew was tragically killed in Kabul.

History of Afghan Migration

It is important to discuss and understand the historical and political contexts in which people from Afghanistan immigrated to the United States and other countries when caring for patients of this background.² Afghanistan has steadily endured multiple cycles of oppression, invasion, and civil war, leading to several waves of civilians exiting the country. Early Afghan immigrants arrived in the United States in the 1930s and 1940s. Most were from the upper classes, highly educated, and were trained in a profession. In the 1980s, large numbers of Afghan refugees arrived in the United States (about 2,000 to 4,000 per year), as well as in Pakistan and Iran, in the wake of the Soviet invasion in 1979.³ During this ten-year proxy war of the Cold War, with the Soviets backing an unpopular socialist Afghan government and the U.S. providing aid to small insurgent groups (the ‘*mujahedeen*’), it is estimated that over 500,000 civilians were killed,⁴ while over 2 million others fled the country.⁵ From the ashes of Afghanistan’s post-Soviet civil war rose the Taliban, a predominantly Pashtun Islamic fundamentalist political group, which ruled from 1996 until December 2001,⁶ when a U.S.-led invasion toppled the regime for providing refuge to al Qaeda.⁷ Many Afghan civilians fled the country out of fear of persecution from the Taliban.⁵ While the first Afghan arrivals to the U.S. had higher levels of

education and professions, later immigrants had fewer experiences with Americans and were less educated.³ Since 2007, the U.S. has authorized Special Immigrant Visas (SIV) that guarantee permanent lawful U.S. residence for Afghan and Iraqi citizens and their families, who were employed by the U.S. government as interpreters and other positions.⁸ It is an expensive application process and can be very slow, with an average processing time of 736 days.⁹ From 2015 to 2017, there was a substantial increase in the number of Afghans and their dependents who were granted SIVs: from 7,156 to 16,871, making up the vast majority of SIVs, compared to only 2,456 Iraqi citizens.⁸

Explanatory Models of Depression

Culture contributes significantly to how depression is experienced and what interventions are pursued.¹⁰ Understanding refugees' beliefs about the etiology of their depression in their own terms through explanatory models is especially important for providing appropriate, holistic care to refugees while reducing miscommunication between patients and clinicians. In many cultures, depression is thought of as situational, aligning with the belief that mental health problems arise from concurrent social problems rather than biological factors such as chemical imbalances and genetics.¹¹ As evident from the historical events outlined above, Afghan refugees have suffered extreme pre- and post-resettlement stressors, such as witnessing war atrocities, losing loved ones, socioeconomic hardships, cultural and intergenerational dissonance, and loss of status. Depression is indeed a recognized concept in Afghan culture. In the Dari language (derived from Persian), depression is termed *asfurdagi*, meaning low mood, grief, and sadness. Sadness or *gham* is said to result from hardships according to a 1991 study on Pashtun women living in Afghanistan. Another closely related term is *jigar khuni*, which may be more of a temporary reaction to an immediate event of interpersonal loss or a deeply painful experience in the form of grief or dysphoria.¹¹

Etiology and Risk Factors

Earlier studies from the 1990s focused on the effects of war trauma on the psychological well-being of Afghan refugees. One small study by Mghir and Raskin examined the effects of war on 38 adolescents and young adults and their parents from two different ethnic backgrounds, the Pashtun people and the Tajik people, living in Seattle, WA. The researchers interviewed the subjects using the Harvard Trauma Questionnaire (HTQ) to measure torture, war trauma, and PTSD, the Beck Depression Inventory (BDI), and the Hopkins Symptom Checklist-25 (HSCL-25) for anxiety and depression. They found that the Pashtun adolescents and young adults scored significantly higher on the BDI (more severe depression) and more often received a diagnosis of PTSD based on HTQ and DSM-III-R criteria than the Tajik subjects. Pashtun mothers also scored higher than their Tajik counterparts on the BDI and HSCL-25 depression score, while there were no significant differences between the Pashtun and Tajik fathers. Although both ethnic groups spent over four years in Afghanistan during the war and both experienced war trauma and subsequent resettlement in Pakistan and then the U.S., the Pashtuns had more first-hand experience with combat and torture. The Tajiks were more insulated from the effects of war; they were better educated and wealthier, which gave them an advantage in physical survival during wartime, having the means to more easily obtain food and other necessities and to leave the country. Significant correlations between the events experienced by the subjects and their overall depression and PTSD scores suggested that these social circumstances had a differential effect on the post-war mental health of these two groups.¹² From this and other studies, it is evident that there is serious negative impact of trauma associated with civil war on the mental health of multiple generations of Afghan refugee families, with a substantial portion of children suffering from undiagnosed psychological problems. Mental health screening by family medicine physicians and pediatricians is important to establish necessary prevention and treatment.¹³

A more recent study by Alemi *et al* in 2016 investigated beliefs about depression among Afghan residents in San Diego, CA, using qualitative “free listing” interviews, from which salient concepts and themes were used to construct culturally meaningful questionnaires which were later administered to 93 Afghan participants. The study found that explanatory models of depression were similar between men and women. Both groups believed depression to be caused by mild traumatic experiences, such as arbitrary searches and negative memories of being a refugee in Pakistan; cultural adjustments and cultural conflicts, including children leaving home after marriage; and interpersonal challenges, such as not having close family nearby or not having peers of a similar age to socialize with. Other causes included English language difficulties, transportation challenges, uncertainty about one’s future, and losing culture and identity. The identified risk factors for depression were being female, having a chronic disease, aging, and living with a depressed family member. Depression was not viewed as being inherited or prevalent among children. Regarding gender-specific beliefs, women endorsed having to care for a lot of children and having responsibility for children who wear Western or revealing clothing as causes of depression, which mirrors women’s social roles in Afghan culture.¹¹

Symptoms

Symptoms of depression reported in Afghan refugees include culturally relevant idioms of distress, such as *asabi* (meaning irritability and anger), *goshagiry* (self-isolation), *ghamgeen* (sadness), and *jigar khuni* (an immediate reaction of grief or dysphoria). Other universal symptoms include difficulty concentrating that affects daily functioning, indecisiveness, recurrent nightmares, thinking too much, loss of appetite, and many somatic complaints, such as tension or pain in the neck and shoulders, headaches, low energy, a feeling of pins and needles all over the body (perhaps similar to the “beeping” or perioral numbness described in the above patient case), and chest or heart pains.¹¹ The high prevalence of somatization in clinical practice was endorsed,

through personal interview, by a leading expert in refugee behavioral health at UVA, Dr. Richard L. Merkel.¹⁴ Of note, women tend to describe more symptoms as being part of depression than do men. For instance, in one study, women endorsed the following as symptoms of depression: paleness, a bitter taste in the mouth, dizziness, abdominal pain, hearing buzzing noises in the ears, experiences of darkness and mist in front of the eyes (both similarly described in our patient case), feelings of a hot or burning head, being suddenly scared for no reason, indigestion, and cold hands or feet. Men did not endorse these symptoms.¹⁰ One explanation for this discrepancy might be that women have higher distress experiences as measured by the Afghan Symptom Checklist¹⁵ (ASCL, see Appendix), even though both genders reported similar levels of social support, economic stability, and acculturation. Correlation analysis has shown significant negative relationships between women’s ASCL scores and employment, income, language proficiency, and being unmarried (including being widowed).¹¹ From personal interview with Ms. Erica Uhlmann, a case manager who works extensively with refugee families at the International Rescue Committee in Charlottesville, many Afghan women, especially those with SIVs, married to former interpreters for the U.S. military, have traditionally never worked outside the home and are very reluctant to begin employment upon arrival to the U.S., although there have been a number of successful transitions into the workforce.¹⁶

Treatment

Afghans have been found to view depression as a disorder that is curable, will not go away on its own, and, if left untreated, could lead to other diseases. With regards to seeking help from specialists, people believe that a psychiatrist can help treat depression. Medications, including both anti-depressants and herbal medicines, are believed to treat the disorder, whereas sleeping pills are not seen as effective.¹¹ From the clinical experience of Dr. Merkel at UVA, Afghan patients tend to be more reluctant than, for example, Bhutanese patients, to take anti-depressive medications, such

as SSRIs, and view them as a last resort.¹⁴ Treating other illnesses is also believed to help treat depression. Lifestyle changes include eating right, exercise, resting, listening to Afghan music, and visiting Afghanistan. Religious interventions include *namaaz* (prayer) and reciting the Qur'an. Again, there are some differences in beliefs about treatment between men and women. More so than men, women report consulting a *tabib* (herbal specialist) and seeking counsel from an Imam as treatments for depression.¹¹

Regarding Western psychotherapeutic approaches, Kananian *et al* performed a small pilot study to assess the feasibility and effectiveness of a twelve-week culturally adapted cognitive behavioral therapy (CBT) program for Farsi-speaking male Afghan refugees with mental health problems in Germany.¹⁷ CBT has been empirically shown to be an effective treatment for depression, among many other conditions, such as anxiety and somatoform disorder.¹⁸ In this pilot study of 9 male patients with one or more diagnoses of major depression, PTSD, panic disorder, and generalized anxiety disorder, the results indicated statistically significant and strong reductions in depression and anxiety after the completion of the culturally adapted CBT, which was held in a group setting. These results were accompanied by significant improvements in quality of life measures.¹⁷

Help- Seeking Behavior

In order for any treatment to be utilized and have efficacy, patients must be willing and able to seek out health care services. A recent study by Slewa-Younan *et al* in 2017 investigated the help-seeking behavior of 150 Afghan refugees living in South Australia. Forty-four percent of the participants had clinically significant PTSD symptoms and 14.7% had evidence of clinically significant depression. The most common source of help with regards to mental health problems were general practitioners, while very few participants reported seeking help from specialists in trauma and torture mental health services. However, the overall percentage of people who sought help remains low at about 50%. The study also found that only self-recognition of a mental health problem and

functional impairment levels were independently associated with help-seeking. These findings support the need for mental health promotion, particularly by primary care providers. In some circumstances, given that stigma surrounding mental illness still exists in Afghan and many other cultures, patients' expressed requests for biomedical care, such as medication, may actually serve as culturally acceptable or intelligible ways of communicating distress and seeking help.¹⁹ Healthcare providers should be aware of this possibility and keep their differential diagnosis open to include psychosocial issues. One plausible option to help patients obtain appropriate mental health care is to work with traditional healers or religious leaders, such as imams, trusted by the patient, who can assist with psycho-education and facilitate referrals to mental health services.¹¹

Approach to Asking about Mental Health

Many refugees want physicians to be interested in discussing the historical and political contexts of their symptoms. Although Afghans were not included, one 2014 study using focus groups of 111 refugees from Burma, Bhutan, Somalia, and Ethiopia yielded helpful advice for providers when addressing mental health issues.² Certain participants were quoted as saying, "Don't just focus on pain. There are histories that are causing pain", and "Connect pain to our problems at home". Participants also emphasized that physicians should take the time to make refugees feel comfortable and ask direct questions about mental health (e.g. about "worrying too much"). As some participants stated, "If you don't ask, I'm not going to answer". Focus group participants also preferred that physicians provide psychoeducation about health and assure patients that it is okay to talk about these issues. Other recommendations were to provide trained interpreters and cultural brokers, interview some family members separately (e.g. teenagers), and to use the family as an ally.² Similar strategies could be applied when caring for Afghan patients as well.

Conclusion

Depression is highly prevalent among individuals of a refugee background, especially

those from Afghanistan.^{5, 11, 12} Research has found that depression is viewed by many cultures as situational, caused by negative experiences such as war trauma, displacement and resettlement, and post-migration socioeconomic difficulties. While this paper discusses several documented beliefs of certain Afghan refugees on the concept, etiology, symptoms, and treatments of depression, it is important not to make generalizations based on cultural stereotypes about depression when caring for individual refugee patients. Rather, the information from the above studies should be used as a framework to guide in-depth discussions about a patient's cultural and personal preferences in order to provide appropriate support because, for

example, not all Afghans adhere to traditional customs or devoutly practice Islam. It is an undoubtedly challenging and time-consuming endeavor, but can be profoundly rewarding when a patient's quality of life after resettlement changes for the better. In returning to our patient case presented above, Ms. N had a negative cardiac work-up for her symptoms and will be returning to Afghanistan for the first time since coming to the U.S. to visit her family for a few months.

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Appendix

Note: The Afghan Symptom Checklist was developed as tool to be used by organizations doing mental health work in conflict and post-conflict situations to measure levels of psychological distress and assess the needs of the target population so that appropriate program planning and implementation can begin.¹⁵

Afghan Symptom Checklist

English Version

Sex _____

Age (best guess) _____

District _____

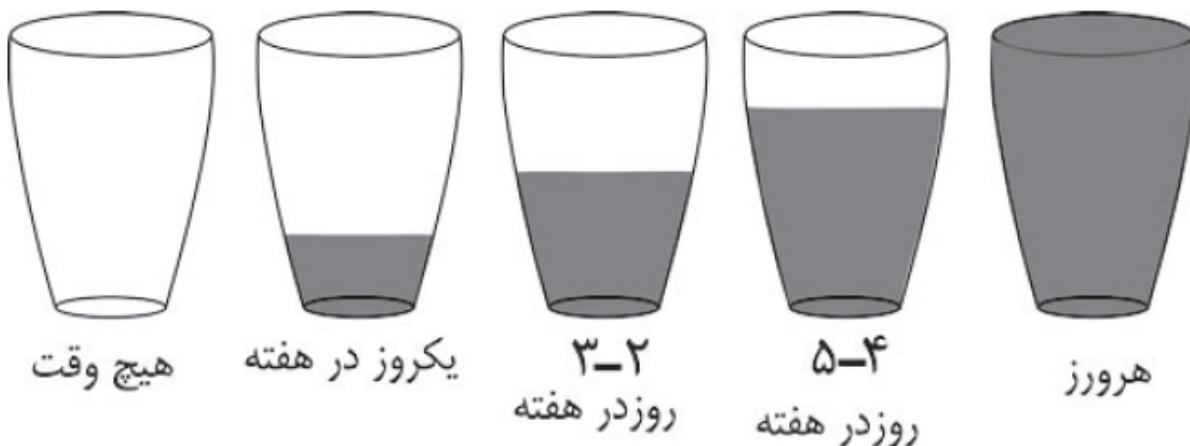
Marital status: Married _____ Single _____ Widowed _____

Number of children _____

Did you leave the country during the war? _____ Yes _____ No

Checklist continued on next page.

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?

1	2	3	4	5
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?

1	2	3	4	5
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?

1	2	3	4	5
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?

1	2	3	4	5
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?

1	2	3	4	5
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?

1	2	3	4	5
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?

1	2	3	4	5
never	1 day/week	2–3 days/week	4–5 days/week	everyday

Continued on next page.

8. During the last 2 weeks, how many times have you isolated yourself socially?
- | | | | | |
|-------|------------|---------------|---------------|----------|
| 1 | 2 | 3 | 4 | 5 |
| 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?
- | | | | | |
|-------|------------|---------------|---------------|----------|
| 1 | 2 | 3 | 4 | 5 |
| 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?
- | | | | | |
|-------|------------|---------------|---------------|----------|
| 1 | 2 | 3 | 4 | 5 |
| 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?
- | | | | | |
|-------|------------|---------------|---------------|----------|
| 1 | 2 | 3 | 4 | 5 |
| 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?
- | | | | | |
|-------|------------|---------------|---------------|----------|
| 1 | 2 | 3 | 4 | 5 |
| 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?
- | | | | | |
|-------|------------|---------------|---------------|----------|
| 1 | 2 | 3 | 4 | 5 |
| 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?
- | | | | | |
|-------|------------|---------------|---------------|----------|
| 1 | 2 | 3 | 4 | 5 |
| 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?
- | | | | | |
|-------|------------|---------------|---------------|----------|
| 1 | 2 | 3 | 4 | 5 |
| 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?
- | | | | | |
|-------|------------|---------------|---------------|----------|
| 1 | 2 | 3 | 4 | 5 |
| 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*?
- | | | | | |
|-------|------------|---------------|---------------|----------|
| 1 | 2 | 3 | 4 | 5 |
| 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?
- | | | | | |
|-------|------------|---------------|---------------|----------|
| 1 | 2 | 3 | 4 | 5 |
| 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?
- | | | | | |
|-------|------------|---------------|---------------|----------|
| 1 | 2 | 3 | 4 | 5 |
| 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 Bala* or *fishar payin*?
- | | | | | |
|-------|------------|---------------|---------------|----------|
| 1 | 2 | 3 | 4 | 5 |
| never | 1 day/week | 2-3 days/week | 4-5 days/week | everyday |
21. During the last 2 weeks, how many times have you had trouble concentrating?
- | | | | | |
|-------|------------|---------------|---------------|----------|
| 1 | 2 | 3 | 4 | 5 |
| 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 difficult meeting your responsibilities at home or at work because of *jigar khun*?
- | | | | | |
|-------|------------|---------------|---------------|----------|
| 1 | 2 | 3 | 4 | 5 |
| never | 1 day/week | 2-3 days/week | 4-5 days/week | everyday |