PeaceRep
Peace and Conflict Resolution Evidence Platform

AFGHANISTAN RESEARCH NETWORK

Addressing Afghan Refugee Mental Health through Culturally Fluent Interventions: A Call to Incorporate Lay Mental Health Workers while Addressing SDOH

Halima Ahmadi-Montecalvo, Amanda Terry, Rosalind Rogers

Afghanistan Research Network

This series highlights the work and analysis of the Afghanistan Research Network (ARN), a project convened by LSE / PeaceRep, and the Civic Engagement Project (CEP). The network brings together over 20 Afghan researchers (and several non-Afghans) with diverse expertise and backgrounds investigating a range of issues. This project aims to support Afghan researchers who were recently forced to leave Afghanistan; to ensure expert and analytical provision; inform contextually-appropriate international policies and practices on Afghanistan; and to deepen understanding of evolving political, security, and economic dynamics.

PeaceRep: The Peace and Conflict Resolution Evidence Platform
School of Law, Old College, The University of Edinburgh
South Bridge, Edinburgh EH8 9YL
Tel. +44 (0)131 651 4566
Fax. +44 (0)131 650 2005
E-mail: peacerep@ed.ac.uk
Website: PeaceRep.org
X: @Peace_Rep_

The Afghanistan Research Network is supported by the Peace and Conflict Resolution Evidence Platform (PeaceRep), funded by UK International Development from the UK government. However, the views expressed are those of the authors and do not necessarily reflect the UK government's official policies. Any use of this work should acknowledge the authors and the Peace and Conflict Resolution Evidence Platform.

About the authors:

Dr Halima Ahmadi-Montecalvo is a first-generation Afghan-American, a social and behavioral scientist, and epidemiologist with nearly 20 years of experience in social and behavioral research and evaluation work. She is the Associate Vice President of Research and Evaluation at Unite Us, where she leads evaluation efforts to measure the value of social care investments. Dr Ahmadi-Montecalvo's research focuses on the social drivers of health and health inequities, with a particular interest in issues explaining factors within the social and built environment that affect the lives of vulnerable population groups. She is also an adjunct public health professor at George Washington University.

Dr Amanda Terry is a medical anthropologist and public health professional with nearly 20 years of experience in community engaged research and applied mixed methods design. She is the Senior Director of Research and Evaluation at Unite Us, where she leads the company's qualitative research and evaluation efforts. Dr Terry's research focuses on the social drivers of health associated with maternal and child health outcomes and chronic disease prevention and management, with a particular interest in understanding the unique role culture and social capital play in driving health outcomes.

Dr Rosalind Ghafar Rogers is an Afghan-American Psychologist, specializing in global mental health and trauma, humanitarian mental healthcare, forced displacement, and substance use and co-occurring disorders. As a Clinical Behavioral Health Subject Matter Expert with the US Committee for Refugees and Immigrants (USCRI), she provides clinical expertise on interventions and services that support the mental health and psychosocial well-being of refugees. As a consultant for USCRI, Dr Rogers developed, implemented, and managed mental health and psychosocial support programs for Afghan evacuees under Operation Allies Welcome (OAW) and the care of the Office of Refugee Resettlement (ORR).

Contents

Introduction

The mental health needs of refugees are complex and cumulative. Individuals forced to flee their home countries due to violence, face multiple sources of distress during each phase of migration. Refugees present unique mental health diagnostic challenges because of complex combinations of pre-migration traumatic experiences and post-migration socio-cultural difficulties and acculturation challenges, often not found in non-refugee populations. The experience of migration itself carries risks for mental health issues that impede refugees' existing coping strategies, disrupt social support systems, and cause significant economic, cultural, professional, and social losses.

Prevalence of mental health conditions among refugees and asylum seekers vary within the academic literature, but it is generally accepted that rates of mental health conditions among these groups have been found to be similar to that of the general host country populations, with the exception of Post Traumatic Stress (PTS) and depression. Higher prevalence of PTS and depression among resettled refugees, compared with the general population, has been found to persist for years and even worsen over time, indicating that adverse socioeconomic conditions and acculturative factors do not necessarily lessen over time. This indicates that both short and long-term access to mental health services should be an important factor in host country planning to address the needs of refugee populations.[1]

While the world's attention for the plight of refugees and asylum seekers tends to shift with new global conflicts, this paper will highlight the challenges in diagnosing and delivering culturally appropriate mental health care for Afghan refugees in the United States [2] who report more significant psychological distress, adverse living conditions, and post-resettlement mental health problems than other migrant groups.[3,4,5,6]

The authors highlight the experiences of a number of newly resettled Afghan refugees throughout this paper. The first author, Halima Ahmadi-Montecalvo, documented anecdotes (with permission) from newly arrived Afghan refugees through her voluntary work in the resettlement process. Names and other identifying details have been changed throughout.

Unique Mental Health and Psychosocial Support Needs of Refugees in the US

Integration and Culture Shock

Farah is a 42-year-old journalist and activist who fled Afghanistan with her two daughters. They left Kabul airport on a military plane and ended up on a military base in Qatar, where they stayed for two weeks. She recalls their experience on the base, stating "*We were lucky to be able to leave Kabul. We left in a military plane and landed in Qatar, where we remained in a military base for weeks but it felt like months. It was so hot and uncomfortable, with hundreds of people crowded together. Of course, I'm grateful and relieved that we were able to get out of Afghanistan and away from the Taliban, but I also feel a tremendous sense of loss. I lost my country, my identity, a life I had spent decades building.*"

For Afghan refugees in the US perhaps one of the biggest barriers they face is navigating a complex cultural landscape after leaving behind everything that is familiar. Not only are there cultural differences in values, language, religion, gender norms, and family structure and dynamics between the US and Afghanistan but there are also structural barriers in place that make access to resources and services more difficult. These cultural integration stressors may place Afghan refugees at a higher risk of developing symptoms of depression, anxiety, PTS, and related somatic health symptoms. Paired with the stress of dealing with survivors' guilt, traumatic experiences, and socioeconomic challenges, the process of resettlement in the US can be long and difficult for Afghan refugees.

Stigma

Farid, a 40-year-old Afghan refugee who was a physician and professor in Kabul, mentioned a recent incident in a store. He explained that he walked into the store with his eight-year old son and they were followed around by the store security guard. "I tried to ask the guard why he was following us but he got very angry and grabbed my arm and walked me toward the exit door." He went on to say that it was "one of the most humiliating experiences I've ever had, especially in front of my son. I am still confused about why I was treated that way." He went on to say that if he was fluent in English perhaps he could have better communicated with the security guard and not been treated the way he was."

It is well recognized that feeling connected and not isolated from society are important for mental health outcomes among refugees. Yet, instances of stigma and discrimination experienced by Afghan refugees, as illustrated by Farid's story, preclude the ability to inherently trust institutions, organizations, or individuals, making it difficult to establish meaningful social connections. This, in turn, can deter refugees who would otherwise benefit from assistance, from seeking community support, and learning how to navigate systems to meet their basic needs.[7]

Social Support

Refugees' social support networks have been systematically eroded by the migration process, which in turn, adversely impacts their mental health, wellbeing, and integration into the host country. Four decades of war and conflict in Afghanistan have violated social relationships and undermined many Afghan refugees' ability to trust. Due to forced migration, Afghan refugees have been separated from their family members, friends, and community ties, contributing to social losses and resulting in the breakdown of vital support systems and networks. Afghan refugees face additional post-resettlement challenges, such as lack of host country language proficiency, unemployment, economic disadvantages, and experiences of discrimination and marginalization, that all hinder social integration and further contribute to isolation and a lack of a sense of belonging. When asked what was the biggest challenge she has faced since re-settling in the US, a 72-year-old woman who was a former teacher said, "Loneliness. I am far away from my friends, I don't know anyone my age to talk to and have a cup of tea with. I don't even have access to books in Dari so I can read."

Family Conflict

The clash of values, cultural norms, and expectations between Afghan refugee parents and children due to different rates of acculturation often lead to increased family conflicts, parent-child alienation, and poorer mental health outcomes.[8,9] There is a higher risk for family conflict and developing mental health problems when both refugee children and parents have experienced trauma. These accumulated experiences can lead to feelings of social exclusion and isolation, a lack of a sense of belonging in the host society, difficulties dealing with adjustment challenges, and family dysfunction or violence.

Zohra, a 16-year-old recently resettled Afghan refugee, noted, *"I feel like I'm living a double life. I want to fit in at school but am expected by my family to practice traditional values – meaning dress in Afghan clothes/garbs, don't talk to boys in class, pray five times a day – all of these things make me stand out more – I'm being bullied in school because my classmates think I'm weird. I can't talk to my family about any of this because they wouldn't understand and will think I'm being ungrateful for all the sacrifices they've made to get me to the US I feel so alone."*

Best Practices in Delivering Culturally Appropriate Mental Health Care to Refugee Communities

Linguistic and Cultural Fluency

When asked what was one of the biggest barriers he faced since arriving in the US, Farid replied, *"Language. I feel like because I don't speak the language, and don't totally get the systems here in the US, my years of education and professional experience don't mean a thing. I have to start from scratch and build a life all over again."*

Many of the words used to describe mental health, like depression, anxiety, or trauma, do not have a direct translation in Dari or Pashto. This is not because Afghans do not suffer from these mental health issues, but rather, they have different ways of describing them. Cultural idioms of distress used by many Afghans include words such as tashweesh (worry), jigar khoon (heartbroken), asabi (a description of extreme anger) and fishar bala and fishar payeen (which translates literally to high and low blood pressure, but Afghans use this to express extreme emotions of anger or sadness).[10]

Cultural idioms of depression include the concept of 'thinking too much', which closely aligns with one of the symptom clusters of PTSD, negative alterations in cognition. Somatic complaints are also prominent, in the form of headaches, chest pains, tension in the body or pins and needles. Moreover, concepts of well-being, such as *aram* (feeling emotionally and socially well) and *rahat* (feeling comfortable and relaxed), are closely associated with peace and security, strong family relationships, friendship and support outside the family, and engaging in religious/cultural practices.[10] In order to provide culturally appropriate mental health care to Afghan refugees, awareness and application of these and other expressions of distress and mental well-being are critical to appropriate diagnosis and treatment.

In addition, those working with refugee groups have a personal and professional responsibility to examine and acknowledge their own implicit biases, racist and discriminatory beliefs, and actively work towards culturally responsive care, equity, and inclusion. Recognize that Western-centric treatment methods may not be culturally appropriate in all cases and that culturally adapting Western approaches with cultural traditions and rituals, or a focus on strengthening cultural connections, may be more suitable. In the absence of cultural humility and responsiveness in addressing the mental health needs of Afghan refugees, we may put them at risk for retraumatization.

Consider Spiritually Informed Psychosocial Support

For many migrants, "western" mental health services may be perceived as stigmatizing, contradictory to their culture and values, or unlikely to help.[11] Yet, spirituality is often a cultural touchstone among refugee populations and, for newly arrived Afghan refugees, may represent an important facet in their daily lives that provides a sense of comfort and purpose. Faith and spirituality also serve as a coping strategy in response to hardship.

Incorporating spiritually-sensitive support into mental health and psychosocial programs and services by trained professionals has been shown to be more effective and beneficial for Afghan refugees, compared with traditional western-centric mental health approaches. Religious leaders are often respected and trusted in their communities, placing them in a unique position to connect refugees with adequate services and assist in improving relations with host communities. Refugees may better accept and access mental health support if those services incorporate traditional healing and spiritual support.

Focus on Family Dynamics

In some Afghan families, hierarchical and traditional gender roles with male heads of households may be the norm. It is imperative that interventions to improve mental health do not overlook this gendered dynamic and the importance of garnering trust and buy-in from male and elder family members, when appropriate.[12]

An Emerging Mental Health and Psychosocial Support Intervention that can Serve as a Model of Care

Guided by principles of immediate and midterm mass trauma interventions, therapeutic interventions for refugees should promote a sense of safety and self and community efficacy, foster social connections, and instill hope. Based on the Inter-Agency Standing Committee's (IASC, 2007) guidelines, mental health services for forcibly displaced populations in the US need to be based on a multifaceted, multilevel public health model where services are offered concurrently, as needed, to address the real-world problems that refugees face and must be responsive to individual, family, and community needs.[13] A multilevel model would include services and programming that promote safety and stabilization, community-based mental health prevention, and specialized mental health treatment.

A number of approaches to refugee mental health are emerging as best practice, including school-based interventions, creative arts therapies, and mind body interventions.[12,14] While these approaches show good efficacy, the challenge remains that there are simply not enough mental health providers to address the needs of Afghan refugee communities in the United States. Lay mental health workers have emerged as a potential solution to address this shortage, increase access to needed mental health services, and provide the additional cultural support and peer-connections that can help establish long-term trust and community connectedness.

Health Extension for our Afghan Allies (HEAL) Project

In response to the growing mental health and psychosocial needs of Afghans resettled in the US after their evacuation in 2021, the US Committee for Refugees and Immigrants (USCRI), with funding from the Office of Refugee Resettlement (ORR), developed a comprehensive and multi-tiered program aimed to mitigate resettlement challenges by expanding access to culturally and linguistically tailored, trauma-informed behavioral health services for resettled Afghans across the US In partnership with the Afghan Medical Professional Association of America (AMPAA) and Healis Health, USCRI operates a full-service telehealth platform, called the HEAL Project.

The HEAL project provides Afghanistan Supplemental Appropriation (ASA) eligible Afghans across the US virtual holistic medical and psychosocial support services that are culturally and linguistically informed when requested by State agencies and local resettlement partners. Each Afghan patient who is eligible and referred to the HEAL Project is assigned a Patient Navigator by AMPAA who speaks Dari and/or Pashto and actively participates in each step of the process, including virtual sessions with patients and medical providers. The HEAL Project is an example of a task-sharing approach and scalable service that addresses the gap between mental health needs and availability of culturally and linguistically informed mental health professionals and services for refugees in the US.

Considerations and Recommendations

In addition to treating mental health conditions, it is critically important to identify and address the social drivers of health (SDOH), defined by the World Health Organization (WHO) as the "conditions in which people are born, grow, live, work, and age [that] are shaped by the distribution of money, power, and resources at global, national, and local levels" [15] Economic stability, education, health and healthcare, neighborhood and environment,
and social and community contexts impact health and how people access care. Economic instability, lack of access to formal education, transportation challenges, language skills, and limited health literacy may be barriers to healthcare for many refugees, negatively affecting their long-term health, management of chronic health conditions, and self-sufficiency in the United States.

Some ways we can address these social determinants of refugee health include:

- Supporting social integration through education, housing and employment;
- Providing community outreach services to facilitate access to care;
- Coordinating different services within a health care system to ensure the integration of physical and mental health care and appropriate care pathways;
- Providing information on care entitlements and available services both to people from these groups and to professionals; and
- Training health care professionals to ensure that they are open to working with these groups in a culturally responsive manner, aware of the barriers to accessing care and engaging with services, and making use of trained interpreters and cultural brokers.

Conclusion

Almost three years after the historic US-led evacuation of tens of thousands of desperate Afghans in Kabul, Afghanistan, many of those Afghans have now resettled into communities across the US, but continue to struggle with their mental health. In addition to the pre- and peri-migration trauma that continues to adversely affect their daily lives, many Afghan refugees face numerous post-resettlement challenges that either cause or exacerbate existing mental health issues including stigma and discrimination, prolonged visa insecurity, absent or limited social support networks, isolation and social exclusion, unemployment or underemployment, intergenerational conflicts, separation from family members, lack of English language proficiency, and a host of other acculturation challenges. When working with Afghan refugees, attention must be given to various contextual and practical issues that influence mental health, intercultural communication and understanding, patterns of coping and help-seeking, and integration into US society.

Endnotes

[1] Priebe S, Giacco D, El-Nagib R. Public Health Aspects of Mental Health Among Migrants and Refugees: A Review of the Evidence on Mental Health Care for Refugees, Asylum Seekers and Irregular Migrants in the WHO European Region [Internet]. Copenhagen: WHO Regional Office for Europe; 2016. (Health Evidence Network Synthesis Report, No. 47.) Available from: https://www.ncbi.nlm.nih.gov/books/NBK391045/

[2] The authors highlight the experiences of a number of newly resettled Afghan refugees throughout this paper. The first author, Halima Ahmadi-Montecalvo, documented anecdotes (with permission) from newly arrived Afghan refugees through her voluntary work in the resettlement process. Names and other identifying details have been changed throughout.

[3] Jakobsen, M., Meyer DeMott, M. A., Wentzel-Larsen, T., et al. (2017).The impact of the asylum process on mental health: a longitudinal study of unaccompanied refugee minors in Norway. *BMJ Open* 7:e015157. doi: 10.1136/bmjopen-2016-015157

[4] Straiton, M. L., Reneflot, A., and Diaz, E. (2017). Mental health of refugees and non-refugees from war-conflict countries: data from primary healthcare services and the Norwegian prescription database [journal article]. *J. Immigr. Minor. Health* 19, 582–589. doi: 10.1007/s10903-016-0450-y

[5] Barstad, A. (2018). *Livskvalitet Blant Innvandrere. En Analyse Basert på Levekårsundersøkelsen Blant Personer Med Innvandrerbakgrunn 2016* (31). S. sentralbyrå. https://www.ssb.no/sosiale-forhold-og-kriminalitet/artikler-og-publikasjoner/_attachment/362063?_ts=165ccb60e80

[6] Tronstad, K., Nygaard, M. O., and Bask, M. (2018). *Accumulation of Welfare Problems Among Immigrants in Norway.* Retrieved from Norwegian Institute for Urban and Regional Research (NIBR). Available at: http://urn.kb.se/resolve?urn=urn:nbn:se:oru:diva-69148

[7] Harder, N., Figueroa, L., Gillum, R. M., Hangartner, D., Laitin, D. D., and Hainmueller, J. (2018b). Multidimensional measure of immigrant integration. *Proc. Natl. Acad. Sci.* 115, 11483–11488. doi: 10.1073/pnas.1808793115

[8] Julia Rosenberg, Patricia McDonough Ryan, Camille Brown, Rachel Schaffer, Caroline O'Brien, Fereshteh Ganjavi, Mona Sharifi, Exploring the determinants of successful implementation of a preventive mental health and wellness intervention for Afghan refugee families: a qualitative analysis, *Health Education Research,* 2023;, cyad034, https://doi.org/10.1093/her/cyad034

[9] Sangalang, C. C., Becerra, D., Mitchell, F. M., Lechuga-Peña, S., Lopez, K., & Kim, I. (2019). Trauma, Post-Migration Stress, and Mental Health: A Comparative Analysis of Refugees and Immigrants in the United States. *Journal of Immigrant and Minority Health,* 21(5), 909–919. https://www.jstor.org/stable/48709582

[10] Alemi, Qais et al. (2023). Afghan mental health and psychosocial well-being: thematic review of four decades of research and interventions. BJPsych open. 9. e125. 10.1192/bjo.2023.502.

[11] The Lutheran World Federation and Islamic Relief Worldwide (2018) A faith-sensitive approach in humanitarian response: Guidance on mental health and psychosocial programming. LWF and IRW: Geneva and Birmingham.

[12] Stempel C, Sami N, Koga PM, Alemi Q, Smith V, Shirazi A. Gendered Sources of Distress and Resilience among Afghan Refugees in Northern California: A Cross-Sectional Study. Int J Environ Res Public Health. 2016 Dec 28;14(1):25. doi: 10.3390/ijerph14010025. PMID: 28036054; PMCID: PMC5295276.

[13] Inter-Agency Standing Committee (IASC) (2007). IASC Guidelines on Mental Health and Psychosocial Support in Emergency Settings. Geneva: IASC.

[14] Grasser, L. R. (2022). Addressing Mental Health Concerns in Refugees and Displaced Populations: Is Enough Being Done? *Risk Management and Healthcare Policy,* 15, 909–922. https://doi.org/10.2147/RMHP.S270233

[15] Srinivasan, S. and S.D. Williams, *Transitioning from health disparities to a health equity research agenda: the time is now.* Public Health Rep, 2014. 129 Suppl 2(Suppl 2): p. 71-6.

View Our
Key Findings

peacerep@ed.ac.uk
PeaceRepResearch
@Peace_Rep_
PeaceRep

www.peacerep.org
pax.peaceagreements.org

About Us

PeaceRep: The Peace and Conflict Resolution Evidence Platform is a research consortium based at Edinburgh Law School. Our research is rethinking peace and transition processes in the light of changing conflict dynamics, changing demands of inclusion, and changes in patterns of global intervention in conflict and peace/mediation/transition management processes.

Consortium members include: Conciliation Resources, Centre for Trust, Peace and Social Relations (CTPSR) at Coventry University, Dialectiq, Edinburgh Law School, International IDEA, LSE Conflict and Civicness Research Group, LSE Middle East Centre, Queens University Belfast, University of St Andrews, University of Stirling, and the World Peace Foundation at Tufts University.

PeaceRep is funded by UK International Development from the UK government.

THE UNIVERSITY *of* EDINBURGH

PeaceRep: The Peace and Conflict Resolution Evidence Platform
peacerep@ed.ac.uk | **https://peacerep.org** | **@Peace_Rep_**

University of Edinburgh, School of Law
Old College, South Bridge EH8 9YL