



# From Crisis to Care: Trauma-Informed Treatment Strategies for Supporting Afghan Refugees

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## Reading and Misreading Traumatic Stress Along the Acculturation Continuum in Afghan Refugees

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## Cultural Competence (CC) and Cultural Identity (CI)



For the past 25 years Cultural Identity in relation to mental health has been central to the field of transcultural psychiatry. At the 1999 World Psychiatric Association (WPA) XI<sup>th</sup> Congress in Hamburg, Germany, Dr. Dinesh Bhugra stated that clinicians underestimate the relation between cultural identity and mental health and emphasized an urgent need to place cultural identity at the core of the refugee patient's wellbeing.

The 2001 Report of the Surgeon General on Mental Health (Dr. David Satcher) kickstarted the *CC Reform in MH* in the State of CA. See *Mental Health: Culture, Race, and Ethnicity A Supplement to Mental Health: A Report of The Surgeon General*. In 2003, CA passed laws encouraging the implementation of CC in education. In 2005 CA adopted laws requiring CC training as a part of health education and/or licensure and accreditation.

And yet, many mental health providers in US do not conduct a formal cultural identity assessment of the refugee they serve. Where have we failed? In the dissemination? Implementation? Enforcement and monitoring? In the evaluation of CC programs?

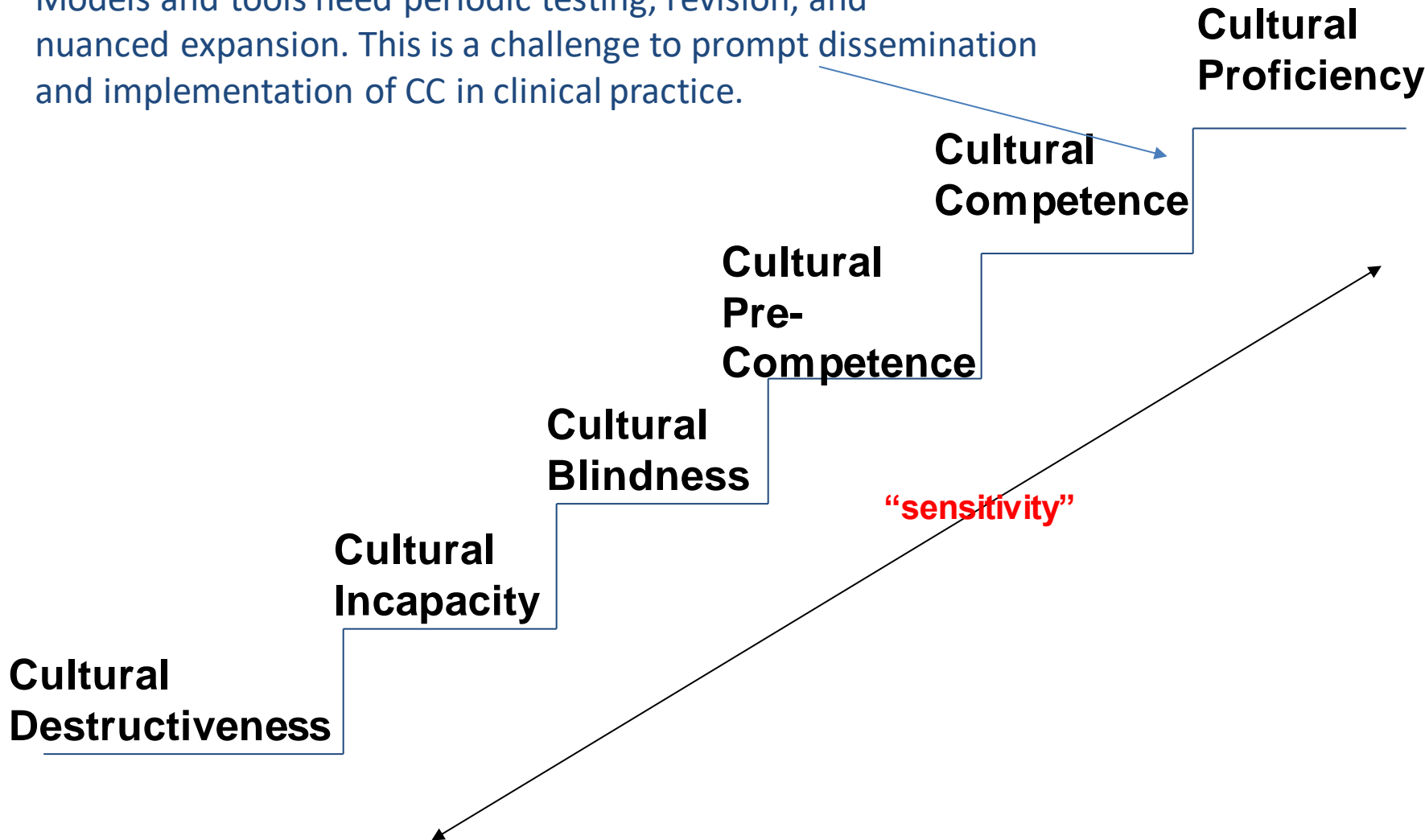
Although 20 years have passed since we mandated Cultural Competence in Mental Health, many providers still use the term “**sensitivity**” instead of “**competence**”.

# Stages of Cultural Competence (CC)

Cultural Humility  
(Murray, UCD)

Research risks: to replace old artifacts with new ones.

Models and tools need periodic testing, revision, and nuanced expansion. This is a challenge to prompt dissemination and implementation of CC in clinical practice.



Cultural Proficiency

Cultural sensitivity is adequate for an orientation but **grossly insufficient** for clinical practice

# Trauma and Cultural Identity

Traumatic stress and the resulting personal and social losses, grief, and bereavement have a strong impact on cultural identity. The memory of traumas tends to form a cognitive reference point for the organization of other memories leading to an enhanced integration of traumas in a person's understanding of the self, the community, and the world.

Because traumatic memory is so central and inextricably connected to identity, clarity about the patient's **cultural identity** is necessary for most types of trauma treatments and crucial for mental health care professionals.

Reducing the meaning of a patient's story to an assortment of psychiatric symptoms increases the risk of misunderstanding between patient and clinician, of systematic misjudgments in diagnosis and treatment, and borders on colonizing malpractice.

Moreover, psychiatric constructs like PTSD have limited explanatory value for non-Westerners. Many Afghan refugees do not share Western assumptions about the appropriate ways to assess and respond to suffering and adversity.

## **Brief Cultural Interview (BCI; Groen et al. 2016).**

The BCI is a standard part of the diagnostic assessment of many refugee centers in EU but is not so in the US. The semi-structured BCI questionnaire is used in a narrative fashion, in which its 27 questions serve as a guideline leaving space for dialogue.

BCI explores three domains of cultural identity:

1. personal identity
2. ethnic identity, and
3. social identity

Within each domain relationships with stress and acculturation are identified. The results offer insight into the intensity of changes in cultural identity, caused by pre- and post-migration stressors and the process of acculturation.

# BCI-cont'd

**Personal identity** offers the clinician information about the personal characteristics and circumstances of the individual patient that are subject to change under the influence of stress and acculturation.

**Ethnic identity** shows how crucial ethnic belonging is to stress in the home country.

Around **social identity**, stress is felt around the family, both in the home and in the host country, inability concerning social expectations within the family that have altered, and the diminished level of social functioning, for example by stress in social contacts. Social identity is of particular interest to migration from an interdependent society(Afghanistan) to an independent society (USA) which, in many cases, leads to feelings of alienation.

The results of this study therefore support the inclusion of cultural identity in the Cultural Formulation Interview in DSM-5 (American Psychiatric Association 2013) and a supplementary module (Lewis-Fernandez et al. 2016).

# Cultural identity (CI)

CI includes more than the Operationalizing Cultural Formulation in DSM 5 (OCF) implies: ethnicity, race, country of origin, language, acculturation, gender, age, sexual orientation, religious or spiritual beliefs, and socioeconomic class and education (Lu et al. 1995; Ton and Lim 2006). Basing cultural identity on a list of aspects only is a so-called “*trait list approach*”, which risks stereotyping and is avoided in ethnography (Kleinman and Benson 2006).

At UC Davis Ulysses Refugee Research Program our approach to CI focuses on

1. norms and values that constitute an image a person holds of the self,
2. what urges a person to decide what is right or wrong,
3. what kind of behavior is appropriate or not;
4. norms and values that are negotiated within the (ethnic or ethnoreligious) group the individual belongs to, and within local society.
5. Self image after an abrupt loss of self-efficacy, social status, social capital, and old support network

These points are easily overlooked in our fast-paced managed care mental health system driven by coding, reimbursement, and a culture of individual self-reliance. Moreover, the very CI of refugee patients is not static but fluid, multiple, and everchanging through acculturation into a new host society.

# What is Acculturation? Berry's Model

Acculturation refers to the degree of identification with the host culture and/or with the culture of origin.

**Positive identification** with both cultures results in lowest risk for mental distress.

**Negative identification** with both cultures leads to the highest risk.

**Berry's Model:** weaknesses on the acculturation continuum

	Identification with Heritage culture: <b>HIGH</b>	Identification with Heritage culture: <b>LOW</b>
Identification with US culture: <b>HIGH</b>	<b>Integration (Bicultural)</b>	<b>Assimilation</b>
Identification with US culture: <b>LOW</b>	<b>Separation</b>	<b>Marginalization</b>



# Afghan Refugee Idioms of Distress: Challenges for MH screening, Dx, and Tx

(Western vs Afghan)

**DISEASE**

The Triad of

(Western vs Afghan)

**ILLNESS**



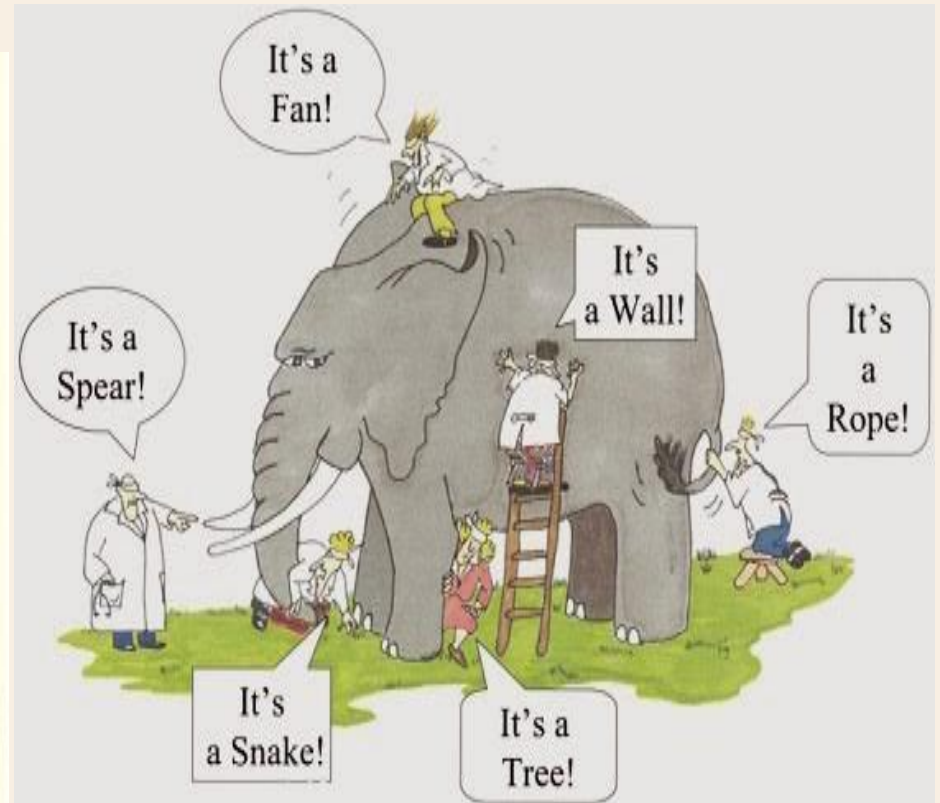
**SICKNESS**

(Western vs. Afghan)

# The Multiple Contexts of Trauma

*“It is not as important what happens to a person, as to the meaning that the person gives to what has happened.”* – Epictetus – 50-135 CE

## THE SEVEN BLIND INDIAN MEN



## MEANING: How do Afghans conceptualize their mental distress?

Afghans (like Kyrgyz and Uzbeks) have three categories of mental distress:

- (1) disorders caused by **biology** (e.g., schizophrenia);
- (2) distress caused by **jinns** (i.e., spirits that can take over a person's mind and body and cause them to experience acute emotional and physical discomfort). [The Arab word "*majnoon*" means "possessed by jinns"]
- (3) distress caused by severe **adverse life experiences** such as war, chronic oppression, poverty, family violence, and forced displacement.

Given the difference and dissonance in symptom clustering, presentation, and explanation of etiology of distress, it would be useful for MH professionals to explore Afghan refugees' conceptualization and expression of distress.

# Afghan expression (idioms) of distress and culture-bound syndromes

## **1-Asabi**

refers to feeling very nervous or highly stressed. People with high levels of *asabi* feel overwhelmed by major life stressors, including poverty, domestic violence, and single parenting.

## **2- Naharat**

In many instances, *Asabi* is exacerbated by *narahat* (severe discomfort with anxiety or depression). Displacement is often associated with naharat.

## **3-Fishar**

***Fishar-e-bala*** and ***fishar-e-payin***; both terms are missinterpreted as high and low blood pressure, respectively. However, these terms are unrelated to blood pressure and in fact refer to an internal state of **emotional pressure and agitation** (*fishar-e-bala*) or **low energy and low motivation** (*fishar-e-payin*).

## **4) Jigar-e- khun (“bleeding liver”)- Culture-bound Syndrome**

A form of extremely intense sadness that includes grief following interpersonal loss but may also be a reaction to any deeply disappointing or painful experience.

# Mahnur (ماه نور)

## A Pashtun refugee case of *jigar-e-khun* with poor service utilization

### Symptom clusters

Mahnur, a 36 yr. old Pashtun woman who saw the killing of her eldest son the year before, said “*jigaram khun hast*” (“my liver is bleeding”) and that her *fishar* was high (“*fisharam-bala hast*”).

Mahnur was grief-stricken and also anxious as manifested in *naharat*, and she found herself “thinking too much” about gruesome images of her son’s body.

In terms of *jigar-e-khun*, she knew that her liver was only metaphorically bloody/bleeding, but it pointed to her grief feeling physically intensely manifest, including physical agitation and displaced aggression (beating her other three children and anger towards her disabled husband).

### Awareness of reduced functioning

Mahnur clearly identified her grief as reducing her daily functioning and ability to fulfill family and social responsibilities.

### Health literacy and help-seeking

She knew of several traditional ways to seek help. She had an Afghan-informed mental health literacy. Ascribing low MH literacy to Mahnur may describe her lack of familiarity with biomedicine, but it would incorrectly ascribe faulty reasoning to her poor pursuit of MH services in Sacramento.

### Structural barriers

Mahnur’s low service utilization was due to repeated failure to reach adequate help. She was dissuaded from using the available health systems because she had to interface with many men prior to securing help from a female provider. Also, as providers failed to see her concern about the perceived nature of her ailments, she felt dismissed.

## Jigar-e-khun: Key Points

The Afghan culture-bound syndrome *Jigar-e-khun* points out that Afghans may perceive and cluster certain emotions and somatic complaints together in ways different than those standardized in the Diagnostic and Statistical Manual (DSM-5) and the International Classification of Disease (ICD-11).

Moreover, the expression of *Jigar-e-khun* is **gendered**: men are expected to endure and to display numbing of soft emotions, and women are expected to cry, pray, and somatize.

### **MH service utilization by refugees**

To Afghan refugees, targeting certain symptom sets without addressing others may seem to offer incomplete resolution.

Studies assessing mental health service uptake need to ensure minimal barriers to service. Before attempting to measure Afghan willingness to engage with the available systems, they should first provide proactive education about how to access MH service in a format acceptable to the refugee. Afghan focus groups may inform better formats.

# Afghan female patients - Communicating depression

(following the 2012-2015 Sacto Refugee Clinic study – Patterson, K., Koga, PM, Ramos, M, 2017)

## 1<sup>st</sup> generation

### *Affective Symptoms*

- Feeling sad and **angry/jigar e-khun**
- **“inability to hold emotions”**
- Feeling lonely/isolated, **“thinking too much”**

### *Somatic Symptoms*

- Very tired, **fishar e-payin, migraines**
- Pain in the body & muscle cramps
- **“Veins behind neck pull and burn”**
- Increase/decrease in appetite & sleep

### *Behavioral Symptoms*

- **Wanting to fight with children/family**  
**Wanting to shout and scream; crying**

***Cognitive Symptoms*** : **“poor memory”**

## 2<sup>nd</sup> generation

### *Affective Symptoms*

- Intense sadness
- Loss of enjoyment
- **Hopelessness & worthlessness**
- Loss of confidence
- **Low self-esteem**
- ***Somatic Symptoms***
- Insomnia/hypersomnia
- Loss of appetite
- Headaches
- Stomach problems

### *Behavioral Symptoms*

- Crying
- Social withdrawal
- Not wanting to get out of bed

***Cognitive Symptoms*** : **none**

# Afghan female patients : Stated causes of depression

## 1<sup>st</sup> generation

### *Most Significant Causes*

- Family members left behind old, vulnerable, or in danger
- Loss of extended family support system
- Fear of loss of cultural heritage
- Some aspects of host culture are repugnant and dangerous

### *Other Causes*

- Economic strains, humiliation
- Different expectations before/ after arrival, disillusionment
- Inability to speak English
- Power reversal with own children

## 2<sup>nd</sup> generation

### *Most Significant Causes*

- Adjusting to a new culture & feelings of not belonging in either culture
- Lack of understanding between 1st and 2nd generations, conflict with parents
- Stressful vacillation between gender differences (Afghan) and gender equity (American)

### *Other Causes*

- Unemployment, financial difficulties
- Worrying about family members back home
- Feeling sad about how much their parents sacrificed for their future
- Not being able to share their emotions with their parents



## Challenges in using BCI with Afghan refugees

*How is Afghan selfhood conceptualized (collective? individual? relational? embedded?), expressed, lived, and how does it change in post-resettlement?*

### **Expanded acculturation model**

**Dimensions:** not two-D but multidimensional

**Direction:** not unidirectional but bidirectional. Some biculturated migrants revert to origin.

**Age:** 1st generation? 1.5? 2<sup>nd</sup> generation?

**Context of reception:** the receiving society directs the acculturation options available to migrants, and we frame acculturative stress and discrimination under the heading of an unfavorable context of reception.

**Enculturation:** not a 2x2 matrix of acculturation categories but a more nuanced and fluid variation of patterns in choosing what to keep, what to adopt, what to reject, and what to blend.

**The Immigrant Paradox:** Acculturation is not always good for mental health. *La cultura, cura.*

**Hybrid:** ethnic, racial, etc. mixed marriages.

**Caveat for Afghan cultural validation of trauma assessment**

**instruments and interventions:** “**which Afghans and where along their journey?**” A good Cronbach alpha does not exclude an artifact.

# Clinical and socio-political objections to overmedicalization of Afghan refugee trauma

Automatically applying a PTSD label to victims of war, political violence, torture, and displacement may pathologize, disempower and stigmatize the survivors, delegitimize grievances, and it may be counter-therapeutic. Patients may get worse, not better.

**To build bridges** between clinical concerns and the social contexts in which experiences and suffering are embedded, we must focus on “what is at stake” in the lives of individuals and communities. A **cultural analysis** provides a common ground on which the shared and disparate concerns of lawyers, anthropologists, psychiatrists, psychologists, and social workers can be addressed and potentially integrated.

Very importantly, working with traumatized Afghan refugees is extremely taxing. Cascading stories of atrocities and loss could lead to burnout in providers.

Next speaker, our respected colleague **Dr. Omar Reda** will talk about **secondary or vicarious trauma** and guide us in preventing and addressing it.