Article

Examining help-seeking patterns within modern and traditional resources for support in Afghanistan

Qais Alemi, Susanne Montgomery[1], Valerie Smith[2], Carl Stempel[3], Patrick Marius Koga[4], Brianna Taylor[5] & Catherine Fisher[6]

PhD, MPH, MBA, Department of Social Work & Social Ecology, [1]PhD, MPH, MS, School of Behavioral Health, Loma Linda University, Loma Linda, California, USA, [2]PhD, MPH, Department of Health Sciences, California State University, East Bay, Hayward, California, USA, [3]PhD, Department of Sociology and Social Services, California State University, East Bay, Hayward, California, USA, [4]MD MPH, Refugee Health Research, Department of Public Health Sciences, UCD School of Medicine, University of California, Davis, California, USA, [5]MPH, Department of Epidemiology, School of Public Health, Loma Linda University, Loma Linda, California, USA, [6]MSW, Graduate Student; Department of Social Work & Social Ecology, School of Behavioral Health, Loma Linda University, Loma Linda, California, USA

Abstract

Little is known about who and what Afghans turn to cope with mental distress precipitated by ongoing socio-political and economic problems. In a cross-sectional survey, the authors examined help-seeking behaviour for mental distress in 306 Afghans residing in Kabul, Afghanistan, and how their choice of what to access for help is influenced by various social and mental health-related factors. Factors predicting the use of six distinct resources for support were examined, including biomedical and behavioural health and community-based resources. Results indicated that Afghans mostly draw on their faith, followed by social support, to cope with mental distress. Higher distress symptoms had a moderate, but statistically significant influence, on seeking help across all resources, whereas demographic factors only predicted encounters with primary care physicians. Female gender predicted social support seeking, and income increased the likelihood of encounters with herbalists. Meeting the psychosocial needs of Afghans through promoting a more integrated mental healthcare system is discussed.

Key implications for practice

- Help-seeking for mental distress among Afghans in Kabul is highly pluralistic
- Although religious activities were the most widely used coping resource, those seeking care outside, from biomedical practitioners and traditional healers were, on average, more distressed.
- An integrated mental health system that embraces both modern and traditional healing practices may be more efficacious than medicalised mental health systems in meeting the unmet psychosocial needs of Afghans.

Keywords: Afghanistan, healers, help-seeking, primary care, stress

Introduction

Mental health accounts for a substantial proportion of the global burden of disease worldwide (Whiteford, Ferrari, Degenhardt, Feigin, & Vos, 2015), with significantly higher incidence and prevalence of mental disorders in war affected populations (Murthy & Lakshminarayana, 2006). In Afghanistan, a country nearing four decades of political violence, mood and anxiety disorders have emerged as a major cause of disability [Institute for Health Metrics and Evaluation (IHME), 2017] due to the rising number of people affected by social problems, violent conflict, civil wars, displacement and disasters. Today, more than one million Afghans suffer from depressive disorders and over 1.2 million suffer from anxiety disorders [Institute for Health Metrics and Evaluation (IHME), 2017]. The Afghan mental health toll signifies a hidden consequence of war often overshadowed by loss of life and a ruined country. However, little is known about what Afghans view as being helpful to remediate mental health problems from war traumas, further aggravated by the ongoing stressful social and material conditions (Miller, Omidian, Rasmussen, Yaqubi, & Daudzai, 2008).

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Address for correspondence: Dr. Qais Alemi, Assistant Professor, Department of Social Work & Social Ecology, School of Behavioral Health, Loma Linda University, 1898 Business Center Drive, San Bernardino, CA 92408, USA.
E-mail: qalemi@llu.edu

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Help-seeking can be defined as any attempt to maximise wellness or to ameliorate, mitigate or eliminate distress (Saint Arnault, 2009). In addition, in many conflict-affected countries such as Afghanistan, help-seeking resources for individuals include help from the professional medical sector, traditional healers, drawing on one's support systems and faith (Saxena, Thornicroft, Knapp, & Whiteford, 2007). Although early household surveys show that Afghans rely on traditional healers such as clergy ('Imams') and herbalists ('Tabibs'), they draw extensively more from cultural resiliency assets, such as family and friends and by engaging in religious activities (Cardozo *et al.*, 2004; Scholte *et al.*, 2004). Others report that Afghans cope by self-medicating with psycho-pharmacological drugs (e.g. anti-depressants, mood stabilisers), seeking refuge in religious shrines (van de Put, 2002; Ventevogel, Azimi, Jalal, & Kortmann, 2002), and 'keeping oneself busy' or distracted (Wildt, Umanos, Khanzada, Saleh, Rahman, & Zakowski, 2017).

Perceived vulnerability and need (typically lower among males), perceived structural barriers such as service accessibility and cost (higher among young people and those with lower education) and attitudinal barriers or social stigmas associated with mental illness are substantial determinants of help-seeking decisions (Andrade *et al.*, 2014). Moreover, a recent systematic review of 50 studies pertaining to help-seeking behaviours among conflict-affected populations (Seguin & Roberts, 2017) found that coping decisions are influenced by an array of factors including gender, exposure to trauma, religious beliefs and cultural mores that may, for example, prohibit Afghan women from engaging in coping styles in the presence of men. This review also suggests that coping strategies (e.g. support seeking, positive cognitive structuring, escape and/or avoidance) are not always effective in terms of improving mental health outcomes.

In fact, an increasing concern exists about the heavy emphasis on prescribing drugs as a substitute for addressing the psychosocial aspects of treatment for distress that is largely context generated (Ventevogel, 2016). Indeed, treating mental disorders accompanied by a community-based approach that focuses on psychosocial problems has been found to be more effective (Ventevogel, van de Put, Faiz, van Mierlo, Siddiqi, & Komproe, 2012). Such an approach might reduce what Patel (2014) refers to as a 'credibility gap'; that is, the difference in how biomedical practitioners conceptualise mental disorders and how communities conceptualise psychological suffering.

In light of these findings, the authors examined help-seeking patterns among Afghans residing in Kabul, Afghanistan. Data from a cross-sectional survey conducted in late 2015 were used to answer the following questions: (1) when facing mental distress, to what extent do Afghans turn to professional help from mental health professionals (MHPs) and primary care physicians (PCPs), seek informal services from clergy and herbalists, and/or draw on lay coping strategies such as support seeking and engaging in religious activities, and (2) what factors influence this help-seeking?

We conceptualise these resources as either 'modern' or 'traditional' mental healthcare systems. The modern system includes biomedical and behavioural services, such as help from MHPs and PCPs, and traditional systems include community sources for mental health needs, such as help from traditional healers, social supports and religious activities. Based on sparse, yet insightful, prior research on this topic in Afghanistan, the authors theorise that

- need factors measured by (distress) symptom severity will be most influential in predicting help-seeking for all of these resources;
- help-seeking will be higher among older people (Andrade *et al.*, 2014), and dictated by cultural gendered mores, for example Farooqi (2006) in neighbouring Pakistan found that women's limited mobility and the taboos against them interacting with male traditional healers, affected their help-seeking; and
- lower education, unstable income and not having access to a healthcare provider will serve as structural barriers for seeking help from professionals, whereas higher income specifically may serve to facilitate help from herbalists to pay them for herbal remedies (Sato, 2012a).

The significance of exploring access to a wider variety of professional and community-based choices rests on the idea that filling this void in knowledge will help distressed persons in Afghanistan. Such knowledge will avoid telling a partial story of utilisation that focuses only on professional help-seeking (Sato, 2012b). Our findings may also inform public mental health policies in terms of improving access, affordability and acceptability of mental health resources within both formal and informal resources for support.

Subjects and methods

Participants and procedures

Participants for this cross-sectional survey were recruited from various districts in Kabul, where according to the most recent Asia Foundation survey, concerns regarding crime, unemployment and governance issues such as corruption are rampant (The Asia Foundation, 2017). These social conditions help explain the high levels of psychological distress observed in previous cross-sectional studies conducted in Kabul (Alemi *et al.*, 2018; Miller *et al.*, 2008; Panter-Brick, Eggerman, Mojadidi, & McDade, 2008). In addition, despite mental health services being integrated into the primary care sector, services are still limited and compounded by widely pervasive stigma and financial, human, infrastructural and information resource limitations (World Health Organization, 2016).

Data were collected by two data collectors, during a two-week period in September 2015, using a combination of convenience sampling techniques by approaching individuals congregating around local universities, mosques and other public venues; snowball sampling by having data collectors access individuals in their own personal social networks and having these individuals refer their friends and relatives; and street intercept techniques. Data

collectors shared an information sheet detailing this study's purpose and participant rights before obtaining verbal consent from participants. Surveys were completed mainly through self-administration, although some individuals with literacy challenges were interviewed. As a show of appreciation for their time and consideration of their real economic needs, participants were offered a US$5 equivalent cash incentive for participating. The study was approved by the Institutional Review Board (IRB) at Loma Linda University, and by the IRB at the Ministry of Public Health in Kabul.

Instrumentation

Resources for support (outcome variable)

The authors assessed help-seeking by asking participants: *'in the past 12 months, did you see/consult the following in episodes of "thinking too much", worry, or stress?'* followed by a list of provider/coping resources with a binary 'yes/no' response choice. This wording was chosen based on previous work on culturally salient idioms of distress familiar to Afghans (Feldmann, Bensing, & de Ruijter, 2007; Miller *et al.*, 2006). The list of providers and coping resources included both modern and traditional services and coping resources, informed by prior research (Cardozo *et al.*, 2004; Scholte *et al.*, 2004), and included mental health MHPs (psychologists and psychiatrists), PCPs, faith healers/*Imams*, herbalists/Tabibs, social support from family and friends, and religious activities including prayer and reciting the Qur'an.

Socio-demographic characteristics

The authors assessed a number of individual demographics (age, gender, ethnicity and marital status) and economic factors including educational attainment (0 = high school diploma or less, 1 = college degree), employment (0 = unemployed, 1 = employed). Household income stability was assessed by asking participants if they were able to comfortably pay monthly household expenses with their current income (0 = no, 1 = yes).

Perceived need factors

The authors assessed psychological distress symptoms using the *Afghan symptom checklist* (*ASCL*), a culturally grounded measure of mental health developed and validated in Afghanistan, which consists of three categories of indicators related to functioning in the community, functioning within one's family, and one's internal state (Miller *et al.*, 2006). Scores range from 23 to 115 (higher scores indicative of higher distress). The ASCL demonstrated excellent reliability in this sample (Cronbach's $\alpha = 0.914$). All measures [with the exception of the ASCL, which was provided in Dari courtesy of its developer (Dr. Ken Miller)] were translated from English to Dari through a systematic translation-back-translation process with the assistance from the Afghan refugee community in southern California.

Data analysis

SPSS, *version 25.0* (IBM Corp, Armonk, New York, USA) was used for all data analyses. Upon evaluating standard assumptions of parametric tests and using mean imputation for variables with less than 10% missing responses, bivariate relationships between the independent variables along with each type of provider and coping resource were examined by generating *unadjusted* odds ratios (ORs). In addition, a principal component analysis with a varimax rotation was performed on the data to explore and assess the factor composition between the six types of help-seeking. To build parsimonious multivariable logistic regression models, variables based on their statistical significance at the bivariate level as well as their conceptual relevance to the resources for support were then selected. Separate models for each provider and coping resource by computing *adjusted* ORs with 95% confidence intervals and *P*-values of the association between each factor and outcome were explored. Statistical significance was considered at $P < 0.05$ (though relationships approaching significance as well, $P < 0.10$ were signified).

Results

Socio-demographic characteristics

Table 1 displays socio-demographic characteristics for the 306 participants taking part in our study. The age of participants ranged from 18 to 75 years, with the majority being male, unmarried and a close-to-equal distribution of Pashtuns and Tajiks. Most were unemployed with unstable incomes and had attained a high school education or less. The majority reported having access to a health care provider. Moreover, participants reported moderate levels of distress symptoms and social functioning, though the majority did respond with 'very little' to the question about whether their physical health or emotional problems interfered with social activities with family and friends. Distress Symptoms (ASCL score) were moderate ($M = 45.63$, SD = 15.29). In terms of help-seeking, participants resorted to prayer and reciting the Qur'an the most in the past 12 months, followed by help from family and friends, whereas substantially lower numbers sought help from the professional medical sector and traditional healers.

Bivariate associations with resources for support

Bivariate analysis indicated that the likelihood of seeking help across providers and coping resources was significantly associated with higher distress or ASCL scores, in which unadjusted ORs ranged from 1.026 ($P = 0.021$) for Imams to 1.044 ($P = 0.000$) for family and friends.

Aside from distress symptoms, few socio-economic characteristics demonstrated significant effects. Older age was significantly associated with seeking help from PCPs, whereas female gender was associated with a lower likelihood of seeking help from Imams (OR = 0.504, $P = 0.079$), but higher for seeking help from family and friends (OR = 1.934, $P = 0.006$). Being married was marginally associated with seeking help from a PCP (OR = 1.677, $P = 0.097$). Higher education was significantly associated with a lower likelihood of encounters with Tabibs (OR = 0.491, $P = 0.041$), whereas access to health care (OR = 0.430, $P = 0.040$) and higher income was associated with a lower likelihood of encounters with Imams (OR = 0.413, $P = 0.028$).

Table 1: Socio-demographic characteristics

Variables	*n* (%)
Age: $M = 28.41$, SD = 12.03	–
Gender	
Female	118 (39.3)
Male	182 (60.7)
Ethnicity	
Pashtun	116 (38)
Tajik	110 (36.1)
Other[a]	79 (25.9)
Marital status	
Married	145 (49.7)
Unmarried[b]	147 (50.3)
Education	
University degree	123 (40.3)
HS diploma and lower	182 (59.7)
Employment	
Employed	130 (43.8)
Unemployed	167 (56.2)
Income	
Comfortable	122 (41.1)
Not comfortable	175 (58.9)
Access to health care	
Yes	254 (84.4)
No	47 (15.6)
Social functioning: $M = 46.06$, SD = 9.06	–
'Not at all'	84 (28.0)
'Very little'	109 (36.3)
'Somewhat'	62 (20.7)
'Quite a lot'	37 (12.3)
'Could not do social activities'	8 (2.7)
Distress symptoms (ASCL score): $M = 45.63$, SD = 15.29	–
Help-seeking (past 12 months)	
Mental health professional	34 (11.2)
Primary care physician	53 (17.6)
Clergy/Imam	38 (12.6)
Herbalist/Tabib	48 (15.9)
Family and friends	152 (50.7)
Prayer and reciting Qur'an	209 (69.4)

[a]Includes Hazaras, Nuristanis, Uzbeks; [b] Includes 'never married', and two participants widowed, and four participants divorced/separated.

Inter-correlations between resources for support

Based on our factor analysis, it was found that traditional healers, PCPs and MHPs explained 30% of the variance in help-seeking, seeking help from family or friends and prayer or reciting the Qur'an explained an additional 21% of the variance, and seeking help from an Imam was the sole item loading, explaining an additional 17%.

The patterns in the first and second components showed a clear division between seeking expert assistance outside the home and more family-based help. This division reflects help-seeking that matches the severity of psychological distress. Those seeking care outside the family reported average higher ASCL scores than those seeking help through prayer or from family and friends. Thus, the structure of the factor analysis might be viewed as reflecting severity of distress.

In addition, separate factor analyses of types of help seeking for men, women, less than college degree and those with college degrees were conducted to see if their patterns matched the full sample factor analysis. The factor analyses for men and college educated deviated from the full factor analysis. For men, seeking support from family and friends loaded with PCPs, Tabibs and MHPs on one component, whereas prayer/reading the Qur'an and visiting an Imam loaded on the second component. Thus, it appears that for men, more than women, family and friends are part of the network that leads them to seek help from MHPs, PCPs and Tabibs.

Multivariable associations with use of resources for support

Adjusted ORs, shown in Table 2, indicate that after controlling for all other variables, higher distress symptoms remained statistically significant by predicting a higher likelihood of help-seeking across all services and coping resources. Female gender significantly predicted seeking help from family and friends, as did older age. Older age also predicted use of PCPs. In addition, those possessing a university degree were significantly less likely to seek help from a Tabib. A marginally significant relationship was observed between higher income and seeking help from Tabibs. Although non-significant, the opposite with relation to income stability and help-seeking from Imams, such that those with unstable incomes, were more likely to seek help from Imams was observed. Other non-significant relationships observed included the positive association between higher education and help-seeking from PCPs, but its inverse relationship to all other services and coping resources.

Discussion

In a cross-sectional survey, we examined help-seeking for mental distress in Afghans residing in Kabul, Afghanistan, and how their choice of what to access for help is influenced by various social and health-related factors. As expected, religious activities were the most widely used resources, which supports previous research in this area (Cardozo *et al.*, 2004; Scholte *et al.*, 2004). A plausible explanation for their reliance on religious activities is that Afghans, such as many other Muslim populations, may view mental health problems as an estrangement from spiritual dimensions or the will of Allah, which they believe can only be treated through ritual practices, such as prayer and reciting Qur'an (Adib, 2004). In addition, their faith, an important coping strategy rooted in their cultural values (Seguin & Roberts, 2017), may be offering much hope, despite living in uncertain social conditions (Eggerman & Panter-Brick, 2010).

The stressors Afghans face likely manifest in somatic complaints and impairments in functioning, as captured in the ASCL. This was an important determinant of help-seeking behaviour across both modern and traditional care systems. Although the relationships between ASCL and all six methods of help-seeking behaviour are positive and significant, as expected, the relationships are modest. In

Table 2: Multivariable logistic regression analysis testing factors associated with help-seeking across modern and traditional resources for support

Variables	Adjusted OR (95% CI)					
	Modern (bio-medical and behavioural mental health services)		Traditional (community sources for mental health needs)			
	Mental health professional[a]	Primary care physician[b]	Imam/ clergy[c]	Tabib/ herbalist[d]	Family and friends[e]	Prayer and reciting Qur'an[e]
Age	0.10 (0.96, 1.03)	1.05(1.03, 1.08)*	1.01 (0.98, 1.04)	1.00 (0.97, 1.03)	1.03 (1.00, 1.05)**	1.00 (0.97, 1.02)
Gender						
Male	1.00	1.00	1.00	1.00	1.00	1.00
Female	0.67 (0.29–1.56)	1.32 (0.65, 2.67)	0.53 (0.28, 1.24)	0.66 (0.32, 1.38)	1.80 (1.04, 3.10)**	1.31 (0.73, 2.36)
Education						
≥HS diploma	1.00	1.00	1.00	1.00	1.00	1.00
University degree	0.77 (0.34–1.77)	1.14 (0.57, 2.27)	0.50 (0.22, 1.17)	0.39 (0.18, 0.84)**	0.72 (0.43, 1.22)	0.63 (0.36, 1.10)
Income						
Unstable	1.00	1.00	1.00	1.00	1.00	1.00
Stable	1.75 (0.73, 4.21)	0.93 (0.44, 1.97)	0.70 (0.29, 1.71)	2.132 (0.99, 4.60)***	0.85 (0.49, 1.46)	1.464 (0.82, 2.61)
Distress symptoms	1.05 (1.02, 1.07)*	1.05 (1.03, 1.07)*	1.03 (1.01, 1.06)**	1.05 (1.02, 1.07)*	1.05 (1.02, 1.07)*	1.04 (1.02, 1.06)****
	Pseudo $R^2 = 0.10$	Pseudo $R^2 = 0.17$	Pseudo $R^2 = 0.09$	Pseudo $R^2 = 0.12$	Pseudo $R^2 = 0.16$	Pseudo $R^2 = 0.09$

Due to missing data: [a] $N = 270$, [b] $N = 267$, [c] $N = 268$, [d] $N = 253$, [e] $N = 269$; * $P < 0.001$, ** $P < 0.05$, *** $P < 0.10$, **** $P < 0.01$.

addition, our factor analysis showed a clear divide between seeking expert assistance outside the home and more family-based help. Those seeking care outside the family, reported average higher ASCL scores than those seeking help through prayer or from family and friends. The authors were surprised to find that those seeking outside help were, on average, more distressed, which we speculate may be explained by the need for psychotropic medicines, herbs or therapies to reduce symptoms and improve functioning. Thus, as mentioned in the 'Results' section, the structure of the factor analysis might be viewed as reflecting severity of distress. However, the separate component for seeking help from Imams does not fit either the personal/family vs. outside the family difference or differences in severity of distress. Understanding why Imams are not linked with other sources of care is an important question for future research.

In some cultural contexts, including this one, distress symptoms are stigmatised by being viewed as weakness or a social failure (Saint Arnault, 2009). This may especially be an issue for males, given the role they must uphold within the family unit as arbiters and authority figures (Dupree, 2004). This may help explain the finding that men are much less likely to seek help from family and friends. The non-significant multivariable associations between gender and help-seeking from traditional healers, contradicts previous findings by Farooqi (2006) who noted women being constrained from seeking help outside the home and family. The reason for women's reluctance to seek help in public spaces is not entirely clear, but it may be due to our urban sample vs. Farooqi's respondents from more conservative rural areas, where gender segregation may be more pronounced.

The most intriguing finding is that seeking help from a Tabib is negatively associated with education level, but very close to positively associated ($P = 0.05$) with higher income. Although counterintuitive, this pattern makes sense when considering the context of Kabul, where many have high levels of education, which however does not necessarily align with income (Alemi *et al*., 2018). Indeed, in Kabul, money/wealth and higher education may be attached to different social functions. Higher education may challenge traditional methods and instils support for rational, scientific thinking, whereas reliance on Tabibs is perhaps the most 'traditional' (i.e. non-rational) method of help-seeking from a moderniser's perspective. Regardless, sufficient money is essential for getting help from a Tabib, whereas wealth may not contribute to 'modern attitudes', except through its association with education. Recall that income was *not* associated with seeking help from a Tabib at a bivariate level. Its positive relationship with seeking help from a Tabib only emerged when controlling for education.

Because distress was associated with all resources used, it is critically important what factors (besides need) underlie Afghans using different kinds of systems to address their mental health needs. In addition to going to professionals, a small but significant number of individuals seek help from Imams and Tabibs. In a climate where mental health problems are highly stigmatised, some clearly prefer to seek help from traditional healers because these agents, according to Rathod *et al.* (2017), tend to normalise, not

overpathologise life and subsequent mental health challenges. Furthermore, in this resource-poor, highly religious environment, unstable income allows persons with needs to access services (from Imams) that are free of charge and not as stigmatised. Although this finding did not hold in the multivariate analyses, income stability emerged as marginally significant predictor of seeking help from Tabibs, purveyors of herbs often used in self-help. Obtaining herbal medicines/substances requires the ability to pay, which may be expensive in urban Kabul, compared to rural areas where they are cultivated (Sato, 2012a,b).

Our findings on the whole point to the need for multipronged interventions to ameliorate adversity related distress and non-psychotic disorders among Afghans. Schools of medicine and mental health education programmes should educate their students in the value of community-based psychosocial supports, distinct from professional and in addition to biomedical and behavioural mental health services. As our results show, Afghans consider it both worthwhile, and indeed more natural, to turn to community based, more culturally congruent supports in times of stress.

Biomedical and behavioural health professionals should consider building professional relationships with Imams and Tabibs as a means to better understand the complex nature of the psychosocial supports that their patients draw upon, as demonstrated in our study, and to provide referrals for patients as warranted as part of an integrated care plan, which may help bridge the unmet service need in Afghanistan. The care plan should also include seeking help from family members and friends that each patient identifies as significant sources of social support. This care plan would formalise, and thus strengthen, the help-seeking that Afghans otherwise conduct informally. It would also include evidence-based practices from behavioural health, together with culturally based psychosocial approaches better understood by the practitioner, on a case-by-case basis. Much has been written on aligning social supports with both general and specialised medical care, but much less on an actual integration.

The Inter-Agency Standing Committee (2007) suggested a concurrent implementation of a layered system of support to meet the needs of different groups in emergency settings. These layers would comprise (a) basic services and security; (b) community, family and religious supports; (c) focused, non-specialised supports; and (d) specialised services, to be offered to (1) all individuals, (2) individuals able to maintain mental health and psychosocial wellbeing with assistance in accessing key support, (3) individuals requiring focused interventions, and (4) those requiring psychological or psychiatric supports due to substantial difficulties in basic daily functioning, respectively. Although a dearth in literature exists as to the nature of psychosocial supports, our results reveal a pattern of support that is instructive in at least two ways. First, Rogers (1962) *Diffusion of Innovations* theory informs many social work, community-based intervention programmes (refer to Dearing, 2009) and relies on the notion of spreading information, in this case, evidence-based supportive mental health beliefs and behaviours, through credible and trusted sources. Our results indicate Imams, Tabibs and certainly family members and friends serve in the supportive roles of advisory sources, or what Rogers would call ‘opinion leaders’. Biomedical and behavioural professionals can identify and connect with these opinion leaders to, together, develop interventions to spread positive mental health messages and practices.Second, although the literature is sparse in the field of mental health and psychosocial support in Afghanistan, patterns of social support somewhat similar to those found in our study have been effectively used in other health contexts in the country and would be useful to reference to build effective intervention programmes. For example, the well-known community health worker (CHW) model has been used to provide maternal and newborn health services (Haver, Brieger, Zoungrana, Ansari, & Kagoma, 2015). The CHWs were selected by trusted opinion leaders, the community health ‘shura’ (councils) and developed supportive relationships with clients resembling friendship. In Mayhew, Ickx, Stanekzai, Mashal, and Newbrander’s (2014) study, nonliterate CHWs provided nutritional counselling and assistance to clients using easily understood pictorial tools such as colour-coded pictorial charts for recording children’s weight gain, which could for example be important for monitoring the severity of distress symptoms over the course of psychosocial interventions as well.

Limitations

This study clearly has some limitations. First, the urban character of our study sample prevents findings from being generalisable to the Afghan population as a whole. Second, our survey relies on self-report data and not medical records to indicate use of various resources for support. In addition, the survey was limited in terms of measuring perceived stigma as a potential barrier to seeking help and specifying the types of medicinal herbs and perceived efficacy of such medicines or any of the other resources for help, which future studies should investigate further.

Conclusion

Our study examined the extent to which Afghans draw on modern and traditional resources for support and coping resources for addressing mental distress, and the factors that influence this help-seeking. We found that Afghans rely heavily on religious activities and support from family and friends, whereas a small, yet notable proportion of participants reported encounters with medical professionals and traditional healers – all of which were significantly influenced by higher severity of distress symptoms.

Given the broad types of both professional and community systems used to address mental health needs found here, future research should explore the reasons and the relative effectiveness behind these diverse approaches. Because many struggle with mental health challenges, as evidenced by the ASCL, it is not financially or otherwise feasible (given the lack of manpower/practitioners) for all to access biomedical and behavioural health systems. Tapping into

community-based systems, as so many already do, provides an opportunity for more to have access and improve their functioning, if these systems are indeed effective for some. To more adequately address the tremendous needs of post-war Afghans, important work lies ahead to integrate community-based informal supports with formal, professional systems.

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Conflicts of interest

There are no conflicts of interest.

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