Transcultural Psychiatry 0(0) 1–24 © The Author(s) 2016
Reprints and permissions: sagepub.co.uk/journalsPermissions.nav
DOI: 10.1177/1363461516660937 tps.sagepub.com
SAGE

transcultural psychiatry

Article

Contextualizing Afghan refugee views of depression through narratives of trauma, resettlement stress, and coping

Qais Alemi
Loma Linda University

Sigrid James
Loma Linda University

Susanne Montgomery
Loma Linda University

Abstract

This qualitative study explored how Afghan refugees conceptualize frames of mind that may reflect depression in general and as it relates to trauma they experienced. We performed in-depth interviews with 18 Afghans residing in the San Diego area. Views regarding the causes, symptoms, and perceived treatments of depression were gathered through free-listing techniques, and supplemented with narratives relating to pre- and post-resettlement stressors and coping mechanisms. Data were analyzed with standard qualitative content analysis methods. Items endorsed with relation to depression causality included pre-migration war traumas, notably separation from family, and post-migration stressors including status dissonance and cultural conflicts that ranged from linguistic challenges to intergenerational problems. Depressive symptoms were viewed as highly debilitating, and included changes in temperament, altered cognitions, avoidance and dissociative behaviors, and somatic complaints. Relief was sought through family reunification and community support, reliance on prayer, and the academic success of their children in the US. The findings underscore the need for practitioners to take into account situational stressors, cultural aspects of mourning and symptomatology, and existing coping mechanisms in developing interventions that are based on refugees' articulated needs.

Keywords

Afghan, beliefs, depression, qualitative, refugees

Corresponding author:
Qais Alemi, Department of Social Work & Social Ecology, Loma Linda University, 1898 Business Center Drive, San Bernardino, CA 92408, USA.
Email: qalemi@llu.edu

Introduction

The Afghan diaspora represents one of the most profound humanitarian crises of modern times. At the height of Afghanistan's political turmoil over six million refugees sought protection mainly in Iran and Pakistan (United Nations High Commissioner for Refugees [UNHCR], 2010). Approximately 65,000 Afghans (US Census Bureau, 2011) have resettled in the United States (US) with numbers consistently growing since 9/11 (US Department of Health & Human Services [USDHHS], 2012). Given refugee collective and personal experiences of loss and trauma (Kleinman, 2004), it is not surprising that a meta-analysis of depression in refugees exposed to political violence found depression rates as high as 44% (Lindert, von Ehrenstein, Priebe, Mielk, & Brähler, 2009).

Among Afghans specifically, prevalence rates were found to exceed 50% in the Netherlands (Gernaat, Malwand, Laban, Komproe, & de Jong, 2002; Gerritsen et al., 2006), similar to that of Afghans detained in Japan (Ichikawa, Nakahara, & Wakai, 2006), in a community dwelling sample in Australia (Sulaiman-Hill & Thompson, 2012), and in the US where researchers found that 45% met criteria for a lifetime diagnosis of depression (Mghir et al., 1995) . While diagnostic studies in the US are still lacking, mainly due to the hard-to-access nature of the population and the stigma attached to the term "depression," most recently, Alemi, James, Siddiq, and Montgomery (2015) found that a significant proportion of Afghans in the San Diego area experienced depressive symptoms at least once per week, corroborating findings of widespread depression previously identified in a mixed-method systematic review of studies on Afghan refugees and asylum seekers (Alemi, James, Cruz, Zepeda, & Racadio, 2014).

In addition to pre-migration experiences of loss and trauma (Mollica, Wyshak, de-Marnaffe, Khuon, & Lavelle, 1987), the prevalence of such negative mental health outcomes is further explained by Sluzki's (1979) seminal contribution showing that the migration process—from the initial preparatory stage to host country resettlement and thereafter—is laden with triggers for conflicts and symptoms. Namely, the *period of decompensation* or *crisis* occurring among newly resettled families precipitates a number of stressors that are rooted in familial confrontations. Such factors include value clashes that occur between parents and children who acculturate more readily, changes in family rules and ties, and distortions of (gender) roles and norms (Sluzki, 1979). Indeed, these experiences parallel the challenges that Afghans face in exile given the salience of "family" in Afghan culture (Dupree, 2002).

Despite this, the extent to which professional psychological help for depression is utilized or even favorably viewed among Afghan refugees has remained understudied. Apprehensions towards professional psychological help may be influenced by multiple factors, such as refugees' perceptions of suffering and illness etiology, distrust of Western medicine, unfamiliarity with Western medical methods, communication issues between physicians and patients, and lack of cultural awareness on the part of practitioners (Uba, 1992). Limited evidence suggests that Afghans perceive mental health care as culturally incongruent (Omeri, Lennings, & Raymond, 2006). The traditional response to refugee post-resettlement mental

health needs has generally adhered to a biomedical model, which emphasizes professional treatment (e.g. psychotherapy, antidepressants) for posttraumatic stress (Keyes, 1985). However, this approach of standard psychological care has been questioned given the more pressing fundamental refugee needs (Nicholl & Thompson, 2004) of physical health problems, employment, social support, and improving linguistic skills (Ryan, Dooley, & Benson, 2008).

Increasingly, psychosocial frameworks (Miller, 1999; Watters, 2001) suggest asking refugee patients for their views regarding the causes of their distress and focus on building protective qualities through identifying resiliency assets (e.g. family support, spirituality) (Weine, 2011) and increasing social capital (Strang & Ager, 2010) toward cultural integration. Support of such frameworks is exemplified in recent research with Bosnian (Sossou, Craig, Ogren, & Schnak, 2008), Iraqi (Arnetz, Rota, Arnetz, Ventimiglia, & Jamil, 2013), and Sudanese refugees (Khawaja, White, Schweitzer, & Greenslade, 2008), although Miller and Rasco (2004) suggest this does not negate the importance of psychological services. In view of this, Murray, Davidson, and Schweitzer (2010) propose that interventions must support refugees psychologically, educationally, financially, and socially and that such services need to correspond with refugees' cultural beliefs and norms.

Beliefs about depression and other mental health problems

Currently, our understanding of Afghan refugees' cultural perceptions about disorders such as depression is limited. Mental health studies of Afghans, both of refugees and those based in Afghanistan (Lopes Cardozo et al., 2004; Scholte et al., 2004), have predominantly focused on identifying depressive and posttraumatic stress levels. However, Eggerman and Panter-Brick (2010) recently found that among Afghans residing in Afghanistan, common reactions to life stressors (rooted in social problems) are characterized as irritability and anger, lethargy, agitation, chronic fatigue, headaches, and generalized bodily pain, and that family unity and harmony as well as strong religious convictions can mitigate such stressors. Miller et al.'s (2006) Afghanistan-based validation study of a culturally grounded mental health measure shows that psychological distress presents in varied ways including social withdrawal (e.g. self-isolation), somatic distress (e.g. headaches), ruminative sadness (e.g. *thinking too much*), and stress-induced reactivity (e.g. quarreling with neighbors and/or family members). In another study, Afghan refugees viewed health as inseparable from physical functioning, with causes of illness being "mental worries" (or "thinking too much") because of loneliness, unemployment, war experiences, and loss of family (Feldmann, Bensing, & de Ruijter, 2007). This, along with findings from other migrant populations, suggests that Afghans have a more *situational* (Patel, 1995) rather than biomedical belief system, describing depressive symptoms in the context of social problems or as emotional reactions to situations rather than a medical problem (Jacob, Bhugra, Lloyd, & Mann, 1998).

Situational belief systems may be more prominent among non-European-American (EA) populations. In a comparison of EA and South Asian (SA) women, EAs associated the etiology of depression with biological factors, and SAs with family and home problems related to "thinking too much" with consequences of "going crazy" if left untreated (Karasz, 2005). The notion of "thinking too much" (excessive rumination with intrusive thoughts and memories) or *koucharang* was a common response to stressors also observed among a sample of Cambodian refugees in the US (Frye & D'Avanzo, 1994) and also found in a comparison of Anglo-Australians and refugees from East Africa (Kokanovic, Dowrick, Butler, Herrman, & Gunn, 2008). Anglos in the latter study viewed depression as being "inherently individual" while the refugee subsample contextualized depression according to cultural dislocation, gender-role changes, and disruptions in family ties.

The salience of maintaining family bonds is also evident among Somali refugees resettled in New Zealand, whose preoccupation with reunifying with their families and other resettlement stressors were viewed as direct causes for "mental illness" rather than traumatic experiences, which were readily accepted as God's will (Guerin, Guerin, Diiriye, & Yates, 2004). In contrast, Maier and Straub (2011) show that among a heterogeneous sample of refugees in Switzerland, participants favorably viewed biomedical professionals in terms of treating their distress symptoms. However, among this sample psychological distress was conceived as resulting from a multitude of stressors linked to suffering of mind, body, and their whole person as a social self.

In addition, stigmatization of mental health challenges is widespread. Latino (Pincay & Guarnaccia, 2007) and Iranian immigrants (Martin, 2009) viewed mental health services as being for "crazy" persons, and there is evidence of apprehension toward anti-depressants among Hmong and Cambodian refugees (Lee, Lytle, Yang, & Lum, 2010), and Latinos (Cabassa, Lester, & Zayas, 2007). Chen and Mak (2008) argue that "understanding how people attribute mental health problems may illuminate whether and where they solicit professional care" (p. 448). For example, among Asian Americans, the reporting of somatic complaints resulting from depression has been associated with a greater likelihood of endorsing professional help-seeking given the social acceptability of seeking treatment for physical illnesses (Wong, Tran, Kim, Van Horn Kerne, & Calfa, 2010). Thus, framing psychiatric treatment as a way of coping with physical complaints may raise its acceptability for some (Kirmayer & Young, 1998). Apprehensions toward medical treatment may partly be explained by unfamiliarity with psychotherapy. For example, Daley (2005) showed that parents of Cambodian children with direct mental health treatment experiences perceived depression as more responsive to intervention than did a community comparison group with no experiences of treatment.

Aims of the current study

Allowing refugees to articulate their views with regard to the etiology of their problems (Watters, 2001) and exploring the lived experience of depression

(Kokanovic et al., 2008, p. 458) along with cultural aspects of mourning (Keyes, 2000) can contribute to the development of more culturally acceptable models of care and thus improve clinical outcomes (Bhui & Bhugra, 2002). To this end, the current study aimed to explore Afghans' conceptualizations of depression and experiences with depressive symptoms. Of note, we did not use diagnostic criteria, which would allow us to separate different forms of related mental health conditions, but focused on patients' own characterization of a state of feeling "depressed," wording commonly used among this population. The types of states described by our participants as "depression" are likely emotional reactions to situational stress, and therefore in many cases might be remediated through "low intensity" psychosocial interventions offered outside of formal mental health settings (Patel, 2014). Syndromes such as PTSD, although likely also prevalent among Afghan diasporic communities, were not specifically explored. Through a qualitative protocol, we examined views on the various subdomains of depression, that is, causes and risk factors, symptoms and consequences/sequelae, as well as treatments, using free-listing techniques. As a secondary aim, we augmented exemplary free-listed items/belief models by categorically linking them to participants' narratives of pre-migration traumas, post-resettlement stressors, and coping mechanisms using a standard content analysis technique (Sandelowski, 2000).

Methods

Salient methodological considerations in research with Afghan refugees

Afghans are generally considered a hard-to-access group for recruitment into research studies due to suspicions of outsiders (Spring et al., 2003), possibly due to their unfamiliarity with the research process, and in this case, particularly with respect to the potential stigma of taking part in a mental health study. This necessitated identifying culturally sensitive methods for gaining trust, access, and rapport with the Afghan refugee community as a preliminary step in the research process. Hence, before initiating the current study, we conducted preliminary key-informant interviews with clergy and community leaders from the Afghan community and Afghan and non-Afghan health and resettlement personnel, as well as focus groups with community members of various ages. Topics included: 1) the Afghan refugee population's size and socio-demographic make-up in the San Diego area; 2) suggestions on effective strategies for sampling, recruiting, and gauging the receptivity of Afghans for participating in a "mental health" study; and 3) the stressors and mental health conditions affecting Afghan refugees.

With relation to items 1 and 2 above, we learned that in order to gain access, trust, and rapport with the community, research with Afghans should: a) gain buy-in from religious leaders who can advertise research efforts within mosques given their established trust with community members; b) have researchers explain how the information from their interviews will be used (and avoid promising the

development of a mental health clinic to address their needs); c) give a more discrete tone to the mental health aspect of the study by describing the research as an effort to "learn about life experiences"; and d) adapt standard research procedures to increase cultural fit. These suggestions are reflected in our recruitment and data collection procedures below. With relation to item 3, we initially planned on only exploring the *concept* of depression shared by Afghans, but through key-informants found that there was a common word in the Dari language for this disorder, *afsurdagi*, to which participants attributed the themes described in the Results section.

Sampling and recruitment

This study was reviewed and approved by the affiliated university Institutional Review Board (IRB). Maximum variation sampling techniques were used to represent a wide range of variation in depression beliefs and narratives. We recruited participants of both genders, and of different age, education, ethnicity, and time since resettlement in the US. Inclusion criteria were: a) identification as Afghan; b) 18 years of age or older; c) resettlement in the US as a refugee, asylum seeker, or immigrant (provided there initially was a coercive element in their decision to flee Afghanistan). These criteria were made clear in advertisements for this study, which were announced immediately after Friday prayers by clergy in a local mosque predominantly attended by Afghans in the San Diego area. Potential participants were asked for their telephone numbers, and later contacted by the first author, who is also Afghan, to set up an appointment. Other recruitment activities included contacting general informants from our previous qualitative feasibility study, which in turn resulted in snowballing referrals of their peers. Additionally, the appointment of a female Afghan research assistant facilitated rapport with her personal social network of (ethnic Nuristani) women—subgroups otherwise inaccessible by merely recruiting through the local mosque.

Interview procedures

The first author conducted all interviews in Dari between July and October 2012. With the exception of two interviews conducted in a local mosque, all other interviews were conducted in participants' homes. As generally required by Afghan culture, spouses of some female participants (three of the seven) were present during interviews. Interviews lasted between 45 minutes and one hour. Participants were informed that a $10 cash donation would be made on their behalf to a mosque or charity of their choosing (in appreciation for their participation). Requests to audio-record the interview were turned down by participants. As a result this prevented verbatim transcriptions of responses; therefore, copious notes were taken by the first author during and immediately after interviews to optimize recall. Quotes from participants are thus slightly paraphrased but nevertheless accurately capture close-to-verbatim what the participants described.

To assure comparable theoretically salient concept exploration, a semi-structured interview guide was developed and translated from English to Dari. The interview was initiated with questions (and probes for clarification purposes) relating to 1) experiences while living in a "theater of war," 2) the process of fleeing Afghanistan and seeking refuge, 3) post-resettlement challenges, and 4) perceived gains and losses as a result of their resettlement. Interview responses allowed for subtle transitions between topics. For example, as most respondents described the effects of post-resettlement stressors on their well-being, we used these as segues to our last set of questions eliciting their beliefs on depression garnered through free-listing techniques. Free-listing is an elicitation technique that is designed to delineate the boundaries of a semantic and cultural *domain* or "subject matter of interest" that has no absolute definition (Weller & Romney, 1988), in this case depression. The process consists of asking respondents about a domain using open-ended questions to compile a list of salient items that represent elements in that domain. To elicit their beliefs about depression, we asked participants: 1) "What are the causes and risk-factors?;" 2) "What are the symptoms?;" 3) "What are the treatments?;" and 4) "What happens if a person with depression is not treated?" (related to disease consequences). To avoid inconsistences in responses due to the potentially hard-to-understand nature of the Dari equivalent for the term "risk factor," we substituted this with a phrase that was consistently applied in all interviews: "Who or what types of individuals are likely to be depressed?"

Data analysis

Free-listed items within the major subdomains of depression (i.e., causes and risk factors, symptoms and consequences, treatments) were augmented and contextualized through participant narratives regarding their migration experiences. In doing so, Qualitative Description (QD) techniques (Sandelowski, 2000) were applied for purposes of systematically analyzing narratives and ultimately aligning or linking them to free-listed items. QD is a preferred method when a rich description or presentation of the facts in everyday language is desired (Sandelowski, 2000), rather than thick description, theory development, or interpretive meaning (Neergaard, Olesen, Andersen, & Sondergaard, 2009). Hence QD stays close to the data for gathering straight descriptive summaries of experiences from the informants' point of view. Our qualitative content analysis procedure involved: 1) systematically applying a preexisting set of codes to the data (based on the interview guide), that is, interview transcripts, notes, insights, and reflections; 2) slightly modifying these codes and adding new codes based on emergent themes that were verified in debriefings with researchers; and 3) identifying similar patterns and phrases through counting in order to arrange data within coherent categories necessary for developing common themes. Data was collected and analyzed throughout the research process until sufficient saturation or a consistent pattern of responses to the interview protocol was reached.

Ensuring trustworthiness and rigor

The first author's own preconceived notions and potential biases based on experiences as an Afghan refugee were recognized. We addressed this by employing bracketing during data analysis (Tufford & Newman, 2012). This consisted of writing reflective commentaries and memos citing initial impressions and emerging patterns in the data, which were documented within a reasonable time after each interview and examined in light of previous research findings. Furthermore, credibility of our findings was assured by following guidelines provided by Shenton (2004). As noted earlier, we developed relationships with the local Afghan community through preliminary entry work. To promote honesty in participant responses, we emphasized data confidentiality as part of the informed consent process. Transparency in our analysis was documented through extensive (paraphrased) statements from participants (translated from Dari). Member checking was deemed non-feasible given the hard-to-reach nature of this group who view outsiders with suspicion, and to avoid increasing participant burden.

Results

Participants

We recruited 18 Afghans, 11 males and seven females ranging in age from 36 to 71 years, using maximum variation sampling, a type of purposive sampling (Patton, 1990) . Participants were predominantly of Pashtun ethnicity ($n = 8$). Educational attainment, ranged from the completion of grade school (mainly among women) to the possession of a college degree (only among men). Of the seven participants with college degrees (obtained in Afghanistan), only two were employed in their fields of study. The majority of the sample ($n = 12$ or 67%) reported being unemployed while two were in retirement. Time in the US varied widely, with three participants arriving less than one year prior to interview, while the majority arrived 10 or more years ago. Three participants originally resettled in the US seeking asylum, while the remainder resettled under refugee status. Characteristics of the sample are listed in Table 1.

This study identified several free-listed items describing participants' views regarding depression, which are presented here by themes that correspond with the subdomains of depression. Theme 1, "Causes and Risk Factors," consists of two subthemes, pre-migration traumas and post-migration stressors, respectively. Theme 2, "Depressive Symptoms and Consequences," contains two subthemes: "culture-bound syndromes," which can be defined as widely recognized prototypical cultural ailments (Rasmussen, Ventevogel, Sancilio, Eggerman, & Panter-Brick, 2014); and "idioms of distress," which are more general ways of experiencing and expressing distress (Rasmussen et al., 2014). Theme 3, "Treatments," contains two subthemes as well: "social support," and "making meaning of life." Free-listed items were augmented with narratives for contextual purposes. Whenever possible we conducted comparisons by sub-group of respondents. Overall, depression or its

Table 1. Sample characteristics ($N = 18$).

Variables	*N* (%) or *Mean* (*SD*)
Mean age (*SD*) [years]	55.7 (9.5)
Gender	
Males	11 (61.1)
Educational attainment	
Less than HS diploma	3 (16.7)
HS diploma	8 (44)
Bachelor's degree/equivalent or higher	7 (39)
Employment	
Employed	6 (33.3)
Unemployed	12 (66.7)
Ethnicity	
Hazara	2 (11.1)
Nuristani	5 (27.8)
Pashtun	8 (44.4)
Tajik	3 (16.7)
Marital status	
Married	15 (83.3)
Other (never married, separated, widowed)	3 (16.7)
Mean time in US (*SD*) [years]	17.3 (10.7)
<1 to 2	4 (22.2)
>10	14 (77.8)
Mean time in Afghanistan during war (*SD*) [years]	7.4 (8.3)
<1	2 (11.1)
1 to 10	11 (61.1)
>10	5 (27.8)
Communication w/family in Afghanistan	2 (11.1)

Dari equivalent, *afsurdagi*, was conceptualized by participants as an everyday way of communicating distress, dissatisfaction, or disgruntlement resulting from the migration process. Table 2 summarizes themes and denotes the frequency of free-listed items endorsed within each of these themes.

Theme 1: Causes and risk factors

Subtheme 1a: Pre-migration traumas. Half of the participants ($n = 9$) endorsed "*war-related experiences*" as a cause of depression, irrespective of socio-demographic strata. In particular, narratives indicated that experiences common to virtually all participants included imprisonment of family members, arbitrary home invasions, and interrogations that were carried out by government agents under the

direction of the communist regime in power during the 1980s and earlier part of the 1990s. Also, fears of being killed and the eminent threat of maltreatment at the hands of ruling and/or warring factions that vied for power after the Soviet withdrawal stripped many of their sense of safety. These events, along with destroyed infrastructure, ultimately led to participants' decision to flee Afghanistan to neighboring Pakistan with the help of smugglers. Participants recounted traversing mountain passes on foot and/or horseback, temporarily seeking shelter in villages, enduring periods of hunger, and facing the threat of being killed along the way. The sentiments noted below reflect some of these experiences:

> Anyone that has come to the US with any memory of life experiences in Afghanistan is scarred emotionally (Male, 51)
> I could never forget my memory of seeing a person's (amputated) hands and feet hung off a lamp post, of a person who had stolen something, I will never forget this . . . It's a very bad memory. (Male, 36)
> My husband has a nervous tic . . . His head and hands shake and it's because of the things we experienced. . . Someone had accused him of something, and he was kidnapped and beaten. (Female, 63)

In spite of such horrific accounts, for many participants, the abrupt separation from their families was apparently the most detrimental source of trauma. This was evidenced by participants ($n = 10$) who cited "distance from family" or "not having family around" as a cause of depression. Narratives suggested that the overarching consequence of the migration process as a whole was that it broke families apart and left many worried about family abroad. Notably six of the seven females in our sample endorsed this item, one of whom discussed her main worries stemming from having all of her children scattered throughout central Asia.

Subtheme 1b: Post-resettlement stressors. Resettlement was associated with a great deal of hardship for all, which exacerbated stressors relating to the loss of family and support systems. Specifically, males associated depression causality with being "unable to culturally adjust" ($n = 7$) (i.e. gaining environmental mastery), while females noted fears of facing transportation ($n = 5$) and English language proficiency problems ($n = 3$). Female participants ($n = 4$) who linked their gender group to being at highest risk for depression noted that these difficulties affected them particularly during the first year of resettlement. These post-resettlement challenges deterred normal social interaction with the mainstream culture, exacerbating feelings of loneliness and isolation in light of being overwhelmed with having to control their children who were adapting to US culture at a much faster pace:

> When we first arrived to the US I had a lot of stress and *gham*/sadness, my kids were young and sitting at home really made my stress worse . . . it really affects me that I can't speak the language. (Female, 53)

Narratives of several participants indicated that language difficulty was a deterrent for obtaining gainful employment leading to financial strains on families. Not surprisingly, six male participants felt that financial difficulties cause depression. Financial problems were, and for some continued to be, a major burden, as exemplified by the accounts of all recently resettled males and other males' recounting of their pasts. While originally resettling in Denmark as a refugee, one of these participants' current legal status as an immigrant to the U.S. disqualified him from any sort of government assistance:

> Because I arrived here as an immigrant [and not a refugee] I can't get health insurance for my children, or even welfare benefits, my main concern is that I don't have a stable job. (Male, 56)

Two ($n = 2$) of the recently resettled male participants endorsed their particular "housing/accommodation related difficulties" as a cause of depression. For example, one participant indicated that he resided in a small apartment with his wife and five children and constantly had to discipline his children who often drew noise complaints from other tenants along with eviction warnings from his lessor:

> We are a very loud people, you can't tell your children to be quiet, they don't understand why you want them to be quiet because back home they never needed to be... here you spend your days controlling your children, which leaves little time for teaching them anything right. (Male, 49)

Additionally, this participant described the amount of cash assistance he received monthly from welfare agencies, his high rent, and inability to find a larger place to live, as well as the need to make ends meet by taking up jobs that paid in cash (to avoid reporting income to social services). One female participant suggested that, despite wanting to work, welfare agencies would place her in jobs that she could not perform because of physical labor demands. This was also mentioned by other participants who described social services agencies as insensitive to their needs, referring them to unsustainable jobs that did not match their interests, skills, and language abilities:

> God protect us [Afghans] from welfare... they would just put us in jobs that we could not do. (Female, 54)
> Welfare would threaten to cut my benefits because they thought I was being dishonest about my English ability... they just wanted me to get a job and cut my benefits. (Male, 58)

Sentiments about social services were generally negative as they described the lack of commitment to assisting newcomers with various needs. For example, five men holding medical licensures from Afghanistan found that they could not practice their professions in the US. Three of these men further suggested that no assistance or direction was provided on how to seek recognition for degrees earned abroad.

One participant who was a physician in Afghanistan discussed how a local resettlement agency assisted him in passing an initial examination for medical re-licensure. However, he later realized that he could not pursue the subsequent examinations given his pressing economic need. On his own, he then obtained a certificate certifying him to work an entry-level job in a local hospital. Participants also indicated that Afghans who had previously resettled were unwilling to assist new arrivals with various resettlement challenges, including navigating social services systems, seeking higher education, or finding employment.

Mainly among males, the perceived sense of "losing culture and identity" ($n = 7$) was linked to causing depression. Participants noted that the events taking place in their lives ultimately stripped them of everything they valued—their country and identity as Afghans, as well as their culture, childhood memories and friends, and professions. Some declared they did not know whether to identify as an "Afghan" or an "American." Interview transcripts of three newly resettled males indicated a sense of disconnection from or misunderstanding of mainstream (American) culture. Several male participants also suggested that family bonds had been shattered in America given the fulfillment of overwhelming life demands needed in order to survive. Some discussed the fact that they no longer sat at the same *dastarkhan* (cloth spread out on floor) to eat meals together as they did in Afghanistan.

> I lost my country, childhood memories and friends. In Afghanistan friends are like brothers and having that here isn't possible. (Male, 43)
>
> Go to our cemeteries and look at the poems on peoples' [i.e. Afghans'] tombstones, the common things you read are that people wanted to die in their country, which means they were under some type of stress and pressure . . . We always have a desire to return home and that is because we feel a void here. We are lacking something because we deal with schools that don't teach Islam, obtaining halal foods is an issue . . . The culture is just different. (Male, 49)
>
> I have gained financial stability, but emotionally, no matter how comfortable your life is, you are always focused on how to survive. (Male, 51)

Several participants ($n = 6$) (mainly males) cited "disrespect and value changes" observed in children as a cause of depression. Subgroups such as the elderly were viewed by many ($n = 11$) as being at highest risk for being socially isolated and depressed. The narratives linked this in large part to young Afghans' choice to not speak Dari at home. All of the male participants related their frustrations with being unable to instill proper values in their children. In addition to not maintaining their native language, participants related young Afghans' disrespect to not spending much time at home, as well as eating pork and drinking alcohol. Some discussed how their children chose to live independent and private lives and deliberately disassociated themselves from the family unit:

> Because Afghans have become independent strong relations that have held families together in Afghanistan become loosened . . . many households have lost their children

> because they have boyfriends and girlfriends, and they get involved with using drugs and alcohol, which leads to depression for us. (Male, 60)
> Many suffer from not being able to control children . . . their children let go of who they are and that lifestyle doesn't fit with us. (Male, 54)
> We can no longer eat together, there is no *dastarkhan*, and respect towards parents back home was high . . . here children don't associate with parents nor do they respect them. (Male, 63)

Theme 2: Depressive symptoms and consequences

Subtheme 2a: Cultural concepts of depression. Participants viewed depression as a debilitating disorder, which manifests itself in various ways and that can lead to more severe mental and physical conditions. Items endorsed with relation to depressive symptoms included an array of culture-specific symptoms. The most frequently mentioned was *asabi* ($n = 11$), which can be equated to "irritability." In relation to this, one male participant described that people with depression lose control of their temper, complain often, and find excuses for fighting or arguing with others. One female participant characterized depression as "being in a daze" or "in another world," which can be linked to the excessive rumination that many participants thought depressed persons succumbed to, such as "thinking too much" ($n = 5$). This excessive rumination was the basis for their belief that depression leads to unexplained sadness or its indigenous equivalent *gham* ($n = 2$). Additionally, free-listing also revealed that behaviors such as *goshagiry* or "self-isolation" ($n = 8$) were seen as indicative of depression. For example, one male participant indicated that depressed individuals "do not like associating with family nor hold relationships with people."

Subtheme 2b: Consequences of depression. Participants indicated that depression affects functioning, as a few participants endorsed "inability to perform daily tasks" as a symptom ($n = 4$), akin to impairments in concentration. Several individuals described depression in the context of somatic symptoms. Items endorsed included "abdominal pain" ($n = 2$), "dizziness" ($n = 2$), "insomnia" ($n = 2$), "pale complexion" ($n = 2$), and "overeating" ($n = 2$). One female, 54, described the fact that she reacted to the stress resulting from many years of facing money problems by overeating, and eventually developed terminal cancer. Others believed that not controlling depression would lead to "going crazy" ($n = 6$), the "disease getting worse" ($n = 5$), "suicide" ($n = 5$), "dementia" ($n = 3$), and "chronic diseases" ($n = 2$).

Theme 3: Treatments for depression

Subtheme 3a: Social support. Free-listing indicated that the use of "medicine" ($n = 8$) was the most highly endorsed method of treating depression; others included "keeping oneself busy" ($n = 3$), "leisure" ($n = 2$), and having a "stable income"

($n = 2$). However, another salient aspect of treating depression endorsed was "being together with family" ($n = 6$), which was described in virtually all narratives. Additionally, the need for social supports was further validated by a few participants who felt depression could be treated by "socializing with people of similar age and language preference" ($n = 2$). Participants discussed the need for Afghan community leaders to establish an organization to assist fellow Afghans with resettlement obstacles as well as to promote cultural integration. The statements below reflect this need:

> With the help of the government, Afghans should establish a place where elderly Afghans who can't speak English, and who prefer to speak Dari or Pashto could socialize. (Female, 62)
> An Afghan-led community-based organization could link Afghans with non-Afghan [American] communities in order to facilitate cultural exchanges. (Male, 48)
> Refugees who arrive in America are given all types of welfare benefits . . . but the government has to do more in developing a community association for newcomers that could help them adjust to their environment. (Male, 56)

Subtheme 3b: Making meaning of life. Some ($n = 4$) endorsed prayer as a treatment of depression, which is illustrated by a few participants who shared sentiments of gratitude for "Allah's protection" in assuring their safety and security in the US in their discussions. Participants also endorsed "accepting one's situation" ($n = 2$) as a treatment of depression, which resonated within narratives suggesting that events taking place in their lives, ultimately bringing them to America, were viewed to be preordained by God. Furthermore, the attribution of depression to "God's will" is exemplified by the following:

> God has willed diseases such as depression on people, and therefore can take them away, so asking God for help is a solution. (Male, 36)

All participants expressed that despite losing everything, their country, culture, and material possessions, they at least felt safe in America. One male participant described the fact that even though he left many things behind in Afghanistan and had to constantly remind his daughter to speak Dari and observe Islam, he felt that he was a winner. The statement below also reflects the sense of safety gained:

> I could not live a safe life in Afghanistan, there is no meaning in life when there is no safety. (Female, 39)

Despite the limited number of participants directly endorsing "children's success" ($n = 2$) as a treatment for depression, it was apparent in several narratives that success was primarily conceived in terms of children obtaining a college degree, and secondly, as prospering in terms of jobs and money. Virtually all participants

Table 2. Views of depression by theme and frequency of endorsed free-listed items ($N = 18$).

Theme 1: Causes and risk-factors	Subtheme 1a. Pre-migration traumas	war-related experiences ($n = 9$); separation from family ($n = 10$)
	Subtheme 1b. Post-resettlement stressors	cultural adjustment/environmental mastery ($n = 7$), financial hardship ($n = 6$), inability to drive ($n = 5$), English language difficulties ($n = 3$), overcrowded housing situation ($n = 2$); loss of culture and identity ($n = 7$), children losing cultural values/disrespect towards parents ($n = 6$), children wearing un-Islamic/revealing clothing ($n = 1$); marital problems ($n = 4$), thinking too much ($n = 4$), uncertainty about future ($n = 2$), gender role reversals ($n = 1$), counseling others' emotional problems ($n = 1$);
		risk-factors include: old age ($n = 11$), female gender ($n = 4$), male gender ($n = 3$), stressful lifestyle ($n = 1$)
Theme 2: Symptoms and consequences	Subtheme 2a. Cultural concepts of depression	*asabi*/irritability ($n = 11$), *goshagiry*/self-isolation ($n = 8$), "thinking too much" ($n = 5$), *ghamgeen*/sadness ($n = 2$)
	Subtheme 2b. Consequences of depression	inability to complete daily tasks ($n = 4$), crying ($n = 2$), insomnia ($n = 2$), overeating ($n = 2$), fearfulness ($n = 1$), lack of patience ($n = 1$), inconsiderate towards others ($n = 1$), mute, self-harm ($n = 1$), talking to oneself ($n = 1$);
		sequelae include: going crazy/madness ($n = 6$), disease gets worse ($n = 5$), suicide ($n = 5$), dementia ($n = 3$), abuse of alcohol and other drugs ($n = 2$), chronic diseases ($n = 2$), ineffective immune system ($n = 2$), chemical imbalances ($n = 1$), *goshagiry*/self-isolation ($n = 1$), hospitalization ($n = 1$), lack of respect towards others ($n = 1$), laziness ($n = 1$), ulcers ($n = 1$)
Theme 3: Treatments	Subtheme 3a. Social support	being together with family ($n = 6$), socialization w/people of similar age and language ($n = 3$)
	Subtheme 3b. Making meaning of life	prayer ($n = 4$), acceptance of one's life situation (as God's will) ($n = 2$), children's educational success ($n = 2$)
	Other treatments	medicine ($n = 8$), keeping oneself busy ($n = 3$), leisure ($n = 2$), stable income ($n = 2$), being calm ($n = 1$), getting out and about ($n = 1$), good environment ($n = 1$), self-efficacy ($n = 1$), self-sufficiency/not having to rely on others ($n = 1$), counseling ($n = 1$)

equated succeeding in life with their children's progress. Participants who had resettled earlier discussed the strides their children had made in the US, while recently resettled participants, although currently facing many obstacles, discussed their hopes for the future in terms of their children having opportunities they would not have had in Afghanistan or elsewhere. In sum, a striking feature in almost all interviews was that leaving everything behind in Afghanistan was viewed as a *qurbaani* or "sacrifice" for their children's prosperity:

> For me coming to America was a blessing . . . they provided us with good housing and assistance, my children got good jobs and an education. (Female, 70)
> I sacrificed my profession so my children could find a way in life. (Male, 71)
> Here it is good for the children, but I can't work, I can't talk to anyone, I can't have friends. (Female, 53)
> My hope is that my daughters will receive an education, and that their future is good, we feel more certain about this here in America. (Female, 63)

Table 2 summarizes themes, subthemes, and associated free-listed items. The values assigned to free-listed items represent the number of respondents who endorsed such items, which are not mutually exclusive of one another.

Discussion

This study contributes to a sparse but growing body of literature on Afghan refugee resettlement experience. Our findings broaden the understanding of pre- and post-resettlement stressors unique to this population by providing insights into what the community sees as fitting interventions. Our findings on Afghans' views of depression are consistent with studies of Afghans exploring similar domains (Guerin et al., 2004; Kokanovic et al., 2008; Lee et al., 2010), which have demonstrated that the causes of depression are believed to be situational. We also confirmed Feldmann and colleagues' (2007) finding that mental worries resulting from pre- and post-resettlement stressors are an integral facet of health status for Afghans.

Participants attributed depression to *loss*, a common experience among refugees that includes losing family and friends, material possessions, as well as a shared language and culture (Wojcik & Bhugra, 2010). Participants recounted negative experiences that essentially took from them everything they held dear—notably their Afghan "identity," which Miller (1999) defines as the social roles played within the household and community that give a sense of purpose in life. This was particularly a problem for highly educated men, who by their own accounts were virtually powerless upon resettlement in the US because they could not use the degrees they earned in Afghanistan and as a result faced unemployment and dependence on public assistance.

Our findings coincide with Panter-Brick and Eggerman's (2012) assertion that war traumas may not be the principle driver of poor mental health among refugees;

rather, it is fractured family relationships, along with failures in achieving personal, social, and cultural milestones that result in distress. The predicaments described by our participants give credence to Porter and Haslam's (2005) comment that rather than having a protective effect against displacement-related stressors, higher social status pre-displacement may result in greater post-displacement loss of status. Other social stressors for both men and women included: perceptions of being subjected to the whims of social services programs in terms of benefits allocation, housing arrangements, and unsuitable job placements due to language, money, and transportation problems; lack of social supports; and intergenerational conflicts.

In view of these predicaments, the depressive symptoms of Afghans and other refugees might be viewed as a normal emotional reaction (Jacob et al., 2008) to the chronic and multiple stresses of unmet needs and lack of resources (e.g. emotional support) (Ryan et al., 2008). Proponents of a holistic framework (Watters, 2001) call on clinicians to be open and receptive to the explanations given by refugees as to the causes of their depressive symptoms, which may provide a basis for initiating a more culturally sensitive therapeutic process.

Our results also show that participants viewed depression as having effects on temperament, cognition, and functioning, with indicators inclusive of various physical ailments consistent with prior studies (Cabassa et al., 2007). Symptoms such as "self-isolation" are consistent with previous studies of Cambodian refugees (Frye & D'Avanzo, 1994), and align with avoidance behaviors found in persons diagnosed with depression and in persons with PTSD. Other symptoms reported that also overlapped with symptoms of PTSD included becoming *asabi*, or irritable, resembling "affect dysregulation;" "inability to carry out daily tasks," which relates to impaired concentration; and, "being in a daze," which parallels disturbances in consciousness found in dissociative subtypes of PTSD. Similarly, Miller and colleagues (2006) found overlap between symptoms of distress and PTSD in Afghanistan. The descriptions of depression suggest that for some depression may be a *sociosomatic* experience where social instability and disorder create suffering in the body (Karasz, 2005). Here, this disorder partly relates to changes in family structures rooted in the many disruptions caused by the migration process, as similarly observed among Latino migrants (Pincay & Guarnaccia, 2007).

Moreover, similar to Latinos (Cabassa et al., 2007), the association of risk of suicide and dementia with depression, and the view that depression worsens over time suggest that participants perceive the condition as one that can be highly debilitating if symptoms are not resolved. Consistent with findings among South Asian immigrants (Karasz, 2005), "thinking too much" and concerns about depression leading to "madness" or "going crazy" were common among our participants.

A striking aspect of participants' views on treating depressive symptoms related to the use of medication, which was the most highly endorsed item within this domain. This is similar to Maier and Straub's (2011) findings in a heterogeneous sample of refugees and is in contrast with the apprehensions about antidepressants

documented among Hmong and Cambodian refugees (Lee et al., 2010). This endorsement of a biomedical approach to treatment may be explained by the fact that most of our participants were linguistically acculturated and thus perhaps exposed to western models of disease treatment or the fact that antidepressants are simply viewed as an effective yet temporary solution. However, consideration should be given to medication side-effects, which may reinforce refugees' preconceived notions that pharmaceuticals are too strong and are likely to do more harm than good (Lin, Fancher, & Cheung, 2010). Given this potential openness to utilizing medical treatments, psychoeducation about (available) mental health services is important. Additionally, clinicians in primary care settings, a portal through which ethnic minorities have been shown to seek mental health care, should be more cognizant of somatic symptoms and perhaps tailor interventions around addressing physical complaints (Kirmayer & Young, 1998).

This study also points to the potential value of implementing psychotherapy in community settings outside of stigmatized mental health clinics (Miller, 1999). These settings may include mosques where Imams and lay Afghan community members could take part in delivering interventions that build resilience by drawing on religious and family coping mechanisms. Preventative interventions organized around resilience themes may benefit families who are reluctant to engage in mental health care because of persistent stigma of mental illness (Weine, 2011; Sossou et al., 2014).

The importance of social support was emphasized across many narratives in this study; indeed some viewed it as a treatment for depression. Participants alluded to the need for stronger bonds within the Afghan community and the limited support they received from the already settled Afghan community. Lipson's (1991) research in northern California found that Afghans showed little interest in cooperating with each other, were slow to build new friendships given distrust of those outside the extended family circle, and sometimes jealously guarded valuable pieces of information (Lipson & Omidian, 1997). Additionally, participants expressed desires to engage with non-Afghan communities to promote integration and mutual understanding of cultures. This accords with Strang and Ager's (2010) principles of promoting integration by building social capital. Such models have the potential to connect newly resettled Afghans with Afghans experienced in the migration process for addressing situational stressors related to finding gainful employment, learning how to drive, and seeking vocational training and/or higher education.

Limitations

We had limited variation in age in our sample as men and women (between the ages of 18–35) who resettled in the US with their parents at a young age were not recruited because most had already moved away from predominantly Afghan communities. Views of depression may vary greatly from this presumably more acculturated group with possibly higher adherence to western or biomedical models

of mental illness gained through adaptation to US culture and formal education. Nonetheless, findings here capture the essence of the Afghan refugee experience as informed by a sample composed of both recent arrivals and those with long-term resettlement who stayed close to their US Afghan community and reflect variation in education, ethnicity, and gender.

The free-listing technique may not have elicited an exhaustive list of items related to depression because of informants' recall or understanding of the instructions (Weller & Romney, 1988). Additionally, because participants refused to be audiotaped during interviews, we were limited to note-taking. Lastly, since we never asked the respondents if they themselves had experienced depression (or administered a screening scale) the relationship of the free-listed items to clinical depression is uncertain. Also, items related to depression may overlap with symptoms of PTSD. However, we know that rates of depression in this community are high (Alemi et al., 2014), and our approach provided insights into how the term depression and related symptoms are understood and thought to evolve.

Conclusions

The challenges that Afghans continue to face in exile are multifaceted and many of our respondents aligned them with the concept of depression. Our research also points to a general openness to interventions that take into account situational stressors, cultural aspects of mourning and symptomatology, and existing coping mechanisms. We suggest the need to develop culturally sensitive interventions that take into account multiple aspects of the refugee experience. Future research with Afghans should evaluate the efficacy of interventions that respond to their basic needs for improving health and well-being. Research in this relatively closed community should begin by building rapport with trusted key stakeholders and using culturally contextualized methods as described in this study.

Acknowledgments

The authors of this study dearly thank the leaders of the San Diego Afghan community for their valuable insights. We also extend our sincere gratitude and appreciation to the participants of this study.

Declaration of conflicting interests

The author(s) declared no potential conflicts of interest with respect to the research, authorship, and/or publication of this article.

Funding

The author(s) disclosed receipt of the following financial support for the research, authorship, and/or publication of this article: This manuscript was supported in part by the Sigma Xi dissertation scholarship, Loma Linda University (recipient Q. Alemi), and by the National Institute of Mental Health (NIMH) K01 MH077732-01A1 (PI: S. James).

References

Alemi, Q., James, S., Siddiq, H., & Montgomery, S. (2015). Correlates and predictors of psychological distress among Afghan refugees in San Diego County. *International Journal of Culture & Mental Health*. doi: 10.1080/17542863.2015.1006647

Alemi, Q., James, S., Cruz, R., Zepeda, V., & Racadio, M. (2014). Psychological distress in Afghan refugees: A mixed-method systematic review. *Journal of Immigrant & Minority Health*, *16*(1), 1247–1261.

Arnetz, J., Rofa, Y., Arnetz, B., Ventimiglia, M., & Jamil, H. (2013). Resilience as a protective factor against the development of psychopathology among refugees. *The Journal of Nervous and Mental Disease*, *201*(3), 167–172.

Bhui, K., & Bhugra, D. (2002). Explanatory models for mental distress: Implications for clinical practice and research. *The British Journal of Psychiatry*, *181*(1), 6–7.

Cabassa, L. J., Lester, R., & Zayas, L. H. (2007). "It's like being in a labyrinth": Hispanic immigrants' perceptions of depression and attitudes toward treatments. *Journal of Immigrant and Minority Health*, *9*(1), 1–16.

Chen, S. X., & Mak, W. W. (2008). Seeking professional help: Etiology beliefs about mental illness across cultures. *Journal of Counseling Psychology*, *55*(4), 442–450.

Daley, T. C. (2005). Beliefs about treatment of mental health problems among Cambodian American children and parents. *Social Science & Medicine*, *61*(11), 2384–2395.

Dupree, N. H. (2002). Cultural heritage and national identity in Afghanistan. *Third World Quarterly*, *23*(5), 977–989.

Eggerman, M., & Panter-Brick, C. (2010). Suffering, hope, and entrapment: Resilience and cultural values in Afghanistan. *Social Science & Medicine*, *71*(1), 71–83.

Feldmann, C. T., Bensing, J. M., & de Ruijter, A. (2007). Worries are the mother of many diseases: General practitioners and refugees in the Netherlands on stress, being ill and prejudice. *Patient Education and Counseling*, *65*(3), 369–380.

Frye, B. A., & D'Avanzo, C. (1994). Themes in managing culturally defined illness in the Cambodian refugee family. *Journal of Community Health Nursing*, *11*(2), 89–98.

Gernaat, H. B., Malwand, A. D., Laban, C. J., Komproe, I., & de Jong, J. T. (2002). Many psychiatric disorders in Afghan refugees with residential status in Drenthe, especially depressive disorder and post-traumatic disorder. *Nederlands Tijdschr Geneeskd*, *146*(24), 127–131.

Gerritsen, A. A., Bramsen, I., Devillé, W., Van Willigen, L. H., Hovens, J. E., & Van Der Ploeg, H. M. (2006). Physical and mental health of Afghan, Iranian and Somali asylum seekers and refugees living in the Netherlands. *Social Psychiatry and Psychiatric Epidemiology*, *41*(1), 18–26.

Guerin, B., Guerin, P., Diiriye, R. O., & Yates, S. (2004). Somali conceptions and expectations concerning mental health: Some guidelines for mental health professionals. *New Zealand Journal of Psychology*, *33*(2), 59–67.

Ichikawa, M., Nakahara, S., & Wakai, S. (2006). Effect of post-migration detention on mental health among Afghan asylum seekers in Japan. *Australian & New Zealand Journal of Psychiatry*, *40*(4), 341–346. doi: 10.1080/j.1440-1614.2006.01800.x

Jacob, K. S., Bhugra, D., Lloyd, K. R., & Mann, A. H. (1998). Common mental disorders, explanatory models and consultation behaviour among Indian women living in the UK. *Journal of the Royal Society of Medicine*, *91*(2), 66–71.

Karasz, A. (2005). Marriage, depression and illness sociosomatic models in a South Asian immigrant community. *Psychology & Developing Societies*, *17*(2), 161–180.

Keyes, C. F. (1985). The interpretive basis of depression. In A. Kleinman, & B. J. Good (Eds.) *Culture and depression*. Berkeley: University of California Press.

Khawaja, N. G., White, K. M., Schweitzer, R., & Greenslade, J. (2008). Difficulties and coping strategies of Sudanese refugees: A qualitative approach. *Transcultural Psychiatry*, *45*(3), 489–512.

Kirmayer, L. J., & Young, A. (1998). Culture and somatization: clinical, epidemiological, and ethnographic perspectives. *Psychosomatic Medicine*, *60*(4), 420–430.

Kleinman, A. (2004). Culture and depression. *The New England Journal of Medicine*, *351*(10), 951–953.

Kokanovic, R., Dowrick, C., Butler, E., Herrman, H., & Gunn, J. (2008). Lay accounts of depression amongst Anglo-Australian residents and East African refugees. *Social Science & Medicine*, *66*(2), 454–466.

Lee, H. Y., Lytle, K., Yang, P. N., & Lum, T. (2010). Mental health literacy in Hmong and Cambodian elderly refugees: A barrier to understanding, recognizing, and responding to depression. *The International Journal of Aging and Human Development*, *71*(4), 323–344.

Lipson, J. G. (1991). Afghan refugee health: Some findings and suggestions. *Qualitative Health Research*, *1*(3), 349–369.

Lipson, J. G., & Omidian, P. A. (1997). Afghan refugee issues in the US social environment. *Western Journal of Nursing Research*, *19*(1), 110–126.

Lin, K., Fancher, T., & Cheung, F. (2010). Psychopharmacology for refugees and asylum seekers. In D. Bhugra, T. Craig, & K. Bhui (Eds.) *Mental health of refugees and asylum seekers* (pp. 141–159). New York, NY: Oxford University Press.

Lindert, J., von Ehrenstein, O. S., Priebe, S., Mielck, A., & Brähler, E. (2009). Depression and anxiety in labor migrants and refugees–a systematic review and meta-analysis. *Social Science & Medicine*, *69*(2), 246-257.

Lopes Cardozo, B., Bilukha, O., Gotway Crawford, C., Shaikh, I., Wolfe, M., Gerber, M., & Anderson, M. (2004). Mental health, social functioning, and disability in postwar Afghanistan. *Journal of the American Medical Association*, *292*(5), 575–584. Retrieved from http://jama.jamanetwork.com/article.aspx?articleid=199195

Maier, T., & Straub, M. (2011). "My head is like a bag full of rubbish": Concepts of illness and treatment expectations in traumatized migrants. *Qualitative Health Research*, *21*(2), 233–248.

Martin, S. S. (2009). Illness of the mind or illness of the spirit? Mental health-related conceptualization and practices of older Iranian immigrants. *Health & Social Work*, *34*(2), 117–126.

Mghir, R. I. M., Freed, W., Raskin, A., & Katon, W. (1995). Depression and posttraumatic stress disorder among a community sample of adolescent and young adult Afghan refugees. *The Journal of Nervous and Mental Disease*, *183*(1), 24–30.

Miller, K. E. (1999). Rethinking a familiar model: Psychotherapy and the mental health of refugees. *Journal of Contemporary Psychotherapy*, *29*(4), 283–306.

Miller, K. E., & Rasco, L. M. (2004). An ecological framework for addressing the mental health needs of refugee communities. In K. E. Miller, & L. M. Rasco (Eds.) *The mental health of refugees: Ecological approaches to healing and adaptation* (pp. 1–64). Mahwah, NJ: Lawrence Erlbaum.

Miller, K. E., Omidian, P., Quraishy, A. S., Quraishy, N., Nasiry, M. N., Nasiry, S.,. . . ,Yaqubi, A. A. (2006). The Afghan symptom checklist: A culturally grounded

approach to mental health assessment in a conflict zone. *American Journal of Orthopsychiatry*, *76*(4), 423–433.
Mollica, R. F., Wyshak, G., de-Marnaffe, D., Khuon, F., & Lavelle, J. (1987). Indochinese versions Hopkins Symptom Checklist-25: A screening instrument for the psychiatric care of refugees. *American Journal of Psychiatry*, *144*(4), 497–500.
Murray, K. E., Davidson, G. R., & Schweitzer, R. D. (2010). Review of refugee mental health interventions following resettlement: Best practices and recommendations. *American Journal of Orthopsychiatry*, *80*(4), 576–585.
Nicholl, C., & Thompson, A. (2004). The psychological treatment of Post Traumatic Stress Disorder (PTSD) in adult refugees: A review of the current state of psychological therapies. *Journal of Mental Health*, *13*(4), 351–362.
Neergaard, M. A., Olesen, F., Andersen, R. S., & Sondergaard, J. (2009). Qualitative description – the poor cousin of health research? *BMC Medical Research Methodology*, *9*(1), 52.
Omeri, A., Lennings, C., & Raymond, L. (2006). Beyond asylum: Implications for nursing and health care delivery for Afghan refugees in Australia. *Journal of Transcultural Nursing*, *17*(1), 30–39.
Panter-Brick, C., & Eggerman, M. (2012). Understanding culture, resilience, and mental health: The production of hope. In M. Ungar (Ed.) *The social ecology of resilience: A handbook of theory and practice* (pp. 369–386). New York, NY: Springer.
Patel, V. (1995). Explanatory models of mental illness in sub-Saharan Africa. *Social Science & Medicine*, *40*(9), 1291–1298.
Patel, V. (2014). Rethinking mental health care: Bridging the credibility gap. *Intervention*, *12*, 15–20.
Patton, M. (1990). Purposeful sampling. *Qualitative evaluation and research methods*, *2*, 169–186.
Pincay, I., & Guarnaccia, P. J. (2007). "It's like going through an earthquake": Anthropological perspectives on depression among Latino immigrants. *Journal of Immigrant and Minority Health*, *9*(1), 17–28.
Porter, M., & Haslam, N. (2005). Predisplacement and postdisplacement factors associated with mental health of refugees and internally displaced persons: a meta-analysis. *JAMA*, *294*(5), 602–612.
Rasmussen, A., Ventevogel, P., Sancilio, A., Eggerman, M., & Panter-Brick, C. (2014). Comparing the validity of the self reporting questionnaire and the Afghan symptom checklist: Dysphoria, aggression, and gender in transcultural assessment of mental health. *BMC Psychiatry*, *14*(1), 206.
Ryan, D., Dooley, B., & Benson, C. (2008). Theoretical perspectives on post-migration adaptation and psychological well-being among refugees: Towards a resource-based model. *Journal of Refugee Studies*, *21*(1), 1–18.
Sandelowski, M. (2000). Focus on research methods: Whatever happened to qualitative description? *Research in Nursing and Health*, *23*(4), 334–340.
Scholte, W. F., Olff, M., Ventevogel, P., de Vries, G. J., Jansveld, E., Cardozo, B. L., & Crawford, C. A. G. (2004). Mental health symptoms following war and repression in eastern Afghanistan. *Journal of the American Medical Association*, *292*(5), 585–593.
Shenton, A. K. (2004). Strategies for ensuring trustworthiness in qualitative research projects. *Education for Information*, *22*(2), 63–75.
Sluzki, C. E. (1979). Migration and family conflict. *Family Process*, *18*(4), 379–390.

Sossou, M. A., Craig, C. D., Ogren, H., & Schnak, M. (2008). A qualitative study of resilience factors of Bosnian refugee women resettled in the southern United States. *Journal of Ethnic & Cultural Diversity in Social Work*, *17*(4), 365–385. doi: 10.1080/15313200802467908

Strang, A., & Ager, A. (2010). Refugee integration: Emerging trends and remaining agendas. *Journal of Refugee Studies*, *23*(4), 589–607.

Sulaiman-Hill, C. R., & Thompson, S. C. (2012). Afghan and Kurdish refugees, 8–20 years after resettlement, still experience psychological distress and challenges to well being. *Australian and New Zealand Journal of Public Health*, *36*(2), 126–134. doi: 10.1111/j.1753-6405.2011.00778.x

Tufford, L., & Newman, P. (2012). Bracketing in qualitative research. *Qualitative Social Work*, *11*(1), 80–96.

Uba, L. (1992). Cultural barriers to health care for southeast Asian refugees. *Public Health Reports*, *107*(5), 544–548.

UNHCR. (2010). 2009 global trends: Refugees, asylum seekers, returnees, internally displaced and stateless persons. Retrieved from http://www.unhcr.org/4c11f0be9.html

US Census Bureau. (2011). Place of birth for the foreign-born population in the United States. *American Fact Finder*. Retrieved from http://factfinder2.census.gov/faces/tableservices/jsf/pages/productview.xhtml?pid=ACS_11_1YR_B05006&prodType=table

US Department of Health and Human Services (USDHHS). (2012). Refugee arrival data. *Office of Refugee Resettlement*. Retrieved from http://www.acf.hhs.gov/programs/orr/resource/refugee-arrival-data

Watters, C. (2001). Emerging paradigms in the mental health care of refugees. *Social Science & Medicine*, *52*(11), 1709–1718.

Weine, S. M. (2011). Developing preventive mental health interventions for refugee families in resettlement. *Family Process*, *50*(3), 410–430.

Weller, S. C., & Romney, A. K. (Eds.). (1988). *Systematic data collection*. Newbury Park, CA: Sage.

Wojcik, W., & Bhugra, D. (2010). Loss and cultural bereavement. In D. Bhugra, T. Craig, & K. Bhui (Eds.) *Mental health of refugees and asylum seekers* (pp. 211–224). New York, NY: Oxford University Press.

Wong, Y., Tran, K. K., Kim, S.-H., Van Horn Kerne, V., & Calfa, N. (2010). Asian Americans' lay beliefs about depression and professional help seeking. *Journal of Clinical Psychology*, *66*(3), 317–332.

Sigrid James, PhD, MSW, is faculty on sabbatical in the Department of Social Work and Social Ecology at Loma Linda University and currently holds a guest professorship at the University of Kassel at the Institute for Social Work and Social Policy. She completed her graduate studies at UCLA and the University of Southern California and a Fellowship in Dissemination and Implementation Research at Washington University. Her research, which has in part been funded by the National Institute of Mental Health, lies at the intersect of child welfare and mental health, and she has published numerous articles about services for youth in the child welfare system, in particular those who have experienced episodes in residential care and psychiatric settings.

Qais Alemi, PhD, MPH, MBA, is a behavioral scientist and an assistant professor of research methods in the Department of Social Work & Social Ecology at Loma Linda University. Dr. Alemi completed his doctoral education in Social Policy & Social Research, along with graduate degrees in (global) public health and health administration at Loma Linda University. His research focuses on global mental health issues, specifically, investigating the psychosocial well-being of conflict-affected populations along with exploring methods for improving "cultural fit" within health and mental health care delivery systems.

Susanne Montgomery, PhD, MSN, MPH, is a social/behavioral epidemiologist with a focus on hard-to-access underserved populations, on issues of health disparities from a behavioral health and prevention research perspective. A "translational" researcher Dr. Montgomery has been a principal investigator and co-investigator of NIH, CDC, and State of California funded research projects since 1990. She has extensive experience in conducting community-based translational participatory research (CBPR) and evaluation—advocating for translating and applying research findings to the community level. She has published over 80 peer-reviewed articles concerning cancer prevention, teen pregnancy, HIV/AIDS, and alcohol and tobacco use, and regularly serves as a reviewer of several national peer-review journals.