Shahlo Mustafaeva, candidate for the degree of Doctor of Philosophy in Clinical Psychology, has presented a thesis titled, *The Cultural Shaping of Depression: A Qualitative Investigation Into Afghan Women’s Perspectives on Depression*, in an oral examination held on August 25, 2015. The following committee members have found the thesis acceptable in form and content, and that the candidate demonstrated satisfactory knowledge of the subject material.

External Examiner: *Dr. Randal Tonks, Camosun College*

Co-Supervisor: Dr. Mary Hampton, Department of Psychology

Co-Supervisor: Dr. Angelina Baydala, Adjunct

Committee Member: Dr. William Smythe, Department of Psychology

Committee Member: Dr. Kristi Wright, Department of Psychology

Committee Member: Dr. Jennifer Tupper, Faculty of Education

Chair of Defense: Dr. Bruno Dupeyron, Johnson-Shoyama Graduate School

*via Teleconference*
Abstract

In recent years, Major Depression has become one of the most widely researched areas in the field of cross-cultural psychology. Since the beginning of the 20th century, the number of people diagnosed as having this disorder has increased substantially not only in Western cultures, but also in Asian cultures. While much literature focuses on the rates of depression, less research has studied cultural variations of depression in various immigrant and refugee groups. Understanding culture-specific symptoms and idioms of distress will enable clinicians to identify psychiatric conditions and psychological distress and provide culturally sensitive services. Because little is known about Afghan refugee women’s conceptualization of depression, this study explores their conceptualization of depression and their help-seeking behaviours. First and second generation Afghan women were recruited to participate in focus groups and individual interviews. A total of 19 women (eight first generation and 11 second generation) participated in this study. Two focus groups (one for each generation) followed by eight individual interviews were conducted. Grounded theory was used to identify common themes across participants’ accounts. Four common themes emerged from this study: communicating depression, stated causes of depression, coping, and recommendations for support. These themes overlapped with first and second generation women.
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CHAPTER 1- INTRODUCTION

1.1 Positioning self in the research

The purpose of this research is to investigate depressive disorder in terms of metaphors, cultural syndromes, and cultural construal as they occur and are shaped in Afghan culture and communicated in the context of immigration to a new culture. This allows a more complete understanding of how Afghan women perceive depression and perhaps suggests ways for sensitive clinical inquiry and the effective delivery of therapy.

My personal experience as an immigrant woman who moved from a highly traditional culture to a highly modern culture has played a significant role in shaping the academic interests I have pursued over the years. It was my dream to have the chance to achieve a solid education and I believed I could only do so in a country where I would feel safe, independent, and free. Thus, I started to learn English and attended the University of Fergana in Uzbekistan, where I majored in English, graduating in 2003. The previous year, 2002, was a pivotal period in my life. At this time, relations between my country’s government and the West were improving and developing very quickly, and in 2002, a U.S. Department of State humanitarian assistance mission came to the Fergana Valley. This mission, Provide Hope, came to help rebuild the healthcare system in the larger cities within my region. I competed for an opportunity to serve as an interpreter on this mission, and was selected as interpreter for the lead physician. I worked on the Provide Hope mission for 7 months, and when it was finished, the lead physician offered to sponsor me to attend the University of Regina. I decided to accept this rare opportunity, and so I left my home and family and came to Regina in 2003.
After leaving Uzbekistan for Canada, I found myself struggling to adjust to a new culture. Beginning a day where nothing was familiar— not the language I heard around me, nor people’s behavior, clothing, customs or expectations— was a challenging experience. Although I do not believe I suffered from depression, I wrestled with the changes in my life and there were many times where I felt down, guilty, homesick, uncertain about my future, and experienced a sense of not belonging to my new home, Canada. During this time, I was taking my first psychology class where I learned about depression, which led me to question how Uzbek people experience depression. It was then that I realized I had never encountered an Uzbek person who suffered from depression (i.e., someone who would meet the Western criteria for depressive disorder), nor did I know the “Uzbek” symptoms of depression or even the Uzbek word for depression. This is of course due to the stigma and shame associated with mental illness, but while I was living in Uzbekistan I did not learn about depression or that it is a mental illness. From then on, studying depressive disorder, dysphoria, and mental health issues in general in other cultures has become my passion.

In 2008, while working on my master’s degree, I came across Miller et al.’s (2006) article *The Afghan symptom checklist: A culturally grounded approach to mental health assessment in a conflict zone*. In this article Miller describes idioms of distress, such as *asabi* (i.e., feeling nervous or highly stressed) and low/high blood pressure, used by Afghani women to describe distress. The same idioms of distress are used in my culture and it was not until I read this article that I started to look into the depressive experiences of Afghan people. I found many similarities between Uzbek culture and Afghan culture, and one of the similarities that struck me the most was the status of
women in both cultures. The more I read about Afghan women, the more fascinated I became by the resilience and strength of these amazing women, but I was also saddened by their status in their culture and by the abuse they experience. Their stories also reminded me of many of my cousins and girlfriends who are in the type of abusive relationships from which there is sometimes no escape. Although I realize that not all Afghan women experience abuse or suffering, there are many who suffer in silence and do not have anyone to turn to.

While reading the stories, I started to wonder if, as a future mental health professional, I would be able to recognize depression in Afghan women. Are there specific terms or idioms of distress they use to talk about depression? I wondered if more acculturated Afghan women would describe their dysphoria using Western concepts of depressive illness. I therefore embark upon this project to gain a deeper understanding of Afghan women’s conceptualization and their help-seeking behaviours.

As a woman who was able to escape a patriarchal society where a woman’s role is to cook, clean, care for others, and bear children, I feel very fortunate to receive the education I always dreamt of and this fills me with a profound desire to work with women and develop practices that will support them in their healing, if or when needed, and practices that will respect their cultural heritage. I feel lucky to be involved in a profession where I can make a difference, even a small one, in the lives of many refugee and immigrant women. I hope that this study represents one of the initial steps to helping Afghan women find their voices and share their stories which, in turn, will help to develop practices which will allow them to feel safe.

1.2 Purpose and aims of the study
Many Afghan refugee women have fled their country because they were either victims of violence or were politically endangered (Lipson, 1991). A review of the literature reveals that, to date, the studies conducted by Miller (2006) and Omidian (1996) are the only ones that identify culturally specific terms used by Afghan people to describe distress. However, neither of these studies explored these terms in relation to depression. Because of the paucity of research on Afghan refugee women and their experiences with depression there is a need for qualitative research that will explore their unique culture and their understanding of mental health and mental health care. Thus, the purpose of this study is to explore Afghan women’s narrations of depression. Specifically, this research will seek to understand why and how symptoms of depression are developed and expressed in this population, the reasons for depression, the impact depression has on the lives of depressed people, and the strategies used to cope with depression. The specific aims of the study are to explore first and second generation Afghan immigrant and refugee women’s conceptualization of depression and their help-seeking behaviors. By exploring two generations this research looks at: (1) whether there are differences in symptom presentation between the different generations; (2) how and when the changes in symptom presentation have occurred and (3) whether help-seeking behaviours have changed between the generations.

1.3 Dissertation outline

This dissertation begins with a brief statement of the research problem. From this, a discussion of cultural conceptions of depression follows. This discussion explores the history of depression, current diagnostic criteria for depression, and various symptomatologies of depression in Asian cultures. It is important to note here that
throughout this dissertation I will talk about “Asian cultures” and although the word *Asian* ignores the significant differences that exist among subgroups and even within groups (Chang & McConkey, 2008) in many instances I was not able to determine what Asian group or groups the research papers specifically discussed. Therefore, I had no choice but to refer to them as *Asians*. As such, for the purposes of this research, whenever clarification is not given, the term *Asian* will refer to persons directly from or having descendants from the following areas: South Asia, Southeast Asia, Central Asia, China, and Taiwan.

The section on history traces the origins of depression to Ancient Greece and the changes in the concept of depression that have taken place since. This discussion helps us to understand our current diagnostic approach to depressive disorder. The exploration of various symptomatologies illustrates the difficulty in diagnosing depression in Asian cultures as well as the various idioms used by many Asian populations to talk about distress and dysphoria. Then, current cross-cultural challenges will be discussed. This section explores the current challenges we face in studying depression in various cultures. More specifically, the utilization of Western screening instruments with people with various cultural backgrounds and the problems associated with it will be discussed. Afghan culture is then explored. The aim is to provide more detail in relation to the social and cultural context of the research and knowledge of the group to be studied. The areas covered include a political profile of Afghanistan, ethnicity and languages spoken, religion, and the status of Afghan women. I then go on to discuss the need for this research, followed by the methodology and research questions. The dissertation will conclude with the implications of this study.
CHAPTER 2 - LITERATURE REVIEW

2.1 Statement of the problem

During the past few decades, Canada has received a large influx of immigrants and refugees from Asian countries (Statistics Canada, 2006). Canada has become pluralistic in every sense: linguistic, religious, cultural, and racial. Given current population trends, this diversity will continue to be a salient feature of Canadian society (Naidoo, 1992). As a result of this increasing migration, clinicians increasingly find themselves diagnosing and managing psychiatric conditions, such as depression, in persons from different linguistic and cultural backgrounds (Hinton et al., 1994). Their task of preventing, recognizing, and providing appropriate treatment for immigrant populations is complicated due to differences in language, culture, patterns of seeking help, and ways of coping (van de Put, 2002). Research has shown that relying on the language and constructs of Western psychiatry risks not only the under-recognition and misidentification of psychological distress, but also inappropriately prioritizing psychiatric syndromes that are familiar to Western practitioners but that may lack meaning in Asian populations for whom local idioms of distress are more salient (Kirmayer, 2001; Miller et al., 2006). Therefore, to recognize psychological distress in Asian populations and to provide culturally sensitive care, clinicians should be aware of cultural variations and culturally specific idioms of distress (Kirmayer, 2001).

According to Murray and Lopez (1996), unipolar depression among women will be the second most important cause of disease burden by the year 2020. It was also estimated that it would be women in their reproductive years, between the ages of 15 and 44, who will suffer the most (Thara & Patel, 1998). Studies have shown that refugee
women are more susceptible to depression because of potential mental health stressors, such as pre-migration experiences, intolerable memories, acculturation, unemployment, and structural characteristics of the new society that oppress or limit opportunities for these women (Beiser, 2005; Lipson & Miller, 1994). In general, the rates of depression among refugee women are often higher than in the general population of the host country (Kirmayer et al., 2007; Mojtabai & Olfson, 2006). Refugees experience many pre-immigration traumas and stressors, such as war, torture, terrorism, natural disasters, and famine. Moreover, after arrival to the host country, they also experience acculturative stress as a result of cultural conflicts, social isolation, alienation, low socio-economic status and/or discrimination (Pumariega, Rothe, & Pumariega, 2005; Berstein, Lee, Park, & Jyoung, 2007; Lipson et al., 1995). As a result of the traumas and stressors faced by refugee women during their physical and psychological journeys, they have been found to be at high risk for depression (Keyes, 2000). While much literature focuses on rates of depression, less research has studied culturally specific conceptualizations of depression (Akbiyik et al., 2009; Miller et al., 2006).

Currently, one of the fastest growing ethnic groups in the world is Afghan refugees. According to UNHCR (2011), one out of every four of the world’s refugees originated from Afghanistan. Moreover, Afghan refugee women are one of the largest refugee populations in the world. In the United States and Canada, they deal with many losses, such as the loss of family members, property, status and cultural, familial, and religious roles. In addition, they struggle with generational conflict in making the transition from a traditional patriarchal society to a more egalitarian postindustrial society (Lipson et al., 1995). Due to the complete uprooting from their family and homeland,
resettlement in an unfamiliar land, and years of unrest in Afghanistan, Afghan women are exposed to risk factors that could lead to various mental health issues in the host country. In addition to their traumatic pre-migration experiences, Afghan women also encounter a variety of problems, such as language, economic, and occupational problems, and substantial challenges in psychological, family, social, and cultural adjustment to Canada and the United States. Although many Afghan women are doing well, many others have depression, psychosomatic symptoms, and anxiety disorders, such as PTSD (Lipson & Omidian, 1997).

2.2 Cultural conceptions of depressive disorder

2.2.1 Culture and psychological phenomena

Culture in mental health care is a multifaceted concept. Culture is a system of enduring thinking as well as behavioral patterns that are created, adopted, and promulgated by a number of individuals jointly. These behavioral and thinking patterns are social rather than individual, and are artificial rather than natural. Moreover, culture is a dynamic process that links the past to the present and is shaped in part by social, historical, and political contexts. People form definitions of health and illness and perceive and assimilate health messages through the prism of culture (Waite & Calamaro, 2009). As such, psychological phenomena are as cultural as they are social artifacts; that is, their content, mode of operation, and dynamic relationships are socially created and shared by a number of individuals (Ratner, 2002). According to Berry et al. (2011), culture is something psychological and inside of people, as such differences in psychological variables tend to be interpreted as reflecting differences in psychological functioning that are rooted in the psychological histories of cultural populations.
The way in which depression is expressed, confronted, and managed varies among cultures, and cultural meanings and practices shape its course. The experience of symptoms, the idioms used to report them, decisions about treatment, doctor-patient interactions, the likelihood of outcomes (e.g., suicide) and the practices of professionals are all induced by culture. Consequently, some conditions may be universal and some culturally distinct, but all are meaningful within particular contexts (Kleinman, 2004). For instance, for Buddhists in Sri Lanka the concept of suffering and sorrow imbues sadness with a distinctive quality. These experiences are expected, understandable and shared, and accepting this state defines one as a good person, whereas avoiding it or altering one’s fateful position is a manifestation of hubris. As a result of this concept, sadness is paradoxically pleasurable. It not only testifies to one’s strength of character but also to one’s commonality with other people. Because sadness is socially shared, accepted, and understood it rarely degenerates into depression (Ratner, 2002). For instance, studies conducted in the U.S. and Canada showed that the prevalence rates of depression in the countries’ Korean populations ranged from 3.5% to 5.6% and 5.1% to 5.6%, respectively (Robins & Regier, 1991; Noh et al., 1992a; Noh et al., 1992b). These rates are lower than depression rates in the general U.S. population (7-10%) (Surgeon General Report, 1999).

In contrast, sadness in Western culture has quite different qualities because of its conceptual underpinning. For many in this culture sadness is regarded as a deviant state that contravenes normative values of success, pleasure and optimism. Moreover, it is regarded as a personal state caused by personal misfortune and is shared by few people. This conceptual basis of sadness makes it a solitary, lonely, unusual, disturbing,
unpleasant, pitiful, helpless, and overwhelming state of failure that an individual
anxiously tries to overcome. These qualities, however, make it difficult to overcome and
may lead to degeneration into depression (Ratner, 2002, 1997). The difference between
these two forms of sadness is that it is not the situation that triggers it, but rather the
nature of the feeling itself. Thus, psychological phenomena and emotions possess a
definite content that originates in cultural factors, is formed by them, embodies, and
perpetuates them (Ratner, 2002).

Dramatic differences in social organization, personal experience, and the
consequences of emotions such as sadness, grief, and anger, of behaviors such as
withdrawal or aggression, and of psychological characteristics such as passivity and
helplessness or resorting to altered states of consciousness are found across cultures.
Moreover, they are organized differently as psychological realities, communicated in a
wide range of idioms and metaphors, related to varied local contexts of power relations,
and are interpreted, evaluated, and responded to as fundamentally different meanings of
realities. Thus, depression is not only interpreted differently in many non-Western
cultures but is also constituted as a fundamentally different form of social reality that may
be associated with different symptoms of distress and may have widely varied
consequences for the sufferer (Kleinman & Good, 1985).

To explore and understand depression, it is important to look at the manner in
which symptoms of depression depend on, embody, and resemble activities, artifacts, and
concepts of a specific culture. It is not sufficient simply to compare characteristics and
symptoms of depression in Afghan and Western culture. Rather, we need to relate the
characteristics of depression to cultural activities, artifacts, and concepts. Although the
comparison of the characteristics and symptoms of depression is fascinating and important, at some point psychological characteristics need to be grounded in the cultural factors that constitute them (Ratner, 2002).

2.2.2 What is depression?

Depression has been an omnipresent phenomenon throughout several millennia of human history. As mood, affect, or emotion, the experience of being melancholic or depressed has been as well known to Homo sapiens as any human feeling. The wide range of terms and emotional variations to which they have referred have reflected matters at the very heart of being human: feeling down, feeling blue or unhappy, being dispirited, discouraged, disappointed, dejected, despondent, melancholy, sad, or depressed (Jackson, 2008). From the earliest writings of ancient Greek physicians to the late twentieth century, Western diagnosticians consistently distinguished depressive disorders, as a form of madness, from normal sadness responses to a wide range of painful circumstances that everyone experiences. In order to understand depression and current diagnostic approaches to depressive disorders we need to place it in historical context. The history of depression illustrates that the way we think of depression now is quite new and diverges from what has traditionally been considered appropriate (Horowitz & Wakefield, 2007).

2.2.2.1 History of depression in the socio-cultural context

Conditions resembling depression are documented in the earliest human records, such as Hindu and Biblical literature. However, it was the ancient Greeks who provided the first causal theories of depression. The medical writers of Ancient Greece referred to depressive disorder as melancholia, which meant a mental disorder involving prolonged
fear and depression (Ingram, Scott, & Hamill, 2009; Horowitz & Wakefield, 2007). The term was derived from *melaina chole*, translated into Latin as *atra bilis* and into English as *black bile*. As one of the four humours in the humoral theory, melancholia was hypothesized by Hippocrates (fourth century B.C.) to stem from an imbalance of black bile (Ingram et al., 2009). Hippocrates described melancholia as a condition “associated with aversion to food, despondency, sleeplessness, irritability, restlessness” (Goodwin & Jamison, 1990, p.56). His definition, however, indicated that it is not such symptoms alone but symptoms of unexpected duration that indicate the disorder. His insistence that the sadness or fear must be prolonged was a first attempt to capture the notion that disproportion to circumstances is an essential aspect of depressive disorder (Horowitz & Wakefield, 2007). Moreover, Hippocrates made a distinction between non-disordered, normal sadness responses to painful circumstances and a malady.

A century after Hippocrates, one of his students, Aristotle, elaborated the distinction between a variety of normal mood states of sadness and disordered sadness (Horowitz & Wakefield, 2007). He believed that disordered sadness was disproportionate to events. He noted that if the black bile were disproportioned to the circumstances it would produce groundless despondency (Aristotle, 2000). Moreover, according to Aristotle, the key distinction in definitions of melancholia was between states of sadness without cause and those with similar symptoms that arose from actual losses. Thus, the former were considered mental disorders; however, without cause did not mean uncaused. Rather, it meant that the symptoms of melancholia were not proportional to environmental events, such as bereavement, rejection in love, economic failure, etc., that would lead to sadness (Holowitz & Wakefield, 2007).
In the late second century A.D., Galenus, also known as Galen, unified much of the psychiatric knowledge that had accumulated over the previous 600 years. He agreed with Hippocrates’ humoural theory of melancholia and noted that melancholia involved the accumulation of black bile below the rib cage with symptoms of abdominal pain, flatulence and belching, along with psychological symptoms. The reference to the area below the diaphragm was important for Greeks as well. This region was believed to be the seat of melancholic disposition (Stone, 2006). Galen also presented a vivid analogy of the *without cause* criterion. He used the colour of black bile to characterize the fear the melancholia was generating from the body, a fear that would normally be considered as being generated from external circumstances. For Galen, a melancholic condition was a chronic, non-febrile disorder. He noted these patients were fearful, sad, misanthropic, and tired of life (Jackson, 2008). With variations, and yet essentially faithful to their Hippocratic-Galenic origins, these notions of the pathogenesis of melancholia survived into the seventeenth century. However, scientific advances in the late seventeenth century promoted more freedom of thought. During this time the humoural theory was challenged and a new look at melancholia was facilitated (Stone, 2006).

During the sixteenth and seventeenth centuries, greater emphasis was placed on the *without cause* criterion of the disorder. Moreover, references to guilt crept into descriptions of melancholia with increasing frequency (Jackson, 2008). Timothy Bright (1550-1615), a Cambridge-trained doctor of medicine, distinguished between sorrow *with* and *without cause* to allow differential diagnoses between true melancholic disorder and non-disordered states of intense sadness due to the belief that one had sinned and would be the object of God’s wrath. Bright also noted that there was a “natural passion” or
emotion of sadness that was designed to operate a certain way but had gone wrong in the disorder (Holowitz & Wakefield, 2007). Towards the latter part of the eighteenth century, however, there was marked change in the way mental illness was understood. During this period there was a trend toward a neurocentric system with an ethereal nerve fluid in which irregular motions were believed to lead to melancholia. William Cullen constructed a theory based on the belief that the nerve fluid might be electrical in nature. His theory of pathogenesis was based on either too much or too little energy in the brain and mobility in the nervous fluid. The anergic behaviour of the melancholic person was associated with the idea of a depleted state, thus melancholia was thought to be the result of a depleted amount of excitement (Jackson, 2008).

2.2.2.2 From melancholia to depression

In the middle of the nineteenth century, psychiatric nosology began to take on a more modern appearance. This time saw an increasingly frequent use of the word *depression* and related terms in literary contexts to mean depression of spirits, melancholia, and melancholy (Jackson, 2008). The term *depression* derived originally from the Latin *de* “down from,” *premere* “to press” and *deprimere* “to press down,” and carried the meanings from these Latin terms of pressing down, being pressed down, and being brought down in status or fortune. This term came into use with these meanings in English literary works during the seventeenth century; however, it was not until the middle of the nineteenth century that *depression* started to emerge in medical contexts (Jackson, 2008). One of the first appearances of the term *depression* in a medical context was in 1856. Delasieuve, while on staff at the Bicêtre Hospital in Paris, had begun to use the word *depression* in place of melancholy (Stone, 2006). The initial uses were usually
in descriptive accounts of melancholic disorders to denote affect or mood, rather than having yet acquired any sort of formal status as a diagnostic term (Jackson, 2008).

Around the mid-century, Wilhelm Griesinger, the teacher of Emil Kraepelin, introduced the term *states of mental depression* as a synonym for melancholia that mainly indicated affect or mood. During the latter half of the nineteenth century descriptive uses of *depression* to indicate affect became increasingly common; however, the basic diagnostic term was still *melancholia* or *melancholy*. Early twentieth century literature was marked by two distinct schools. On one side, Freud emphasized the psychological aetiology of depression and its continuity with normal functioning. On the other side, Kraepelin applied a classical medical model that examined the symptoms, course, and prognosis of depression. However, it was not until the mid-twentieth century when both schools were combined into one (Jackson, 1986).

### 2.2.2.3 Appearance of depression in DSM

In 1952, the American Psychiatric Association codified mental disorders and produced the first edition of a new manual, the *Diagnostic and Statistical Manual of Mental Disorders (DSM-I)*. A combination of psychodynamic and Meyerian approaches dominated the characterization of depression; however, the biological aspects of the disorder were downplayed and unconscious psychological mechanisms were emphasized. DSM-I was the official manual of the APA between 1952 and 1968. Its successor, DSM-II, recognized the distinction between depressions that were proportionate responses to loss and those that were “excessive” and disproportionate. However, the symptom presentation was not specified or suggested, it was merely assumed that psychiatrists knew what symptoms constituted depression. The definition relied on etiology in the
form of internal conflict but it also recognized that losses may trigger disproportionate, disordered reactions, even in the absence of internal conflict. Although Freud’s ideas were recognized in the early classification manuals, Kraepelin’s ideas were neglected until the development of DSM-III in 1980 (Horowitz & Wakefield, 2007).

Kraepelin’s categorization, based on careful attention to symptoms, appeared in DSM-III. Moreover, the diagnostic criteria for depression were significantly improved. Major Depressive Disorder was introduced into DSM-III by U.S. clinicians in the mid-70s. Unlike DSM-II, its successor included the symptom criteria that required an episode lasting at least 2 weeks, the presence of a prominent and persistent dysphoric mood or pervasive loss of interest or pleasure, five out of eight additional symptoms, and help seeking or impaired functioning because of the disorder. During this time psychoanalytic influence had waned and the psychiatric profession was divided into numerous theoretical schools. Moreover, different clinicians shared few assumptions about the fundamental nature, causes, and treatments of mental disorders; therefore, a new manual had to be serviceable for clinicians of diverse perspectives (Horowitz & Wakefield, 2007; Jackson, 2008). Although the term melancholia disappeared it resurfaced again as a subtype of the major depressive episode in the newest classification system. This depression with melancholia implies a more severe form of depression, and is characterized by symptoms much like those of the earlier category of endogenous depression (Jackson, 2008). From the earliest writings of the ancient Greek physicians to the late twentieth century, Western diagnosticians consistently distinguished melancholia or depressive disorders as a form of madness, from normal sadness responses to a wide range of painful circumstances that almost everyone experiences. However, with the
development of DSM-III we abandoned this critical traditional distinction, which is now essentially lost in our current thinking about depression. The aim of DSM-III was to enhance reliability, develop a common language for psychiatrists with a variety of theoretical persuasions, and to bolster the scientific credentials of the profession. These decontextualized and symptom-based criteria of the DSM, however, inadvertently rejected the previous 2,500 years of clinical diagnostic tradition that explored the context and meaning of symptoms in deciding whether one is suffering from intense normal sadness or a depressive disorder (Horowitz & Wakefield, 2007).

Depression can be understood either as a feeling (mood) or a syndrome (disease), and either as an emotional or bodily state (Pang, 1998). The Western medical conception of depression maintains that it consists of somatic, behavioural, cognitive, and affective symptoms (Marsella et al., 1985). Due to the broad symptomatology, the origins of depression, depending on one’s perspective, are presented as having a social, a biological, or a psychological aetiology (Kangas, 2001). Within psychiatry, for instance, explanations concerning the causes of depression are increasingly physiological and neuroendocrinological. Psychological explanations, on the other hand, offer causes such as personality traits, losses and other provoking agents, and vulnerability factors such as problems in early psychological development leading to low self-esteem (Carr & Vitaliano, 1985; Kangas, 2001). Within psychiatry and psychology the dual conception of depression is: (1) a neurophysiological disorder caused by a chemical imbalance in the brain, and (2) a psychological disorder caused by mental vulnerability factors and provoking agents. Consequently, this operationalisation results in dual treatment strategies that include both medication and psychotherapy. The social explanations of
depression, however, do not offer a straightforward treatment option, since they focus more on structural issues at the societal level (Kangas, 2001).

2.2.3 Diagnosis

In current psychiatric nosology, depression is defined by operationalised diagnostic criteria found in the Diagnostic and Statistical Manual of Mental Disorders 5 (DSM 5) (APA, 2013) and the World Health Organization (ICD-10) (WHO, 1992) classification of mental disorders. DSM 5 identifies several categories of depression. The diagnosis of major depression is predicated on the presence of five or more symptoms, which must include either a predominantly depressed mood and/or loss of interest in most activities for at least a 2-week period of time and adversely impact one’s personal, social, and professional life. Other symptoms include significant changes in weight or appetite, insomnia or hypersomnia, psychomotor retardation or agitation, fatigue or loss of energy, feelings of worthlessness or excessive guilt, diminished concentration, loss of clarity of thought or indecisiveness, and recurrent thoughts of death (see Appendix A for the DSM 5 criteria) (APA, 2013).

2.2.4 The cultural shaping of depression

In Western cultures, depressive symptomatology is viewed as part of the psychiatric syndrome of Major Depressive Disorder, characterized by specific affective, cognitive, behavioral, and somatic symptoms (Yeung & Kam, 2005). The biopsychiatric model of depression, which emphasizes the roots of the disorder in anatomy, heredity, and disease process, is also very common in Western societies (Karasz, 2005). Depression has an identifiable and lengthy history and has been a widely studied construct—as an emotion, a mood disorder, and as a personality trait in Western culture.
(Horowitz & Wakefield, 2007; Koh et al., 2007). As a result, the English language has abundant depression-related vocabularies deeply embedded within Western and European institutions. In addition to “depressed” or “sad” one can describe his or her state as disconsolate, dispirited, gloomy, melancholic, miserable, morbid, blue, and so on. Not all of these words are used in everyday vocabulary, but most English-speaking North Americans will use some of them and recognize others (Rack, 1982). In many non-Western languages, however, no such vocabulary exists (Kim, 2002). In Ghana, for instance, three words cover all shades of unpleasant emotions: one of them refers primarily to the somatic accompaniments and another implies “hurt” (i.e., inflicted). In Yoruba, one word suffices for both “angry” and “sad”—two emotions that most Westerners would consider quite distinct (Rack, 1982). Moreover, even if there is a term for depression in other cultures, a high proportion of the population may not be familiar with it or simply not use the term. For instance, older Caribbean people rarely use the terms sad or unhappy and instead articulate that they are low spirited, fed up, weighed down, or feeling low (Abas, 1996; Baker et al., 1995). This of course is not to say that these groups do not experience some things which Westerners might call “depression,” but rather that the experience may be embedded in a different cultural context, which thus alters its meaning and subjective appraisal (Tanaka-Matsumi & Marsella, 1976).

These linguistic differences pose an important question: is the experience of depression the same even if the vocabulary is different? Marsella and colleagues (1985) believed that, although no conceptually equivalent terms for depression exist in many non-Western and non-European cultures, this does not mean that depressive disorder does not exist. It is likely that the subjective experience of depression, its behavioral
manifestations, and the social responses to it differ across cultures. Furthermore, Marsella (1980) posited that individuals from different cultural groups have similar psychological states; however, the recognition of the problem, its interpretation and social responses to it vary. Bebbington (1993) suggested that some cultures use conceptualisations of dysphoria that differ from the syndromes employed by Western researchers, but that it is possible to identify a common core of symptoms and terms which can be recognized as conforming to depression. For instance, Good, Good, and Moradi (1985) conducted a study in Iran and found that depressed individuals had poor concentration, rumination, forgetfulness, numbness, and aches and pains. Sulaiman and colleagues (2001) identified key symptoms of depression in the Arab community in Dubai that included social withdrawal, loss of sleep, loss of appetite, sadness, and crying. The symptoms identified in these cultural groups are also common symptoms of depression in the West.

Depression is an emotion, a feeling, and a clinical syndrome, and as such symptoms associated with it may vary from culture to culture and some symptoms may be more prevalent in one culture than in another (Leveck, 1991; Sulaiman, Bhugra, & de Silva, 2001). A number of researchers in cross-cultural psychology have taken the view that depression and all psychopathological behaviour should be seen as culture-bound syndromes (Kleinman, 1982; Naidoo, 1992; Sellers, Ward, & Pate, 2006). This, in turn, points to the importance of understanding the cultural context in which words and terms are used to express depression, both as an emotion (transient or long-term) and as a disease or syndrome (Good, Good, & Moradi, 1985; Carr & Vitaliano, 1985; Kleinman, 1982). Leff (1988) has pointed out that culture establishes not only what constitutes an illness, but also the appropriate response to that illness. Thus, culture affects the way in
which biological changes in the body and psychological factors are perceived and acted upon depending on expectations, taboos and current knowledge of cause and effect in that culture (Rack, 1982). Moreover, cultural ideologies, institutions, and practices provide the context and rules for interaction processes that underlie complex emotions, such as depression (Kirmayer, 2001).

2.2.5 Depressive symptomatology in Asian cultures

Each culture has its own idioms and metaphors to express their symptoms of depression (Kim, 1995). Cultural factors such as self-concept, the process of socialization, culturally embedded stressors, and the language used for daily communications intimately influence and mediate the phenomenological experiences of emotions and their communications (Koh et al., 2007). Consequently, symbols that reflect individual psychological states are often socially constructed and understood by all members of a society (Kirmayer, 1989). According to Kleinman and Kleinman (1985), in Asian cultures the existence of affective disorders, such as depressive disorder, is often expressed in terms of cultural metaphors and syndromes, as adapted to local ideas and the understanding of human health, the body, and physiology. Moreover, in these cultures depression is not construed in terms limited to sadness only. For instance, there are many translations for depression in Chinese: “gloomy/depressed/frustrated sickness,” dejection, sadness, dispiritedness, “lost meaning,” inhibited, constrained, worried, and restrained (i.e., a lack of movement) (Pritzker, 2003). Japanese people, however, associate more external referent terms, such as “dark,” “grey,” “rain” and “cloud,” and somatic terms, such as “headache” and “fatigue” to the Western concept of depression (Tanaka-Matsumi & Marsella, 1976). These external and non-individualized expressions
suggest that the subjective experience of depression by Japanese people take outward-directed rather than inner-directed channels. Asserting one’s individual emotional state does not comply with their predominant emphasis on the social affinity, harmony, and collaterality of the Japanese group. Thus, in accordance with their cultural values and traditions, Japanese tend to project their mood to external referents and avoid the individualization of their mood (Tanaka-Matsumi & Marsella, 1976). Similar to Japanese, Koreans also use colours when expressing depressive emotions. Koreans usually use “black” to express depressed feelings, whereas Westerners often describe their depressive moods by saying “I feel blue.” Koreans also describe their general environment as having the same qualities as their moods. A common phrase used by Koreans to express feelings of depression is, “Everything that surrounds me is dark and black” (Kim, 1995).

In other cultures depression is experienced or expressed symbolically. Punjabi women participating in focus groups (Bhugra, Desai, & Baldwin, 1997) described depression by using terms such as “weight on my heart/mind,” or “pressure on the mind.” Symptoms of “gas” and “feelings of heat” were also identified, which is in accordance with traditional Punjabi and Ayurvedic (i.e., An Indian system of medicine) models of hot and cold. Women from north India express depression by using the term “sinking heart” and Turkish people describe depression as related to feelings of heaviness in their chest, “as if the heart is squeezed” (Bhugra, Desai, & Baldwin, 1997; Good, Good, & Moradi, 1985). These physical terms are different from somatisation as they are neither bodily nor emotional, but are in between and connected to one another on what could be described as a spiritual level (Pang, 1998). A qualitative study conducted with depressed
Korean immigrant women showed that the participants expressed their emotional turmoil using metaphors such as “trapped in the pitch black dark cliff,” “my body shrunk like a dried squid,” “breathing tank is clogged up,” and “working till bone is rubbed off” (Bernstein, Lee, Park, & Jyoung, 2007).

In other cultures, however, expressing depression or even interpreting the expressions used can be quite difficult. For instance, depressed Taiwanese people often use the term *fan-zao* to describe anxious and worried feelings (Kleinman, 1980; Tzen, Lipson, & Faan, 2007). Although the dictionary definitions of *fan* include worry, unhappiness, annoyance, fretting, and boredom, Tzeng and colleagues (2007) found that their Taiwanese patients repeatedly complained of feeling *fan* but had difficulty describing it and articulating their feelings associated with *fan*. Tzeng and colleagues reported that the translation of this term posed a barrier to their research; however, on the basis of their study they described *fan* as a state of being bothered by things that are beyond one’s expectation. Moreover, those experiencing *fan* may not be able to control their behaviour and fear of making mistakes. Consequently, they feel sad, are easily agitated, lose interest in their surroundings, cannot get to sleep, and even think of attempting suicide (Tzen, Lipson, & Faan, 2007).

As evident from these examples there are no “single standard” complaints of depression. Emotional processes do not operate and are not experienced alone, thus the phenomenological experiences and manifestations of depression vary from culture to culture (Koh et al., 2007). In Asian cultures, emotions or affective disorders, such as depression, may be grouped with moral values rather than with internal disruption, may be linked with logical thoughts as much as or more than internal conflict, and may be
seen as characteristics of situations or relationships rather than as the property of individuals (Lutz, 1985; Pang, 1998). In addition, depression might be communicated in spiritual terms (“spirit loss or soul loss”) or using traditional or semi-medical allegories such as “high” or “low blood pressure” or “wind” (Mezzich, Caracci, Fabrega, & Kirmayer, 2009). Culture mediates whether individuals focus on bodily sensations or mental states, worry about somatic disease or emotional loss of control, and whether they might attribute symptoms to either physical or psychological causes (Robbins & Kirmayer, 1986; Pang, 1998).

2.2.6 Somatisation

2.2.6.1. Definitions of somatisation

The body is an important symbolic and experiential component in distress and suffering. While we know that complaints of physical symptoms or somatisation can be seen in depressed patients from all cultural groups, the percentage of patients in international primary care clinics who report unexplained physical symptoms ranges from 45% to 95%, with an average across all groups of 69% (Kim, 2008; Simon et al., 1999). Somatisation is often the cultural equivalent of depression in non-Western cultures (Al-Issa & Toussignant, 1997). By definition, it accounts for the “expression of personal and social distress in an idiom of bodily complaints and medical help seeking” (Kleinman & Kleinman, 1985, p. 430). There are two general categories of definitions of somatisation: (1) a pattern of complaint presentation that may reflect a culturally prescribed mode of communication and (2) a clinical phenomenon in which the presentation of somatic symptoms occurs as an affective or psychological complaint (Yen, Robins, & Lin, 2000). In official psychiatric nosology, somatisation refers to a group of psychiatric disorders
(i.e., Somatic Symptoms and Related Disorders) and refers to the presentation of psychiatric disorders through physical symptoms in which somatic symptoms are presented to the exclusion of emotional distress and social problems (Kirmayer & Weiss, 1997). This discrete category of somatoform disorders in psychiatric nosology implies a separation of affective and somatic symptoms and largely reflects the mind-body dualism of Western medicine which is not evident within most of the great medical traditions of Asian cultures (Fabrega, 1991; Burr & Chapman, 2004). Within Western culture, psychiatric disorders are perceived as mental disorders, notwithstanding their prominent somatic symptoms. Consequently, somatoform disorders seem to be a category lying between the somatic and the psychiatric and are deemed to be useful in the diagnosis of patients whose problems do not fall neatly into either category (Burr & Chapman, 2004). The distinction between soma and mind, however, was not always a characteristic of Western medicine. In ancient and Renaissance times Western medicine also followed a holistic approach (Dwairy, 1997).

The mind-body duality has a lengthy history in the Western tradition. Once this Cartesian dualism became the dominant philosophical basis for characterising problems, the psychologisation of mind-body problems became evident (McMahon & Sheikh, 1984). During this time Western cultures also adapted a dualistic perspective toward people’s health. The “self” emerged as an independent entity from the body and depression has been subsequently conceptualized as a psychological problem related to psychological constructs, such as the self or ego, or to psychological processes, such as conflict or repression, almost completely separate from the physical aspects of the body (Dwairy, 1997). According to mind-body dualism, human distress is displayed by
psychological symptoms (depression), whereas physical problems are caused by genetic factors or germs. The mind-body division also provides a window into the stigma of mental illness. For instance, Luhrmann (2000) and Sinclair (1997) suggest that Western psychiatrists are trained to operate in a healing profession where the body is perceived as real, but the mind less so. According to Jackson (1994), a person feels “real” pain when a cause is located in the body, and can be profoundly stigmatized when it is said to be “all in the mind.” Ultimately, sufferers of mental illness find the “reality” of their distress questioned, and they must incur the stigma of a social and clinical label of a mental or psychological problem versus a “true” physical disease (Kohrt & Harper, 2008).

2.2.6.2 Cross-cultural aspects of somatisation

Culture shapes the meanings and expressions people give to sadness, unhappiness, hopelessness, and a lack of pleasure (Kleinman & Good, 1985). For instance, many Asian cultures use bodily terms metaphorically to refer to their inner emotional states. In these cultures there is a fair correspondence between expressions for internal parts of the body, such as the stomach, liver, lung, heart, and emotions that would be considered psychological states in the Western tradition (Lindstrom, 2002). For instance, in Chinese medicine anger is expressed in relation to liver problems and anxiety in relation to heart problems (Ots, 1990; Russell & Yik, 1996). In traditional Chinese medicine liver-anger terms are *gan zhu nu* (“liver is the host of anger”), *nu shang gan* (“anger hurts the liver”), and *gan xi tiao da* (“the liver likes to expand”). When a Chinese says *wo sheng qi le* (literally: I got angry), he means that the anger was kept inside and that he was not able to vent it. If anger is not allowed to express itself, then liver-*qi* (“vital energies”) will lose its
harmony, will become stagnant, and eventually flow in perverted directions, and the anger will attack other abdominal organs and cause discomfort (Ots, 1990).

This use of bodily terms metaphorically can also be seen in an examination of interactions between Chinese physicians and their patients. Ots (1990) found that both physicians and patients related internal organs with emotions, and both groups carefully examined bodily perceptions when discussing emotions. In his sample, the liver was seen as the cause of headaches, epigastric pain, hypertension and anger, while the heart was related to anxiety, uncertainty and fear. Emotional distress, such as feelings of “unhappiness” and “worry”, is expressed through the heart and the liver. The heart is considered the emperor among the internal organs and thus the seat of the mind and emotional control. In Chinese culture the label of mental disorder is more easily applied to patients with a “distressed heart” than to withdrawn, introverted, and depressive patients (Ots, 1990).

Asian cultures express depression and many other emotions in ways that merge the mind and body, rather than clearly separating the two (Kleinman, 1977). Many Asian groups’ conceptualisations of physical and emotional health, or mind and body, are influenced by classical Confucian beliefs and medicine, which do not differentiate between psychological and physical functioning. As a result of the holistic nature of Eastern medicine, people from these societies are not usually skilled in communicating emotional states with affective terms (Kleinman, 1982; Kim, 2002). For instance, research conducted with native people of Dubai showed that they expressed depression in somatic terms. Common somatic symptoms they used included a feeling of tightness or constriction in the chest. The depressed person described it as though he or she feels as if
they are unable to take a deep breath, so that he or she may feel shortness of breath and sigh repeatedly. The chest is described as being tightly packed with an excess of unpleasant feelings to accommodate the inspiration of air. Although the person may wish to cry to relieve this feeling, they often feel unable to do so. Moreover, the native Dubai people described feelings of giddiness or faintness (dora), which cannot be attributed to neurogenic, cardiovascular or metabolic facts, and a depressed person usually locates this feeling in the head. Fatigue due to generalized aches, feelings of a lack of body energy and soundness (ta’bana), suffering of the limbs, nausea or sickness, and poor appetite which are attributed to the abdomen and particularly liver (chabid) were also reported (Sulaiman, Bhugra, & de Silva, 2001).

This inability to express emotional states has been suggested to be due to vocabulary inadequacies in the original language of these communities (Al Busaidi, 2010). A series of studies conducted in China and Taiwan showed that somatisation was the main language of distress and was used to express psychological and affective disorders (Kleinman, 1980). Furthermore, Ying and colleagues (2000) who studied the dimensional structure of the Center for Epidemiological Studies Depression scale (CES-D) found that (compared to Euro-American samples) Chinese samples mixed somatic symptoms with either depressed affect or interpersonal problems showing the centrality of somatic symptoms in Chinese depression, which was attributed to a reduced distinction between mind and body.

Kang (1982) and Kim (2002) also found that there is little distinction made between mind and body among Korean Americans in that Koreans expressed depression through back pain, headaches, indigestion, and chest pain. Koreans may express
emotional and psychological distress in somatic idioms in order not to be conspicuous and to be harmonious with others in communicating their true feelings clearly and vividly. Traditionally, it is considered unacceptable and even unfilial to talk about one’s feelings in bare emotional terms, particularly with parents, elders, or children (Pang, 1998). Moreover, according to Pang (1998), elderly Koreans may express symptoms of depression through direct verbalisation, verbal expression of depression with seemingly somatic idioms, and hurting others by hurting the self-instilling guilt in others by making them feel responsible for one’s self-destructive behaviours (e.g., suicide). Their somatic metaphorical idioms express not only emotional distress, but also serve as warnings of imminent danger of somatic injury or dysfunction, or the exacerbation of existing bodily afflictions.

Along with cultural differences in the experience of mind and body, another common explanation of Asians’ somatisation is the denial and suppression of emotions (Kawanishi, 1992). Western cultures value individual autonomy and responsibility, and the concept of personal control and experiences including powerlessness, helplessness, and detachment are closely related to depressive disorders, whereas in Asian cultures the loss of personal control does not have the same aversive consequences because of the emphasis on selfless subordination to family and non-personal controls (Marsella, 2003). Because there is less tolerance for cognitions regarding the self, an illness such as depression is often perceived as self-indulgent. Self-definition tends to be in terms of social roles and relationships, and consequently self-esteem is dependent on fulfilling these roles properly rather than cultivating individual potential. For instance, when an
Asian woman fulfils her role in society and in the family she is usually considered healthy (Pang, 1998).

Collective harmony is valued and wins out over individual psychological well-being. In order to maintain group harmony, individuals are discouraged from expressing extreme emotions. Excessive and overt expressions of one’s feelings are viewed not only as a weakness, but also as an assault on social harmony (Yoo, 2001). To maintain group harmony Asians overemphasise conventional normative behaviour. Patience and self-control are considered to be desirable according to the ethical systems of Asian societies (Ryder, Yang, & Heini, 2002; Yoo, 2001). Bhui (1999), exploring the ways in which Pakistani people express depression, concluded that Pakistani patients, when visiting their general practitioner, more often had “depressive ideas” (worthlessness, hopelessness, and suicidal ideas) but were more likely to express them through “pain.” Pain was the most common physical symptom among Punjabis. They were less likely to identify an emotional origin of their somatic complaint as pain reflects “suffering” and dependency needs and disguises the affective aspects of common mental disorders (Bhui, Bhugra, Goldberg, Dunn, & Desai, 2001).

Kleinman and Kleinman (1985) stated that bodily complaints are more culturally acceptable and allow an individual to maintain existing social ties. For instance, Korean women’s expression of their depression as feeling clogged up in their chests, feeling trapped inside their bodies or having a heavy mind reflect a cultural emphasis that differs greatly from the predominant Western understanding of depression (Berstein et al., 2007). Yamashiro and Matsuoka (1997) also found that language may not accommodate all that individuals think and feel in Asian cultures. Although this linguistic limitation
applies to all cultures, expressing oneself openly and honestly, especially concerning strong emotions, is discouraged across Asian cultures. Somatic and metaphorical complaints in Asian cultures seem to be influenced by the syncretism of multiple religions. All the major Asian religions have holistic spiritual aspects, but each seems to emphasize different aspects that ultimately bear on mental health or maturity: correct behaviours in Confucianism and Islam, cognitive insight in Buddhism, nature and cosmology in Taoism (Pang, 1998). In addition, somatic terms or body-oriented terms may have also derived from the beliefs that souls, emotions, and spirits all dwell in the body, which is a center for manifestation from the physical, emotional, cognitive, and spiritual realms, stimulated by socio-cultural environments (Pang, 1998).

Another important factor leading to somatisation is the cultural stigma attached to mental illnesses, particularly those with overt behavioural pathology. Although there may in fact be a greater tolerance for symptoms when the illness can be kept within the family, Asian families are likely to attempt to shield the afflicted family member from the rest of the community (Ryder, Bean, & Dion, 2000). Because Asian cultures are collectivistic the burden of mental illness often falls not only upon the individual, but upon the entire extended family. This can have a catastrophic effect on family life and family standing in the community. Mental illness becomes a community issue as a result of the belief that a healthy mind contributes to social harmony. Family members are often seen as sharing the same problems that led to the individual developing a mental disorder, with serious implications for their interactions with the community. For example, within the arranged marriage system any type of mental illness has grave prospects for marriageability and the illness of one family member affects the reputation of the whole
family. Accordingly, families would rather hide mental illness or, if necessary, communicate it in terms of a socially acceptable physical illness (Bhui et al., 2001).

Preservation of self-image and the family’s image prevents the free expression of depressive feelings (Kuo & Kavanagh, 1994). For example, in Japanese culture, *haji*—“face” or “shame”—is an important term that reveals concerns over the process of shame or loss of face. The development of a mental health problem may compromise a person’s productivity or status and can result in significant loss of face. Therefore, Japanese people may have lower rates of “depression” since it is characterised by “headaches and fatigue.” In Japan, it was found that 15 out of 25 patients presenting with complaints of both headache and fatigue had what Western scholars would identify as significant depressive symptoms (Sue, 1994). The onset of the first depressive episode was strongly associated with and preceded the onset of chronic fatigue.

Although somatisation has been solely attributed to Asian cultures, it is not solely an Asian phenomenon and is also observed in the West. Somatic symptoms form a part of the experience of most depressed individuals in Canada and the U.S. and have become a focus of renewed attention (Kirmayer et al., 1998). However, an English-speaking patient might experience the somatic manifestations of depression and describe them in a roughly similar manner as would an Asian patient, but the former would also be able to refer directly to the emotional experience without relying on metaphor because more specific terms are available to them and they differentiate between mind and body (Rack, 1982). Asian patients, on the other hand, may not distinguish between the emotions of depression and irritability. Instead, they may express different types of emotional distress in somatic terms or may organize their concepts of dysphoria in ways that differ from
English-speaking patients due to a lack of vocabulary or tendency not to separate the mental from the physical (Rack, 1982; Ryder, Yang, & Heine, 2002; Yen, Robins, & Lin, 2000). In Korea, for example, Hwa-Byung is the most widely-studied depressive-like bodily disorder that has symptoms that overlap with the symptoms listed by the DSM for major depression (Herrick & Brown, 1999). It is described as an anger syndrome that encompasses elements of depression, resentment, somatic illness, and neurotic symptoms (Pang, 1998, 2000). This disorder primarily looks like a physical illness rather than major depression. Somatic symptoms include feelings of constriction in the chest, palpitations, heat sensations and headaches (Herrick & Brown, 1999). Kim (1995) stated that hwa-byung is typical of the way emotional problems are expressed as a physical illness among Korean patients and that the illness should be treated as depression.

Taken together, these studies demonstrate the important interconnection between physical and emotional distress among Asian groups, and that this relationship may be different for Asians and Westerners. Currently, there is growing evidence that somatic symptoms are a common presenting feature of depression throughout the world and are not observed in Asian cultures only. However, the above-mentioned clinical and ethnographic studies also suggest that symptoms that comprise the Western conceptualisation of depression (i.e., changes in sleep, appetite, lethargy, joint pain) may not be sufficient to capture the somatic distress experienced by people in Asian samples (Arnault & Kim, 2008).

2.3 Cross-cultural challenges in studying depression

Even though depression has been identified as a prominent concern among refugee populations, little has been written about Afghan women’s conceptualisation and
understanding of depression. Most research in this population has looked at prevalence rates of depression (e.g., Cardozo et al., 2004; Rasekh, Bauer, Manos, & Eacopino, 1998) and mental health symptoms following war (e.g., Scholte et al., 2004; Bolton & Betancourt, 2004). In examining various psychopathologies in this population, existing research used translated Western instruments to explore the prevalence rates and occurrence of various symptoms. The use of translated measures in the Afghan population is an understandable starting point. However, many researchers suggest that the application of existing instruments to the assessment of depression in ethnic minorities may not only misrepresent the illness they suffer from but may also mislead prevention and treatment efforts (e.g., Kim, 2002; Phan, Steel, & Silove, 2004; Miller et al., 2006; Okello & Ekbald, 2006).

Although depression screening instruments have been validated and extensively studied in Western countries and various translating methodologies have been employed to enhance the linguistic equivalence of measures, their translation and use in other cultures is not nearly as simple as it might appear (Ahmad, Kernohan, & Baker, 1989; Bravo, Canino, Rubio-Stipec, & Woodbury-Farina, 1991; Bravo, Woodbury-Farina, Canino, & Rubio-Stipec, 1993). Symptom terms often sound awkward or incomprehensible when translated, even if the wording is semantically correct (Yeung et al., 2002). Although terms that address biologically-based symptoms can be more easily translated and understood across cultures, subjective psychological aspects of depression are much more influenced by culture and language and vary across cultures (Ghubash et al., 2000). The application of these instruments to Afghan people whose cultural traits differ from the population for which they were initially developed and standardized could
lead to misleading research and erroneous conclusions (Kazarian & Evans, 1998). Moreover, one risk associated with translated Western-derived measures is that culturally specific dimensions of mental distress experienced by people of Asian origin will be distorted (Good & Good, 1981; Good, Good, & Noradi, 1985; Lewis-Fernandez & Kleiman, 1995). For instance, research conducted by Ying (1988) with Chinese-Americans showed that although the Center for Epidemiologic Studies Depression Scale (CES-D) had good internal reliability, the meaningfulness of the items and conceptual validity of the scale were not clear. Ying found that somatisation was not differentiated from psychological distress. Thus, the items captured in the CES-D naturally reflect the language usage and daily expressions in the Western cultural context (Koh, Chang, Fung, & Kee, 2007) and thus might not align with the phenomenology of depression in Chinese people. Therefore, the widely assumed cross-cultural portability of psychiatric theory, diagnosis, and practice is being challenged (Kirmayer, 2006).

Spijker and colleagues (2004) conducted a study on the utility of the translated version of the CES-D with Turkish and Moroccan migrants in Western Europe, and found that Turkish respondents had difficulties understanding some of the CES-D items. Moreover, Moroccan males were unwilling to respond to interpersonal items, such as, “people were unfriendly” and “I felt people disliked me” due to their cultural background in which these items were embarrassing for men. Moroccan women, on the other hand, were unwilling to respond to the item “enjoy life.” Tran, Ngo, and Conway (2003) used a translated version of the CES-D with Vietnamese Americans to assess depression. They found that the item “I felt that I was just as good as other people” was the most difficult statement to translate and thus had an unacceptable correlation with other items and
exceptionally poor factor loading. In Vietnamese culture, being humble is considered a social virtue; however, this statement requires the respondents to compare themselves with others in ways that suggest an inferiority or superiority dialectic, which is socially unacceptable (Tran et al., 2003).

For research to advance on cultural variations in psychopathology, we need to go beyond applying Western instruments and conceptualisations of psychopathology and distress. Using Western instruments and conceptualisations cannot shed much light on the impact of culture on psychopathological processes. For research to advance on cultural variations in psychopathology we need to go beyond our understanding of psychopathology and look at other cultures’ conceptualisations from their point of view and from their cultural perspective. For instance, if cultures differ in the categories and concepts they provide to interpret and explain physical symptoms, we need to examine individuals’ uses of these attributions directly. To accomplish this we need to look at cultural influences on behaviour, which include bodily processes, cognitive models, modes of expression and narratives of distress, social interactions, and institutional practices (Kirmayer & Sartorius, 2007).

Cultural sensitivity in assessing for mental health problems and the development of effective psychological interventions requires an understanding of the ways in which people in particular cultures experience and articulate the ways they have been affected by adverse life events (Rogler, 1999; Summerfield, 1999). Familiarity with culturally specific idioms of distress allows practitioners to communicate effectively with distressed community members and to develop mental health interventions that are likely to be perceived as responsive to local beliefs and values (Summerfield, 1999). Depression—
sadness, hopelessness, unhappiness, a lack of pleasure with the things of the world and with social relationships—has different epistemologies and ontologies between cultures. For instance, for Buddhists, attachment to or desire for pleasure is the main cause of sorrow and willfully accepting dysphoria is the first step on the road to freedom (Obeyesekere, 1985; Kleinman & Good, 1985). For Shi’ite Muslims, grief is a religious experience that is associated with recognition of the tragic consequences of living justly in an unjust world. For them, the ability to experience dysphoria fully is a marker of the depth of a person and their understanding. Other societies, such as the Kaluli of Papua New Guinea, value full and dramatic expression of sadness and grieving. Such variations in the experience and understanding of dysphoria indicate that the translation of emotional terms requires much more than finding semantic equivalents (Kleinman & Good, 1985). To improve our understanding of the symptoms expressed by Afghan women, we need to interpret what their symptoms mean in the context of their culture. As Good and Good (1981, p.177) put it “all symptoms have personal significance and are inherently ‘culturally patterned’”. As such, a symptom of illness contains “a network of meanings for the sufferer: personal trauma, life stresses, fear and expectations about the illness, social reactions of friends and authorities, and therapeutic experiences” (Good & Good, 1981, p. 176; Pang, 1998). Thus, to obtain a complete picture of the mental health needs and conceptualisations of depression of Afghan women, mental health issues must be examined within their cultural context.

2.3.1 Importance of studying one single culture

In a world with much conflict, anger, and violence, an increased understanding of our own and others’ culture is one of the most pressing needs for the field of psychology.
For many years, research originating in Canada and the U.S. presented its work as natural
fact, even when the studies included few participants from other cultures (Keith, 2011).
Further, studies often had various cultural groups aggregated into a single,
undifferentiated category referred to as Asians (Kim, 2006). The practice of aggregating
Asians (e.g., Vietnamese, Thais, Laotians, Koreans, Chinese, Afghans, Pakistanis) into a
monolithic population may have originated from methodological challenges. Due to the
characteristics of this population (e.g., widely dispersed, limited proficiency of English),
recruiting an adequate Asian sample is challenging. Despite their growing numbers this
population is still relatively small in absolute numbers and there is also a lack of bilingual
interpreters (Liu & Cheung, 1985). Due to these constraints researchers have been forced
to consolidate groups into a single “Asian” group (Ying & Hu, 1994). However, although
these different cultural groups may share some similar characteristics and experiences,
differences do exist and should not be ignored (Chung & Lin, 1994). The research
practice of aggregating across Asian groups does not provide accurate information about
any of these Asian ethnic groups. Moreover, attempts to generalise mental health
knowledge about individuals to a combined population of different Asian groups holds
little utility (Kim, 2006) and might create discrepancies in the cultural conceptualisation
of mental health problems between each ethnic group.

Furthermore, culture plays a significant role in how people observe and respond
to the world around them and the behaviors of individuals from specific cultures change
due to the language the person uses and the degree to which he or she feels assimilated
into the culture to which he or she is exposed (Keith, 2011). Psychological processes are
interpreted, passed on to others, and created through language. Some researchers believe
that there is a close relationship between the characteristics of a language and the thoughts that are found among speakers of that language (Berry, 2011). For instance, Ji and colleagues (2004) presented participants of Chinese and American backgrounds with word triads: monkey-panda-banana. Their results revealed that the Chinese participants were more likely to choose relational pairings (e.g., monkey-banana because monkeys eat bananas), whereas the American participants favored categorical pairings (e.g., monkey-panda because both are animals). These results have been interpreted to support the notion that people of Chinese background, as well as many people of East Asian background, preferentially focus on overall context, which is arguably compatible with a collectivist perspective, and people with Western backgrounds make use of taxonomic concepts, which is arguably compatible with an individualistic perspective (Keith, 2011).

There is no aspect of human behaviour in which cultural groups differ more than in the languages they speak. Cognition and reasoning styles differ across cultures and language plays an essential role in cognitive development. The relationship between language, culture, and cognition has been debated in anthropology, philosophy, linguistics, and psychology. The center of the most heated debate is the famous Sapir-Whorf linguistic relativity hypothesis that states that culture, through language, determines people’s thinking (Whorf, 1956). Whorf believed that linguistic patterns, such as grammars, in different languages have an impact on people’s habitual thinking; that is, languages are reflected in habitual thought and habitual behaviour. Consequently, certain properties of a given language affect the way people perceive, think, and remember (Ji, Zhang, & Nisbett, 2004). Whorf also believed that culture and language are inseparable (Whorf, 1956). In contrast to Sapir-Whorf theory, Logan (1986) proposed that language
can be used to account for cultural differences in reasoning styles. He believed that learning how to read and write with the alphabet provides us with a conceptual framework for analysis and structures our perceptions of reality. According to Logan, a phonetic alphabet, such as the English alphabet, provides a ground for abstract, logical, and systematic thought, which explains why science started in the West and not in the East. In contrast, the Chinese writing system is based on drawn, concrete characters and seems to be reflected in Chinese thought discouraging the development of the abstract notions of codified law, abstract science, and deductive logic, which are basic prerequisites for the development of science (Ji et al., 2004). Although Whorf’s and Logan’s theories were challenged by various studies, they inspired numerous studies on language-culture relationships, not only in psychology and anthropology, but also in other disciplines (Kashima & Kashima, 1998).

To fully understand and appreciate the complexity of the language-culture relationship it is important to observe metaphors and idioms in speakers’ everyday linguistic and conceptual practices. According to Pritzker (2007), meaning-making exists as a complex and dynamic process at the intersection of personality, personal history, and the appropriation of various cultural models. As Garro (2003) posits, individuals draw upon cultural and personal understandings to make sense of their experiences and to narrate their experiences of illness or health. Thus, to obtain a more complete picture of mental health needs and the conceptualisations of depression of visible ethnic minority Canadians, mental health issues must be examined within a cultural context of a single society with a common language (Hsu, Davies, & Hansen, 2004).

2.3.2 Afghan refugees and Afghan culture
The purpose of this study is to obtain a deeper understanding of Afghan women’s narration of depression. However, without an understanding of Afghan people’s commonly held attitudes, beliefs, and customs, it would be difficult to explore their concepts of depression. Therefore, in order to understand, and make meaningful comparisons, it is necessary to examine and learn about Afghan culture first. This exploration will establish a better context for understanding cultural idioms of distress and cultural understanding of mental health. Moreover, this exploration will also establish cultural aspects that can be subsequently compared to the culture of settlement (i.e., Canada) and serve as a tool for gauging cultural discrepancies in the conceptualisation of depression, help-seeking behaviour, and mental health.

2.3.2.1 Overview

Afghanistan is a landlocked multiethnic country located in the heart of south-central Asia along important trade routes that connect southern and eastern Asia to Europe and the Middle East. Its history has largely been determined by its geographic location at the crossroads of Central, West, and South Asia (Graig, 1997; Encyclopedia Britannica, 2015). Twenty-six consecutive years of war in Afghanistan have had and continue to have a profound effect on all aspects of the Afghan people’s lives, even in the host country (Mehrabi, 2004). The Soviet invasion and subsequent occupation of Afghanistan from 1979 to 1989 caused 1 million deaths and generated 6 million refugees. The period following the Soviet withdrawal until 1996 was characterized by the radical Islamist Taliban’s taking control of Kabul, the war against the Soviets, and the subsequent civil war. This unrest has led to the death of tens of thousands of civilians, the displacement of millions of people, destruction of infrastructure, and roughly one third of
the pre-war population going into exile, creating the world’s largest refugee population of 6 million people (Cardozo et al., 2005; Miller et al., 2009; Goodson, 2001). Between 1996 and 2001, the Taliban regime imposed extreme fundamentalist Islamic law in which basic human and civil rights were routinely violated, and severe punishment for the smallest infractions created an environment of pervasive fear (Miller et al., 2009; Rashid, 2000). The fall of the Taliban regime ended the extreme conservatism, however, it did not lead to an overall liberalization in Afghanistan. The country has been left with little capacity to support the economic, social, or health needs of its people. There is extreme poverty, unemployment, and an ongoing lack of security in Afghanistan (Scholte et al., 2004; Cardozo et al., 2005).

2.3.2.2 Ethnicity and languages

Afghans are diverse in their ethnicity and languages. Each ethnic community has its own history, culture and speaks its own language. Approximately 49 languages are spoken throughout the country and the two primary ones were declared official in the 1964 constitution: Dari (Afghan Farsi)—the original language of the Tajiks; and Pashtu—the language of the largest ethnic population, the Pashtuns (Emadi, 2005; Morioka-Douglas, Sacks, & Yeo, 2004). According to Omidian (1996), 98% of the men speak Dari, even though Pashtu is the first language of 50% of the population. The Pashtuns are Sunni Muslims and account for about 85% of the 6.2 million Afghan refugees who fled the Russian invasion and the war (Afghan Network, 2001). The second largest ethnic group of Afghan refugees is the Tajiks, who come primarily from the north of the country. Other ethnic groups include the Uzbek and Hazara, the latter being primarily Shia Muslim (Omidian, 1996). Islam is the pillar on which Afghan culture
rests, whether in Afghanistan or the host country, and Islamic identity is a basic factor in how Afghans define themselves and explain the world around them (Dupree, 2002; Omidian, 1996).

2.3.2.3 Afghan culture

The traumatic experiences of Afghans cannot be well understood outside of their cultural context. Family life is the core of Afghan culture and psychological well-being. Afghans maintain close ties with extended family and spend most of their free time socializing with family members and close friends (Lipson, 1993). The family structure of Afghans is based primarily on the patriarchal system. Members of the family defer to the authority of the head of the family, usually the father and the eldest son after the father’s death. The father has absolute authority in supervising and controlling the lives of family members, male and female, within and outside of the household. The father decides what type of education his children will receive, if any, and what type of profession they will undertake (Emadi, 2005). Enmeshment or connectedness is a normal family behaviour in Afghan culture, and extended family obligations, especially to parents and older siblings, often supersede other responsibilities, including allegiance to one’s spouse, one’s job, and one’s own needs (Lipson & Miller, 1994). Enmeshed relationships are strongly valued and grandparents, uncles, aunts, nephews, and nieces have strong close relationships with each another. These family relationships are closer than those in Western cultures (Hong & Ham, 2001).

Individual honour, respect for the elderly, loyalty to colleagues and friends, tolerance of others, fulfillment of family obligations, forthrightness, an abhorrence of fanaticism, and a dislike for ostentation are cultural qualities that characterize most
Afghans (Dupree, 2002). An individual’s honour, social status, and personal code of conduct are largely determined by the institution of the family. Social values stress the cohesiveness of the family through maintaining the kinship system. Members of the extended family prefer to live in the same compound of adjoining buildings, allowing family members to easily interact (Morioka-Douglas, Emadi, 2005). Honour is the rock upon which social status rests in Afghan culture and the position of women is central to the value of family and honour. In this patriarchal society women are the standards by which morality is judged and the responsibility of passing on the values of the society to younger generations rests on women. These values are implicit in the rules of etiquette which emphasize respect for elders and guests, such as standing in welcome, exchanges of prescribed greetings, appropriate dress, and above all, decorum and deportment, which are crucial for both men and women. The criteria for appropriate behaviour may vary from group to group and even within each group; however, central to the rules of etiquette are those designed to uphold honour. Accordingly, dignity is one of their more visible traits (Dupree, 1998).

In Canada and the U.S., Afghan culture is in transition, with families ranging from quite traditional to more cosmopolitan, based on their background and personal choice. However, despite this range, language and cultural dissonance keep most Afghans from associating with North Americans. In addition, elderly and homebound Afghan women in the U.S. are often isolated and lonely when their English is insufficient to talk with neighbours or if they are culturally restrained from moving outside their family circle. They miss the constant visiting characteristic of life in Afghanistan (Lipson, 1993). Those Afghans who remain within their ethnic communities base their views of
Western culture mainly on their observations, on TV, and on discussions with family members and Afghan friends. Afghans are very private and most employed Afghans do not discuss their personal problems with non-family members. Thus, they have little access to information from U.S. and Canadian peers about dealing with public agencies and law (Lipson & Omidian, 1997).

Furthermore, Afghans new to Western culture tend to assume that people relate to government agencies as they do in Afghanistan. For instance, business with the Afghan government was often facilitated by giving bribes, and thus, many Afghans still assume that the government’s main occupation is obtaining money and services for its own uses. This distrust and cynicism of many Afghans was further increased in Pakistan as they observed corrupt administrators skimming off funds meant for refugee relief from the United Nations High Commissioner for Refugees (UNHCR) and governmental organizations (Lipson & Omidian, 1997). This mistrust in their interactions with “outsiders” is very understandable. Due to prolonged violence and uprooting, many refugees may have been subject to political and/or ethnic persecution, torture, and rape. Furthermore, many refugees may have been in situations where they were unable to exercise political or socio-economic power and were in many respects at the mercy of others. This may be the case in refugee camps and in neighboring countries where refugees become dependent and reliant upon humanitarian relief agencies providing assistance. They may also have been in conflicts where rebel or government forces were responsible for their persecution. Since many aspects of their lives were under the control of others, their scope for exercising self-determination was very limited. Prolonged periods in protracted displacement situations can undermine people’s sense of their own
identity, sense of worth, and their trust in themselves and others. This mistrust often gives rise to a generalized mistrust or a particular mistrust of officials such as agency workers, translators or local community representatives. Refugees may also mistrust the motives and independence of researchers as well as the information provided to them about the research. They may become very wary about how the information they provide will be used. Some refugees, however, may have unrealistic expectations of the benefits of the research, believing that researchers may have the power to influence legal or resettlement processes. Therefore, it is important to find ways to build relationships of trust between the researcher and refugee participants (Mackenzie, McDowell, & Pittaway, 2007). It is also very essential to explain the reasons for audiotaping and how the information they have given will be used. Lastly, refugee participants must be made aware that the discussion transcript will be sent to all of them for their approval.

2.3.2.4 Status of women in Afghan culture

Gender differences in mental health are well documented and it is recognized that women with mental disorders pay a heavy toll, not only with regard to the prevalence rate but also in terms of the social and family consequences of mental illness for women (Rosenfield & Mouzon, 2013). Women are at higher risk compared to men to develop anxieties, depression, or attempt suicide (Douki, Zineb, Nacef, & Halbreich, 2007). This is particularly true in traditional societies, such as Afghan culture, where gender inequality is pervasive. Pressure generated by women’s multiple roles, gender discrimination, poverty, hunger, malnutrition, overwork, domestic violence and sexual abuse, and differences in living and working conditions account for women’s poor mental health in many traditional societies (Douki et al., 2007). Research has consistently
reported that cultural factors arising mainly from the subordinate position of women in the Muslim world influence the prevalence, pattern, and management of depression and a number of anxiety disorders in women (Fakhr El Islam, 2001). As a result of mental health issues in traditional societies, mentally ill women are at greater risk of not marrying or of being divorced by their husbands and separated from their children. They are also at higher risk to be sexually or physically abused and eventually killed (WHO, 2000). Moreover, Afghan women experience a transition from a traditional, patriarchal family- and home-centered society to a technologically oriented, individualistic, and more egalitarian society. This transition leads to Afghan women to experience culture conflict, a loss of status, and social isolation that may make them prone to depression and stress-related psychosomatic symptoms (Lipson & Miller, 1993). Therefore, to understand Afghan women’s unique mental health issues, help-seeking behaviour and access to health-care, it is important to understand their role and their status in Afghan culture as well as their changing roles in Western culture. This understanding will allow us to explore Afghan women’s beliefs regarding depression, which in turn will help in formulating a more culturally and gender sensitive approach to mental health delivery.

The kinship system in Afghan culture centers around the patriarch, and males and females are raised in a family environment that stresses the primacy of the patriarch, and by extension the tribal chiefs and religious leaders, mullahs, are almost exclusively male. Women as a whole, in Afghanistan and even in Western countries, experience varying degrees of gender oppression, both familial/social and political (Emadi, 2005). In a patriarchal society, such as Afghan culture, women are often subordinated to men and are obligated to obey them and follow their orders without questioning their merits. Afghan
women are often less educated than men, marry young, have many children (preferably boys), do not work outside the home, and are restricted to socializing mainly with female relatives (Lipson & Miller, 1994). Although some women of low-income and poor families work outside their homes out of necessity to maintain and support the family, a man is still regarded as the guardian of the family (Emadi, 2005). As in many other Muslim cultures, marriage is the rite of passage to adulthood for Afghan women. Until they marry, women are called girls and live with their parents and their families decide their future (Lipson & Miller, 1994).

The tradition of arranged marriage is common in Afghanistan and girls are often married at a very young age. Selection criteria for a partner vary from one ethnic community to another, but most families prefer that suitable mates be related to one another and economically stable. Other reasons for arranged marriage may include reciprocation of a favor a man received during a time of need or when two families try to maintain friendly ties or resolve an existing fight between them. Since the 1990s, “parceled marriage” has become very common in Afghanistan. A parceled marriage is a type of arranged marriage in which a man who lives in North America or Europe sends his picture and money to the bride’s family in Afghanistan or within the settled refugee communities in Pakistan, Iran, and elsewhere. In the hopes that their daughter will have a better life in the West, families betroth their daughters to the prospective husband. It is quite normal and common for the girl not to have a choice but to agree to the family’s decision (Emadi, 2005). Moreover, Islam allows a man to marry up to four wives but requires the husband to provide the wives with financial support and treat them equally. Thus, polygamy is practiced occasionally among all ethnic groups, although
monogamous relationships prevail among the vast majority of the people. A man usually marries a second, third, or fourth wife when his previous wife dies, or does not bear him a son, or when the wife becomes old, or if his first wife was from an arranged marriage and the second wife is his personal choice (Emadi, 2005).

It is common to punish a woman who violates the established social and cultural traditions in Afghan culture. For instance, if a woman is suspected of having a sexual affair, whether proven or not, she will likely be put to death by the men in her family, such as her father, her brother, and her husband, to restore the family’s honour. Death by stoning is still practiced in many parts of Afghanistan (Campbell & Guiao, 2004). Women have no rights or the means to defend themselves on charges leveled against them. Furthermore, the society looks poorly upon women who take matters into their own hands and attempt to expose men’s brutality (Emadi, 2005). Women can be victimized not only by the husband but also by the husband’s family (e.g., mother-in-law, sister-in-laws), by men of power and authority, and women do not have recourse to fight back (Emadi, 2005; Campbell & Guiao, 2004).

2.3.2.5 Islam and its place in Afghan culture

The relationship between religion and mental health has long been a subject of investigation in the social sciences (Sternthal et al., 2010). Over the past few years, numerous studies have shown that religious beliefs and practices are associated with greater life satisfaction and psychological well-being, increased hope and optimism, less anxiety and fear, reduced substance abuse and addictive behaviour, and decreased depression (Koenig, McCullough, & Larson, 2001). Moreover, religiosity often provides comfort during high-stress periods and offers a means of preserving a sense of meaning
and security in dealing with situations beyond one’s control (Sternthal et al., 2010). Religious participation often times encourages social integration and increasing interaction among people with similar value systems (Idler, 1987), which fosters strong and weak social ties. Such ties provide emotional, instrumental, and anticipated support and improved mental health (Paykel, 1994; House, Landis, & Umberson, 1988). However, such social networks may also cause distress to an individual and his or her family by being demanding, burdensome, or overly critical (Krause, Ellison, & Wulff, 1998).

Among Muslims, cultural and religious formation, attribution, and conceptualisation play an important role in identifying an individual’s mental health or psychological problems as well as the selection of specific services (Aloud & Rathur, 2009). In many Islamic countries, religion is one of the primary influences dictating the values attached to mental health and mental health is regarded as far more important than physical health. Islam plays a major role in determining the value system in many Muslim cultures. On the one hand, Muslim societies are generally contemptuous of and biased against individuals who are mentally ill (Qidwai & Azam, 2002; Naeem et al., 2005). On the other hand, however, good treatment of individuals who are mentally ill is deemed greatly desirable under the society’s strong religious and ethical values (Gilani et al., 2005). It is widely perceived that mental illness is caused by supernatural forces such as spirit possession, the evil eye, testing by God as punishment for one’s sins, and black magic, whereas others believe that taking “Western” drugs can cause mental illness (Karim et al., 2004).
Religion has played an important role in various eras of Afghan people’s history, from the ancient worship of natural forces to the concept of a supreme deity as expressed in Zoroastrianism. Buddhism also influenced social and artistic development in the country before Islam ascended and spread throughout the country. Afghan people’s practice of Islam and belief in their view of Islam play a fundamental role in providing daily moral, ethical, and social guidance (Emadi, 2005). Islam fosters a pluralistic community, in which various interpretations and practices of Islamic faith and paths (tariqah) exist. Although there are many interpretive traditions, only two are dominant in the Islamic world: Sunni and Shia. Many Afghan traditions, rituals, and folk beliefs are based upon Islamic ideology derived from the Quran (the Islamic holy book) and Hadith (traditions of the Prophet Muhammad). These derivations led to beliefs in the existence of ghosts, jins (evil spirits) and demons, the existence of spirits of good and bad, miracle healing, the cults of saints, witchcraft, and pilgrimage (Majid, 2001; Farooqi, 2006). There are also commonly held superstitions that certain people possess the “evil eye,” and with that comes the power to cause others misfortune. Grandparents tell their children stories about jins and evil spirits, and ensure that the belief in the supernatural and good/bad luck as causative factors in daily life will persist through future generations (Emadi, 2005).

The Islamic faith explains mental illness as caused by doubt and dissociation due to one’s own compelling needs or outer pressures that are counter to the teachings of the prophet and Quran. Accordingly, as doubt and conflict increase, the person may develop symptoms of mental illness (Farooqi, 2006). As a result, the majority of Muslims adhere to belief in One Allah and the Final Prophet Muhammad (peace be upon him)—to five
prayers a day, to Zakat (i.e., almsgiving), to fasting, to Hajj/Pilgrimage to Mecca, and to other obligatory practices pertaining to diet, gender roles, dress, interpersonal relationships, and family values to promote their mental and physical health (Farooqi, 2006; Hassouneh-Phillips, 2001; Mazhar, 2000). Therefore, traditionally in Afghanistan, people who are mentally ill are treated by traditional healers, and in severe cases they are brought to traditional healing centers (van de Put, 2002).

2.3.2.6 Mental health of Afghan refugees

Although the universality of mental illness such as depression is well acknowledged, the cultural background of an individual influences their depression in terms of conception, perception, experience of symptoms, recognition and labeling, help-seeking, social response to depression, classification and treatment and course of depression (Kleinman, 1977a; 1977b). Each of these ways in which culture may influence the regulation of emotion has potential implications for the expression of dysphoric affect in clinical settings (Kirmayer, 2001). Moreover, culture provides categories as well as a lexicon for emotional experience, making some feelings more salient and others more difficult to articulate. Culture also sets limits of tolerance for specific emotions and strong affect and provides lay theories and strategies for managing depression. Consequently, culture helps to shape the symptoms exhibited when one is emotionally disturbed. The manner in which the individuals present their symptoms, how they communicate their health problems, and the decisions they make about health care are all influenced by cultural beliefs and values concerning mental health (Dow, 2011).

Many Afghans, adults and children, have undergone difficult and traumatic pre-migration experiences that constitute salient risk and stressors to their mental health.
Many of them have witnessed and experienced war, torture, violence, targeted persecution, forced labour, forced migration and family separation, the death of family members, sexual assault by armed combatants, and a chronic fear of being injured or killed (Wilson, Murtaza, & Shakya, 2010; Miller et al., 2008). Numerous epidemiological surveys have documented high prevalence rates of mental health issues, specifically depression, anxiety, and PTSD, associated with exposure to traumatic events (Cardozo et al., 2004; Scholte et al., 2004). For instance, Cardozo and colleagues (2004) found high prevalence rates of symptoms of depression (67.7%) in the Afghan population. Moreover, a survey conducted among a community sample of Afghan women living in Kabul or in refugee camps in Pakistan showed that 97% exhibited symptoms of major depression and 86% reported significant anxiety symptoms (Rasekh, Bauer, Manos, & Iacopino, 1998). According to a survey conducted by the United Nation’s Children Fund (Gupta, 1997), of 310 children and adolescents aged 8 to 18 years in Kabul, 80% reported feelings of sadness, fear, and an inability to cope with life; 40% had lost a parent; and 67% had seen dead bodies or parts of bodies on the street. In comparison to other war-affected areas, studies show that the prevalence of depression and anxiety was relatively high in Afghanistan (de Jong, Komproe, & Van Ommeran, 2003).

Although pre-migration trauma puts refugees at salient risk for developing mental health issues, post-migration stressors faced by this group can also compound their mental health issues (Wilson, Murtaza, & Shakya, 2010). Being forced to migrate from one’s home can produce stressful changes for many refugees and may affect their mental and physical health (Kalafi, Hagh-Shenas, & Ostovar, 2002). Grief for family, separation from relatives at home, a lack of social support, poverty, unemployment, different food,
culture, language, isolation and many other cultural differences can impact their mental health. Numerous studies have shown that post-migration stressors are strongly related to the mental health status of refugee populations, and in particular to levels of depression and anxiety (Gorst-Unsworth & Goldenberg, 1998; Lavik, Hauff, Skrondal, & Solberg, 1996; Miller et al., 2002; Pernice & Brook, 1996). Furthermore, in the context of resettlement, Hymen and colleagues (1996) found that experiences of poverty, interracial conflict, family instability, parental psychosocial distress, youth unemployment, and intergenerational conflict were all found to be sources of poor mental health.

While being selected for resettlement in Canada is viewed positively and provides hope for a better life, particular policy anomalies and process challenges related to their resettlement in Canada appear to worsen rather than alleviate mental health issues that refugees face. Stressors related to the refugee resettlement process include delays in processing applications, errors in the paper work, delays in family reunification, a lack of information, and having little or no input into which province or city they get settled in Canada. After their resettlement in Canada, Afghan refugees also face labour market challenges (i.e., difficulties finding decent jobs, non-recognition of foreign credentials, having to meet financial challenges with precarious jobs), poverty, linguistic barriers and difficulties in learning the English language, isolation, and discrimination. While non-refugee groups may also face these barriers and challenges, refugee groups may experience these determinants in acute and unique ways. According to Wilson and colleagues (Wilson, Murtaza, & Shakya, 2010), the acute impact on refugees results from traumatic experiences they may have faced and/or due to gaps in educational, economic, and political opportunities.
When refugees experience isolation when adapting to a new culture they may not know where to turn when faced with mental health issues, such as depression, due to their unfamiliarity with mainstream mental health services, their cultural attitudes, and beliefs about mental health in general (Dow, 2011). When migrating, individuals do not leave their beliefs or idioms of distress behind no matter what the circumstances of the migration are. Their cultural beliefs influence their idioms of distress and how these idioms are then used to express symptoms and employ help-seeking patterns (Bhugra, 2005). For example, Bhugra, Desai, and Baldwin (1997) found that Punjabi women who had been in the UK for a number of years still believed that depression was not a medical condition. These women recognized the symptoms of depression and sought help from religious practitioners and by reading scriptures.

No culture can mitigate all of the stresses of life, but refugees have to cope with more potentially devastating stressors due to the very reason of flight (Bustos, 1990; Omidian, 1996). Afghan refugees may be at risk for multiple stress-related illnesses and/or emotional problems due to their pre- and post-migration experiences. According to Omedian (1996), many Afghan refugees that she worked with spoke of death and the destruction of land, friends, and family. Every Afghan family has been personally touched by the destruction of their country: some family members were imprisoned, some lost forever, others released, some were beaten and tortured, and others just detained. In addition to these past experiences, Afghans have to deal with life in a country that expects them to take charge and cope as individuals (Omedian, 1996).

2.4 Application of Western models of psychiatric illness to culturally diverse Afghan populations
While part of the depressive experience may be universal, it is increasingly recognized that there are culture-specific elements to this experience (Matsumoto, 2000; Draguns, 1997; Kleinman & Good, 1985). Due to cultural variations, achieving a universal operational definition of depression that is valid across cultural boundaries constitutes a major challenge in cross-cultural research (Noh, Avison, & Kaspar, 1992). The Western perspective conceptualises depression as existing within a relatively strict set of biological (e.g. disruptions of appetite, fatigue) and psychological (thoughts of uselessness, feeling “down and depressed”) parameters. In Asian cultures, such as Afghan culture, however, depression may be expressed in terms of sadness or guilt, complaints of nervousness and headaches, weakness, tiredness or imbalance, and feature predominantly somatic symptoms (Bhugra & Mastrogani, 2004). Thus, symptom expression is not universal but tied to local knowledge about the body and pathology, and particular systems of religious beliefs (James et al., 2009).

Furthermore, Western and European societies rely almost exclusively on the Diagnostic and Statistical Manual of Mental Disorders (DSM 5; APA, 2013) and International Statistical Classification of Diseases and Related Health Problems (ICD-10; World Health Organization, 1992) to define mental illness and, in the case of depression, the DSM-5 often situates human problems within the physiology of the brain, which then determines the psychology of the individual. Even though many human problems brought to the attention of mental health practitioners arise in the context of patterns of familial interactions, cultural settings, and wider social spheres, the first line of treatment often involves the prescription of psychotrophic medications to alter brain chemistry. This is a uniquely Western way of understanding and treating depression, whereas in many Asian
cultures disturbances of mood, affect, and depression are not viewed as mental health problems but as social or moral problems and as part of life or faith (Kirmayer, 2001). Even when Asians meet the DSM criteria for a depressive episode, perceptions about aetiology, consequences and cure may differ amongst non-Western ethnic groups and those trained in the Western tradition (Lavender, Khondoker, & Jones, 2006).

Research conducted by Omeri and colleagues (2006) in Australia showed that Afghan refugees described feelings of sadness and depression associated with missing family and friends and being unemployed; feelings of shame, anger, guilt, and fear. Added to this were multiple health problems, such as heart disease, diabetes, and hypertension, as well as additional ones that resulted from prolonged stress due to war, and the hardships of escape and even life in a refugee camp (1996). For women, closely-spaced pregnancies were a source of additional stress and few people considered themselves to be healthy. When these Afghan participants sought help for their medical problems they were often told that these problems were caused or exacerbated by stress. Lastly, for most of these refugees, there were no cures and no way to alleviate the physical or psychological pain (Omidian, 1996).

A study conducted by Miller et al. (2006) in Afghanistan also revealed high levels of distress among Afghani men and women. This study also showed culturally specific idioms of distress such as jigar khun, a form of sadness that includes grief following interpersonal loss but may also be a reaction to any deeply disappointing or painful experience, and asabi, which refers to feeling nervous or highly stressed. People with high levels of asabi were described as feeling overwhelmed by major life stressors, including poverty, domestic violence, and single parenting. A study conducted by
Omidian (1996) also found that the term *asaabee* or *asabi* described physical and emotional discomfort. Moreover, *asaabee*, in many instances, was exacerbated by *narahat* (discomfort and/or anxiety and depression). In Miller’s study (2006), other common culturally specific idioms of distress were *fishar-e-bala* and *fishar-e-payin*; both terms were interpreted as high and low blood pressure, respectively. According to Miller and colleagues (2006), these terms were usually unrelated to blood pressure and referred to an internal state of emotional pressure and agitation (*fishar-e-bala*) or low energy and motivation (*fishar-e-payin*). Moreover, this study also showed that Afghans have three categories of psychological distress: (1) disorders caused by biology (e.g., schizophrenia); (2) distress caused by *jinns* (i.e., spirits that can take over a person’s mind and body and cause them to experience acute emotional and physical discomfort); and (3) distress caused by stressful life experiences such as war, poverty, and family violence.

Given this variation in symptom presentation and unique explanation of aetiology of distress, it would be useful to explore Afghan refugees’ understanding and conceptualisation of depression.

Cultural sensitivity in assessing for mental health problems and the development of effective psychological interventions requires an understanding of the ways in which Afghan people experience and articulate the ways they have been affected by adverse life events (Rogler, 1999; Summerfield, 1999). Familiarity with culturally specific idioms of distress allows practitioners to communicate effectively with distressed community members and to develop mental health interventions that are likely to be perceived as responsive to local beliefs and values (Summerfield, 1999). For example, Phan, Steel, and Silove (2004) developed the Phan Vietnamese Psychiatric Scale (PVPS), which is
derived entirely from indigenous idioms, expressions, and cultural understandings of mental illness. The culturally unique dimensions of the items reflect distinctly non-Western health beliefs. For example, the item “felt downhearted, pale, or had dark rings around the eyes” combines dysphoric mood and physical symptoms in a way that is culturally meaningful but does not adhere to the usual practice in Western measures of separating affective and somatic domains. Many of the symptom descriptions of the PVPS demonstrate culturally distinct concepts and metaphors that draw directly on traditional Chinese health beliefs regarding the flow of energy in the body and the location of particular emotional states in the physical organs of the body that have no immediate parallel in Western descriptions (Silove, 2004).

Afghan culture has a quite distinct and different cosmology from that found in industrialized Western nations. As such, a strict reliance on the language and constructs of Western psychiatry risks inappropriately prioritizing psychiatric and cultural syndromes that are familiar to Western practitioners, but that may be of secondary concern or simply lack meaning to Afghan populations to whom perhaps local idioms of distress are more salient (Miller et al., 2006). Cross-cultural research has been cautioned against the category fallacy, the term coined by Kleinman (1987), which entails the erroneous assumptions that a diagnostic construct developed in one cultural context is meaningful in a different cultural context simply because the symptoms that constitute it can be identified in both settings. The category fallacy suggests two essential and overlapping lines of research: one line entails studying the cross-cultural validity of Western diagnostic constructs, and the second involves the identification of culturally specific ways in which psychological distress is expressed and understood (Miller et al.,
2006). For the purposes of this research the latter is especially important, as the
development of effective psychological interventions requires an understanding of the
ways in which Afghan people experience and articulate the ways they have been affected
by adverse life events (de Jong, 2002; Summerfield, 1999). By observing emotional
experiences as they naturally unfold within the context of Afghan culture, and by
listening to Afghan descriptions of their experiences, we will gain a deeper understanding
of the cultural meanings of human emotions (Whiting & Whiting, 1975).
CHAPTER 3- METHODOLOGY

3.1 Current study

Although the concept of depression and various depression screening instruments have been extensively studied and validated in Western countries, there is a need to study and understand Afghan women’s understandings and conceptualizations of depression. Numerous studies conducted with Afghan participants show that there are cultural differences in their conceptualization of mental disorders and the ways they cope with them (e.g., Omidian, 1996; Miller et al., 2006). Although these studies contribute tremendously to our understanding of Afghan culture and various symptomatologies, they do not tap into Afghan people’s experiences with depression or the culture-specific idioms used by them to describe these experiences. In order for us to capture and understand Afghan women’s unique perspective on depression a qualitative approach is required. A qualitative approach will allow us to get at the inner experiences of Afghan women, to determine how meanings are formed through and in culture, and to discover rather than test variables (Corbin & Strauss, 2008). More importantly, this approach will give us an opportunity to connect with Afghan women and see the world from their perspective. Thus, the current study used grounded theory to explore Afghan women’s understanding of depression and their help-seeking behaviours. Grounded theory will allow Afghan women to communicate in their own words about depression and their help-seeking behaviours.

The qualitative discussions for this study were conducted using a constructivist approach focused on (1) the creation of a sense of reciprocity between participants and the researcher in the construction of meaning and ultimately a theory that is grounded in
the participants’ experiences, (2) the establishment of relationships with participants that clarifies power imbalances and attempts to modify these imbalances, and (3) clarification of the position the researcher takes in the text and how one renders participants’ stories into theory through writing (Mills, Bonner, & Francis, 2006). In a constructivist grounded theory design it is important to position the researcher as the participants’ partner in the research process rather than an objective analyst of the subjects’ experiences. This position, in turn, provokes a need to critically reflect upon one’s underlying assumptions and heighten one’s awareness of listening to participants’ stories as openly as possible. Moreover, it provides the reader with a sense of the analytical lenses through which the researcher gazes at the data and how participants construct their worlds (Mills, et al., 2006).

I was drawn to Charmaz’s constructivist perspective because of her emphasis on multiple realities and the complexities of particular realities. Charmaz recognizes that ‘the discovered’ reality arises from the interactive process and that theories are constructed by the researcher and the research participant. This interpretive approach was more appropriate to address my research questions and to seek out meaning and understanding. Constructivist approach allowed for exploration of cultural complexities and perspectives from the perspective of Afghan women themselves. My role in this process was to address the complexity of their perspectives by listening to the views of the participants and the meaning they assigned to them within the context of their own lived experiences (Charmaz 2000; 2006; Wilson, 2012).

My focus on Afghan women and not men is based on research that shows there are differences in symptom presentation between men and women (Renner & Salem,
2009) and the prevalence rates of mental illness are higher among refugee women than men (Schubert & Punamaki, 2011). In addition, as a female, Muslim woman, it was more appropriate for me to focus on women than men. Research has shown that culture and gender interact between interviewers and participants within the research process. A study conducted by Archer (2002) has shown that Muslim men attempted to assert themselves as powerful Muslim men in relation to the Muslim female researcher by criticizing her appearance (short hair, Western clothes) and lifestyle (living away from her parents) as unacceptable for a Muslim Pakistani woman. This interaction in turn impacted the interview and generated moments of conflict and resistance (Archer, 2002). As a researcher I have encountered the same interview situation during my work with Muslim men. As a result of those experiences I decided to only focus on Afghan women as it is more culturally appropriate.

3.2 Study design

3.2.1 Focus groups and interviews

First and second generation Afghan women, ages 18 and above, were recruited to participate in focus groups and individual interviews. A total of two focus groups (one with first generation and one with second generation Afghan women) followed by eight individual interviews were conducted. The women who participated in the study were recruited through word of mouth, contacts from other women, and interpreters. The interviews ranged in duration between 60 to 120 minutes and were audio recorded with the participants’ permission. The structure of the discussions consisted of general discussion, followed by the vignette (see Appendix C), and definition of terms.
The discussions were conducted with a female interpreter. The interpreter signed a confidentiality form prior to the interviews. At the beginning of the discussions the participants were given a consent form to review. Before signing the consent form the participants were informed about their rights to withdraw from the study at any point during the discussion. They were also notified that they were free not to answer any questions they did not feel comfortable answering. The participants were informed that all information would be treated as confidential and that their names and identifying information would not be associated with the data. Moreover, the participants were asked to respect the privacy of fellow participants and not share the identifying information outside of the group. The participants were interviewed in their native language with the aid of interpreters, who translated the conversations from Pashtu into English. Most of the second generation women were sufficiently fluent in English. The interpreters were acquainted with the participants (two of them were daughters of the participants). No one else was present at the interview besides the researcher, the interpreter, and the participants. The focus groups took place at the University of Regina, and interviews took place in the participants’ homes or at a location of the participant’s choice.

3.2.2. Participants

A total of 19 women (8 first generation and 11 second generation) participated in this study (see Table 1 for demographic information). The focus groups consisted of six first generation and five second generation Afghan women. The individual interviews consisted of two first generation and six second generation Afghan women.

The first generation women’s ages ranged from 36 to 64. All women identified themselves as Afghan; however, seven women indicated that due to their relocations to
neighboring countries prior to their arrival to Canada they call themselves Persian as well. Their average length of time living in Canada was 7 years. Only one woman was employed, and the rest identified themselves as “housewives.” With regard to education, two women had no education, four had high school, and two had some grade school. When asked to identify their religion, seven women identified themselves as Shi’a Muslim and one as Sunni Muslim.

The second generation women’s ages ranged from 18 to 35. Similar to the first generation women, they identified themselves as Afghan, but due to their relocations to neighboring countries prior to their arrival in Canada three of them identified themselves as Afghani and Persian as well. Their average length of time living in Canada was 9 years. Five of the participants were employed, one was unemployed, and the rest were students. With regard to education, most of the women (64%) had some university and 18% had Bachelor’s degrees. In terms of their religion, 55% identified themselves as Shi’a Muslim and 36% as Sunni Muslim. One of the participants reported having “no” religion.

3.3 Discussion questions

The objective of this study is to explore Afghan women’s conceptualisation and understanding of depression. To achieve this objective, Afghan women were asked to describe how they feel when experiencing a personal loss, such as the loss of a loved one, loss of a job, or when she is unable to financially help her family back in Afghanistan or neighbouring countries. The participants were also asked to describe jigar khun (a form of sadness following interpersonal loss), asabi (feeling nervous or highly stressed), and fishar-e-bala and fishar-e-payin (high, low blood pressure) if these idioms were not
mentioned during the discussion. An effort was made to make all the participants feel that they are teachers educating us on their cultural nuances, concepts, and their understanding of depression.

In the second half of the focus groups, participants were presented with a vignette (see Appendix C) describing individual emotional and somatic symptoms of depression. The purpose of the vignette was to present Afghan women with a case of an individual experiencing depression without using technical language or the word “depression.” Due to the lack of research in this area, we do not know whether there is a word for depression in Afghan culture or whether depression is conceptualised in a way that is similar to the Western conceptualisation. In order not to lead participants on or ask biased (or culturally inappropriate) questions, we wanted to present a vignette that would open up a discussion of their conceptualisation and understanding of illness or the problems that the person in the vignette was experiencing. Thus, the purpose of the vignette was to ascertain the perception of Afghan women. Specifically, data was sought on: (1) whether the individual in the vignette has a problem/illness; (2) what are the symptoms of this illness/problem; (3) what other terms and expressions one would use to describe the illness/problem; (4) the causes of this illness/problem.

The vignette was derived from one of seven used by Wig et al. (1980) and one used by Karasz (2005). Wig et al. used a vignette with Sudanese, North Indian, and Philippine populations to study their attitudes toward depression. This vignette was adapted and used in studies conducted with Ethiopian and Arab ethnic groups to study attitudes toward depression (Mulatu, 1999; Sulaiman, Bhugra, & Silva, 2001). Karasz (2005) used a vignette describing a woman experiencing depression with South Asian
and European Americans residing in New York City. The purpose of the vignette was to study differences in the conceptualisation of depression in these particular ethnic groups. This vignette was later used with South Asian women to examine their conceptual representations of the causal relationship between marriage roles and depression (Karasz, 2005).

Based on the DSM-5 (2013), symptoms of depression are affective and interpersonal. In order to present depression from Western and Asian perspectives we will use emotional symptoms from Karasz’s vignette and somatic symptoms from Wig et al.’s vignette:

> For the past two weeks Delbar had felt that something was wrong with her. She complained of different troubles at different times; troubles such as headaches, pains in the stomach, general weakness of the body, difficulty breathing and tiredness. She couldn’t do her work as well as she usually could. Often during the day her eyes filled with tears, and she felt intense sadness. Her close friends and relatives couldn’t cheer her up. She found it difficult to fall asleep and she lost her appetite (Wig et al., 1980; Karasz, 2005).

For the first-generation Afghan females the vignette was translated into their native language and was blindly back-translated (i.e., without the original source material as reference) into English and was reviewed by two independent bilingual speakers to ensure conceptual equivalence. Special attention was given to Afghan vocabulary for illness and emotion states.
A total of two focus groups and eight individual interviews were conducted. All discussions were audio recorded with the participants’ permission. The discussions were conducted with a female interpreter. The interpreter signed a confidentiality form prior to the interviews. At the beginning of the discussions the participants were given a consent form (see Appendix D and E) to review. At the end of the focus groups, the participants were offered an honourarium of $20 for their time and effort. Table 1 shows the participants’ characteristics:
Table 1. Characteristics of the two groups of participants.

<table>
<thead>
<tr>
<th></th>
<th>First Generation (N = 8)</th>
<th>Second Generation (N = 11)</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Age</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Mean age in years</td>
<td>48.9</td>
<td>23.4</td>
</tr>
<tr>
<td>Minimum age</td>
<td>36</td>
<td>18</td>
</tr>
<tr>
<td>Maximum age</td>
<td>64</td>
<td>35</td>
</tr>
<tr>
<td><strong>Marital Status</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Single</td>
<td>7</td>
<td></td>
</tr>
<tr>
<td>Married</td>
<td>6</td>
<td>2</td>
</tr>
<tr>
<td>Common Law</td>
<td></td>
<td>1</td>
</tr>
<tr>
<td>Separated</td>
<td>1</td>
<td></td>
</tr>
<tr>
<td>Widowed</td>
<td>1</td>
<td></td>
</tr>
<tr>
<td>Did not wish to identify</td>
<td></td>
<td>1</td>
</tr>
<tr>
<td><strong>Education</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Grade school</td>
<td>2</td>
<td>1</td>
</tr>
<tr>
<td>High school</td>
<td>4</td>
<td></td>
</tr>
<tr>
<td>Some university</td>
<td></td>
<td>7</td>
</tr>
<tr>
<td>Bachelor’s degree</td>
<td></td>
<td>2</td>
</tr>
<tr>
<td>Other (did not wish to identify)</td>
<td></td>
<td>1</td>
</tr>
<tr>
<td>No education</td>
<td>2</td>
<td></td>
</tr>
<tr>
<td><strong>Length of Stay in Canada</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Mean in years</td>
<td>7</td>
<td>9.8</td>
</tr>
<tr>
<td>Minimum</td>
<td>6</td>
<td>3</td>
</tr>
<tr>
<td>Maximum</td>
<td>10</td>
<td>15</td>
</tr>
<tr>
<td><strong>Religion</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Sunni Muslim</td>
<td>1</td>
<td>4</td>
</tr>
<tr>
<td>Shi’a Muslim</td>
<td>7</td>
<td>5</td>
</tr>
<tr>
<td>Other (identified themselves as spiritual)</td>
<td></td>
<td>2</td>
</tr>
<tr>
<td><strong>Occupation</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Administrative worker</td>
<td>1</td>
<td></td>
</tr>
<tr>
<td>Childcare worker</td>
<td>1</td>
<td></td>
</tr>
<tr>
<td>Hair stylist</td>
<td>1</td>
<td></td>
</tr>
<tr>
<td>Homemaker</td>
<td>8</td>
<td></td>
</tr>
<tr>
<td>Nurse</td>
<td>1</td>
<td></td>
</tr>
<tr>
<td>Student</td>
<td>5</td>
<td></td>
</tr>
<tr>
<td>Teaching assistant</td>
<td>1</td>
<td></td>
</tr>
<tr>
<td>Unemployed</td>
<td>1</td>
<td></td>
</tr>
</tbody>
</table>
3.4 Data Analysis

The discussions of each group and individual interviews were audio taped and transcribed verbatim by the principal investigator immediately following the interviews. Moreover, after each discussion the researcher documented in a field book observations, reflections, and personal reactions or any emotions that arose during the discussions. This documentation allowed me to keep a self-reflective account of how I was affected by this experience (Corbin & Strauss, 2008).

The lack of existing theory relating to depressive disorder in Afghan women led to the identification of grounded theory as the methodology of choice for this study. Given that I share some cultural similarities with Afghan women and had some knowledge and experience of the concept of interest it seemed important to select an approach that would make use of my experience throughout the research. As such, I chose the constructivist grounded theory approach (Charmaz, 2000; 2006) which emphasizes: (1) the creation of a sense of reciprocity between participants and the researcher in the construction of meaning and ultimately a theory that is grounded in the participants’ experiences, (2) the establishment of relationships with participants that clarifies power imbalances and attempts to modify these imbalances, and (3) clarification of the position the researcher takes in the text and how one renders participants’ stories into theory through writing (Mills, Bonner, & Francis, 2006. Moreover, it provides the reader with a sense of the analytical lenses through which the researcher gazes at the data and how participants construct their worlds (Mills, et al., 2006).

Data were analysed using the constant comparative method which involved a process of line-by-line and focused coding (Charmaz, 2006). Line-by-line coding allowed
specific focus on lines of data that conveyed key ideas. These codes allowed me to compare incidents within interviews and between interviews. The tentative and flexible nature of line-by-line coding allowed me to remain open to emerging concepts and reflect as accurately as possible the concept of the transcripts. After the establishment of analytic directions through initial line-by-line coding, focused coding took place. Focused coding involved taking earlier codes that continually reappeared in initial coding and using those codes to sift through large amounts of data. This coding technique facilitated separation, sorting and synthesizing larger segments of data. Focused coding allowed me to clarify themes by examining all of the data covered and identifying the variation within and between various themes (Charmaz, 2006).

3.5 Ethics

A full research proposal was submitted for ethical approval to the University of Regina Ethics Board. The participants were approached until the approval was granted (see Appendix B for Ethics application). A consent form was given to all participants before the administration of the questionnaires and interviews.
CHAPTER 4- RESULTS

4.1. Personal reflections

As I started my data collection for this research, I expected the second generation women’s experiences to be a lot like mine and to identify with them more. However, during the time I was working on my dissertation I went from dating a Canadian-born man to marrying him and having a child. As I went through this journey as a first generation Uzbek woman, I started to identify with first generation as well as second generation women. It is through their stories that I started to understand more what it is like to be a parent and want your child to grow up with your cultural traditions and values. At the same time, however, I was able to empathize with second generation women who were struggling with feelings of not fitting in and guilt due to going along or against their cultural heritage. My aim for this research is to articulate the women’s stories and to give the reader insight into how depression is conceptualized in Afghan culture and also present the reader with a picture of how these women have lived their lives and what their struggles are in their new home, Canada. To do so, women’s stories were presented in third-person narrative combined with direct quotes from the interviews. Constructing the third person narrative allowed me to tell their stores from the outside and be as true to their voices as possible. The supporting quotes are identified within the text and contain the participant number. Given that an interpreter was used for focus groups, identifying individual participants for each focus group quote was not feasible as the interpreter translated simultaneously as the participants spoke. As such, focus group quotes will be identified as FG/1st Generation and FG/2nd Generation. Excerpted quotes
are typical of the dominant opinions expressed in the focus groups as well as individual interviews.

4.2 Themes

Four common themes emerged as the women engaged in dialogue and painful reflections during the discussions. These themes overlap between first and second generation women (see Table 2 for a summary). The results are organized according to the themes identified followed by findings from the vignette, and end with a description of the terminology found in Miller et. al.’s study (2006).
Table 2. Four common themes.

<table>
<thead>
<tr>
<th></th>
<th>First Generation</th>
<th>Second Generation</th>
</tr>
</thead>
<tbody>
<tr>
<td>Communicating</td>
<td><strong>Affective Symptoms</strong>&lt;br&gt;Feeling sad&lt;br&gt;Feeling angry&lt;br&gt;“inability to hold emotions”&lt;br&gt;Feeling lonely/isolated</td>
<td><strong>Affective Symptoms</strong>&lt;br&gt;Intense sadness&lt;br&gt;Loss of enjoyment&lt;br&gt;Hopelessness&lt;br&gt;Feelings of worthlessness&lt;br&gt;Loss of confidence&lt;br&gt;Low self-esteem</td>
</tr>
<tr>
<td>depression</td>
<td><strong>Somatic Symptoms</strong>&lt;br&gt;Feeling tired&lt;br&gt;Headaches&lt;br&gt;Pain in the body&lt;br&gt;Muscle cramps&lt;br&gt;“Veins behind neck pull and burn”&lt;br&gt;Increase/decrease in appetite&lt;br&gt;Problems with sleep</td>
<td><strong>Somatic Symptoms</strong>&lt;br&gt;Insomnia/hypersomnia&lt;br&gt;Loss of appetite&lt;br&gt;Headaches&lt;br&gt;Stomach problems</td>
</tr>
<tr>
<td></td>
<td><strong>Behavioural Symptoms</strong>&lt;br&gt;Wanting to fight with children/family members&lt;br&gt;Wanting to shout and scream&lt;br&gt;Crying</td>
<td><strong>Behavioral Symptoms</strong>&lt;br&gt;Crying&lt;br&gt;Social withdrawal&lt;br&gt;Not wanting to get out of bed</td>
</tr>
<tr>
<td></td>
<td><strong>Cognitive Symptoms</strong>&lt;br&gt;Poor memory</td>
<td></td>
</tr>
<tr>
<td>Stated causes of</td>
<td><strong>Most Significant Causes</strong>&lt;br&gt;Family members left behind&lt;br&gt;Fear of loss of cultural heritage</td>
<td>Financial difficulties&lt;br&gt;Worrying about family members back home&lt;br&gt;Unemployment&lt;br&gt;Feeling sad about how much their parents sacrificed for their future&lt;br&gt;Adjusting to a new culture&lt;br&gt;Lack of understanding between 1st and 2nd generations&lt;br&gt;Feelings of not belonging in either culture&lt;br&gt;Not being able to share their emotions with their parents&lt;br&gt;Gender differences</td>
</tr>
<tr>
<td>depression</td>
<td><strong>Other Causes</strong>&lt;br&gt;Economic strains&lt;br&gt;Different expectations before/after arrival&lt;br&gt;Inability to speak English</td>
<td></td>
</tr>
<tr>
<td>Coping</td>
<td>Getting together with friends&lt;br&gt;Distraction behaviours: e.g., watching movies&lt;br&gt;Crying&lt;br&gt;Praying (some find it helpful, some not)</td>
<td>Engaging in various activities (e.g., listening to music, exercising)&lt;br&gt;Volunteering&lt;br&gt;Obtaining education&lt;br&gt;Seeking professional help</td>
</tr>
<tr>
<td>Recommendations for</td>
<td>Support groups&lt;br&gt;Immigration services to help with documentation&lt;br&gt;English classes</td>
<td>Support groups&lt;br&gt;Educational services about how to use public transportation, bank system, etc.&lt;br&gt;Interpretive services</td>
</tr>
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<td>support</td>
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4.2.1 First generation women

In the interviews and focus groups participants tended to convey experiences that echoed those of the community as a whole. Depression was seen as a mental health problem only after sadness turned into something “much deeper.” One participant stated “if you can’t resolve sadness, then you become depressed.”

Communicating Depression: Somatic symptoms seemed to be a common way of expressing depression. The somatic symptoms reported by participants included feeling tired, headaches, pain in the body, muscle cramps, “veins behind neck pull and burn,” eating more than usual or a loss of appetite, crying, and problems with sleep. Other symptoms included poor memory, “feeling like [you] don’t have anybody here even when the family is here,” feeling angry and sad, wanting to fight with children/family members, “inability to hold emotions,” and wanting to shout and scream. Participants mentioned that when they are unable to cry, they feel like shouting or screaming to get the sadness and pain out.

Personally, when too much depression comes to me I just forget everything (FG/1st Generation);
I have a short memory and I can’t remember where my keys are or my wallet. I just forget everything that comes to me. I feel angry and sad and I like to fight. I have this problem too. I forget everything. Sometime I want to fight with my children. You try to control but you cannot control and you want to shout and scream and bring out that thing from inside of your body. Especially when you cannot show other people how you feel (FG/1st Generation).

Stated Causes of Depression: The main cause of depression reported by the first generation women was the family members who were left behind. They all cried when discussing their family members who were still in Afghanistan and/or neighbouring countries. A second important cause was women’s worries that their children will lose their cultural heritage and not “recognize themselves as Afghans anymore.” These
worries encapsulated their children having boyfriends or girlfriends, using alcohol, not wanting to go to the mosque, or not having an interest in learning Farsi:

Some children that are born in Canada or brought to Canada when they were little speak really little Farsi or Persian. Even though their parents make them read Farsi they are not very interested. And what happens when they grow in the society, and it’s not like it’s children’s fault they are in a social environment where English is the first language, they end up growing in a way they don’t understand Farsi or Persian at all and then parents think that they are not good parents, not qualified parents, that they made their children forget their culture, language and everything (Participant A).

Other causes involved economic strains, different expectations prior to and after their arrival to Canada, an inability to drive, and inability to speak English. Participants discussed the difficulties associated with finding time to study the language. The reason for not obtaining education was attributed to financial strains and their need to find a job to be able to provide for their families. However, once they adjust to a new culture and they are able to make time to take English classes, participants reported not being eligible for classes at a regional non-profit organization that provides settlement and integration services to refugees and immigrants, the Regina Open Door Society in Regina, SK. This meant they had to pay for classes at a community college, which some reported as being unaffordable.

Parents don’t really have time for the children. You know, sometimes parents can’t speak English but why they can’t is because they don’t really have time. They either have to go and work, low paying job, to support family or the mums have little kids to take care [of] so they don’t really have time or they cannot put that effort to go out there and learn English (FG/1st Generation).

Women also discussed their difficulties with English classes. According to them, many classes that are offered do not spend much time on learning the alphabet. After decades of civil war many Afghani women did not have a chance to go to school and thus many of the participants reported not knowing how to read or write in their own
language, and thus taking classes in a foreign language where very little time is spent on learning the alphabet makes it difficult for them to learn the English language. Their inability to speak the language makes them feel as though they are “no longer the head of the family,” referring to the fact that they depend on their children for everything that requires language: answering the door and the phone, going for groceries, going to doctors’ appointments, etc. Women stated feeling “old and retired because we can’t do anything on our own anymore.”

Back in Afghanistan and Iran they, women, knew the language, they knew everything, they knew the money so they would go for groceries themselves and do everything themselves. Now they have to rely on kids and have them do things for them because they don’t know it. Everything is in English so we need to have someone who speaks English (FG/1st Generation).

Coping: Women reported coping with depression by getting together with friends to cook, dance, and socialize. Social gatherings help them cope with depression temporarily and they often do not talk about problems and try to focus on positive things in their lives:

They might all seem happy like in everyday life. [Be]cause obviously you cannot stop your life because of one thing in Afghanistan, right? They still have to live. So they enjoy life to the fullest as I can see them, they go out and they socialize. But at the same time there is something behind their life which is like basically related to Afghanistan like their families. I don’t know, just seeing your country on TV every day is not easy. But they all enjoy their lives in here, Canada. (interpreter talking about focus group participants)

Other coping skills involve watching movies with happy endings, distracting themselves with different tasks, and crying. Although crying was mentioned as one of the symptoms of depression they also use it to cope with depression “to get things out.”

Praying and/or reading the Quran was mentioned by some women but other women
reported that praying does not change anything and therefore does not alleviate depression:

    Most women pray and actually they try to help their depression this way. But that cannot get rid of your depression (Participant B).

Other women were not sure if praying helps with depression:

    [My mother] prays all the time, she just doesn’t want to talk to anyone, see anyone, and she just prays all the time (Participant A).

Recommendations for Support: Women also discussed services that could help them adjust to their new homes. These services included support groups where women can talk about their struggles and “get the emotions out,” immigration services that could help them with documents for their families back home, English classes that focus on learning the alphabet so that they can do their own immigration papers, and Farsi classes for their children.

Vignette: After reading the vignette the participants became tearful and reported feeling as though the story was about their own lives. They believed that the person in the vignette was experiencing depression because her symptoms are not from sadness alone. Participants felt as though the person had heard bad news about her family back home and she was not telling the news to anyone to protect them from sadness and that was the cause of her depression. They also believed that Delbar was going through the same difficulties that the participants were going through:

She is like us, homesick (FG/1st Generation);
She came to a country where she doesn’t know the language, none of her family is here and she is unable to communicate. She can’t express herself in any way (Participant B);
She feels lonely because there is no one around her that she can talk to about her problems or how she feels (Participant A).
To help her cope with her depression the participants believed she needed to talk to someone, socialize with friends (dance and laugh), read the Quran, or pray, and learn the language:

Learning the language is the biggest step to feeling better because learning the language is going to allow you to be able to get a job, to be able to make friends, to be able to become part of this culture. And once you do that, then you can start feeling better. But if she was able to learn the language, but also be more stable financially, then she would feel so much better then where she is right now (Participant A).

Terms: Culturally specific idioms of distress, jigar khun, gamgeen, fishar-e-bala and fishar-e-payin, identified by Miller et al. (2006) were queried during the interviews.

According to the participants, jigar khun literally means “blood in the liver” and it was described as “someone who’s been through depression and sadness and it’s to the point where they just have no hope anymore.” Gamgeen was defined as very sad but they noted that the word is rarely used in everyday language and that it is mostly used in literature.

Fishar-e-bala was defined as “high blood pressure” and described as someone whose “blood is boiling”, which was described as feeling frustrated, angry, or anxious. Fishar-e-payin was defined as “low blood pressure” and described an individual with low energy.

4.2.2 Second generation women

Second generation women, similar to first generation women, reported that a person develops depression when “sadness gets deeper and deeper.”

Communicating Depression: The symptoms they associated with depression included crying, feeling intense sadness, insomnia or hypersomnia, loss of appetite, not wanting to be around other people and isolating oneself, loss of confidence, low self-esteem, loss of enjoyment, hopelessness, headaches, feeling worthless or not good enough (“less than other people” or “you are not worthy of anything”), not wanting to get out of bed, and
feeling sick to one’s stomach, “feeling like one’s heart is like a glass that can shatter very easily.”

When I feel really sad I feel like I’m just, I feel hopeless and I feel like I’m less than other people. Like I feel like I’m less than the people that are here and that I don’t fit in;
People feel unmotivated, they don’t want to get up, they don’t want to do anything, they can’t feel happy, they feel very stressed out and probably like there is no way out for them, like everything is going wrong at once. And sometimes [depression] can manifest itself physically like lots of sleeping (Participant F).

Throughout the discussion women also discussed the symptoms of depression that their mothers experience:

A lot of physical [symptoms] and [be]cause their life was tough growing up. It was tough. They did a lot and they had a lot of stress. And a lot of stress with their own life later when they got married and had kids. So [depression] is both actual physical pain and sadness (Participant E).

**Stated Causes of Depression:** Similar to first generation women, second generation women reported financial difficulties, worrying about family members left behind in Afghanistan and/or neighbouring countries, and unemployment or difficulty finding a job as causes for developing depression. Second generation women also spoke about other causes that were more related to their families such as experiencing sadness due to watching their families feel sad, watching how much their parents sacrificed for their children’s future (e.g., working 2-3 jobs so that their children could obtain an education):

I think, the main thing, the one thing that makes a woman really depressed is that they sacrifice their lives, they’re parents – Dad and Mom, they sacrifice their lives to give a better life for their children who become something/somebody because they didn’t have these opportunities in our country because of the war or the other countries they weren’t able to become somebody. It’s a free country I know life is very hard and we have to work really hard, but at least we have freedom, at least we have a chance if we want to become somebody. I know they, [parents] cannot do anything, they cannot go to university, they cannot read, they cannot write and they must take care of their children. But, the way I understand they sacrifice their happiness so their children will become happy. You know they will do anything for their family they are so concentrated about the family, they’re just giving
away everything of their personal things. If you ask everybody they just say I
came here so my children can be somebody, so they can study, they can go to
university (Participant H).

Other cases included adjusting to a new culture and new ways of living (e.g., going to
university or “sitting next to a boy in a classroom”), and a lack of understanding between
parents and children, which was attributed to parents being uneducated. Other causes
were related to feelings of not fitting in with their own families and Canadian culture
(e.g., “sometimes you can’t be yourself because you want to fit in”):

Depression, being in Canada, clashes with family. You know, Afghans are very
conservative. And they expect their children to follow the culture and the
traditions by the book. And not mingle with anyone from outside. And for the
girls especially to, you know, listen to their parents all the time and marry who
they want them to marry and not talk to boys and not go out with friends and
that’s what they expect from their daughters. So Dilbar (vignette character) could
be having a problem with her family because she wants to be free or she doesn’t
want to be a different person inside the house and a different person outside the
house because that’s what my problem was (Participant E).

Not being able to share their feelings with their parents because the expression of
emotions is discouraged:

I went to high school here and I think so much about how we are raised not to
share feelings so you keep everything inside. And you feel like if I tell anyone
how I feel they will laugh at me or will say you are just so uneducated (FG/2nd
Generation).

Being treated differently by parents because of their gender and not having freedom or
independence (e.g., cannot have boyfriends or spend time with a male friend):

[My mom] puts the guys first and I don’t agree with that. I fight and argue with
her all the time because she is not right. I don’t want this to continue with my
family, with my children. I don’t want to follow her footsteps. I don’t want to
treat my daughter like this, like she is lesser than her brother. I want her to feel
equal (FG/2nd Generation);

Your parents’ and siblings’ expectations: what they want from you and you
should be. For example, how you should be dressing, who you should be hanging
out with. You can’t really make a decision for yourself, somebody else like your
father or brother makes it for you. If you do not take an action against it then you
are kind of accepting and even though you are going through hard times you are
detaching from your important relationship with certain people because your
family doesn’t like it (FG/2nd Generation);
Personally, I went through expectations like ‘be kind to your brother, just because
he’s your brother.’ I remember when I was back home my older brother always
expected so much from me ‘you two, take care of my kids because I’m your
brother and you are my sister and you have to help me.’ The key word is have to
help me, but I don’t have to help him because I have my own life, right? I need to
respect that. I can’t always give my dad and my brother everything because I am a
woman (FG/2nd Generation).

Many participants were crying when discussing the challenges their mothers and women
from their culture in general have experienced:

I feel bad for my mom because she’s gone through a lot of stuff, you know
[crying]. I am sorry. It just hurts me because she didn’t have much support in her
life, but she had expectations from her kids and my dad because she is a woman.
She gives mentally, physically and when she turns fifty she looks like a seventy
year old woman. I mean that’s not acceptable because she gives her life to her
kids, her husband you know. I have to tell my dad ‘no dad, you have to support
my mom. Who cares what the community says’. She went through so much
(FG/2nd Generation);
As a woman I feel that we have to support each other more in the community. We
have to support each other rather than be accepted by men, dads, and brothers.
They put so much expectation on us, you are expected to do this and that, you
know. And it just hurts because you know. We shouldn’t let another woman
experience the same expectations form another man, whether it’s my brother, or
my cousin or whoever (FG/2nd Generation).

Throughout the discussions it seemed like the women felt guilty talking about the men in
their lives. Their stories seemed to be filled with a mixture of sadness and frustration.
However, they all expressed how much they love and care for their brothers and fathers,
but they also seemed deeply saddened by how they are treated simply because they are
women:

I love my dad and my brothers, but they think differently, they will never
understand me (FG/2nd Generation).
Coping: To cope with depression second generation women reported engaging in many activities that help them distract themselves such as listening to music, reading, keeping oneself busy with volunteering, exercising, and focusing on studying. They also emphasized the importance of seeking professional help and/or talking about your emotions with someone you trust. Second generation women believed that obtaining education is a key in battling depression:

*I put myself anywhere there is volunteering after work. *[Volunteering] keeps me busy and the sad part of my life kind of disappears. It’s not like I’m not acknowledging it, I am. There were times when the sad part came and you could not run away or keep yourself busy enough. That’s when I started finding books on how to overcome sadness. But you need to have education to understand them (FG/2nd Generation).

Unlike first generation women, second generation women also discussed the importance of mental health workers. They discussed the importance of seeking counseling to cope with depression:

*Talk to your counselors in high school, for girls who are still in high school. They have to be a support system for them, a place where they can go if they have problems. Like the family is trying to lock them up inside the house or don’t want them to go to school because they saw her with a guy so now you’re not allowed to go anywhere. These girls need to get out and they need to make their own path. They need to get out, they need to go to the system, the support system, if there is any, and say hey, I need help (Participant E).*

Women also believed that education can give you a purpose and help you with depression:

*Going to school gives me purpose which makes me feel like I am contributing and I am doing something positive (Participant F).*

Recommendations for Support: Across all the discussions, the women identified steps that could be taken to help Afghan women cope with depression, including support groups for women where they can talk about their difficulties, but also groups or services that will encourage them to obtain education to help them become independent, services that will
provide them with information on how to use public transportation, shop for groceries, and be safe with money. The women also discussed language barriers and using interpreters. They indicated that many women do not feel comfortable using an interpreter from their own communities when attending physician appointments. This discomfort was attributed to their fears and beliefs that their difficulties are discussed in the community because they do not believe confidentiality is honored among interpreters from their communities. Some of the suggestions to improve access to interpreters included using an interpreter over the phone or setting up an office in such a way that the interpreter is not able to see the client but only hear their voice (e.g., have a room divider between the client and interpreter).

Stigma: Unlike first generation women, second generation women also spoke about the stigma of mental illness in their community:

There is no mental illness. If they even hear the word mental illness they would conclude that that person is insane. To them that’s mental illness, they are sick. There’s no depression or anything like that. I know there isn’t because I didn’t know there was till I diagnosed myself and then went to the doctor. I was like oh my god that must be depression. I said I should go to the doctor because I learned in school before that there was no word for depression (Participant E). You need to understand the reason behind her being so sad and I’m like she might be depressed. And they all attacked me. What depression? What do you mean depression? Why would she be depressed? There’s no reason for her to be depressed. They were so upset that I even mentioned the word depression. They don’t think there’s anything like that (Participant E).

Vignette: Similar to first generation women, second generation women also related to Dilbar.

She feels similar to us. She is showing the signs of depression. She takes everything inside and feels like she might be the problem, you know she is blaming herself for everything. She needs professional help (Participant H).
They believed Delbar was experiencing depression and not just sadness because her symptoms were much “deeper.” The causes of her depression were attributed to feeling as though she did not fit in with her own culture or majority culture and misunderstandings between parents and children. In addition, they also related Delbar’s difficulties to how their mothers felt:

She might have all of these problems. She actually does, yeah. This sounds very familiar, it sounds like my mother (Participant E).

To cope with depression they believed Delbar needed help and that depression does not go away on its own:

You need help when you’re depressed and it’s not just going to go away on its own. You have to get help, either medication or counseling, you just have to; you have to reach out to somebody to help you. You can see a doctor, a friend, a counselor, you do need help. You need a support system (Participant F and G).

Terms: The definitions of the terms jigar khun, gamgeen, fishar-e-bala and fishar-e-payin were similar to those of first generation women. According to the participants, jigar khun literally means “blood in the liver” and it was described as “sad from deep inside,” “being sad from deep inside and hopeless,” “unable to move on” and “heartache.” Gamgeen was defined as “full of sadness” but they noted that the word is rarely used in everyday language. Fishar-e-bala was defined as “high blood pressure” and described as someone who is feeling frustrated, angry, anxious, or hyperventilating. Fishar-e-payin was defined as “low blood pressure” and described an individual who has low energy, and is tired.
CHAPTER 5 - DISCUSSION

The group format, that included an interpreter to assist individual participants and/or family members, offered me a wonderful opportunity to collate a range of opinions. Prior to the interviews, I sensed that all the participants were curious about me, my background, and why I wanted to learn about Afghan women. Once they became acquainted with me and my interest in this topic, they relaxed. I was perceived as a member of the same religion, gender, having the similar immigration status and so, seen as more of an insider than an outsider. This connection enabled the development of trust that helped data collection. Lipson (1991), in her research with Middle Eastern groups, found that the real data comes not from the formal interview protocol, but from other aspects of the encounter, such as the initial warm up period before the interview and the end of discussion as one is leaving. Any discussion arising from an interview question between these times could only act as a catalyst for deeper description and understanding of psychological issues for the community (Omidian, 2000; Lipson, 1991).

5.1 Symptoms of depression

Depressive experiences and disorder have long been a source of concern in Western cultural traditions (Marsella, 2003). The present study does not assess diagnostic criteria for depression. But in order to understand the cultural differences between the ways in which the Afghan women presented depression and the Western conceptualization of its symptoms, it is important to look at current diagnostic criteria for depression. In current psychiatric nosology, depression is defined by operationalized diagnostic criteria found in the DSM-5 (APA, 2013) and the World Health Organization’s (ICD-10) (WHO, 1992) classification of mental disorders. Diagnosis of
major depression is predicated on the presence of five or more symptoms being present. These must include either a predominantly depressed mood and/or loss of interest for at least a 2-week period of time that adversely impacts one’s personal, social, and professional life. Other symptoms to be noted include significant changes in weight or appetite, insomnia or hypersomnìa, psychomotor retardation or agitation, fatigue or loss of energy, feelings of worthlessness or excessive guilt, diminished concentration, loss of clarity of thought or indecisiveness, and recurrent thoughts of death (see Appendix A for the DSM-5 criteria) (APA, 2013). These diagnostic criteria cover affective, cognitive, and somatic components of depression.

While affective and cognitive symptoms of depression differed among the two generations of Afghani women, the physical symptoms observed were similar across the population studied. Kleinman and Kleinman (1985) reported that individuals who lived in cultures that emphasized interdependence in relationships tended to express their emotional distress in the form of bodily complaints, which were more culturally acceptable and allowed one to maintain the existing social ties (Bernstein et al., 2007). First generation Afghan women’s expressions of their depression through crying, headaches, pain in the body, muscle cramps, fatigue, changes in appetite, problems with sleep, and “veins behind neck pull and burn” reflect that cultural emphasis. These women also reported a cognitive and affective symptom of depression, such as, poor memory and intense sadness. The above mentioned symptoms (except “veins behind neck pull and burn”) as well as the desire to fight with children/family members were also identified by Miller and his colleagues (2006) as indicators of distress in Afghani culture.
Conceptualizations of depression in second generation Afghani women included somatic symptoms, such as, headaches, insomnia or hypersomnia, loss of appetite, and feeling sick to one’s stomach, as well as behavioral symptoms, such as, social withdrawal and not wanting to get out of bed. Unlike the first generation women who reported one affective symptom (i.e., intense sadness), the second generation women reported more affective symptoms that were more consistent with the Western understanding of depression, such as, feelings of intense sadness, loss of confidence, low self-esteem, loss of enjoyment, hopelessness, and feelings of worthlessness or not being good enough (“less than other people” or “you are not worthy of anything”). Based on these findings, it may be concluded that second generation Afghani women were more likely to meet the Western diagnostic criteria for depression than their first generation counterparts.

5.2 Factors that cause depression

Afghani women identified several contextual factors that were associated with the emergence of depression. These factors not only reflected their lived experiences with immigration and depression, but also, the emergence of depression in terms of social or environmental circumstances. The contextual factors – difficulties with immigration documentation for family members, obtaining education and/or employment, language classes, etc., – appeared to reside within the social environment rather than the individual. As such, participants sought help from the social environment to improve their social condition. This has important implications for provision of health care in that health care institutions may serve not just as a resource for immigrants to obtain information about health and wellbeing, but also offer information on community activities, education systems, legal services, and employment opportunities (Sellers, Ward, & Pate, 2006).
Therefore, contextual factors can also be utilized in treatment approaches such that Afghani women as well as other immigrant women may benefit from a holistic treatment approach that consists of psychological services, social service support, and psychopharmacological services. This treatment approach may be effective in treating depression effectively as it encapsulates body, the mind, and the social conditions in which the women reside (Sellers, Ward, & Pate, 2006). Our findings show that for this group of Afghani women, depressive symptoms emerged from painful real-life problems and as such, treatment should involve solving problems as well as offering counseling and/or pharmacology.

In addition to the contextual factors, first generation Afghan women reported, for example, concerns about family members back home and fears about Afghan youth losing their culture as the other causes of depression. These concerns were also found in Lipson’s (1993) as well as Lindgren and Lipson’s (2004) research with Afghan women.

5.3 Coping with depression

To cope with depression, the first generation women organized gatherings with friends that centered around cooking, dancing, and socializing. Given resettlement, isolation, and disconnection with their families, friends, and all that was familiar, it is these social gatherings that now allow them to experience a sense of community within larger host communities. Such displacement often results in nostalgia, disorientation, and alienation. Resettlement in a new place requires not just the mourning of their home countries but also the establishment of attachment, familiarity, and identification with their new home (Green et al., 2008). It was felt that this process could be eased not only by the social environment but also through community participation. According to
Lindgren and Lipson (2004), community participation was considered key to improving the health and well-being of communities. Lindgren’s research showed that community participation not only provided support but also allowed women to share their expertise in navigating health and social services. For instance, a study conducted by Bhattacharya (2005) found that Indian immigrants in the United States (US) were seen as key sources of information and social support as they provided advice on daily life, information about transport and shopping as well as cultural advice and language tips to each other. Having a visible Indian community was found to be a protective factor against the stresses of isolation and acculturation. Social support, instrumental and emotional, was seen as being desirable and beneficial for immigrants and refugees as it assisted them in imagining the possibility of well-being post-migration.

In addition, peer or family support was deemed key in deciding where to live and this also motivated internal relocation post-immigration (Simich & Mawani, 2003). However, social network or community participation did not always promote health. According to McMichael and Manderson (2004), social networks could prevent women from using and creating social capital in the wider community. Studies conducted by Bui (2003) and Senturia et al. (2005) showed that social networks created significant barriers by community members being concerned about the maintenance of family structures and gender roles around women seeking help or trying to leave abusive relationships.

Both generations, however, showed interest in support groups where women could talk about their struggles and express their emotions. Support groups or group counseling were seen as significantly impacting treatment of depression, as they will provide a safe place for women to talk about their struggles, provide them with problem
solving skills, and may also open up avenues for a more direct discussion of mental health concerns (Sellers, Ward, & Pate, 2006). Such a safe group setting could help women to open up more and lift the stigma attached to mental illness in these communities.

Coping skills for the second generation Afghan women differed greatly from what was endorsed among the first generation women. This group emphasized the importance of activities, such as listening to music, reading, exercising, and focusing on their education. In addition, they believed in importance of mental health workers and seeking counseling in times of stress. This difference in generations could be indicative of mental health issues being less stigmatized in the second generation Afghans owing greatly to their levels of acculturation. Numerous studies have demonstrated that acculturation does play a role in the help-seeking behaviours of Asian Canadians (Atkinson & Gim, 1989; Kim & Omizo, 2003; Omizo, Kim, & Abel, 2008). For instance, research that examined Asian international students’ acculturation and their attitudes toward seeking professional help found that the higher the students’ acculturation levels, the more positive were their attitudes toward seeking help. This study also showed that as students’ acculturation increased their tolerance to stigma, they also became confident in mental health professionals (Zhang & Dixon, 2003).

5.4 Generational differences

Existence of intergenerational conflicts in immigrant families could exist primarily due to the differential acculturations between immigrant parents and their immigrant or Canadian-born children. This was reported over 30 years ago by Sluzki (1979). Since then, many studies have shown that children of immigrant parents do not
retain their ethnic culture to the same degree as their parents (e.g., Kwak, 2003; Okagaki & Bojczyk, 2002). Hwang’s Acculturative Family Distancing construct defined as “the distancing that occurs between immigrant parents and children that is a result of immigration, cultural differences, and differing rates of acculturation” (2006, p. 397) also highlighted the generational differences of the present study. First generation Afghan women in this study reported their fears of Afghan children losing their Afghan cultural heritage that included traditions, values, and language as the second cause of depression. This fear, coupled with second generation women’s feelings of not “fitting in” their own culture and that of the majority population, led to clashes of cultural values resulting in increased risk of mental illness or family dysfunctions (Hwang, 2006).

In the present study, the first generation Afghan women were born and raised in Afghanistan. As such, having been socialized in their culture of origin, they tended to prefer to retain those values and acculturate slowly with Canadian culture. In contrast, their children acculturated more quickly because developmentally they were more susceptible to the environmental influences and had more opportunities to engage with those from the majority culture—through schooling and participating in activities with their peer groups (Ying & Han, 2007). Language, or the inability to speak English, was found to be a primary acculturative stressor (Vega et al., 1995; Hwang, 2006). Due to greater exposure and access to the mainstream majority culture through schooling, many immigrant children were able to acquire fluency in English faster than their immigrant parents (Uba, 1994). In addition, many children do not undergo any formal schooling in their native language, resulting in some children not gaining linguistic ability and/or
losing fluency because of lack of use (Lee & Chen, 2000; Rhee, Chang, & Rhee, 2003; Usita & Blieszner, 2002).

This loss of common language increases the chances of misunderstandings and decreases family cohesion (Tseng & Fuligni, 2000), which in turn increases the likelihood of conflict, mental illness, and limits their abilities to develop a positive, emotional bonds (Hwang, 2006). One of the other problems was the role reversal and shifts in parental authority created as a result of language. Women, in the present study, reported that parents did not feel as though they were an authority in their children’s lives anymore because they relied on their children as mediators/translators in their dealings with social institutions (schools, hospitals, social services, etc.) and the host society’s culture. Thus, while children may acquire new roles and responsibilities in their families during the resettlement and after the settlement process, many parents expect the customary retention of authority over their children. This often results in tension within the family (Tyyska, 2008; Creese, Dyck, & McLaren, 1999).

Faster cultural adjustment of second generation women as well as changes in their role could also be a possible cause for them feeling torn between cultures and “not fitting in.” According to Lalonde and Giguere (2008), cultural conflict could occur when immigrant children’s heritage and Canadian norms offered incompatible behavioral prescriptions. They stated that at the group level, the second generation immigrant children could possibly find it difficult to fit in based on skin color, accent, or type of dress. At the interpersonal level, there could be some conflict with parents or even their peers. However, research shows that second generation immigrant children are bicultural -- that is, they have psychological access to two sets of cultural norms that may be tied to
geography, ethnicity, and/or religion. Given their biculturalism, their identity may often be contextually driven and usually, only one behavior will be salient in a particular situation. In the event of a conflict occurring, it will be attributed to the two cultural identities of a bicultural individual being simultaneously salient and this will evoke two sets of norms that are incompatible. In such cases, the individual will feel some commitment to each set of norms (Lalonde & Giguere, 2008).

Second generation immigrant children learn to balance two different worlds and move fluidly between them. Children who do not connect in a meaningful way or feel connected with their peers, family, or school are at increased risk for suicide, substance use/abuse, school failure, health problems, and criminal activity. Immigrant children who are alienated from school and rejected by their native-born peers because of their lack of fluency in English or their different cultural practices may be at even greater risk (McCarthy, n.d.). The second generation women’s narratives in this study point to the taxing and complex nature of the acculturation process, for it entails their feeling different from their own cultural heritage as well as from the Canadian culture and finding a sense of belonging. They face cultural conflicts because they have to negotiate and compromise between the expectations of their parents or their own cultural heritage and, the Canadian society’s norms. Further research is needed on second generation immigrant women as they are at the threshold of establishing their identity, autonomy, and developing intimate relationships all of which are closely tied to the cultural expectations from their heritage and the Canadian culture.
5.5 Culturally sensitive services

To deal with losses, social and cultural, it is important to help immigrant women rebuild their community networks in a bid to not only improve their health, but also help them find resources to make their immigration experience easier. Both generations of women in this study spoke of the importance of developing services, such as English classes and support groups for immigrant women to help them adjust and cope with depression. The study conducted by Lazear et al. (2008) found similar results in that women reported better access to basic support systems, such as jobs, housing, childcare, opportunities to talk with other women, and access to supportive professionals as being helpful in adjusting to their new lives and coping with depression.

The importance of language acquisition and English classes was also reported by both generations of women. Several studies have shown that language proficiency goes a long way in protecting mental health by facilitating social contact, militating against dependence on others, by promoting the development of new social resources, and increasing immigrants’ sense of internal coherence (Ying & Miller, 1992; Ying & Akutsu, 1995). According to Beiser and Hou (2001), lack of language compromised employability and access to services of particularly immigrant women and elderly, which in turn promoted isolation. In the study conducted by Mollica and colleagues (2002), it was found that refugees who were working were less likely to suffer depression, compared to those who were unemployed. Results from the present study showed that Afghan women face challenges in accessing language classes, which in turn limits their employability and independence (e.g., depend on their children for translations).
Another area that has been mentioned by both generations of Afghan women is that of education as a critical coping strategy. This has been found by other researchers as well. For instance, in the field of international health, women’s education is seen as the single-most important determinant of health worldwide. This may be equally true of mental health (Mollica et al., 2002). Education, therefore, not only serves as a coping strategy but enables help-seeking behaviours. For instance, studies have shown that individuals with lower levels of education report less positive help-seeking attitudes toward mental health professionals than individuals with secondary education (Knipscher & Kleber, 2005; Sheikh & Furnham, 2000). For middle-aged and elderly adults (aged 45 and over), higher levels of education were associated with increased odds of consulting a health professional for mental health or emotional problems in Canada (Crabb & Hunsley, 2006). Given the above sited research findings as well as our findings, it will be important to foster services that will allow immigrant and refugee women to obtain education. This, in turn, will decrease their risk of developing mental health difficulties.

Taken as a whole these results point to the importance of providing culturally sensitive psychodiagnostic and psychotherapy services. The stories of the participants stress the importance of recognizing their narratives of psychological distress and health, language use, expressions of distress, and the cultural system of meaning in which they are rooted. This approach also entails attending to the feelings of ambivalence that accompany transformations in cultural identity and their sense of belonging and/or uncertainty about belonging (Tummala-Narra, 2014).
CHAPTER 6 - IMPLICATIONS

This research aimed at exploring Afghan women’s conceptualizations of depression and their help-seeking behaviours. The findings of this research provide insights into the concepts of depression among Afghan women. Emotional expression and its related variables in a society share many features with other cultures yet, simultaneously, show distinctive features and this finding has been demonstrated in other studies (e.g, Kaiser, Katz, & Shaw, 1998).

Thus, it is important to understand the cultural context in which words and terms are used to express depression, both as an emotion and as a disease or syndrome. The findings of this study may have implications for health care providers working with this population. Understanding Afghani women’s perceptions of depression, as well as their values, and beliefs is expected to help provide culturally competent care. Empathic listening and understanding of the symptoms expressed may help Afghani women engage more fully in the diagnostic and therapeutic process and facilitate their retention in treatment (Bernstain et al., 2007).

In addition, both generations discussed the importance of creating a support group for women, specifically, first generation women. Support groups, it was believed, could help women better understand and address depression where they could discuss their concerns in a safe place in a non-stigmatizing manner. This, in turn, could help reduce the stigma about mental health and encourage them and others to seek treatment when needed.

This research has also demonstrated that trust between the participants and the researcher is critical when discussing their suffering. Thus, a possible challenge for health
care professionals could be emphasis on the development of a trusting relationship. One approach could lie in partnering with non-traditional helpers and community service providers with whom women were already comfortable. Another approach could be to reach out and engage with families who had been isolated and/or distrustful of the health care system or who simply did not know how the health care system operated (Lazear et al., 2008).

This research has helped me grow as a clinician and shape my provision of therapy. As a clinician I have become even more aware of the complexity of the various layers of experience the culture brings (e.g., parents and children live increasingly live in different worlds) as well as importance of transference/countertransference in sessions (i.e., Muslim women may be reluctant to disclose their difficulties to me). This experience has helped to partner with community-based organizations (e.g., Regina Community Clinic) in providing services and encouraged me to take ecological perspective (i.e., interrelationships between individuals and their environments and the impact the environment has on individuals) to develop and guide interventions.
CHAPTER 7 – DISSEMINATION OF RESULTS

The findings of this research will be shared with physicians, general practitioners, nurses, clinicians, and counselors through presentations and seminars that will talk about Afghan women’s understanding of depression, the different symptoms they have used to describe it, and how they have tried to cope with it. Moreover, the findings will be shared with colleagues at conferences, seminars, and through peer-reviewed journals. The cardinal purpose of this dissemination is to create awareness among health care professionals about the uniqueness of each culture and how cultures differ in their conceptualization of mental health problems.
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Appendix A

DSM 5 Criteria for Major Depressive Episode

A. Five (or more) of the following symptoms have been present during the same 2-week period and represent a change from previous functioning; at least one of the symptoms is either (1) depressed mood or (2) loss of interest or pleasure.

**Note:** Do not include symptoms that are clearly due to a general medical condition, or mood-incongruent delusions or hallucinations.

(1) Depressed mood most of the day, nearly every day, as indicated by either subjective report (e.g., feels sad or empty) or observation made by others (e.g., appears tearful). **Note:** In children and adolescents, can be irritable mood.

(2) Markedly diminished interest or pleasure in all, or almost all, activities most of the day, nearly every day (as indicated by either subjective account or observation made by others).

(3) Significant weight loss when not dieting or weight gain (e.g., a change of more than 5% of body weight in a month), or decrease or increase in appetite nearly every day. **Note:** In children, consider failure to make expected weight gains.

(4) Insomnia or hypersomnia nearly every day.

(5) Psychomotor agitation or retardation nearly every day (observable by others, not merely subjective feelings of restlessness or being slowed down).

(6) Fatigue or loss of energy nearly every day.
(7) Feelings of worthlessness or excessive or inappropriate guilt (which may be delusional) nearly every day (not merely self-reproach or guilt about being sick)

(8) Diminished ability to think or concentrate, or indecisiveness, nearly every day (either by subjective account or as observed by others)

(9) Recurrent thoughts of death (not just fear of dying), recurrent suicidal ideation without a specific plan, or a suicide attempt or a specific plan for committing suicide

B. The symptoms do not meet criteria for a Mixed Episode.

C. The symptoms cause clinically significant distress or impairment on social, occupational, or other important areas of functioning.

D. The symptoms are not due to the direct physiological effects of substance (e.g., a drug of abuse, a medication) or a general medical condition (e.g., hypothyroidism).

E. The symptoms are not better accounted for by Bereavement, i.e., after the loss of a loved one, the symptoms persist for longer than 2 months or are characterized by marked functional impairment, morbid preoccupation with worthlessness, suicidal ideation, psychotic symptoms, or psychomotor retardation.
Appendix B

Ethics Application

UNIVERSITY OF REGINA
RESEARCH ETHICS BOARD
Application for Approval of Research Procedures
(last updated April 2010)

Section I: Identification and Purposes

1. Date: August 15, 2011

Name of Applicant(s): Shahlo Mustafaeva (principal researcher) and Dr. Angelina Baydala (research supervisor)

Department or Faculty: Psychology

Co-Applicants: N/A

Student # (if applicable): 200241238

Mailing Address (if different than Department): Box 226, Kronau, SK, S0G2T0

Telephone #: (306) 502-5795

E-mail: mustafsh@uregina.ca

Title of Research: The Cultural Shaping of Depression: A Qualitative Investigation into Afghan Women’s Perspectives on Depression

2. Students please provide:

Student level X Graduate □ Undergraduate

Name of supervisor: Dr. Angelina Baydala Department: Psychology

3. Signatures and Acknowledgement:

Your signature(s) below acknowledges that:
- the information in this application is correct to the best of your knowledge
- you will notify the REB of any changes or amendments to this application
- contact with human subjects in the proposed research will not commence until ethical approval is obtained
- all members of the research team are aware of, and adhere to, University of Regina regulations and policies for conducting research, including the Tri-Council Policy Statement (TCPS).
Signature of Applicant(s)  

Signature of Advisor or Instructor

____________________________                  ______________________________

Date

Reminder: Please attach a copy of your recruitment letter or poster, consent form, questionnaire, interview questions, etc.

4. Provide an overview of the main features and variables of the research problem. Include a brief review of the relevant literature, a statement that describes the significance and potential benefits of the study, your hypotheses (if applicable), a brief description of your measures and some information about your design and analytic approach (e.g., "narrative data will be analyzed through grounded theory methodology"; "a 2 x 2 Multivariate Analysis of Variance will be employed for the data analysis"). Maximum one page.

Please see attached

5. Researcher Qualifications: Describe any special training or qualifications you and/or the research team have - only in cases where the research involves special or vulnerable populations (e.g. children, incarcerated individuals, etc), distinct cultural groups, or the research is above minimal risk, otherwise this section may be omitted.

The research team includes myself, Shahlo Mustafaeva, as the principal investigator. I am a clinical psychology doctoral student. The research team also includes my research supervisor Dr. Angelina Baydala who is a registered doctoral psychologist and clinical psychology associate professor.

Section II: Application Checklist

1. Do you consider that this project involves:

☐ HIGH RISK to subjects
☐ MORE THAN MINIMUM RISK to subjects
☒ MINIMUM RISK to subjects

Researchers are advised that "Risk" is defined broadly to include not only threats to one's physical integrity or health but also temporary as well as permanent psychosocial consequences (e.g., experiencing negative mood for a brief period as a result of
research participation, potential for violations of privacy, potential for upsetting a third party because of research participation).

If other than MINIMUM RISK, please explain and submit the full research proposal (e.g., grant application, thesis proposal) or, if a full proposal is not available, contact the REB Chair.

The research will be conducted with refugee groups who might be at risk of depression. Afghan women who might exhibit symptoms of depression will be directed to services offered at the Regina Community Clinic, which is a non-profit clinic. The services offered at the Regina Community Clinic are tailored towards providing culturally sensitive care, as the majority of their clients are refugees and immigrants from different cultures. Refugees who fall under the federally sponsored Interim Federal Health Program (IFH) receive their health care at the Regina Community Clinic, and the Afghans who come to Regina are IFH clients. The practitioners (i.e. psychologist, physicians) have had their credentials reviewed by the IFH and are authorized to provide care to refugees. Moreover, there were numerous presentations conducted with the Regina Community Clinic psychiatrist and physicians on cultural variations in the conceptualization and understanding of depression. While the services provided at the RCC are not ideal with respect to providing culturally sensitive care, the practitioners at the RCC have worked with Afghan women in a number of contexts including psychotherapy and provision of medical care.

The REB reserves the right to request a copy of the full research proposal for any project that is assessed (by any one of the reviewers of the application) as involving more than minimum risk.

2 What are the sources of funding (if any) for the proposed research?

Regina Community Clinic and Regina Qu'Appelle Health Region

3a. Will the researcher(s), members of the research team and/or their immediate family members receive any personal benefit (e.g. financial benefit such as remuneration, intellectual property rights, rights of employments, consultancies, board membership, share ownership, stock options, etc) as a result of or in connection to this study?

☐ Yes
☒ No

If Yes, please describe the benefits.

3b. Is there any compensation for this study that is affected by the study outcome?

☐ Yes
☒ No

If Yes, please explain.
3c. Do you think that the research findings from this project might be commercially valuable to others (e.g. the researchers’ employers, the project sponsors)?

☐ Yes
X No

If Yes, please explain.

3d. If yes to any of the above, please describe the arrangement and discuss the implications of a potential conflict of interest. Please describe how the conflict is being managed and what additional protections have been put in place to protect the study participants. This should be included in the Letter of Information to participants.

N/A

4. Where relevant, please explain any pre-existing relationship between the researcher(s) and the researched (e.g. instructor-student, manager-employee, co-workers, etc). Please pay special attention to relationships in which there may be a power differential. Describe any safeguards and procedures to prevent possible undue influence, coercion or inducement.

N/A

5. Does your research project require approvals from other organizations such as school boards, aboriginal communities, local governments, etc? Please describe. What steps will you take (or have taken) to obtain these approvals?

No

6. How long do you expect your research project (contact with human subjects for data collection) to last?

X Less than one year from the date of approval
☐ More than one year from the date of approval (an annual renewal will be needed every year)

Section III: Subjects

1. Briefly describe the number and characteristics of participants required for the study, and how a potential sample of such participants will be identified.

Potential participants will be first, second, and third generation Afghan refugee women, ages 17 and above, residing in Regina. The first generation Afghan women will be identified through the Regina Open Door Society (RODS) and the Regina Community Clinic (RCC). The second and third generation Afghan women will be identified with the help of Afghan Student Club at the University of Regina. The goal of this study is to have
42 participants (7 participants per group). The Regina Community Clinic supports this study and provided a support letter (please see attached).

2. Describe the recruitment procedures. Who will approach potential participants (researcher, assistant or third party) and how (e.g. by phone, mail)?

Participants for this study will be recruited in three ways: (1) the first generation Afghan women will be recruited through the RODS and the RCC. The research outline in native language will be posted at both locations as well as at the Immigrant Women Center (see attachment for the script). Furthermore, the researcher will go into ESL classes at the RODS and invite Afghan women to participate in the focus group discussion after being given information about the general purpose of the study and their roles as participants (see attachment for the script). We believe that it is important for women to see and get to know the principal researcher to feel comfortable to participate in the study. Therefore, the researcher herself will go into the classrooms at the RODS; (2) The second and third generation Afghan women will be recruited through the help of the Afghan Students Club (ASC) at the University of Regina. The ASC will send out emails inviting Afghan women to participate in the study after being given information about the general purpose of the study (see attachment for the script); (3) lastly, the posters outlining the research will be posted at the Afghan Restaurant in Regina.

3. What will the participants be required to do in the course of the project?

The objective of this study is to explore Afghan women’s conceptualisation and understanding of depression. To achieve this objective Afghan women will be asked to describe how they feel when experiencing a personal loss, such as loss of a loved one, loss of a job, or if they are unable to financially help their family back in Afghanistan or neighbouring countries. In the second half of the focus group, participants will be given a vignette (translated into local language for the first generation Afghan women) portraying depression without using technical language (see attached). Participants will be asked about their knowledge and understanding of the causes of such an illness or problem; the symptoms they associate with it; the terms and expressions they use to describe that illness or problem; several questions about what can be done about this illness or problem and where one should seek help.

4. What information about the research project and their role will participants be given during the initial contact?

Participants will be informed about the main purpose of the study, their rights as participants, and confidentiality. Moreover, participants will be made aware that they can withdraw from the study at any time (i.e., by excusing themselves from the focus group or by contacting the researcher after the focus group to decline further participation) and that there are no consequences for withdrawing.

5. Will a consent form be used? If so, when will it be presented (e.g. immediately before interviews take place)?
Consent form (on University of Regina letterhead) will be used immediately before the focus group discussions. Translated version of the consent form (on University of Regina letterhead) will be used with the first generation Afghan women. The interpreter will be briefed about issues of confidentiality before the recruitment and focus group discussions. The researcher and the interpreter will keep participants’ identities confidential.

6. a) Will participants be anonymous in the data gathering phase of the study? (Anonymous means that no link can be established between the participant and the research – no one including the researcher knows who has participated in the research)

X No
☐ Yes, the researcher only
☐ Yes, no one including the researcher knows

b) Will the confidentiality of participants and their data be protected? (Confidentiality means that no link can be established between the collected information and the participant’s identity)

☐ No
☐ Yes

X Yes, with the following limits:

☐ Limits due to the nature of group activities (e.g. focus groups): the researcher cannot guarantee confidentiality

☐ Limits due to context: individual participants could be identified because of the nature or size of the sample or because of their relationship with the researcher.

☐ Limits due to selection: procedures for recruiting or selecting participants may compromise the confidentiality of participants (e.g. participants are referred to the study by a person outside the research team)

☐ Other:

X Yes, with the following limits:

☐ Limits due to the nature of group activities (e.g. focus groups): the researcher cannot guarantee confidentiality

☐ Limits due to context: individual participants could be identified because of the nature or size of the sample or because of their relationship with the researcher.

☐ Limits due to selection: procedures for recruiting or selecting participants may compromise the confidentiality of participants (e.g. participants are referred to the study by a person outside the research team)

☐ Other:

c) What assurances will participants be given and what precautions will be taken regarding the confidentiality of the data or information which they provide in the study?

Participants will be informed that all information will be treated confidentially and that names and identifying information will not be associated with the data. Participants will be reminded of limits to confidentiality in a focus group situation. However, participants
will be asked to respect the privacy of fellow participants and not share the identifying information outside of the group. The participants will be given the name and contact information of the research supervisor, Dr. Angelina Baydala (306-585-4187; Angelina.Baydala@uregina.ca), whom they can contact if they have any questions or concerns.

7. Will children be used as a source of data?

☐ Yes
☐ No

If Yes, indicate how consent will be obtained on their behalf.

8. Describe any apparatus, substance, element of the physical environment or other materials that could cause harm to a participant if a side effect, malfunction, misuse accident or allergic reaction were to occur. If the participant comes into contact with a potentially hazardous apparatus or material, who is responsible for checking defects or malfunctions, and on what schedule will inspections be made? If participants come into contact with some substance that could cause harm, please document your safeguards.

N/A

9. Will deception of any kind be necessary in the project?

☐ Yes
☐ No

If yes, explain why.

10. Describe any debriefing procedures that will be used. (Note that if deception is used, debriefing is necessary).

N/A

11. Will participants be compensated?

☐ Yes
☐ No

If yes, explain how and when they will be compensated and why you think that amount and form of compensation is appropriate.

At the end of the focus group discussion participants will be given $20.00 honorarium for their participation and time. The amount is based on the minimum hourly wage.
Section IV: Access to Data and Findings

1. Who will have access to the original data? (For example co-investigators, students) How will all those who have access to the data be made aware of their responsibilities concerning privacy and confidentiality?

Only researchers (principal investigator and research supervisor) will have access to the data. The researchers are familiar with their responsibilities concerning privacy and confidentiality.

2. How do you anticipate disseminating your research results?

a) Directly to participants, describe how (e.g. website location of findings, location of published study, etc)

b) Check all others that apply:

X Thesis/Dissertation/class presentation

☐ Media (e.g. newspaper, radio, TV)

X Presentations at scholarly meetings

X Published article, chapter or book

☐ Internet

X Other, explain:

A summary report will be prepared and distributed to Regina Open Door Society and Regina Community Clinic. Moreover, the findings of this research will be shared with physicians, general practitioners, nurses, clinicians, and counselors through presentations and seminars. Moreover, participants will be notified that they can review the transcription of the discussion for accuracy and a summary report will be given after the completion of the study.

3. Describe your plans for protecting data as well as preserving or destroying data after the research is completed. For all data (e.g. paper records, audio or visual recordings, electronic recordings), indicate the:

a) means and location of storage (e.g. a locked filing cabinet, password protected computer files)

b) time duration of storage. (REB requires that data be archived for a minimum of three (3) years)

c) final disposition (archive, shredding, electronic file deletion)

(See Section IV-3 of the Guidelines)

The data will be kept in locked filing cabinets for a period of three years following the completion of the study, after which they will be shredded.
Research Overview

Currently, one of the fastest growing ethnic groups in Canada is Afghan refugees. According to Statistics Canada (2005), Afghanistan represents the highest percentage of refugees in Canada (i.e., 23%; approximately 38,000 in 2001). Moreover, Afghan refugee women are one of the largest refugee populations in the world. In the United States and Canada, they deal with many losses, such as loss of family members, property, and status and cultural, familial, religious roles. In addition, they struggle with generational conflict in making the transition from a traditional patriarchal society to a more egalitarian postindustrial society (Lipson et al., 1995). Due to the complete uprooting from family and homeland, resettlement in an unfamiliar land, and years of unrest in Afghanistan, Afghan women are exposed to risk factors that could lead to various mental health issues in the host country. In addition to their traumatic pre-migration experiences, Afghan women also encounter a variety of problems, such as language, economic, and occupational problems, and substantial challenges in psychological, family, social, and cultural adjustment to Canada and the United States (Lipson & Omidian, 1992). Although many Afghan women are doing well, many others have depression, psychosomatic symptoms, and anxiety disorders, such as PTSD (1992).

Afghan refugee women fled their country because they were either victims of violence or were politically endangered (Lipson, 1991). Review of the literature revealed that to date, studies conducted by Miller (2006) and Omidian (1996) are the only studies that identified culturally specific terms used by Afghan people to describe distress. However, neither of the studies explored these terms in relation to depression. Because of the paucity of research on Afghan refugee women and their experiences with depression there is a need for qualitative research that will explore their unique culture and their understanding of mental health and mental health care. Thus, the purpose of this study is to explore Afghan women’ narrations of depression. Particularly, this research will seek to understand why and how symptoms of depression are developed and expressed, reasons for depression, the impact depression has on the lives of depressed people, and strategies used to cope with depression. The specific aims of the study are to explore first, second, and third generation Afghan immigrant and refugee women’s conceptualisation of depression and their help-seeking behavior. By exploring three generations this research aims at looking at: (1) whether there are differences in symptom presentation among generations; (2) how and when the changes in symptom presentation have occurred and (3) whether help-seeking behaviours have changed among the generations.

Methodology

First and second generation Afghan refugee and immigrant women, ages 17 and above, will be recruited for this study. This study will be conducted at the Regina Open Door Society (RODS) and Regina Community Clinic (RCC) or at a location of participants’ choice. The first generation Afghan women will be recruited from the RODS and RCC. The research outline in native language will be posted at both locations as well as at the Immigrant Women Center. Furthermore, the researcher will go into ESL classes at the RODS and invite Afghan women to participate in the focus group discussion after being given information about the general purpose of the study and their roles as participants. The second and third generation Afghan women will be recruited through the help of the Afghan Students Club (ASC) at the University of Regina. The ASC will send out emails inviting Afghan women to participate in the study after being
given information about the general purpose of the study. Moreover, the posters outlining the research will be posted at the Afghan Restaurant in Regina.

**Focus groups**

Focus groups and individual interviews will be conducted. Each discussion will be approximately two hours and will be audio recorded with participants’ permission. Discussions with first-generation Afghan women will be conducted with a female interpreter. The interpreter will sign a confidentiality form prior to the focus group. At the beginning of the discussion participants will be given a consent form to review. Before signing the consent form participants will be informed about their rights to withdraw from the study at any point during the discussion. They will be also notified that they are free not to answer any questions that they do not feel comfortable answering. Participants will be informed that all information will be treated confidential and that their names and identifying information will not be associated with the data. Moreover, participants will be asked to respect the privacy of fellow participants and not share the identifying information outside of the group. Lastly, participants will be notified that they can review the transcription of their discussion for accuracy. For participants who do not speak English all transcriptions will be translated into local language. At the end of the discussions, participants will be offered an honourarium of $20 for their time and effort.

**Data Analysis**

The discussions will be audio taped and transcribed verbatim by the principal investigator immediately after. Moreover, after each discussion the researcher will document observations, reflections, and personal reactions or any emotions that may arise during the discussions in a field book. This documentation will allow me to keep a self-reflective account regarding how I am affected by this experience and will become part of the data analysis (Corbin & Strauss, 2008).

The discussions will be analysed using a grounded theory approach to identify common themes across participants’ accounts (Corbin & Strauss, 2008). Coding will be done manually through organizing interview text into codes and themes. The coding process that will be used in this study will be line-by-line coding that will prompt me to remain open to the data and to see nuances in it. Moreover, this coding method will allow me to gain a close look at what participants say and maybe even what they struggle with (Charmaz, 2006).

**Implications**

The findings of this research will provide insight into the concepts of depression in Afghan women. Emotional expression and its related variables in a society can share many features with other cultures yet at the same time show distinctive features (Kaiser, Katz, & Shaw, 1998). Thus, it is important to understand the cultural context in which words and terms are used to express depression both as an emotion and as a disease or syndrome. The identification of culturally distinctive features of depression will help to pave the way for sensitive clinical inquiry and the effective delivery of therapy for Afghan women. Not only will our findings have implications for the design and delivery of culturally sensitive services, they will allow us to explore the appropriateness of Western models of diagnosis and symptom management which may suggest a number of directions for the development of innovative approaches to treatment for Afghan women. Furthermore, the findings of this study may be used in developing culturally sensitive instruments for assessment of depression with Afghan women.
Appendix C

The Vignette
For the past two weeks Delbar had felt that something was wrong with her. She complained of different troubles at different times; troubles such as headaches, pains in the stomach, general weakness of the body, difficulty breathing and tiredness. She couldn’t do her work as well as she usually could. Often during the day her eyes filled with tears, and she felt intense sadness. Her close friends and relatives couldn’t cheer her up. She found it difficult to fall asleep and she lost her appetite (Wig et al., 1980; Karasz, 2005).

Questions for Vignette:
1. What is the distress and difficulties?
2. What could be the cause of this distress and difficulties?
3. How might she recover from this distress or difficulties?
Appendix D

Focus Group Consent Form

Consent Form

**Title**: The Cultural Shaping of Depression: A Qualitative Investigation into Afghan Women’s Perspectives on Depression

**Researcher**: Shahlo Mustafaeva (principal investigator) and Dr. Angelina Baydala (research supervisor),

**Objectives**: The purpose of this study is to describe Afghan women’s understandings of sadness and related difficulties or problems.

**Role of the Participants**: You are being asked to participate in a focus group discussion that will last approximately two hours. At the beginning of the focus group you will be asked to describe how you feel when experiencing a personal loss, such as loss of a loved one, loss of a job, or when unable to financially help family back in Afghanistan or neighboring countries.

In the second half of the focus group, you will be given a brief story portraying a person experiencing distress (see attached). You will be asked about your understanding of such difficulties; related problems; terms traditionally used to describe such problems; what can be done, how one moves through such difficulties, and where one should seek help.

**Potential Benefits**: At the end of the focus group discussion you will be given $20.00 honorarium for your time and participation.

**Potential Risks and Discomfort**: There are no known expected discomforts or risks involved in the study. However, it may be emotionally difficult to speak on these topics. If you require any counseling after the focus groups please contact the Regina Mental Health at (306) 766-7800 or the Regina Community Clinic at (306) 543-7880.

**Confidentiality of the Data**: With your permission, the interviews will be taped with a cassette recorder. The contents of the tape will be transcribed and your name or any identifying information will never be recorded with your answers. The transcripts and audio tapes will be kept in locked filing cabinets for a period of not less than three years following the completion of the study, after which they will be shredded. No identifying information will appear on any of the documentation used in the study.
Confidentiality and Anonymity of the Participants: We cannot guarantee your confidentiality or anonymity. However we ask that you please not identify any other individuals by name or speak your name or identifying information if you do not want it used and keep comments made during the focus group discussion confidential. If you inadvertently say something that you do not want to appear in the records, please say so.

Withdrawal from the Study: Your decision to participate in this research is completely voluntary. You are free to withdraw your consent at any time. If you have any reservations at all about participating in this research process, please feel free to leave the study by excusing yourself from the focus group or by contacting the researcher after the focus group to decline further participation. Contact information for the researchers is provided below. There are no consequences for withdrawing. Furthermore, you are free to refrain from answering any questions during the focus group or at follow-up.

This project was approved by the Research Ethics Board, University of Regina. If research subjects have any questions or concerns about their rights or treatment as a research participant, they may contact the Chair of the Research Ethics Board at 585-4775 or by e-mail: research.ethics@uregina.ca

I have read the above information and understand it.

Your signature indicates that you (1) understand the scope of this study, and (2) having read the above information you are willing to participate in this study.

Participant's Signature                                           Date

Researcher's Signature                                            Date

I have received a copy of the informed consent form: _______ (Initials)

Research Team:

Dr. Angelina Baydala                                                  Shahlo Mustafaeva, MA
Department of Psychology                                             Department of Psychology
University of Regina                                                   University of Regina
Regina, SK, S4S4P1                                                   Regina, SK, Canada, S4S 0A2
Tel.: (306) 585-4187                                               Tel.: (306) 502-5795
E-mail: Angelina.Baydala@uregina.ca                                   E-mail: mustafsh@uregina.ca
Appendix E

Individual Interview Consent Form

**Title:** The Cultural Shaping of Depression: A Qualitative Investigation into Afghan Women’s Perspectives on Depression

**Researcher:** Shahlo Mustafaeva (principal investigator) and Dr. Angelina Baydala (research supervisor),

**Objectives:** The purpose of this study is to describe Afghan women’s understandings of sadness and related difficulties or problems.

**Role of the Participants:** You are being asked to participate in an individual interview that will last approximately an hour. At the beginning of the interview you will be asked to describe how you feel when experiencing a personal loss, such as loss of a loved one, loss of a job, or when unable to financially help family back in Afghanistan or neighboring countries.

In the second half of the interview, you will be given a brief story portraying a person experiencing distress (see attached). You will be asked about your understanding of such difficulties; related problems; terms traditionally used to describe such problems; what can be done, how one moves through such difficulties, and where one should seek help.

**Potential Benefits:** At the end of the interview you will be given $20.00 honorarium for your time and participation.

**Potential Risks and Discomfort:** There are no known expected discomforts or risks involved in the study. However, it may be emotionally difficult to speak on these topics. If you require any counseling after the focus groups please contact the Regina Mental Health at (306) 766-7800 or the Regina Community Clinic at (306) 543-7880.

**Confidentiality of the Data:** With your permission, the interviews will be taped with a cassette recorder. The contents of the tape will be transcribed and your name or any identifying information will never be recorded with your answers. The transcripts and audio tapes will be kept in locked filing cabinets for a period of not less than three years following the completion of the study, after which they will be shredded. No identifying information will appear on any of the documentation used in the study.
Confidentiality and Anonymity of the Participants: We cannot guarantee your confidentiality or anonymity. However we ask that you please not identify any other individuals by name or speak your name or identifying information if you do not want it used and keep comments made during the focus group discussion confidential. If you inadvertently say something that you do not want to appear in the records, please say so.

Withdrawal from the Study: Your decision to participate in this research is completely voluntary. You are free to withdraw your consent at any time. If you have any reservations at all about participating in this research process, please feel free to leave the study by excusing yourself from the focus group or by contacting the researcher after the focus group to decline further participation. Contact information for the researchers is provided below. There are no consequences for withdrawing. Furthermore, you are free to refrain from answering any questions during the focus group or at follow-up.

This project was approved by the Research Ethics Board, University of Regina. If research subjects have any questions or concerns about their rights or treatment as a research participant, they may contact the Chair of the Research Ethics Board at 585-4775 or by e-mail: research.ethics@uregina.ca

I have read the above information and understand it.

Your signature indicates that you (1) understand the scope of this study, and (2) having read the above information you are willing to participate in this study.

______________________________  ________________________
Participant's Signature     Date

______________________________  ________________________
Researcher's Signature    Date

I have received a copy of the informed consent form: ________ (Initials)

Research Team:

Dr. Angelina Baydala
Department of Psychology
University of Regina
Regina, SK, S4S4P1
Tel.: (306) 585-4187
E-mail: Angelina.Baydala@uregina.ca

Shahlo Mustafaeva, MA
Department of Psychology
University of Regina
Regina, SK, Canada, S4S 0A2
Tel.: (306) 502-5795
E-mail: mustafsh@uregina.ca
Table 1

*Table 1*. Characteristics of the two groups of participants.

<table>
<thead>
<tr>
<th></th>
<th>First Generation (N = 8)</th>
<th>Second Generation (N = 11)</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Age</strong></td>
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<td></td>
</tr>
<tr>
<td>Mean age in years</td>
<td>48.9</td>
<td>23.4</td>
</tr>
<tr>
<td>Minimum age</td>
<td>36</td>
<td>18</td>
</tr>
<tr>
<td>Maximum age</td>
<td>64</td>
<td>35</td>
</tr>
<tr>
<td><strong>Marital Status</strong></td>
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<td></td>
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<tr>
<td>Single</td>
<td>7</td>
<td></td>
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<tr>
<td>Married</td>
<td>6</td>
<td>2</td>
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<tr>
<td>Common Law</td>
<td>1</td>
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<tr>
<td>Separated</td>
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<td></td>
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<tr>
<td>Widowed</td>
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<td></td>
</tr>
<tr>
<td>Did not wish to identify</td>
<td>1</td>
<td></td>
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<tr>
<td><strong>Education</strong></td>
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<td></td>
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<td>Grade school</td>
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<td>1</td>
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<tr>
<td>High school</td>
<td>4</td>
<td></td>
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<tr>
<td>Some university</td>
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<td></td>
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<tr>
<td>Bachelor’s degree</td>
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<td></td>
</tr>
<tr>
<td>Other (didn’t wish to identify)</td>
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<td></td>
</tr>
<tr>
<td>No education</td>
<td>2</td>
<td></td>
</tr>
<tr>
<td><strong>Length of Stay in Canada</strong></td>
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<td></td>
</tr>
<tr>
<td>Mean in years</td>
<td>7</td>
<td>9.8</td>
</tr>
<tr>
<td>Minimum</td>
<td>6</td>
<td>3</td>
</tr>
<tr>
<td>Maximum</td>
<td>10</td>
<td>15</td>
</tr>
<tr>
<td><strong>Religion</strong></td>
<td></td>
<td></td>
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<tr>
<td>Sunni Muslim</td>
<td>1</td>
<td>4</td>
</tr>
<tr>
<td>Shī’a Muslim</td>
<td>7</td>
<td>5</td>
</tr>
<tr>
<td>Other (identified themselves as spiritual)</td>
<td>2</td>
<td></td>
</tr>
<tr>
<td><strong>Occupation</strong></td>
<td>8 - Homemakers</td>
<td>5 - Student</td>
</tr>
<tr>
<td></td>
<td></td>
<td>1 – Nurse</td>
</tr>
<tr>
<td></td>
<td></td>
<td>1 – Hair Stylist</td>
</tr>
<tr>
<td></td>
<td></td>
<td>1 – Childcare worker</td>
</tr>
<tr>
<td></td>
<td></td>
<td>1 – Teaching assistant</td>
</tr>
<tr>
<td></td>
<td></td>
<td>1 – Administrative worker</td>
</tr>
<tr>
<td></td>
<td></td>
<td>1 – Unemployed</td>
</tr>
</tbody>
</table>
Table 2

Four common themes.

<table>
<thead>
<tr>
<th>Stated causes of depression</th>
<th>First Generation</th>
<th>Second Generation</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Most significant causes</strong></td>
<td>Family members left behind</td>
<td>Financial difficulties</td>
</tr>
<tr>
<td>Fear of loss of cultural heritage</td>
<td>Worrying about family members back home</td>
<td></td>
</tr>
<tr>
<td><strong>Other Causes</strong></td>
<td>Economic strains</td>
<td>Unemployment</td>
</tr>
<tr>
<td>Economic strains</td>
<td>Feeling sad by how much their parents sacrificed for their future</td>
<td></td>
</tr>
<tr>
<td>Different expectation before/after arrival</td>
<td>Adjusting to a new culture</td>
<td></td>
</tr>
<tr>
<td>Inability to speak English</td>
<td>Lack of understanding between 1st and 2nd generations</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Feelings of not belonging in either culture</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Not being able to share their emotions with their parents</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Gender differences</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Coping</th>
<th>First Generation</th>
<th>Second Generation</th>
</tr>
</thead>
<tbody>
<tr>
<td>Getting together with friends</td>
<td>Engaging in various activities (E.g., listening to music, exercising)</td>
<td></td>
</tr>
<tr>
<td>Distraction behaviours: e.g., watching movies</td>
<td>Volunteering</td>
<td></td>
</tr>
<tr>
<td>Crying</td>
<td>Obtaining education</td>
<td></td>
</tr>
<tr>
<td>Praying (some find it helpful, some not)</td>
<td>Seeking professional help</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Recommendations for support</th>
<th>First Generation</th>
<th>Second Generation</th>
</tr>
</thead>
<tbody>
<tr>
<td>Support groups</td>
<td>Support groups</td>
<td></td>
</tr>
<tr>
<td>Immigration services to help with documentation</td>
<td>Educational services about how to use public transportation, bank system, etc</td>
<td></td>
</tr>
<tr>
<td>English classes</td>
<td>Interpretive services</td>
<td></td>
</tr>
</tbody>
</table>