Working with Afghan Sanctuary Seekers:

A guide for mental health professionals

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‘I didn’t know the English word asylum, I never heard it.
Mentally in anxiety, physically you have to sit.
The description of yourself from yesterday is incomplete,
Coming from a dark stage to see a light, your fate is lit’

A poem by Ghaanim, an Afghan who sought sanctuary in the UK many years ago.

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The poem is drawn from an interview on the asylum process and mental health and is part of a poetry anthology. You can read the full anthology here: www.sohailj.com/wp-content/uploads/2022/04/Final-Zine.pdf

Introduction

Given the high rates of mental health problems, the large number of people fleeing Afghanistan, and severe stress of the migration bureaucracy, health professionals urgently need guidance in treating mental ill health in Afghan sanctuary seekers. The British Psychological Society has published guidelines for those working with refugees and asylum seekers, with key recommendations including ‘showing respect’, using ‘professional interpreters’, addressing ‘experiences of racism, hostility and hate crimes’, and ‘recognising the diversity and the resilience of asylum seekers and refugees’ (Patel et al. 2018). This guide supplements these recommendations by providing culturally grounded guidance. Through this cultural knowledge, this guide hopes to support health professionals in talking about and treating mental ill health in Afghan sanctuary seekers.

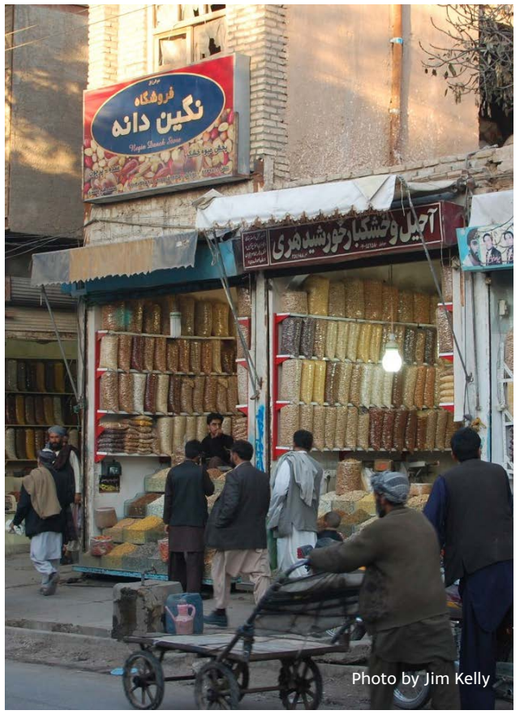

Photo by Jim Kelly

This guide is not a how-to describing every aspect of how Afghan culture influences mental health. Afghanistan is a country of many languages, people’s traditions, religious beliefs, and diaspora connections, and we would need many books to even begin describing them all. Rather, we aim to create a starting point and resource for mental health professionals to think about mental health conversation starters, how to tailor access to mental health for Afghan sanctuary seekers, improving the quality of care after access, considering a range of culturally appropriate treatment options, and identifying mental health difficulties in the first instance. At the heart of this, is encouraging cultural humility in mental health professionals offering counselling, therapy, medication and other forms of treatment to Afghan sanctuary seekers.

This guide is needed because the best people to advise on Afghan mental health are Afghans. Yet, their expertise can often be dismissed by professionals. The guide was written via contributions from an advisory group of people with expertise in Afghan mental health. Most of those in the group are Afghans who have lived in Afghanistan, have worked with Afghans experiencing mental health problems, and have experience of seeking sanctuary in the UK. These individuals represent a diverse range of Afghan organisations and communities. Their experiences were crucial in supplementing the limited literature around culturally specific conditions and symptoms, treatment preferences and more. These individuals were supported by members of the Qualitative Applied Health Research Centre at King’s College London who provided supervision and reviewed work as it progressed.

Developing a background understanding

Afghan sanctuary seekers

The Taliban regained control of Afghanistan in August 2021. Their return to power has seen the number of Afghans leaving the country increase almost exponentially. There were over 200,000 people leaving in the month of July compared to 19,000 in April (UNHCR 2022), and almost 114,000 evacuated by Western countries in the last two weeks of August, including 15,000 by the UK (Reuters 2021). Countries across the world are welcoming Afghan arrivals. For example, neighbouring Tajikistan expects to host 100,000 Afghans, while Canada and the UK have created resettlement schemes with 20,000 places each (UNHCR 2022).

However, in the context of the war in Ukraine, there is a concern that government and NGO support for Afghans may dwindle (e.g. **Manchester Evening News 2022**) and that living circumstances for Afghans in the UK may deteriorate further (e.g. **McLean 2022**). **Chatham House (2022)** suggest that some European countries have a double standard in their approach to Afghan, Syrian and Iraqi refugees versus Ukrainian refugees. For example, in terms of visa free travel, state support and the numbers of people welcomed. Drawing on media coverage and political statements, **Howard et al. (2022)** argue that race is behind these differences. Moreover, the government's plan to send sanctuary seekers arriving by boat to Rwanda has, in our team's experience, already created anxiety and fear among Afghan sanctuary seekers.

Afghans currently have two bespoke resettlement schemes through which they may enter the UK: the **Afghan Citizens' Resettlement Scheme** (ACRS) and the **Afghan Relocation and Assistance Policy** (ARAP). The former was set up in response to the Taliban takeover of Afghanistan in 2021 and prioritises 'those who have stood up for values such as democracy, women's rights, freedom of speech and the rule of law' among others. The latter was set up for Afghans who were employed by the British and may, consequently, be at risk from Taliban reprisals. Applications for resettled Afghans are processed outside of the UK. They are automatically given refugee status and are entitled additional support. This includes English language provision, housing assistance, and mental health support.

Rates of mental ill health

The rate of mental health symptoms among Afghan sanctuary seekers suggests the need for mental health support is likely to be high. In Tehran, Iran, **Dadfar et al. (2015)** conducted psychometric surveys with 453 Afghans. They found that 55% of respondents had symptoms related to anxiety and depression, with insecure immigration status a risk factor. Similarly, **Azizi and colleagues (2005)** spoke to '321 resettled Afghan refugees' in a camp in the Southwest Iran, finding symptoms relating to 'social dysfunction, psychosomatic problem, anxiety and depression in the studied population were 80.1%, 48.9%, 39.3% and 22.1%, respectively' (p1). These high rates continue into Europe. In the Netherlands, **Gernaat and colleagues** worked with 51 Afghans, reporting 65% of participants reported symptoms around psychiatric disorders, 57% around depression, and 35% symptoms around PTSD.

Symptoms of mental ill health in Afghan sanctuary seekers can be linked to post-migration stressors. **Bogic and colleagues (2012)** conducted a narrative synthesis of 'long-term mental health of war-refugees', finding that social support, economic factors, language deficiency and inadequate accommodation were associated with mental health problems. The few studies specifically looking at mental health risk factors in Afghans suggest that acculturation might be important. **Jibeen (2017) conducted a study** with 137 married male Afghan refugees in Pakistan, finding 'that acculturative stress was positively associated with negative affect (0.26, p<.01)' (p148). Similarly, in their field study with Afghans in a refugee camp in Karachi, Pakistan, **Kassam and Nanji (2006)** found that different cultural norms were a source of stress.

Migration processes negatively affect mental health

Migration bureaucracy, such as the asylum process, might also constitute a major mental health risk factor. When someone flees their country, they may enter a safe country and ask for protection based on a well-founded fear of persecution. Asking for this protection is known as asking for asylum. The processes through which a state decides whether someone is deserving of protection is called the asylum process. In the UK, this can include a screening interview, substantive interview, an ever-increasing waiting time for a decision, an appeal to the first tribunal, an appeal to the second tribunal, a judicial review and a fresh claim.

Jannesari (2022) found that Afghan sanctuary seekers felt attacked during their substantive asylum interview. There was an atmosphere of suspicion, and asylum applicants felt that nothing they said would be believed. A few people reported how they felt dazed and distant from reality as officials denied the fundamental truths of their case. Participants also reported that the pressure to recall distressing memories during the interview led sanctuary seekers to feel suffocated and retraumatised. This echoes quantitative Schock et al.'s (2015) findings on the potential link between the asylum interview and onset of posttraumatic symptoms

After the interview, the waiting begins. **Jannesari (2022)** found that Afghan sanctuary seekers felt trapped in an unending cycle of overwhelming bureaucracy, gradually grinding down their will to continue. Interviewees explained how, while waiting, people watched their plans unravel and that the uncertainty attached to waiting was a constant source of stress and even fear. This concurs with research highlighting the mental health effects of the uncertain duration of asylum processes, including feelings of incoherence (**Brekke 2010**), suicide ideation (**e.g., Procter et al. 2018**), and fear of deportation (e.g., **Sourander 2003**).

Afghan participants in Jannesari (2022) described everyday life in the asylum process as one of deprivation and precarity. People had barely enough to survive each day. Deprivation pushed sanctuary seekers into a negative spiral of thoughts that could end in suicide, death, or insanity. Sanctuary seekers were also physically marginalised by deprivation and discrimination, spending time in a few free spaces: libraries, churches, and parks. Many people felt worthless, neglected and humiliated. This emulates research covering the right to work (e.g., **Fleay and Hartly 2016**, **Shishehgar et al. 2015**).


Photo by Masoud Akbari

Initiating mental health conversations

Initiating a conversation about mental health, whether that be with a friend, family member or a healthcare professional, has never been an easy task. Over the last two decades there has been an increased focus on mental health literacy, with the advent of mental health awareness week in 2001 and a stream of programmes working with schools, the military and prison staff. There have been calls for these awareness raising efforts in refugee communities (e.g., Simkhada et al. 2021). Attempts at implementation have often centred on online solutions, including a browser-based intervention with young refugee men in Australia (Nickerson et al. 2020) and a self-help app for Syrian refugees in Germany (Rohr et al. 2021). Notably for this guide, Mind in Harrow undertook the Nedaye Zan project in 2013 (Economic Change 2015). The project's peer group sessions aimed to increase understanding of mental health for Afghan women in a part of London with a high Afghan population. Relatedly, the Refugee Service at the Tavistock Centre used cultural heritage workshops with Afghan families to facilitate 'understanding and knowledge of mental health services' (Hughes 2014).

Barriers to discussing mental health

A barrier to discussing mental health relates to stigma in Afghan diaspora communities (e.g., **Byrow et al.'s 2019 work with refugee men in Australia**). In his work with Iranian and Afghan sanctuary seekers, **Jannesari (2022)** found that mental health problems can be seen as weakness and personal indulgence by established members of the diaspora. An acceptance of mental health problems was seen as an acceptance of a failure in migration and the asylum process. Diaspora stigmatisation of mental health problems was perpetuated by a "pioneering migrants" myth. In this myth, previous generations of migrants made a life for themselves against all odds and with little help from others. More established migrants often described how on arriving in the UK, they were almost instantly helping others, and became pillars of the community.

However, it is important to look beyond stigma when thinking about initiating conversations with Afghan sanctuary seekers. In their work with Bhutanese, Somali and Ethiopian refugees **Shannon et al. (2015)** state that mental health can be difficult to discuss because of a 'history of political repression, fear, the belief that talking does not help, lack of knowledge about mental health, avoidance of symptoms, [and] shame' (p281). Jannesari (2022) suggests that this shame could be linked to family dynamics and cultural expectations of the "perfect son" or "perfect daughter". Iranians and Afghans in his study often hid issues until they escalated beyond the point that they could be kept secret, and there was a cultural fear of severe social sanctions against those who suffered from mental health problems. In Jannesari (2022) and **Anstiss and Ziaian (2010)**, Afghans only discussed mental health with close family or friends.

> **The problem is how badly you need something. If somebody's having almost a mental breakdown, they're probably not going to care too much about the stigma of it - they probably just want to be like, rid of those feelings. When somebody's feeling a little bit uneasy even if they're young for example, they may want to just...hide it a bit, you know. – Shapoor, an Afghan recently granted asylum, from Jannesari (2022)**

Despite potential barriers around stigma, sociopolitical issues and cultural expectations, there are many spaces where Afghans talk about mental health related issues. In their pilot of a mental health intervention in Afghanistan's Nangarhar province, for instance, **van Mierlo (2012)** suggests that men 'were more open and willing to share daily issues than commonly expected' and 'could be approached in the street, or surroundings of a mosque'. Moreover, **Grima (1992)** suggests that in Pashtun women navigate social relationships through stories of grief and suffering. There may be a slight difference in the expression of mental health issues based on gender. In their summary of the literature **Ventevogel and Faiz (2018)** suggest that men might be expected to remain more stoic than women.

There is some evidence to suggest that there is medicalised mental health literacy is limited in Afghanistan among the general population and community health workers (**Sayed 2011**). However, the evidence on mental health literacy among Afghan refugees is mixed and discussions on mental health literacy can veer into victim blaming. **Yaser et al. (2016)** worked with 150 resettled Afghan refugees in Australia, finding that 31% of participants correctly identified a vignette as an example of PTSD, as opposed to 34% of the general population. Moreover, as is explained in this guide, there is an extensive language around mental health in Afghanistan. **Saberi et al. (2021)** did find low levels of literacy in their qualitative work with young Hazara men in Melbourne. They suggest that mothers are key to passing down mental health knowledge, and it may be that unaccompanied minor Afghan refugees may need support with mental health literacy.

Addressing race in mental health conversations

Slewa-Younan et al. (2017) argues that the main task of mental health professionals is to 'bridge the gap between Western biomedical models for mental health care and the knowledge and beliefs of resettled refugee populations' (p10). However, members of our team have worked in Muslim mental health for many years and have seen no evidence of this gap being bridged despite the number of publications by Muslims that explain different cultural beliefs and the limitations of current theoretical models. At a systemic level, this process of "bridging" does not account for the racism that is within the European mental health provision.

The Race and Health Observatory (2022) reports that ethnic minorities experience 'clear inequalities in access to Improving Access to Psychological Therapies [and] Cognitive Behavioural Therapy'. Evidence suggests that Afghan sanctuary seekers frequently make use of GPs (**Gerritsen et al. 2006**), though there can still be barriers to access around language (**Rintoul 2010**). Racial inequalities in accessing services may, therefore, be related to the attitude of GPs to Afghan refugees and other minorities. This resonates with Jannesari's (2022) findings that GPs were not generally well-placed to understand or use the metaphors and language needed to speak about mental health with Iranian and Afghan sanctuary seekers. A few participants also attributed the difficulties of communicating with GPs about mental health to being new to the country and having different concepts of normality. Rintoul (2010), similarly, found that Afghan refugees in Melbourne found that GPs can be reluctant to consult refugee clients due to their 'complex health needs'. Adopting the **Doctors of the World Safe Surgeries** initiative could address some of these issues.

I had a quite recent case where a lady telephoned me… she said she went to the GP and the GP didn't give antidepressants… when I explored the symptoms she had the psychotic symptoms, but she was ashamed to tell the doctor, the GP. I am not blaming the GP: the GP does the assessment based on what the patient says. So yeah, it is one of the examples of the difficulties.
– Tala, an Afghan mental health practitioner in Jannesari (2022)

Bearing witness and acknowledging socio-political struggles can be key to beginning mental health conversations that address the systemic racism of the mental health system. Jannesari (2022) found that Iranian and Afghan sanctuary seekers wanted therapists who actively listened to and empathised with them and were familiar with their circumstances. Part of bearing witness was being listened to and believed, countering experiences with a distrusting Home Office and judgemental diaspora community. It also means giving space to people to counter negative public and political framings of sanctuary seekers as parasites and associated reported feelings of worthlessness. In circumstances where interactions with sanctuary seekers are restricted and their conditions severe, such as in detention, bearing witness might be all a therapist can do (**see Fleay and Brishman 2011**).

Photo by McKay Johnson

[The psychoanalyst] just listened, and sometimes my English was so broken that maybe she didn't understand, but she showed that she understood. She cried with me, she laughed with me. Like this, I felt that there is someone in this world to share my sorrows with.
– Nur, an Afghan diaspora member in Jannesari (2022)

Creative methods can also be a portal into speaking about mental health. For example, **Olszewska (2015)** observed a poetry circle of Afghan refugees in Iran. In the circle, people spoke about their difficult living circumstances and the discrimination they faced. Olszewska describes how people's poetry was 'frequently a personal cry of pain' around depressed moods, suicidal thoughts and mental health treatment. Relatedly, in Jannesari (2022) Iranians and Afghans talked about mental health through metaphor and community-understood imagery. For example, many participants used the weather as a metaphor for their wellbeing difficulties. The weather was used to emphasise the difficult conditions people went through and how the UK could be an unwelcoming land. One participant felt that the process of waiting for an immigration-related appointment was made deliberately uncomfortable, emphasising this through the constant rain and how they ended up soaked. This use of metaphor is not surprising given that one of the most common Persian words for depression, afsordegi, has its roots in the word 'wilted' (**Kaviani and Hamedi 2011**).

Difficulties starting group conversations: a case study from Ramzia Akbari-Noor, an Islamic counsellor working with Afghan evacuees staying in a hotel

I was commissioned to run peer support groups for Afghan evacuees. My understanding was that within the Muslim and Afghan community collective grief is part of the cultural and faith custom that many would be familiar with. However, I soon came to realise that close knit community built within the hotel was not a safe place for many. It seemed with the crisis of the country, everyone was dismayed with each other and all trust at a community level was broken, perhaps as a continuation of the crisis that started in Afghanistan. Many later told me that they did not want to be judged for how they experience their difficulties, as they were consoled with "you should be grateful" and "those left behind have it worse". This trivialised their experiences and people internalised this invalidation. Others were scared that they would add to the grief of others so they wanted to protect their community members from further hurt, while others did not trust that everything would stay in the room. Instead, I started offering one-to-one support. In this context, we were able to establish a safe and open space. This encouraged people to start sharing their experiences which, in turn, enabled them to reframe difficult experiences in a more positive light and remove the stigma attached to mental ill health. I suggest that in circumstances of acute trauma and with more Afghan arrivals, it is useful to begin with one-to-one work.

Symptoms of mental ill health

Cultures can be seen as a system of symbolic meanings that shapes both social reality and personal experience (Kleinman 1978). They not only influence the motivation to seek help but impact how mental illness is experienced and how people describe their symptoms. Eggerman and Panter-Brick (2010) found that, among Afghans residing in Afghanistan, common reactions to life stressors (rooted in social problems) are characterised as irritability and anger, lethargy, agitation, chronic fatigue, headaches, and generalised bodily pain. Miller et al. (2006) found that, in Afghanistan, psychological distress presents as social withdrawal (e.g., self-isolation), somatic distress (e.g., headaches), ruminative sadness (e.g., thinking too much), and stress-induced reactivity (e.g., quarrelling with neighbours and/or family members).

Afghans use a vast array of words to describe mental ill health. An understanding of these terms can help communication between professionals and patients, improving referral and treatment. Table 1 describes common words used by Afghans for mental ill health in Dari. Please be mindful though, that there are many other languages in Afghanistan such Pashto, Hazara, Turkmen, and Tajik.

Table 1: Culturally Relevant Mental Health Terms in Dari

Terminology	Meaning
Afsurdagi	A close equivalent of depression; denotes grief, low mood and sadness. A key symptom might be 'thinking too much' (**Alemi et al. 2015**).
Asabi/ Na-aram	Irritability, anger, emotional instability, concentration difficulties, indecisiveness, and recurrent nightmares as well as many somatic complaints. Miller et al. (2016) describe asabi as 'feeling nervous or highly stressed'. Asabi can manifest in beating oneself. Asabi is associated with the experience of displacement and the chronic poverty of everyday life in a war-torn city. Additionally, Miller et al. (2016) suggest that 'domestic violence and single parenting' are potential triggers for asabi.
Dewana	Literally translated as madness. 'Saying nonsense; being a stranger to yourself… [caused by] difficult living conditions; bad financial situation of the family; war and bereavement; envy of other's good fortune; illness; bad food; lack of follow up for treatment of sickness; unrequited love' (**de Berry et al. 2003, p85**).
Fishar-e-bala and Fishar-e- payin	Literally speaking, these words mean high and low blood pressure. 'However, they are actually unrelated to blood pressure and refer instead to an internal state of emotional pressure and agitation (Fishar-e-bala) or low energy and motivation (Fishar-e-payin)' (Miller et al. 2016, p425).
Gham, Ghamgeen	Low-mood and worry. Alemi et al. (2016) finds this condition is related to an unexplained sadness.
Goshagiry	Sadness, self-isolation, concentration difficulties impacting daily functioning, loneliness, quietness, unsociable and distance from others.
Jigar khuni	Grief and sadness, pain resulting from interpersonal loss or a deeply painful experience, i.e., temporary emotional reaction to an immediate event (e.g., news depicting violence in Afghanistan. 'A form of sadness that includes grief following interpersonal loss but that may also be a reaction to any deeply disappointing or painful experience.' (Miller et al. 2016, p425).
Kamzor	'Yellow/pale colour; feeling weak; dehydrated dry lips; no energy to walk… [caused by not being fresh, not being hopeful' (de Berry et al. 2003, p85)
Khafaghan	The feeling of being strangled. 'Means sadness or sorrow, but, particularly if preceded by an adjective such as ***jawar*** ('very') then refers to a person who has "deep sadness… somatic features are 'constriction of the chest'"' (Ventevogel and Faiz, 2018, p208).
Na-rami, Narahat	Not comfortable, worry. sensitivities to stressors within one's social environment, a heightened sense of insecurity, and mistrust, with symptoms including uncontrollable anger and complaints about feeling naˆraˆhat or uncomfortable, a domain that includes feelings of sadness or gham
Pereshany	'Look ill; look like they have bitterness; withdrawn; look sorrowful; don't laugh; lost in their own thoughts… [caused by] illness; bad economic conditions in the family; thinking about the difficulties of the home; losing a father; envy and jealousy of others who are better off than oneself; no money and dependent on others' (de Berry et al. 2003, p85)
Peryan	'Characterised by pseudo seizures and could be accompanied by a variety of different somatic complaints' - (Ventevogel and Faiz, 2018, p208). This refers to non-epileptic seizures and is similar to conversion disorder.
Tars	Fear. 'Thinking that bad things will happen all the time; mental problems; shocked; wild look of terror; worry… [caused by] witnessing traffic accidents; witnessing mine accidents, fighting; bomb and airplane explosions; darkness; earthquakes; being afraid of your own fears' (de Berry et al. 2003, p85)
Tashwish	Worries about the future such as 'age quickly; teeth fall out; lose weight; always have pain… [caused by] bad financial condition of the family; being alone; losing friends; war' (de Berry et al. 2003, p85).
Wahm	'An unreasonable fear, easily being frightened and frightening dreams.' (Ventevogel and Faiz, 2018, p208)
Waswasa	Obsession. 'Characterised by constant worry including about daily and insignificant issues, thinking a lot, social isolation and repetitive actions.' (Ventevogel and Faiz, 2018, p208)

Understanding somatisation: reflections of Ramzia Akbari-Noor, an Islamic counsellor working with Afghan sanctuary seekers

I have been working with many Afghans who have been evacuated from Afghanistan and are living in hotels. Most of my clients start the therapy session by listing somatic symptoms. I find that a discussion of these symptoms is a useful way to begin understanding the extent and circumstances of people's mental ill health. Offering the opportunity for people to describe their mental health struggles as somatic symptoms is helpful as there is less stigma attached to this. Once somatic complaints have been identified, they can be linked to Afghan mental health terminology, and a conversation can be gradually developed around mental health.

Common symptoms Afghan sanctuary seekers described in sessions were headaches, aches and pain in shoulder blades, knees, neck, lower back. Many were also experiencing heart palpitations, trembling of hands, shortness of breath, a sense of choking, digestive issues, sleeping issues, night terrors, intrusive thoughts, being easily startled and irritated, annoyed, and enraged. Several clients were present at the airport attack in Kabul during the evacuations and related traumatic symptoms were still active in the body of these clients. Many could still feel the vibration in their skin, in their ears and all around them. Body work would be beneficial for these survivors and treatment options should include body and nervous system work as well as conventional methods of expressing such as talking, drawing and painting.

Culturally relevant treatment options

Biomedical mental health treatments are taken up and used by refugee populations to varying extents. Gerritsen et al. (2006), for instance, found that Afghan refugees used medication almost twice as often than Somali refugees in treating mental health issues, though not as much as Iranian refugees. Alemi et al (2016) also found that Afghan refugees in the US highly endorsed medication as a treatment for issues such as depression. Relatedly, in Sweden, **Brendler-Lindqvist et al. (2014)** found that Afghan refugees were four times as likely to be prescribed neuroleptics and antidepressants than refugees from the horn of Africa, and **Irfan (2016)** reported a general compliance with medication among Afghan refugees at a mental health clinic in Pakistan. Some Afghan sanctuary seekers may be resistant to medication however, as it might be associated with torture, for instance from occupying U.S. doctors (**Beck 2014**) or a sign of weakness (Irfan 2016).

Similarly, in their survey with 150, primarily Dari speaking Afghans living in Australia, Yaser (2017) found that participants were positive towards a range of mental health treatments. Yaser reported that physical health treatments around hobbies and exercise were the most popular treatments (rated by 18% and 16% of participants as 'most helpful' respectively), followed by 'psychotherapy focussing on changing thoughts/behaviours' (15%). Reading the Koran or Bible was also chosen by some (6%) as the 'most helpful' form of treatment, though prayer sessions and other traditional therapies were less popular (1% of participants describing them as the 'most helpful' of treatment). All the aforementioned treatments were, however, rated by at least one third of respondents 'helpful' or 'most helpful' suggesting that a combination of treatments, or a selection from a range of treatment options might be useful. Yaser's (2017) survey also suggested that 'shame, humiliation, stigma and fear of gossip within the community… created barriers to help-seeking' regarding mental health issues and participants were keen for confidentiality in their treatment choice, above all else.

This guide strongly advocates for the use of talking therapies with Afghan sanctuary seekers. According to **Herman's (1992) triphasic model of trauma recovery**, which influences the trauma-informed models of charities such as the Helen Bamber Foundation, mental health support should begin with a process of safety and stabilisation. Due to the instability and insecurity of the asylum process it may be difficult to even begin therapy. However, while evidence suggests that both short-term (**Drozdek et al., 2013**) and long-term (**ter Heide and Smid, 2015**) therapy might be slightly less effective during the asylum process compared with after status has been awarded, they still appear to positively affect sanctuary seeker mental health. Drozdek et al. found positive results of group therapy for PTSD when working with refugees from Afghanistan, 'regardless of unstable living conditions'. **Kananian et al. (2020)** found positive improvements to general health with a 'cognitive behavioural therapy plus problem management' intervention in a sample of Afghan refugees that included asylum seekers. **Stenmark et al.'s (2013)** narrative exposure therapy research with Afghans and other groups in Norway, even indicates that certain treatments can be equally effective for people seeking asylum compared to those who have refugee status.

In the UK, Western mental health concepts dominate the treatment options for Afghan sanctuary seekers. However, there are also a wealth of culturally relevant options available, particularly around religion. These include reading, reciting and listening to the Qur'an, prayer and interactions with God, Islamic relaxation, embracing faith and belief systems (see **Ahmed and Amer 2012**, **Skinner 2010**). Islamic counselling has been practiced in the UK since 1996 with the first fully qualified counsellors completing their training in 2001. It has been developed by practitioners such as Sabnum Dharamsi, Rasjid Skinner, Shaykh Fadhlalla Haeri, Abdullah Maynard, and Aliya Haeri, and effectively used with Afghan, Iranian refugees and Somali refugees in the UK (**see Rasool 2015**).

In his work with Afghan refugees, for instance, in the US, Alemi et al. (2016) found that many people managed mental health issues by praying, reciting the Qur'an and seeking help from an imam. These beliefs promoted and acceptance of one's situation, and the idea that current challenges are part of a bigger life plan. Acceptance has been identified as a key part of moving on from traumatic migration experiences such as human trafficking (Jannesari, Paphitis, Damara et al. 2022). Focussing on mental health is an integral part of many types of Islamic belief. For example, **Baasher (2001)**, writing from the University of Khartoum, argues that the Qur'an comments on mental health when giving directives for 'a firm belief… endurance of hardship and resolution of stress'. Sufism, a sect of Islam with a long history and many believers in Afghanistan, includes rituals that are meditation and relaxation exercises that are used by Afghans to manage mental health stressors **(Sayed 2011)**.

"God has willed diseases such as depression on people, and therefore can take them away, so asking God for help is a solution". An Afghan man in Alemi et al. (2016)

Pargament and Lomax's (2013) suggestions around religious sensitivity could be followed. This could include practitioners 'demonstrating an openness to, interest in, and appreciation of religiousness' by speaking about it during therapy or when desired by participants, adopting religiousness as an intervention outcome.

This guide encourages more mental health practitioners to acknowledge and respect cultural beliefs in administering and creating treatment. **Omidian (2012)**, for instance, developed 'a wellness training for teachers at schools in Pakistan for Afghan refugee girls' (p237). This intervention was developed by asking teachers and parents, 'what are Afghans doing right?' in terms of children's mental health. They also attempted to contextualise definitions around wellbeing and resilience into people's everyday lives and Afghan culture. Similarly, Miller et al. (2006) developed the Afghan Symptom Checklist in collaboration with Afghan academics and community members. This scale was partly developed by identifying common elements in community narratives of wellbeing.

As **Groen et al. (2018)** emphasise in their work with Afghan refugees in the Netherlands, mental health treatment must avoid stereotyping people when factoring in cultural identity. There are a large range of cultural characteristics that might affect someone's preference around mental health treatment including 'ethnicity, race, country of origin, language, acculturation, gender, age, sexuality'. Crucially, mental health practitioners should 'use their patients as their primary source in meaningful dialogue' around culture and treatment. Overall, however, we echo Miller et al.'s (2011) conclusions recounting their experiences working in the Afghan city of Kabul, that there is a place for traditional Western psychiatric medications in treatment for certain people, alongside extensive culturally-relevant psychosocial and therapeutic support.

Incorporating Islam into therapy: case study from Ramzia Akbari-Noor, an Islamic counsellor working with Afghan evacuees

Fawzia is a newly arrived Afghan refugee who was evacuated from Afghanistan in the August 2021 crisis. She was referred to treatment in the second month of her stay at a bridging hotel as she disclosed to professionals that she was experiencing suicidal ideation. Fawzia did not understand the concept of counselling, she had never attended counselling sessions and her knowledge of mental health and emotional health was very limited. Initial sessions were used to help her understand what counselling was, how it could support her, the issue of confidentiality and its limits. This allowed her to feel safe in the sessions.

We started reframing Fawsia's perception of what she was experiencing, naming what she was experiencing in her body and allowing her to understand how to manage these experiences. A turning point was when she was alone in the theatre room in hospital and used her faith and prayers to ground herself. As she lay trembling, scared in an alien environment, not knowing if she would make it through, she remembered God, gave herself and her affairs to Him, and trusted that she would be okay. This allowed her to bring the locus of control back to herself and it was something we would come back to over and over again.

Appendix

Guide Methodology

As a starting point, we conducted a literature review that aimed to answer four research questions: 1) What are the common cultural signs and symptoms of mental health problems in Afghan sanctuary seekers; 2) What words to Afghan sanctuary seekers use to describe mental health problems, and what mental health problems do they refer to; 3) What are some ways to initiate conversations and ask about mental health with Afghan sanctuary seekers; and 4) What are some culturally relevant treatment options?

We conducted weekly searchers of Google scholar from July to September 2021 using keywords such as: Afghan, refugee, Afghanistan, mental health, stress, stateless person, war victim and mental disorder. These combinations of keywords and searches resulted in 993 papers to screen through. After full-text screening, 15 papers complied with our inclusion criteria. We also asked for relevant documents from 4 Afghan charities in the UK: Afghanaid, Aryana Aid, Paiwand and the Association of Afghan Healthcare Professionals (AAHPUK). This produced 3 eligible papers. At the same time, we reached out to three healthcare professionals and two senior medical lecturers from Afghanistan and requested printed resources that could aid with our research. Afghanistan's Ministry of Public Health website was also searched for resources in Farsi (Dari) and Pashto. This did not yield any further papers.

After full text screening, 15 papers were included. From the papers used as part of our research, basic information was extracted, such as the title, publication date, authors and organisation. Furthermore, information which assisted with our research question was extracted, such as common signs and symptoms found on Afghan sanctuary seekers and how mental health diseases are described. The data extracted was recorded in an Excel document. This data was supplemented through monthly discussions with the advisory group.

All but two of the studies that this guide draws on were written after 2010, reflecting a sharply increasing interest in the mental health of Afghans as the US invasion of Afghanistan continued. Studies were conducted and led by authors from five countries, USA (8 studies), Australia (7 studies), the UK (2 studies), the Netherlands (2 studies) and Austria (1 study). Overall, studies involved 2,768 participants at a roughly equal gender split. Dari was the primary language used to communicate with participants, present in every study. Pashto, on the other hand, was only used by 3, even though it is the most common language in Afghanistan.

Key references

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'It is the obligation of every person born in a safer room to open the door when someone in danger knocks'

- Dina Nayeri

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