Article

Mental disorder or emotional distress? How psychiatric surveys in Afghanistan ignore the role of gender, culture and context

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Abstract

Over the last decades, mental health surveys in Afghanistan found very high prevalence figures for mental health problems among the Afghans. These epidemiological data suggest that the majority of the Afghan population suffer from a mental disorder such as depression or post-traumatic stress disorder. Such findings are often met with surprise by the Afghans who doubt that most of the people around them would suffer from a psychiatric illness. This paper explores the discrepancy between the findings from surveys using brief symptom-based questionnaires and the lived reality of the Afghan people. The authors argue that the outcomes of such mental health surveys should be interpreted with caution and can be better seen as indicators of 'non-disordered' psychosocial distress rather than as a general mental disorder. To better understand psychosocial wellbeing of the Afghan people, the survey data need to be put into context and have an eye for the cultural and social ecologies in which symptoms are produced. Many symptoms may actually be normal responses to living in difficult circumstances. Moreover, mental health surveys may conflate cultural idioms of distress with mental illness and often do not take into consideration that the Afghan social world is highly gender segregated. Future mental health research in Afghanistan should use contextually appropriate and culturally validated instruments and be complemented by in-depth ethnographic explorations of emotional suffering among Afghans.

Keywords: Afghanistan, gender, idioms of distress, mental health, surveys, validity

KEY IMPLICATIONS FOR PRACTICE

- MHPSS practitioners should critically examine the results of psychiatric epidemiological surveys in humanitarian emergencies.
- Mental health researchers need to go beyond estimating prevalence figures of discrete mental disorders and move towards using dimensional approaches to mental health.
- Qualitative research can provide important insights around cultural idioms of distress that may be gender-specific.

THE PITFALLS OF PSYCHIATRIC EPIDEMIOLOGY IN AFGHANISTAN[1]

In the end of 2002, about a year after the fall of the Taliban, the authors, at that time both working for HealthNet TPO, a non-governmental organization (NGO) implementing health programmes in Afghanistan, were involved in a survey to assess the mental health status of the people in Nangarhar, a province in Eastern Afghanistan (Scholte *et al.*, 2004). Doing epidemiological research in complex humanitarian settings like Afghanistan is extremely challenging. For example, how to take a representative sample of the adult population of an entire province in the country, without reliable statistics, and where most of the population had been displaced at some time – and to do that while the security situation remained precarious? The research team was able to solve these issues by using inventive methodologies for sampling and logistics. But that did not solve the true challenges, which lay outside of the realm of sampling and logistics and have everything to do with the contextual validity of the research instruments that are

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commonly used in surveys like this (Ventevogel, 2005). The main instruments, the Harvard Trauma Questionnaire (HTQ) and the Hopkins Symptom Checklist-25 (HSCL-25), had been carefully translated, back-translated and pilot tested but *not* clinically validated for use in this particular setting. Our request to conduct a cultural validation of the instruments before the research began was not accepted by the funder, who was striving for results as quickly as possible. Using non-validated cut-off points, the study found high symptom rates for depression (36.5%), anxiety (51.8%) and post-traumatic stress disorder (PTSD, 20.4%), with a marked gender difference: odds ratios for women compared to men were 7.3, 12.8 and 5.8, respectively. At the same time, a related study using similar methodology found considerably higher symptom rates for depression (67.7%), anxiety (72.2%) and PTSD (42.1%) again with marked gender differences (Cardozo *et al.*, 2004). Rasekh, Bauer, Manos, and Iacopino (1998), who had conducted an earlier study among women in Afghanistan under the Taliban, utilizing similar research tools, reported even that they found demonstrated evidence of major depression in 97% of the women, and that 86% of the women had significant anxiety symptoms and 42% met diagnostic criteria for PTSD. In 2000, when the Taliban were still in power in most parts of Afghanistan, a study among 724 women estimated the prevalence of depression among women in a Taliban controlled area to be 78%, whereas in a non-Taliban controlled area and a refugee camp in Pakistan, the prevalence was 28% and 73%, respectively. The presence of depression was established through a nine-item yes/no questionnaire, the Primary Care Evaluation of Mental Disorders (PRIME-MD) Screening, which according to the authors is a 'well-validated, highly sensitive instrument for identifying individuals with current and past depression' (Amowitz, Heisler, & Iacopino, 2003). The mentioned validation was however conducted among American patients visiting primary care physicians in the east-coast of the United States (Brody, Hahn, Spitzer, Kroenke, Linzer, & Williams, 1998), which makes one wonder how appropriate this validation actually was.

The results of the survey we were involved in were published in a high-impact medical journal and accompanied by a rather critical editorial that questioned whether the rates reported by Scholte *et al.* (2004) and Cardozo *et al.* (2004) could be interpreted as proxy for prevalence rates of mental disorder. It is worth quoting from this editorial at length:

'The data may not be so useful for determining rates of mental illness and informing clinical or focused interventions. The screening tools used by both studies – the HSCL and HTQ – were not originally designed to distinguish between mental disorder and normal reactions to severe environmental stress. For example, most of the symptoms assessed in the HSCL (loss of appetite, feeling sad, difficulty sleeping, loss of interest and energy) might reasonably be expected in someone who has no income, is experiencing a breakdown of normal environmental and social supports, and has extreme uncertainty about the future. Similarly, the symptoms assessed by the HTQ (such

as nightmares, feeling detached, jumpiness, irritability, and avoidance behavior) could also be expected in someone who is still living in a highly stressful and dangerous environment. With its recent history, continuing instability and unrest, and a devastating drought, Afghanistan is clearly a highly stressful and dangerous environment. Thus, interpretations of the results of these 2 studies must include consideration of whether symptoms reported among the Afghan respondents represent actual psychopathology or a normal response to severely abnormal circumstances.'
(Bolton & Betancourt, 2004, p. 627)

This critique was fundamental but fair, and not unexpected. In fact, the main author of the other Afghan study already gave a veiled reference to this issue in the search for an explanation as to why their study did not find a significant association between trauma events and symptoms of PTSD:

'Extreme poverty and concerns for day-to-day survival caused by economic hardship commonly causes stress. In Afghanistan, socioeconomic factors may have been more important risk factors than traumatic events for PTSD.'
(Cardozo *et al.*, 2004, p. 583)

The critique of Bolton and Betancourt resonated strongly with one of the main lessons Afghanistan taught us: *'Do not underestimate the suffering of the Afghans, and do not overestimate their psychopathology'*. So, when the opportunity arose to do a clinical validation study, we grabbed it with both hands. We took a random sample of 116 Pashto-speaking patients (53 men, 63 women) attending primary healthcare facilities in Eastern Afghanistan and administered them the HSCL-25 and the Self-Reporting Questionnaire (SRQ)-20–an instrument that had been developed by the World Health Organization (1994) as a case finding instrument for detecting common mental disorders in research and clinical practice. Compared with the results of a structured psychiatric interview, both questionnaires had rather modest properties to correctly identify mental disorders with an area under the curve of 0.73 and 0.72, respectively. These study results shed new light on the results of the earlier studies in Afghanistan with the HSCL-25, and we concluded that these may have overestimated the prevalence of mental disorders among women and underestimated the prevalence in men (Ventevogel *et al.*, 2007).

The limited validity of the HSCL-25 among Afghans was later confirmed in research among Afghan refugees in Japan (Ichikawa, Nakahara, & Wakai, 2006). An important finding of our study was that the optimal cut-off points of the questionnaires were different for women than for men. A gender variance in using the SRQ-20 was later also found in a study that compared the SRQ-20 with a locally developed measure for psychological distress, the Afghan symptom checklist (ASCL): whereas the ASCL and SRQ-20 had substantial overlap in construct and external validity, the ASCL captured more variance for women but not for men (Rasmussen, Ventevogel, Sancilio, Eggerman, & Panter-Brick, 2014).

Research in the Netherlands among Afghan refugee women with experiences of sexual violence suggests that

although the women had high scores on symptom-based questionnaires like the HTQ and HSCL-25, the major defining factors for their current suffering and wellbeing were related to their interpersonal and social circumstances (Tankink, 2009). Similarly, in a research in the 1980s among Pashtun women from Pakistan who had migrated to the United Kingdom, the symptoms scores on mental health scales did not capture their mental state adequately because 'neither the social situation nor the shared ideology of respondents' was taken into consideration, whereas these can significantly influence the meaning of symptoms for individuals (Currer, 1986).

THE SOCIAL LIVES OF AN EPIDEMIOLOGICAL SURVEY

In hindsight, the survey in Nangarhar left us with a general feeling of discomfort related to the issue of how to distinguish 'non-disordered distress' from mental disorder. To be fair, the study of Scholte *et al.* (2004) carefully avoided talking about prevalence of mental disorder, but instead used terms such as 'symptom scores' and 'rates of symptoms'. However, that sort of nuance was often lost: the findings of the papers published in the Journal of the American Medical Association (JAMA) (Cardozo *et al.*, 2004; Rasekh *et al.*, 1998; Scholte *et al.*, 2004) were frequently used in the media to make the point that the majority of the Afghan population suffered from mental disorders (Badkhen, 2012). The journalist Hasrat-Nazimi (2012) for example wrote that that 'mental illness is rampant in Afghanistan' and Rasmussen (2015) saw an 'epidemic of mental disorder in Afghanistan'. This not only happened in the popular media, but also in publications such as the Lancet (Ahmad, 2004) and reports from the World Bank (Sayed, 2011). Similarly, policy makers, including various Afghan ministers of public health, have cited these and other studies while stating that the majority of the Afghan population suffers from a mental disorder. For example, Dr Mohamed Amin Fatimie, Minister of Public Health, declared in 2009 that '[. . .] *Surveys conducted by national and international organizations indicate that 66 percent of Afghans are suffering from stress disorders and mental problems*' (IRIN, 2009). His successor as Minister, Dr Sorya Dalil, said in 2010 that '*over 60 percent of Afghans suffer mental health problems*' (AFP News Agency, 2010).

Our Afghan colleagues at the NGO were impressed that we had contributed to a publication in a prestigious medical journal but reacted with disbelief when they realized that the results suggested that most Afghans, particularly women, had a psychiatric disorder. This simply did not resonate with the reality they lived on a daily basis, in which people suffered a lot and were unhappy about the hardships and misery that they continued to face, but also found strength and courage to continue, with many able to thrive and who had certainly not massively fallen mentally sick.[2]

The effects of declaring most Afghans mentally ill has certainly contributed to giving more attention to mental health among policy makers and has highlighted the urgent need for something to be done to strengthen mental health services. In December 2004, a few months after the JAMA studies were published, the new Afghan Minister of Public Health declared in his first policy announcement that mental health issues were his third highest priority to address in the next 5 years (Fatimie, 2004). Of course, it remains unclear whether the Afghan minister really needed these data to make mental health a priority. Whatever the case, the interest of financial donors to invest in Afghan mental health has increased over the years (Epping-Jordan *et al.*, 2015; Missmahl, 2018; Ventevogel, Faiz, & van Mierlo, 2011) and the alarmistic psychiatric epidemiological surveys may have contributed to the growing awareness around mental health care in the international community and among donors.

HOW CAN MENTAL HEALTH EPIDEMIOLOGY IN AFGHANISTAN BE IMPROVED?

In general, the use of brief questionnaires based on self-reported symptoms tend to give inflated prevalence estimates of mental health disorders in post-conflict settings because of the risk of conflating adaptive distress reactions with psychopathology (Rodin & van Ommeren, 2009; Tol, Rees, & Silove, 2013). Studies using instruments with clinical criteria for mental disorders (measuring specific symptom constellations, incorporating duration, severity and function loss) tend to provide much lower prevalence estimates. For example, the World Mental Health Survey Initiative, using a fully structured, lay-administered psychiatric diagnostic interview (the Composite International Diagnostic Interview – CIDI) estimated the prevalence for having any mental disorder in the range from 4.5% (China) to 26.4% (United States) (Demyttenaere *et al.*, 2004). In Afghanistan, the European Commission and the Ministry of Public Health have recently commissioned a nationwide survey to estimate more accurate prevalence estimates, using elements of the CIDI. The results have not yet been published, but we expect the prevalence figures to be significantly lower than those with self-report questionnaires. Although such data will undoubtedly provide a more robust basis for policy making, we do not believe that all problems around cultural and contextual validity will be addressed by using clinical instruments.

The remainder of this article will use results from ethnographic work in Afghanistan to shed light on the importance of cultural and contextual factors in the expression of mental health symptoms in Afghanistan. We will focus on two aspects in particular: (1) gender differences in the expression of emotional distress and (2) the importance of cultural idioms.[3]

THE EMOTIONAL WORLDS OF AFGHAN MEN AND WOMEN

Afghan men and women vary greatly from each other in the way they express emotional wellbeing and distress. To understand this, we need to look deeper into the gendered social world of Afghanistan. The main qualities for Afghan women are '*acceptance, suffering and patience*' (Billaud,

2015, p. 201). Such values are enshrined in tribal customs and provide a context in which women, who otherwise have limited space or agency in the public sphere, can openly and relatively easily express their hardships and emotional pain and find support among each other (van Mierlo, 2012). Ethnographic work among the Pashtun in Pakistan's North-West Frontier Province showed that cultural norms encourage women to publicly express sorrow and grief (*gham*) though culturally prescribed ways of storytelling and lamenting (Grima, 1993). Women gain status and recognition within their female peer group by expressing their suffering, which is regarded the predicament of women (Grima, 1991). According to Grima (1986), suffering and pain constitute the main components of 'feminine honour' for the Pashtun. A well-known Pashto proverb says, '*A woman is born with sorrow, married with sorrow, and will die with sorrow*' (Sanauddin, 2015). Similarly, rural Pashtun women in Afghanistan have a culture of '*storytelling centred around illness and suffering, of shrine visitations and dependence on ta'wiz, an amulet made of verses of the Quran written on a small piece of paper that is sewn inside little pouch of cloth or leather and of alternative healing methods associated with religious beliefs*' (Grima, 2002, p. 39). Being publicly sad is not necessarily something shameful for an Afghan woman and may, in fact, be the only way to mobilize social support and gain access to outside resources.

For men, it is quite the opposite. Masculine honour is centred on prowess and endurance of pain without showing it and rather staying outwardly indifferent to their ills. For Pashtun men, a public display of emotions, such as sadness, fear, jealousy or tenderness, is considered to be a sign of weakness and demonstrates a pitiable lack of self-control (Glatzer, 1998; Lindholm, 1988, p. 233). This does, of course, not imply than Pashtun men do not feel such emotions, but simply that outward expression would be restrained (Lindholm, 1982, pp. 191-192). Perhaps the values ascribed to holding emotions inside and denying their existence to the outside world is to avoid humiliation and shame, and are best illustrated by the following lines of Khushal Khan Khattak, the great 17th century Pashtun warrior-poet:

'*If it is your hope never to be shamed before anyone.*
It is best to keep in your heart even the least affair . . .
Let your heart bleed within itself, if bleed it must.
But keep your secrets well concealed from enemy and friend.'
Kushal Khattak, cited in Lindholm (1996, p. 192)

Khattaks' poem illustrate key characteristics of what it means to be a Pashtun man, which has all to do with *nartob* ('manliness'), the desired qualities of a man who is a 'real' man or a 'manly' man: possessing pride, courage, strength, fearlessness and assertiveness, but also protecting the rights of the weak, supporting the poor, defending women and children, and being able to manage social tensions and conflict.[4] Being a *nar* implies displaying *ghairat*, the aptitude to take effective action when one's honour (*namus* or *izzat*) is being compromised by another person who

shows lack of respect or displays improper public behaviour (Chiovenda, 2015). Leila Suleiman-Khel, who studied the experiences of loss among Afghan and Pakistani young adult Pashtun men in the border region of Afghanistan and Pakistan, noted that the sadness of the men about their interpersonal losses was embedded in larger narratives about loss-experiences related to communal values and strongly felt threats against religion and the Pashtun way of life. In the words of one of her informants,

'*Everybody was sad and fearful about protection of their ghairat. When people were told to leave their communities, their homes were looted by unknown others who are hard to trace. We Pashtuns consider this great beizzati (dishonor) that the privacy of our homes was compromised. This is a great grief to see and experience what happened to our community because we consider the protection of our once-proud community as that of our own family.*' (Suleiman-Khel, 2013, p. 172)

In their seminal work on resilience in Afghanistan, Catherine Panter-Brick and Mark Eggerman demonstrated how cultural concepts such as 'honour', 'family unity' and 'hope' play a significant role in building resilience to adversity (Eggerman & Panter-Brick, 2010; Panter-Brick & Eggerman, 2012; Panter-Brick, Eggerman, Gonzalez, & Safdar, 2009; Panter-Brick, Goodman, Tol, & Eggerman, 2011). However, their work also demonstrates how such cultural values are not just an asset. The very cultural values that may help people survive war and misery can also function as a straight jacket, thwarting individual people's aspirations and freedom. The anthropologist Andrea Chiovenda, in his ethnography on masculinity among Pashtun men in Jalalabad, found

'*Striking evidence for well-established patterns of inner psychological conflict, contradiction and suffering that the men I interviewed underwent as they coped with internalizing the uncompromising standards of behavior and attitude that constituted "being a real Pashtun man".*' (Chiovenda, 2015, p. vii).

The relation of the Afghan men with the shared cultural idioms was often a cause for psychic conflicts related to '*an inner rejection of shared cultural idioms alongside outer conformity to social injunctions*' (Chiovenda, 2015).

This brief and cursory overview of the different ways Pashtun men and women relate to their emotions, and how they are expected to express them, may be sufficient to make clear that the Afghan men and women may be predisposed to answer the questions about emotional states in very different ways.

IDIOMS OF DISTRESS

Apart from these gender-specific attitudes towards expressions of emotional distress, it is important to explore how people in Afghanistan conceptualize mental health issues. In Afghanistan, expressions of psychological distress do not necessarily present themselves in a psychological idiom (Fish & Popal, 2003). For example, Bizouerne (2008), who did research among lactating women in Kabul

in the early post-Taliban years, found that 'not having enough milk' was often a way for mothers to express psychological distress in an acceptable way, and that it was often related to symptoms of maternal depression.

In August and September 2002, my first months in the country, we explored local categories of mental illness among community members in villages around Jalalabad, using rapid qualitative techniques such as 'focus groups discussions' and 'card sorting' (Bolton, 2001; Bolton & Tang, 2004). The most salient idioms were

(1) *Khapgan,* which literally means sadness or sorrow, but, particularly if preceded by an adjective such as *jawar* ('very') then refers to a person who has 'deep sadness' and who always thinks about the bad in life, worries a lot, isolates him or herself, does not eat properly and cannot sleep well; somatic features are 'constriction of the chest', *jegar khonee* ('bleeding liver'), 'heaviness' and stomach problems. These findings are consistent with the 'thick description' of the emotional suffering of an Afghan migrant to the United Kingdom by Khan (2013, p. 521). Her informant describes *khapgan* as 'feeling down', and as qualitatively different from *gham* (sadness) or *takleef* (being hurt, feeling pain). *Khapgan* is more than sadness and connotes frustration and may be expressed through self-recrimination, blame, punishment and hostility.

(2) *Waswasi*, which is characterized by constant worry including about daily and insignificant issues, thinking a lot, social isolation and repetitive actions. For example, if a person with *waswa* travels to the city he is always worried about what might have happened to their family. A related concept is *churti*, with also 'thinking a lot' as central feature. It is accompanied by somatic symptoms such as 'chest tightness' and headache.

(3) *Wahmi,* which is an unreasonable fear, easily being frightened and frightening dreams. The fear is not based on real events but is 'inside the mind of the person' and it hurts him or her a lot. Imagination can temporarily take over from reality: seeing images or hearing strange sounds, like those of birds or dogs, but they are not real. *Wahmi* is thought to be caused by bad events that happened, such as death of family members, or more precise by the sadness caused by these events.

(4) *Peryan*, the more elusive idiom of *peryan* ('being possessed by spirits') is characterized by pseudo seizures and could be accompanied by a variety of different somatic complaints. The concept of *peryan* or *peri* is more or less similar to that of *jinn* in the Arabic world (Sidky, 1990). Most vulnerable for *peryan* attacks are women and children. *Peryan* are attracted to chaos and disorderly behaviour and women who are possessed will often have an assortment of illnesses and difficulties fulfilling the women's role in the household. Possession by *jinn* may thereby, provide legitimacy for behaviour that would otherwise be unacceptable (Anderson, 1985; Tapper, 1991). Tankink and Vysma (2005) found that the

pseudo-seizures that were abundant among the women in Nangarhar were often nominally attributed to *peryan*, had a clear association with family violence – and as such were clear 'idioms of distress'. *Jinn* possession is a widely reported phenomenon in Afghanistan and surrounding countries. In Baluchistan, the Iranian province bordering the Southwest of Afghanistan, a cross-sectional survey among randomly sampled 4129 adults in rural areas, found a prevalence of *jinn* possession syndrome in 1% of the women (Bakhshani, Hosseinbore, & Kianpoor, 2013). Reported symptoms included paralysis and numbness of limbs, altered consciousness, muteness, laughing, crying, unclear speech, and seeing and hearing things that are not real. In Afghanistan's survey by Cardozo*et al.*(2005), 10.8% of women and 7.0% of men reported having had symptoms of *jinn* possession in the last month.

The group around psychologist Ken Miller and anthropologist Patricia Omidian has done important work around Afghan expressions of feeling emotionally unwell. Based on rapid ethnographic methodology, they identified various idioms among Afghans in Kabul, such as *jigar khun* (literally 'bleeding liver', which occurs in the wake of strongly painful event in a person's life, or after chronic stress), *asabi* ('being nervous' or 'being irritable') and 'fishar', an internal state of emotional pressure and/or agitation, or conversely, of very low energy and motivation (Miller *et al.*, 2006; Omidian & Miller, 2006). Earlier qualitative research in Kabul had already documented how children in Kabul used a rich and complex vocabulary for negative emotional states (Berry, Nasiry, Fazili, Hashemi, Farhad, & Hakimi, 2003).[5] The group around Qais Alemi found broadly similar concepts among Dari speaking Afghan refugees in the United States, with some indications that *asabi* as a generic indication of mental unwellbeing can sometimes turn into *gham* or 'unexplained sadness' (Alemi, James, & Montgomery, 2016). People also used the more formal term *afsurdagi* (Dari) to indicate depression. In a more detailed study, again among Afghan refugees in the United States, depression was generally attributed to severe or multiple loss and expressed through *asabi* (irritability), *goshagiry* (self-isolation), *ghamgeen* (sadness) and *jigar khuni* (sadness following interpersonal loss) (Alemi, Weller, Montgomery, & James, 2017). The researchers also asked their respondent what they thought were symptoms and signs of depression and, remarkably, women acknowledged many more phenomena as a being a symptom of depression, including paleness, having a bitter taste in the mouth, dizziness, excessively sweaty palms, laboured breathing, hearing buzzing noises in the ears, experiences of darkness or mist in from of the eyes, indigestion and having cold hands and feet (Alemi *et al.*, 2017).

These Afghan Dari concepts have some overlap with the Farsi idioms of distress used among Iranians, such as *nârâhati* ('being in distress') that may include sadness and grief (*gham o gosseh*) or excessive worry (*ziâdi fekr kardan*) and anxiety (*negarâni*). The word is associated

with the heart (*nârâhati-e qalb*), characterized by pain in the chest and the sensation of the heart being squeezed and with the nervous system (*nârâhati-e a'sâb*), 'distress of the nerves', accompanied by irritability weakness and tiredness (Good, Good, & Moradi, 1985; van Marrewijk, 1997).

The presence of idioms of distress does, of course, not imply the absence of symptoms of PTSD or depression. On the contrary, Miller and Omidian found that symptoms of PTSD were as prevalent as in our research from Nangarhar. But they also found that having experienced traumatic events did not correlate any stronger with PTSD than with depression, anxiety or general distress, as measured by the ASCL, the locally constructed questionnaire that captured Afghan idioms of distress. More importantly, it was found that having PTSD symptoms did not strongly impair social functioning, while having depressive symptoms clearly did so (Miller, Omidian, Rasmussen, Yaqubi, & Daudzai, 2008). The stressful conditions of everyday life in Kabul explained a great deal of the variance in the quality of mental health and psychosocial functioning. Miller *et al.* (2009, p. 233) conclude, therefore, that PTSD had limited clinical utility in Afghanistan, whereas in contrast, depression was a much more useful construct for the people of Kabul: '*What is most salient for Afghans is the profound sadness resulting from experiences of violence, destruction and loss*'. This corresponds quite closely with our experience in Nangarhar. During dozens of trainings of health workers and workshops for community members, we found it hard to explain what PTSD was Afghans did not have a word for it and did not seem to recognize the symptoms of PTSD as belonging together. Depression, on the contrary, was easy to explain as people could relate to it and immediately had words and idioms to express it and knew people who suffered from it. The people in Nangarhar related the deep sadness of depression with a multitude of losses.

Conclusion

This article highlighted various challenges related to psychiatric epidemiology in volatile humanitarian contexts such as Afghanistan. We argue that research with brief symptom-based mainstream psychiatric questionnaires is fraught with difficulties. A major risk of uncritically accepting the estimates of huge prevalence of the mental disorders is to seek reductionist and medical solutions to treat these 'disorders', devoid of context and in ways that make little sense to the persons involved and do not help them to reclaim their lives.[6]

Some of the shortcomings of research with self-report questionnaires can be addressed by using more comprehensive instruments aimed at establishing a clinical diagnosis instead of merely measuring symptoms, devoid of clinical significance. In addition, thorough contextual and cultural adaption and validation of instruments and using words and expressions that 'make sense' to the respondents will assist tapping into salient idioms through which distress is being expressed. Using properly validated clinical instruments would greatly enhance the quality of the outcome data of surveys. But it would not necessarily increase our understanding of what is 'at stake' in the lives of the people we study, nor would it help unravelling the complex web of meanings related to using terms for emotional states. For that we need qualitative approaches that aim to embed individual experiences of suffering and pain within larger narratives of structural violence, armed conflict and sociocultural and economic change. Future mental health research in Afghanistan should therefore include in-depth ethnographic explorations to provide a more holistic and accurate description of the emotional suffering of the Afghan people.

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[1]Sections of this article are based on the unpublished doctoral dissertation of the author (Ventevogel, 2016).

[2]See also the experience of the American Anthropologist James Weir who recorded and analysed the life narratives of men in Kabul. To his surprise, while all had experienced the devastating effects of war including loss of family members and forced displacement, they did not did not see these war-related traumatic events and losses as central to their life stories who instead were strongly defined by events related to injustice or interpersonal conflicts in their daily life (Weir, 2010).

[3]Another major challenge for mental health research Afghanistan is the linguistic diversity in the country. People in different regions of Afghanistan have various ethnic backgrounds. Although most people speak Dari and/or Pashto, the linguistic differences between different parts of the vast and mountainous country are significant (Barfield, 2010; Dupree, 1973 [1980]).

[4]Poetry plays in important role in the life of Afghans. Many Afghans can recite famous poems in Persian or Pashto. Poetry can describe elaborate and complex feelings, including those related to sadness, suffering and loss. The anthropologist Olszewska (2015) describes how for Afghan refugees in Iran, writing poetry had therapeutic effects through releasing their *dard-e daruni* (inner pain) or the *takhliyeh* (emptying, purging) of their turbulent emotions through poetry and that poetry has a strongly gendered dimension.

[5]The research, based on 63 focus group discussions in Dari, documented 17 partially overlapping words an idioms to express negative emotional states: (1) Gham (sorrow), (2) khafaquan (feeling strangled), (3) tashwish (worry), (4) tashwish asaby (worry/mental anxiety), (5) 'shock asaby' (mental shock), (6) kamzory (weakness), (7) tars (fear), (8) pereshany (worry), (9) dewana (madness), (10) rawany taklef (mental illness), (11) khulsu jonoon (dizzy madness), (12) narum (being uncomfortable), (13) tanhayee (loneliness), (14) taklef rohy (social problems), (15) yud awarenda (remembrance), (16) dard-e-nagahani tasagufy (empathetic pain and aches), (17) ochdar (jealousy/resentment) (Berry *et al.*, 2003).

[6]As Missmahl (2018) poignantly states elsewhere in this issue, we need to 'resist the temptation to treat social problems, which are being expressed through mental health symptoms of depression, fear and anxiety as a mental health pathology requiring treatment within the mental health sector'.