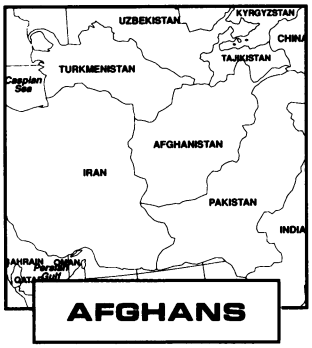
Cross-cultural Medicine
A Decade Later

- **Worldwide, in 1990 Afghans were the largest refugee population, with over 6 million people displaced**
- **Migration has been triggered by 10 years of fighting between pro-Communist forces and *mujahideen* (Freedom Fighters)**
- **Total Afghan population in US is estimated to be at least 100,000**



Health Issues of Afghan Refugees in California

JULIENE G. LIPSON, RN, PhD, *and* PATRICIA A. OMIDIAN, MA,
San Francisco, California

Since the 1979 Soviet invasion of Afghanistan, more than 6 million Afghan refugees have become the world's largest refugee population. Although refugees in Pakistan and Iran are now beginning to repatriate, continuing political turmoil in Afghanistan and children's acculturation and educational opportunities will keep many Afghans in the United States permanently. Although there are no accurate statistics, local resettlement agencies and Afghan community leaders estimate that there are 10,000 to 35,000 Afghans in northern California. They suffer from a variety of problems common to refugees: language, economic and occupational problems, and substantial challenges in psychological, family, social, and cultural adjustment to the United States. Although many Afghans are doing well, many others have depression, psychosomatic symptoms, and posttraumatic stress disorder.

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Migration and subsequent adjustment cause stress, which increases the risk of sickness.[1,2] Stress may be greater in refugees who leave in fear for their lives and have had traumatic escapes. Uprooting is often associated with mental disorders because it disrupts the continuity of a person's self-concept and interrupts meaningful relationships with surroundings.[3] Depression and stress-related symptoms are prevalent. Afghan refugees have had many losses: Relatives were killed or left behind, and the refugees lost their status, language and vocational competencies, and their country, for which they mourn.

The primary problems of one Afghan physician's patients, 75% of whom are Afghan, are depression and psychosomatic illness; their major complaints are headaches and musculoskeletal problems, such as joint and back pain.[4] A 37-year-old woman described her experience as follows:

> From the day I come to this country, I feel terrible pain in my back and right arm. I went to so many doctors. They took x-rays but every time, they told me that everything is OK. I'm so confused. I ask myself, "what kind of doctors are they that they don't know my problem?"

In this article we focus on Afghan refugees in California, basing our discussion on ethnographic research and clinical work with Afghans. Since 1985, we have worked with Afghans in several capacities: consulted with health providers, served as cultural interpreters and advocates, and provided information and health education to Afghans through the Mid-East Study of Immigration, Health, and Adjustment (S.I.H.A. Project), a health resource center for Middle Eastern immigrants in the School of Nursing, University of California, San Francisco.

The ethnographic research on which this article is based includes an interview study from 1985 to 1988 in which 28 Afghans reported 70 ongoing symptoms; psychosomatic indications of stress, elicited by the Health Opinion Survey, were significantly higher than among Latino and Iranian immigrants.[4] Since 1990, one of us (J.G.L.) has focused on health and adjustment issues and access to care; 20 health and social service providers were interviewed, and two research assistants interviewed 62 Afghans in Dari or Pashto. One of us (P.A.O.) did dissertation research on family intergenerational conflict and the adjustment of the elders, for which 60 Afghans from three generations were interviewed.

Afghan Culture

Traditional customs in Afghanistan include arranged marriages, ideally between first cousins, polygyny when affordable (as many as four wives), and a strongly patriarchal family system. Women are less educated than men, do not work outside the home, and interact almost exclusively with female relatives. The most important social unit is the extended family, which averages 50 to 75 people, contained within a tribal unit of 1,000 or more.

Most Afghans are staunch Muslims, with the majority following the Sunni branch. Muslims pray directly to God privately or in a mosque or *jumat* (congregation). They must act in accordance with God's commands as described in the *Qur'an* (Koran); these include rules of cleanliness, diet (avoidance of pork and alcohol), and prayer (five times a day, facing *Kaba,* Mecca).

Although there are 19 ethnic groups in Afghanistan,[5]

From the Department of Mental Health, Community and Administrative Nursing, School of Nursing (Dr Lipson), and the Medical Anthropology Division, Department of Epidemiology and Biostatistics (Ms Omidian), University of California, San Francisco.

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Reprint requests to Juliene G. Lipson, RN, PhD, Associate Professor, Department of Mental Health, Community and Administrative Nursing, Box 0608, School of Nursing, University of California, San Francisco, CA 94143.

most Afghans in the United States are Pushtun and Tajik. The two major languages are Dari (Afghan Farsi) and Pashto. The Afghan population is heterogeneous and divided based on ethnicity, politics, social class, and urban or rural origin. The first Afghans to arrive in California (1980) were the urban, formerly wealthy, and highly educated elite. They were followed by their middle-class relatives who were less educated, with some illiterate in their own language.[6]

Afghan culture in the United States is not homogeneous and is in transition. Families range from traditional to cosmopolitan, depending largely on urban and educational background and personal preference. For example, one traditional family eats only specially butchered meat, maintains strict prayer rituals, and wears traditional clothes outside the house. The wife, however, is educated, drives a car, works with men, and even swims wearing a sweat shirt and pants. One cosmopolitan family wears Western clothes exclusively, eats "fast food," and prays informally rather than ritually, yet the husband does not allow his educated wife to drive. Differences exist even within the same family: one man lets his wife swim in public in a bikini, but his brother says he would divorce his wife if she were to swim at all. Divorce, more difficult in Afghanistan than in the United States, is becoming common here.

Despite such variation, language and cultural dissonance keep most Afghan refugees from socializing with Americans. Socializing almost exclusively with family members leads Americans to conclude that Afghans are uninterested in cohesive community action. Having recently brought their tribal orientation to the United States, there is much distrust between families. When asked why Afghans cluster in specific neighborhoods, an informant said, "We just want to see others like ourselves."

Immigration and Adjustment Issues

Afghan refugees have problems with English, employment, cultural conflict, children's education, and the absence of culturally appropriate health and social services.[4] More than 90% of Afghan families are supported by Aid to Families with Dependent Children. They are unwilling to give up its benefits, particularly Medi-Cal (California's Medicaid) for their large families in exchange for minimum wage jobs with no security. A resettlement counselor complained that Afghans come to California believing that "welfare is a must for making it in this country; they were told what to ask for before arriving by those already here."

Men have depression linked with a loss of status brought on by unemployment and changing family roles.[5,7] The traditional patriarchal role of the husband as the authority and breadwinner is devalued when they are unable or unwilling to obtain employment, especially if their wives take jobs, however menial. Most Afghans are downwardly mobile. Men from middle-class backgrounds are more willing to accept entry-level jobs than are well-educated or upper-class refugees, who frequently do not qualify for the kinds of work they did in Afghanistan—for example, physicians who are unable to pass the licensure examination because of finances, language problems, or outdated medical training. Some occupational problems are cultural, such as absenteeism on Fridays—the Sabbath—to attend the mosque or visit family.

Children learn English quickly and must often act as family spokespersons in relation to community institutions. Adolescent girls in particular are torn between traditional cultural values of modesty and chastity and behaving like their American peers.[4] One father, concerned about his daughter's physical education class, said,

> Our culture says we have to cover the entire body. Especially the swimming part is very insulting. I told the teacher to excuse my daughter from swimming. They ignored my request, which forced me to stop my daughter from taking that class. She was scored F, but deep in my heart I am happier about the F than her exposing her body in public.

Homebound women and elders are socially isolated and lonely. They miss the bustling social life of Afghanistan, which revolved around constant visiting. Here, visiting is constrained by distance, transportation problems, and the faster pace of American life. Older people have the most unhappiness and ill health. Many women and elders speak insufficient English to socialize with American neighbors, but even with English they describe Americans as "smiling and nice, but not friends."

Most women married young in Afghanistan (at 14 to 16 years) and have at least five or six children. They frequently appear older than the US norm for chronologic age: 40-year-old grandmothers have missing teeth or dentures. Coming to the United States separates polygynous families: a third wife feels "stranded" because she cannot go back home and her husband and co-wives cannot come to the United States from Pakistan unless they lie about being "sisters." Women who work face a triple burden of job, homemaker, and family mediator. Women are caught between their husbands' expectations that they behave traditionally and their own desires for more freedom and between their own traditional values and their children's rapid acculturation.

Cultural conflict is central to adjustment difficulties. A key difference between Afghan and American cultures is family interdependence versus individualism. Family life is the core of Afghan culture and psychological well-being. What Western psychiatrists call family "enmeshment" is normal family behavior. Each member is the responsibility of the entire family. Family obligations come before anything else, including the demands of American society. A parent, husband, or older sibling has the right to make demands: One woman described being telephoned by her older sister who was upset and asked her to "come over right away." Lack of transportation and other obligations made it difficult, but she went anyway because "I am younger, I have to obey." A newly arrived woman spent her days cooking and cleaning for her son. She became lonely, however, and insisted that he stay home from work to be with her; he was fired from his job.

Child Protective Services receives calls regarding possible child abuse in Afghan families, stemming from Afghan men's depression, alcohol abuse related to frustration with life in California, or the difference in disciplinary style. A young widow recounted,

> In Afghanistan, we discipline our children to respect their parents and elders, and, if they don't, we punish them; my 12-year-old told her teacher "my mom hits me"; the teacher called the Social Service Department, and they took my children away.

Because of this kind of incident, some Afghan parents have become afraid to discipline their children.

Health Problems in the United States

In 1985, in a medical record review of 59 new Afghan refugees served by the San Francisco General Hospital Medical Center Refugee Clinic, the most frequently diagnosed

conditions were found to be dental caries (41%), dermatologic disorders (39%), intestinal parasites (36%), gastrointestinal disorders (23%), and musculoskeletal pain (joints, back, 12%).[8] After the first year, physical complaints give way to psychological ones.

Motor vehicle injuries, too, are common; traffic accidents occur because of inadequate knowledge of the driving code and a lack of experience with urban driving. In addition, few Afghans wear seat belts. Observations by public health nurses, interpreters, and Afghan community members concur with our impressions of much active tuberculosis, diabetes mellitus, asthma, hypertension, and intestinal parasites. Birth control is a problem, and women do not want Papanicolaou smears and breast examinations.

A community mental health psychiatrist described Afghans as suffering "lots and lots of depression." Afghans themselves comment on the prevalence of "mental problems" in their community: "Afghans are sick because of thinking too much"; "Sadness is the sickness Afghans are faced with"; "They lost everything, members of their family, and the effects will remain forever"; "Whenever I see the good food cooked by my wife, I cannot enjoy it because I wonder whether my brothers and sisters in the refugee camp have enough food to survive"; and "The things they got from Afghanistan—murder, bombs—and the things they got here—children's freedom and not obeying, fear for children's future—all together make them mentally sick."

Posttraumatic Stress Disorder

Posttraumatic stress disorder is common among Afghans and is expressed in nightmares, sleep disorders, somatic complaints, depression, withdrawal, avoidance, loneliness, persecution reactions, apathy, and hopelessness.[9,10] Some refugees were imprisoned in Kabul, sometimes for several years, by the Communist regime. A number of the imprisoned were also tortured[11]: a 40-year-old physician's imprisonment resulted in hands that shake so much that he cannot work. Many escaped the country by walking for weeks over mountains while being shelled by Soviet helicopter gunships. These escapees were malnourished, suffered exposure to freezing weather, observed massive destruction, and experienced injuries and the death of family members along the way. A 50-year-old woman cannot sleep; she spends the night praying and often cries if someone speaks to her. Five years ago, after a missile attack on an apartment building, she picked her way through the scattered parts of 130 shattered bodies and saw a disembodied beating heart and an eyeball stuck to a tree like a leaf.

Health and Illness Beliefs

Afghans are concerned about their health. One woman said, "If you have health, the key to the whole city is in your hand, but if you are sick, what are you going to do with riches?" Most Dari words for health mean "whole," "wholeness," or "completeness."[12] Informants say that health is maintained through good habits: regular exercise, eating fresh food and a balanced diet, staying warm, and getting enough rest. Some illness can be prevented, Afghans believe, by living in accordance with the precepts of Islam, which strongly emphasize personal daily hygiene. One Afghan said, "Afghans are obsessive about cleanliness; we keep our bodies, our houses, and our children clean."

Concepts of purity and impurity are integrated into ideas of health and disease.[12] The ritual of ablution before prayer includes washing hands and arms, feet, face, nose, and inside the throat. If a person urinates, defecates, passes gas, falls asleep, vomits, or bleeds, he or she becomes impure and must wash again. After sexual intercourse, the entire body, head to toe, needs to be washed before the person is fit to pray. Women are prohibited from prayer or fasting during menstruation and must perform a full purification ritual seven days after the cessation of bleeding.

Illness may be interpreted as the will of God and should be "borne with patience and steadfastness as it cleanses one of individual sins, and God will have mercy on a sick person." The meaning of suffering and the purifying effect of illness, however, do not mean that the sick person should avoid treatment. Illness is thought to result from not adhering to the principles of Islam. An older woman who became acutely ill after someone told her that she had inadvertently eaten pizza with pork said, "I was very stupid. It is against Islam to eat pork, it is forbidden to us by our Book (*Qur'an*). If we eat it, it means we are against our religion."

Prayer in general is considered useful for healing, but religious leaders and healers know specific effective verses of the Koran for specific illnesses. Ritual prayer includes the following: *ta'wiz*—verse written on paper that is covered with clean cloth and worn like a necklace by a baby or ill person; *shuist*—verse written on paper that is then soaked in water and the water drunk; and *dudi*—verse written on paper and burned with rue near the patient so that the smoke will ward off evil spirits and kill germs.[12]

Natural Illness

Natural (physical or biologic) illness is caused by things that exist in nature, such as "germs," dirt, cold, or wind. It is believed that people are more vulnerable to colds or flu during the change of seasons.[12] Some Afghans explain that illness is associated with not taking proper care of the body:

> When we eat lamb and rice for lunch, it is not digestible here because we don't have time to walk and exercise after, so the amount of cholesterol goes up and blood pressure goes up, creating the possibility of heart disease.

Traditional Afghan medical beliefs emphasize the humoral concepts of Arabic-Persian medicine, which originated with the Greeks and were carried to Central Asia with the spread of Islam.[12] "Hot" and "cold" are qualities of food, drink, and medicinal herbs, of individual human nature—related to age, sex, and temperament—and of illnesses. Illness results from humoral imbalance and is classified as either hot or cold. Hot illnesses, such as fever or measles, are treated with a diet emphasizing cold foods and medicines; cold illnesses, which include arthritis, malaria, and chickenpox, are treated with hot foods and medicines.[13]

Both traditional and Western biomedical treatments are used. There is no strict hierarchy of resort, and Afghans often use several kinds of treatments at once. Mild natural illnesses are treated with home remedies and dietary means alone, and biomedical care is added for more severe illnesses. In most families there is an older woman who knows how to prepare home remedies: "Medicine that I make by myself from the roots of the bushes I learned from my mother, and now my family learns from me." Home remedies include a variety of herbs, roots, and "bushes" available in Afghan, Iranian, and Indian food stores. Natural illnesses are often also treated by religious means, such as prayer or *ta'wiz*.

Supernatural Illness

Jinns or other supernatural beings can cause illness, as can "the evil eye" or punishment from God. Mentioned in the *Qur'an,* jinns are described as ghosts or spirits. Some are good and some are bad, but people generally do not like them. Epilepsy is an example of an illness caused by a jinn.

The evil eye, *nazar,* is the belief that someone can cause illness or harm by looking at another person. Although it can originate with anyone, a more powerful "gaze" is thought to come from green-eyed, impure, or ill people. *Nazar* can be unintentionally caused by expressing excessive admiration or love for another without remembering to say a preventive phrase, such as "In the name of God." Intentional *nazar* is cast out of jealousy, envy, or enmity and is meant to hurt another person or the person's property.[12] *Nazar*-caused illness is distinguished from other illnesses by its sudden onset. Susceptible people, such as children, beautiful women, or fortunate people, can be protected through charms or amulets, such as blue stones or beads. *Espand* (wild rue) can also be used to prevent *nazar:* "When burned in the fireplace," explained one woman, "*espand* forces the evil spirits out; the sounds of the seeds popping are like the sounds of eyes popping." There are many curing rituals for *nazar,* including some that use eggs, other white substances, prayers, or verses.[12]

Practice Implications

Providing culturally sensitive health care to Afghans is similar to providing care for Middle Eastern immigrants. These groups share the same kinds of expectations and behavior: "doctor shopping," grilling a physician to see if he or she is competent, expecting injections or pills, storing bags of medicines at home to be used for other family members, and missing appointments because of social obligations or lack of transportation, interpreters, or child care. Suggestions for disclosing grave information, using a personal approach, establishing trust through continuity of care, and using cultural interpreters are described elsewhere.[14-16]*

Access to Services

Afghans have poor access to health care in general and few culturally specific services. Language is a barrier, and few health facilities employ Afghan translators. Although most refugees have Medi-Cal, they have difficulty locating physicians who take it. Seeking care is complicated; one Afghan complained that several people are required to "find the doctor who accepts Medi-Cal, make the appointment, translate, give ride to us."

Although most Afghans agree that mental health is a problem in their community, families seek such services only as a last resort. Afghans do not value "talk therapy," preferring a medicine for a "quick cure." Even when culturally sensitive services are available, such as a local Afghan psychotherapist, many Afghans are still loathe to use such services. They are afraid of gossip, losing face, or sharing sensitive "personal" information, such as nearly anything about the family. If the problem is seen as shameful—for some men, this means almost anything that could show "weakness"—both the problem itself and admitting it are difficult. Some Afghans would see Iranian therapists, whose language and culture are sufficiently similar to allow understanding, but most of these therapists do not take Medi-Cal. Whatever the background, Afghans prefer a competent middle-aged and gender-matched therapist, although perceived competency is more important than gender.

Gender and Communication Issues

Because of traditional male-female social restrictions, women patients are more comfortable with women physicians, especially for obstetric and gynecologic concerns. If female health professionals are unavailable, women patients will see male obstetricians and gynecologists recommended by a trusted interpreter or other women. Male physicians, however, should restrict touch to that which is necessary for examination, except for shaking hands, and should be careful to restrict direct eye contact.

Afghans, like Middle Eastern immigrants, have a cultural communication style that is often misinterpreted by American physicians as being devious or insincere. Ritual courtesy is practiced between people of unequal status; this appears as an easy acceptance of medical regimens when it is really simply showing respect.[17] Afghans avoid saying "no" directly and do not like to hear "no" being said to them. Histories are difficult to take "efficiently" from Afghans, who communicate by means of stories.[14] Health care professionals must also deal with the whole family, rather than with just the patient.

In many cases only a family member, often a child, is available to translate. This situation is undesirable because of a lack of vocabulary and the tendency to hold back information because of embarrassment. If there is no one else to translate, it is helpful to first ask the parent, "Do you permit your child to translate?" to give the adult patient some say in a self-esteem–reducing situation.

Health providers should make every effort to secure the help of trained bicultural, bilingual interpreters. Ideally, interpreters should be

- Gender matched to the patient, but if only one is available, a woman is preferable;
- Married;
- Of good reputation;
- Not too young;
- Not "too modern" or "too traditional"; and
- Not identified with a political party, otherwise they might not be trusted with important information.

Remember that interpreters work with three or four languages (medical terminology, English, Dari, Pashto), several accents, and the patient's inadequate knowledge of anatomy. For example, the patient says "I have kidney pain" yet points to his chest or says "liver" when he means "heart." If the interpreter uses the physician's style of short direct questions, an Afghan patient will probably perceive the interpreter as impolite and withhold information; on the other hand, an interpreter who communicates appropriately with Afghans irritates an impatient American health provider.

When working with an interpreter, talk directly to the patient and do not refer to the patient in the third person. Afghans do not like direct personal questions, especially regarding the family, and interpreters know how to phrase questions and get information in a polite, culturally acceptable manner. A public health nurse with 15 years' experience working with refugees comments:

You have to trust your interpreters, they are your lifeline. Tell them the information you want, and trust that they will get it, even if it takes two hours

*See also L. Haffner, "Translation Is Not Enough—Interpreting in a Medical Setting," on pages 255-259 of this issue.

and many stories. Health providers don't understand how different their refugee clients think and behave; they expect to get the information they need right away.

Traditional Health Beliefs and Remedies

Many Afghans, especially men, who are ashamed of believing something old-fashioned, may not admit to traditional beliefs and practices. Physicians should ask about the use of traditional remedies, however, because of possible interactions with prescribed medications or their influence on symptoms. In one case, an herbal concoction used for a cold proved to be a powerful sedative. Because of fear of the "evil eye," health professionals should be careful about compliments, unless they add such statements as "Thanks to God." Afghan patients are reassured by following a statement about the potential for recovery with an expression like "knock wood" or "God willing."

Health Education and Community Support Services

Afghans need health education in relation to emergencies and acute care, such as how to dial 911, basic cardiopulmonary resuscitation, what to do when a child is sick, and how to use a first-aid kit. They also need information on immunizations, reading labels and the correct use of prescription and over-the-counter medicines, poisons, child safety, and basic knowledge of how the body works.

Because many of the symptoms presented by Afghan patients are stress related, health professionals should locate or lobby for community support services for this population. Psychosomatic symptoms of many Afghan women and older persons may be related to their social isolation. A successful project was started through inviting seven unrelated older women to several weekly picnics in a park. The women became friends and now take the initiative for organizing weekly outings, depending on the initiators only for transportation. Striking changes have been observed: one woman was originally so "weak" that she could not get off the couch or raise her teacup to her mouth; recently, she walked three miles around a lake.

In conclusion, physicians should attempt to assess their Afghan patients within the sociocultural context of their lives in the United States, including inquiring about their journey to this country. Past traumatic experiences, cultural conflict, economic problems, family strain, or loneliness may be the key to symptoms for which medication can do little.

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